

THE CASE AGAINST “HEALTH COURTS”

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I. EXECUTIVE SUMMARY

This report evaluates a proposal to replace the current civil justice system for compensating patients who have been injured by medical malpractice with a system called “health courts,” in which claims that were not settled in response to an apology and offer of settlement on behalf of providers would be adjudicated by medically-trained decision-makers employing pre-established guidelines and schedules.

The report concludes that the health court proposal is ill-conceived, that it would be unfair to patients, that it would be unlikely to achieve its objectives, and that such of its goals as are reasonable can be achieved more fairly and with greater efficiency under the existing civil justice system.

Specifically, the report makes the following findings:

1. **The “health court” concept is the latest in a series of proposals over the years to eliminate or drastically reduce the rights of injured patients in order to accomplish various goals.** The health court concept is still emerging, and its details are vague and sometimes inconsistent. (See Sections III & IV.) But the following appear to be its basic components:
 - a. To create a new bureaucracy to adjudicate claims, staffed by medically-trained decision-makers and employing decision-aids created and maintained by the medical establishment.
 - b. To deprive injured patients of their right to a jury trial and thus to eliminate problems thought to be associated with the use of juries.
 - c. To provide an environment that would, it is thought, encourage providers to admit errors and encourage liability insurers to offer limited compensation to a limited class of injured patients.
 - d. To discourage injured patients from obtaining legal representation and thus reduce recoveries by injured patients and, ostensibly, the administrative costs of the system.
 - e. To deprive many patients injured by malpractice of the right to obtain legal redress by creating a tort immunity for smaller claims so that the costs of the new health court system will not explode.
 - f. To compensate a larger number of injured patients but with smaller amounts of compensation than successful claimants would receive under the traditional system.
 - g. To collect information for use in improving patient safety and providing greater guidance to practitioners about appropriate medical practices.
 - h. To finance the new system with higher malpractice insurance premiums and funds diverted from health insurance (mostly paid by employers and employees) and public benefit systems (paid by taxpayers).
2. **The ostensible rationale for health courts—that the existing civil justice system does a poor job—is not supported by the data.** An extensive amount of empirical

data is now available about the functioning of the medical malpractice system and has been carefully analyzed by independent scholars. These analyses show that:

- a. **The civil justice system does a good job of sorting valid from invalid medical malpractice claims.** Numerous studies have revealed a fairly consistent picture. As a mechanism for adjudicating claims, the malpractice system does remarkably well. With surprisingly small rates of error, it separates claims without merit from those with merit and compensates the latter. (See Section V.A.)
- b. **Frivolous lawsuits are not a serious problem.** The available empirical evidence shows that the great majority of malpractice claims are filed against doctors who made medical errors. In addition, the incentive structure for plaintiffs' attorneys assures careful screening of the merit of potential claims before filing. (See Section V.B.)
- c. **Plaintiffs attorneys do not refuse to settle cases.** The data show that an overwhelming majority of medical malpractice lawsuits are settled without trial. Moreover, in most medical malpractice cases that go to trial, the defendants make no settlement offers whatsoever. (See Section V.C.)
- d. **Juries are competent to decide medical malpractice cases.** There is no evidence that juries are incompetent to evaluate the kinds of evidence presented in malpractice cases, including the testimony of expert witnesses. Indeed, jury verdicts on liability are correlated with the judgment of neutral physicians asked to assess the same cases, and damage awards by juries are correlated with the severity of injury. Studies show that jurors, if anything, are predisposed to favor defendant physicians. (See Section V.D.)
- e. **The tort system is not causing serious problems of "defensive medicine" or lack of patient access to care.** Not only is the concept of defensive medicine ill-defined, but there are no reliable data showing that it occurs. Moreover, claims that the malpractice system is causing patients problems of access to care are unsupported. Shortages of doctors do occur but are explained by factors such as rapid population growth in particular parts of the country, a lack of health insurance, and long-standing efforts to restrict the supply of doctors. (See Section V.E.)
- f. **The malpractice system does not prevent the disclosure of errors.** There are no data showing that fear of litigation is driving error reporting underground. In fact, the evidence shows that error reporting does not increase when the risk of litigation is low. (See Section V.F.)
- g. **Weakening the tort system risks reducing, rather than improving, the quality of care.** The available data show that the civil justice system makes a positive contribution to patient safety. (See Section V.G.)
- h. **The somewhat higher administrative costs of the malpractice system, as compared to other tort litigation, are largely due to uncertainty about what constitutes proper medical care.** Measures of the administrative efficiency of the mal-

practice system cited by health court proponents are misleading. The costs of the civil justice system are unfortunately high, but unsurprisingly so. This is due largely to the uncertainty among physicians about what constitutes proper medical care. (See Section V.H.)

- i. **The cost of the medical malpractice system has little impact on the overall cost of health care, physician income, or fluctuations in malpractice premiums.** The costs of the malpractice system comprise less than half of one percent of total health care spending. Even the sharp increases in malpractice insurance premiums during the so-called malpractice insurance crises had only a small effect on overall physician income, and these crises were not caused by the malpractice system. (See Section V.I.)
3. **Health courts would not perform as well as proponents contend.** Health court advocates claim that health courts would yield substantial benefits to all parties. This is extremely unlikely.
 - a. **“Avoidability” holds little promise of being a better standard than “negligence.”** Health court proponents propose to replace the negligence standard for defining compensable injuries with the standard of “avoidability.” In fact, the avoidability standard is imprecise and is defined largely in terms of fault. (See Section VI.A.)
 - b. **The use of “accelerated compensation events” offers a false hope of scientific objectivity.** Health court proponents propose to create a list of scientifically and statistically valid “accelerated compensation events” (ACEs) to identify compensable claims. In fact, ACEs would be based ultimately on the opinions of a group of physicians, and the statistical standard underlying ACEs turns out to be nothing more than an arbitrary determination of probability by these physicians. (See Section VI.B.)
 - c. **Practice guidelines are of limited feasibility and usefulness. Health court proponents’ expectation that claims that were not covered by ACEs would be adjudicated with the use of practice guidelines is fanciful.** As one of the leading health court proponents admits, “[w]e have yet to resolve basic issues such as which set of guidelines is the authoritative prescription for a particular medical problem, what procedures should be used to create guidelines, what institutions, goals, and values should drive their development, and how we can ensure that guidelines are disseminated and adopted by physicians. It would be foolhardy to make [clinical practice guidelines] the centerpiece of malpractice litigation before the science of creating and implementing them on a wide scale has fully evolved.” (See Section VI.C.)
 - d. **It is unlikely that more patients would discover that they had suffered a compensable injury.** A central feature of health court proposals is that providers would disclose avoidable medical injuries to patients, apologize, and offer compensation. Disclosure is key to the professed goals of compensating more patients

and improving patient safety. Yet health court proposals are devoid of effective incentives to induce providers to engage in this behavior. Moreover, a number of features of health courts would discourage disclosure, such as experience-rating malpractice insurance premiums. (See Section VI.D.)

- e. **Physicians who committed errors would still have abundant reasons to fear that stigma and punishment would follow voluntary disclosure.** Not only is the avoidability standard essentially a fault standard in disguise, but the financial and regulatory pressures on hospitals and other institutions can be expected to lead them to take adverse personnel actions against professionals who acknowledge mistakes. (See Section VI.E.)
- f. **There is no reason to believe that health courts would improve patient safety.** A health court system would reduce the deterrent effect of the civil justice system, for example, by withholding from regulatory bodies the identities of physicians who injured patients. Moreover, health court proponents do not provide any plausible reason why a health court system would be any better at identifying and preventing errors than the current system. (See Section VI.F.)
- g. **Health courts would not reduce so-called “defensive medicine.”** There is no reason to believe that ACEs, practice guidelines, or a database of health court decisions would provide more meaningful guidance to practitioners about what constitutes appropriate patient care than what could be available from records of jury verdicts, judgments, and settlements. (See Section VI.G.)
- h. **Health courts would not prevent malpractice insurance “crises.”** Health courts would do nothing to change the insurance industry practices that are responsible for periodic disruptions in the availability or affordability of medical malpractice insurance. In fact, a health court system might exacerbate the volatility of premiums by increasing them significantly in order to finance the new health court bureaucracy and increased compensation costs. (See Section VI.H.)
- i. **A health court system would not be affordable without substantial increases in malpractice premiums or some mix of undesirable consequences.** By making it easier for patients to seek redress and liberalizing the standard for recovery, health courts as proposed have the potential dramatically to increase claim volume and total claim amounts. Health court proponents recognize that their proposals to allow offsets for compensation from collateral sources and to reduce administrative overhead, even if successful, would not prevent substantial rises in total direct system costs and malpractice premiums. Hence, their proposals would entail some combination of (1) dramatic reductions in recoveries to levels well below actual losses, and (2) wholesale tort immunity for a large percentage of claims. (See Section VI.I.)
- j. **The experience with other compensation systems does not demonstrate that health courts would work well.** Other compensation systems that proponents point to as evidence of the benefits of health courts, such as workers’ compensa-

tion and foreign governments’ administrative malpractice systems, do not incorporate all of the problematic features of health courts and do not work as well as proponents maintain. (See Section VI.J.)

4. **Not only would health courts not perform as well as proponents contend, but they would be unfair to patients.** The current malpractice system already disfavors claimants. A health court system would be even more unfair.
 - a. **Liability and compensation decisions would be made by decision-makers biased against patients.** Every aspect of health court adjudication would be controlled by medical or insurance interests, including the selection of judges and expert witnesses and the adoption of standards for liability and damages. At many points there is not even a pretense of even-handedness in the proposals. For example, while the fees for claimants’ attorneys would be severely limited, defendants’ legal expenditures would remain unconstrained. (See Section VII.A.)
 - b. **Providers and insurers would take advantage of patients to settle cases for too little.** It is clear from the models cited by health court proponents that disclosures and apologies would function as part of a system intended to discourage patients from obtaining legal advice and adequate compensation for their injuries. (See Section VII.B.)
 - c. **Successful health court claimants would be under-compensated.** In all likelihood, compensation for lost wages would be limited, there would be little compensation for pain and suffering, and successful claimants nevertheless would be expected to pay their attorneys on a contingent fee basis. Total compensation costs would be artificially suppressed, eliminating the linkage between harm done and compensation paid, in order to suit the preferences of those who would control the health court system. (See Section VII.C.)
 - d. **Statutory “deductibles” would unfairly limit access of injured patients to legal redress.** In order to keep costs from escalating, health courts would be limited by statutory tort immunities, misleadingly called “deductibles” by health care proponents, which would bar otherwise legitimate claims just because they were relatively small, without offering any alternative remedy. They also would arbitrarily limit the recoveries of those who could obtain redress within the health court system. (See Section VII.D.)
 - e. **Health courts would not adequately punish wrongdoers.** Unlike the current system, recoveries under a health court system would not vary according to the degree of provider wrongdoing. A provider who committed an avoidable error would incur no greater liability if this were accompanied by a breach of fiduciary duty to a patient. Reporting to disciplinary bodies would be severely limited or nonexistent. (See Section VII.E.)
 - f. **Patients would be forced into a health court system without being given a meaningful choice.** Patients would not be given the choice of being covered under a health court approach or remaining within the civil justice system. In a

demonstration project, patients at most would be given the option of switching to a provider that did not participate in the demonstration. As a practical matter, patients may not have the ability to change providers. On a more permanent basis, all providers would be likely to participate, eliminating patient choice completely. (See Section VII.F.)

5. **To the extent that health court proposals seek to achieve appropriate goals, these goals can be achieved more fairly and less expensively under the current system.**
 - a. **No rule of law prevents providers under the current system from disclosing errors and apologizing to patients.** An increasing number of health care providers are already adopting this approach, in recognition of their ethical obligations to their patients. (See Section VIII.A.)
 - b. **Nothing but perceived economic self-interest prevents providers and their insurers under the current system from compensating more malpractice victims at lower cost.** By disclosing errors and offering reasonable compensation to injured patients, providers could reduce the costs of paying claims. In place of an expansive new bureaucracy to handle all claims, an optional system could be created to compensate less severe cases. (See Section VIII..B.)
 - c. **The current system might be modified to give more specific guidance to juries and greater predictability to providers.** If appropriate compensation guidelines could be devised (a very big “if”), there is no reason why they could not be provided to help guide jurors under the current system. Similarly, if appropriate practice guidelines or “accelerated compensation events” (ACEs) could be developed, they could be used by practitioners and given some legal effect. In any event, reporting requirements for the National Practitioner Data Bank could be improved without the need to establish a new database. (See Section VIII.C.)
 - d. **The current system might be modified by adopting reasonable regulations relating to recoverable damages.** Changes suggested by health court proponents, such as periodic payment of damages, already have been implemented by many states. Although much depends on the details, these and other changes, if appropriate, could be made in the current system as well. Again, a separate health court system is not necessary to do these things, if they have independent merit. (See Section VIII.D.)
 - e. **The current system’s use of expert witnesses could be improved.** Courts could make greater use of court-appointed experts to supplement experts retained by the parties. This, and other procedural reforms, could ameliorate problems associated with “dueling experts” better than anything presented in health court proposals. (See Section VIII.E.)
 - f. **Under the current system, nothing prevents the use of information regarding errors to improve patient safety.** A standardized error reporting system could be established. Hospitals already have made significant progress in addressing errors. (See Section VIII.F.)

- 6. The constitutionality of health courts is highly questionable.** Health courts violate the right to trial by jury found in the constitutions of 48 states, and, if enacted by Congress, the Seventh Amendment. Health courts deny patients their constitutional rights to open access to courts and to a remedy for their injuries. Health courts do not provide the same quid pro quo that courts have required to uphold the constitutionality of schemes like workers' compensation. Health courts may deny patients equal protection and due process of law.(See Section IX.)

Conclusion. Rather than seriously improving the quality of health care, health courts would create an expensive health court bureaucracy, dominated by the medical and insurance industries, which can be expected to drive down compensation awards to already under-compensated claimants. What we would get from health courts is very modest recoveries, well below full compensation for those who were compensated, including a substantial and unfair reduction in the compensation of those who would recover under the existing tort system; a statutory ban on claims by the vast majority of victims of malpractice; and a shift of significant portions of the burden of malpractice onto taxpayers and those who pay for private health care provision and disability insurance (especially employers and employees). In return for these unequivocally undesirable results, we are promised that there would be an increase in the number of patients who would receive at least some compensation, however minimal, but there are no good reasons to believe this would be so and good reasons to suspect it would not. If there were a substantial increase in the number of patients receiving more than nominal compensation, we could also expect increases in malpractice premiums and efforts to shift even greater portions of the burden of malpractice onto taxpayers, employers, and employees. This "improvement" would be purchased at the cost of blunting the deterrent effect that the tort system now provides. Health court proponents' attack upon the tort system is misguided and their proposal should be abandoned as bad public policy.

II. INTRODUCTION

This report was prepared under a grant from the American Association for Justice Robert L. Habush Endowment to evaluate proposals to replace the traditional tort system for resolving medical malpractice claims with a set of “health courts.” The authors of the report are Maxwell J. Mehlman, Arthur E. Petersilge Professor of Law and Director of the Law-Medicine Center at Case Western Reserve University School of Law, and Professor of Bioethics at Case Western Reserve University School of Medicine; and Dale A. Nance, Professor of Law, Case Western Reserve University School of Law. They wish to express their appreciation for the research assistance of Sarah Blake, JD, and for comments received on drafts presented to Tom Baker, David Hyman, and Neil Vidmar. The content and conclusions of this report are solely those of the authors.

III. THE HISTORY OF THE HEALTH COURT CONCEPT

The health court concept is the latest in a series of proposals over the years to eliminate or drastically reduce the role of the common law in resolving medical malpractice disputes, and it incorporates many of their features. One of the earliest suggestions was to replace judges and juries with an administrative system similar to workers' compensation. In a 1973 article, for example, law professor Clark Havighurst and physician/attorney Laurence Tancredi proposed a scheme they called "medical adversity insurance."¹ A pre-established list of "compensable events" would be created, which would be used by health care providers and insurers to determine when to compensate injured patients,² and by an administrative entity to resolve liability disputes.³ Havighurst and Tancredi described their scheme as a "no-fault" system because, in their opinion, it would dispense with "the expensive process of assigning blame in each case."⁴ In the years to come, the compensable events to be placed on the list would come to be called "designated compensable events" (DCEs), and eventually ACEs, which stands for either "accelerated compensation events" or "avoidable classes of events."⁵

In contrast to Havighurst and Tancredi's call for a no-fault administrative scheme, the American Medical Association in 1989 put forth the idea of a fault-based administrative scheme.⁶ The AMA rejected the no-fault administrative approach on the grounds that either it would be too expensive or it would have to base compensation on a schedule of damages that would be perceived as inadequate.⁷ The AMA recommended employing an "adversarial approach" and retaining the common-law requirements that plaintiffs prove "duty, negligence, causation, and damages," but proposed that claims be tried "by experienced and qualified hearing examiners instead of randomly selected juries."⁸

Another idea that has influenced the development of the health court concept, and is apt to be confused with it, is the creation of "medical courts" exclusively to handle medical malpractice cases. In a "medical court" system, medical malpractice claims would remain within the traditional civil system; however, the claims would be adjudicated by a special court that exclusively handled medical malpractice, and would be heard without a jury.⁹ The judges would either be appointed or elected.¹⁰ The parties would retain their appellate rights within the civil system.¹¹

There also have been repeated calls to reduce the amount of compensation that successful medical malpractice claimants receive, especially for pain and suffering, as well as to decrease payments received by plaintiffs' attorneys. A variety of measures have been adopted by some states, including caps on damages, elimination of joint and several liability, reduction in the period of time allowed to file suit, offsets for amounts received from collateral sources, pretrial screening panels, periodic payments for future losses, and stricter limitations on plaintiff attorneys' contingent fee agreements.¹² At the federal level, Congress has limited contingent fees available for suits against the federal government under the Federal Tort Claims Act,¹³ which includes medical malpractice claims in certain circumstances.¹⁴ On July 28, 2005,

the House of Representatives passed H.R. 5, introduced by Representative Phil Gingrey (R-Ga.), which would have enacted a shorter period of time in which to bring suit and limitations on damages, as well as a provision limiting contingent fees in medical malpractice actions.¹⁵ On March 1, 2006, Representative Shaw E. Clay (R-Fl.) introduced a similar bill, H.R. 4838.¹⁶ In the 2004 presidential campaign, moreover, President Bush called for a \$250,000 cap on non-economic damages in medical malpractice suits.¹⁷

Finally, the health court proposal comes at the time of a major push to reduce the number of adverse medical events. One of the loudest criticisms of the malpractice system is that it fails to prevent medical errors.¹⁸ This criticism was fueled by *To Err is Human*, the 2000 report of the Institute of Medicine of the National Academy of Sciences (IOM), which claimed that medical error costs as much as \$29 billion and causes as many as 98,000 deaths every year in the United States.¹⁹

The main problem, according to the IOM, is that the medical system does not adequately identify mistakes and take steps to prevent them from occurring.²⁰ Instead of conceiving of errors as the product of individual wrongdoing, the IOM believes that errors must be understood as resulting from faulty processes or systems:

Building safety into processes of care is a more effective way to reduce errors than blaming individuals The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. This does not mean that individuals can be careless. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.²¹

Because the principal cause of errors in the IOM's view is the failure of systems to prevent them, error prevention is a matter of "designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing."²² The key is to identify errors when they occur so that their causes can be evaluated and changes to systems can be made to prevent their recurrence. The problem with the current malpractice approach, according to the IOM, is that "[l]iability concerns discourage the surfacing of errors and communication about how to correct them."²³

How can physicians and other health care professionals be encouraged to admit mistakes? In its 2000 report, the IOM recommended adopting a combination of mandatory and confidential voluntary reporting systems.²⁴ These efforts are unlikely to be effective.²⁵ Two years later, the IOM issued another report, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*.²⁶ One of the experiments or "demonstrations" it proposed was a systems-failure approach to medical error called "Provider-Based Early Payments." The proposal adopts a continuous improvement model of quality assurance, which lies at the heart of the systems-failure approach.²⁷

In addition to its systems-failure focus, the IOM plan combines features of a number of other proposals. It recognizes the value of having providers admit and apologize to patients for their mistakes.²⁸ It also incorporates a version of the “early-offer” idea suggested years ago by Jeffrey O’Connell. O’Connell proposed to encourage providers to make early settlement offers by giving them a quid pro quo;²⁹ under the IOM proposal, the quid pro quo would be immunity from tort liability. Settlement offers would be based on compensation schedules similar to those used by state workers’ compensation programs, but tailored to medical rather than workplace injuries.³⁰ All admitted errors would be reported to state officials, who would implement oversight programs that would analyze the reports and develop system-wide measures to prevent the same mistakes from occurring in the future.³¹

The health court concept is an amalgamation of aspects of all of these proposals, as described in Section IV below. It appears to have been put forward originally in a 2002 op-ed piece by Philip K. Howard, founder and chair of Common Good, in which Howard suggested the use of a “special medical court.”³² The health court idea was discussed at a 2003 forum sponsored by the American Enterprise Institute—Brookings Institution Joint Center for Regulatory Studies and Common Good,³³ and fleshed out and lobbied for by Howard in a series of subsequent articles and editorials.³⁴ The Progressive Policy Institute, an organization associated with the centrist/conservative Democratic Leadership Council, also has endorsed health courts.³⁵

Philip K. Howard is a partner in the law firm of Covington & Burling, where he represents corporate clients. He founded Common Good in 2002. His firm biography describes him as “a senior corporate advisor and strategist,” and goes on to state: “Representative clients include KKR and UBS’s M&A Group. He was co-counsel in the Bank of New York takeover of Irving Trust, lead counsel in MetLife’s challenge as a bondholder of the RJR Nabisco buy-out, and represented ex-Salomon CEO John Gutfreund before the SEC.”³⁶ His Common Good biography describes him as his law firm’s “vice-chairman.”³⁷

Howard’s health court proposal stems in part from disdain for lawyers, or more accurately, since Howard himself is a lawyer, disdain for trial lawyers, or rather plaintiffs’ lawyers. He asserts that:

More than 60 percent of the total cost of the malpractice system is consumed by lawyers’ fees and administrative costs. The lawyers portray themselves as a kind of Robin Hood for injured patients, but the modern twist is that they keep most of the money. This trial-lawyer wealth comes in handy politically and, indeed, has become an opiate to one of our political parties. ... Let the lawyers, increasingly isolated by their self-interest, talk about the right to sue. We should talk about the rule of law and how it should support the functioning of a free society.³⁸

It is also clear that the health court proposal is part of a much broader attack on the common-law jury system in general. In an April 17, 2006, op-ed piece entitled “Making Civil Justice Sane,” for example, Howard asks rhetorically: “[I]s civil justice supposed to be a kind of mini-election, where 12 (or six) voters decide, case by case, what’s right and wrong?”³⁹ He adds:

People believe, on the whole accurately, that any aggrieved person can haul another into court over an accident or disagreement and put his claim, in almost any amount, before a jury. Because one jury can’t bind the next, civil justice has become an ad hoc process, without meaningful guidelines or limits. Restoring freedom in social interaction requires a basic shift in the goals of civil justice. Judges must see their role not as referees of a neutral dispute-resolution system but as guardians of reasonable choices, constantly making rulings that draw the boundaries of reasonable dispute.⁴⁰

In short, in Howard’s opinion, the only proper function for the jury, outside of criminal cases, is to resolve factual disputes:

The use of a jury in a particular civil lawsuit should depend on whether the case hinges on a factual dispute—who’s telling the truth, for instance. But in other cases, the judge should decide. If the claim implicates the functioning of society—say, a claim that a seesaw or jungle gym is unreasonably risky—juries can resolve specific factual disputes (using what are known as special interrogatories), but the judge should then rule as a matter of law whether the activity constitutes an unreasonable risk.⁴¹

The goal of transferring the traditional powers of the jury in civil litigation in general to legislatures and judges is reflected in statements by health court supporters who advocate the use of health courts beyond medical malpractice cases. An editorial extolling health courts in the *Washington Examiner* is entitled “Specialized Medical Courts Should Try Complex Cases,” and begins with a lengthy complaint about jury behavior in a products liability case, the Texas Vioxx litigation.⁴² In a Heritage Foundation publication,⁴³ the behavior of the jury in the same products liability case was attacked in an article supporting health courts. The article went on to applaud the behavior of a judge in a silicosis case.⁴⁴

One of the motivations for wanting to diminish the role of juries is the belief that they lack sufficient expertise to correctly decide cases involving complex medical or scientific issues. The Heritage Foundation article states, for example: “Unable to decide between conflicting experts in a complex malpractice case, juries often turn to inappropriate considerations that are irrelevant to the legal questions of causation and the standard of care.”⁴⁵ Similarly, a 2006 article on health courts cites as one of the arguments put forward by proponents that “[special medical malpractice courts] will offer better understanding of the detailed medical facts, which under the cur-

rent adversarial system are poorly understood by lay juries without specialized knowledge."⁴⁶

Health court advocates distrust the ability of judges as well as juries to understand medical issues. A leading proponent of the use of ACEs by health courts, Randall Bovbjerg, states in an article he wrote with Brian Raymond for the Kaiser Permanente organization: "The essence of this proposal is that today's lay juries and judges (mainly state judges, often elected) lack expertise and are too easily swayed by technically irrelevant factors in assessing liability and damages."⁴⁷ The president of the Michigan State Medical Society states:

Today, juries and trial judges without medical or scientific training consider medical issues that are complex and technical, including the key question in most malpractice cases: Did the doctor comply with the appropriate standards of care? ... Special health courts would include judges dedicated solely to addressing health care cases and trained in the issues that they would be facing.⁴⁸

Philip Howard's disdain for juries in civil actions also extends to judges, and he looks to legislatures for help in addressing what he sees as the failures of the judiciary:

Of course, legislatures, not judges, have the ultimate authority for drawing the boundaries of law in our society. So far, though, Congress and the statehouses have treated civil justice as a fight between special interests. Even when passing specific tort reforms, they have ducked responsibility for sorting out the underlying systemic flaws. While legislators cannot crowd into the courtroom to make rulings of reasonableness in a particular case, they can certainly direct judges to take that responsibility, and they can provide appropriate goals and guidelines. Judges need such help: after four decades of letting trial lawyers argue almost anything, they have no idea how to draw the required legal boundaries.⁴⁹

Due to the perceived lack of expertise of common-law judges and juries, advocates analogize health courts to other specialized courts. Howard states, for example, that "[s]pecialized courts are common in such areas as taxes, workers' compensation, labor issues and vaccine liability."⁵⁰ In later statements, he also refers to bankruptcy, admiralty, and drug courts.⁵¹ Common Good general counsel Paul Barringer adds patent and mental health courts.⁵²

The health court idea has been embraced by then Senate Majority Leader Bill Frist. In a July 12, 2004 speech to the National Press Club, in which Frist laid out his plan for transforming the U.S. health care system, he made the following recommendation:

Pass medical liability reform and patient safety legislation to stop the litigation lottery, curb frivolous lawsuits, and reduce medical errors. Ultimately, set up an expert medical court with transparent

decisions, limits on punitive damages, and scheduled compensatory damages to provide rapid relief to truly injured patients (instead of trial lawyers) and hold negligent doctors accountable.⁵³

On April 13, 2005, Representative Mac Thornberry (R-Tex.) introduced H.R. 1546, the “Medical Liability Procedural Reform Act,” to provide grants to states to establish health courts.⁵⁴ (See Appendix A.) On June 29, 2005, Senators Max Baucus (D-Mont.) and Mike Enzi (R-Wyo.) introduced S. 1337, the “Fair and Reliable Medical Justice Act,” to provide grants to states to conduct health court demonstration projects.⁵⁵ (See Appendix B.) On January 17, 2006, H.J. 183 was introduced in the Virginia legislature by Representative Clifford L. Athey Jr. to establish a task force charged with studying the feasibility of a health court system.⁵⁶ Similar bills have been introduced in Alaska (H.B. 396), Maryland (H.B. 1136), and Washington (H.B. 1777).⁵⁷

On January 10, 2006, the Robert Wood Johnson Foundation awarded \$1.5 million to the Harvard School of Public Health and Common Good to design a health court “prototype.”⁵⁸ The Harvard press release states that the purpose of the grant is “to perform further research and consensus-building work needed for demonstration projects of such courts to take place,” and that “researchers will analyze the functioning of administrative systems handling medical injury cases already in place in countries such as Sweden and New Zealand.”⁵⁹ The press release states that the researchers will attempt to provide “definitions for the range of covered injuries, the qualifications for judges and expert witnesses, notice and consent procedures for patients covered by the system, nonlegal mechanisms for resolution of simple claims, standards for liability, procedures for appellate review and a way to integrate the system into patient safety regulation.”⁶⁰ In the spring of 2006, Common Good and researchers at the Harvard School of Public Health released a draft document entitled “Design of a ‘Health Courts’ System Demonstration” and a “Model Medical Injury Act.”

IV. DETAILS OF THE HEALTH COURT PROPOSALS

The 2006 draft document by Common Good and the Harvard School of Public Health entitled "Design of a 'Health Courts' System Demonstration" (hereinafter "Common Good Draft Proposal") lists the following "elements" of the health court proposal:

Trained judges with expertise in adjudicating medical malpractice disputes. These judges would consult with neutral medical experts to determine the standard of care in medical injury cases. Health court judges would issue written rulings of their decisions.

Compensation decisions based on "avoidability," a standard that is broader than negligence but does not approach strict liability. In essence, injuries would be compensated if they could have been avoided if care had been provided according to best practice. This differs from the negligence standard, which focuses on whether care fell below customary practice.

Evidence-based guidelines to aid decisionmaking. Medical experts and key stakeholders would review the best available scientific evidence about how adverse events occur and the extent to which they are preventable, and develop compensability recommendations for health court judges to apply. Clear-cut cases would be fast-tracked for compensation, and efforts would be made to encourage early offers of compensation.

Predictable damages paid to claimants. A schedule of noneconomic damages would specify a range of values for specific kinds of injuries.

Patient safety improvements facilitated by the system. Information from the adjudication process would be made available for root cause analysis, and standard event reporting would facilitate development of preventive practices.⁶¹

A section of this document entitled "Health Courts Proposed Skeleton," dated October 17, 2005, lists the following "core principles":

1. Compensation decisions are made outside the regular court system by trained adjudicators. An explicit record of decision making is kept in order to provide greater clarity in key areas (for example, expected levels of compensation, what constitutes acceptable/optimal care) to improve reliability of decision making.
2. Compensation decisions are based on a standard of care that is broader than the negligence standard, but does not approach strict liability.

3. Compensation criteria are “evidence-based,” in the sense that they are grounded in experts’ interpretations of the leading scientific literature. To the maximum extent feasible, compensation decisions are guided by *ex ante* determinations about the preventability of common medical adverse events made through a process of deliberation and review of scientific evidence involving clinical experts and other key stakeholders. Certain kinds of injuries would be “fast-tracked” for expedited compensation.
4. Guidelines for compensating both economic and noneconomic losses are created for the system and applied to each claim that is judged eligible for compensation. Valuations of noneconomic damages are made using methods that are explicit, rational, and consistent.
5. De-identified information from the adjudication process is made immediately available to caregivers for root cause analysis and development of preventive practice. Information is also extracted from standardized event reporting for epidemiological analysis to understand new prevention strategies.⁶²

As shown by comparing these two lists, the key proponents of the health court plan have yet to formulate a consistent description of its fundamental elements. The “Elements” envisions health court judges consulting with neutral medical experts; the “Core Principles” do not mention this. The “Elements” mentions both fast-tracked compensation for clear-cut cases and encouraging early offers of compensation; the “Core Principles” only talk about fast-tracking. The “Elements” anticipates a compensation schedule for non-economic damages; the “Core Principles” call for guidelines for both economic and non-economic damages. Only the “Elements” version states that information from the health court process will be made available on a “de-identified” basis.

If it is difficult at this time to delineate the basic principles of the health court proposal, it is even more difficult to describe its particulars. The approaches being proposed differ in a number of key respects. Current articulations are vague or include a range of alternatives. The following is an analysis of the differing descriptions of the components of the proposal.

A. What Would the Health Court Process Be?

One version of the health court proposal contemplates an initial, private phase in which hospitals or medical malpractice insurers would determine whether a patient has been injured by an avoidable medical mistake and, if so, orchestrate an apology to the patient and an offer of compensation. This private phase would be followed by an administrative phase in which some type of expert decision-making body would deal with unresolved claims. The Common Good Draft Proposal describes the private phase as follows:

The first level of review would be an internal process at the involved hospital or insurer. This level of review is not intended to be a neutral adjudicatory process, but rather a formal mechanism for encouraging expeditious settlement of claims. A panel of experts convened by the involved hospital or insurer would review the event and, using decision aids and schedules make an early offer of compensation within four weeks. This would be done in concert with disclosure of the event by the caregivers. Counseling for patients would proceed along the lines developed by the insurer COPIC (the “3-Rs” program) in an effort to resolve as many claims [sic] in this early stage.⁶³

The Model Medical Injury Act distributed by Common Good (hereinafter “Model Act”) (see Appendix C) describes a different initial process in which the provider would inform a patient that an avoidable injury had occurred and the patient would file a claim with the provider’s “Medical Professional Liability Claim Review Panel.” Section 4-102 of the Model Act provides:

When a patient experiences a medical adverse event that may be causally connected to health care received, the provider must, within 14 business days of discovery of the adverse event, inform the patient that s/he may have experienced an avoidable medical injury and may be eligible for compensation through the Medical Injury Court process. The provider shall provide a Medical Injury Claim Form to the patient or his/her representative.

The wording is curious in that, read literally, it would require the provider to notify the patient whenever a “medical adverse event” (defined in §6-101 as “an incident in which harm has resulted to a person receiving health care services”) occurred, even if the provider were not aware of it. However, under §4-102(e), a provider would only be penalized if it “failed to disclose information known about the injury” (emphasis added).

Although it does not say so, the Model Act presumably contemplates that the patient would be told to file the claim form with the Medical Professional Liability Claim Review Panel. Using clinical practice guidelines, past written decisions of the health court, standard event reporting data, and ACEs, the panel would determine, by a preponderance of the evidence, if the injury was avoidable (§4-102(d)). If so, then the patient would be entitled to compensation. Either the patient or the provider would have the right to de novo review by the “Medical Injury Court” (§4-102(d)(3)). If the court found that the panel made a “clear error” in the provider’s favor, the provider would have to pay a monetary penalty to the court (§4-103(d)). Either party could request review of the court’s decision by a “Medical Administrative Appellate Court,” in which administrative law judges would apply a “substantial evidence” standard of review (§4-105(a)). A decision of the appellate court could be overturned, presumably by a regular court, only if the decision was arbitrary or capricious (§4-105(a)).

The Progressive Policy Institute (“PPI”) appears to take yet a third approach, although the details are even sketchier. In contrast to the Model Act’s review panels, which would be operated by providers, the PPI describes something it calls a “local health court review board,” located “in or near hospitals,” which would “triage” patient injury claims.⁶⁴ The health court itself would consider cases that were not covered by ACEs or practice guidelines.⁶⁵ Appeals from health court decisions would go to “a dedicated court of medical appeals at the state level.”⁶⁶ Beyond that, a “federal administrative health court” established by the U.S. Department of Health and Human Services would “arbitrate when state health court decisions interpret federal guidelines differently, and are thus contradictory.”⁶⁷ It is not clear what the PPI means by “federal guidelines.” Its publication mentions guidelines listed in the National Guidelines Clearinghouse operated by the Agency for Healthcare Research and Quality, but as the clearinghouse website states, the guidelines it lists are not created by the federal government but instead “are the products of named organizations that are solely responsible for their content.”⁶⁸ The PPI publication also describes an independent commission that would be established by Congress to develop ACEs and a schedule of benefits for health courts.⁶⁹

Finally, a 2004 editorial on health courts in the publication *Contemporary OB/GYN* states that, under a proposal put forward by Senator Frist, “recalcitrant plaintiffs” who refused settlement offers would be held to “a higher burden of proof,” presumably in health court hearings.⁷⁰

B. Would the Health Court Process Be the Exclusive Remedy for Injured Patients?

The Common Good/Harvard School of Public Health Model Act states that the health court process would be the exclusive remedy for patients who sustained injury from a covered health care provider at a participating facility.⁷¹ Moreover, the act defines a “medical professional liability claim” as including, but not limited to, “a claim grounded in negligence, informed consent, breach of contract, misrepresentation or fraud” (§6-101(j)). The definition of a medical professional liability claims goes on to exclude “an action at law for claims of sexual misconduct, wanton or willful acts with intent to harm the patient, criminal offenses, premises liability (for injuries not occurring in connection with health care), product liability against a manufacturer or distributor, or liability for wrongful denial of coverage by a health insurer” (§6-101(j)). Another section of the Model Act, however, states that the health court “shall have jurisdiction over all medical professional liability claims, for which adequate notice of rights has been provided to patients [if provider participation is mandatory] or [where the provider has elected to participate in the Medical Injury Court demonstration project]” (§2-102). This suggests that, if provider participation in a health court system were mandatory, patients might be able to bring actions in traditional courts if they could show that they were not given adequate notice of their rights.

C. Would There Be Any Role for Juries?

As described earlier, Philip K. Howard of Common Good is critical of juries in civil cases generally, and one objective of the health court proposal clearly is to eliminate their function in medical malpractice cases. However, one call for health courts by a professor of economics at the University of Washington would preserve jury trials in “extraordinarily unusual circumstances,” which the professor does not define.⁷² The Republican Policy Committee, on the other hand, would leave the role of juries up to the states:

[T]he health courts will be a part of each state’s own court system, and so some may find it advisable to integrate the new health courts with any existing preference for juries—thereby preserving some sort of role for jurors, but ensuring that the specialized expertise of health court judges is given full effect so that the failures of the current system are corrected.⁷³

D. What Would the Qualifications Be for Becoming a Health Court Judge?

The Fair and Reliable Medical Justice Act, S. 1337, introduced by Senators Baucus and Enzi, calls for judges “with health care expertise who meet applicable State standards for judges.”⁷⁴ The PPI proposal states that health court judges “should have the background and training in science or medicine to enable them to define and interpret standards of care, based on the advice of experts.”⁷⁵ The PPI proposal goes on to state that the judges “could be lawyers, but could also be doctors”⁷⁶ It is not clear if the PPI means that judges who were lawyers also could be physicians, or instead, that judges could be physicians rather than lawyers.⁷⁷

E. How Would Health Court Judges Be Selected?

Health court proponents differ widely on how health court judges would be chosen. Some recommend that they be elected. For example, a professor of economics at the University of Washington maintains that electing health court judges would provide accountability: “If a judge is seen as being biased or just not very good, we can see he doesn’t get re-elected.”⁷⁸ The President of the Pennsylvania Medical Society suggested in 2003 that judges be selected by a “non-partisan panel for their expertise in health care.”⁷⁹

The Progressive Policy Institute recommends that health court judges be appointed by state governors “for long terms (10 years, for example).”⁸⁰

Common Good’s Model Act contains an appendix that describes “sample language for one possible approach to judicial selection.”⁸¹ It calls for health court judges to be chosen by the state governor following a selection process conducted by a “Medical Injury Court Board of Qualifications.” The board of qualifications would be comprised of 12 members, 3 of whom would be appointed by the pres-

ident pro tempore of the state senate; 3 by the senate minority leader; 3 by the speaker of the state house of representatives; and 3 by the minority leader of the state house of representatives.⁸² The Model Act stipulates that 1 of each of the 3 board members appointed by each of these individuals must be an attorney licensed to practice in the state; 1 must be a physician licensed to practice in the state; and 1 must be neither a physician nor a lawyer. Furthermore, during their terms of service, board members may not hold any paid public office or appointment, or hold office in any political party or “organization.”⁸³ The selection process would begin with the board publicly advertising and soliciting applications, apparently from individuals “otherwise qualified to be a judge in this state.”⁸⁴ The board then would vote on the applicants, and forward to the governor a list of names, equivalent in number to the number of judicial vacancies, of those applicants who received at least 7 votes, in the order of the number of votes they received. Within 30 days of receiving the list, the governor would have to accept or reject the list in its entirety.⁸⁵

F. How Would Health Court Judges Be Trained?

The Common Good Model Act states that health court judges would have to complete “an annual training curriculum providing an overview of medical and legal issues that may arise in Medical Injury Court proceedings.”⁸⁶ Appendix 1 to the Model Act, headed “Sample language for one possible approach to judicial selection,” states that judges must receive “an overview of ... developments in clinical medicine and changes to the lists of accelerated compensation events.”⁸⁷ The Model Act also contains a second appendix, headed “Sample language for one possible approach to judicial training.”⁸⁸ It delegates to the Medical Injury Court Board of Qualifications, described in Section E above, the tasks of establishing specifications for the judicial training program, including the number of hours of training required annually, and of contracting with “appropriately trained institutions or professionals within the state, such as medical organizations, schools of medicine or nursing, or other entities providing medical education services,” to conduct the training.⁸⁹ Appendix 2 also stipulates that the training must address “such topics as the use of clinical practice guidelines in medical treatment, assessing the qualifications of independent expert witnesses, and fundamentals of anatomy, pharmacology, pathology, surgical care, and preventive care,” and adds that “medico-legal issues shall also be addressed.”⁹⁰

G. How Would Experts Be Selected, Paid, and Used?

Philip K. Howard states that health court judges would have the authority to hire neutral experts “instead of having experts-for-hire who now confuse and prolong malpractice cases.”⁹¹ The Common Good Draft Proposal calls for health court judges to be assisted by “medical experts with relevant expertise who come from a panel

constituted through volunteers or selection by the court.⁹² The Model Act specifies that judges must seek the opinion of at least one expert, and may “retain” up to two additional experts,⁹³ and that these experts must be drawn from a list of experts maintained by the Medical Injury Court Board of Qualifications, described in Section E above, and “qualified in specialties relevant to the nature of the claim.”⁹⁴ These experts would be compensated “at a reasonable rate” from the health court’s operating funds.⁹⁵ The list of experts would be made up of persons who “meet the minimum state requirements for serving as an expert witness, and shall be currently licensed in the same profession as the health care provider against whom a claim has been lodged, and, if certified by a board recognized by the American Board of Medical Specialties, certified in the same specialty or another specialty relevant to the nature of the claim.”⁹⁶ The act also provides that “the provision of consultation as an expert witness in a Medical Injury Court proceeding shall constitute the practice of medicine, as that term is defined in the [state medical practice act].”⁹⁷ This is significant because it would enable state medical boards to sanction experts for giving false testimony.⁹⁸

Under the Model Act, the parties also would be entitled to select and retain their own experts at their own expense,⁹⁹ although the act states that they may present expert witness testimony at or in preparation for a health court hearing “at the discretion of” the judge.¹⁰⁰ The Model Act also states that “[n]o expert in any Medical Injury Court proceeding shall provide consultation if the expert witness has any material conflict of interest, or for any reason feels that a fair and impartial decision cannot be given.”¹⁰¹ Each expert is required to submit a written report, which “shall be based on the expert’s review of prior Medical Injury Court Explanations of Decision, clinical practice guidelines, lists of accelerated compensation events, and other information as appropriate.”¹⁰²

The Progressive Policy Institute states that “[h]ealth courts would use expert witnesses paid by the court, so they are not beholden to either the plaintiffs or the defendants,” and adds that “[a]ccess to impartial, unbiased expert testimony on the standards of care is essential for a reliable system.”¹⁰³ An editorial in *Contemporary OB/GYN*, however, calls for health court experts to be “chosen with the help of such organizations as the American College of Obstetricians and Gynecologists.”¹⁰⁴ The PPI concedes that “[p]atients and providers could possibly submit written expert testimony of their own in addition to court-appointed expert opinion.”¹⁰⁵

H. What Would Be the Role of Attorneys and How Would They Be Paid?

Health court proponents are determined to reduce the role of plaintiffs’ attorneys in the medical malpractice compensation process, and to alter the way in which plaintiffs’ attorneys are paid for their efforts. In terms of the role for lawyers, most health court advocates distinguish between the initial claim stage of the health court process, and the later hearing stage. During the latter, they agree that claimants should have the right to be represented by attorneys. The Heritage Foundation, for

example, states: “While lawyers would still represent the parties at trial, judges would rely more heavily on court-appointed expert witnesses to offer unbiased testimony on the range of possible treatment options as well as clinical guidelines that make up the standard of care.”¹⁰⁶ The Republican Policy Committee agrees that, “[l]ike civil trials, both the patient and the provider would be represented by attorneys.”¹⁰⁷ An article in the *Milbank Quarterly* by a group of health court advocates, including Troyan Brennan and Michelle Mello from the Harvard School of Public Health (hereinafter referred to as “the Milbank article”), states that “[i]f the circumstances of the injury were complex ..., counsel could explain the contested issues in a health court review or judicial appeal.”¹⁰⁸

During the initial stage of the health court process, however, health court proponents hope to minimize or eliminate the role of attorneys for claimants. Bovbjerg and Tancredi state for example, that “[r]eceiving ACE payment should not typically require making an adjudicatory claim or hiring an attorney.”¹⁰⁹ Similarly, the Common Good Draft Proposal says that “[c]laimants would have ... the right to be represented by an attorney, though representation would not be needed in many cases as the health court process would be consumer-friendly in design.”¹¹⁰ The Milbank article states: “For relatively straightforward claims, we expect that many plaintiffs would choose to proceed on their own in order to avoid paying attorneys’ fees.”¹¹¹ The draft proposal also appears to endorse the approach used by COPIC Insurance in its “3-Rs” early-offer-and-compensation program.¹¹² That approach, which is discussed more fully in Section VII.B of this report, does not offer compensation for patient claims “with attorney involvement.”¹¹³

Most health court proposals would do away with contingent fees altogether. The Common Good Draft Proposal states that claimants’ attorneys should be compensated “based on a multiple of hours worked rather than a fixed percentage.”¹¹⁴ The Model Act concurs, and in addition, would limit claimants’ attorneys’ fees to “a maximum of one-third of the amount recovered.”¹¹⁵ On the other hand, the Milbank article states that “[c]laimants would pay their attorneys on a contingent basis (i.e., only if the claim resulted in a compensation payment), but the fee would be based on a multiple of hours worked rather than a percentage of the award.”¹¹⁶ A 2004 editorial on health courts in the publication *Contemporary OB/GYN* states that Senator Frist’s health court proposal would limit attorney contingent fees “to hourly rates or a small percentage (such as 10%) of settlement offers.”¹¹⁷

These proposals are silent on the question of the recoverability of the plaintiff’s attorneys fees from the defendant. That is, they do not indicate whether the plaintiff’s attorney’s fee, however calculated, would be added to the award made to the plaintiff or whether, as in current practice, the plaintiff would have to lose some of his or her compensation for other economic and non-economic losses by paying the attorney fee out of an award that does not include recovery of such fees. The PPI report, on the other hand, refers to “legal costs” as a component of recoverable economic damages, but does not explain how they would be calculated, other than to imply that they would be specified in a “schedule of benefits.”¹¹⁸ Only the Milbank

article speaks to the question of whether attorneys for the plaintiff would be paid even if the plaintiff lost, as is typical for attorneys (including insurance defense attorneys in malpractice litigation) who are employed on an hourly basis. As indicated, the Milbank article makes clear that the plaintiff’s attorneys would be paid only if the plaintiff obtained compensation. It is unclear, however, whether the authors of that article mean to preclude the possibility of an agreement between the plaintiff and his or her attorneys to pay for representation on an hourly basis, win or lose.

I. What Would Be the Role of ACEs?

A number of health court proponents envision important roles for ACEs. Those who propose that hospitals or insurers make an initial admission of error to an injured patient and offer compensation would make the ACE list the determinant for when this process should take place. The Common Good Draft Proposal states, for example, that “[w]hen an adverse event occurs, the hospital makes an initial determination whether the event falls within the class of adverse events covered by the system,” and that its determination should be “guided by pre-established decision aids, including a definition of avoidability and a compendium of accelerated compensation events that carry a presumption of avoidability.”¹¹⁹ A Kaiser Permanente report written by Bovbjerg and Raymond similarly envisions ACEs as “triggering” the responsibility of a provider to make “an early offer of limited compensation”¹²⁰ Bovbjerg and Tancredi make essentially the same proposal.¹²¹ The Progressive Policy Institute, which proposes that claims be made initially to a health court review board, states that, in investigating the claims and determining if they are “clear, uncontestable cases of malpractice,” the boards “would refer to a catalogue of predetermined medical malpractice scenarios.”¹²²

The Model Act also contemplates that ACEs would be employed by health court judges: “If the record and expert opinions provide a sufficient basis for the Medical Injury Court judge to make a determination that the injury constitutes an accelerated compensation event, the Medical Injury Court judge at his or her sole discretion may award compensation without convening a hearing.”¹²³

J. What Does “Avoidable” Mean?

Health court proponents want to provide compensation to patients who have suffered injuries that were “avoidable.” This is key in proponents’ minds in order to reduce the stigma associated with compensating injured patients based on a negligence standard. Proponents believe that less stigma in turn will encourage providers to cooperate with the health court system. As the Common Good Draft Proposal states:

The avoidability standard is desirable because it moves away from the notion of individual fault and the negative connotations that the

medical profession associates with negligence. It comports with the notion of preventability, which is critical to the patient safety movement's insistence on lack of blame. But it does not have the onerous financial implications associated with a move to strict liability.¹²⁴

What is meant by “avoidable”? The Progressive Policy Institute states: “A health court system would compensate patients who are injured by medical care as the result of an [sic] mistake that should have been prevented. This broader, more liberal standard of recovery goes beyond the current haphazard standard that is based on individual negligence.”¹²⁵ PPI also calls for federal guidelines for health courts that include “[a] liberalized standard for negligence (a mistake or medical treatment falling outside a range of good practice, without need to show personal fault).”¹²⁶ In another place in its report, PPI expects judges to resolve cases “in light of expert testimony about whether the provider's actions were within the range of reasonable actions given the circumstances.”¹²⁷

The Common Good Draft Proposal states that “injuries would be compensated if they could have been avoided if care had been provided according to best practice.”¹²⁸ It goes on to explain that “[t]his differs from the negligence standard, which focuses on whether care fell below customary practice.”¹²⁹ Elsewhere, the draft proposal states that “[t]o obtain compensation, claimants must show that the injury would not have occurred if best practices had been adhered to, but they need not meet the more exacting negligence standard and show that a defendant acted as ‘no reasonable practitioner’ would have.”¹³⁰ The draft proposal adds that “[the avoidability criterion] could be modified by additional criteria based on the injury's severity, its rarity, or a focus on particular types of outcomes (e.g. birth injuries).”¹³¹ The Model Act defines an avoidable medical injury as “a medical adverse event that would not have resulted if care had been delivered in a manner consistent with that of an experienced practitioner or specialist in the relevant clinical area. In making the determination of avoidability, the lack or presence of local or regional resources may be taken into account.”¹³²

There appears to be disagreement among health court proponents about whether an “avoidable” injury should be considered one that would not have occurred if the patient had received “good” care, or one that would not have occurred if the patient had received the “best” care. The original architects of ACEs, Bovbjerg and Tancredi, consistently employ the “good care” standard of avoidability. Most recently, for example, they state that “ACEs do not cover all bad outcomes, only events that should seldom occur, given good medical care.”¹³³ As stated above, the Progressive Policy Institute appears to agree.¹³⁴ But as also noted above, Common Good uses the avoidability standard of “best practice.”¹³⁵

Other formulations of the ACE concept use still other standards for avoidability. Havighurst and Tancredi, in one of the first discussions of ACEs, state: “A decision to make an event compensable must also reflect a judgment of unexpectedness and of preventability through correct application of medical knowledge.”¹³⁶ In a 1974

article entitled "Identifying Avoidable Adverse Events in Medicine," Tancredi observes that "[t]he difficulty lies in the necessary task of distinguishing between injuries that could have been avoided by virtue of timely and appropriate diagnosis and treatment and those that are merely incidents of the disease or dysfunction that brings the patient to the physician in the first place."¹³⁷

K. What Compensation Would Be Available to Successful Claimants and How Would the Amount of Compensation Be Determined?

Health court claimants would be entitled to some degree of compensation for economic damages. The Common Good Draft Proposal articulates the goal of "full compensation" for economic damages but at the same time contemplates imposing a "deductible:" before they could receive compensation, claimants would have to have been out of work for from 4 to 6 weeks, or to have incurred \$3,000-\$4,000 in out-of-pocket medical expenses.¹³⁸ The Model Act includes a provision that would deduct from economic damages an unspecified amount of lost wages and, for unemployed claimants, an unspecified amount of "lost household production."¹³⁹

The Common Good Draft Proposal states that "[m]ethods for evaluating the different components of economic loss would be based on those used in the tort system," and that, in determining how much compensation to offer patients for economic injury, "[t]he valuations would be made by an expert employed by the [hospital's or insurer's] decision panel, based on information provided by the plaintiff."¹⁴⁰ The Milbank article states essentially the same thing.¹⁴¹ Bovbjerg and Tancredi state: "ACE benefits (that is, covered services) should generally resemble what well-insured Americans finance for themselves in health and disability coverage."¹⁴² In terms of compensation for lost wages, Bovbjerg and Tancredi claim that "[i]t would be reasonable to set wage allowances at a median level (as Virginia did [in its birth-related injury compensation program]) or to assure that the top and bottom allowances not range as widely as under tort."¹⁴³

The Common Good Draft Proposal recommends that there be offsets for collateral sources and "restrictions on subrogation activities," so that the health court program would be a "secondary or tertiary payer."¹⁴⁴ The Model Act would deduct "[a]mounts paid, reimbursed, or eligible for reimbursement by a health insurer, disability insurance program, or other collateral source."¹⁴⁵ The proposal is silent on the question of what would happen if the health court determined that the claimant was "eligible for reimbursement" from a collateral source but the collateral source denied eligibility, a situation that would be certain to occur.

Economic damages reflecting future losses would be paid periodically. According to the Common Good Draft Proposal, "[a]wards that include a future loss component would be re-examined every few years."¹⁴⁶ The Milbank article similarly states that "awards that included a future-loss component could be reexamined in the future."¹⁴⁷ An appendix to the Common Good Draft Proposal provides that "[a]

health court administrator has responsibility for periodically contacting the patient/family to query whether any adjustment to compensation for future medical expenses, rehabilitation, custodial care, home care, or other expense is required due to unforeseen circumstances. The patient/family may also apply for such an adjustment directly.¹⁴⁸

Health court claimants also would receive some compensation for non-economic losses. Bovbjerg and Tancredi state, for example:

ACE payouts should probably include some allowance for pain and suffering, a “non-monetary” but quite real loss. After all, people are willing to pay money themselves to reduce non-monetary risks from injury, although private insurance never includes such losses because of the moral hazard involved in valuation. Payouts should be modest relative to tort because ACEs are not grounded in fault and are not needed to fund high legal fees as under tort. Allowances should be structured to avoid moral hazard and to assure proportionality across cases (meaning that more severe cases always receive more than less severe and that similar claimants receive similar amounts).¹⁴⁹

A key aspect of the health court system is that compensation for non-economic loss would be based on a pre-established schedule of damages. Various methods are suggested for creating the schedule. The Common Good Draft Proposal states that “[n]on-economic damages will be paid according to a schedule tied to severity of injury and based on decision science research about utility losses and public deliberation about reasonable compensation.”¹⁵⁰ The proposal adds that “[a]cademic research into utility variations can be used to inform public deliberation.”¹⁵¹ The proposal also calls for generating “a matrix of levels of injury severity” based on one of the following: “National Association of Insurance Commissioners’ 9-point disability scale, AMA Guides to Evaluation of Permanent Impairment, decision science research about utility losses associated with different health states, [or] any of the above scales plus age categories.” Next, “a dollar value range would be assigned to each cell in the matrix. The adjudicator would select a value in the range depending on the specific facts of the case compared to other like cases.”¹⁵² The Model Act provides that “[n]on-economic damages shall be paid pursuant to a schedule of benefits based on patient circumstances and severity of injury and developed by the Board of Qualifications,”¹⁵³ and that, in contrast to the periodic payment of economic damages, non-economic damages should be paid on a lump-sum basis.¹⁵⁴

The Progressive Policy Institute wants the schedule of non-economic damages to be set by an independent commission created by Congress.¹⁵⁵ The members of the commission would be appointed by the President and Congress, “reflecting diverse interests and perspectives.”¹⁵⁶ The commission would develop the schedule “through a consensus process involving research on similar benefit schedules in the United States and abroad.”¹⁵⁷ PPI explains:

The experts would weigh injury awards commonly won in the current U.S. legal system against typical awards for similar injuries in other countries. In Britain, for example, damages paid for quadriplegia run from \$311,000 to \$387,000, depending on the patient’s residual movement, pain, depression, and age. ... In developing the schedule of benefits, experts would also consider objective economic analysis of the personal cost of injury.¹⁵⁸

The Institute’s report adds that “[o]bjective analyses of the cost of pain and suffering have included such things as spending on safety equipment, and salaries and wages in risky professions.”¹⁵⁹

L. Would Health Court Claimants Have a Right of Judicial Review?

The Model Act provides for an appeal by “either party” to a “Medical Administrative Appellate Court” comprised of 3 administrative law judges selected by the Medical Injury Court Board of Qualifications.¹⁶⁰ The appellate court would overturn a ruling on issues of fact only if it was “contrary to the substantial evidence presented by either party in the Medical Injury Court proceeding,” and would have “plenary review for issues relating to the standard of care and other policy issues.”¹⁶¹ Decisions by the appellate court could be appealed to a regular state court of appeals only on the basis that they were arbitrary and capricious.¹⁶² The Common Good Draft Proposal explains that “[a]nything but a rather high standard of review would lead to large lawyering costs at the appeal level.”¹⁶³ The Milbank article states that “[e]ither party also could appeal the decision to a higher-level administrative tribunal and ultimately a judicial court, both of which would apply a deferential standard of review (meaning that the court would give considerable weight to the tribunal’s decision).”¹⁶⁴ A proposal by the Medical Society of Virginia states merely that the health court system would “retain current rights of appeal.”¹⁶⁵

M. How Would Health Courts Be Financed?

Presumably, compensation for claimants under a health court system would continue to come from the same sources as under the traditional tort system, that is, medical malpractice insurance or provider self-insurance. None of the health court proposals suggests a different method of funding compensation offers or awards, with the exception that several recommend the adoption of an experience-rated premium structure whereby institutional providers, such as hospitals, that paid a greater number of claims would be required to pay higher premiums, similar to workers’ compensation insurance.¹⁶⁶

One issue is how insurers would set premiums in anticipation of claims for “avoidable” rather than negligent adverse events. Bovbjerg acknowledges that “making preventable injury or ACEs the compensable event would fundamentally shift the nature of the risk insurers are underwriting. The actuaries would be upset

because they don't have any data on preventability."¹⁶⁷ But he adds that "over time insurers can shift from one type of risk to another."¹⁶⁸ The Common Good Draft Proposal also is concerned about this issue:

The participants would likely make participation contingent on some protection against major losses in the early years of a demonstration project. From an actuarial standpoint, the avoidability standard will create an element of uncertainty that would limit voluntary participation, especially if there were insufficient numbers of participants to provide actuarial stability. Some type of stop-loss guarantee from a reinsurance entity will be a key issue in securing liability insurers' participation.¹⁶⁹

The proposal adds:

In a voluntary demonstration, large self-insuring systems might choose to go wholly over to the new approach and underwrite based on the avoidability standard. Commercial malpractice insurers might need to set up a subsidiary to accommodate hospitals and physicians interested in participating in the demonstration.¹⁷⁰

Presumably the creation of the subsidiary would protect the parent from the consequences of unforeseen losses due to the unfamiliar compensation standard.

A health court system also would establish a new bureaucracy, which would need operating funds in addition to the funds used to compensate claimants. Health court proponents seem to expect the administrative expenses of the new system to be paid through traditional sources, in the form of a surcharge on malpractice insurance premiums. The Common Good Draft Proposal thus recommends a "modest annual surcharge for state administrative expenses."¹⁷¹ The Progressive Policy Institute speaks of a "small assessment" on premiums to provide federal start-up funds.¹⁷² The Model Act calls for a special operating fund to be established in the state treasury, financed by a combination of appropriations and "fees and charges assessed through the operation of the Medical Injury Court."¹⁷³ The act states that "the operating and capital expenses of the Medical Injury Court shall be paid primarily from the Medical Injury Court Fund,"¹⁷⁴ but does not explain what other sources of payment would be used.

N. How Would Health Courts Improve Patient Safety?

A major claim by health court proponents is that the system would reduce medical errors and improve the quality of care. As Bovbjerg and Raymond state, "[t]he basic idea of the reform options using ACEs is to create better incentives to prevent avoidable adverse outcomes in medical care."¹⁷⁵

Health court advocates maintain that the health court system would accomplish this, in the first place, by producing much more and far better information about errors than the tort system. Greater information would result from greater acknowl-

edgement and admission of errors by physicians and other providers. As the Progressive Policy Institute explains, “the system must encourage the reporting and discussion of medical mistakes and near misses instead of driving that discussion underground by a fear of lawsuits.”¹⁷⁶ Bovbjerg and Raymond concur, and also point to greater reliance by ACEs on medical expertise: “An ACE system could well be less threatening to caregivers than courtroom liability and should be more congruent with patient safety approaches because ACEs are grounded in medical expertise, applied prospectively and implemented dispassionately.”¹⁷⁷ Additionally, more information would be available because patients would file more claims. The Common Good Draft Proposal states, for example, that “[d]ue to patient incentives to file claims, the health court administrative staff may be able to more readily gather rates of nosocomial infections with significant patient adverse outcomes.”¹⁷⁸ The Progressive Policy Institute also recommends “holding hospitals accountable for mistakes that happen in their facilities” as “an important way to improve safety,” since this “would help catch recurring safety issues in hospital settings”¹⁷⁹ PPI also does not want to seal “settlements in health court cases ... from public view.”¹⁸⁰

Health court proponents envision an elaborate system for collecting and analyzing adverse event data. The Common Good Draft Proposal wants to create a single state or federal agency, which it calls the “Administrative Compensation Agency,” which would be given the responsibility for fostering safety improvement activities.¹⁸¹ Common Good also expects the health court itself to maintain “a database of all claims filed and all claims paid,” which “could serve as a repository for information of all medical injury for covered providers” and which would be “searchable (many fields would be predetermined), permitting epidemiological research and periodic reports on medical injury.”¹⁸² The Common Good proposal explains:

We would recommend that the state fund a claims database with standard reporting and data fields which would facilitate epidemiological analysis of the claims by approved researchers. Either a local staff, or experts identified through grants, would analyze the data for new prevention strategies. We recommend that the state fund at least a modest health court administrative staff to maintain the database, liaise with researchers around data requests, and disseminate analytical findings to hospitals and other health care providers.¹⁸³

Information from claims patterns that revealed “early warning on the dangers of medications and devices” would be provided to the Federal Food and Drug Administration.¹⁸⁴ De-identified information¹⁸⁵—i.e., information that did not reveal the identity of the health care provider—would be subject to “root cause analyses”;¹⁸⁶ shared with “other patient safety bodies, including state offices of patient safety and the Joint Commission on Accreditation of Healthcare Organizations, and research organizations”;¹⁸⁷ fed back to hospital “patient safety offices” or “patient safety teams” so that they could “undertake root-cause analyses at the same time that patients were being informed”;¹⁸⁸ and made available to “the public,

researchers, ... and/or payors.”¹⁸⁹ (The proposals are silent on whether patient identities would be revealed or also “de-identified.”) In addition, “[a]t the request of a health care organization, the health court administrative staff may provide detailed claim and compensation information of that organization compared with that of all other claims [sic].”¹⁹⁰

The Common Good Draft Proposal also provides that, in cases of “egregious provider misconduct” in which the health court determines “that a risk of significant harm continues to exist for other patients or that [the] event was clearly outside of the bounds of professional behavior,” the court may “notify the appropriate regulatory, disciplinary, or licensing agency.”¹⁹¹ “Where a more immediate benefit to patient safety and welfare may be gained,” the health court also could require “remediation or improvement in an underlying contributing factor”¹⁹² or “further training,”¹⁹³ which may come with “deadlines for implementation,”¹⁹⁴ and the court may report “a failure to comply with a health court request”¹⁹⁵ to external authorities.

Finally, the Progressive Policy Institute states that “[p]ublic reporting of health court cases would be an essential part of a new national patient safety strategy,”¹⁹⁶ presumably through the use of this information in future health court proceedings.¹⁹⁷

O. How Would Health Courts Set Precedent?

A final objective of health court proponents is for health court decisions to serve as precedent for the resolution of future cases. The Common Good Draft Proposal states that “[c]ompensation decisions will be recorded in a searchable database that health court judges can refer to in future cases.”¹⁹⁸ The Model Act states that “Medical Injury Court judges shall refer to precedent from past Medical Injury Court proceedings in [determining that an injury constitutes an accelerated compensation event such that compensation can be awarded without a hearing].”¹⁹⁹ Some health court advocates believe that this body of precedent would aid physicians in ascertaining how they should act in specific situations. The Heritage Foundation explains, for example, that “[t]he written determination then becomes part of a consistently applied body of law to which physicians can look with more certainty.”²⁰⁰

* * *

The foregoing describes how health court proponents envision their system would work. Before analyzing whether their expectations are realistic, it is necessary to consider whether the functioning of the current system makes a health court system necessary.

V. THE TORT SYSTEM PERFORMS BETTER THAN HEALTH COURT PROPONENTS CONTEND

Health court advocates excoriate the traditional malpractice system. Philip K. Howard asserts that it “tolerates, indeed encourages, wildly inconsistent verdicts,” that “80 percent of claims are made against doctors who made no medical error at all,” and that “[t]he legal process is not only unpredictable and emotionally wrenching, but also staggeringly inefficient”²⁰¹ Elsewhere he states:

— “There’s a universal distrust of justice among health care providers because it’s an ad hoc system. It provides no legal guidelines to improve or to follow, it provides no consistency of results because it’s an ad hoc system.”²⁰²

— “Patients who have been severely injured—but it’s not worth the big bucks—basically go without a remedy.”²⁰³

— “Justice in healthcare today is *almost random*.”²⁰⁴

Jeffery Pariser, former executive director of Common Good, goes one better; in his opinion, “[m]edical justice today, studies show, is *worse than random*.”²⁰⁵ Pariser adds that “[l]awsuits go on for years, with the truth obscured by technical jargon and experts-for-hire,” and that “[a]t present, juries are making the major decisions in medical liability cases. But juries can’t set precedent; they can only make judgments in individual cases.”²⁰⁶ While Pariser laments a lack of precedent in tort law, the Heritage Foundation criticizes tort law’s excessive rigidity: “Tort law’s rigidity makes it an ineffective compensation system for injured parties or watchdog for the medical profession.”²⁰⁷

The Common Good Draft Proposal claims that it “starts from the point that America’s medical liability system works poorly for both providers and patients,” and adds:

Substantial and growing malpractice insurance premiums strain physicians and hospitals, threatening access to health services in some areas. The system compensates few injured patients, and has very high administrative costs. As the Institute of Medicine has noted, it also adversely impacts health care quality by discouraging reporting of information about errors and near misses in treatment.²⁰⁸

As explained in Sections VI and VII, below, health courts are unlikely to function substantially better than the tort system, and in a number of significant respects they can be expected to perform far worse. But before turning to that discussion, it is important to consider how well the traditional medical malpractice system actually performs. Critics of the tort system should base their arguments on valid data, not on folklore. Fortunately, there is considerable evidence about the workings of

the current system, much of which has been carefully analyzed by distinguished experts. Overwhelmingly, this evidence contradicts health court proponents' key assumptions.

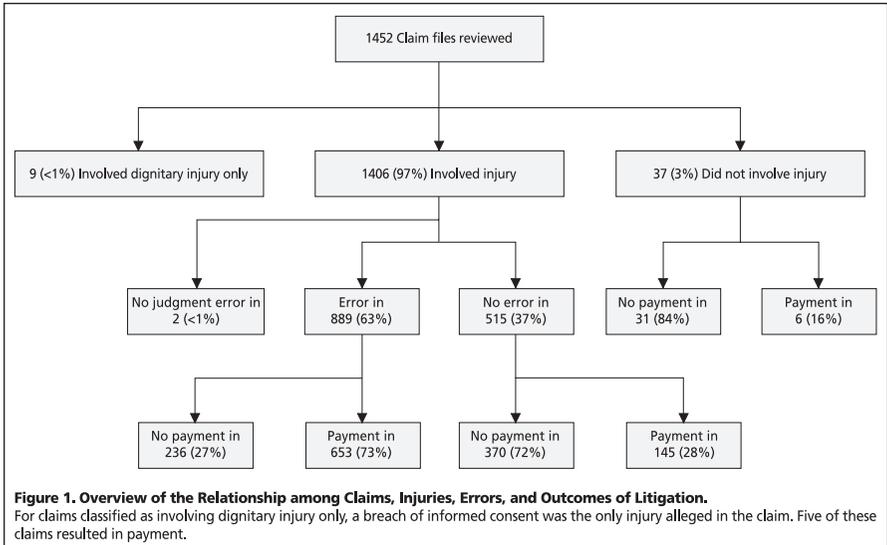
A. The Tort System Does A Good Job of Sorting Medical Malpractice Claims.

Contrary to the assertions of health court advocates, who use terms like "litigation lottery" and describe the results of litigation as "almost random" or "worse than random," the tort system effectively differentiates between viable and non-viable claims. Data from nine studies were analyzed by Tom Baker, Connecticut Mutual Professor of Law and Director, Insurance Law Center, University of Connecticut School of Law, and re-analyzed, along with a tenth study, by David Hyman, a physician who is also Professor of Law and Galowich-Huizenga Faculty Scholar at the University of Illinois College of Law,²⁰⁹ and Charles Silver, Co-Director, Center on Lawyers, Civil Justice, and the Media, and McDonald Endowed Chair in Civil Procedure at the University of Texas School of Law. Hyman and Silver conclude their analysis as follows: "The bottom line is that a strong correlation exists between the likelihood of receiving payment and the merits of malpractice claims. ... [W]hen patients do sue, the malpractice system sorts their claims relatively well."²¹⁰ The same authors made the same assessment in a slightly earlier piece: "After patients file malpractice cases, the system does a reasonably good job of sorting the wheat from the chaff—a much better job than many proponents of tort reform suggest. Many studies report high frequencies of settlement and payment in cases where experts agree that defendants violated the standard of care and low frequencies when experts agree otherwise."²¹¹

The most recent study is illustrative of the sorting efficiency of the tort system.²¹² Published in May of 2006 and conducted by some of the same researchers at the Harvard School of Public Health who call for health courts, that study used trained physicians to review a random sample of 1452 closed malpractice claims from five liability insurers in four regions of the United States collectively covering about 33,000 physicians, 61 acute care hospitals, and 428 out-patient facilities.²¹³ The sorting function of the system is nicely displayed in Figure 1 (*see page 31*), taken from the Harvard study report.²¹⁴

Putting aside the nine cases involving only dignitary harm, and noting that in two cases where injury occurred the reviewers did not make a judgment about whether error had occurred, one can use this figure to follow the researchers' conclusions:

Overall, 73 percent (1054 of 1441) of all claims for which determinations of merit were made [by research reviewers] had outcomes concordant with their merit. Discordant outcomes in the remaining 27 percent of claims consisted of three types: payment in the absence of documented injury (6 of 1441 [0.4 percent of all claims]), payment in the absence of error (10 percent), and no payment in the presence of error (16 percent). Thus, nonpayment of claims with merit occurred more frequently than did payment of claims that were not associated with errors or injuries.²¹⁵



Source: David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 N. ENG. J. MED. 2024, 2028 (2006).

While not noted by these researchers, the 73 percent agreement rate probably underestimates the accuracy of the common-law system. The reason is simple: in at least some of the cases of disagreement, the common-law system will have generated a better result than the reviewing experts, whereas it is much less likely that in cases of agreement both the system and the reviewers got it wrong. In any event, using the results of the reviewers’ rated degrees of confidence in their ascriptions of error (not shown in the figure above), the researchers also reported that “[t]he probability of payment increased monotonically with reviewers’ confidence that an error had occurred.”²¹⁶ Although noting that their findings showed that many victims of medical error did not assert claims, and that the tort system was administratively expensive, these researchers nonetheless concluded that “the malpractice system performs reasonably well in its function of separating claims without merit from those with merit and compensating the latter.”²¹⁷ Hyman and Silver had access to preliminary data from this study and agree that they “confirm that the medical malpractice system does a surprisingly good job of differentiating between plaintiffs who should and should not receive compensation.”²¹⁸

Against all this accumulation of empirical research, health court proponents can point to very little to support their claims. A study published in 1996,²¹⁹ based on the data from the original Harvard Medical Practice Study published in 1991,²²⁰ is perhaps the only source that seems to support the inference that negligent injury and payment are uncorrelated. Professor Baker, however, demonstrates clearly why this inference is unsound.²²¹ He points especially to the many problems resulting from the very conservative system employed by reviewers in the original Harvard

study to determine whether negligent injury had occurred, the small sample size of the follow-up study (a mere 46 cases arising from hospitalizations in New York), and the resulting statistical aberrations.²²² Taking into account the large body of contrary research results, Baker concludes that “[n]egligence matters a great deal to the outcome of a medical malpractice claim”²²³ and that “[t]he legal system does a remarkably good job at weeding out weaker claims.”²²⁴

Equally revealing is the manner in which health court proponents handle the empirical evidence that does not support their position, when they mention it at all. A recent “oped” written by Philip Howard, of Common Good, and appearing in *The Wall Street Journal*, cites a “recent Harvard study” (presumably, the 2006 Harvard School of Public Health study detailed above) in support of the creation of health courts.²²⁵ Howard argues:

It is not that most juries are unwise: Overall, according to a recent Harvard study, the error rate in this system is about 25%. But playing Russian roulette with one bullet in four chambers is not a source of comfort to most doctors.

With the benefit of the summary of that Harvard study given above, the “spin” involved in Howard’s argument is palpable. Remember that, in that Harvard study, any compensation paid (no matter how small, and whether as a settlement or as a result of a jury verdict) was counted as a determination by the legal system that the defendant was liable. Consequently, Howard’s statement involves the following confusions and distortions. First, the roughly 25% “error rate” reported in the study refers to the results of cases settled as well as tried, with the former vastly outnumbering the latter; most of these cases never reached trial, so the results do not speak directly to the wisdom of juries, as Howard suggests.²²⁶ Second, just because the physician reviewers disagreed with the result of the legal system in about 25 percent of the cases does not mean that the error rate of the system is about 25 percent. As noted above, in some cases the legal system will have been right and the reviewers will have been wrong. Third, even if we assume that the reviewers were always right and the legal system’s error rate is about 25 percent, the majority of these “errors” favored physicians, and the chance that the insurance company of a physician who is sued will be erroneously required to compensate a claimant is only about 10 percent.²²⁷ In other words, instead of a one in four chance of the physician dying a gruesome death, there is less than a one in ten chance that the insurance company of a physician who is sued will be required erroneously to pay some compensation (however small).²²⁸ That is quite a difference.

B. Frivolous Lawsuits Are Not A Serious Problem.

Some frivolous lawsuits probably occur in all areas of law, but are they a serious problem in the medical malpractice context? Health court advocates attribute at least some of the perceived problems of the malpractice system to the filing of unmeritorious claims, referring to “greedy lawyers” who are “egging injured patients to sue.”²²⁹

These contentions fail to appreciate that the contingent fee system invests plaintiffs' attorneys heavily in the outcome of their cases and creates powerful incentives for the attorneys to screen out weak cases. An attorney who takes on a weak malpractice case and invests substantial resources in pressing it is making a very bad investment, especially when insurers maintain that they rarely pay settlements for frivolous cases.²³⁰ Research by Herbert Kritzer, Professor of Political Science and Law at the University of Wisconsin, confirms that the economic reality of contingent fees drives lawyers, including medical malpractice lawyers, to reject about 90 percent of cases after the first appointment with the client.²³¹ Kritzer reports:

Lawyers are extremely cautious in accepting medical malpractice cases, and the lawyers I observed spent a lot of time explaining to these potential clients why their negative medical outcome did not constitute malpractice, or the difficulty in establishing that it did arise from malpractice, or that even if it was malpractice, the ultimate medical outcome was probably not affected by the error (and the interim consequences did not give rise to sufficient damages to make pursuing the matter financially attractive).²³²

Health court proponents are fond of making statements like "80 percent of claims are made against doctors who made no medical error at all."²³³ The sole support for this assertion is a portion of the 1991 Harvard Malpractice Study and the follow-up analysis of the same claims in 1996,²³⁴ both of which have been thoroughly discredited in this respect. In his lengthy and careful analysis, Baker points out that the Harvard study "was not designed or powered to reach strong conclusions about the validity of medical malpractice claims."²³⁵ "Indeed," he adds, "the [Harvard] data are as likely to support a very different finding, namely that most malpractice claims are reasonably related to medical management injury and provider negligence."²³⁶ Baker notes that many of his findings "can be found in caveats and qualifications contained in the [Harvard] report to the State of New York and in publications by [the Harvard] researchers, as well as by early critics of the malpractice claiming aspects of the [Harvard study]. But these caveats and qualifications have not received adequate attention in the public debate."²³⁷ Like Baker, Hyman and Silver comment that "[a]lthough [Harvard] researchers noted many of these shortcomings in early publications, they did not emphasize them in later works and the study's weaknesses gradually dropped out of the policy debate."²³⁸ Baker concludes: "What the public heard was that medical malpractice claims are frivolous and that the wrong people get paid. The [Harvard report] and the follow up study prove no such thing and the rest of the literature suggests exactly the opposite conclusion."²³⁹

Confirming this more sanguine view of the tort system is the recent study, discussed in the previous subsection, conducted by researchers at the Harvard School of Public Health, the same institution that produced the earlier research. As compared to the earlier quoted assertion that 80 percent of claims are made against doctors who made no medical error, this later research produced a figure between 35 and 37 percent.²⁴⁰ This, and the other results noted above, led these researchers to

conclude that “portraits of a malpractice system that is stricken with frivolous litigation are overblown. Although one third of the claims we examined did not involve errors, most of these went unpaid.”²⁴¹

It might be asked, however, whether the fact that as many as 37 percent of the claims filed were rated by reviewers to be without merit indicates that such claims were frivolous. Is this not confirmed by the fact that 39 percent of claims resolved without trial were dropped or dismissed without any compensation paid?²⁴² To the contrary, careful observers understand that the discovery process can reveal weaknesses in a case originally thought to have potential.²⁴³ As Hyman and Silver observe:

The frequency with which plaintiffs’ attorneys drop medical malpractice cases after taking them might be thought to indicate that these dropped cases were actually frivolous. Empirical studies do not support the inference that plaintiffs’ attorneys file lawsuits they know are weak. The studies find that “drops” occur when cases thought to be strong initially turn out to be weak once discovery is performed. The pattern of filing cases that look good and withdrawing them when doubts arise indicates that the malpractice system itself weeds out weak cases. This is, of course, the intended result of the pretrial process.²⁴⁴

In their observation that discovery does its job of weeding out weak cases, Hyman and Silver are joined by the Harvard School of Public Health researchers themselves:

The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers.²⁴⁵

Again, that is not to deny that there may be occasional frivolous claims. But little would be gained by their elimination. Because of the discovery issues noted above and legitimate differences of opinion, few if any lawsuits in which a medical error did not occur can be called frivolous. But even if they could be, elimination of these cases would not save the system much in terms of administrative and compensation costs. The Harvard researchers conclude, for example:

[E]liminating the claims that did not involve errors [according to reviewers employed for the study] would have decreased the direct system costs by no more than 13 percent (excluding close calls) to 16 percent (including close calls). In other words, disputing and paying for errors account for the lion’s share of malpractice costs.²⁴⁶

C. Plaintiffs Attorneys Do Not Refuse to Settle Cases.

Another oft-heard criticism of the tort system, although not expressly made thus far by health court proponents, is that defendants are forced to litigate cases because plaintiffs' attorneys resist settling them in order to collect a larger contingent fee.²⁴⁷ This criticism is belied by the fact that an overwhelming majority of medical malpractice lawsuits, over 85 percent, are settled without trial.²⁴⁸ Furthermore, because a strategy of forcing trial would only make sense in cases that plaintiffs' attorneys believe to be relatively strong, it is relevant to consider that the percentage of *paid* claims that go all the way to trial is variously estimated at between only 2 and 6 percent.²⁴⁹ This hardly presents a picture of plaintiffs (or their attorneys) unwilling to settle.

Focusing on those cases that do go to trial, Hyman and Silver further debunk this claim:

A government report argues that lawyers paid on contingency "have incentives to pursue selected cases to the end in the hope of winning the lottery, even when their client would be satisfied by a settlement that would make them whole economically." The unstated assumption is that in the cases that are tried, insurance companies routinely offer malpractice victims settlements that fully cover their economic losses. This assumption is untrue. Professors Gross and Syverud found that in most medical malpractice cases where trials occurred, defendants (or their insurers) made no settlement offers at all.²⁵⁰

Hyman and Silver call the refusal to make settlement offers in certain contexts "settlement hardball," and explain how it accounts for what may appear to be unmeritorious verdicts:

The account just offered ["settlement hardball"] also explains why juries sometimes find malpractice in cases where providers honestly believe patients received proper care and can offer convincing evidence for this assessment. Long-shot cases are ones in which the evidence weighs in favor of the defendant, but is not conclusive. If enough of these cases are tried, the malpractice system will eventually produce a body of verdicts favoring plaintiffs in cases defendants think they should have won. Some frequency of jury verdicts in favor of plaintiffs with long-shot claims is predictable in a world where providers play "settlement hardball."²⁵¹

Rather than encouraging unreasonable refusals to settle, contingent fees serve a critically important function: By spreading the costs of litigation among a group of plaintiffs with plausible claims, some of whom recover money and some of whom recover little or nothing, they finance claims by plaintiffs too poor to be able to pay their attorneys in the event that their cases fail.²⁵² This function is unnecessary for insurance defense attorneys because their clients are wealthy repeat players in the litigation system.

D. Juries Are Competent to Decide Medical Malpractice Cases.

Tort reform generally and medical malpractice reform in particular have repeatedly targeted the lay jury for criticism. In the health court context, this is a prelude to suggesting that decision-making should be transferred to health courts staffed by specialists. Among health court proponents, although there is some ambivalence about their confidence in juries,²⁵³ one can discern several related claims: (1) that jurors are befuddled by complex scientific and medical questions, and, as a consequence, (2) that jury verdicts are erratic and unpredictable, but (3) that juries tend to give verdicts based on sympathy for the severely injured patient.²⁵⁴ What is most striking about these claims is that they are supported only by appeals to intuition or, at best, anecdote; one searches in vain for citations to systematic social science about jury behavior, despite the fact that extensive pertinent research has been conducted and reported. Virtually all of the jury research available, briefly summarized below, fails to confirm, indeed contradicts, health court proponents' apparent beliefs.

In one of the few instances where an empirical study of jury behavior is cited by health court supporters, the citation is embarrassingly inapt. Specifically, both the PPI Report and an article from the Heritage Foundation claim that juries let inappropriate factors, such as sympathy for the severely injured patient, affect their verdicts.²⁵⁵ They both cite the same empirical study in support of this claim.²⁵⁶ A careful examination of that article, however, reveals that it considered only 46 malpractice cases of which one (yes, that's right, one) was tried to a jury.²⁵⁷ How this study could possibly be the basis for an inference about jury behavior in general is left unexplained by those citing it. The authors of the empirical study cited certainly made no such claim. (And by the way, the one jury verdict was for the defendant.²⁵⁸)

So what do we really know about juries in malpractice cases? In the first place, as already noted, medical malpractice cases go as far as a jury verdict in only a small proportion of cases.²⁵⁹ Consequently, the impact of the jury is probably less than what is commonly assumed by tort reformers' focus on jury verdicts.²⁶⁰ Of course, dismissals and negotiated settlements occur in the shadow of potential jury verdicts, so counsel try to be keenly attuned to the likely results of a jury verdict in their case. In this regard, anecdotal references to aberrant jury verdicts are misleading, because these few verdicts are often corrected by trial judges or appellate courts, and the jury must be seen in the context of a procedural system that provides avenues for correcting clear mistakes.²⁶¹ Negotiators must also take into account the substantial reductions of jury verdicts that routinely occur as a result of statutory damage caps and insurance policy limits.²⁶² The high incidence of settlement before trial suggests that counsel do well enough in making such predictions. In any event, one must assess the jury as a component of an overall system which, as explained above (in Section V.A), does a remarkably good job in sorting good claims from bad claims.

It is also reasonable to believe, and research confirms, that the few cases that actually do go to a jury tend to be those that involve clearly strong cases for liability in which the amount of damages is the main controversy as well as relatively close cases

on the issue of liability; clearly weak cases tend to be dismissed before trial and clearly strong cases tend to settle before trial.²⁶³ The question then is how jurors deal with what are predominantly close cases,²⁶⁴ plus some clearly strong liability cases in which damages are still contested. What we know about that is the product of extensive research on jury verdict records, claims files of insurance companies, systematic interviews with jurors, and experiments with mock juries. Each of these sources has its advantages and disadvantages in terms of what may be inferred from them, but fortunately the results of these investigations tend to converge.

The first specific claim recurring in the health court proposal context, that juries do not understand the complex issues presented in many medical malpractice cases, is not supported by the empirical research. In a thorough review of the available research on jurors' understanding of expert testimony in civil and criminal trials, two of the most respected researchers in the field of jury behavior, Neil Vidmar (Russell M. Robinson II Professor of Law and Professor of Psychology at Duke University) and Shari Diamond (Professor of Law and Psychology at Northwestern University and Senior Research Fellow at the American Bar Foundation), conclude:

There is a consistent convergence in juror interview studies and experimental studies involving both civil and criminal juries. Jurors appear motivated to critically assess the content of the expert's testimony and weigh it in the context of the other trial evidence, as they are instructed to do. They appear to understand the nature of the adversary process, at least in the context of their specific trial. Even though many jurors may not have had prior exposure to the trial process, it appears that they develop an understanding from the give and take of examination and cross-examination and exposure to opposing experts. Indeed, rather than simply deferring automatically to experts, as critics have claimed, the trial process appears to make them aware of the fallibility of expert testimony. This is not to say that every juror is motivated and grasps the expert testimony, because the data seldom shed light on the thought processes of individual jurors, but the deliberation process appears to result in closer examination of diverging views and understandings—just as the legal system assumes it does....

Insofar as it can be assessed, there is no evidence that juries are incompetent to evaluate expert testimony.²⁶⁵

Focusing specifically on medical malpractice cases, Vidmar emphasizes several important facts in regard to the jury competency question, including: (1) many malpractice cases are not particularly complex, and many that do involve complex scientific questions also involve crucial questions of credibility that are the kind routinely entrusted to juries in other kinds of cases; (2) there is not always a clear answer to debates about technical medical issues, in which case the prospect of scientific and objectively correct decisions is often an illusion; and (3) the empirical research shows that jurors are not naïve about experts or easily misled.²⁶⁶

The second specific claim made by health court proponents is that jury verdicts are erratic and unpredictable. To some extent this is not really a criticism of juries, but rather a complaint about the need for greater specificity in the substantive standard of liability and, as a result, the jury instructions that express that standard,²⁶⁷ a complaint that we later show to be without merit (see Section VI). Moreover, to the extent that jury verdicts applying the standards of liability are stable and predictable, the concern about the lack of specificity in the substantive standard is muted. In fact, this disparagement of the jury system ignores the results of several research projects that have found jury verdicts on liability to be clearly and positively correlated with the judgment of neutral physicians asked to assess the same cases,²⁶⁸ as well as the results of several studies that have found that damage awards by juries are positively correlated with the severity of injury.²⁶⁹ Two important experiments, comparing mock jurors and experienced lawyer-arbitrators or lawyer-mediators in their evaluations of malpractice damages, and using statistical methods for simulating the effects of group deliberation for juries, found that the damage awards of the experienced arbitrators were more variable (i.e., less predictable) than those of twelve-person and even six-person juries.²⁷⁰

The study recently produced by researchers at the Harvard School of Public Health, previously discussed, sheds additional light on these issues. Although the authors do not discuss the point, their data show the jury verdict in agreement with expert reviewers in about 70 percent of cases.²⁷¹ That is slightly lower than the agreement figure for all cases, whether tried, settled, or dismissed (73 percent), but that difference—even if it is statistically significant—is unsurprising because, as noted above, the closer cases, the cases about which reasonable minds could reach different conclusions, tend to be the ones that go to trial. Again, jury disagreement with reviewers does not necessarily mean the jury was wrong. Tried cases generally involve live (or at least tape-recorded) testimony and issues of credibility as to which the juries may well be better judges than expert reviewers working from a paper case file. In any event, it should also be noted that, of the 30 percent of cases with discordant outcomes between juries and research reviewers, jury verdicts favored the defendants five times more often (25 percent) than they favored the plaintiffs (a mere 5 percent).²⁷² Even if one assumes that in cases of conflict the reviewers were always right, this would mean that jury error in favor of defendants was five times more common than jury error in favor of plaintiffs. This point brings us to the third specific claim made by health court proponents.

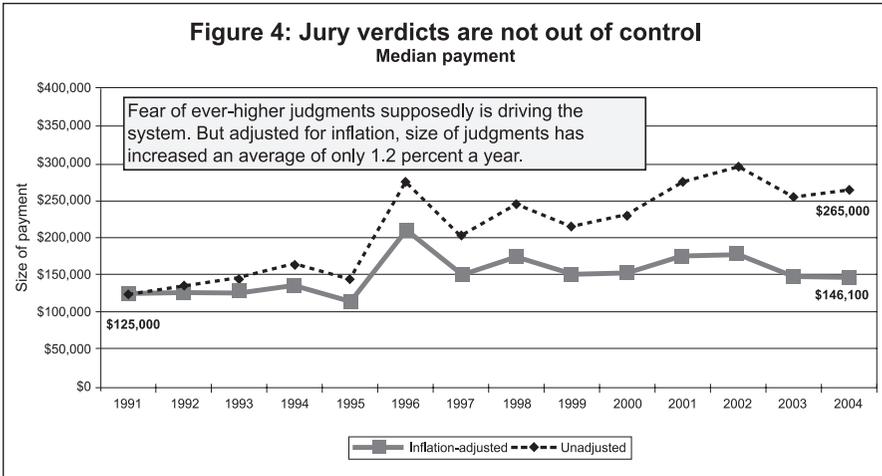
The third claim is that juries commonly let sympathy for the injured victim resolve their confusions. This, and the related idea that jurors will side with the injured victim against a “deep pocket” defendant, have been mainstays of tort reform rhetoric for some time, but they are not supported by the existing empirical research into jury behavior.²⁷³ Medical malpractice cases that are tried result in a verdict for the plaintiff in only about 25 percent of cases, hardly indicative of a pro-plaintiff bias.²⁷⁴ As compared to the roughly 50 percent win rate for plaintiffs in all tort cases carried to verdict, “[t]he remarkably high defense win rate in medical mal-

practice cases ranks as one of the most robust findings of empirical studies of the civil justice system.²⁷⁵ At the same time, jury interviews consistently reveal a skeptical attitude toward malpractice plaintiffs and a forgiving attitude toward doctors,²⁷⁶ a predisposition confirmed by the data reported above. Moreover, contrary to what the “deep pocket” hypothesis would suggest, research on trial results has found that the likelihood of a malpractice plaintiff winning at trial is not correlated with the severity of the plaintiff’s injury.²⁷⁷ Finally, controlled experiments with mock jurors have found no support for a “deep pockets” effect in medical malpractice settings.²⁷⁸

Health court proponents seem to find support for claims of a pro-plaintiff bias (more precisely, an increasingly pro-plaintiff bias) in data showing increasing jury verdict amounts. Common Good, for example, cites a variety of curious statistics, such as, “[b]etween 1996 and 1999, the average jury award in medical malpractice liability cases rose 76%,”²⁷⁹ and, “[b]etween 1999 and 2000, the median jury award increased 43%.”²⁸⁰ Even if accurate, such statistics can be misleading in a number of respects: changes over time need to be adjusted for inflation; median verdicts are probably more representative than average verdicts, because means can be affected by atypically large or small verdicts, and aberrantly large verdicts are subject to post-verdict correction by trial or appellate courts; and longer time periods are more meaningful than shorter ones, because short term jumps can be offset by short term drops.

To correct for these kinds of problems, a good picture emerges by looking at median verdicts (or better, median payments based on verdicts), adjusted for inflation, over a long period of time. Several analyses that correct for one or more of these factors are available in the literature. One study by Public Citizen, a consumer rights organization, published in April of 2005, addresses all three, using nationwide data from the National Practitioner Data Bank: “The median size of payments from judgments appears to have soared, from \$125,000 in 1991 to \$265,000 in 2004. But adjusted for inflation, the median payment grew from \$125,000 in 1991 to \$146,100 in 2004—an average annual increase of only 1.2 percent.”²⁸¹ Furthermore, year-to-year variations are rarely huge, as shown in Figure 4 (*see page 44*), taken from the Public Citizen report.²⁸²

Notice that if one were to focus only on the change from 1995 to 1996, for example, one might well think the sky was falling. But the long term trends are anything but alarming. In fact, the upward trend in median verdicts is remarkably conservative, when one takes into account the following fact: “Because the cost of medical care for injured patients is a large component of malpractice awards, we should expect awards to rise along with increases in health care spending. Indeed, both average paid claims and per-capita health spending grew 52 percent in real [i.e., inflation adjusted] terms from 1991 [to] 2003.”²⁸³ These data illustrate that inflation in the health care industry, which is higher than general inflation, has understandably pushed up settlements as well as verdicts.²⁸⁴ Another factor contributing to rising jury awards appears to be an increasing average severity of injuries, even as assessed by agents of the insurance companies.²⁸⁵



Source: PUBLIC CITIZEN CONGRESS WATCH, MEDICAL MALPRACTICE PAYOUT TRENDS 1991–2004: EVIDENCE SHOWS LAWSUITS HAVEN'T CAUSED DOCTORS' INSURANCE WOES 4 (Apr. 2005)

Reviewing a variety of jury verdict studies, Professor Baker aptly concludes:

A consistent picture does emerge from the research on juries and medical malpractice. We see conscientious jurors who take their responsibilities seriously, pay attention to their instructions [from the trial judge], and, if anything, give doctors the benefit of the doubt. . . .

Jury verdicts do seem to be getting larger over time, but the increase is not out of line with the underlying costs. Because of advances in medical technology, the costs of injuries are increasing. . . . Also, juries are deciding more and more severe cases. These developments help explain the increase in jury verdicts.²⁸⁶

The leading proponent of health courts even appears to acknowledge this body of work. Philip Howard recently testified before a Senate committee that, “[s]tudies over the years on the effectiveness of justice tend to vary in their results, but they tend to show that, if the case goes to a jury trial, most juries come to a reasonable result.”²⁸⁷

It would be a mistake, moreover, to think of jury competence only in terms of the narrow question of whether juries make the right factual assessments. There is more to the jury institution than that, although you would hardly know it to read the disparaging views of health court proponents.²⁸⁸ These myopic views ignore the lessons of history, well known since at least the time of Tocqueville, that astute nineteenth-century observer of the new American nation, who realized that the jury, in

both criminal and civil cases, is fundamentally a “political institution” that places power over concrete cases in the hands of the governed and that serves as a “public school” that teaches citizens about the difficulties of governance.²⁸⁹ By many accounts, the jury—including the civil jury—has been a crucial instrument in the evolution of a middle class educated and accustomed to addressing legal problems and thus prepared to accept the responsibilities of democracy.²⁹⁰ Any proposal to eliminate the jury or to reduce the scope of its operation must recognize the potential loss in these terms.

E. The Tort System is Not Causing Serious Problems of “Defensive Medicine” or Lack of Patient Access to Care.

Claims about undesirable “defensive medicine” are common in the calls for health courts.²⁹¹ Yet rarely is an attempt made to be clear even about what “defensive medicine” means. One definition commonly used is “practices undertaken primarily for the purpose of reducing legal risk.”²⁹² However, tort liability is supposed to have a deterrent effect on unreasonable conduct, so the fact that the risk of liability might cause a physician to do what he or she otherwise would not cannot be the hallmark of defensive medicine in any pejorative sense of that term. In short, one must recognize that some liability-conscious decisions by physicians are a good thing.²⁹³ But the term “defensive medicine” is typically used in a purely pejorative fashion, focusing on “unnecessary” or “unjustified”²⁹⁴ tests and procedures, without explaining exactly in what sense they are unnecessary. In reality, they entail cost/benefit tradeoffs and policy considerations over which the medical profession has no monopoly of insight.

Consider, for example, a diagnostic test that has a small chance of detecting a serious health condition. If a doctor orders the test to avoid liability in case the patient turns out to suffer from the condition and would be harmed if the condition were not detected, critics of the tort system would call this defensive medicine.²⁹⁵ But another way of looking at this is to compare the cost of the test with its potential benefit—its ability, albeit in a small number of cases, to avoid patient harm. To call this defensive medicine, meaning that doctors should never order the test, is to make an implicit determination that the cost of the test will never be outweighed by its potential benefit. This ignores the fact that it may be appropriate to order the test in some circumstances—for example, when a highly risk-averse patient opts for it. A determination that the test should never be ordered is a determination that it should never be offered, an illustration of bedside rationing that many deem an inappropriate decision for the doctor to make.²⁹⁶

Even if one takes a purely pejorative view of defensive medicine, it is still not clear how much of it occurs. Hyman and Silver review the claim by health court proponents that defensive medicine is a serious problem: “Doctors, medical societies, insurers, and tort reform advocates argue that defensive medicine is widespread. Philip Howard—a member of Common Good, an organization that oppos-

es use of courts to regulate physicians—contends that defensive medicine costs more than \$100 billion per year.”²⁹⁷ The reality, they point out, is quite different, however: “The empirical evidence supporting claims of defensive medicine is far from conclusive, and it appears that Howard’s claims are grossly exaggerated.” Hyman and Silver proceed to quote from an article by Troyen Brennan and Michelle Mello, health court proponents at the Harvard School of Public Health: “Most defensive-medicine studies have failed to demonstrate any real impacts on medical practice arising from higher malpractice premiums.”²⁹⁸ Hyman and Silver explain:

The difficulty in proving the causal link between malpractice exposure and higher levels of defensive medicine arises from the multitude of motives providers may have for performing “unnecessary” tests and procedures, including greater risk-aversion, a difference of opinion as to comparative utility, and the desire to generate income.²⁹⁹

And Brennan and Mello conclude:

It is likely that defensive medicine, to the extent that it ever took place, may have diminished over time in response to the growing presence of managed care. In a fee-for-service system, the economic incentive structure encourages defensive medicine, but physicians in capitated practices lose money with each additional service ordered. Even if physicians ignore such economic incentives, their ability to order tests and procedures of questionable medical necessity is increasingly circumscribed by the oversight of cost-conscious managed care payers.³⁰⁰

Baker’s recent book contains an extensive discussion of the problem of “defensive” medicine.³⁰¹ He explains why even the commonly encountered figure of \$50 billion is both “fanciful and misleading.”³⁰² It is fanciful because it rests on unwarranted extrapolation from limited studies (concerning the treatment of heart disease among the elderly); it is misleading because it fails to account for the positive health effects of liability-conscious decision-making. After systematically reviewing the available empirical research on the issue, Baker concludes:

In combination, the defensive medicine research tells us that malpractice lawsuits probably do affect how doctors practice medicine, and some of what they do may not help patients. But the overall impact of this defensive medicine on health-care costs is not very large.³⁰³

In another chapter, Baker rejects the claim that malpractice problems are leaving patients without access to providers:

Despite the periodic complaints, no one has ever documented in systematic research that malpractice lawsuits prevent people from getting the medical care that they need. In fact, even the complaints

often do not stand up to serious fact-checking. The Government Accounting Office [now the Government Accountability Office] recently checked stories from five states that the American Medical Association said were having a malpractice crisis and concluded: "Although some reports have received extensive media coverage, in each of the five states we found that the actual number of physician departures were sometimes inaccurate or involved relatively few physicians."³⁰⁴

Baker points out that in some specialties, such as obstetrics, where one can observe a decrease in the number of practicing physicians in some locales, the real phenomenon may be greater specialization, as doctors who infrequently deliver babies refocus their practices by declining such work and specializing obstetricians consequently take over more of that practice, thus quite possibly benefiting patients by providing more specialized care.³⁰⁵ Similarly, using data on cardiac surgery in New York hospitals, Hyman and Silver illustrate that "some health care providers should curtail services or close because they are serving patients worse than others."³⁰⁶ Just as in other industries, "the public expects the market to force inferior producers to close their doors. The resulting loss of capacity is only a temporary setback, because superior producers will expand to better serve consumers."³⁰⁷ Consequently, it is not surprising that "[w]hen the GAO investigated alleged access problems in so-called 'crisis states,' it often found that other providers picked up the slack left by those that departed."³⁰⁸

Baker adds that "the real health problem stems from the demographic trends and public policy decisions that created the physician shortage."³⁰⁹ Reviewing the history of the regulation of the medical profession, he concludes:

[S]hortages of doctors do exist, but they come from rapid population growth in some parts of the country, a lack of health insurance and other problems that disproportionately affect rural areas and the poor, and from long-standing efforts [by medical leaders, acting through government] to restrict the supply of doctors.³¹⁰

F. The Malpractice System Does Not Prevent the Disclosure of Errors.

The perception of Common Good and others that malpractice concerns discourage the disclosure and reporting of medical errors, thereby hampering efforts to improve the quality of care, is false. In contrast, declares Baker, "there is no research testing the conventional wisdom that medical malpractice lawsuits drive medical mistakes underground."³¹¹ Hyman and Silver agree: "No statistical study shows an inverse correlation between malpractice exposure and the frequency of error reporting, or indicates that malpractice liability discourages providers from reporting mistakes."³¹² Moreover, they cite the observation in the *New England Journal of Medicine* by Lucien Leape of the Harvard School of Public Health, one of the authors of the Harvard malpractice study and "a strong proponent of error reporting and a

leading advocate for patient safety,” that “[f]ear of litigation may ... be overblown. No link between [error] reporting and litigation has ever been demonstrated.”³¹³

As Baker observes, “to prove that lawsuits drive medical mistakes underground, you first have to prove that mistakes would be out in the open if there were no medical malpractice lawsuits. That is clearly not the case.”³¹⁴ Hyman and Silver make the same point. In the first place, they point out, there is no evidence that physicians were more forthcoming about disclosing errors prior to the era of liability concerns: “Exhaustive chronicles of malpractice litigation’s impact on physicians never once assert that physicians freely and candidly disclosed errors to patients once upon a time, but stopped doing so when fear of malpractice liability increased. Instead, the historical evidence indicates that there was never much *ex post* communication with patients, even when liability risk was low.”³¹⁵ Nor is there evidence that there is more disclosure in legal regimes with a lower risk of liability:

Error reporting is no more frequent in the United Kingdom than the United States, even though malpractice suits are far more common in the latter. If anything, systems for gathering information about errors and health care quality are more developed in the United States, suggesting that liability and provider interest in errors are positively correlated. Reports of near misses and no-harm events are rare even though these errors cannot result in liability. Underreporting and a punitive practice culture were serious problems at VHA [Veterans Health Administration] hospitals, even though the FTCA [Federal Tort Claims Act] protected doctors and nurses who work there from malpractice suits.³¹⁶

A recent report for the Canadian government by Canadian law professor Joan Gilmour also found no substantially greater incidence of error disclosure in New Zealand despite its history of no-fault and quasi-no-fault compensation for medical injuries:

In the United States, Canada, the United Kingdom and Australia, health care providers’ reluctance to disclose errors to patients, or to colleagues so their experience can be used to develop safer systems is often blamed on fear that the information will be used to fuel lawsuits. In New Zealand, there is no such threat. One would have hoped that practitioners would be more willing to share this type of information, and that quality assurance and quality improvement would be much advanced. That does not seem to be the case. Recent inquiries into substandard care reveal many of the same kinds of deficiencies in incident reporting, complaints handling, clinical governance and management as in other countries. Many patients are not told that a mistake was made in their care, or even that they suffered an adverse event.³¹⁷

Why, then, are providers so reluctant to disclose errors? Hyman and Silver explain that this stems from many factors:

These causes include a culture of perfectionism within the medical profession that shames, blames, and even humiliates doctors and nurses who make mistakes; fragmented delivery systems requiring the coordination of multiple independent providers; the prevalence of third-party payment systems and administered prices; overwork, stress, and burnout; information overload; doctors’ status as independent contractors and their desire for professional independence; the Health Insurance Portability and Accountability Act (HIPAA); a shortage of nurses; and underinvestment in technology that can reduce errors.³¹⁸

Hyman and Silver also quote Northwestern University law professor Steven Lubet, who explains that “doctors, being human are simply reluctant to admit mistakes to their patients, and instead seize upon any available rationalization. Today, the excuse is malpractice liability. In the old days, it was the patients’ own welfare—they would not heal as rapidly, it was said, if they lost confidence in their physicians.”³¹⁹ “Given the significance of these factors,” Hyman and Silver conclude, “it is naive to think that error reporting and health care quality would improve automatically by removing the threat of liability.”³²⁰

G. Weakening the Tort System Risks Reducing, Rather than Improving, the Quality of Care.

The history of the U.S. health care system shows that tort liability increases patient safety. As Hyman and Silver observe, “No study has shown that liability exposure causes health care quality to decline overall. Instead, the best available evidence shows that liability makes a modest positive contribution to patient safety despite the definitive and unqualified claims to the contrary”³²¹

Some of the best evidence comes from the field of surgical anesthesia. Ironically, health court proponents cite the manner in which anesthesiologists reduced their malpractice liability by adopting practice guidelines as an example of how health courts could improve the quality of care.³²² But as Hyman and Silver explain, the anesthesia story in fact demonstrates the critical role that tort liability plays in promoting patient safety:

Why did the [American Society of Anesthesiologists] act when it did? According to Ellison C. Pierce, Jr., the leader of the patient safety campaign, two major factors forced the ASA’s hand: malpractice claims and negative publicity. “Anesthesiology [malpractice] premiums were ... among the very highest—in many areas, two to three times the average cost for all physicians. By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to be able to continue to be insured.”³²³

In short, Hyman and Silver conclude, “[a]nesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it.”³²⁴

Evidence for the protective impact of malpractice liability also can be found in the Harvard Malpractice Study. “[T]he [Harvard study] found an inverse relationship between the magnitude of the malpractice risk and the rate of negligent injuries, meaning as the size of the malpractice risk increased, both the frequency of mistakes and the frequency of negligence declined.”³²⁵ The authors of the Harvard study acknowledged this themselves: “[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.”³²⁶ Hyman and Silver continue:

The [Harvard study] also demonstrated that patients who are least likely to sue, the aged and the poor, were the most likely to be negligently injured—precisely the result a standard model of deterrence predicts. Finally, the [Harvard study] found that the experience of being sued “made [doctors] twice as likely to take more time in explaining the risks of treatment to their patients,” which is the opposite of the effect that patient safety advocates, who argue that malpractice liability discourages candor, predicted. Not surprisingly, the [Harvard study] report recommends that policymakers accept and act on the “indication ... that malpractice litigation does have an injury prevention effect.”³²⁷

As Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious. As the title of their most recent article says, “it’s the incentives, stupid”:

Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients. Stated more delicately, when insurance rates go up, they create a highly salient incentive for providers to improve the quality of the services they are offering.³²⁸

In short, the notion that errors would decline if tort liability diminished is ridiculous:

Many providers have failed to adopt patient safety measures of proven effectiveness, and they have similarly failed to use information already in their possession to protect patients from harm. Given that providers subject to liability for negligence behave in this fashion, it is absurd to think they would voluntarily spend hundreds of millions or billions of dollars implementing patient safety initiatives if the threat of liability were removed.³²⁹

If anything, say Hyman and Silver, the deterrent effect of the tort system ought to be increased: “The main problem with the legal system is that it exerts *too little* pressure on health care providers to improve the quality of services they deliver. ...

Safe health care is expensive, and the tort system forces providers to pay only pennies on the dollar for the injuries they inflict. Rather than spend money improving their systems, providers find it cheaper to tolerate the status quo.³³⁰

Baker adds a broader perspective, observing that “[w]ith few exceptions, all the research documenting the medical malpractice epidemic came in response to medical malpractice lawsuits.”³³¹ In a passage that relates clearly to health court proposals, Baker articulates the irony in modern tort reform efforts aimed at medical malpractice. He observes that, in the wake of recent empirical studies of malpractice, the nature of opposition to malpractice litigation has shifted:

[N]o serious researcher would ever claim that medical malpractice lawsuits are a bigger problem than medical injuries. Nevertheless lawsuits remain one of the driving forces behind the research on medical injuries. What has changed is simply the nature of the concern. It used to be that too many patients were bringing lawsuits, leading doctors to engage in too much unproductive, defensive medicine. Now the concern is that too few patients get compensated and lawsuits get in the way of patient safety.

Patient compensation and patient safety are legitimate concerns. But those are the goals of malpractice lawsuits, not a reason to make them harder to bring or less effective. Certainly there is room for improvement on both fronts. But there is also a certain irony in the complaint that medical malpractice lawsuits do not do enough.

The medical establishment used to say that injured patients and their lawyers were making up the medical malpractice problem. Now they say that patients and their lawyers are not doing enough to fix that problem: “Get out of the way and let the medical professionals do the job.”³³²

A 2002 study in the *New England Journal of Medicine* found that, in general, physicians did not accept the IOM’s 98,000 figure as the number of hospital deaths caused by medical errors and did not think that medical errors were one of the most important problems in health care.³³³ One may fairly ask: Why should we turn over the problem of under-compensation of deserving plaintiffs even more to a profession that has long denied, and for the most part continues to deny, that this is the important problem to be solved?³³⁴

H. The Administrative Costs of the Malpractice System Are Not Easily Avoidable.

Health court proponents claim that the legal process of malpractice claims is “staggeringly inefficient.”³³⁵ Much of their case for a different bureaucracy is based on the idea that it will handle malpractice claims more expeditiously and inexpensively. We have previously discussed how the malpractice system sorts claims remarkably well. (Section V.A.) Here we add that, under the circumstances, it does so at a reasonable, if unfortunately high, overhead cost.

Finding meaningful measures of the efficiency of the tort system is not as difficult as assuring consistency in their use. A plausible measure is the ratio of the total net compensation received by claimants to the total system costs. The problem is that the “total system costs” can be defined in various ways. When defined in terms of the total premium dollars paid by insureds, one gets a ratio for medical malpractice cases of about 40 percent, in accordance with Howard’s previously quoted statement:

More than 60 percent of the total cost of the malpractice system is consumed by lawyers’ fees and administrative costs. The lawyers portray themselves as a kind of Robin Hood for injured patients, but the modern twist is that they keep most of the money.³³⁶

This statement, however, is misleading in two ways. First, it suggests that, putting aside some minor “administrative costs,” nearly 60 percent of the total cost is consumed by lawyers, whereas in fact the administrative costs to which Howard refers include the insurer underwriting and overhead costs as well as insurer profits, which collectively constitute about a third of the 60 percent.³³⁷ Second, Howard’s statement suggests that the remainder of the 60 percent goes to the only category of lawyers discussed in the rest of the passage—plaintiffs’ lawyers—whereas in fact the remaining 40 percent is divided roughly equally between plaintiffs’ and defendants’ lawyers.³³⁸ Contrary to the implicit message of the quoted passage, insurers and defense attorneys collectively consume roughly two-thirds of the 60 percent.

In any event, this is an expansive concept of total system costs, one that measures the efficiency of the insurance system as well as the litigation system itself. Without changing any of the underlying reality, total system costs could be made even larger, and the efficiency measure thus even smaller, by including public (taxpayer paid) costs of running the court system as well as time lost from work by plaintiffs and defendants to handle claims, which are not paid out of insurance premiums. Other researchers have defined total system costs to include these latter expenses but to exclude the non-litigation costs of insurers, such as insurers’ underwriting costs and profits.³³⁹ There is, perhaps, no uniquely correct frame of reference here, and the point is to be clear about what is being discussed and, in making comparisons, to compare “apples to apples.”

Selecting a consistent convention for total system costs, the efficiency of medical malpractice litigation may be compared to that of other tort litigation. For example, several studies take “total system costs” to mean the sum of three items: (1) net compensation to plaintiffs; (2) plaintiffs’ out-of-pocket litigation expenses (attorneys’ fees, expert fees, and court costs); and (3) defense out-of-pocket litigation expenses (attorneys’ fees, expert fees, and court costs). (This excludes lost work time for plaintiffs and defendants, insurer underwriting costs and profits, and public court expenses.) One such national estimate for the year 2001 puts the sum of the first two items (which constitutes payments on claims) at \$4.4 billion and the third item at \$1.4 billion.³⁴⁰ Using 35 percent as an average fee for plaintiffs’ attorneys,³⁴¹ this would mean \$1.54 billion for item (2). In that case, item (1), plaintiffs’ net recov-

eries (\$2.86 billion) constitute 49 percent of total system costs; the remaining 51 percent is divided between plaintiffs' litigation expenses (27 percent) and defense litigation expenses (24 percent). Using the same (or a very similar) convention for total system costs and the same assumption for measuring plaintiffs' attorneys share of the indemnity payments, the data from a recent study by researchers at the Harvard School of Public Health show that plaintiffs' net recoveries constitute about 54 percent of total system costs.³⁴²

How does this 49-54 percent efficiency range compare with other tort litigation? A thorough study of tort claims in 1985, though somewhat dated, provides useful comparisons. (Dollar amounts will have changed substantially since 1985, but percentages probably have remained fairly stable.) For all torts, the comparable ratio (net compensation as percentage of total system costs as defined above) was 57 percent.³⁴³ For automotive torts, the figure was somewhat better, 58 percent.³⁴⁴ For all other torts (which include medical malpractice, products liability, aviation accident cases, premises liability, etc., and collectively accounted for about half of all filings and payments),³⁴⁵ the comparable figure was 53 percent.³⁴⁶ It is fair to infer that litigation expenses are only modestly higher (as a percentage of total system costs) in medical malpractice cases than in automobile torts, and they are comparable to percentages found in other non-auto torts, which, as the authors of that study observe, tend to be more complex than automobile cases.³⁴⁷

Again, these measures of efficiency would all be somewhat lower if other system costs, such as work time lost by plaintiffs and defendants to litigate cases, were added to the definition of "total system costs," but this would not greatly affect the comparison between malpractice and other torts.³⁴⁸ Moreover, it is important to note that all these measures of efficiency would be *higher* if successful claimants were not under-compensated.³⁴⁹ In particular, these measures would be significantly higher for all categories of tort cases if successful plaintiffs were entitled to recover their litigation expenses in addition to the other costs that are imposed on them by the tortious conduct of providers. For example, using the data from the recent Harvard School of Public Health study, if total system costs are increased by the amount of the plaintiffs' litigation expenses, and plaintiffs' net recoveries are increased by the same amount, the efficiency ratio rises from 54 percent to 65 percent.³⁵⁰ Consequently, if what one wants is a system that maximizes efficiency, understood as the ratio of net plaintiff recoveries to total system costs (however plausibly defined), one of the simplest and most dramatic positive reforms would be to allow successful plaintiffs to recover reasonable attorneys' fees as a separate component of their economic losses.³⁵¹

In any event, the transaction costs of the current medical malpractice system are relatively high for a number of reasons, but as suggested above, a primary reason is the lack of certainty about what constitutes proper medical care. This point bears amplification. As Hyman and Silver observe: "A great deal of uncertainty exists about the 'best' treatment for particular clinical conditions, and about the 'best' way to perform these treatments. The efficacy of most medical treatments has never been

proven, and many treatments have some upside potential. Many treatments can also be administered in a variety of ways.”³⁵² This was recently underscored by a cover article in *Business Week*, which quoted physician and health care quality expert David Eddy as admitting: “The problem is that we don’t know what we’re doing.”³⁵³ The article continues:

And while there has been progress in recent years, most of these physicians [who endorse Eddy’s critique] say the portion of medicine that has been proven effective is still outrageously low—in the range of 20% to 25%. “We don’t have the evidence [that treatments work], and we are not investing very much in getting the evidence,” says Dr. Stephen C. Schoenbaum, executive vice-president of the Commonwealth Fund and former president of Harvard Pilgrim Health Care Inc. [Eddy states:] “I’ve spent 25 years proving that what we lovingly call clinical judgment is woefully outmatched by the complexities of medicine.” Think about the implications for helping patients make decisions, Eddy adds. “Go to one doctor, and get one answer. Go to another, and get a different one.” Or think about expert testimony. “You don’t have to hire an expert to lie. You can just find one who truly believes the number you want.”³⁵⁴

Hyman and Silver concur:

A final problem affecting healthcare quality is the lack of information regarding the absolute efficacy (let alone cost-effectiveness) of many diagnostic tests and medical treatments. Manufacturers must provide evidence of effectiveness to gain regulatory approval for new pharmaceuticals, but no such requirement applies to medical procedures. Consequently, doctors can administer unproven treatments, and those treatments can rapidly become the standard of care. For example, about 300,000 Americans receive arthroscopic knee surgery for osteoarthritis annually, at an estimated cost of \$1.5 billion per year. Yet, a study published in the *New England Journal of Medicine* in 2002 found that patients who received the surgery handled tasks like walking and climbing stairs less ably than patients who did not. Other common procedures, such as coronary artery bypass surgery and spinal fusion surgery, also fail to help many patients. In one recent high-profile example (bone marrow transplant for advanced breast cancer), the treatment provided no benefits and killed an appreciable number of the women who received it.³⁵⁵

Hyman and Silver go on to describe how uncertainty affects medical training:

Medical schools and other training programs for health care professionals do not teach modern quality assessment and improvement techniques. Instead, they teach students to make independent judgments and treasure clinical autonomy. This training may often

benefit patients by supplying them with confident agents. But professional independence can have a significant downside for patients as well. A great deal of uncertainty exists about the "best" treatment for particular clinical conditions, and about the "best" way to perform those treatments. . . . Given these uncertainties, independent medical agents have significant discretion to recommend procedures that are sub-par and to implement procedures in sub-optimal ways.³⁵⁶

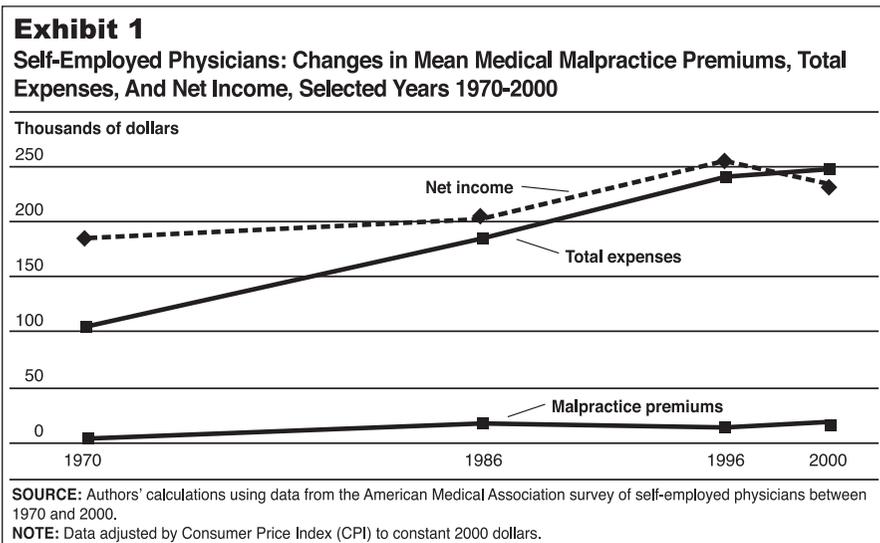
Given the uncertainty within the field of medicine itself, it is not surprising that the malpractice system has to expend considerable resources to determine when a patient has suffered a compensable injury. As Professor Frank Sloan of Duke University explains: "To the extent there is highly incomplete knowledge about the effect of particular interventions by health care providers on outcomes, it is unrealistic to expect courts to be omniscient in this regard."³⁵⁷ While it is important to be alert to possible ways of reducing malpractice litigation costs, we should not misunderstand the nature of the problem. Health court proponents point the finger at the legal system's failure to provide more specific standards to juries,³⁵⁸ but the legal system takes its cues largely from the medical community, and (justifiably or not) the latter has been unable to provide the desired specificity.

I. The Cost of the Tort System for Medical Malpractice Has Little Impact on the Overall Cost of Health Care, Physician Income, and Even the Fluctuations in Malpractice Premiums.

It is important to recognize several facts about the economics of malpractice and health care, facts that tend to get lost in the tort reform rhetoric that accompanies health court proposals. First, the malpractice system has little impact on the overall cost of health care. Direct medical malpractice system costs, however defined, are a very small portion of the cost of health care itself. For example, "[t]he cost of defending U.S. [medical] malpractice claims, including awards, legal costs, and underwriting costs, was an estimated \$6.5 billion in 2001—0.46 percent of total health care spending."³⁵⁹ Referring to the myth that increasing malpractice premiums are what drive increasing health care costs, and using comparable figures available for the year 2003, Baker comments: "Something [total malpractice premiums] that amounts to less than 1 percent of health-care costs simply cannot have the impact on health care costs that the medical malpractice myth would have us believe."³⁶⁰ Bovbjerg and Berenson observe that even if malpractice insurance premiums decreased nationally by 25-30 percent, the reduction in overall health care spending would be in the neighborhood of only .05 percent.³⁶¹ In the same vein, researchers comparing data from the United States and other industrialized nations have concluded that this country's malpractice litigation system explains little of the fact that per capita spending on health care is so much higher in this country; rather, "[t]he two most important reasons for higher U.S. spending appear to be higher incomes and higher medical care prices."³⁶²

Of course, including indirect costs might change this picture. If defensive medicine costs were as high (and as undesirable) as health court proponents believe, then a real (and undesirable) impact on health care costs would be possible. As discussed above (Section V.E), however, claims about defensive medicine are both confused and exaggerated. Moreover, if one takes indirect costs into account, then one must also account for indirect savings, that is, the malpractice that is deterred by the risk of liability and by the consequent public exposure of the flaws in the medical system (Section V.G). Unfortunately, the literature contains no reliable estimates of the net impact of these forces.

Nor is there evidence that malpractice costs have a substantial impact on physician incomes. Nationwide surveys of self-employed physicians from 1970 to 2000, conducted by the American Medical Association, were recently analyzed to determine the validity of repeated public claims during this period that increasing malpractice premiums were stressing the practice of medicine.³⁶³ Several important results emerged. First, between 1970 and 2000, mean physician net income (adjusted for inflation) went up substantially, despite steeply increasing total expenses.³⁶⁴ Second, “premiums have consistently been a small percentage of total practice expenses except within anesthesiology, which is a result of its having much lower than average nonpremium expenses.”³⁶⁵ The non-premium expenses include “office rent or mortgage payments, medical equipment and medical supplies, nonphysicians’ salaries, office expenses, utilities, and so on.”³⁶⁶ In the category of “a picture is worth a thousand words,” Exhibit 1 (*below*) from that article³⁶⁷ displays the relationships clearly.



Source: Marc A. Rodwin, et al., Malpractice Premiums and Physicians' Income: Perceptions of a Crisis Conflict with Empirical Evidence, 25 HEALTH AFF 750, 752 (2006)

The authors of this study note that “[w]hen premium increases occurred between 1970 and 1986, and from 1996 to 2000, they had only a small effect on net income.”³⁶⁸ While it is true that premiums increased some 200 percent over this thirty-year period (after adjusting for inflation), the increase in premiums was less than 9 percent of the increase in total expenses; the average annual premium increase over the period was \$416, while the average annual increase in total expenses was \$4,625.³⁶⁹ Similar patterns are observed when focusing on practice specialties and regional data.³⁷⁰ The authors of the study added the following comment:

What accounts for the common perception that premiums have steadily increased and caused large decreases in practice income? . . . Frustrations with contemporary medical practice might focus on malpractice as a source of problems caused by other factors. . . .

. . . It was revenue decline and increases in nonpremium expenses, not premium increases, that account for the overwhelming share of falling income [between 1996 and 2000].³⁷¹

It is not surprising, therefore, that “[t]he strongest studies have found that the malpractice environment,” as measured by premium levels, “has had only small or no effects on the supply of physician services overall”³⁷²

The figure displayed above tells us something else: if the increases in the non-premium expenses are being driven to a large extent by “defensive medicine,” then the concern that drives these defensive activities is wholly out of line with the underlying litigation risk reflected in the premium levels.

Of course, even if total health care costs and physician incomes are largely unaffected by the relatively small costs of the malpractice system, one might at least think—and tort reform rhetoric encourages one to think—that the annoyance of premium hikes is attributable to sudden surges in the costs of liability. To be sure, malpractice system costs (compensation and overhead) do drive malpractice premiums in the long run, but “long run” is an important qualification. Claims that variability in malpractice verdicts drives short-term fluctuations in premium rates are unsupported. There is abundant evidence that the surges in malpractice premiums that occasionally occur are not directly related to the supposed “lottery” of malpractice payouts, but rather to the result of periodic swings in the optimism or pessimism of insurers with regard to expected average payouts and necessary reserves, a fact discussed further in Section VI.H.

J. Summary.

No system is perfect. But the medical malpractice system works substantially better than health court advocates contend. As Bovbjerg and Tancredi, the experts on ACEs, admit, “[t]he system resolves individual disputes better than often appreciated.”³⁷³ Its performance is best summed up by Hyman and Silver:

Patients rarely sue, and those who sit on their rights rarely receive compensation. Virtually all patients who do sue suffered adverse outcomes involving serious physical injuries, and most have plausible or valid claims. Truly frivolous complaints are rare. Far more common are claims that seem strong initially but that turn out to lack merit. The malpractice system weeds out these claims fairly well. Patients with meritorious complaints are more likely to receive payments and tend to receive larger amounts. Over the past fifteen years, the system also appears to be stable in important respects. Claim frequency, payment frequency, payment amount, and jury verdicts have all fallen slightly, held roughly constant, or risen slightly. There are no dramatic changes in any of these measures, and the trends that have been noted appear to reflect rising health care costs or the progressive removal of smaller cases from the system.³⁷⁴

In short, conclude Hyman and Silver, “[t]he conclusion that the malpractice system is generally stable and predictable seems surprising only because health care providers and tort reform advocates complain so loudly and so often that it is ‘broken’ and ‘spinning out of control.’”³⁷⁵

VI. HEALTH COURTS WOULD NOT PERFORM AS WELL AS PROPONENTS CONTEND.

Health court proponents not only claim that the tort system is broken, but that health courts would do a better job at handling medical malpractice claims. First, they maintain that more patients would receive compensation. The Republican Policy Committee states that “the administrative nature of the claim-filing process would allow easier access to compensation for a greater number of injured patients.”³⁷⁶ The Heritage Foundation asserts that combining aspects of the workers’ compensation, Social Security, and Medicare administrative law systems into the health court process is aimed at “expanding the number of claimants who can receive compensation for their injuries.”³⁷⁷ The Progressive Policy Institute also wants patients to have “easy access to compensation,”³⁷⁸ and Philip Howard contemplates “a liberalized standard of recovery” under which “liability is automatic where there is a clear mistake.”³⁷⁹

Health court advocates also claim that their system would facilitate the disclosure of medical errors to patients, enabling more of them to seek compensation. One of the main reasons for adopting an ACE approach, according to Bovbjerg and Tancredi, is “enhanced disclosure,” which they believe “is far more workable with ACE lists and changed rules than under tort.”³⁸⁰

Health court proponents contend that, by abandoning the focus on negligence, health courts would eliminate the shame-and-blame approach of the tort system. The Common Good draft proposal states, for instance, that “[t]he avoidability standard is desirable because it moves away from the notion of individual fault and the negative connotations that the medical profession associates with negligence. It comports with the notion of preventability, which is critical to the patient safety movement’s insistence on lack of blame.”³⁸¹ According to health court advocates, the “avoidability” standard not only would avoid shame-and-blame, but it would be based on sound science, as the third of the “core principles” listed in the Common Good Draft Proposal makes clear:

Compensation criteria are ‘evidence-based,’ in the sense that they are grounded in experts’ interpretations of the leading scientific literature. To the maximum extent feasible, compensation decisions are guided by ex ante determinations about the preventability of common medical adverse events made through a process of deliberations and review of scientific evidence involving clinical experts and other key stakeholders.³⁸²

In addition, health courts, supporters assert, would provide compensation rationally and consistently. This would result from the use of “guidelines for compensating both economic and noneconomic losses,” with the “[v]aluations of noneconomic damages ... made using methods that are explicit, rational, and consistent.”³⁸³ Furthermore, health courts would employ practice guidelines and create

a body of precedent to help guide providers about appropriate care, thereby reducing both medical errors and defensive medicine. The Progressive Policy Institute expects the system to provide “consistent, rational rulings that send clear signals to health care providers about what constitutes good medical practice,”³⁸⁴ while the Harvard School of Public Health press release asserts that “[t]he judges’ rulings would help set clear and consistent standards for healthcare delivery.”³⁸⁵ According to the Public Policy Institute, this would “help eliminate the uncertainty that encourages doctors to practice defensive medicine and contributes to medical errors.”³⁸⁶

Supporters also maintain that health courts would promote patient safety and improve the quality of health care. This would follow from the “public reporting of health court cases,” which “would replace ad-hoc decisionmaking based on testimony of dueling experts,”³⁸⁷ as well as from the fact that the system would “encourage the reporting and discussion of medical mistakes and near misses instead of driving that discussion underground by a fear of lawsuits.”³⁸⁸ Furthermore, “[d]e-identified information from the adjudication process [would be] made immediately available to caregivers for root cause analysis and development of preventive practices,” and “[i]nformation is also extracted from standardized event reporting for epidemiological analysis to understand new prevention strategies.”³⁸⁹

At the same time, the proponents of health courts expect this new system to be “affordable.”³⁹⁰ This will result, it is said, from savings in administrative expenses and claimants’ legal fees.³⁹¹

The foregoing are worthy objectives. It certainly would be desirable to have greater disclosure of errors so that more patients would be compensated and the quality of care improved; to reduce the administrative costs of compensating victims; and to give practitioners clearer and more scientifically-validated signals about what constitutes proper care. But there are good reasons to doubt that a health court system would achieve these goals.

A. “Avoidability” Holds Little Promise of Being a Better Standard Than “Negligence.”

Health court supporters want to replace the negligence standard of the tort system with an avoidability standard, which they believe would be broader, easier to apply, and less stigmatizing for health care providers. In practice, however, “avoidability” may not differ significantly from “negligence.” Both imply fault. In a 1992 paper, for example, Tancredi and Bovbjerg acknowledge that “ACEs could be termed ‘quasi-fault’ because of their emphasis on preventability.”³⁹² Earlier, Tancredi and Havighurst cautioned that, in adopting an avoidability standard, “[w]e would not require compensation to be confined to highly avoidable events, since that would be to reintroduce fault through the back door.”³⁹³ Yet Bovbjerg and Tancredi propose exactly such a threshold of high avoidability for health court ACEs: “Avoidability: Events are medically caused and moderately or highly preventable as a class (e.g., 70% or more, relative to not good care).”³⁹⁴

Numerous formulations of the standard for liability in a health court system, moreover, effectively adopt a negligence approach. As noted earlier in Section IV, the Progressive Policy Institute wants patients to be compensated when they are injured as the result of a medical mistake “that *should have been prevented*,”³⁹⁵ and expects judges to resolve cases “in light of expert testimony about whether the provider’s actions were within the range of *reasonable* actions given the circumstances.”³⁹⁶ Havighurst and Tancredi state that “[a] decision to make an event compensable must also reflect a judgment of unexpectedness and of preventability through *correct application of medical knowledge*.”³⁹⁷ In a 1974 article entitled “Identifying Avoidable Adverse Events in Medicine,” Tancredi observes that “[t]he difficulty lies in the necessary task of distinguishing between injuries that could have been avoided by virtue of *timely and appropriate diagnosis and treatment* and those that are merely incidents of the disease or dysfunction that brings the patient to the physician in the first place.”³⁹⁸ Finally, the Model Act defines an “avoidable medical injury” as “a medical adverse event that would not have resulted if care had been delivered in a manner consistent with that of an experienced practitioner or specialist in the relevant clinical area.”³⁹⁹ Saying that an action “should have been prevented,” that it did not reflect “correct” application of medical judgment, that it would have been avoided by “timely and appropriate diagnosis and treatment,” or that it was not care that was delivered in a manner “consistent with that of an experienced practitioner,” not to mention depicting it as not within the range of “reasonable,” are all ways of describing an action as negligent.⁴⁰⁰

Indeed, the Republican Policy Committee’s version of health courts explicitly adopts a negligence standard for identifying compensable events, including ACEs:

Injured patients would obtain claim forms from their health care providers and would submit them to the local health court review board. These boards would be responsible for investigating the claims to determine whether the alleged malpractice does, in fact, constitute *negligent* behavior on the part of the provider. If the board determines that the case for negligence is clear, the board will order the patient’s provider to pay damages to the patient according to a standing schedule of benefits This schedule of benefits would compensate any number of *negligence [sic] events* compiled by medical experts. These “*avoidable classes of events*” or “*accelerated compensation events*” (ACEs) would be immediately compensable because their occurrence would be a “*clear indication*” of wrongdoing by the provider.⁴⁰¹

Another argument asserted in favor of an avoidability standard is that it is easier to apply because, unlike a negligence standard, it focuses on the *outcome* of an episode of care rather than on the appropriateness of the *process* of care that was employed. Tancredi and Bovbjerg state, for example, that “[i]n contrast to the current system, which relies on retrospective, highly idiosyncratic testimony about allegedly faulty processes of care in particular cases, the creation of ACEs relies on generalized expert judgments about statistical outcomes of medical care, applied in

advance.”⁴⁰² Supposedly, this focus on avoidable outcomes eliminates the need for the health court system to trouble itself with whether what the provider *did* was inappropriate; instead, the system only needs to reach the simpler deduction that the *result* was inappropriate.

Regardless of whether it is easier to identify inappropriate outcomes as opposed to inappropriate processes of care, however, this goal is illusory. Bovbjerg and Tancredi admit that the ACE approach is “closely tied to clinical processes.”⁴⁰³ As they point out, “ACEs often contain specifications of medical processes or standards deemed to be linked to avoidable outcomes.”⁴⁰⁴ A table of eleven sample ACE listings that they provide includes, for example, “complications from failure to diagnose and treat hypoglycemia in a newborn,” “complications from foreign body unintentionally left in the operative site after any general surgical operation or procedure,” and “complications from falls from table during surgical operation or procedure or delivery.”⁴⁰⁵ All of these describe both processes and outcomes. Moreover, as noted earlier, the definition of avoidability hinges on whether a patient injury could have been avoided by “best” or “good” medical care.⁴⁰⁶ Clearly, therefore, creating lists of avoidable events entails considering what processes of care would be “best” or “good.”

The imprecision about whether an avoidable outcome is one that would be prevented by “best” practices or “good” practices highlights the general imprecision of the avoidability standard. Common Good admits this vagueness—“We recognize that delineating avoidable from unavoidable events will not be straightforward in all situations”—but seeks to downplay it by observing that “the negligence distinction itself is not clearcut.”⁴⁰⁷ Yet this ignores the fact that classic medical malpractice doctrine distinguishes between “reasonable” and “optimal” medical care, and only makes providers liable when they fail to deliver the former. A compensation system that was unclear about which standard it should apply not only would be more difficult to operate, but would send more ambiguous signals to providers about how they should behave.

B. The Use of ACEs Offers a False Hope of Scientific Objectivity.

Health court supporters claim that ACEs will replace the “capricious” malpractice system⁴⁰⁸ with compensation based on science and statistics. Tancredi and Bovbjerg describe ACEs as “strongly grounded in scientific understanding of the development of adverse outcomes.”⁴⁰⁹ ACEs, they explain, combine statistics with epidemiology: “The standard for being listed as an ACE is statistical avoidability, as in epidemiology. It is not individual error or ‘smoking gun’ noncompliance with some standard, generally articulated after the fact, as in peer review or liability law.”⁴¹⁰ The same scientific foundation, they maintain, characterizes the standard of “avoidability”: “The determination of ‘avoidability’ ... relies on a probabilistic association between a type of medical intervention and a class of adverse outcomes, not on a detailed examination of a specified incident. The view of causation, therefore, is scientific rather than legal”⁴¹¹

The scientific basis for ACEs is an illusion, however. ACE lists, Tancredi and Bovbjerg admit, are nothing more than the opinions of a handful of physicians: “ACEs are created by medical experts who review case scenarios of medical injuries from which they generalize to sets or classes of events.”⁴¹² Judgments based on the opinions of a group of experts are known as “consensus statements.”⁴¹³ They are not themselves science. They may not even be based on scientific evidence. As Lars Noah, Professor of Law at the University of Florida, observes in connection with the use of consensus statements as guidelines for appropriate practice: “Some researchers have attempted to model the consensus-building process that underlies the development of clinical practice guidelines, which may employ special procedures for polling expert panels for an assessment of the appropriateness of using particular procedures in a series of hypothetical scenarios, but this still does not convert it into a scientific endeavor.”⁴¹⁴ Noah then quotes David Eddy, the father of truly scientific, “evidence-based” medicine, who cautions that “a consensus may do no more than identify the point at which all the errors, oversimplifications, and biases converge; it does not necessarily identify what is best.”⁴¹⁵ Noah also quotes Charles E. Phelps, who points out that “[m]ethods based on reaching a consensus among experts do not create new scientific data, they only codify old beliefs.”⁴¹⁶ Even the standard for determining whether a patient’s injury was “unavoidable”—“moderately (70%+) preventable”⁴¹⁷—which Tancredi and Bovbjerg describe as a “scientific, rather than legal” view of causation,⁴¹⁸ turns out to be not only non-scientific but entirely arbitrary: “70 percent avoidable,” they disclose, was merely “a level the expert consultants deemed appropriate.”⁴¹⁹

Ultimately, Tancredi and Bovbjerg back off their claim that ACEs are based on empirical data. “[E]pidemiological research on injuries remains almost as rare today as in the past. Hence, the ACE definition necessarily relies on expert clinical judgment”⁴²⁰ The science behind ACEs, in short, is nothing more than the expert’s opinions “informed by knowledge of the clinical literature and using an epidemiological perspective.”⁴²¹ In the end, Tancredi himself acknowledges that ACEs were “to a great extent, subjective since there are limited data of an epidemiological nature to establish an association between certain medical interventions and adverse medical outcomes”⁴²²

This is not to say that standards of liability should not be informed, to the extent possible, by epidemiological and other empirical science. But that is already possible using the negligence standard. Reliance on ACEs presents the potential for the medical profession to control the standard of liability to be applied to it by making value judgments and policy choices in the guise of objective science. Medical expertise deserves no monopoly on such decisions.

C. Practice Guidelines Are of Limited Feasibility and Usefulness.

According to its backers, health courts would rely extensively on practice guidelines to determine whether an adverse event was compensable. The Progressive

Policy Institute, for example, proposes that “[i]n cases involving medical circumstances not covered by the ACE index ... health courts’ neutral experts would rely on scientific literature and consider evidence-based guidelines listed in the National Guidelines Clearinghouse operated by the U.S. Agency for HealthCare Research and Quality (AHRQ).”⁴²³

Practice guidelines are one of the holy grails of medicine. In an early overview, Professor Arnold Rosoff observed in 1995 that “the use of clinical practice guidelines will bring substantial benefits to our health care system. While there will always be a need and a place for professional medical judgment, it is wise to make maximum use of available empirical evidence of what works and does not work, synthesizing those data into carefully analyzed, widely disseminated guidelines to assist physicians in the application of their judgment. Benefits to the legal system will flow from this as well, making possible more accurate, efficient, timely, and affordable resolution of disputes about the quality and appropriateness of health care provided.”⁴²⁴

Although heralded with much promise, practice guidelines in large part have been a disappointment. Lars Noah, Professor of Law at the University of Florida, explains why.⁴²⁵ First, as described above in regard to ACEs, practice guidelines may be based on opinion and habit rather than on sound science. As John D. Ayres observes in an understatement quoted by Noah, guidelines “are constructed on a somewhat fragile data base.”⁴²⁶ Second, Noah points out, “[t]he process of developing guidelines, which some commentators have described as ‘haphazard,’ may itself introduce serious distortions.”⁴²⁷ There may be conflicts of interest on the part of the entity issuing the guidelines, such as when specialty societies seek to preserve their turf against inroads by non-specialists, or when guidelines are issued by health insurers or drug companies.⁴²⁸ Third, a guideline may become out of date,⁴²⁹ and the issuing entity may not employ an adequate method for updating it. Fourth, there is a proliferation of guidelines and no clear way to identify which guidelines are better than others, and which are definitive.⁴³⁰

Another key issue that health court advocates have not addressed is the fact that physicians do not necessarily follow practice guidelines.⁴³¹ Studies reviewing compliance with clinical practice guidelines consistently show a low compliance rate.⁴³² Compliance rates decrease further when hospitals, insurers, or medical societies issue the clinical practice guidelines but do not take steps to ensure that the guidelines are followed.⁴³³

As mentioned above, the Progressive Policy Institute proposes that health court experts rely on guidelines listed by the National Guidelines Clearinghouse operated by the U.S. Agency for HealthCare Research and Quality. But as its name indicates, this clearinghouse is no more than a collection of guidelines from different sources. AHRQ expressly states that it makes “no warranties concerning the content or clinical efficacy of the clinical practice guidelines and related materials,” that “inclusion of any guideline in NGC does not constitute or imply an endorsement by

AHRQ,” and that the guidelines “are the products of named organizations that are solely responsible for their content.”⁴³⁴ The Progressive Policy Institute acknowledges this problem itself, stating that in 1994 there were more than 1600 guidelines, and that they “vary greatly in quality and scope.”⁴³⁵ Moreover, the proliferation of guidelines ensures that there will be conflicts. As Noah observes, “[o]ne need only point to situations where practice guidelines deviate from one another in making recommendations for treating the same condition”⁴³⁶ Finally, guidelines may be too general to provide significant direction in specific cases, or too narrow to have widespread applicability. “Overly prescriptive guidelines,” points out Noah, “may incorrectly suggest definitive scientific support for a particular intervention and also fail to account for the inevitable need for flexibility in dealing with patient variability.”⁴³⁷ The Progressive Policy Institute admits that “[i]n order to avoid what is sometimes called ‘cookbook medicine,’ health courts would consider practice guidelines in the context of each case, according to the individual needs and characteristics of patients.”⁴³⁸ But this would substantially eliminate the ability of guidelines to provide clear-cut standards of care.

The Progressive Policy Institute ultimately recognizes many of these limitations: “Establishing standards of medical care is remarkably complex. There may often be several courses of treatment that fall within a range of reasonableness, rather than one acceptable course, depending on variables such as a patient’s health, age, or other circumstances. Sometimes a widely used practice does not always constitute good care.”⁴³⁹ It is difficult to understand, therefore, how the Institute can place such great store in the ability of practice guidelines to aid health court experts.

Michelle Mello, a member of the Harvard School of Public Health team that the Robert Wood Johnson Foundation has funded to develop a health court prototype, also recognizes the shortcomings of clinical practice guidelines (“CPGs”) at this stage in their development when she states succinctly:

We have yet to resolve basic issues such as which set of guidelines is the authoritative prescription for a particular medical problem, what procedures should be used to create guidelines, what institutions, goals, and values should drive their development, and how we can ensure that guidelines are disseminated and adopted by physicians. It would be foolhardy to make CPGs the centerpiece of malpractice litigation before the science of creating and implementing them on a wide scale has fully evolved.⁴⁴⁰

D. It Is Unlikely That Many More Patients Would Discover That They Had Suffered a Compensable Injury.

A key goal of health court proponents is to alert more patients that they had been injured so that they could assert claims for compensation. Supporters routinely cite findings showing that few victims of medical error actually file a claim.⁴⁴¹ The health court concept is intended to remedy this by encouraging hospitals to disclose mis-

takes to patients and make early offers of compensation.⁴⁴² But health court proponents are quite vague about what mechanisms actually would lead to such disclosures and offers.

The Common Good Draft Proposal would impose a monetary penalty on a hospital or health care provider that failed to disclose to a patient a known error, or known information about an error.⁴⁴³ But penalties like those envisioned by Common Good for failure to disclose errors would only be effective if patients subsequently found out that errors had occurred and brought this to the attention of a health court. It is well-accepted that patients cannot easily determine whether they have been victims of medical error. As Hyman and Silver state: “[M]edical errors are often hard to spot. The popular literature on health care quality is replete with stories of patients who either never discovered their harms or never identified medical errors as the cause. Even physicians asked to review patients’ charts often miss departures from the standard of care.”⁴⁴⁴ Nothing suggests that patients would be any more likely to discover undisclosed errors under a health court system than under the tort system.

Even if patients eventually found out that they had not been informed about an error, it may be too late for penalties to be imposed. None of the health court proposals addresses what the statute of limitations should be for filing claims, much less for imposing penalties for non-disclosure. Conceivably the statute of limitations would be the same under a health court system as under the tort system. Yet as part of recent changes in malpractice laws, many legislatures have cut back the time in which malpractice suits can be filed.⁴⁴⁵

Incentives do not change just because of wishful thinking. And the specifics of health court proposals actually cut the opposite way. For example, both the Common Good and Progressive Policy Institute proposals call for the health court system to be financed by experience-rated malpractice insurance premiums.⁴⁴⁶ Since hospitals with larger numbers of paid claims would pay higher premiums than hospitals with fewer paid claims, experience-rating would discourage disclosing errors to patients, because that would increase the hospital’s claims.

Additionally, health care providers may be required to disclose only those injuries that fall within pre-established lists of ACEs. That certainly seems to be the expectation of Bovbjerg and Tancredi, the main architects of the ACE concept. They state, for example:

Medical providers should disclose injuries and routinely compensate patients injured with an ACE. Voluntary acceptance of patient eligibility and compensation should be the normal rule under ACEs, not the exception as under tort. Enhanced disclosure is desirable for all the reasons already discussed (first reform above), and it is far more workable with ACE lists and changed rules than under tort.

...

It is desirable to promise prospective patients that covered providers will make early offers of compensation for all listed ACEs and will arbitrate any disputes over ACEs and over all other medical injuries.

...

ACEs would address a key weakness in workers comp-style reform—relying on patients to bring claims, as does the tort system now. Not only would the public availability of listings help potential claimants recognize legitimate claims, but *the administrative agency and private risk bearers could also use the lists to make prompt settlements for all ACEs.* Case-by-case adjudication would not be needed, which would speed resolutions and reduce administrative expense.⁴⁴⁷

Similarly, Bovbjerg states in an article he wrote with Raymond for the Kaiser Permanente organization that “ACE listings could be used to ‘trigger’ responsibility for providers to make an early offer of limited compensation”⁴⁴⁸ The Common Good Draft Proposal picks up this theme as well:

When an adverse event occurs, the hospital makes an initial determination whether the event falls within the class of adverse events covered by the system. ... The decision-making process is guided by pre-established decision aids, including a definition of avoidability and a compendium of accelerated compensation events that carry a presumption of avoidability.⁴⁴⁹

The problem here is that, even according to the designers of the ACE approach, ACEs cover only a portion of compensable medical injuries.⁴⁵⁰ The Milbank article notes, for example, that only “up to half of all obstetrical claims could be resolved, for example, through the application of an ACE list.”⁴⁵¹ Moreover, even for cases falling within ACEs, Bovbjerg and Randall admit that “[i]t is unknown to what extent using ACEs in place of most tort suits would make caregivers more willing to discuss errors and other problem cases openly.”⁴⁵²

In the end, it is not clear what in the health court proposals would be sufficient to induce a substantial amount of additional disclosure. Given the costs of disclosing error, health care professionals and hospitals might find it “cost-effective” to identify those potential claimants most likely to file a claim *without* disclosure and then make disclosure only to those individuals. They might even find it in their self-interest to withhold information altogether and pay an occasional penalty if they get caught.

E. Physicians Who Committed Errors Would Still Have Abundant Reasons to Fear that Stigma and Punishment Would Follow Voluntary Disclosure.

Health court backers are adamant that switching to a standard of “avoidability” would reduce the fear of liability and stigma attached to the tort process.⁴⁵³ The Common Good Draft Proposal states that “[t]he avoidability standard is desirable because it moves away from the notion of individual fault and the negative conno-

tations that the medical profession associates with negligence. It comports with the notion of preventability, which is critical to the patient safety movement's insistence on lack of blame.⁴⁵⁴ Yet as shown in the preceding discussion, as a practical matter, avoidability is a fault-based standard that differs little, if at all, from negligence.⁴⁵⁵

Even if health courts employed an avoidability standard that was clearly distinct from negligence, it is not clear, despite health court proponents' contentions,⁴⁵⁶ that physicians or other health care professionals would view injuring patients by committing avoidable errors as any less stigmatizing than injuring patients through negligence. In either case, the quality of the professional's care and his or her competence is being called into question. What physician would not experience shame upon being accused of avoidable error? If the physician made repeated avoidable errors, what patients would want to go to them for care? What colleague would want to refer patients to them? The belief on the part of health court proponents that providers will be blasé about causing avoidable injury assumes an intolerable degree of professional callousness.

Moreover, the health court approach does not significantly reduce the threat that health care professionals will suffer adverse consequences for committing mistakes. The Milbank article acknowledges that "physicians are concerned that reporting adverse events to ... peer-review mechanisms may trigger concerns about their competence ...,"⁴⁵⁷ and that "[p]hysicians will hesitate to disclose information if they believe that avoidable injuries reported to patients could result in a disciplinary proceeding."⁴⁵⁸ Yet it is important to realize that disciplinary proceedings—which technically comprise actions by state medical boards and other public entities—are not the only peer-review mechanisms that can punish physicians. As the Common Good Draft Proposal points out, "[i]nformation [about claims] would also be fed back to patients [sic] safety teams at each place of original occurrence..."⁴⁵⁹ and the Milbank article confirms that "[h]ospitals, wielding their credentialing authority, would be the key avenue of redress for recurrent injuries associated with 'bad apple' doctors or dangerous conditions."⁴⁶⁰ If a hospital discovered that staff members had injured patients, it would have an incentive to sanction the parties responsible in order to prevent errors in the future, limit its risk of liability, and reduce the premiums that it would have to pay under an experience-rated health court financing system. As the Milbank article states: "The hospital's or care unit's premiums would be indexed to the frequency of its avoidable injuries. Hence there would be strong economic incentives ... for hospitals to understand the causes of avoidable injury and try to prevent recurrences."⁴⁶¹ The hospitals' predictable responses include loss or restriction of hospital privileges and "de-selection" from managed care provider networks.⁴⁶²

F. There is No Reason to Believe that Health Courts Would Improve Patient Safety.

Health court advocates claim that their approach would improve patient safety, but they do not explain how. Bovbjerg and Tancredi state, for example:

As for safety, ACEs’ emphasis on preventability and using ACE data to improve makes them an early forerunner of today’s patient-safety thinking. Payment based on ACEs would be much more consistent with patient safety reporting and analysis than are today’s fault-based determinations. ACE experience would also likely provide relatively objective and consistent indicators of problems for safety analysis within and even across institutions.⁴⁶³

Bovbjerg and Tancredi apparently believe that a health court approach would improve patient safety because it would employ a “preventability” standard rather than a negligence standard. This is nothing more than saying that a health court system would prevent patient injury because it would describe itself as “preventive.” This same sort of wishful thinking is reflected in Bovbjerg and Tancredi’s statement elsewhere that “[i]n the long run, the greatest benefit of ACEs may be as a quality measure” because “[a]fter all, the best response to medical injury is to prevent it, not to compensate it after it occurs.”⁴⁶⁴ As for their assertion that ACE experience would identify problems for safety analysis, the same would be true for any method of categorizing adverse events, and given the idiosyncrasies likely to characterize individual cases, as discussed in a previous section (see Section VI.B), there is no reason to believe that the ACE method would be superior.

Another way in which Bovbjerg and Tancredi believe that health courts would improve patient safety is that the ACE approach would enable health courts to give credentialing and licensing bodies “better data on a doctor’s practice record than do the tort claims that state boards are increasingly taking into account.”⁴⁶⁵ But this contention is belied by the fact that health court advocates would not permit disclosure of the identity of the providers whose practice data was forwarded. The Progressive Policy Institute states, for example, that “[r]eporting [information to improve the quality of care] should be kept separate from the specifics about the proceedings of individual cases,”⁴⁶⁶ while the Common Good Draft Proposal envisions that only “[d]e-identified information from the adjudication process is shared with patient safety regulatory bodies”⁴⁶⁷

To be sure, patient safety might be advanced by a health court system if it really were the case that such a system would lead to an increase in the number of victims compensated and the total amount of money paid for compensation, thus causing the health care industry to more completely internalize the costs of malpractice. But there are reasons, expressed elsewhere in this report, to doubt that this will occur and to believe that, if the political will is present to do such a thing, it could be done better under the present tort system. It is, moreover, conspicuous that health court proponents do not make this incentives-based, deterrence argument in support of their proposals. Presumably, they are quite aware that no such increases in compensation would be forthcoming from health courts as they would in fact operate.

G. Health Courts Would Not Reduce So-called “Defensive Medicine.”

Health court advocates bemoan the cost of defensive medicine and view their proposal as an antidote. Bovbjerg and Tancredi, for example, assert that “ACE reforms should cut defensive medicine practices,”⁴⁶⁸ arguing as follows:

Defensive medicine is essentially a response to the ambiguity of current standards of care, as applied in a legal process that providers find unpleasant and unpredictable. Where ACEs supplant legal process to govern payment, doctors need not fear liability, and unproductive defensiveness has no reward ACEs have many of the virtues of guidelines in terms of reassuring practitioners that they will not be held liable arbitrarily for bad outcomes.⁴⁶⁹

Proponents contend that health courts’ use of ACEs and guidelines would give practitioners direction on how to practice medicine correctly, and that the practitioner-friendly process would alleviate their liability fears.

We have already explained why there is less than meets the eye in the claims about defensive medicine (Section V.E). But there is still value in predictability. All other things being equal, it would be desirable for providers to have a clear sense of what the law expects of them. Nonetheless, as discussed above (Sections VI.B and VI.C), there are many difficulties in constructing and applying ACEs or practice guidelines, and there is no reason to expect that better ACEs or practice guidelines would be available under a health court system than under the tort system.

With regard to ACEs in particular, proponents stress that one of their prime virtues is that they focus on outcomes rather than on processes of care.⁴⁷⁰ Even if this were so, a list of avoidable outcomes would not tell practitioners what practices they should follow to avoid the adverse results. Tancredi and Bovbjerg contend that a focus on outcomes would prevent defensive medicine: “ACEs should not promote unnecessary defensive procedures because they are defined largely by the occurrence of listed outcomes, rather than by whether a provider actually performed certain tests or procedures, and documented doing so.”⁴⁷¹ It is true that a system based purely on bad outcomes would not award compensation based on the fact that bad processes of care had been used. But practitioners would still fear that poor procedures might lead to compensable outcomes and therefore would have incentives to identify the proper procedures. Moreover, unlike the tort system, where an adverse outcome is deemed reasonable if the proper process was employed, an outcome-based system would not protect practitioners from liability on the basis that they had employed a correct process. As Bovbjerg and Tancredi make clear, “[l]isting an event as an ACE [should] not distort medical decision making, for example by making a bad outcome for condition X compensable if it occurs after treatment alternative A but not after alternative B.”⁴⁷² This leaves the door wide open—or at least no less open than it already is—to defensive medicine, as practitioners struggle to figure out how to prevent a bad result.

Health court proponents also maintain that ACEs would avoid defensive medicine because "it is a criterion in the process of creating ACE listings that they have no undesirable incentive effects"⁴⁷³ The only actual example they give of how this criterion would be applied is the following:

[M]ost wound infections following operations, including cesarean sections, were included as an ACE. Hence, the incentive might be to use a less invasive mode, such as vaginal delivery with forceps, to avoid risking the ACE. Forceps might result in more serious damage, such as a skull contusion or fracture or injury to the brachial plexus; however, these outcomes are also ACEs, so no distorting incentive is introduced. The key is to maintain balanced incentives for clinical alternatives.⁴⁷⁴

It is true that under an ACE scheme, practitioners would have no incentive to employ vaginal delivery with forceps in order to avoid liability for a wound infection following a cesarean section, but the same would be true under the tort system, where a doctor would be liable for either negligently causing wound infection or negligently using forceps causing a skull contusion or fracture or injury to the brachial plexus.⁴⁷⁵

Another important benefit of health courts, according to their supporters, is that they would create a body of legal decisions to which providers could refer in order to determine how they should care for their patients. Health court proposals thus call for judges to issue written rulings that would be placed on a searchable electronic database.⁴⁷⁶ The Progressive Policy Institute states:

The rulings of health court judges would begin to establish new standards of practice to cover medical circumstances where common standards have not previously been agreed upon. The health court system would thus provide an essential benefit where our current system of medical justice fails: it would provide consistent, rational rulings that send clear signals to health care providers about what constitutes good medical practice. In doing so, it would help eliminate the uncertainty that encourages doctors to practice defensive medicine and contributes to medical errors.⁴⁷⁷

It is unrealistic, however, to expect that such a database would be of any significant use to practitioners in guiding their practice. Judicial practice standards would suffer from the same drawbacks that plague practice guidelines generally. As Catherine Struve, a law professor at the University of Pennsylvania, observed in a report she prepared for the Pew Charitable Trust as part of the Project on Medical Liability in Pennsylvania, medicine is just too uncertain: "[T]he nature of medical practice raises questions about the feasibility of developing a body of legal precedent concerning the appropriate standard of care."⁴⁷⁸ Struve explains: "In many medical contexts, there exist multiple treatment approaches rather than a single standard of care. Further, the specific circumstances of each case render it difficult

to draw general conclusions concerning the appropriate standard of care, and as medical knowledge and technology rapidly advance, a ‘precedent’ concerning the standard of care could quickly become obsolete.”⁴⁷⁹

Proponents of health courts are forced to acknowledge these points. The Progressive Policy Institute report, for example, after declaring the importance of precedents that create consistent rulings and send clear signals, admits that “in order to avoid what is sometimes called ‘cookbook medicine,’ health courts would consider medical practice guidelines *in the context of each case, according to the individual needs and characteristics of patients.*”⁴⁸⁰ But health court advocates cannot have it both ways: fixed rules, despite their many virtues, sacrifice the accuracy that follows from individualized tailoring of the general standard to handle specific cases.⁴⁸¹ To the extent that flexibility is considered important—and it seems to be a widely shared value in this context—fixed rules will remain elusive in the fast changing world of medical practice.

Finally, as noted earlier in Section V.E, what some regard as “defensive medicine” is in reality taking greater care to avoid injurious mistakes. Quite aside from the potential benefits of more predictable standards, therefore, health courts proponents’ expectation that practitioners would feel less pressure to practice defensive medicine under a more practitioner-friendly dispute resolution process would be bad public policy. As discussed earlier, the problem with the current system is not too much deterrence but too little. Recall Hyman and Silver’s caution: “The main problem with the legal system is that it exerts too little pressure on health care providers to improve the quality of services they deliver.”⁴⁸²

H. Health Courts Would Not Prevent Malpractice Insurance “Crises.”

The health court proposals come on the heels of the latest so-called malpractice crisis, in which, according to health court proponents, “many states faced shortages of liability insurance coverage and even more saw very high premium increases”⁴⁸³ Proponents of health courts argue that the spike in premiums was due to the flaws in the malpractice system. An article in *The Economist* describing health courts as “a more sensible idea” asks “Can legal costs be curbed?”⁴⁸⁴ The Progressive Policy Institute claims that “[r]ationalizing [non-economic damages] will be one of the most important innovations in a health court system, and the key means of eliminating the runaway inflation in malpractice insurance costs that has caused doctors either to abandon their fields or practice defensive medicine.”⁴⁸⁵

Scholars who have studied the malpractice system more carefully, however, conclude that malpractice litigation is not the cause of spikes in insurance premiums. Hyman and Silver state, for example: “[T]hree longitudinal studies were published in 2005—and all three come to broadly similar conclusions. ... [T]he frequency of paid claims was stable [over the years]. ... These three studies indicate that factors outside the medical malpractice system were responsible for the premium spikes that commenced in 1999.”⁴⁸⁶

Baker describes these factors in a passage that bears quoting in full:

Liability insurance goes through a boom-and-bust cycle. In the early years of the cycle, insurance companies take a pessimistic view of future losses and set aside more reserves than they need. Toward the end of the cycle, they take an increasingly optimistic view of future losses and do not set aside enough reserves. As a result, they begin charging prices that are too low in relation to the risk. Because medical malpractice claims take so long to resolve and contain such a high percentage of high-value claims, the shortfalls in the reserves to pay medical malpractice claims accumulate over a number of years. When the insurance climate shifts back toward a pessimistic view of future losses, insurance companies need to increase their reserves, sometimes quite dramatically, to make up for the underreserving of the past, and prices rise accordingly. This means that the swings of the insurance cycle are more dramatic for medical malpractice insurance than for most other kinds of insurance.

The public policy problem here is not the overall size of malpractice premiums. Premiums are low in relation to the total social cost of medical malpractice. Because the vast majority of injured patients do not bring claims, they and their families and health insurers bear most of those costs. ... [T]he average premium for doctors in the United States is about \$12,000. While \$12,000 is not an insignificant amount of money, it is not an unaffordable business expense for doctors who generally earn good six-figure incomes, after they pay for medical malpractice insurance. Even if that number were doubled to take into account the fact that some doctors are not practicing and that many doctors are covered by hospitals or other large organizations that do not purchase traditional medical malpractice insurance, the cost per doctor is not as high as most people think.

The real public policy problem stems from the way that insurance companies divide up the premiums among doctors. Most doctors pay relatively affordable premiums. But some specialists, such as obstetricians, pay very high premiums, and they are not equipped to deal all by themselves with the ups and downs of the insurance cycle.⁴⁸⁷

In short, states Baker: "[T]he insurance industry goes through a boom-and-bust cycle that creates medical malpractice insurance crises like this past one. Lawyers, judges, and juries have little or nothing to do with it."⁴⁸⁸

Like the malpractice litigation system, health courts would be unlikely to have any great effect on the recurring malpractice crises. Malpractice insurance would still be necessary under a health court system, and investment and reserve cycles would continue to be experienced. Of course, if health courts were successful in

routinizing claims and suppressing variance in recoveries, the results might be somewhat more predictable from the insurance industry's point of view. But variance in the damages suffered by malpractice victims is a fact, even if the insurance industry would like to ignore it. Moreover, as noted earlier, proponents expect to finance the new health court bureaucracy by *increasing* malpractice insurance premiums,⁴⁸⁹ which would surely cause instability, at least during any transition to the new system.

I. A Health Court System Would Not Be Affordable Without Substantial Increases in Malpractice Premiums or Some Mix of Undesirable Consequences.

Obviously, a health court system as proposed would entail some huge potential increases in total system costs. There are several sources of such increased costs:

(1) *Additional Claims Involving Negligence.* Health court proponents contemplate a claimant-friendly process that would increase the number of injured individuals who would find it practicable to seek redress. Studies, including those upon which health care proponents rely, indicate that only about 2 or 3 percent of injuries resulting from malpractice generate claims.⁴⁹⁰ We have explained elsewhere why there are strong reasons to doubt that all these victims would even become aware of their potential claims (see Sections VI.D and VI.E.) If, however, we take health care proponents at their word, their goal is to bring these currently non-claiming people into the process, certainly a laudable goal in itself. This, however, would multiply the number of claims involving negligence by a factor between 33 and 50. As we have seen, claims involving error account for at least 84 percent of total system costs (as earlier defined),⁴⁹¹ so that, even if we assume that only claims involving error are brought into the system, the system costs should increase by a factor of at least 28, all other things (like system efficiency) being equal. Because, however, the most serious injuries now tend to be the ones most likely to result in claims, this figure might overstate this otherwise conservative measure of the increase. Reliable data on the potential claims pyramid (the number of potential claims generally being inversely related to the size of the claims) are not available, but even if we assume that the average per patient damages under a new system embracing all potential claimants (including those who claim under the existing system) would be only 30 percent of the average damages for claims now paid, that still leaves total direct system costs multiplied by a factor of about 8.5, again as a low end estimate.⁴⁹²

(2) *Additional Claims Involving Avoidable Harms.* Health court proposals contemplate an "avoidability" standard that is more generous than the negligence standard. Again, we question whether this distinction in fact can be maintained (see Section VI.A.) But taking the proponents at their word, one must assume that this shift will increase the number of claimants, all other things being equal. Based on an Australian study that used the related concept of "preventability," Professor Baker has concluded that preventable injuries occur about twice as frequently as negligent

injuries.⁴⁹³ Health care proponents agree.⁴⁹⁴ If so, this would double total system costs, all other things being equal.

(3) *New Bureaucracy Costs.* Health court proposals involve the creation of a new judicial bureaucracy, including specially-trained judges, a cadre of experts to advise them, and what are effectively investigating magistrates located within hospitals or otherwise working with providers. Health courts also would require enormous staff expenditures to articulate and revise practice guidelines and ACEs, to the extent those are part of the system, and to analyze and disseminate data. We have no estimate of what these tasks and the necessary bureaucracy to carry them out would cost, but it would certainly be substantial, vastly more than the public (taxpayer borne) judicial costs currently associated with the adjudication of malpractice claims.⁴⁹⁵ Of course, health court advocates claim that, when one aggregates these costs with a planned reduction in attorneys’ fees and other litigation expenses, there would actually be a net savings. We take this factor into account below.

(4) *New Jurisdictional Conflict Costs.* Health court proposals involve jurisdictional separation of some kinds of torts now considered malpractice, such as intentional batteries, that would remain within the common-law courts, and any such split jurisdiction will necessitate litigation over the jurisdictional boundaries, litigation that does not presently occur because all malpractice cases are handled within the tort system. The Florida Birth-Related Neurological Injury Compensation Plan (NICA) illustrates this problem, as Harvard School of Public Health researchers have acknowledged:

The definition of birth-related neurological injury set forth in the statute is quite narrow in scope. It limits NICA’s applicability to the most severe obstetrical injuries. Even for that limited group of injuries, however, there is ample empirical evidence of forum shopping and duplicative claiming over the past decade. Malpractice claims persist for precisely the kind of injuries NICA was introduced to preempt. In an effort to maximize their chances of gaining remedies, participating families appear to lodge claims in both no-fault and tort venues. In the latter case, courts have proven reluctant to yield jurisdiction to NICA. This stance reached a high watermark in 1996 with a decision by the Florida Supreme Court essentially reserving for the courts a right of first refusal over claims ostensibly covered by NICA, although the legislature quickly intervened in an attempt to reverse the impact of this decision and preserve NICA’s role.⁴⁹⁶

Health court proponents have given us little by which to assess the magnitude of these impacts,⁴⁹⁷ but collectively, the features described above would increase the costs of handling malpractice claims dramatically. Using conservative figures, the first two alone suggest multiplication of costs by a factor of 17 (that is, 8.5×2). Nevertheless, health court proponents expect the system to be “affordable.”⁴⁹⁸ The Milbank article states that “the system could compensate a much broader group of patients (at a more modest award level) than can the tort system at about the same

cost, due in part to savings on administrative overhead costs.⁴⁹⁹ Other health court advocates concede that, if the system actually compensated substantially more patients, it might not be cheaper than the tort system. The Republican Policy Committee states, for example: “The health court proposal is not about reducing costs overall (since many more people may be compensated at smaller amounts).”⁵⁰⁰ Either way, it is important to grasp the measures that proponents contemplate taking in order to prevent the total costs of the system from exploding.

Aside from dubious and unquantifiable claims about reducing the incidence of medical error (see Section VI.F), health court proponents point to three main sources of potential savings in direct system costs: reduced administrative costs, offsets for compensation from collateral sources, and application of a “deductible.”⁵⁰¹ Rhetorically, they place primary emphasis on reducing administrative expenses, particularly attorneys’ fees, by moving away from the common-law adversarial system to something that works more like a benefits system. According to proponents, the percentage of administrative overhead (attorneys’ fees and other litigation expenses) for malpractice claims is nearly twice that of workers’ compensation systems.⁵⁰² To be sure, it is unlikely that health courts could achieve the level of efficiency of workers’ compensation tribunals, because the nature of the claims in health courts would be more complex, on average, and because health courts would require a better (i.e., more expensively) trained corps of bureaucrats to administer the system. But even if we assume—quite optimistically—that the same level of efficiency could be attained in health courts, such a reduction in administrative overhead would reduce total system costs (all other things being equal) only by a factor of about one-third, given that administrative costs are now about 50 percent of total system costs.⁵⁰³ Combining this savings with the putative increases described above, total direct system costs still would be multiplied by a factor of $17 \times .67 = 11.39$, as a conservative estimate.

As noted earlier, health court advocates propose to pay for this by increasing malpractice insurance premiums.⁵⁰⁴ If physicians already feel overburdened by high premiums, it is hard to understand why they would support a system that could raise premiums by over a thousand percent. But a close reading of the health court proposals indicates that its proponents have no such consequence in mind. Despite their reliance on the idea of reducing administrative costs, this is likely not to be the major source of “savings.”

As part of their proposal making health courts secondary or tertiary payers, health court proponents also suggest “paying the balance of damages after contributions by collateral sources.”⁵⁰⁵ Although this proposal has already found some support in the states, it is a decidedly bad idea. Why should the patient’s choice to pay for extra protection in the form of first-party insurance, either directly or as part of a contract of employment, adversely affect his or her right to recover from a negligent provider?⁵⁰⁶ Furthermore, among the main collateral sources that Common Good has in mind, it turns out, are public benefits such as Medicare and Medicaid, which, as Common Good notes, “enforce second payer rules of their own.”⁵⁰⁷ But this means that, under a health court system, taxpayer funded programs for the aged and the poor, rather

than providers and malpractice insurers, would be required to pick up part of the tab for the providers’ medical mistakes. In any event, this offset for collateral sources would be inadequate to address the huge potential cost increases described above. For one thing, thirty states already have adopted some form of collateral source offsets, so a significant portion of the potential cost shifting has already been incorporated into the system.⁵⁰⁸ Moreover, studies of collateral source offsets have rarely found significant effect on claims payouts or malpractice premiums.⁵⁰⁹

The third conspicuous means of controlling costs endorsed by health court proponents is the allowance of a “deductible.” Common Good, for example, recommends “that eligibility begin when patients reach 4-6 weeks lost work time or \$3,000 - \$4,000 in medical expenses.”⁵¹⁰ Presumably these would be out-of-pocket expenses not covered by collateral sources. As explained more fully later (Section VII.D), to call this a “deductible” is a misnomer; in truth, it would be a statutory tort immunity, albeit a limited one. If health courts were enacted, we could expect to see a steady pressure from the medical establishment and its insurers to increase the “deductible” in order to reduce the total payments made to injured patients and thereby avoid the enormous potential increases in malpractice premiums.

But other pressures can be expected as well. As will be described more fully below, a number of processes can be expected to be implemented, processes that suppress the levels of patient recoveries below any fair measure of actual losses sustained. For example, in discussing measures of damages, especially non-economic damages, health care proponents emphasize the problem of unpredictability (variance), rather than the average amounts of recovery. Thus, one might think that, as to claimants who would recover under the tort system, proponents would be content with less variance in the recoveries but the same mean (and thus total) recoveries as now occur. But once one examines some of the precedents and theories upon which the proponents rely for calculating awards, it becomes clear that they expect and intend to reduce recoveries dramatically. (See Section VII.)

To get a sense of the magnitudes of these effects, consider that at least one study, of dubious reliability, estimated non-economic damages (sometimes called “pain and suffering” awards) under the current system to be as high as 75 percent of total recoveries.⁵¹¹ Even assuming this figure is approximately correct, and assuming further that health courts suppress non-economic damages to a *de minimis* level—generous assumptions for this purpose—this would reduce our multiplicative factor from 11.39 to 2.85, meaning that the total direct system costs would still be increased nearly three-fold. (Using more realistic assumptions, the same result is obtained if, by some combination of restrictions on non-economic or economic damages, collateral source offsets, and “deductible” offsets, health courts were to suppress average compensation per paid claimant by 75 percent of what they would recover under the tort system.) In order to keep total system costs constant and avoid premium increases, the “deductible,” which would eliminate relatively small claims entirely, would have to eliminate well more than two-thirds of all potential claims. Under more plausible assumptions, that figure would have to be much higher.

These rough calculations give results comparable to the projections made by health court proponents themselves. In the only published study attempting to estimate quantitatively the impact of health courts on total system costs, researchers applied the “avoidability” standard used in Sweden to data compiled on malpractice events and claims in Utah and Colorado in 1992.⁵¹² The report of this study is difficult to follow, but it appears that, in order to prevent costs from increasing dramatically under the contemplated system, recoveries would have to be limited by rigorous collateral source offsets, the elimination of all non-economic damage components, and the use of an eight-week disability “deductible” that would bar 79 percent of all injured patients from seeking legal redress.⁵¹³

There is also the possibility that, once the health court system were implemented and its high costs begun to be felt, its supporters would try to shift significant portions of the costs of the system, particularly the administrative costs, to the taxpayer. They can be expected to argue that running courts is the government’s business and should not be paid for by private insurers. But such an argument loses much of its appeal when it is recognized that the courts in question would have abnormally high budgets and would be largely designed by, and serve the interests of, the medical and insurance industries.

Of course, assuming that the system could be operated to provide compensation more efficiently to injured individuals, it is simple mathematics to conclude that more injured persons could be compensated at the same total cost, assuming they would come forward to make claims (see Sections VI.D, VI.E, and VII.B). But in the absence of much more detailed and transparently justified projections than have so far been forthcoming from health court proponents, it is fair to infer that what we would get from health courts is mainly the following: very modest recoveries, well below full compensation, for those who were compensated, including a substantial reduction in the compensation of those who would recover under the existing tort system (see Sections VII.A, VII.B, and VII.C); a statutory ban on claims by the vast majority of victims of malpractice (see Section VII.D); and the shifting of a greater portion of the burden of malpractice onto taxpayers and private health care providers (i.e., employers and employees). If, as health care proponents promise, there were a substantial increase in the number of patients who received more than nominal compensation, then additional effects would be likely, specifically increases in malpractice premiums and further pressure to shift the burden of malpractice onto taxpayers, employers, and employees.

J. The Experience With Other Compensation Systems Does Not Demonstrate That Health Courts Would Work Well.

Health court supporters cite a number of other compensation systems, some in the United States and some abroad, that, in their view, provide evidence that a health court system would work successfully. These include workers’ compensation,⁵¹⁴ the National Childhood Vaccine Injury Act of 1986,⁵¹⁵ birth-related injury

compensation programs in Virginia and Florida,⁵¹⁶ and the compensation programs in countries such as Denmark, Sweden, and New Zealand.⁵¹⁷

This argument is difficult to assess because none of these systems combines the basic features of the health court approach. None of them, for example, employs an "avoidability" standard, uses practice guidelines to guide decision-makers, or attempts to construct a body of precedent to guide practitioners. Still, there are several important observations that cut against health courts.

First, the systems held up as examples do not work as well as health court proponents would like. While it may be true, as health court proponents maintain, that the malpractice system operates with nearly twice the "overhead" (administrative expense) rate of the typical workers' compensation system,⁵¹⁸ the issues that must be decided in malpractice cases render this analogy less than persuasive. As one prominent health economist, Patricia Danzon, explains in the related context of no-fault proposals:

The argument that no-fault would reduce litigation costs rests on the assumption that it would be simpler, less litigious and less costly to define a compensable event as a medical injury rather than a negligent injury. However, evidence from workers' compensation is not necessarily persuasive because of the difference in context: workers are generally in good health, hence the occurrence of a work-related injury is easy to define. This demarcation is less clear and litigation costs are correspondingly higher for occupational diseases and cumulative trauma than for acute injuries.⁵¹⁹

The same point applies even more strongly to health court proposals that eschew genuine "no-fault" in favor of an avoidability standard.

Moreover, the workers' compensation system has been widely criticized as costly, unfair, and inefficient. In their book *True Security: Rethinking American Social Insurance*, Yale Law Professors Michael Graetz and Jerry Mashaw criticize the workers' compensation system as "a bad deal that has delivered inadequate benefits at exorbitant administrative cost with dubious effects on occupational health and safety."⁵²⁰ Professor Joan Gabel makes a similar observation in a 1999 article in the *Wake Forest Law Review*:

Workers' compensation is now costly and inefficient. In 1984, employers paid an estimated \$30 billion in annual workers' compensation costs. Between 1988 and 1991, costs rose 29%, resulting in an annual employer payout of approximately \$60 billion. In 1993, employers paid \$70 billion and finally demanded reform. The frantic efforts of reformers began to show results, and, in 1994, there were slight decreases in the average rates of cost growth. Despite reformers' success in some states, the system's goals of uniformity, efficiency, predictability, and fairness have been diluted. Today, the overall condition of workers' compensation in America remains dismal.⁵²¹

And Professor Martha McCluskey observes:

Workers generally have not been covered for a major portion of work-related injuries and illnesses for most of the century, if we assume that a broad range of injuries and illnesses beyond the traumatic industrial-machine accident can be work-related. In addition, workers have neither been compensated for major portions of their economic losses for work-related injuries nor have they been protected from many cheaply avoidable injuries.⁵²²

In terms of inefficiency, Professor McCluskey cites studies showing that workers' compensation programs paid more for medical care than the costs of the same care for the general public:

For instance, the NCCI reports that workers' compensation costs in the late 1980s grew one and one-half times faster than general medical costs.... In a Minnesota study, medical care for back injuries treated through workers' compensation cost an average of two and one-half times the medical costs charged to health insurers; in a California study, the average workers' compensation charges were four times the average nonwork medical costs.⁵²³

In regard to another system health court proponents point to, Bovbjerg and Tancredi admit that fewer than expected claims have been filed for the Virginia and Florida birth-related injury programs, and that "this prevented the unaffordable cost overruns predicted by some opponents of reform, but kept the programs too small to conduct patient safety analysis or to implement any loss-prevention mechanisms."⁵²⁴ If what saves the system from disaster is that the very benefit it is supposed to achieve does not materialize, then what reason is there to adopt the system?

The compensation program established by National Childhood Vaccine Injury Act is not an apt analogy to health courts for the simple reason that, unlike under health courts, claimants who are dissatisfied with the award from the former program may pursue a civil action for damages.⁵²⁵

New Zealand, another system pointed to by health court proponents as a model, has shifted its compensability standard from no-fault to fault and back again, as it has struggled with the costs of its compensation system. Furthermore, it fails to compensate many deserving victims, and has achieved no better hospital error rates than hospitals in countries with tort systems.⁵²⁶ Finally, the experience from countries such as Denmark and Sweden is an inapt basis for comparison since the compensation system in those countries operates on top of a substantial social safety net that is absent in the United States. As a result, injured patients in those countries do not have to be as reliant on a medical injury compensation system for the resources to overcome a medical error. At a forum hosted by the Progressive Policy Institute and Common Good on October 31, 2005, for example, representatives from the Danish and Swedish compensation funds noted that "Sweden has an extremely

comprehensive social welfare structure so that even before any compensation is given for an injury claim, the Swedish welfare system, would cover about 80 percent of a sick or injured worker's salary," and that "Denmark has public health and extensive welfare systems, so patient injury compensation is considered 'on top' compensation."⁵²⁷

* * *

In conclusion, as far as it can be discerned, based on the extant proposals, there is little likelihood that a health court system would provide the benefits and advantages its proponents claim.

VII. HEALTH COURTS WOULD BE UNFAIR TO PATIENTS.

Contrary to the views of its proponents,⁵²⁸ not only is a health court system unlikely to accomplish its objectives, but it would operate in a manner that is likely to be unfair to patients. Ironically, despite all the complaining by providers, the current tort system itself favors defendants. Hyman and Silver point out that “[d]espite the conventional wisdom to the contrary, the medical malpractice system does not seem to favor the interests of plaintiffs, as demonstrated by the frequency of under-compensation and its magnitude, the exceptional win rates defendants enjoy at trial, the willingness of plaintiffs to discount jury verdicts when settling, and the amounts these patients give up.”⁵²⁹ It hardly seems fair to replace the current system with one that it is even more biased against patients, but that is exactly what adopting health courts would bring about.

A. Liability and Compensation Decisions Would Be Made by Decision-Makers Biased Against Patients.

The essence of the health court approach is to replace traditional neutral decision-makers—lay judges and jurors—with decision-makers dominated by medical interests. Struve notes that specialized courts in general are prone to “capture” by private interests: “Commentators have long pointed out that the more specialized a court is, the greater the incentives and opportunities for interest groups to seek to influence the court’s decisions, both by lobbying to select judges who will favor the desired position and by exerting pressure on the court in connection with particular cases.”⁵³⁰ Health court proponents are fond of drawing an analogy between health courts and other specialized courts, such as patent courts.⁵³¹ Yet as Struve observes, patent courts are not prone to capture by one set of interests:

[I]n contrast to a field such as patent law, where a repeat litigant will likely be on different sides in different disputes ..., a repeat player in the medical malpractice field will be habitually on one side or the other—thereby increasing the player’s incentive to seek selection of judges favorable to the player’s expected position.⁵³²

It is clear that proponents intend for health court judges to be controlled by medical interests. The proposals call for judges “with health care expertise”; if they are not physicians themselves, the judges must “have the background and training in science or medicine to enable them to define and interpret standards of care.”⁵³³ The Model Medical Injury Act would have judges selected by a Medical Injury Court Board of Qualifications; one third of those on the Board would be physicians. It is true that another one-third must be attorneys licensed to practice in the state,⁵³⁴ but the act does not specify what type of attorney; they all could represent providers or malpractice insurers. Moreover, all the judges would be trained in medical issues that were likely to arise (see Section IV.F), and inevitably this training would come predominantly from the medical establishment.

Not only would health court decision-makers be part of the medical establishment, but medical interests would create the decision-making aids that they would employ. An editorial in *Contemporary OB/GYN* calls for experts selected by medical groups to use guidelines devised by those groups: “Chosen with the help of such organizations as the American College of Obstetricians and Gynecologists, the experts would render opinions based on solid peer-review evidence and guidelines published by medical societies.”⁵³⁵ The list of compensable events would be created by medical experts: “ACEs are created by medical experts who review case scenarios of medical injuries from which they generalize to sets or classes of events.”⁵³⁶ Furthermore, court-appointed experts who rely on expert fees for a significant portion of their income can be expected to make recommendations consistent with the interests of the court, including limiting compensation to keep health court expenditures as low as possible. As described above (Section IV.G.), the Common Good proposal would codify the view that giving expert medical testimony constitutes the practice of medicine, so that medical boards would be able to sanction experts for testimony that does not meet the standards set by those boards. Experience with the AMA’s policy in this regard strongly suggests that this power would be used selectively to suppress testimony favoring plaintiffs in medical malpractice cases.⁵³⁷

Then, too, as noted earlier (Section V.C), the contingent fee system that has evolved in the market for legal services provides crucial support for indigent individuals to be able to seek compensation for the injuries inflicted by medical negligence, individuals who do not have the insurance companies’ advantage of being repeat players in the system of litigation. Strikingly, under health court proposals, while the fees for claimants’ attorneys would be strictly limited, there would be no restrictions on what attorneys for providers could receive.

In short, the entire thrust of the health court concept is to create a system that is friendly to providers. According to Tancredi and Bovbjerg, a benefit of ACEs is that “[e]xpert determination in advance of avoidable types of injury will enhance credibility among providers”⁵³⁸—not among patients. “Fully non-judicial processes are needed,” they assert, “to make case resolutions more expert and provider cooperation more likely”⁵³⁹—not patient cooperation. In an early iteration of the ACE model, Havighurst and Tancredi state: “There would be no windfalls to patients or large legal fees included in the payments, and no doctor would have reason to feel victimized, as physicians often do now, by an *ad hoc* judgment against him and his professional reputation by a seemingly hostile agency of the state.”⁵⁴⁰

The traditional malpractice system already favors defendants. There is no justification for favoring them even more.

B. Providers and Insurers Would Take Advantage of Patients to Settle Cases for Too Little.

The initial phase of the health court process envisioned by Common Good and other health court proponents would place patients in a position in which they

could be taken advantage of by providers and their insurers. As described earlier, this phase contemplates that hospitals or medical malpractice insurers would determine whether a patient had been injured by an avoidable medical mistake and, if so, orchestrate an apology to the patient and make an offer of compensation.⁵⁴¹ While this could enable more patients to discover that they had been injured by medical error and to receive rapid payment, it instead could be a way of manipulating patients so that they would accept unfairly small settlements.

In the first place, patients may mistakenly believe that hospital personnel who disclosed errors and offered compensation were looking out for the patients' interests rather than their own. The role of these "apologists" would resemble that of infamous "patient advocates," a misleading name for hospital employees whose job is not to advocate for patients so much as to deflect them from pursuing legitimate grievances.⁵⁴²

On the surface, the notion of providers disclosing mistakes and apologizing to the victims is appealing, but the practice is prone to misuse. Erin Ann O'Hara has examined the social role of apology and notes that its purpose can be to deprive victims of their rights: "[A]pology can be used as a tool for organizations to strategically take advantage of individual victims' instincts to forgive in the face of apology."⁵⁴³ O'Hara observes that "apologies are used to reinforce the fact of hierarchy. While the subordinate uses apology to reestablish the dominant's favor, the dominant uses apology in lieu of other compensation."⁵⁴⁴ In a chilling analogy between the use of apologies by physicians and spousal abusers, she states that "the negligent doctor context is similar to spouse abuse in that there is some evidence that victims too easily accept apology"⁵⁴⁵ O'Hara also notes that organizations seeking strategically to use apologies to extract settlements from victims may employ special personnel to give a false sense of remorse: "An institution that wishes to exploit victims' cognitive and emotional structures will send its most empathic employee or member to apologize to the victim. Although the organization may be using the apology strategically, the individual who is sent credibly may convey a sense of heartfelt remorse for harming the victim. Some, though perhaps not all, victims will respond to the individual rather than the organization and agree to settle their claims."⁵⁴⁶

Health court proponents cite the practices of a malpractice insurance company named COPIC as a model for how the apology and offer process should take place. The Common Good Draft Proposal states that "[c]ounseling for patients would proceed along the lines developed by the insurer COPIC (the "3-Rs" program)"⁵⁴⁷ COPIC is a physician-owned malpractice insurer that is a member of the Physician Insurers Association of America.⁵⁴⁸ As of March 31, 2006, it had paid only 588 "reimbursements" out of 2,456 "qualifying incidents," at an average payment of only \$5,567 per incident. Furthermore, COPIC makes no payment for non-economic damages.⁵⁴⁹

In addition, COPIC seems to be well aware of the strategic use of apologies and compensation offers to convince patients to accept an inadequate amount of com-

pensation: It emphasizes the need for providers to be "coached" by 3Rs program administrators in preparation for "disclosure encounters,"⁵⁵⁰ and the authors have been informed that COPIC uses trained actors to interact with patients.⁵⁵¹ A description of coaching persons on how to apologize to patients, although not necessarily the process employed by COPIC, is provided in a 2006 article by Gail Weiss in *Medical Economics*:

If you determine that you have indeed erred, Hatlie and other experts in physician/patient communication recommend a prompt, straightforward apology that steers clear of medical jargon and finger-pointing and focuses on the facts. This should be done in person, says Hatlie, not via e-mail or telephone.

"It's important to review what you'll say and to have answers to questions you can predict," says FP Sarah P. Towne, assistant dean of clinical education at Touro College of Osteopathic Medicine in Vallejo, CA. "Charging in without doing your homework is ill-advised and might leave everyone feeling worse." Additionally, as with most sensitive conversations, the "how you say it" factor is crucial. Experts recommend the following:

Set the scene. "Choose a private area where no one will interrupt," says Brenda Sumrall Smith, a clinical social worker and family therapist in Brandon, MS, who teaches medical students communication skills. "Sit next to the patient rather than across from her, to convey that you're in fact on her side," Smith continues. "Having a desk between you and the patient creates a gulf and makes you seem distant and separate."

Reach out and touch. You can say you're sorry and that you regret what happened, but nothing conveys caring as much as gently touching the patient's hand, says Smith. "Don't pat someone on the back, head, or shoulder; that's sometimes seen as condescending. Stay between the elbow and the fingertips."

Watch your body language. Assume an open body posture, Smith advises. Don't cross your legs. Let your arms rest at your side. Keep your hands open. That telegraphs to patients that you're being honest with them.

Give the patient some control. Allowing people to make choices, even small ones, reduces their hostility. If you're going to tell a patient you've made an error, Smith suggests the following language: "I'd like to talk about some things that have happened with your care. When can you come in?"

Resist the urge to make excuses. "An apology should never include the word *but*," says Gerald Hickson, who teaches a course in disclosure at Vanderbilt. "You dilute the value of an apology if, for example, you say, 'I'm so sorry I prescribed the wrong medication for

you, but I'd been seeing patients for 10 hours without a break and I was exhausted when I wrote that prescription.”

Don't deflect the apology. A patient who has been harmed wants to know that you care about what happened to him, not that you're looking for ways to absolve yourself of responsibility by pointing a finger at your nurse or another healthcare professional.

Smith recommends having others in the room. “Not a lawyer; but perhaps a family member of the patient and a nurse. The latter can help the patient, while at the same time serving as a witness to what was said.”⁵⁵²

Not only does this type of coaching prevent genuineness and spontaneity, but instructions like “sit next to the patient rather than across from her, to convey that you're in fact on her side” and “nothing conveys caring as much as gently touching the patient's hand” seem less intended to communicate sincere remorse than to manipulate patients emotionally.

The manipulative intent of the COPIC approach is most clearly evidenced by its refusal to permit a patient to involve an attorney in the settlement process: “The patient retains the right to pursue legal action if desired; no waiver is sought or required as a condition of receiving program benefits. However, if a patient submits a written demand for compensation or pursues legal recourse [i.e., involves an attorney], he/she becomes ineligible for further program benefits.”⁵⁵³ The refusal to allow patients to consult attorneys is all the more unfair since hospitals, physicians and COPIC are all permitted to consult *their* attorneys. Patients thus are left unprotected in the face of COPIC-coached “apologists” pressuring them to settle their claims.

COPIC touts the fact that patients are not required to sign a waiver of their legal rights in order to obtain compensation. But as COPIC points out, by not requiring patients to sign waivers, patient injuries are not reportable to the Colorado State Medical Board or to the National Practitioner Data Bank, where they could be detrimental to the interests of providers.⁵⁵⁴ In any event, COPIC's non-waiver policy clearly is not designed to enable patients to assert their legal rights later if they feel that they have been cheated, but to discourage them from becoming suspicious and consulting an attorney in the first place. The success of this tactic is demonstrated by the fact that, according to COPIC, no case in its 3Rs program has “gone to litigation.”⁵⁵⁵

In stark contrast to Common Good's endorsement of the COPIC program, another organization lobbying for greater disclosure and apology, Sorry Works!, recommends that participants urge patients and their families to retain legal counsel to ensure that their rights are protected. The basic Sorry Works! approach calls for all deaths and unanticipated outcomes to be reviewed internally. “If a mistake or error was found, the patient and/or family would be quickly contacted, encouraged to retain an attorney, and a meeting was scheduled.”⁵⁵⁶ Bovbjerg and Tancredi also

admit that "[r]eceiving ACE payment should not typically require making an adjudicatory claim or hiring an attorney. Access to lawyers, however, does provide protection against unfairness if disputes arise about payment eligibility or amounts, particularly for permanent and severe injury."⁵⁵⁷

The VA also has adopted a disclosure policy:

VHA [Veterans Health Administration] facilities and individual VHA providers have an obligation to disclose adverse events to patients who have been harmed in the course of their care, including cases where the harm may not be obvious or severe, or where the harm may only be evident in the future.⁵⁵⁸

As the following implementation instructions demonstrate, the VA approach reflects a much greater degree of candor and good faith than the COPIC program, and it strongly endorses the use of an attorney by claimants:

Notifying a Patient of Negligence

When the risk management committee identifies an instance of accident, possible negligence, or malpractice, it investigates the facts. This investigation includes an interview with the involved physicians, the chief of the relevant clinical service, and other personnel, as appropriate. If the committee finds that malpractice or substantial error resulted in loss of a patient's function, earning capacity, or life, plans are made to notify the patient or next of kin. The patient, surrogate, or next of kin is called (usually by the chief of staff), is told that there was a problem with the care in question, and is asked to come to the medical center at his or her convenience for an explanation. The telephone conversation provides only enough details to indicate the seriousness of the matter (including, if necessary, a statement that a medical mistake was made and that an attorney may accompany the patient or family if desired).

Face-to-Face Meeting

The subsequent meeting is with the chief of staff, the facility attorney, the quality manager, the quality management nurse, and sometimes the facility director. At the meeting, all of the details are provided as sensitively as possible, including the identities of persons involved in the incident (who are notified before the meeting). Emphasis is placed on the regret of the institution and the personnel involved and on any corrective action that was taken to prevent similar events. The committee offers to answer questions and may make an offer of restitution, which can involve subsequent corrective medical or surgical treatment, assistance with filing for service connection under 38 United States Code, section 1151 (a law that confers service connection on the basis of disability resulting from medical care), or monetary compensation.

Claims Assistance

After the meeting, the patient, surrogate, or next of kin is assisted in filing any necessary forms and is given the names and numbers of contact persons who can answer any additional questions. If the patient or next of kin has not already retained counsel, they are advised to do so. The committee is then equally forthcoming with the plaintiff's attorney so that the attorney's review of the medical record will confirm the information that was volunteered. The facility's attorney and the patient's attorney work to reach an equitable settlement on the basis of reasonable calculation of loss.⁵⁵⁹

It is telling that the health court proposal rejects the much fairer approaches that both Sorry Works! and the VA have adopted.

C. Successful Health Court Claimants Would Be Seriously Under-Compensated.

The compensation for successful claimants delivered by the health court system would be severely restricted as compared to what such claimants receive under the current tort system. The Milbank article states: “[A] health court system presents greater possibilities for cost control than the tort system. Although more claims would be filed, *the average award would likely be considerably lower.*”⁵⁶⁰ This is not just because smaller claims would be brought into the system, which alone would reduce average awards, but also—and crucially—because claimants would be paid much less than they would be paid if they recovered under the present tort system.

The most obvious evidence of this is health court proponents' stated intent to use a “deductible” to prevent the total costs of the system from exploding. While a “deductible” would eliminate many smaller claims entirely, it presumably also would reduce the awards that would be recovered by those whose damages exceeded the deductible amount.⁵⁶¹ The effect of these deductibles is discussed more fully in the following section. The same point applies to health court proposals to eliminate the collateral source rule, the unfairness of which we have already noted (Section VII.I): this would eliminate some claims, the damages for which had been entirely or largely paid by third party sources, but it also would reduce the damages paid to many successful claimants under the health court framework.

But there are several other, less obvious but potentially more dramatic, sources of reduced compensation. Compensation for economic loss would be based on a schedule of damages, similar to workers' compensation. While under the tort system, successful plaintiffs receive their actual lost wages, under the health court system, as under workers' compensation, recovery of lost wages may well be limited to some average or arbitrary amount or subject to a pre-established maximum. For example, COPIC, a malpractice insurance program touted by health court supporters, only settles cases for up to \$100 per day for lost earnings, up to a maximum of \$5,000. Moreover, COPIC only pays medical expenses up to \$25,000.⁵⁶²

There is also reason to believe that health courts would not compensate for lost household production, reflecting the value of unpaid household work that the patient can no longer perform. Such losses have been a significant portion of malpractice awards, particularly for patients who are not employed outside the home.⁵⁶³ Yet, as a cost saving device, health court proponents contemplate eliminating any recovery for lost household production, on the quite curious theory that such a limitation is consistent with practice under some workers’ compensation laws.⁵⁶⁴ It is hardly surprising, however, that a system for compensating employees would not include lost household production, as the latter applies mostly to non-employed spouses and retired persons. In any event, there is no morally coherent argument for not compensating a person for the kind of work that the person has been doing but can no longer do.

Health courts also would pay little in the way of damages for pain and suffering. As Bovbjerg and colleagues state, the system will make “[o]nly small allowances for pain and suffering ... because the system is much more like a compensation system than a liability system,”⁵⁶⁵ adding: “Nor will an ACE system encourage dubious claims by paying large amounts for pain and suffering.”⁵⁶⁶ The Common Good Draft Proposal rejects basing non-economic damage awards on data about jury verdicts, and instead recommends that they be based on “public deliberations about (1) reasonable compensation for the various levels of noneconomic loss; and (2) what the maximum total costs of the compensation system should be.”⁵⁶⁷ Common Good adds that “[v]alues should be based on decision science research about utility losses and public deliberation about reasonable compensation. Academic research into utility valuations can be used to inform public deliberation.”⁵⁶⁸

With regard to the determination of “reasonable compensation” by reference to “academic research into utility valuations,” this may sound like a positive endorsement of scientific method and democratic deliberation. But it can also be a sleight-of-hand for valuing a malpractice victim as an abstract individual rather than as the real person who has been injured—as a “statistical” rather than an “identifiable” life. It is well known that abstract lives are valued much lower than identifiable lives; people are willing to spend much more to save an actual person, such as someone drowning or in need of emergency medical care, than an abstract person such as a hypothetical pedestrian or automobile passenger.⁵⁶⁹

The more important problem raised by the Common Good language, however, is the second factor delineated, the reference to “public deliberations about ... (2) what the maximum total costs of the compensation system should be.” That is a striking bit of placing the cart before the horse: the maximum amount of damages injured individuals as a class may recover would be determined not by their actual losses, however determined, but by some separate political determination about what the “maximum total costs of the compensation system should be.” The goal of health court proponents, then, is to reduce substantially the amount of non-economic damages for malpractice victims. Given the financial stress of increasing the number of paid claimants (see Section VI.I), one can predict that the determination of what the “maximum total costs of the compensation system should be” would be

heavily influenced by the desire to avoid increases, or even to produce reductions, in malpractice premiums, so that desired premium levels drive recoveries, rather than justifiable recoveries driving premium levels.

This point bears amplification, and the Milbank article provides a context in which to do so. Its authors write:

Whether malpractice litigation costs currently exceed the socially optimal level is controversial, but the desirability of being able to control the system's costs should not be. Only when we have such leverage can we ensure that the amount we spend on medical injury compensation matches social judgments about how much we should be spending. Controlling compensation costs is fairly difficult in the tort system, which is decentralized and in which compensation decisions are made without reference to guidelines or precedent.

The authors are talking here not just about providing public guidelines as to how to compute the actual losses suffered by malpractice victims, for this alone would not control total system costs, which would still depend on how many errors were made by providers and how many claims were asserted as a result. Rather, they are talking about separately controlling total system costs. This remarkable statement betrays a striking commitment to economic central planning. Imagine suggesting that the total consumption of food should be determined by a political judgment, rather than by the decentralized decisions of producers and consumers, and that the need to control total food costs in some such way should not even be controversial.

Of course, food is generally an economic good, while malpractice is an economic bad. Still, the claim that it should not even be controversial that total system costs should be set politically at a level lower than the aggregate costs imposed on society by the malpractice of providers is breathtaking in its willingness to eliminate market mechanisms for controlling tortious conduct. What producer of public harms would not embrace such an idea? Certainly it should be facially suspect to any economist, who should start with the principle that “externalities” should be “internalized” by their producers if efficient deterrence is to occur.⁵⁷⁰ It is one thing to suggest that there should be guidelines to assist judges and juries in deciding how much an injury is truly worth; it is quite another to say that, even if it is truly worth \$100,000, a political judgment that the medical/insurance industry should not be required to pay that much (in this and similar cases) requires that the award be reduced to, say, \$10,000, in order to keep total payouts at an acceptable figure. This idea is all the more troubling in light of the fact that the entire decision-making system would be biased in favor of the interests of providers and their insurers. What political judgment about the level of payouts that are “acceptable” can we expect such a system to make?

As noted earlier, health court proponents are not clear or consistent about where the money for claimants' legal fees will come from.⁵⁷¹ One possibility, suggested by

their analogizing health courts to the workers’ compensation system, is that attorneys’ fees would be paid out of the proceeds of the award.⁵⁷² This rule, apparently endorsed in the Milbank article, would reduce the amount of net compensation received by successful claimants. The other possibility, at least suggested by the PPI Report, is that legal fees would be a separate item of recoverable economic damages. In that case, the effect for those plaintiffs who did recover damages would be to avoid this particular reduction, but the reduction in their other recoveries for economic and noneconomic losses might well outweigh the savings.

Clearly, then, certain patients would be worse off under a health court system than under the tort system. Among these are the patients with highly meritorious claims and severe injuries, whose entitlement to damages is so clear-cut that their cases are likely to be settled under either system, and who receive substantial awards under the current system, but who would be entitled to substantially lower awards from health courts. Health court proponents argue that this is fair because other claimants would be better off under a health court system: “Such changes in rules of damages are not unfair; in exchange for having more cases covered, more predictably, and faster, claimants as a class will receive some reduction in allowance per case.”⁵⁷³ But it is not fair to sacrifice the welfare of severely-injured patients with the strongest cases for the benefit of less severely injured patients, especially those with less compelling cases. Moreover, since those who would be worse off are those whose cases are likely to settle quickly under the tort system, they would stand to gain little from health courts in the way of greater speed of recovery.

Almost surely, even those who would obtain compensation faster under a health court system would lose out, since the reduction in the amount of damages they would receive would far exceed the discount in the value of a larger recovery later on. Median and mean duration of paid claims processing (from injury to closing of the insurance file by payment) is just over three years.⁵⁷⁴ Even under the health court system, it would take some time to process claims. Using a generous discount rate of six percent per year, the 3-year discounted value of a net award of, say, \$500,000, is still about \$420,000. Receiving compensation substantially less than \$420,000, even if three years earlier, would leave the claimant much worse off than under the current system, unless the patient had a subjective discount rate that was substantially higher than six percent.⁵⁷⁵ As explained earlier (Section VI.I), without substantial increases in malpractice premiums, compensation levels would have to be decreased dramatically, probably much more than the kind of the time-discount involved in most litigated claims.

D. Statutory Tort Immunity (in the Guise of a “Deductible”) Would Unfairly Limit Victims’ Opportunities for Redress of Wrongdoing.

As explained above (Section VI.I), health court proponents are driven to rely upon the idea of a “deductible” to avoid massive inflation in the direct costs of the system they propose. This use of the term “deductible” is a misnomer. It is not the kind of

deductible with which consumers are familiar, for the latter is established between the insured and his or her insurance company; when a consumer pays less for insurance with a higher deductible, the consumer knows that he or she is responsible for the deductible amount. Similarly, in the malpractice context, if a physician has a deductible, then he or she is responsible for covering the cost of the deductible in payments to a malpractice victim. The “deductible” at issue in the health court context would be quite different. It would specify, without the consent of the patient, how much the *patient*, not the physician, would have to bear before gaining access to legal recovery from an insurance company or from the provider. This “deductible” would not be based on contract. In other words, it would be a statutory tort immunity, plain and simple. Calling it a “deductible” may be a rhetorical ploy, attempting to play on the public’s familiarity with—and acceptance of—true deductibles. However that may be, barring claims in the common-law courts while simultaneously creating tort immunity in the only tribunals authorized to hear malpractice claims is a gross violation of injured patients’ rights of redress. Tort immunities have been disfavored and eroded in modern law.⁵⁷⁶ Although they have been defended in the past on the ground that they serve some overarching public necessity, as explained in Section V there is no reason to think that tort immunity for medical malpractice would be in the public interest, let alone a public necessity.

Health court proponents may respond that the persons barred by their “deductibles” are mostly people who would not pursue claims at all under the existing system, generally because their claims are not large enough in amount that a lawyer would be able to afford to take their cases, and that some of the barred individuals would be those whose injuries were the consequence of non-negligent but avoidable injuries, persons who would have no legitimate claim even under the existing system. These points may be correct, but they do not fully address the problem.

First, there will likely be some individuals who would be able to obtain redress under the current system but unable to do so under the proposed health courts on account of the tort immunity created by the deductible. Depending of course on how high the deductibles would be set, patients with very clear cases of liability but only modest medical costs and lost earnings could find themselves in such a situation.⁵⁷⁷ Second, even as to those barred individuals who would not have practical redress under the current system, there is a fundamental difference between, on the one hand, being told that your claim is too small to warrant the costs of pursuing a legal remedy and, on the other, being told that the law does not allow you to pursue a remedy, even if you can find a lawyer who will take your case and even if you are willing to take the chance of losing money in the process.⁵⁷⁸ Especially is this so when the reason for the inability to pursue a legal remedy is not that the claim lacks merit, but rather that barring meritorious claims is necessary to make the system of civil redress sufficiently friendly to the interests of the medical establishment and its insurers. Finally, the “deductible” would apply as well to those who did recover something. It would block recovery for a portion of their actual losses, a portion as

to which the patients’ substantive claims—that their injuries resulted from avoidable errors—were no weaker than their claims for compensable losses. Again, they would be expected to take solace from the notion that the reduction in their recoveries was needed to provide a more practitioner-friendly environment. The unfairness of these results, none of which are based on the kind of contractual consent involved in true deductibles, is patent.

E. Health Courts Would Not Adequately Address Serious Wrongdoing.

As noted earlier, health court proponents eschew a “shame-and-blame” approach, which they associate with the tort system, in favor of a systems-failure approach to medical errors.⁵⁷⁹ This is illustrated by the plan to “de-identify” the information reported out by health courts. The idea seems to be that medical mistakes are “honest” errors, and that the best approach to reducing patient injuries is to identify and correct the features of the medical system that allow such mistakes to occur. Yet there are some forms of inappropriate provider behavior that cannot be considered honest mistakes. These include intentional wrongdoing, such as having sexual relations with an anesthetized patient; repeated failure to correct mistakes; and breaches of fiduciary duty, that is, sacrificing the patient’s welfare for the provider’s self-interest.⁵⁸⁰

Examples of patient harm caused by breaches of fiduciary duty include *Strauss v. Biggs*, in which a podiatrist named Strauss, who operated what the trial court called a “podiatric mill,”⁵⁸¹ was held liable for pretending to perform a certain surgical procedure and instead severely injuring the plaintiff’s heel. The defendant had not performed the correct procedure because it would have had to take place in a hospital, and he did not have hospital privileges to perform hospital surgical procedures. The doctor’s mistake consisted of performing the wrong procedure and doing it badly; his breach of fiduciary duty consisted of allowing his financial interest in conducting a lucrative, high-volume office practice to interfere with his patient’s well-being. This inference was strengthened by evidence that he had billed the plaintiff’s insurer for the surgery and other procedures that were either unnecessary or not performed at all.⁵⁸²

Another example is *Davis v. Superior Court*,⁵⁸³ in which a plaintiff who injured his hand in a workplace accident alleged that physicians retained by the employer’s workers’ compensation insurer had treated him negligently by leaving a 2-inch stick embedded in his hand, and then concealed the negligence, for example by referring to the stick as “a splinter.” The plaintiff demonstrated that the doctors were motivated by the desire to stay in the insurance company’s good graces so that they could continue to receive its referrals.⁵⁸⁴

Similarly, in *Sweed v. Cigna Health Plan*, a patient complained that her primary care provider had failed to make a timely surgical referral after finding a lump in her breast because of her health plan’s financial incentives to withhold care.⁵⁸⁵ By the time she did have a biopsy, her cancer was inoperable. In another case, an

optometrist was successfully sued for allowing his unlicensed, untrained son to examine a patient's eyes, sell her contact lenses, and incorrectly advise her how to care for them, as a result of which she developed an infection that left her with a permanent corneal scar.⁵⁸⁶ Recently, a doctor was accused of diluting the AIDS drugs he prescribed his patients in order to pocket the difference.⁵⁸⁷

The impetus for a breach of fiduciary duty need not be financial. It can involve other personal interests of the provider. In *Medvecz v. Choi*, for example, a patient undergoing an elective renal arteriography alleged that she was paralyzed from the waist down when the anesthesiologist abandoned her in order to have lunch.⁵⁸⁸

Health court supporters acknowledge that the amount of compensation received by successful claimants in a health court system might vary according to the severity of their injury,⁵⁸⁹ but they do not mention the need for compensation to change depending on the degree of provider wrongdoing. In one of the first explorations of ACEs for use in a no-fault malpractice system, Havighurst and Tancredi expressed the need for the more egregious types of cases to be handled on a "fault" basis:

A third category of events was also identified [in the course of attempting to identify ACEs]. Entitled 'Consequences of Conduct Appropriate for Specific Sanctions,' this group included the adverse consequences of failure to obtain informed consent, abandonment of the patient, gross negligence, intentional misconduct, and illegal behavior. Because these behavioral lapses relate to special societal expectations regarding professional conduct, they seemed inappropriate for treatment in a no-fault system. Traditional legal doctrines and forums seem adequately to express and effectuate societal norms with regard to these matters. We recognize, of course, that the letter of the law on informed consent and other matters is apt to be confusing, but we regard the jury's role as substantially more important than stated legal doctrine in enforcing society's paramount expectation that the physician will accord his patients their full due as sovereign human beings. Damages in cases where such duties are violated need not be strictly compensatory.⁵⁹⁰

But over the intervening years, this insight has been lost.

Health court advocates propose to exclude intentional wrongdoing from their system, presumably so that victims could pursue their traditional common law remedies. The Common Good Draft Proposal states, for example, that a health court demonstration project should only cover "medical malpractice claims," and that "[i]ntentional tort claims, medical product liability claims, and mixed coverage/treatment claims against managed care organizations would remain within jurisdiction of the tort system."⁵⁹¹ This jurisdictional division inevitably would produce litigation, as health courts or the regular courts struggled to sort cases between the two systems. More importantly, carving out an exception for intentional wrongdoing by providers would not provide an adequate remedy for patient injuries caused by breaches of fiduciary duty, but instead would treat them the same

as “innocent” mistakes. This stems from the fact that intentionality focuses on the likelihood of injury created by provider behavior, rather than on the motivation for provider error—in the case of breaches of fiduciary duty, placing their own self—interest above the welfare of their patients.⁵⁹²

To be sure, Bovbjerg and Tancredi propose “a narrowly defined alternative remedy” to address “egregious misconduct that borders on criminal behavior or repeated acts of simple negligence showing reckless disregard for safety.”⁵⁹³ But the alternative remedy they have in mind is not the right to bring an action for breach of fiduciary duty, in which the patient may be entitled to punitive as well as compensatory damages, but a mechanism that would determine what conduct is egregious “administratively” or through “private dispute resolution,”⁵⁹⁴ whatever that means.

Health courts as envisioned would not routinely report to external disciplinary bodies the identity of providers whom the courts had found liable for patient injuries.⁵⁹⁵ Common Good would make an exception and report identities in cases of “egregious provider misconduct” where a health court determined “that a risk of significant harm continues to exist for other patients or that [the] event was clearly outside of the bounds of professional behavior.”⁵⁹⁶ The Milbank article would allow disclosure “only in those circumstances in which the danger to patient safety is clear, ongoing, and significant.”⁵⁹⁷ But except for those who suffered intentional torts, patients who were injured by “dishonest” provider wrongdoing would not be able to sue under the traditional system. As a consequence, claims would no longer be adjudicated by juries and judges who can take the degree of provider wrongdoing into account in determining the amount of damages. For example, Tancredi and Bovbjerg state that one ACE is for “complications from abandonment of the patient—failure to treat labor.”⁵⁹⁸ Thus, in a health court system, a patient such as Mrs. Medvecz mentioned above,⁵⁹⁹ who was paralyzed from the waist down when her anesthesiologist abandoned her in order to have lunch, would have no greater remedy than a patient whose physician honestly but incorrectly believed that treatment in the patient’s case was inappropriate.

F. Patients Would Be Forced Into A Health Court System Without Being Given a Meaningful Choice.

Health courts, whether established as a “demonstration” project or as a permanent fixture, would not give patients a meaningful choice about whether or not to participate. Bovbjerg, Tancredi, and Gaylin state, for example: “We do not envisage a system that would allow individual injured patients to elect ACE compensation in lieu of suing, although it is theoretically possible.”⁶⁰⁰ When the Common Good Draft Proposal states that “[a] voluntary demonstration project is probably most feasible as a starting point,”⁶⁰¹ it is referring to provider participation being voluntary, not patient participation: “States likely will be more comfortable with an approach in which insurers/provider organizations elect to participate, rather than one in which participation is mandatory statewide.”⁶⁰² The only sense in which patient

involvement in a health court system would be “voluntary” is that patients would be informed if a provider or health plan had elected to participate, in which case in theory the patient could switch to another provider or plan. The Model Act states, for example:

At the time of the patient’s first medical consultation with a covered health care provider after the provider elects to participate in the program, the covered provider shall furnish the patient with a written notice of the provider’s participation in this program and an explanation of the patient’s rights under the program, including the right to receive care from health care providers not participating in the program. The patient shall by signature acknowledge receipt of such notice, and the covered health care provider shall maintain a record of such signed patient acknowledgements.⁶⁰³

But in practice, many patients do not have the luxury of switching plans or providers.⁶⁰⁴ These patients would be forced to waive their common law rights in order obtain health care.

An illustration of the unfairness of this approach comes from the Virginia and Florida birth-related injury programs, mentioned earlier.⁶⁰⁵ There too, providers are free to decide whether or not to participate in the program or to have claims against them adjudicated by the traditional tort system. Providers must inform patients whether or not the provider is participating in the program, on the theory that patients who do not want to be included can change providers. If providers choose to participate, however, then all of their patients are automatically included, and virtually all eligible providers in Virginia and Florida have chosen to participate.⁶⁰⁶ Voluntary patient choice thus is a fiction.

It also is worth noting that under the Swedish system, whose “avoidability” standard is an important model for health court proponents, patients are given a choice. They “are not precluded from bringing a malpractice action in court against their provider at any stage during or after the claims process.”⁶⁰⁷

Conducting a health court “demonstration project” would not cure the problem. In fact, a demonstration that was “conducted, supported or otherwise subject to regulation by any federal department or agency”⁶⁰⁸ would be required to comply with regulations promulgated by the Department of Health and Human Services for the protection of human subjects.⁶⁰⁹ In addition to requiring that the research project be reviewed and approved by an appropriate institutional review board, the regulations prohibit the involvement of human subjects “unless the investigator has obtained the legally effective informed consent of the subject or the subject’s legally authorized representative.”⁶¹⁰ Moreover, the regulations mandate that “[a]n investigator shall seek such consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence.”⁶¹¹ The regulations specify that the basic elements of informed consent must include,

among other things, "a statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled."⁶¹²

Even if health court demonstrations were not subject to these regulatory requirements, they would violate well-established ethical principles if they did not obtain the patients' informed consent. Alexander Morgan Capron states, for example, that "social experiments in which the government is involved ought to be conducted under the same regulations as have been developed for other human research."⁶¹³ Furthermore, Edward Gramlich and Larry Orr point out that a social experiment is not the same as "normal policymaking":

In its normal policymaking operations, the government is deemed free to carry out activities that harm individuals or groups of individuals as long as, in the process of doing this, it is trying to maximize some concept of collective social welfare and it does not violate certain fundamental rights of individual citizens. Thus the government would be free to impose a tariff that would harm certain groups (consumers) as long as it felt that aggregate national welfare would be improved in the process. ... Experiments raise somewhat different issues because they are designed not as statutory policies but as devices to gain information."⁶¹⁴

Accordingly, they state, "it has become customary to insist that government social policy experiments satisfy a more stringent ethical standard. This standard, similar to that used in medical experiments, maintains that experiments are ethical if subjects voluntarily give their consent to participate"⁶¹⁵

G. Conclusion.

The American Bar Association has called attention to the unfairness of the health court approach. On February 13, 2006, the House of Delegates adopted a resolution opposing "the creation of health care tribunals that would deny patients injured by medical negligence the right to request a trial by jury or the right to receive full compensation for their injuries."⁶¹⁶ The unfairness of the health court system to patients is so obvious that it raises the question of why a 2003 Harris Poll reported that 62 percent of the public favored health courts.⁶¹⁷ The answer is plain from the way the poll was conducted. The poll asked 5 questions: (1) "Would you favor or oppose new legislation to limit the costs of medical liability and reduce the costs of medical malpractice insurance?"; (2) "Overall, do you think that malpractice suits against doctors and their fear of being sued improves or harms the quality of care [a lot or a little]?"; (3) "How often do you think that medical malpractice claims are brought against doctors and hospitals where there has been no malpractice?"; (4) "Would you favor or oppose a limit of \$250,000 for punitive damages and pain and suffering, with no limit on awards for medical costs or lost earnings?"; and (5)

“Would you favor or oppose having medical malpractice cases tried in special courts presided over by medical professionals and other experts to review and decide injury cases?”⁶¹⁸ None of these questions gives respondents any idea of the details of how health courts would operate. The question about health courts does not even make it clear that patients would no longer have a right to a jury trial. Question 4 gives the misleading impression that claimants would be fully compensated for the most substantial components of damage awards. The other questions are calculated to confuse respondents or make them hostile to the traditional malpractice system. Question 1 reminds them of the need to “limit” and “reduce” medical costs. Question 2 describes doctors as being in “fear.” Question 3 signals that malpractice claims are brought without merit. It is not surprising then that, when asked the question about health courts, respondents answered positively. Leading questions directed them to this result.

VIII. SOUND HEALTH COURT OBJECTIVES CAN BE ACHIEVED MORE FAIRLY AND LESS EXPENSIVELY UNDER THE CURRENT SYSTEM.

As noted earlier, some of the objectives of the health court concept are laudable. Even health court proponents now acknowledge that one of the most important problems we face is the huge number of medical errors that go unredressed. It would be desirable to have greater disclosure of errors so that more patients were compensated, thus requiring the health care system to internalize more of the costs of malpractice and providing greater incentives to improve the quality of care. It also would be desirable to reduce the administrative costs of compensating victims and to give practitioners clearer and more scientifically-validated signals about what constitutes proper care.

But in one of the most telling objections to the health court concept, Hyman and Silver point out that it is completely disingenuous for health court proponents to criticize the current system for failing to compensate more patients more quickly at lower cost when providers and insurers could do this under the tort system if they wanted to:

Providers, insurers, and tort reformers often criticize the malpractice system for delivering compensation to only a minority of patients who deserve it, and for taking too long to process valid claims. This argument strikes us as an example of the "chutzpah defense," best exemplified by the individual who killed his parents, and then threw himself on the mercy of the court because he was an orphan. Nothing prevents providers or liability carriers from offering payments before patients sue or from paying valid claims expeditiously.... A few hospitals and insurers have implemented a pro-active approach on which they reach out to patients as soon as possible, and its widespread use would surely enable the malpractice system to operate more accurately, more quickly, and with smaller transaction costs.⁶¹⁹

Similarly, greater predictability for health care providers is as feasible within the existing tort system as it would be in a health court system. In short, the objectives of a health court system can be fulfilled effectively and at a lower cost within the traditional malpractice system, without being unfair to patients.

A. Encouraging Disclosure of Errors

Health court advocates note that disclosing errors to patients and making apologies would enable patients to be compensated and the rate of errors to be reduced. But there is nothing to prevent this from being done within the current malpractice system. Groups like the American Medical Association and the Joint Commission for the Accreditation of Health Care Organizations already call for increased use of apolo-

gies. The JCAHO has made disclosure a standard for hospital accreditation. JCAHO standard RI.2.90 requires that “[p]atients and, when appropriate, their families [be] informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.”⁶²⁰ AMA Ethics Opinion E-8.12 states:

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. ... Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care. ... Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.⁶²¹

As noted earlier, the VA also has adopted a disclosure policy.⁶²² A study of the impact of this policy at one VA facility found that it did not increase malpractice payouts:

Despite following a practice that seems to be designed to maximize malpractice claims, the Lexington facility's liability payments have been moderate and are comparable to those of similar facilities. We believe this is due in part to the fact that the facility honestly notifies patients of substandard care and offers timely, comprehensive help in filing claims; this diminishes the anger and desire for revenge that often motivate patients' litigation.⁶²³

Of course, there is always a risk that ethical demands will be overwhelmed by providers' self-interested fear that they will be penalized for disclosing and apologizing for errors by patients who introduce such disclosures and apologies as evidence of wrongdoing in a malpractice suit. In recognition of this incentive problem, the law of evidence recognizes a quasi-privilege for a variety of such behaviors, including a rule preventing the admission of evidence of paying or offering to pay medical, hospital, or similar expenses occasioned by an injury,⁶²⁴ as well as a rule protecting the confidentiality of settlement negotiations.⁶²⁵ Beyond this, many states have added rules barring the admission of statements by way of apology and, in some cases, even unsworn statements explaining the events about which the apology is made.⁶²⁶

Greater willingness of providers and insurers to disclose errors, apologize sincerely, and make timely settlement offers of reasonable compensation would go far toward improving the relationship between malpractice victims and providers under the current system. The value of sincere apologies is well-known⁶²⁷ and non-controversial. In addition, early, reasonable settlement offers would decrease the need for subsequent adversarial proceedings. If efforts from the medical establish-

ment are not considered adequate to assure an adequate level of disclosure and legal reform is needed, that might just as well take the form of legally mandated disclosures, with appropriate penalties for noncompliance, in coordination with the current tort system. To the extent that ACEs or practice guidelines can be effectively devised, these could be the basis of such disclosure requirements. There is no need to create a new bureaucracy in order to induce disclosure.

B. Compensating More Malpractice Victims at Lower Cost

Again, under the current system there is nothing, other than the self-interest of providers and their insurers, to prevent greater disclosure of errors to patients coupled with early offers of fair amounts of damages so that more patients can be compensated at lower cost. This would avoid the costs from attorneys filing claims before they learned the facts of the case from discovery; reduce the costs of fact-finding; and lower attorneys' fees by resolving cases without protracted litigation.⁶²⁸ Doing this within the current system rather than under a health court system would avoid the need to create and fund a new health court bureaucracy. As Hyman and Silver point out, health court supporters' criticisms of the current system for failing to pay claims quickly and cheaply is thus another example of a "chutzpah defense":

Providers, tort reformers, and insurers claim to be concerned about under-compensation of injured patients and litigation delays. They could mitigate these problems tomorrow, by abandoning the chutzpah defense, paying claims without forcing patients to sue and immediately offering full economic damages to patient-litigants with strong cases. Their choices (forcing patients to sue and aggressively fighting even meritorious claims) reveals [sic] that their true preference, consistent with their economic self-interest, is to force injured patients to bear the largest possible fraction of the cost of negligent treatment.⁶²⁹

In addition, making disclosure and early settlement a more frequent feature of the tort system has the virtue of giving patients a meaningful choice in whether or not to accept what presumably would be a discounted settlement offer or pursue a traditional malpractice action, which would take longer to resolve. From a fairness standpoint, it is critical that patients be permitted to select between these alternatives *after* they have suffered an adverse event. Only then can they realistically weigh the pros and cons of their options. As the ABA stated in rejecting the health court concept:

The most recent evolution [of the health court concept] is the suggestion that patients could "opt in" to the systems and waive their right to a jury trial. This development would be particularly troubling should the "opt in" actually prove to be a mandatory part of health care agreements with HMO's, insurers, hospitals and health care providers might require their patients to sign before allowing

treatment. It has long been ABA policy to endorse the use of alternatives to litigation, such as arbitration, for resolution of medical malpractice disputes under circumstances whereby the agreement to arbitrate is entered into only after a dispute has arisen and is entered into on a voluntary basis.⁶³⁰

Health court proponents also argue that an administrative system like workers' compensation would enable patients with less severe injuries to recover some measure of damages.⁶³¹ But if there is the political will to create a new bureaucracy to handle small claims, then there is nothing to stop the creation of an administrative system, voluntary for patients, alongside the traditional tort system. In 2005, for instance, the British government introduced a bill in Parliament to establish an administrative compensation system for smaller malpractice claims (i.e., less than £20,000). The program is intended to be an alternative rather than an exclusive remedy, with injured patients free to pursue their claims in the traditional tort system.⁶³²

C. Providing More Specific Guidance for Juries and Greater Predictability for Providers

Much of health court proponents' frustration with the existing tort system stems from their belief that the substantive standard of liability is insufficiently definite. There are good reasons, grounded in the principle of the rule of law, to support the view that substantive norms of conduct should be as definite as is reasonably possible under the circumstances.⁶³³ But again, to the extent that greater definiteness is possible in the medical malpractice context, it can be achieved under the existing system.

Health court advocates criticize jury awards because jurors "return verdicts without having any ... precedent on which to rely in making their decisions."⁶³⁴ It is questionable whether compensation guidelines could be constructed that adequately factored in all the important elements of specific cases, including the nature and severity of injury, the degree of wrongdoing, and individual victim characteristics. But if appropriate guidelines could be created, there is no reason why they could not be given to jurors to help them in their decision-making. Indeed, this is something that health court supporters previously have urged as an improvement in the current system.⁶³⁵

Health court proponents complain that providers' efforts to discern how to satisfy the standard of reasonable care under the tort system are hampered by a lack of information, because for the most part only appellate court decisions are readily accessible. Their solution is to place written health court decisions on an electronic database. But there already is an electronic database that records malpractice outcomes—the National Practitioner Data Bank (NPDB). Moreover, in contrast to health courts, the NPDB includes reports of settlements as well as adjudications. If the information in the data bank is deemed incomplete or inaccurate, the solution

is to improve the reporting requirements, not to create a new bureaucracy with a new database.

Similarly, medical groups could attempt to develop scientifically sound, unbiased ACEs and practice guidelines to educate providers, insurers, and the courts about what outcomes should be regarded as avoidable and compensable, so that victims could be compensated quickly and cheaply, and about what processes of care providers should employ to avoid liability and eliminate defensive medicine. Practice guidelines then could be introduced as evidence in malpractice trials or even made the basis for rules of “negligence per se” (in which violation of the practice guideline would be presumptively or *ipso facto* negligent),⁶³⁶ or of “safe-harbor” provisions for physicians. These measures could provide guidance to physicians and reduce the time and expense of controversy over whether a violation of the guideline was negligent, in turn expediting the settlement of lawsuits.⁶³⁷ Similarly, ACEs could be the basis of doctrines analogous to “res ipsa loquitur,” in which a specified outcome becomes presumptively the result of negligence,⁶³⁸ thus again providing guidance to physicians and streamlining the settlement of lawsuits.

If the stigma of negligence is considered a stumbling block to such ideas, then health care providers could simply adopt a policy of compensating patients without admitting fault in cases of ACEs or the violation of a practice guideline, a civil law equivalent of the “nolo contendere” plea in criminal law.⁶³⁹ All would understand that the physician was stipulating to liability for an avoidable injury rather than admitting negligence. Malpractice insurance policies could easily be written to cover such stipulated liability.

This is not to say that the task of establishing ACEs or practice guidelines would be easy; as noted earlier, there is a dearth of scientific evidence supporting the designation of specific outcomes as avoidable and little evidence-based medicine.⁶⁴⁰ The development of practice guidelines in particular is hampered, among other things, by the need to adapt medical practice to the exigencies of the specific case and the need to adjust to rapid changes in medical technology.⁶⁴¹ Furthermore, care must be taken so that medical groups do not design ACEs and guidelines to avoid liability—for example, by deliberately crafting a guideline with a low standard of care so that providers can use the guideline inappropriately as a defense. But if it were feasible to create valid ACEs and practice guidelines, then these tools could perform the same desirable functions in the current system as in a health court system.

D. Adopting Reasonable Regulations Relating to Recoverable Damages

Health court proposals include a variety of measures to avoid what they see as unpredictable or inappropriate damage awards. (See Section IV.K.) Assuming for the sake of argument that such proposals have merit, in many cases there is no reason that they could not be implemented within the existing tort system.

For example, one proposal from health court proponents is paying future medical and other economic damages periodically, rather than in a lump sum.⁶⁴² To be

sure, periodic review of deferred payments would be difficult to incorporate into a system that includes jury trials, but a system of deferred payments not subject to periodic readjustment would be compatible with trial by jury, presents less potential for abusive relitigation of damages by persistent insurance companies, and is favored by economists as working more efficiently in creating incentives for rehabilitation than ones that are subject to periodic review.⁶⁴³ Indeed, some states now permit periodic payments.⁶⁴⁴ The details, however, are many and important—for example, what kinds of payments, if any, would terminate upon the death of the plaintiff?⁶⁴⁵—and would need to be resolved legislatively in a way that complied with applicable state constitutional restrictions.⁶⁴⁶

Another proposal is reducing damage awards by the amount of “collateral” payments from third parties.⁶⁴⁷ As noted elsewhere (Sections VI.I), this idea is a bad one. That said, if the political judgment is that all or some specific kinds of collateral payments should be used in this fashion, this can be done under the existing tort system. In fact, eighteen states have modified the collateral source rule under the traditional system, allowing juries to factor in payments from collateral sources in determining the amount of damages.⁶⁴⁸ An additional twelve states allow courts to reduce awards by collateral source payments after the jury has issued its verdict.⁶⁴⁹ Again, there are numerous important details that would need to be addressed legislatively, including the question of whether the collateral source rule should be retained for first-party insurance purchased by the plaintiff (so as to protect the benefit of the plaintiff’s contractual bargain) but not for governmental benefits.⁶⁵⁰ Again, constitutional restrictions would need to be carefully assessed.⁶⁵¹

To reiterate, our point here is not to endorse any particular proposal regarding damage computation or payment. There are many details in any such proposal that require careful attention in the legislative process. Our point, rather, is simply this: to the extent that health court proposals draw any rhetorical strength from ideas about rationalizing damage awards, these ideas—to the extent they have independent merit—can be incorporated into the existing tort system.

E. Improving the System’s Use of Expert Witnesses

There are ways to improve the existing system’s use of experts. To be sure, exaggerated—and undocumented—claims about the “battle of the experts” are commonplace in the tort reform literature. Representative is the statement by the Progressive Policy Institute that “the cost of dueling experts is a principal driver of the escalating cost of malpractice litigation,…”⁶⁵² Undocumented in this report is the implicit claim that litigation costs for medical malpractice are “escalating” beyond what one would expect from inflation and increases in the number of claims based on the size of the population.⁶⁵³ Also undocumented is the assumption that expert witness fees are a large enough portion of the administrative costs that they could be a “principal driver” in the supposedly escalating litigation costs, and that these fees are themselves increasing in excess of what one would expect based on factors

such as inflation and population growth. On the contrary, available empirical evidence does not report excessive fee arrangements for expert witnesses.⁶⁵⁴

Equally important, critics of the current malpractice system take the view that “[a]ccess to impartial, unbiased expert testimony on the standards of care is essential for a reliable system.”⁶⁵⁵ The implication is that expert witnesses paid by, and thus “beholden to,” the parties do not provide such assistance. But this ignores the possibility that, in many or most battles of experts, each witness honestly believes his or her testimony to be correct. As the PPI Report admits, “often medicine is as much an art as science,”⁶⁵⁶ so it is hardly surprising that party-retained experts in good faith reach opposite conclusions.⁶⁵⁷ The concern typically underlying these claims about biased experts is that juries will be unable to sort the well-grounded opinions from the unsupported ones. We have already addressed this particular concern and shown it to be unsupported by the empirical evidence. (See Section V.D.)

Nonetheless, tribunals, including juries, can benefit from the opinions of court-appointed experts whose opinions are at least very likely to be free from the most obvious sources of bias, including not only raw venality but also the tendency of the party-retained expert to adapt, perhaps subconsciously, his or her opinions to the desires of the party who selects and pays for those opinions. In the presence of conflicting opinions from interested parties, it is not unreasonable to seek yet a third opinion, even though the third opinion comes with no guarantee of perfection.⁶⁵⁸ Unless the trial judge is doing something wrong—somehow signaling to the court-appointed expert which side the judge wants to win—the only desire to which the court-appointed expert can so adapt his or her opinions is the desire to have practically useful and maximally objective testimony.⁶⁵⁹ Accordingly, the common law has long recognized trial courts’ inherent authority to call court-appointed witnesses, an authority now codified in Federal Rule of Evidence 706 and similar state provisions. This authority has been employed in many medical malpractice cases.⁶⁶⁰ Coupled with the authority of the trial judge to limit the number of party-retained expert witnesses to be called,⁶⁶¹ court-appointed experts can be used to limit the costs and partiality of the expertise considered at trial.

Of course, court-appointed experts are no panacea. Aside from the possibility that the occasional unethical judge might select the expert in order to get a predetermined opinion, many if not most experts come with commitments to particular theories or lines of analysis that address the frequently controversial subjects that are especially common at the cutting edge of a field of knowledge. As a consequence, it would be unwise to *substitute* court-appointed expertise for party-retained expertise. Specifically, if there is a legitimate difference of opinion about the standard of medical care appropriate in a particular context, the use of a single court-appointed expert, chosen without regard to his conclusion in the case, would only contribute to a sense of randomness in litigation. For example, if sixty percent of experts favor one standard, and forty percent favor another, there is a forty percent chance that an outcome-random selection will yield a court-appointed expert who endorses the minority view. There are ways to address such prob-

lems, but foremost among them is continuing to allow parties to call their own experts.⁶⁶² Some current health court proposals, while criticizing the battle of experts, are thus forced to recognize the importance of allowing parties to use experts of their own choice.⁶⁶³

It is generally agreed that the authority of the common-law trial judge to call experts is used sparingly, and many have called for increased use of such experts.⁶⁶⁴ The impediments to doing so are several, but foremost among them are probably (1) the inertia of a system that has traditionally relied upon witnesses called by the parties, and (2) the fact that there has traditionally been little by way of organized assistance to trial judges in the identification, selection, and payment of experts.⁶⁶⁵ There have been a number of efforts to overcome the indicated inertia, including encouragement from the Supreme Court,⁶⁶⁶ and one practical avenue of reform might be statutory measures to further encourage or even require court-appointment of experts in medical malpractice cases.⁶⁶⁷

With regard to overcoming the institutional impediment, among recent developments is the pilot project run by the American Association for the Advancement of Science, known as Court Appointed Scientific Experts (CASE). The project is supposed to help judges find a suitably qualified expert who can address the particular issues in a case. CASE has an advisory committee to recruit potential witnesses, identify conflicts of interest, and educate potential witnesses about the legal process.⁶⁶⁸ To be sure, one must always be alert to the danger that those who control such projects might have biases of their own, and we should not be read as endorsing CASE without reservations, but this kind of effort may nonetheless be useful. There are also ways to encourage the attorneys in a case to identify potential court-appointed witnesses. This would take advantage of the bar's developed knowledge of available expert resources.⁶⁶⁹

In short, whatever rhetorical support health courts proponents derive from frustrations with “dueling experts” is ephemeral. What we know about juries suggests that they are reasonably capable of handling such conflicts in testimony. That does not mean, however, that juries, judges, and lawyers cannot benefit from court-appointed experts. Other procedural reforms in how experts are used, such as allowing pre-trial dialogue between opposing experts, also might be of value.⁶⁷⁰ In any event, such measures can ameliorate the problems of these battles of experts as well as anything that would be provided by the proposed health courts and would do so without introducing a system so severely prone to be biased in favor of providers.

F. Using Information Regarding Errors to Improve Patient Safety

Health court supporters want their system to create standardized information about medical errors and to distribute it in a provider-unidentifiable manner to patient safety regulatory bodies so that the root causes could be ascertained and systemic measures taken to prevent recurrences. There is no reason why the same stan-

standardized reporting system could not be adopted under the current system. Several states already require providers to report adverse incidents. Congress could pass legislation requiring all states to create a system of standardized reporting, and the de-identified information could be distributed to the same entities that would receive it under a health court system.⁶⁷¹ Health court advocates also propose that hospital provider malpractice premiums be experience-rated. If this is feasible, it too can be adopted under the present system, as health court proponents themselves have previously recommended.⁶⁷²

Clearly a great deal can be done to improve patient safety based on identifiable risks. In December 2004, the Institute for Healthcare Improvement (IHI) launched the 100,000 Lives Campaign.⁶⁷³ The goal of the campaign is to recruit hospitals to implement six changes, which the IHI believes will result in saving 100,000 lives in the first eighteen months and every year following.⁶⁷⁴ The six changes that hospitals are to implement, in part or in full, are:

- Deploy Rapid Response Teams...at the first sign of patient decline
- Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction...to prevent deaths from heart attack
- Prevent Adverse Drug Events (ADEs)...by implementing medication reconciliation
- Prevent Central Line Infections...by implementing a series of interdependent, scientifically grounded steps called the "Central Line Bundle"
- Prevent Surgical Site Infections...by reliably delivering the correct perioperative antibiotics at the proper time
- Prevent Ventilator-Associated Pneumonia...by implementing a series of interdependent, scientifically grounded steps including the "Ventilator Bundle."⁶⁷⁵

IHI combines data from all of the participating hospitals every month to determine the number of lives saved.⁶⁷⁶ By June 14, 2006, at the end of the first eighteen months, IHI had enrolled over 3,000 hospitals nationwide and saved approximately 122,300 lives.⁶⁷⁷ The campaign is continuing and will launch the next phase of the campaign in December 2006. It is IHI's goal to have every participating hospital to implement all six changes in their entirety by the end of 2006.⁶⁷⁸

The 100,000 Lives campaign has received praise and support throughout the medical community. Joint Commission President, Dennis O'Leary stated "Their [100,000 Lives] rapid adoption of critical best practices offers great hope for raising the standards of care in this country."⁶⁷⁹ Mark McClellan, Administrator of the Center for Medicare and Medicaid stated, "CMS applauds the IHI for its leadership in the campaign that resulted in an estimated 122,300 lives being saved."⁶⁸⁰ The Milbank article acknowledges that, "since the release of the Institute of Medicine's report on medical errors, hospitals have demonstrated an unprecedented commitment to patient safety."⁶⁸¹

G. Summary

The objectives of a health court system can be accomplished by making modest changes in the current malpractice system. This would avoid the costs and uncertainty of creating and operating a new dispute-resolution mechanism and its associated bureaucracy. Moreover, it would be fairer to both providers and patients. Unlike health courts, it would rely on more neutral decision-makers, protect the interests of all parties by giving them access to legal counsel, allow more severely injured patients and those with highly meritorious claims to receive full compensation for their losses, and give patients a meaningful choice of whether or not to accept settlement offers. If providers live up to their ethical obligations to disclose errors and to seek early settlements in regard to them, the present system can significantly extend its protection to those who would not otherwise know that they had legitimate claims and to those whose claims would otherwise not be large enough to justify litigation.

IX. CONSTITUTIONAL ISSUES

The constitutionality of health courts is highly questionable. Although the success of constitutional challenges would depend on the precise details of a health court system, some likely features clearly raise serious constitutional objections.

A. The Right to a Jury Trial

In keeping with Philip Howard’s antipathy toward the jury system, a key feature of health courts would be to deny medical malpractice victims the right to have their malpractice cases decided by a jury. This conflicts with the guarantee of a right to a jury trial in civil cases, contained in the constitutions of 47 states.⁶⁸² In *Sorrell v. Thevenir*, the Ohio Supreme Court declared that the right to a jury trial under the state constitution is a fundamental right that was violated by a statute abolishing the collateral source rule:

“The right to a jury trial does not involve merely a question of procedure. The right to jury trial derives from Magna Charta. It is reasserted both in the Constitution of the United States and in the Constitution of the State of Ohio. For centuries it has been held that the right of trial by jury is a fundamental constitutional right, a substantial right, and not a procedural privilege.” It has also been held that “the right of trial by jury, being guaranteed to all our citizens by the constitution of the state, cannot be invaded or violated by either legislative act or judicial order or decree.”⁶⁸³

An earlier decision by an Ohio appellate court struck down the state’s damage cap on this ground, stating that “[t]he legislature may not in any way attempt to limit or abolish the right to a trial by jury.”⁶⁸⁴ Similarly, court decisions upholding the constitutionality of previous legislative attempts to modify the medical malpractice system emphasized that these changes preserved the plaintiff’s right to a jury trial. In *Etheridge v. Medical Center Hospitals*, for example, the Supreme Court of Virginia, in upholding a cap on damages, noted that “[a] trial court applies the [cap] only after the jury has fulfilled its fact-finding function. Thus, [the cap] does not infringe upon the right to a jury trial because the [cap] does not apply until after a jury has completed its assigned function in the judicial process.”⁶⁸⁵ Likewise, in sustaining the constitutionality of a statute requiring that medical malpractice claims first be screened by a medical review panel, the Supreme Court of Indiana stated: “It is quite clear that the Malpractice Act does not take away the right to a jury trial.”⁶⁸⁶ Accordingly, in 47 states, legislation establishing health courts to decide medical malpractice cases without juries would be unconstitutional.

Congressional enactment of a bill such as S. 1337, which would provide grants to states to establish health court demonstration projects, would not circumvent these constitutional prohibitions. As the Oregon Supreme Court observed in *Salem College & Academy, Inc. v. Employment Div.*, “if federal law imposes a binding obliga-

tion on a state, its constitution cannot obstruct that obligation; but a legislature cannot violate the state's constitution in order to qualify for a benefit that Congress leaves optional.⁶⁸⁷ Nor can a state invalidate, on state constitutional grounds, a particular provision in a federal aid program in order to participate in the program.⁶⁸⁸

It is even clearer that, if Congress enacted a federal law establishing health courts to hear medical malpractice cases, the law would violate the Seventh Amendment, which guarantees a right to trial by jury in suits at common law where the value in controversy exceeds twenty dollars.⁶⁸⁹ In *Granfinanciera, S. A. v. Nordberg*, for example, the Supreme Court stated:

Congress may only deny trials by jury in actions at law, we said, in cases where “public rights” are litigated: “Our prior cases support administrative factfinding in only those situations involving ‘public rights,’ e.g., where the Government is involved in its sovereign capacity under an otherwise valid statute creating enforceable public rights. Wholly private tort, contract, and property cases, as well as a vast range of other cases, are not at all implicated.”⁶⁹⁰

Medical malpractice cases, being wholly private torts, thus clearly are covered by the Seventh Amendment.

In *Granfinanciera*, the Court also made it clear that Congress could not thwart the Seventh Amendment by attempting to transform a common law action into an administrative claim:

Congress may devise novel causes of action involving public rights free from the strictures of the Seventh Amendment if it assigns their adjudication to tribunals without statutory authority to employ juries as factfinders. But it lacks the power to strip parties contesting matters of private right of their constitutional right to a trial by jury. As we recognized in *Atlas Roofing*, to hold otherwise would be to permit Congress to eviscerate the Seventh Amendment's guarantee by assigning to administrative agencies or courts of equity all causes of action not grounded in state law, whether they originate in a newly fashioned regulatory scheme or possess a long line of common-law forebears. [citation omitted] The Constitution nowhere grants Congress such puissant authority.⁶⁹¹

Finally, health court advocates analogize Congress' power to establish health courts to the creation of certain Article I courts, namely tax, bankruptcy, and patent courts, and also point to admiralty cases under Article III as an example of disputes that are heard without the right to jury trial.⁶⁹² But admiralty courts do not decide cases asserting common law causes of action, and all of the other court systems do afford plaintiffs a right to jury trials. In disputes with the Internal Revenue Service, taxpayers can elect to pay the tax deemed owed and sue for a refund. That suit can be tried by a jury.⁶⁹³ The same is true for patent infringement claims⁶⁹⁴ and bankruptcy proceedings.⁶⁹⁵

B. Due Process and Equal Protection

Health courts also would be vulnerable to constitutional challenge on the basis that they deprived malpractice victims of due process and equal protection. Some jurisdictions regard the right to bring a common law malpractice action as a fundamental right requiring a high level of constitutional scrutiny. In striking down a malpractice reform scheme, the New Hampshire Supreme Court stated:

[T]he rights involved herein are sufficiently important to require that the restrictions imposed on those rights be subjected to a more rigorous judicial scrutiny than allowed under the rational basis test. Consequently, the classifications created by [the statutory scheme] “must be reasonable, not arbitrary, *and* must rest upon some ground of difference having a fair and substantial relation to the object of the legislation” in order to satisfy State equal protection guarantees. (Emphasis added.) [sic]⁶⁹⁶

Similarly, the Supreme Court of Ohio stated that “the right to a jury trial in negligence and personal injury actions is a fundamental right. Thus, in order to determine whether [a malpractice reform scheme] violates the Due Process Clause of the Ohio Constitution, a strict scrutiny standard of review applies.”⁶⁹⁷ Some other courts may apply a rational basis test. But even under this lower level of scrutiny, health courts are on a precarious constitutional footing. Cases upholding earlier medical malpractice reforms against due process and equal protection challenges, for example, rested their decisions on a finding that there was a true medical malpractice crisis that only the reforms would alleviate.⁶⁹⁸ Yet as the discussion in Section VI.H demonstrates, not only is the medical malpractice system not causing an insurance crisis but, even if there were a crisis, it is unlikely to be alleviated by the establishment of health courts. Accordingly, even under a rational basis test, courts considering constitutional challenges to health courts are apt to agree with courts that have not found a malpractice crisis to exist and that have concluded that, in any event, the enacted changes would be unlikely to make a positive difference.⁶⁹⁹ This result would be all the more certain in jurisdictions such as New Hampshire and Ohio that apply a stricter standard.

Health courts would be vulnerable to due process and equal protection challenges in a number of other respects. To the extent that the schedule of damages under the proposal would be viewed as a cap on damage awards, such limitations have been declared unconstitutional by numerous courts as violations of due process and equal protection.⁷⁰⁰ Courts have invalidated prior medical malpractice reforms on the basis that they unfairly discriminate against victims of medical malpractice, while not affecting other tort claimants.⁷⁰¹ Courts also have struck down reforms such as caps on damages on the ground that they unfairly discriminate against the most seriously injured malpractice victims.⁷⁰² As the District Court for the Northern District of Texas stated in applying Texas law: “This Court concurs with the three Texas courts and with the reasoning in *Arneson*, 270 N.W.2d at 135-36, that limiting the recovery of the most deserving victims of malpractice is not a

legitimate interest of the state, and, moreover, that this goal deprives such victims of due process of law.⁷⁰³ Health court proponents contemplate imposing a schedule that would limit damages especially for plaintiffs with highly meritorious claims for serious injury,⁷⁰⁴ thus violating due process and equal protection. In addition, if, as noted earlier, health court legislation disqualified claimants whose losses fell below certain thresholds from asserting any claims whatsoever,⁷⁰⁵ it would be a violation of equal protection on its face. Finally, as noted earlier, the PPI proposal states that health court judges could be doctors.⁷⁰⁶ If a physician health court judge tried a case against a physician in the same medical specialty and the judge carried medical malpractice insurance, the outcome of the case would affect the judge's insurance premiums. This could create a sufficient conflict of interest to violate due process under the rule of *Ward v. Village of Monroeville*.⁷⁰⁷

C. Other Constitutional Concerns

Health courts would run afoul of additional constitutional protections. They might violate the guarantee of open access to the courts. According to the Florida Supreme Court, for example, the legislature cannot abolish a common-law right without either providing a reasonable alternative or finding an overpowering public need and no alternative means of meeting that need:

[W]here a right of access to the courts for redress for a particular injury has been provided by statutory law predating the adoption of the Declaration of Rights of the Constitution of the State of Florida, or where such right has become a part of the common law of the State ..., the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the State to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown.⁷⁰⁸

As discussed in Section VII, the health court system is unreasonably unfair to injured patients; as shown in Sections V and VI, there is no overpowering public necessity for health courts; and as Section VIII demonstrates, any legitimate goals of health courts can be achieved within the existing system.

Some courts have insisted that malpractice victims receive an adequate quid pro quo for being deprived of their common law rights. The Supreme Court of Kansas, for example, struck down malpractice reforms that deprived plaintiffs of traditional methods of compensation without providing them with an adequate substitute.⁷⁰⁹ The Texas Supreme Court took the same approach in *Lucas v. United States*,⁷¹⁰ as did the Illinois Supreme Court in *Wright v. Central Du Page Hosp. Association*.⁷¹¹ Health court proponents contend that health courts would be constitutional for the same reasons as workers' compensation programs.⁷¹² But health courts do not provide the same quid pro quo. As the Supreme Court observed in *New York Cent. R.R. Co. v.*

White, workers compensation is a true no-fault system in which employees injured on the job are certain to receive compensation:

The statute under consideration sets aside one body of rules only to establish another system in its place. If the employee is no longer able to recover as much as before in case of being injured through the employer’s negligence, he is entitled to moderate compensation in all cases of injury, and has a certain and speedy remedy without the difficulty and expense of establishing negligence or proving the amount of the damages.⁷¹³

As the discussion in Section VI.A demonstrates, the health court standard of “avoidability” is not a no-fault standard, and health courts are unlikely to provide compensation to many patients injured by avoidable medical mistakes.

Finally, calling the adoption of health courts a “demonstration project”—i.e., a social experiment—may not save its constitutionality. In *Lucas v. United States*, the Supreme Court of Texas noted that the legislature had declared that “the adoption of certain modifications in the medical, insurance, and legal systems . . . *may or may not have an effect* on the rates charged by insurers for medical professional liability coverage.”⁷¹⁴ In short, the Texas legislature was conducting an experiment. This did not sway the court: “In the context of persons catastrophically injured by medical negligence, we believe it is unreasonable and arbitrary to limit their recovery in a speculative experiment to determine whether liability insurance rates will decrease.”⁷¹⁵

In short, an attempt to establish a system of health courts, even as a demonstration project, would be vulnerable to constitutional challenge.

X. CONCLUSION

The health care system has many problems. Rising costs are both part of the problems and symptoms of the problems. For decades, malpractice insurers and medical providers have worked to convince themselves that the tort litigation system is a major source of these difficulties. They have initiated reform proposals in state and federal governments, some of which have been adopted into law. Few have had any impact on the perceived problems because they are based on a set of false assumptions about the malpractice system.

In fact, the malpractice litigation system works reasonably well. It carefully, if imperfectly, sorts those who deserve compensation from those who do not. It compensates the deserving in proportion to their losses. The system has a useful deterrent effect on malpractice. It is certainly not “spinning out of control,” as the tort reform rhetoric would have people believe. Growth in liability awards reflects rather than causes the problem of rising medical costs. The litigation system has very limited impacts on access to health care. It has not been shown to have a major effect on medical costs by virtue of “defensive medicine.” And the total costs of the malpractice system are tiny in relation to the health care industry.

To be sure, the malpractice system does have its own problems. Victims of malpractice are under-compensated even when they obtain a settlement or judgment. In part, this is because the system is stringent in its awards. Litigation costs are unfortunately, if understandably, high, and they are not recoverable from the tortfeasor, which means they consume too much of the money that goes through the system and leave too little for injured patients.

For some time now, however, it has been understood that the most important problem in the arena of malpractice is that there is an enormous amount of undetected malpractice, causing harm to many more patients than ever receive any kind of compensation. Too few victims of malpractice even realize that they have a potential claim or consult an attorney. As a consequence, the medical industry does not internalize the full costs of its negligent activities, and deterrence is thus too weak.

Health court proposals are attempts to address this serious problem and, at the same time, to turn the solution into another misguided attack upon the tort litigation system. Rather than seriously improving the quality of health care, the proposals would create an expensive health court bureaucracy dominated by the medical and insurance industries, which can be expected to drive down compensation awards to already under-compensated claimants, in the name of distributing more money to those victims of malpractice who otherwise would receive nothing.

What we would get from health courts is very modest recoveries, well below full compensation for those who were compensated, including a substantial and unfair reduction in the compensation of those who would recover under the existing tort system; a statutory ban on claims by the vast majority of victims of malpractice; and a shift of significant portions of the burden of malpractice onto taxpayers and those

who pay for private health care provision and disability insurance (especially employers and employees). In return for these unequivocally undesirable results, we are promised that there would be an increase in the number of patients who would receive at least some compensation, however minimal, but there are no strong reasons to believe this would be so and good reasons to suspect it would not. If there were a substantial increase in the number of patients receiving more than nominal compensation, we could also expect increases in malpractice premiums and efforts to shift even greater portions of the burden of malpractice onto taxpayers, employers, and employees. And all this "improvement" would be purchased at the cost of blunting the deterrent effect that the tort system currently provides.

Patients would be better off if efforts were directed at improving the operation of the existing system of tort liability. Some of the ideas endorsed by health court supporters could be useful in that regard. But the major question continues to be: How can medicine reduce the number of errors that harm patients? Health courts are not the answer.

APPENDIX A

H. R. 1546, 109th Cong. (2005)

SECTION 1. SHORT TITLE.

This Act may be cited as the ‘Medical Liability Procedural Reform Act of 2005’.

SEC. 2. GRANTS FOR HEALTH CARE TRIBUNALS.

(a) Grants Authorized— The Attorney General may award grants to States for the development, implementation, and evaluation of health care tribunals.

(b) Duration— The Attorney General may award up to 7 grants under subsection (a) and each grant awarded under such subsection may not exceed a period of 10 years.

(c) Application— Each State desiring a grant under subsection (a) shall submit to the Attorney General an application, at such time, in such manner, and containing such information as the Attorney General may require.

(d) Report— Each State receiving a grant under subsection (a) shall submit to the Attorney General a report evaluating the effectiveness of activities funded with grants awarded under such subsection at such time and in such manner as the Attorney General may require.

(e) Technical Assistance— The Attorney General shall provide technical assistance to the States awarded grants under subsection (a). Such technical assistance shall include the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting to facilitate aggregation and analysis of data both within and between States. The technical assistance shall also include guidance about identification and selection of health care tribunal judges and independent expert witnesses, compensation of injured patients, and clinical resources relating to the standard of care. States not receiving grants under this section may also use such common definitions, formats, data collection infrastructure, and other guidance from the Attorney General pertaining to health care tribunals.

(f) Evaluation—

(1) IN GENERAL— The Attorney General shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to the appropriate committees of Congress. Such an evaluation shall begin not later than 18 months following the date of implementation of the first program funded by a grant under subsection (a).

(2) CONTENTS— The evaluation under paragraph (1) shall include an analysis of the effect of the grants awarded under subsection (a) on—

(A) the number, nature, and costs of health care liability claims;

(B) the liability environment;

(C) health care quality; and

(D) patient safety.

(g) Definitions— In this section:

(1) HEALTH CARE TRIBUNAL— The term 'health care tribunal' means a trial court or administrative tribunal—

(A) the sole function of which is for the adjudication of disputes over injuries allegedly caused by health care providers;

(B) to which all or a portion of such disputes within a jurisdiction are assigned;

(C) the decisions of which are final, binding, and appealable; and

(D) the judges for which have health care expertise and render decisions about the standard of care in dispute adjudication, with reliance on independent expert witnesses commissioned by the court.

(2) HEALTH CARE PROVIDER— The term 'health care provider' means any individual or entity licensed, registered, or certified under Federal or State laws or regulations to provide health care services, but does not include any manufacturer of drugs or devices.

(h) Authorization of Appropriations— There are authorized to be appropriated to carry out this section such sums as may be necessary. Amounts appropriated pursuant to this subsection shall remain available until expended.

APPENDIX B

S. 1337, 109th Cong. (2005)

SECTION 1. SHORT TITLE.

This Act may be cited as the ‘Fair and Reliable Medical Justice Act’.

SEC. 2. PURPOSES.

The purposes of this Act are—

- (1) to restore fairness and reliability to the medical justice system by fostering alternatives to current medical tort litigation that promote early disclosure of health care errors and provide prompt, fair, and reasonable compensation to patients who are injured by health care errors;
- (2) to promote patient safety through early disclosure of health care errors; and
- (3) to support and assist States in developing such alternatives.

SEC. 3. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

‘SEC. 3990. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

‘(a) In General— The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.

‘(b) Duration— The Secretary may award up to 10 grants under subsection (a) and each grant awarded under such subsection may not exceed a period of 5 years.

‘(c) Conditions for Demonstration Grants—

‘(1) REQUIREMENTS— Each State desiring a grant under subsection (a) shall—

‘(A) develop an alternative to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations that may be 1 of the models described in subsection (d); and

‘(B) promote a reduction of health care errors by allowing for patient safety data related to disputes resolved under subparagraph (A) to be collected and analyzed by organizations that engage in voluntary efforts to improve patient safety and the quality of health care delivery.

‘(2) ALTERNATIVE TO CURRENT TORT LITIGATION— Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)—

`(A) makes the medical liability system more reliable through prompt and fair resolution of disputes;

`(B) encourages the early disclosure of health care errors;

`(C) enhances patient safety; and

`(D) maintains access to liability insurance.

`(3) SOURCES OF COMPENSATION— Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

`(4) SCOPE—

`(A) IN GENERAL— Each State desiring a grant under subsection (a) may establish a scope of jurisdiction (such as a designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative.

`(B) NOTIFICATION OF PATIENTS— A State proposing a scope of jurisdiction under subparagraph (A) shall demonstrate how patients would be notified that they are receiving health care services that fall within such scope.

`(5) PREFERENCE IN AWARDING DEMONSTRATION GRANTS— In awarding grants under subsection (a), the Secretary shall give preference to States—

`(A) that have developed the proposed alternative through substantive consultation with relevant stakeholders; and

`(B) in which State law at the time of the application would not prohibit the adoption of an alternative to current tort litigation.

`(d) Models—

`(1) IN GENERAL— Any State desiring a grant under subsection (a) that proposes an alternative described in paragraph (2), (3), or (4) shall be deemed to meet the criteria under subsection (c)(2).

`(2) EARLY DISCLOSURE AND COMPENSATION MODEL— In the early disclosure and compensation model, the State shall—

`(A) require that health care providers or health care organizations notify a patient (or an immediate family member or designee of the patient) of an adverse event that results in serious injury to the patient, and that such notification shall not constitute an acknowledgment or an admission of liability;

`(B) provide immunity from tort liability to any health care provider or health care organization that offers in good faith to pay compensation in accordance with this section to a patient for an injury incurred in the provision of health care services

(limited to claims arising out of the same nucleus of operative facts as the injury, and except in cases of fraud related to the provision of health care services, or in cases of criminal or intentional harm);

“(C) set a limited time period during which a health care provider or health care organization may make an offer of compensation benefits under subparagraph (B), with consideration for instances where prompt recognition of an injury is unlikely or impossible;

“(D) require that the compensation provided under subparagraph (B) include—

“(i) payment for the net economic loss of the patient, on a periodic basis, reduced by any payments received by the patient under—

“(I) any health or accident insurance;

“(II) any wage or salary continuation plan; or

“(III) any disability income insurance;

“(ii) payment for the non-economic damages of the patient, if appropriate for the injury, based on a defined payment schedule developed by the State in consultation with relevant experts and with the Secretary in accordance with subsection (g); and

“(iii) reasonable attorney’s fees;

“(E) not abridge the right of an injured patient to seek redress through the State tort system if a health care provider does not enter into a compensation agreement with the patient in accordance with subparagraph (B) or if the compensation offered does not meet the requirements of subparagraph (D) or is not offered in good faith;

“(F) permit a health care provider or health care organization that offers in good faith to pay compensation benefits to an individual under subparagraph (B) to join in the payment of the compensation benefits any health care provider or health care organization that is potentially liable, in whole or in part, for the injury; and

“(G) permit any health care provider or health care organization to contribute voluntarily in the payment of compensation benefits to an individual under subparagraph (B).

“(3) ADMINISTRATIVE DETERMINATION OF COMPENSATION MODEL—

“(A) IN GENERAL— In the administrative determination of compensation model—

“(i) the State shall—

“(I) designate an administrative entity (in this paragraph referred to as the ‘Board’) that shall include representatives of—

“(aa) relevant State licensing boards;

“(bb) patient advocacy groups;

“(cc) health care providers and health care organizations; and

“(dd) attorneys in relevant practice areas;

- “(II) set up classes of avoidable injuries, in consultation with relevant experts and with the Secretary in accordance with subsection (g), that will be used by the Board to determine compensation under clause (ii)(II);
- “(III) modify tort liability, through statute or contract, to bar negligence claims in court against health care providers and health care organizations for the classes of injuries established under subclause (II), except in cases of fraud related to an injury, or in cases of criminal or intentional harm;
- “(IV) outline a procedure for informing patients about the modified liability system described in this paragraph and, in systems where participation by the health care provider, health care organization, or patient is voluntary, allow for the decision by the provider, organization, or patient of whether to participate to be made prior to the provision of, use of, or payment for the health care service;
- “(V) provide for an appeals process to allow for review of decisions; and
- “(VI) establish procedures to coordinate settlement payments with other sources of payment;
 - “(ii) the Board shall—
 - “(I) resolve health care liability claims for certain classes of avoidable injuries as determined by the State and determine compensation for such claims;
 - “(II) develop a schedule of compensation to be used in making such determinations that includes—
 - “(aa) payment for the net economic loss of the patient, on a periodic basis, reduced by any payments received by the patient under any health or accident insurance, any wage or salary continuation plan, or any disability income insurance;
 - “(bb) payment for the non-economic damages of the patient, if appropriate for the injury, based on a defined payment schedule developed by the State in consultation with relevant experts and with the Secretary in accordance with subsection (g); and
 - “(cc) reasonable attorney’s fees; and
 - “(III) update the schedule under subclause (II) on a regular basis.
- “(B) APPEALS— The State, in establishing the appeals process described in subparagraph (A)(i)(V), may choose whether to allow for de novo review, review with deference, or some opportunity for parties to reject determinations by the Board and elect to file a civil action after such rejection. Any State desiring to adopt the model described in this paragraph shall indicate how such review method meets the criteria under subsection (c)(2).
- “(C) TIMELINESS— The State shall establish timeframes to ensure that claims handled under the system described in this paragraph provide for adjudication that is more timely and expedited than adjudication in a traditional tort system.
- “(4) SPECIAL HEALTH CARE COURT MODEL— In the special health care court model, the State shall—

“(A) establish a special court for the timely adjudication of disputes over injuries allegedly caused by health care providers or health care organizations in the provision of health care services;

“(B) ensure that such court is presided over by judges with health care expertise who meet applicable State standards for judges and who agree to preside over such court voluntarily;

“(C) provide authority to such judges to make binding rulings on causation, compensation, standards of care, and related issues with reliance on independent expert witnesses commissioned by the court;

“(D) provide for an appeals process to allow for review of decisions; and

“(E) at its option, establish an administrative entity similar to the entity described in paragraph (3)(A)(i)(I) to provide advice and guidance to the special court.

“(e) Application—

“(1) IN GENERAL— Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

“(2) REVIEW PANEL—

“(A) IN GENERAL— In reviewing applications under paragraph (1), the Secretary shall consult with a review panel composed of relevant experts appointed by the Comptroller General.

“(B) COMPOSITION—

“(i) NOMINATIONS— The Comptroller General shall solicit nominations from the public for individuals to serve on the review panel.

“(ii) APPOINTMENT— The Comptroller General shall appoint, at least 11 but not more than 15, highly qualified and knowledgeable individuals to serve on the review panel and shall ensure that the following entities receive fair representation on such panel:

“(I) Patient advocates.

“(II) Health care providers and health care organizations.

“(III) Attorneys with expertise in representing patients and health care providers.

“(IV) Insurers.

“(V) State officials.

“(C) CHAIRPERSON— The Comptroller General, or an individual within the Government Accountability Office designated by the Comptroller General, shall be the chairperson of the review panel.

“(D) AVAILABILITY OF INFORMATION— The Comptroller General shall make available to the review panel such information, personnel, and administrative serv-

ices and assistance as the review panel may reasonably require to carry out its duties.

“(E) INFORMATION FROM AGENCIES— The review panel may request directly from any department or agency of the United States any information that such panel considers necessary to carry out its duties. To the extent consistent with applicable laws and regulations, the head of such department or agency shall furnish the requested information to the review panel.

“(F) Report— Each State receiving a grant under subsection (a) shall submit to the Secretary a report evaluating the effectiveness of activities funded with grants awarded under such subsection at such time and in such manner as the Secretary may require.

“(g) Technical Assistance—

“(1) IN GENERAL— The Secretary shall provide technical assistance to the States awarded grants under subsection (a).

“(2) REQUIREMENTS— Technical assistance under paragraph (1) shall include—

“(A) the development of a defined payment schedule for non-economic damages (including guidance on the consideration of individual facts and circumstances in determining appropriate payment), the development of classes of avoidable injuries, and guidance on early disclosure to patients of adverse events; and

“(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting to facilitate aggregation and analysis of data both within and between States.

“(3) USE OF COMMON DEFINITIONS, FORMATS, AND DATA COLLECTION INFRASTRUCTURE— States not receiving grants under this section may also use the common definitions, formats, and data collection infrastructure developed under paragraph (2)(B).

“(h) Evaluation—

“(1) IN GENERAL— The Secretary, in consultation with the review panel established under subsection (e)(2), shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to the appropriate committees of Congress. Such an evaluation shall begin not later than 18 months following the date of implementation of the first program funded by a grant under subsection (a).

“(2) CONTENTS— The evaluation under paragraph (1) shall include—

“(A) an analysis of the effect of the grants awarded under subsection (a) on the number, nature, and costs of health care liability claims;

“(B) a comparison of the claim and cost information of each State receiving a grant under subsection (a); and

“(C) a comparison between States receiving a grant under this section and States that did not receive such a grant, matched to ensure similar legal and health care environments, and to determine the effects of the grants and subsequent reforms on—

“(i) the liability environment;

“(ii) health care quality;

“(iii) patient safety; and

“(iv) patient and health care provider and organization satisfaction with the reforms.

“(i) Option to Provide for Initial Planning Grants— Of the funds appropriated pursuant to subsection (k), the Secretary may use a portion not to exceed \$500,000 per State to provide planning grants to such States for the development of demonstration project applications meeting the criteria described in subsection (c). In selecting States to receive such planning grants, the Secretary shall give preference to those States in which State law at the time of the application would not prohibit the adoption of an alternative to current tort litigation.

“(j) Definitions— In this section:

“(1) HEALTH CARE SERVICES— The term ‘health care services’ means any services provided by a health care provider, or by any individual working under the supervision of a health care provider, that relate to—

“(A) the diagnosis, prevention, or treatment of any human disease or impairment; or

“(B) the assessment of the health of human beings.

“(2) HEALTH CARE ORGANIZATION— The term ‘health care organization’ means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan.

“(3) HEALTH CARE PROVIDER— The term ‘health care provider’ means any individual or entity—

“(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

“(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

“(4) NET ECONOMIC LOSS— The term ‘net economic loss’ means—

“(A) reasonable expenses incurred for products, services, and accommodations needed for health care, training, and other remedial treatment and care of an injured individual;

“(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

“(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and

“(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.

“(5) NON-ECONOMIC DAMAGES— The term ‘non-economic damages’ means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), injury to reputation, and all other non-pecuniary losses of any kind or nature, to the extent permitted under State law.

“(k) Authorization of Appropriations— There are authorized to be appropriated to carry out this section such sums as may be necessary. Amounts appropriated pursuant to this subsection shall remain available until expended.’.

APPENDIX C

MODEL MEDICAL INJURY COURT ACT

INTRODUCTION

The Harvard School of Public Health and the advocacy organization Common Good have been working to develop a proposal for the design and operation of “health courts”—special courts for resolving medical injury cases and compensating injured patients.*

The Harvard-Common Good proposal starts from the point that America’s medical liability system works poorly for both providers and patients. Substantial and growing malpractice insurance premiums strain physicians and hospitals, threatening access to health services in some areas. The system compensates few injured patients, and has very high administrative costs. As the Institute of Medicine has noted, it also adversely impacts health care quality, by discouraging reporting of information about errors and near misses in treatment.

Notwithstanding the substantial and well-documented failings of the current system, little political consensus for reform has developed. To the contrary, debate over medical malpractice reform remains very polarized, with most Republicans vocally calling for caps on non-economic damages and most Democrats equally vocal in protesting that caps will hurt injured patients. Fresh policy approaches to malpractice reform are needed, and health courts offer a new, bipartisan approach.

Working together, Harvard and Common Good have developed the attached model state legislation as an aid to state legislators who are interested in the health court concept. Both this model legislation and the Harvard-Common Good proposal are works in progress, and each will continue to evolve as more research and testing is done with respect to particular aspects of the system design.

For more information about the model legislation or the health court proposal, please contact Paul Barringer, General Counsel at Common Good [pbarringer@cgood.org, or 202-483-3760, x11].

* The Harvard School of Public Health and Common Good are conducting this work with the support of the Robert Wood Johnson Foundation. The Harvard School of Public Health has additional support from the Commonwealth Fund and the Harvard Program on Health System Improvement.

MODEL MEDICAL INJURY COURT ACT

EXECUTIVE SUMMARY

America’s medical liability system works poorly for providers and patients. Medical courts offer a new, bipartisan approach to malpractice reform, and the Model Medical Injury Court Act provides a template for state legislators interested in introducing legislation. The Model Act is summarized below.

Article I — Legislative Findings

Article I states the legislature’s findings that the medical liability system works poorly, and that health courts represent an appealing alternative for reform.

Article II — Establishment and Jurisdiction

Article II establishes the Medical Injury Court and specifies the court’s jurisdiction (at the legislator’s option, either health services in a particular geographic area or health care facilities electing to participate in a demonstration). Article II also establishes a searchable electronic database to receive de-identified data from the court for patient safety analysis.

Article III — Board of Qualifications and Judicial Selection

Article III establishes an independent board (the “Board of Qualifications”) to select Medical Injury Court judges. It also specifies that Medical Injury Court judges shall undergo an annual training curriculum relating to medical and medico-legal issues.

Article IV — Procedure and Standard of Liability

Article IV sets standards for expert witnesses, and directs Medical Injury Court judges to make written rulings. It provides for the creation of a panel to review circumstances associated with medical injury. It also provides a right of appeal.

Article V — Financing and Compensation

Article V offers options for financing the system, including general appropriations and user fees/charges. It also limits non-economic damages to a schedule based on patient circumstances and severity of injury. Claimant attorney fees are limited to a multiple of hours worked.

Article VI — Definitions

Article VI provides definitions for certain terms employed in the Act. Some of these definitions are drawn from the Uniform Health-Care Information Act promulgated by the National Conference of Commissioners on Uniform State Laws.

MODEL MEDICAL INJURY COURT ACT

ARTICLE I—LEGISLATIVE FINDINGS

The Legislature finds that:

- (a) The current medical litigation process is inconsistent, inefficient and unfair; creating an adversarial environment that discourages the open communication required to improve patient safety.
- (b) Comprehensive reform is needed to redress the many failings of the current medical liability system in promoting quality care, resolving medical injury cases, and compensating injured patients.
- (c) It is the public policy of this state that improving health care quality and enhancing patient safety are goals that are in the interests of both patients and health care providers.
- (d) The impact of medical litigation on health care quality initiatives creates a compelling need for law, rules, and procedures to improve the process by which medical injury cases are resolved.
- (e) Health courts represent an alternative for reform that can result in predictable justice for patients and physicians alike, as well as a rapid resolution of claims and assessment of damages.
- <(f) *Health court demonstration projects are an effective way to gain empirical evidence about the potential of health courts.*>

ARTICLE II—ESTABLISHMENT AND JURISDICTION

§2-101. Establishment of the Medical Injury Court.

There shall be a Medical Injury Court, which shall have all powers of a trial court of general jurisdiction in this state, including the power to issue every lawful order necessary or suitable for the exercise of its jurisdiction.

(a) Organization.

The Medical Injury Court shall organize in <the state capital> within the <state Department of Health>. The court shall procure the necessary supplies, equipment and personnel to commence operation and promulgate any necessary rules of court or operating procedures. When the court is organized and ready for the transaction of business, the chief judge of the court shall so certify to the Governor, who shall issue a proclamation stating that the court is organized and ready for the transaction of its judicial business.

(b) Existing cases unaffected.

A change in jurisdiction effected by any provision of or amendment to this Act shall not affect the jurisdiction of any court over any pending matter.

§2-102. Jurisdiction of the Medical Injury Court.

The Medical Injury Court shall have jurisdiction over all medical professional liability claims, for which adequate notice of rights has been provided to patients pursuant to §2-103, [arising out of health care services provided by any health care provider or at any health care facility (<in this state> or <in _____county>)] OR [against a health care provider or health care facility which has elected pursuant to a process specified by the <state Department of Health> to participate in the Medical Injury Court demonstration program which shall be governed by the provisions of this Act]. Notwithstanding the foregoing, claims where total damages do not exceed <_____> shall remain within the jurisdiction of the existing court system.

§2-103. Notice of Rights.

[*Note: Notice requirements vary by jurisdiction. Two alternatives are provided below.*]

Alternative 1

All health care providers falling under the jurisdiction of the Medical Injury Court shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to the Medical Injury Court, and, if applicable, the Medical Professional Liability Claim Review Panel. The notice requirements of this paragraph are satisfied if the notice is displayed prominently in the provider's place of business. The <state Department of Health> shall develop and promulgate the notice required in this subsection.

Alternative 2

(a) Notice of Provider Participation

A patient's agreement to be treated by a covered health care provider at a participating health care facility shall constitute consent to be bound by the provisions of this Act respecting any claim that may arise relating to medical injury incident to the treatment, provided that the following notice provisions are satisfied:

- (1) The covered health care provider shall inform existing patients by mail within 60 days of electing to participate in the program.
- (2) Health insurers subject to regulation by the <state department of insurance> shall inform their subscribers if any health care provider with whom the insurer contracts has elected to participate in the program. The health insurer shall fur-

nish the patient with a written notice at the time of execution of the initial contract for insurance coverage, and at each contract renewal, specifying that certain health care providers participate in this program and explaining the patient's rights under the program should they choose to receive care from those providers, as described in this section.

(3) At the time of the patient's first medical consultation with a covered health care provider after the provider elects to participate in the program, the covered provider shall furnish the patient with a written notice of the provider's participation in this program and an explanation of the patient's rights under the program, including the right to receive care from health care providers not participating in the program. The patient shall by signature acknowledge receipt of such notice, and the covered health care provider shall maintain a record of such signed patient acknowledgements.

(b) The <state Department of Health> shall promulgate a suggested form of the notice to patients, which health care providers and health insurers may adapt so long as the following elements are contained in the notice:

(1) A description of the demonstration project, including a basic description of administrative compensation and a notice that damage awards are limited under the program.

(2) A notice of the provider's participation (for provider notices) or a list of participating providers (for health insurer notices).

(3) A notice that tort remedies are preempted.

(4) A basic description of claims and appeals processes.

(5) Information on where further information about the program may be obtained.

§2-104. Establishment of Claims Database.

There shall be established within the [<state Department of Health> or <Office of the Medical Injury Court>] a searchable electronic database to receive data from the Medical Injury Court relating to claims and decisions pursuant to §4-103(d). Consistent with applicable state and federal law and regulation relating to confidentiality and privacy of health care information, information from this database shall be made available for patient safety analysis to hospital patient safety offices, and to patient safety regulatory authorities, research organizations, and health care purchasing or quality entities. The [<state Department of Health> or <Office of the Medical Injury Court>] shall publish and make available to the public on an annual basis a report summarizing trends in claiming.

§2-105. Nature of Remedy.

(a) Exclusivity.

Recovery of compensation pursuant to this Act for medical injury sustained by a patient as a result of health care services rendered by a covered health care provider at a participating health care facility, whether resulting in death or not, shall be the exclusive remedy against a provider or facility, or any officer, agent, or employee of the provider or facility. Except as provided for by this act, a covered provider or participating facility, or any officer, agent or employee of said provider or facility, shall not be subject to any liability for the injury, disability or death of a patient; and all causes of action, including actions at law, suits in equity, proceedings, and statutory and common law rights and remedies for and on account of said injury, disability or death are abolished except as provided for in this act.

(b) Binding Effect.

The exclusivity of remedy set out hereunder is binding upon the injured patient personally, and upon his or her spouse, widow, children, parents, dependents, next of kin, heirs, personal representatives, executor, guardian, employer, employer's insurance carrier, persons conducting the business of the injured patient during bankruptcy or insolvency, or any other person or entity claiming compensation as a result of injury to the patient as provided herein. The provisions of this Act shall apply to all persons, regardless of minority or legal disability.

(c) Exemptions.

Nothing in this section shall be construed to preclude:

- (1) Any action by an appropriate agency or civil authority to impose upon a provider or medical facility criminal penalties, licensure restrictions, or other sanctions for violations of law or regulations; or
- (2) Any bona fide action at law for claims of sexual misconduct, wanton or willful acts with intent to harm the patient, product liability against a manufacturer or distributor, or liability for wrongful denial of insurance coverage by a health insurer.

§2-106. Accelerated Compensation Events.

The <state Department of Health> shall contract with appropriately trained and credentialed experts to develop and update categories and lists of accelerated compensation events, within the meaning of §6-101(b).

ARTICLE III — BOARD OF QUALIFICATIONS AND JUDICIAL SELECTION

§3-101. Medical Injury Court Board of Qualifications.

There shall be created a Medical Injury Court Board of Qualifications, which shall consist of 12 residents of this state. The Medical Injury Court Board of Qualifications shall meet regularly to evaluate the qualifications of all applicants seeking to become judges of the Medical Injury Court. Members of the Board of Qualifications shall receive a reasonable per diem, as well as compensation for reasonable travel and other expenses incurred in connection with service on the Board of Qualifications. *[Note: For an example of one procedural approach to selecting Medical Injury Court judges, see Appendix 1.]*

§3-102. Organization.

The Medical Injury Court Board of Qualifications shall elect a presiding officer from among its members and shall establish its own rules of procedure. The Board shall have the authority to hire staff as necessary to carry out the functions required by this Act. The cost and expense of the Board shall be paid out of the Medical Injury Court Fund.

§3-103. Judicial Training Program.

On an annual basis and initially before commencement of operation of the Medical Injury Court, Medical Injury Court judges shall complete an annual training curriculum providing an overview of medical and legal issues that may arise in Medical Injury Court proceedings. *[Note: For sample language that might guide such a judicial training program, see Appendix 2.]*

ARTICLE IV — PROCEDURE AND STANDARD OF LIABILITY

§4-101. Rules and Filing Fees.

Except as otherwise provided, the Medical Injury Court shall abide by the <state> Rules of Civil Procedure, and the filing fees applicable in the civil courts of this state shall be applicable in the Medical Injury Court.

§4-102. Medical Professional Liability Claim Review Panel.

(a) Application of Section.

§ 4-102 of this Act applies to claims arising from health care services provided at health care facilities or by health care providers which come within the jurisdiction of the Medical Injury Court.

(b) Establishment of Panel.

Every [*<covered health care facility>* or *<malpractice carrier insuring the covered health care provider>*] shall establish a Medical Professional Liability Claim Review Panel which shall be responsible for the initial administration and review of every claim arising from care provided within the health care facility or by the health care provider.

(c) Disclosure of Adverse Events

When a patient experiences a medical adverse event that may be causally connected to health care received, the provider must, within 14 business days of discovery of the adverse event, inform the patient that s/he may have experienced an avoidable medical injury and may be eligible for compensation through the Medical Injury Court process. The provider shall provide a Medical Injury Claim Form to the patient or his/her representative.

(d) Claim Review.

Within 21 business days of receiving a Medical Injury Claim Form from a claimant, the Medical Professional Liability Claim Review Panel shall transmit an electronic copy of the form to the Medical Injury Court. Within [*<120>* or *<another number>*] business days of receiving a Medical Injury Claim Form from a claimant, the Medical Professional Liability Claim Review Panel shall review the claim to determine whether or not it pertains to an avoidable medical injury. The Panel shall be guided in this review by clinical practice guidelines, past written decisions of the Medical Injury Court, and, pursuant to §2-104, data in the claims database from standard event reporting and lists of accelerated compensation events.

(1) If a preponderance of the evidence in the record indicates that the claimant suffered an injury that was proximately caused by the acts or omissions of a covered health care provider and that constitutes an avoidable med-

ical injury within the meaning in § 6-101(a), then the claimant shall be entitled to compensation pursuant to §5-103.

(2) The Panel shall issue a written Explanation of Decision summarizing the basis for its decision and transmit a copy to each of the parties and to the Medical Injury Court. The Medical Injury Court Board of Qualifications shall develop a standardized reporting form which the Panel shall employ to report information about such decisions to the <state Department of Health> pursuant to §2-104 of this Act. As appropriate, the Panel shall share information relating to drugs and devices with the U.S. Food and Drug Administration.

(3) If either party objects to the finding of the Medical Professional Liability Claim Review Panel, the party may request review by the Medical Injury Court within 60 days of receipt of the Explanation of Decision.

(e) Access to Materials.

Claimants shall have access to any materials used in Medical Professional Liability Claim Review Panel proceedings. If the Panel considered the findings of a peer-review committee in reaching its decision, the Claimant shall have access to any sections of the peer review investigation report containing such findings.

(f) Administration.

The [<state Administrative Office of the Courts> or <Medical Injury Court Board of Qualifications>] shall create a Medical Injury Claim Form which the claimant or his or her representative shall use to submit claims to the Medical Professional Liability Claim Review Panel. This Form shall be available to patients in the offices of all covered providers, and from the [<state Department of Health> or <State Department of Insurance>] and its website.

§4-103. Hearings.

(a) General Rule.

Except as provided in §4-103(b), the Medical Injury Court shall convene a hearing at which the parties shall have the right to be heard, to present material evidence, and to cross examine witnesses. *[Note: It may be desirable to provide additional procedural provisions for such hearings, potentially drawing on provisions related to administrative hearings within Social Security or Medicaid, or the state's provisions for workers compensation hearings.]*

(1) At the hearing, the claimant shall present the claim to the judge and the health care provider shall make a presentation in response. The parties may be represented by legal counsel.

(2) After the presentations by the parties, the Medical Injury Court judge may request from either party additional information to be submitted in writing.

(3) Prior to the hearing, the Medical Injury Court judge may consult with expert witnesses pursuant to §4-104 of this Act, and shall accord appropriate weight to such expert opinion. The parties need not present expert witness testimony at or in preparation for the hearing, but may do so at the discretion of the Medical Injury Court judge. Expert reports prepared by or at the request of the Medical Professional Liability Claim Review Panel shall be provided to the Medical Injury Court. At its discretion, the Medical Injury Court may seek additional expert opinions after the hearing.

(b) Expedited Determination of Certain Claims

(1) After obtaining expert opinions and reviewing all relevant written materials, the Medical Injury Court judge shall make a determination whether the injury involved in the claim meets the criteria for an accelerated compensation event, within the meaning of §6-101(b).

(2) If the record and expert opinions provide a sufficient basis for the Medical Injury Court judge to make a determination that the injury constitutes an accelerated compensation event, the Medical Injury Court judge at his or her sole discretion may award compensation without convening a hearing. This determination shall include findings, through a preponderance of the evidence, that the injury was proximately caused by medical management and that the injury fits within the definition of an accelerated compensation event. This determination shall be made *de novo*, according no deference to the findings of the Medical Professional Liability Claim Review Panel. Medical Injury Court judges shall refer to precedent from past Medical Injury Court proceedings in making such determinations.

(c) Judicial Determination.

After the hearing held in accordance with subsection §4-103(a) of this section, the Medical Injury Court judge shall determine whether a preponderance of the evidence shows that the injury was proximately caused by medical management, and the injury constituted an avoidable medical injury within the meaning of §6-101(a). This determination shall be made *de novo*, according no deference to the findings of the Medical Professional Liability Claim Review Panel. Medical Injury Court judges shall refer to precedent from past Medical Injury Court proceedings in making such determinations.

(d) Written Ruling.

The Medical Injury Court judge shall issue a written Explanation of Decision summarizing the basis for its decision and transmit a copy to each of the parties within 90 days of the hearing. The Medical Injury Court Board of Qualifications shall develop a standardized reporting form which the Medical Injury Court judge shall employ to report information about such decisions to the <state Department of

Health pursuant to §2-104 of this Act. As appropriate, the Medical Injury Court shall share information relating to drugs and devices with the U.S. Food and Drug Administration.

(e) Error Made Against Claimants.

If the Medical Injury Court judge finds that the Medical Professional Liability Claim Review Panel made a clear error in the provider's favor in reviewing the claimant's claim, or that the health care facility or health care provider failed to disclose information known about the injury to the claimant in accordance with §4-102(c), it shall assess a penalty on the health care facility or health care provider in the amount of \$*<some minimum amount>*. This amount shall be paid to the Medical Injury Court Fund.

§4-104. Expert Witnesses.

(a) Authority.

Medical Injury Court judges may seek the opinion of one or more experts in connection with each claim determination. These experts shall be drawn from the list of experts maintained by the Board of Qualifications and shall be qualified in specialties relevant to the nature of the claim. Experts shall be compensated at a reasonable rate for their services from the Medical Injury Court Fund.

(b) Number of Experts.

In each proceeding, the Medical Injury Court judge shall seek the opinion of least one expert; however, the judge may retain either one or two additional experts at his or her discretion. In addition, each of the parties shall also be entitled to select and retain his or her own expert, at his or her expense.

(c) Credentials.

Every expert providing consultation in Medical Injury Court proceedings shall be certified by the Board of Qualifications, which shall accept applications from medical professionals to serve as expert witnesses, and certify professionals to provide expert consultation in cases in which individuals have relevant expertise and credentials. Any expert witness providing consultation in a Medical Injury Court proceeding shall meet the minimum state requirements for serving as an expert witness, and shall be currently licensed in the same profession as the health care provider against whom a claim has been lodged, and, if certified by a board recognized by the American Board of Medical Specialties, certified in the same specialty or another specialty relevant to the nature of the claim. The provision of consultation as an expert witness in a Medical Injury Court proceeding shall constitute the practice of medicine, as that term is defined in the *<state medical practice act>*. No expert in any Medical Injury Court proceeding shall provide consultation if the expert witness has any material conflict of interest, or for any reason feels that a fair and impartial decision cannot be given. Expert wit-

nesses must disclose any such reason for disqualification before providing consultation in any Medical Injury Court proceeding.

(e) Expert Reports.

An expert providing consultation in a Medical Injury Court proceeding shall submit a written report to the Medical Injury Court judge pursuant to §4-103(a). Such written opinions shall be based on the expert's review of prior Medical Injury Court Explanations of Decision, clinical practice guidelines, lists of accelerated compensation events, and other information as appropriate.

§4-105. Appellate Review.

(a) Right of Appeal.

There shall be a right of appeal in all cases from the Medical Injury Court. Any appeal from the Medical Injury Court shall be taken initially to a Medical Administrative Appellate Court, which shall be comprised of three administrative law judges selected to serve this function by the Board of Qualifications. Either party may request appellate review by the Medical Administrative Appellate Court within 60 days of receipt of the Explanation of Decision from the Medical Injury Court. Appeals of Medical Injury Court rulings shall be overturned by the Medical Administrative Appellate Court for issues of fact only if the Medical Injury Court judge's ruling was contrary to the substantial evidence presented by either party in the Medical Injury Court proceeding. The Medical Administrative Appellate Court shall have plenary review for issues relating to the standard of care and other policy issues. Appeals from the Medical Administrative Appellate Court shall be heard by the <state Court of Appeals>. Determinations of the Medical Administrative Appellate Court shall be overturned only if such determinations were arbitrary and capricious.

(b) Time Allowed.

The time for filing an appeal shall be governed by the general rules applicable to civil matters in this state.

§4-105. Health Care Information.

All proceedings conducted pursuant to this Act shall maintain the confidentiality of health care information to the extent required by applicable federal and state law and regulation.

ARTICLE V — FINANCING AND COMPENSATION

§5-101. Medical Injury Court Fund.

There shall be established in the <state Treasury> a special operating fund to be known as the Medical Injury Court Fund. Debits and credits shall be made to that fund under this subchapter. The operating and capital expenses of the Medical Injury Court shall be paid primarily from the Medical Injury Court Fund.

§5-102. Receipts and Other Credits.

There shall be paid or credited to the Medical Injury Court Fund:

- (a) Amounts appropriated to the Medical Injury Court in the manner provided by law.
- (b) Amounts received by the state on account of the fees and charges assessed through operation of the Medical Injury Court.

§5-103. Payments and Other Debits.

There shall be disbursed from or debited to the Medical Injury Court Fund amounts payable by the state on account of the operation of the Medical Injury Court.

§5-104. Limitations on Damages.

(a) General Rule.

Notwithstanding any other provision of law, compensation paid as a consequence of Medical Injury Court proceedings shall be limited as set forth in this section.

(b) Amount Recoverable.

Damages arising from the same cause of action or transaction or occurrence or series of causes of action or transactions or occurrences shall be limited pursuant to the following schedules:

- (1) Economic Damages. Full compensation for economic losses shall be paid to all claimants after deduction of the following:
 - (i) Amounts paid, reimbursed, or eligible for reimbursement by a health insurer, disability insurance program, or other collateral source;
 - (ii) \$<_____> in unreimbursed medical expenses resulting from the injury; and
 - (iii) \$<____> in lost wages or, if the claimant was unemployed at the time of the injury, \$<____> in lost household production.

(2) Non-Economic Damages. Non-economic damages shall be paid pursuant to a schedule of benefits based on patient circumstances and severity of injury and developed by the Board of Qualifications.

§5-105. Payment of Damages.

(a) Non-economic damages shall be paid as a lump-sum payment.

(b) Awards for economic damages exceeding \$<__> shall be paid on a periodic basis.

§5-106. Attorneys' Fees.

Fees paid to attorneys representing claimants shall be paid as a multiple of hours worked rather than as a percentage of recovery, with a maximum of one-third of the amount recovered.

§5-107. Reimbursement.

When regular and other sessions of the Medical Injury Court are held in facilities provided by the counties under this section, reimbursement for actual and reasonable expenses shall be made to the counties from the Medical Injury Court Fund.

ARTICLE VI — DEFINITIONS

§6-101. Definitions.

The following words and phrases when used in this Act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

(a) “Avoidable medical injury” means a medical adverse event that would not have resulted if care had been delivered in a manner consistent with that of an experienced practitioner or specialist in the relevant clinical area. In making the determination of avoidability, the lack or presence of local or regional resources may be taken into account.

(b) “Accelerated compensation event” means an avoidable medical injury that fits within a predetermined list of such events that has been developed by the *<state Department of Health>* pursuant to §2-106 of this Act.

(c) “Health care” means any care, service, or procedure provided by a health care provider:

- (1) to diagnose, treat, or maintain a patient’s physical or mental condition, or
- (2) that affects the structure or any function of the human body. Labor and delivery, whether complicated or uncomplicated, shall be included in this definition.

(d) “Health care facility” means a hospital, clinic, office, or similar place, where a health care provider provides health care to patients. It does not mean a nursing or convalescent home or institution.

(e) “Health care information” means any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and relates to the patient’s health care. The term includes any record of disclosures of health care information.

(f) “Health care provider” means a person who is licensed, certified, or otherwise authorized by the law of this State to provide health care in the ordinary course of business or practice of a profession. The term does not include a person who provides health care solely through the sale or dispensing of drugs or medical devices. The term also includes both of the following:

- (1) An officer, employee, or agent of a health care provider acting within the scope of the person’s duties and authority, and
- (2) A legal entity through which one or more health care providers deliver health care, including, but not limited to, a professional corporation, a partnership, or limited liability company.

(g) “Hospital” means an institution where sick or injured patients are provided medical care and which is operated in accordance with the laws of the jurisdiction in which it is located pertaining to institutions identified as hospitals, and

which is primarily engaged in providing to patients on an inpatient basis diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment, or care of injured or sick persons by or under the supervision of a staff of duly licensed doctors of medicine, and which is not, other than incidentally, a nursing or convalescent home or institution.

(h) "Maintain," as related to health care information, means to hold, possess, preserve, retain, store, or control that information.

(i) "Medical adverse event" means an incident in which harm has resulted to a person receiving health care services.

(j) "Medical professional liability claim" means a claim brought by or on behalf of an individual seeking damages for loss sustained by the individual as a result of an injury or wrong to the individual or another individual arising from a health care provider's provision of or failure to provide health care regardless of the theory of liability. A medical professional liability claim includes, but is not limited to, a claim grounded in negligence, informed consent, breach of contract, misrepresentation or fraud. It does not include an action at law for claims of sexual misconduct, wanton or willful acts with intent to harm the patient, criminal offenses, premises liability (for injuries not occurring in connection with health care), product liability against a manufacturer or distributor, or liability for wrongful denial of coverage by a health insurer.

(k) "Medical Injury Court" means the court established under this Act.

(l) "Medical Injury Court rule" means a rule or order promulgated under the Medical Injury Court.

(m) "Medical Professional Liability Claim Review Panel" means the hospital-based review panel established under this Act.

(n) "Patient" means an individual who receives or has received health care. The term includes a deceased individual who has received health care. The term includes both newborn and stillborn infants.

(o) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

APPENDIX I

Sample language for one possible approach to judicial selection:

§__-101. Medical Injury Court Board of Qualifications.

(a) Establishment and General Rule.

There shall be created a Medical Injury Court Board of Qualifications, which shall consist of 12 residents of this state selected as provided in this subchapter.

(b) Status.

The Medical Injury Court Board of Qualifications shall not be deemed to be an agency for purposes of <the state open meetings law>.

§__-102. Composition of Medical Injury Court Board of Qualifications.

(a) General Rule.

The Medical Injury Court Board of Qualifications shall consist of:

- (1) Three members appointed by the President Pro Tempore of the Senate.
- (2) Three members appointed by the Minority Leader of the Senate.
- (3) Three members appointed by the Speaker of the House of Representatives.
- (4) Three members appointed by the Minority Leader of the House of Representatives.

(b) Member Credentials.

One of the members appointed under each paragraph of subsection (a) shall be an attorney licensed to practice in this state. The second member appointed in each case shall be a physician licensed to practice medicine in this state. The third member appointed in each case shall be neither a physician nor a lawyer. During a member's term of service, no member shall hold any compensated public office or public appointment, or office in any political party or political organization.

(c) Terms of Office.

Except as provided in subsection (d), each member shall be appointed for a four-year term. A member shall not be appointed for more than two successive full terms. An appointment to fill an unexpired term which has fewer than two years remaining shall not be deemed a full term. A vacancy on the board shall be filled for the balance of the term by appointment made by the person who at the time is the ranking member in the same house of the state legislature and of the same political party as the person who appointed the vacating member of the board.

(d) Transitional Provisions.

- (1) The initial Medical Injury Court Board of Qualifications provided for in this section shall come into existence upon the effective date of this chapter.

(2) The initial members of the Medical Injury Court Board of Qualifications shall serve as follows:

- (i) the members appointed by the President Pro Tempore of the Senate, one each for two, three, and four years;
- (ii) the members appointed by the Minority Leader of the Senate, one each for two, three, and four years;
- (iii) the members appointed by the Speaker of the House of Representatives, one each for one, two, and three years; and
- (iv) the members appointed by the Minority Leader of the House of Representatives, one each for one, two, and three years.

§__-103. Organization.

The Medical Injury Court Board of Qualifications shall elect a presiding officer from among its members and shall establish its own rules of procedure. The Board shall have the authority to hire staff as necessary to carry out the functions required by this Act. The Medical Injury Court shall furnish such staff support as may be necessary for the conduct of the business of the Board. The cost and expense of the Board shall be paid out of the Medical Injury Court Fund.

§__-104. Powers and Duties.

(a) General Rule.

At least four times per calendar year, the Medical Injury Court Board of Qualifications shall meet to evaluate the qualifications of all applicants seeking to become judges of the Medical Injury Court, and shall submit to the Governor a list of qualified individuals, pursuant to §__-105(c) of this Act. If the Board fails to provide such list, either the President Pro Tempore of the Senate, if he or she is not of the same political party as the Governor, or the Minority Leader of the Senate, if the President Pro Tempore of the Senate is of the same political party as the Governor, shall submit to the Governor a list of individuals qualified pursuant to §__-105(c) to be a Medical Injury Court judge.

(b) Rules and Regulations.

The Medical Injury Court Board of Qualifications may adopt such rules and regulations as it deems necessary to discharge its duties.

§__-105. Selection of Judges.

(a) General Rule.

A vacancy in the office of judge of the Medical Injury Court shall be filled by appointment by the Governor in the manner provided in this section.

(b) Initial and Ongoing Selection of Judges.

The Medical Injury Court Board of Qualifications shall publicly advertise and solicit applications for individuals to service as Medical Injury Court judges. The process set forth in this section shall begin no later than 90 days and no sooner than 120 days prior to the date upon which the list is submitted to the Governor pursuant to subsection (c).

(c) Preparation and Submission of List.

From the applications received, the Medical Injury Court Board of Qualifications shall prepare and submit to the Governor a list of persons who are qualified to hold the office of judge of the Medical Injury Court. If the Medical Injury Court Board of Qualifications fails to submit such list, the list shall be submitted in the manner prescribed by §__-104(a). Immediately following submission of the list to the Governor, the list shall be filed with the Senate and made public by the Board. The list submitted to the Governor shall contain the names of those persons who receive affirmative votes from seven or more members. If more applicants receive seven or more votes than there are vacancies for Medical Injury Court judges, the list submitted to the Governor shall contain those judges who received the most votes, in number to the then vacancies on the Medical Injury Court. Any individual otherwise qualified to be a judge in this state shall be eligible for consideration by the Board of Qualifications to serve as a Medical Injury Court judge.

(d) Governor Approval or Rejection.

Within 30 days of receipt of the list submitted pursuant to subsection (c), the Governor shall accept or reject the list in its entirety.

APPENDIX 2

Sample language for one possible approach to judicial training:

§__-101. Judicial Training Program.

(a) Requirement of Judicial Training.

On an annual basis and initially before commencement of operation of the Medical Injury Court, Medical Injury Court judges shall complete an annual training curriculum providing an overview of medical and legal issues that may arise in Medical Injury Court proceedings, as well as developments in clinical medicine and changes to the lists of accelerated compensation events.

(b) Specifications of Training.

The Board of Qualifications shall set the specifications for this training program, including the annual required number of hours of training. Such obligations may be met by completing a certain number of hours of training on an annual basis. Training shall address such topics as the use of clinical practice guidelines in medical treatment, assessing the qualifications of independent expert witnesses, and fundamentals of anatomy, pharmacology, pathology, surgical care, and preventive care. Medico-legal issues shall also be addressed.

(c) Training Organizations.

The Board of Qualifications shall contract with appropriately trained institutions or professionals within the state, such as medical organizations, schools of medicine or nursing, or other entities providing medical education services, to conduct this training program.

(d) Administration.

The [*Medical Injury Court Board of Qualifications*] or [*state Administrative Office of the Courts*] shall administer this training program.

NOTES

- 1 Clark A. Havighurst & Laurence R. Tancredi, “*Medical Adversity Insurance*” - *A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK MEMORIAL FUND Q. 125, 128 (1973) (“The proposed compensation scheme would be roughly analogous to the workmen’s compensation system for handling industrial accidents ...”).
- 2 *Id.* at 128 (“Health care providers ... would each be required to purchase from a private insurer a policy of ‘medical adversity insurance’ covering their patients. Under MAI, any patient suffering a ‘compensable event,’ as defined in the policy, would be automatically indemnified for certain expenses and losses associated therewith and would be denied further recovery.”).
- 3 *Id.* at 131-32 (“Occurrence of an event might nevertheless occasionally be in doubt, and claims payment might be resisted on this ground by either the insurer or provider Administrative adjudication or arbitration would be employed ...”).
- 4 *Id.* at 125-26 (“We think we have found a way to organize a no-fault system which would produce substantial net gains Our system for dealing with adverse outcomes of medical treatment is ‘no-fault’ ... in the former sense [of ‘dispensing with the expensive process of assigning blame in each case’] and retains an element of provider responsibility for adverse outcomes as a means of maintaining desirable incentives. The extensive fault-finding process, with its attendant stigmatization and bitterness, is largely eliminated, but we adhere to the principle of using legal means to prevent or reduce the frequency of avoidable harms.”).
- 5 See Laurence R. Tancredi & Randall R. Bovbjerg, *Creating Outcomes-based Systems for Quality and Malpractice Reform: Methodology of Accelerated Compensation Events (ACEs)*, 70 MILBANK MEMORIAL FUND Q. 183 (1992); 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, 485 (2005) (“A very promising alternative that facilitates discovery and prompt resolution of cases is to establish avoidable classes of events, or ACEs, in advance.”).
- 6 Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365 (1989).
- 7 *Id.* at 1376-77 (“No-fault, including its latest manifestation as the Designated Compensable Event, also was rejected ... out of concern that either the costs of such a system would be excessive or it would be necessary to apply strictly scheduled benefits, and that such guaranteed but limited benefits would be widely perceived as inadequate compensation.”).
- 8 *Id.* at 1379.
- 9 See S.B. 3040, 93rd Gen. Assem., Reg. Sess. (Ill. 2003-04), A. 721, 2006 Leg., 212th Sess. (NJ 2006), H. B. 23, 187th Gen. Assem., Reg. Sess. § 841(b) (Pa. 2003-04).
- 10 See H.B. 4847, 93rd Gen. Assem., Reg. Sess. (Ill. 2003-04) (Illinois Supreme Court would establish a circuit judge recommendation panel to recommend persons to preside over the cases. In order to be qualified as a judge, persons must have one of the following: 1) ten years judicial experience in Illinois, five presiding over medical malpractice cases; 2) ten years practicing in Illinois as a medical malpractice attorney; or 3) fifteen years experience practicing in Illinois as either a judge or attorney in medical malpractice cases), A. 721, 2006 Leg., 212th Sess. (NJ 2006) (Judges would be appointed based on their knowledge and experience of medical malpractice), H. B. 23, 187th Gen. Assem., Reg. Sess. § 841(b) (Pa. 2003-04) (Initially, judges would be appointed to establish the court and then elected beginning with the first municipal elections).

- 11 See S.B. 3040, 93rd Gen. Assem., Reg. Sess. (Ill. 2003-04), A. 721, 2006 Leg., 212th Sess. (NJ 2006), H. B. 23, 187th Gen. Assem., Reg. Sess. § 841(b) (Pa. 2003-04).
- 12 See, e.g., Michelle M. Mello, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms*, 10 ROBERT WOOD JOHNSON FOUNDATION, RESEARCH SYNTHESIS REPORT 7 (May 2006).
- 13 See 28 U.S.C. §2678.
- 14 See Thomas Kruppstadt, Comment and Note, *Determining Whether a Physician is a United States Employee or an Independent Contractor in a Medical Malpractice Action Under the Federal Tort Claims Act*, 47 BAYLOR L. REV. 223 (1995) (discussing the history of the Federal Tort Claims Act in medical malpractice cases and which health care providers are not protected by the Act).
- 15 H.R. 5, 109th Cong. (2005). The last action taken on this bill was on July 29, 2005 when the bill was referred to the Senate Committee on Judiciary.
- 16 H.R. 4838, 109th Cong. § 5 (2006)..
- 17 President George W. Bush, Address at the University of Scranton, Scranton, Pennsylvania, January 16, 2003, available at <http://www.whitehouse.gov/news/releases/2003/01/20030116-1.html> (last visited Nov. 6, 2006).
- 18 Critics of the malpractice system have long questioned whether it adequately deters negligent patient injuries. See Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595 (2002). The current debate focuses particularly on why medical errors occur and why the system fails to detect them.
- 19 INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26-27 (2000) (hereinafter IOM REPORT 2000).
- 20 *Id.* at 4 (“All adverse events resulting in serious injury or death should be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events occurring in the future.”).
- 21 *Id.* at 4-5.
- 22 *Id.* at ix. As the IOM report acknowledges, this approach is familiar as the type of continuous or total quality improvement model developed by Edward Deming in the 1950s. When Deming was unable to interest Detroit in his approach for improving the quality of its automobiles, he exported his ideas to Japan. The result, as they say, is history. See Cait Murphy, *1950: Deming Charts Japan’s Remarkable Course*, FORTUNE, June 27, 2005, at 70, 72. The health care system became interested in Deming’s approach in the late 1980s. See Donald M. Berwick, *Continuous Improvement as an Ideal in Health Care*, 320 NEW ENG. J. MED. 53, 53-56 (1989). So far, however, the approach has not been accepted and implemented widely enough to reduce patient injuries.
- 23 IOM REPORT 2000, *supra* note 19, at 22.
- 24 *Id.* at 87-88.
- 25 The IOM did not explain why its mandatory reporting system would work any better than those that are already in place in a number of states, which are widely acknowledged to be defective. See generally Lucian L. Leape, *Reporting of Adverse Events*, 347 NEW ENG. J. MED. 1633, 1634-35 (2002).
- 26 BD. OF HEALTH CARE SERVS., INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS 81-90 (Janet M. Corrigan et al. eds., 2002).
- 27 See Berwick, *supra* note 22, at 53-56 (1989). The continuous or total quality improvement method stresses that quality improvement must be achieved through accountability of the organization itself, beginning with the highest levels of leadership and filtering down through the organization. The model assumes that health care workers strive to perform to the best of their ability and that when a failure occurs, it is the result of wasteful,

- complex, or problematic organizational methods or structures, rather than a failure of an individual worker. Improving the quality of health care and eliminating errors requires organizations to engage in a constant, systematic, and cooperative effort to participate in quality monitoring and to shift the quality curve upward, rather than focusing on punishing the poor performance of individual practitioners or institutions. *Concepts of Assessing, Assuring, and Improving Quality*, in 1 MEDICARE: A STRATEGY FOR QUALITY ASSURANCE 45, 58 (Kathleen N. Lohr ed., 1990).
- 28 See JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR IMPROVING THE MEDICAL LIABILITY SYSTEM AND PREVENTING PATIENT INJURY 26-30 (2005), available at http://www.joint-commission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F/0/Medical_Liability.pdf (last visited Nov. 12, 2006).
- 29 Jeffrey O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U. L. REV. 589, 590 (1982). O'Connell's quid pro quo would have providers offer to pay the victim's out-of-pocket medical expenses and lost earnings. If the victim rejected this offer, in order to have recourse under the tort system, the victim would have to prove beyond a reasonable doubt that the provider was grossly negligent. Jeffrey O'Connell & Evan Stephenson, *Binding Statutory Early Offers by Defendants, Not Plaintiffs*, in *Personal Injury Suits*, 54 DEPAUL L. REV. 233, 233 (2005).
- 30 For a description of such a scheduled compensation approach, see James F. Blumstein et al., *Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injury*, 8 YALE J. ON REG. 171 (1991); Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 NW. U. L. REV. 908 (1989).
- 31 IOM REPORT 2000, *supra* note 19, at 87-88.
- 32 Philip K. Howard, *The Wrong Approach to Gain Better Health Care*, ST. PETERSBURG TIMES, Nov. 10, 2002, available at <http://cgood.org/learn-reading-cgpubs-opeds-11.html> (last visited Nov. 12, 2006). In an op-ed piece that appeared in the Wall Street Journal on January 27, 2003, Howard once again referred to a "special medical court": "America needs a special medical court or tribunal, just as we have separate courts for patents and other specialized problems." Philip K. Howard, *Legal Malpractice*, WALL ST. J., Jan. 27, 2003, at A16, available at <http://cgood.org/learn-reading-cgpubs-opeds-20.html> (last visited Nov. 12, 2006).
- 33 AEI-Brookings Joint Center and Common Good Event Transcript, *Liability and Patient Health*, March 4, 2003 available at <http://cgood.org/assets/attachments/56.pdf> (last visited Nov. 12, 2006). At this forum, the health court concept is put forward by Alex Azar, General Counsel of the U.S. Department of Health and Human Services, who states: "We're also encouraging states to consider specialized medical courts to deal with liability claims with incentives for the parties to accept their results. ... Specialized health courts that would lead to a more reasoned decision-maker [sic]." *Id.* at 5, 8.
- 34 For the set of Howard's op-ed pieces on health courts, see the Common Good website at <http://cgood.org/learn-reading-cgpubs-opeds.html> (last visited Nov. 12, 2006).
- 35 See Nancy Udell & David B. Kendall, *Health Courts: Fair and Reliable Justice for Injured Patients*, PROGRESSIVE POLY INST. POLY REP. (Feb. 2005) (hereinafter "PPI Report"), available at http://www.ppionline.org/documents/healthcourts_0217.pdf (last visited June 16, 2006).
- 36 Covington & Burling, *Philip K. Howard*, at <http://www.cov.com/phoward/> (last visited Nov. 2, 2006).
- 37 Common Good, *Common Good Founder and Chair, Philip K. Howard*, at <http://cgood.org/learn-people-founder.html> (last visited Nov. 2, 2006).

- 38 Philip K. Howard, *Making Civil Justice Sane*, CITY J., Apr. 17, 2006, available at <http://cgood.org/society-reading-cgpubs-opeds-44.html> (last visited Nov. 12, 2006).
- 39 *Id.*
- 40 *Id.*
- 41 *Id.*
- 42 *Specialized Medical Courts Should Try Complex Cases*, WASH. EXAMINER, Sept. 9, 2005, available at http://www.lucidprose.com/exam_medcourts.html (last visited Nov. 16, 2006).
- 43 Randolph W. Pate & Derek Hunter, *Code Blue: The Case for Serious State Medical Liability Reform*, HERITAGE FOUND. BACKGROUNDER, Jan. 17, 2006, at 12 (hereinafter "Heritage Foundation").
- 44 *Id.* at 13.
- 45 *Id.* at 12.
- 46 Debra Sydnor & Natalie S. Whiteman, *Special Malpractice Courts: The Next Bankruptcy Courts or Just a Diversion?*, 23 MED. MAL. L. & STRATEGY 1 (2006). However, a report by the Republican Policy Committee, chaired by Jon Kyl (R-Ariz.), contends that lack of jury expertise is not a factor behind Common Good's endorsement of health courts: "While some proponents of non-jury trials argue that juries cannot be trusted to sift through complex information, this is not part of the Common Good/PPI rationale. Common Good and PPI assert that, since juries decide disputes on a case-by-case basis, there is no precedent, no legal standard of care, by which providers can be guided." REPUBLICAN POLICY COMMITTEE, MEANINGFUL HEALTH CARE REFORM BEGINS WITH HEALTH COURTS 7 (Mar. 7, 2006), available at http://rpc.senate.gov/_files/Mar0706HealthCourtsJS.pdf (last visited Nov. 12, 2006).
- 47 Randall R. Bovbjerg & Brian Raymond, *Patient Safety, Just Compensation and Medical Liability Reform*, KAISER PERMANENTE INST. FOR HEALTH POLY 18 (Jan. 2003).
- 48 Alan M. Mindlin, *Special Health Courts Could Heal State's Liability Costs*, DETROIT NEWS, Mar 2, 2006, at A13.
- 49 See Howard, *supra* note 38.
- 50 Philip K. Howard, *A Case for Medical Justice*, PHILA. INQUIRER, May 15, 2004, available at <http://cgood.org/learn-reading-cgpubs-opeds-26.html> (last visited Nov. 12, 2006).
- 51 Howard, *supra* note 38.
- 52 Paul Barringer, *Health Courts: A Better Approach to Malpractice Reform*, BNA HEALTH L. REP., June 23, 2005.
- 53 Senator Bill Frist, Remarks at the National Press Club (July 12, 2004), available at http://frist.senate.gov/index.cfm?FuseAction=Speeches.Detail&Speech_id=97&Month=7&Year=2004 (last visited Nov. 3, 2006).
- 54 The language of H.R. 1546 appears in Appendix A.
- 55 The language of S. 1337 appears in Appendix B.
- 56 H.J. Res. 183, 2006 Leg., Reg. Sess. (Va. 2006).
- 57 H.B. 396, 24th Leg., 2nd Sess. (Alaska 2006); H.B. 1136, 2006 Leg., 421st Sess. (Md. 2006); H.B. 1777, 2006 Leg., 1st Reg. Sess. (Wash. 2006).
- 58 Press Release, Harvard School of Public Health, Harvard School of Public Health and Common Good to Develop New Medical Injury Compensation System (Jan. 10, 2006) (hereinafter "Harvard Press Release") available at <http://www.hsph.harvard.edu/press/releases/press001102005A.html.html> (last visited Nov. 19, 2006).
- 59 *Id.*
- 60 *Id.*
- 61 Common Good, Design of a 'Health Courts' System Demonstration 1 (Oct. 17, 2005) (hereinafter "Common Good Draft Proposal"),

http://cgood.org/assets/attachments/Health_Court_Proposal_Outline.pdf (last visited Nov. 19, 2006).

62 *Id.* at 5.

63 *Id.* at 8.

64 PPI Report, *supra* note 35, at 10.

65 *Id.* at 12.

66 *Id.* at 9.

67 *Id.* at 14.

68 U.S. AGENCY FOR HEALTHCARE QUALITY & RESEARCH, NATIONAL GUIDELINE CLEARINGHOUSE, DISCLAIMER, *available at* <http://www.guideline.gov/about/disclaimer.aspx> (last visited Nov. 5, 2006).

69 PPI Report, *supra* note 35, at 11.

70 Charles Lockwood, *Editorial: Expert Medical Courts: An Idea Whose Time Has Come*, 49 CONTEMPORARY OB/GYN 11-12 (2004), *available at* <http://www.contemporaryobgyn.net/obgyn/article/articleDetail.jsp?id=123698> (last visited Nov. 1, 2006).

71 Common Good & Harvard School of Public Health, Model Medical Injury Court Act, §2-105(a) (hereinafter “Model Act”):

Recovery of compensation pursuant to this Act for medical injury sustained by a patient as a result of health care services rendered by a covered health care provider at a participating health care facility, whether resulting in death or not, shall be the exclusive remedy against a provider or facility, or any officer, agent, or employee of the provider or facility. Except as provided for by this act, a covered provider or participating facility, or any officer, agent, or employee of said provider or facility, shall not be subject to any liability for the injury, disability or death of a patient; and all causes of action, including actions at law, suits in equity, proceedings, and statutory and common law rights an [sic] remedies for and on account of said injury, disability or death are abolished except as provided for in this act [sic].

The Model Act is presented in Appendix C.

72 Dick Startz, *Here’s a Possible Remedy for Soaring Medical Bills*, BELLINGHAM HERALD, Oct. 17, 2004, *available at* <http://www.uwnews.org/admin/ss/page.asp?pid=247&articleID=5886> (last visited Nov. 12, 2006).

73 REPUBLICAN POLICY COMMITTEE, *supra* note 46, at 8.

74 S. 1337, §3(d)(4)(B), 109th Cong. (2005).

75 PPI Report, *supra* note 35, at 9.

76 *Id.*

77 The PPI report states in relevant part: “They [health court judges] could be lawyers, but could also be doctors, while that would not be necessary - just as U.S. Tax Court judges are lawyers, but not necessarily tax accountants, and Patent Court judges are lawyers, but not necessarily inventors.” *Id.* The examples suggest that health court judges, at a minimum, would have to be attorneys.

78 Startz, *supra* note 72, at 2.

79 William Lander, *It’s Time for Special Health Courts in Pennsylvania*, SUSQUEHANNA VALLEY CENTER FOR PUB. POLY. POLY (Oct. 11, 2005), *available at* <http://www.susvalleypolicy.org/policynews.asp?aid=11112> (last visited Nov. 19, 2006).

80 PPI Report, *supra* note 35, at 9.

81 Model Act, *supra* note 71, at Appendix 1.

82 *Id.*

83 *Id.* The Model Act states that “ ... no member shall hold any compensated public office or public appointment, or office in any political party or political organization.” *Id.* It is not

clear from this language whether board of qualifications members may hold a non-compensated office in a political party or organization.

84 *Id.* at 18 (“Any individual otherwise qualified to be a judge in this state shall be eligible for consideration by the Board of Qualifications to serve as a Medical Injury Court judge.”).

85 *Id.*

86 *Id.* §3-103.

87 *Id.*, Appendix 1.

88 *Id.*, Appendix 2.

89 *Id.*

90 *Id.*

91 Howard, *supra* note 50.

92 Common Good Draft Proposal, *supra* note 61, at 8.

93 Model Act, *supra* note 71, §4-104(b).

94 *Id.* §4-104(a).

95 *Id.*

96 *Id.* §4-104(c).

97 *Id.*

98 State boards and medical societies acknowledge that they have no business delving into clinician’s private lives; their only legitimate concern is the manner in which clinicians practice their profession. A threshold question, therefore, is whether serving as a medical expert is professional practice or an avocation. A review of this issue can be found in an article by attorney Russell M. Pelton, who is legal counsel to the board of the American Association of Neurological Surgeons. Russell M. Pelton, *Medical Societies’ Self-Policing of Unprofessional Expert Testimony*, 13 ANNALS HEALTH L. 549 (2004). Pelton cites a 1997 survey of state medical boards (Douglas R. Eitel, Robert J. Hegeman, & Eric R. Evans, *Medicine on Trial: Physicians’ Attitudes About Expert Medical Witnesses*, 18 J. LEGAL MED. 345, 350 (1997)) that found that of the 32 boards that responded, only six reported disciplining a physician for fraudulent expert testimony, and only eight regarded an expert to be engaged in the practice of medicine. In addition, a Missouri appellate court in 1991 ruled that testifying as an expert did not constitute the practice of medicine and, therefore, a physician could not be disciplined by the state medical board for testifying falsely (*Board of Registration for Healing Arts v. Levine*, 808 S.W.2d 440 (Mo. Ct. App. 1991)). (The false testimony had to do with the expert’s qualifications; he testified once that he had passed his otolaryngology boards on his second attempt and another time that he had passed them on his fourth attempt, but in fact he had passed them on his fifth attempt.) Both the AMA and the American Association of Neurological Surgeons (AANS) have declared that serving as an expert witness does constitute the practice of medicine, and that, therefore, they have the authority to sanction members who testify in an unprofessional manner. Moreover, at its April 2004 annual meeting, the Federation of State Medical Boards adopted a resolution that false, fraudulent or deceptive testimony given by a medical professional while serving as an expert witness should constitute unprofessional conduct, as defined in state licensure acts.

99 Model Act, *supra* note 71, §4-104(b).

100 *Id.* §4-103(a)(3).

101 *Id.* §4-104(c).

102 *Id.* §4-104(e).

103 PPI Report, *supra* note 35, at 9.

104 Lockwood, *supra* note 70, at 1.

105 PPI Report, *supra* note 35, at 10.

106 Heritage Foundation, *supra* note 43, at 13.

107 REPUBLICAN POLICY COMMITTEE, *supra* note 46, at 6.

- 108 Michelle M. Mello et al., “Health Courts” and Accountability for Patient Safety, 84 MILBANK Q. 459, 263 (2006) (hereinafter “Milbank”). Brennan is now Senior Vice President and Chief Medical Officer of Aetna, Inc.
- 109 Bovbjerg & Tancredi, *supra* note 5, at 490.
- 110 Common Good Draft Proposal, *supra* note 61, at 8.
- 111 Milbank, *supra* note 108, at 463-64.
- 112 *Id.* (“The first level of claim review would take place at the involved hospital or insurer. ... The patient or family would be notified and consulted through a process similar to that of the ‘3-Rs’ program,’ a risk management early intervention program administered by the COPIC Insurance Company (2004).”). *Id.* at 462.
- 113 *Lessons Learned*, COPIC’S 3RS PROGRAM NEWSL. (June 2005, at 2) (“Exclusions precluding 3Rs Program: ... Attorney Involvement.”).
- 114 Common Good Draft Proposal, *supra* note 61, at 12.
- 115 Model Act, *supra* note 71, §5-106.
- 116 Milbank, *supra* note 108, at 463.
- 117 Lockwood, *supra* note 70, at 2.
- 118 PPI Report, *supra* note 35, at 11.
- 119 Common Good Draft Proposal, *supra* note 61, at 16.
- 120 Bovbjerg & Raymond, *supra* note 47, at 19.
- 121 Bovbjerg & Tancredi, *supra* note 5, at 489 (“Medical providers should disclose injuries and routinely compensate patients injured with an ACE”).
- 122 PPI Report, *supra* note 35, at 3.
- 123 Model Act, *supra* note 44, §4-103(b). The act defines “accelerated compensation event” as “an avoidable medical injury that fits within a predetermined list of such events that has been developed by [the state department of health] ...” *Id.* §6-101(b).
- 124 Common Good Draft Proposal, *supra* note 61, at 9-10.
- 125 PPI Report, *supra* note 35, at 10.
- 126 *Id.* at 5.
- 127 *Id.* at 12.
- 128 Common Good Draft Proposal, *supra* note 61, at 1.
- 129 *Id.*
- 130 *Id.* at 9.
- 131 *Id.*
- 132 Model Act, *supra* note 71, §6-101(a).
- 133 Bovbjerg & Tancredi, *supra* note 5, at 486. See Laurence R. Tancredi & Randall R. Bovbjerg, *Rethinking Responsibility for Patient Injury: Accelerated Compensation Events, A Malpractice and Quality Reform Ripe for a Test*, 54 L. & CONTEMP. PROBS. 147, 149 (1991) (“ACEs do not cover all injuries, just classes of adverse outcomes that are usually, although not invariably, avoidable through good care.”); Tancredi & Bovbjerg 1992, *supra* note 5, at 191-92 (“Essentially, in reviewing information to develop lists, the experts ask themselves, based on their clinical expertise and knowledge of the medical literature, ‘In what percentage of a large number of similar cases could this outcome be avoided, given good care?’”); Laurence R. Tancredi & Randall R. Bovbjerg, *Advancing the Epidemiology of Injury and Methods of Quality Control: ACEs as an Outcomes-Based System for Quality Improvement*, 13 QRB 201, 203 (June 1992) (“... ACEs cover only those classes of adverse outcomes that are normally avoidable through good medicine”); Randall R. Bovbjerg, *Medical Malpractice: Folklore, Facts, and the Future*, 117 ANNALS INTERNAL MED. 788, 790 (1992) (“predefined lists of bad medical outcomes that should not normally happen when patients receive good care”).
- 134 PPI Report, *supra* note 35, at 5 (“a mistake or medical treatment falling outside a range of good practice”).

- 135 Common Good Draft Proposal, *supra* note 61, at 1 (“injuries would be compensated if they could have been avoided if care had been provided according to best practice”).
- 136 Havighurst & Tancredi, *supra* note 1, at 138.
- 137 Laurence R. Tancredi, *Identifying Avoidable Adverse Events in Medicine*, 12 MED. CARE 935, 935 (1974).
- 138 Common Good Draft Proposal, *supra* note 61, at 10 (“Economic damages would be compensated in full except ... [t]here might be a deductible period or out-of-pocket amount [we suggest that eligibility begin when patients reach 4-6 weeks lost work time or \$3,000-\$4000 in medical expenses]”).
- 139 Model Act, *supra* note 71, §5-104(b)(1).
- 140 *Id.*
- 141 Milbank, *supra* note 108, at 468 (“[t]he methods of valuing the different components of economic losses would be similar to those used in the tort system, except that the valuations would be made by an expert employed by the decision panel [i.e., the hospital or insurer panel that decides whether or not to make an offer of compensation].”).
- 142 Bovbjerg & Tancredi, *supra* note 5, at 488.
- 143 *Id.* at 489.
- 144 Common Good Draft Proposal, *supra* note 61, at 17.
- 145 Model Act, *supra* note 71, §5-104(b)(1)(i).
- 146 Common Good Draft Proposal, *supra* note 61, at 10.
- 147 Milbank, *supra* note 108, at 467.
- 148 Common Good Draft Proposal, *supra* note 61, at 17.
- 149 Bovbjerg & Tancredi, *supra* note 5, at 489.
- 150 Common Good Draft Proposal, *supra* note 61, at 3.
- 151 *Id.* at 11.
- 152 *Id.* Accord Milbank, *supra* note 108, at 465.
- 153 Model Act, *supra* note 71, §5-104(b)(2).
- 154 *Id.*, §5-105(a).
- 155 PPI Report, *supra* note 35, at 5.
- 156 *Id.* at 11.
- 157 *Id.*
- 158 *Id.* at 4 (citations omitted).
- 159 *Id.* at n.13.
- 160 Model Act, *supra* note 71, §4-105(a).
- 161 *Id.*
- 162 *Id.*
- 163 Common Good Draft Proposal, *supra* note 61, at 12.
- 164 Milbank, *supra* note 108, at 465.
- 165 JOINT SUBCOMMITTEE STUDYING RISK MANAGEMENT PLANS FOR PHYSICIANS AND HOSPITALS, SJR 394/HJR 704 (2005), available at <http://dls.state.va.us/groups/RiskMgmt/MEETINGS/083005/Sm083005.pdf> (last visited Nov. 2, 2006).
- 166 See PPI Report, *supra* note 35, at 13 (“Holding organizations as well as individual doctors accountable for patient safety ... would also provide reliable data for what is called ‘experience rating’ of premiums, in which malpractice insurance rates for health care providers are set according to their records of malpractice.”); Common Good Draft Proposal, *supra* note 61, at 12 (“... the financing would be based on an experience-rating system that gives sharp incentives for improvement”).
- 167 Christopher Guadagnino, *Tort Replacement Solution for Medical Malpractice Crisis*, PHYSICIAN'S NEWS DIGEST, June 2003, at 9 (interview with Randall Bovbjerg), available at <http://www.physiciansnews.com/spotlight/603.html> (last visited Nov. 2, 2005).

- 168 *Id.*
- 169 Common Good Draft Proposal, *supra* note 61, at 12.
- 170 *Id.*
- 171 *Id.*
- 172 PPI Report, *supra* note 35, at 5.
- 173 Model Act, *supra* note 71, §5-102(b).
- 174 *Id.* §5-101.
- 175 Bovbjerg & Raymond, *supra* note 47, at 18.
- 176 PPI Report, *supra* note 35, at 12-13.
- 177 Bovbjerg & Raymond, *supra* note 47, at 19.
- 178 Common Good Draft Proposal, *supra* note 61, at 14.
- 179 PPI Report, *supra* note 35, at 13.
- 180 *Id.*
- 181 Common Good Draft Proposal, *supra* note 61, at 13. The proposal states that this agency also would have responsibility for "claims processing," without explaining how it would interface with either the private offer-and-settlement or the health court adjudication process.
- 182 *Id.* at 13-14.
- 183 *Id.* at 13.
- 184 *Id.* at 13- 14.
- 185 PPI Report, *supra* note 35, at 13 ("Reporting such information should be kept separate from specifics about the proceedings of individual cases.").
- 186 Common Good Draft Proposal, *supra* note 61, at 2.
- 187 *Id.* at 13.
- 188 *Id.*
- 189 *Id.* at 15.
- 190 *Id.*
- 191 *Id.* at 14.
- 192 *Id.* at 13.
- 193 *Id.* at 14.
- 194 *Id.* at 15.
- 195 *Id.* at 13.
- 196 PPI Report, *supra* note 35, at 12.
- 197 *Id.* ("Rulings of the health court system would replace ad-hoc decisionmaking based on testimony of dueling experts.").
- 198 Common Good Draft Proposal, *supra* note 61, at 2-3.
- 199 Model Act, *supra* note 71, §4-103(b)(2).
- 200 Heritage Foundation, *supra* note 43, at 13.
- 201 Philip K. Howard, *Re-Evaluating America's Legal System to Remedy the Healthcare Crisis: Specialized Health Courts Set a Precedent*, CLEVE. PHYSICIAN, Sept.-Oct. 2004, at 9.
- 202 Joint Comm'n on Accreditation of Healthcare Orgs. Press Conference, *Medical Liability System Hinders Improvements in Patient Safety*, at 5 (Feb. 10, 2005), available at, <http://www.jointcommission.org/NewsRoom/PressKits/TortReform/transcript.htm> (last visited Nov. 3, 2006).
- 203 *Id.* at 7.
- 204 *Debate Club: The Doctor's Court?* LEGAL AFFAIRS, March 14, 2005 (remarks of Philip K. Howard) (emphasis added) available at <http://legalaffairs.org/webexclusive/debate-clubmedmal0305.msp> (last visited Nov. 3, 2006).
- 205 Jeffery Pariser, *Cure for the Health Care Crisis: Specialized Courts Create Clear Standards and Greater Reliability*, LEGAL TIMES, June 28, 2004 (emphasis added), available at

- <http://cgood.org/healthcare-newscommentary-inthenews-141.html> (last visited Nov. 3, 2006).
- 206 *Id.*
- 207 Heritage Foundation, *supra* note 43, at 3.
- 208 Common Good Draft Proposal, *supra* note 61, at 1.
- 209 Hyman holds both an M.D. and a J.D.
- 210 David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1094 (2006).
- 211 David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 979-980 (2005).
- 212 David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 N. ENG. J. MED. 2024 (2006).
- 213 *Id.* at 2025.
- 214 *Id.* at 2028.
- 215 *Id.*
- 216 *Id.*
- 217 *Id.* at 2031 (emphasis added). Health court proponents will be tempted to reply that this study shows only that the adversary system is a huge waste of time and money. After all, the independent reviewers reached mostly the same results as the tort system, and they did so by spending on average only 1.6 hours per case to make their determinations. *Id.* at 2025. The difficulty with this argument, however, is that the reviewers used “all available information” (*id.* at 2026), including important products of the adversary system such as depositions. (Personal communication with David Studdert, Dec. 5, 2006.) The study tells us very little, therefore, about how well technically trained reviewers would do without the benefit of such adversarially created information.
- 218 Hyman & Silver, *supra* note 210, at 1099.
- 219 Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 N. ENG. J. MED. 1963 (1996).
- 220 See A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence, Results of the Harvard Medical Practice Study III*, 325 N. ENG. J. MED. 245 (1991).
- 221 See Tom Baker, *Reconsidering the Harvard Medical Practice Study Conclusions about the Validity of Medical Malpractice Claims*, 33 J.L. MED. & ETHICS 501 (2005).
- 222 *Id.* at 506-11. Baker refers to 47 cases, because that was the number with which the follow-up study began. Four additional “missing records” cases were identified, bringing the number to 51, but of these, only 46 cases were closed in time for analysis in the study. See Brennan et al., *supra* note 219, at 1964.
- 223 *Id.* at 511.
- 224 TOM BAKER, THE MEDICAL MALPRACTICE MYTH 110 (2005).
- 225 Philip K. Howard, *Strong Medicine*, THE WALL STREET JOURNAL, Jan. 6, 2007, available at <http://cgood.org/healthcare-reading-cgpubs-opeds-50.html>.
- 226 The Harvard study does report data from which comparable “error” rates can be computed for juries. This is discussed later in this report. See *infra*, notes 271-272 and accompanying text.
- 227 Coincidentally, the Harvard data do show that for about one in four physicians (actually, 27%) who did not commit actionable negligence (according to the physician reviewers) some compensation was paid. See Studdert et al., *supra* note 212, at 2028 fig.1. But that cannot be the perspective of the physician who is entering the legal system (playing the “roulette”), because the physician who is sued will not know for certain that he or she is one of the physicians who did not act negligently (or more precisely, one of those whom

- the reviewers would consider to have acted non-negligently). Ordinary mortals without remarkable prescience will know only that if reviewers would consider them non-negligent, then there is about a one in four chance that their insurance company will pay something. They will also know, however, that even if the reviewers would consider them negligent, there is about a one in four chance that their insurance company will not have to pay anything. *See id.*
- 228 How much less depends on the proportion of those cases, involving disagreement between the reviewers and the legal system’s result, that represents cases in which the legal system got it right and the reviewers got it wrong. If this proportion is 100%, then the defendant faces no risk of erroneous payment. If this proportion is zero, then the defendant faces a risk of about one in ten of an erroneous payment. If, more realistically, we assume that the proportion is, say, one-third, then the “roulette” risk drops to one in fifteen. Also, if we take Howard’s statement at face value as really referring to jury verdicts, then the distortion of the data is even more severe. Culling data from the Harvard study, one can determine that the risk of a verdict for plaintiff at odds with the reviewers’ assessment is only 5%, or a “roulette” chance of one in twenty. (*See infra* note 272.) Again, that overstates the risk because sometimes the jury will have got it right and the reviewers will have got it wrong.
- 229 The authors of the PPI Report, for example, state, somewhat cryptically, “[t]he problem is not simply a matter of greedy lawyers egging injured patients to sue.” PPI Report, *supra* note 35, at 1.
- 230 NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS* chs. 7 & 8 (1995).
- 231 *See* HERBERT M KRITZER, *RISKS, REPUTATIONS, AND REWARDS: CONTINGENCY FEE LEGAL PRACTICE IN THE UNITED STATES* 82-83 (2004).
- 232 *Id.* at 87.
- 233 *See supra* text accompanying note 201. *See also* PPI Report, *supra* note 35, at 1.
- 234 Localio et al., *supra* note 220; Brennan et al., *supra* note 219.
- 235 BAKER, *supra* note 224, at 501.
- 236 *Id.* at 502.
- 237 *Id.* at 512.
- 238 Hyman & Silver, *supra* note 210, at 1099.
- 239 BAKER, *supra* note 224, at 512.
- 240 Studdert et al., *supra* note 212, at 2028 fig.1. A finding by reviewers of no error was made in 37% of those claims in which there was a physical injury; if one includes the small number of claims in which no injury was found (in which error may nonetheless have occurred) and in which only dignitary harms were involved, the figure drops to 35%.
- 241 *Id.* at 2031.
- 242 *Id.* at 2027 tbl.1. This figure corresponds to that found in other research. *See, e.g.*, VIDMAR, *supra* note 230, chs. 3 & 4 (reporting data from North Carolina).
- 243 *See, e.g.*, Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingent Fee System, Juries, and Social Policy*, 38 Loy. L.A. Law Rev. 1217, 1250-51 (2005).
- 244 Hyman & Silver, *supra* note 210, at m14 (citation omitted).
- 245 Studdert, et al., *supra* note 212, at 2030-2031.
- 246 *Id.* at 2031.
- 247 *See, e.g.*, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve Quality of Health Care*, March 13, available at <http://www.hhs.gov/asl/testify/t030313.html> (last visited Nov. 9, 2006).

- 248 VIDMAR, *supra* note 230, at 24-25 (over 90%); Studdert et al., *supra* note 212, at 2027 tbl.1 (85%).
- 249 See Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. 315, 349 (2005) (2.3% to 2.9%); Studdert et al., *supra* note 212, at 2027 tbl.1 (5.5%).
- 250 Hyman & Silver, *supra* note 210, at 1123 (emphasis in original).
- 251 *Id.* at 1127.
- 252 Daniel Capra, "An Accident and a Dream:" *Problems with the Latest Attack on the Civil Justice System*, 20 PACE L. REV. 339 (2000).
- 253 See *supra* note 46.
- 254 See, e.g., PPI Report, *supra* note 35, at 1-2.
- 255 PPI Report, *supra* note 35, at 2 & n.5; Pate & Hunter, *supra* note 43, at 12 & n.61 (quoted *supra* in text at note 45)..
- 256 The article is Brennan, et al., *supra* note 219.
- 257 *Id.* at 1964. Because it involved only one jury trial, the study was concerned with compensation practices occurring primarily through settlement, and it should be noted that, even as to settlement practices, this is the study the weaknesses of which have been previously discussed. See *supra* notes 219-224 and accompanying text.
- 258 Brennan, et al., *supra* note 219, at 1964
- 259 See *supra* note 248 and accompanying text.
- 260 See Vidmar, *supra* note 243, at 1245-48.
- 261 *Id.* at 1243-45.
- 262 See David A. Hyman, Bernard Black, Charles Silver, & William M. Sage, *Do Defendants Pay What Juries Award? Post-Vercits Haircuts in Texas Medical Malpractice Cases, 1988-2003*, J. EMPIRICAL LEGAL STUD. (forthcoming 2007), available at <http://ssrn.com/abstract=914415>.
- 263 See Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues? Some Data from Medical Malpractice*, 43 EMORY L.J. 885, 900-01 (1994); VIDMAR, *supra* note 230, ch. 6.
- 264 Vidmar points to various pieces of evidence supporting the proposition that, among the close liability cases, there may be some skewing toward relatively weak cases of liability. VIDMAR, *supra* note 230, chs 5-8.
- 265 Neil Vidmar & Shari Seidman Diamond, *Juries and Expert Evidence*, 66 BROOK. L. REV. 1121, 1174-75. There is a considerable literature concerning the ability of people to assess probabilities and statistical information, some of which is briefly noted by Vidmar and Diamond. *Id.* at 1135-37. Critics of juries often point to this body of research, although none of it (to our knowledge) was developed specifically in the context of malpractice, and little of it was developed in the context of litigation of any kind. Mostly, subjects of psychological studies have been tested to see how well they can handle fairly abstract problems involving statistical or quantitative reasoning. What is to be learned from these studies and their relevance to legal issues are controversial matters. See generally Charles Yablon, *The Meaning of Probability Judgments: An Essay on the Use and Misuse of Behavioral Economics*, 2004 U. ILL. L. REV. 899. One of the contexts in which a number of empirical studies of adjudicative decision making have been conducted is that of juror understanding of random-match probabilities, most commonly encountered in forensic science applications such as the presentation of DNA evidence. The long standing controversy here is whether jurors will be credulously accepting of experts presenting mathematical information or whether they will tend, rationally, to discount such evidence until it is adequately explained to them. The accumulating evidence supports the latter view. See Dale A. Nance & Scott B. Morris, *Juror Understanding of DNA Evidence: An Empirical Assessment of Presentation Formats for Trace Evidence with a Relatively Small Random-Match Probability*, 34 J. LEGAL STUD. 395 (2005).

266 See Vidmar, *supra* note 263, at 896-903.

267 See PPI Report, *supra* note 35, at 1-2; Howard, *supra* note 38.

268 These studies are usefully summarized in Vidmar, *supra* note 263, at 903-06.

269 See Vidmar & Diamond, *supra* note 265, at 1241.

270 See VIDMAR, *supra* note 230, ch. 19. Depending on the experiment and the specific comparison made, average (mean) modeled jury awards were either discernibly smaller than average lawyer awards or else no statistically significant differences were detected. *Id.*

271 Studdert et al., *supra* note 212, at 2030 tbl.2. Using the authors’ Table 2, one can construct the following table comparing verdicts and reviewers’ assessments:

		Reviewers’ Assessments	
		medical error	no medical error
Verdicts	for plaintiff	39	11
	for defendant	52	106

Thus, it appears that juries agreed with reviewers in 39 + 106 of the 208 cases resolved by verdict, or 70% of the total, as stated in the text. The figures in the authors’ Table 2, and thus the table presented above, cover only those cases in which the reviewers determined that there was physical or mental (not just dignitary) injury, although this constituted 97% of the cases in the sample. *Id.* at 2028 fig.1. Consequently, it is possible that the jury/reviewer agreement level would be higher or lower if the 3% of cases involving no injury at all (according to reviewers) was included. The authors do not report data from which this could be calculated directly, but one can calculate lower and upper bound estimates by making worst-case or best-case assumptions regarding that 3% of cases. Those assumptions produce a range of measurements of agreement, between juries and reviewers, from 68% to 71%, in any event a remarkably high rate of agreement for cases that proceed to trial. It should also be noted that it is possible, despite the authors’ use of the term “verdict” to describe the results of these 208 cases, that some of them were bench trials in which juries were not employed; the authors do not clarify the point. Nearly all medical malpractice trials are jury trials, however. See, e.g., THOMAS H. COHEN, BUREAU OF JUSTICE STATISTICS, NO. NCJ 206240, CIVIL JUSTICE SURVEY OF STATE COURTS, 2001: TORT TRIALS AND VERDICTS IN LARGE COUNTIES, 2001, at 2 tbl.1 (2004) (reporting that 96% of medical malpractice trials were before juries).

272 Studdert et al., *supra* note 212, at 2030 tbl.2. Using the table in the previous note, one observes that in only 11 cases (5% of the total) did the jury return a verdict for the plaintiff when reviewers believed there was no medical error, but in 52 cases (25% of the total) the jury returned a verdict for the defendant when reviewers believed there was medical error. Some of this difference might be explained by the fact that the reviewers were told to look for medical error as defined by the Institute of Medicine: “the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).” The authors noted that this may not produce results identical to that which would be appropriate using the legal standard of negligence. *Id.* at 2026.

273 Several studies have purported to find evidence of a deep pockets effect in the differences in compensation patterns among types of cases (e.g., medical malpractice versus negligent operation of a motor vehicle), but these studies are so seriously flawed methodologically that they can do little to eliminate plausible alternative hypotheses that would explain the data. See Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 DUKE L.J. 217, 224-41 (1993).

- 274 Studdert et al., *supra* note 212, at 1235.
- 275 Hyman & Silver, *supra* note 210, at 1107. Hyman and Silver observe that it is difficult to explain this observed fact in terms of predictable behavior, because lawyers on both sides can be expected to adjust their settlement practices so that only close cases go to trial. They offer one potential explanation, that physicians may refuse consent to settle in cases that insurance companies ordinarily would prefer to settle. *Id.* at 1125-28.
- 276 Vidmar, *supra* note 243, at 1235-37. Relatedly, observational studies of jury deliberations (in sets of cases including medical malpractice) report that jurors are more commonly concerned about possible double recovery by plaintiffs (who may have been compensated already by first-party insurance) than about the deep pockets of defendants with liability insurance. See Shari Seidman Diamond & Neil Vidmar, *Jury Room Ruminations on Forbidden Topics*, 87 VA. L. REV. 1857, 1888-89 (2001).
- 277 See 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 (1992) (studying results of over 8000 malpractice cases in New Jersey).
- 278 See Vidmar, *supra* note 273, at 241-55.
- 279 COMMON GOOD, SELECTED MALPRACTICE CLAIM DATA 2 (Nov. 2, 2005), available at <http://cgood.org/healthcare-reading-cgpubs-factsheets-14.html?print=1> (last visited Sept. 3, 2006).
- 280 COMMON GOOD, THE EFFECTS OF LAW ON HEALTH CARE 24 (Nov. 2, 2002), available at <http://cgood.org/healthcare-reading-cgpubs-binders-5.html> (last visited Nov. 3, 2006).
- 281 PUBLIC CITIZEN CONGRESS WATCH, MEDICAL MALPRACTICE PAYOUT TRENDS 1991-2004: EVIDENCE SHOWS LAWSUITS HAVEN'T CAUSED DOCTORS' INSURANCE WOES 4 (Apr. 2005), available at http://www.citizen.org/documents/Malpracticeanalysis_final.pdf#search=%22%22MEDICAL%20MALPRACTICE%20PAYOUT%20TRENDS%201991%E2%80%942004%22%2 (last visited Nov. 3, 2006).
- 282 *Id.*
- 283 Michelle M. Mello, *Understanding Medical Malpractice Insurance: A Primer*, 8 ROBERT WOOD JOHNSON FOUND. RES. SYNTHESIS REP. 4 (Jan. 2006).
- 284 See Vidmar, *supra* note 249, at 344. (presenting data, in note 121, from which it can be calculated that the Consumer Price Index rose an average of 3% per year between 1990 and 2004, while the Medical Consumer Price Index rose twice that fast, an average of 6% per year during that same time).
- 285 See *id.*, at 338-45.
- 286 BAKER, *supra* note 224 at 72-73.
- 287 *Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients: Hearing Before the S. Comm. on Health, Education, Labor and Pensions*, 109th Cong. 8 (2006) (Testimony of Philip K. Howard on June 22, 2006).
- 288 See *supra*, text accompanying note 41.
- 289 See ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* 258-264 (Harvey C. Mansfield & Delba Winthrop eds. 2000) (1830).
- 290 See, e.g., Stephan Landsman, *The Civil Jury in America: Scenes from an Unappreciated History*, 44 HASTINGS L.J. 579 (1993). See also John Gastil & Phil Weiser, *Jury Service as an Invitation to Citizenship: Assessing the Civic Value of Institutional Deliberation*, 34 POLY STUD. J. 605 (2006) (presenting empirical evidence supporting correlations between jury service and civic engagement such as voting).
- 291 See, e.g., PPI Report, *supra* note 35, at 2, 4, & 8.
- 292 See, e.g., Mello, *supra* note 12, at 5 n.3
- 293 BAKER, *supra* note 224, at 118-20.

294 *Id.*

295 See, e.g., Edward B. Hirshfield, *Commentaries: Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?* 140 U. PA. L. REV. 1809, 1849 n.31 (1992) ("Perhaps the most prevalent form of defensive medicine is ordering diagnostic tests when the tests are not clearly indicated by the patient's symptoms, but where there is a remote chance that the tests might reveal an illness or injury. The tests are ordered because of fear that if the patient does have a problem that the test could have detected, the physician would be held liable for not ordering the test."). Hirshfield was the Associate General Counsel of the American Medical Association.

296 See, e.g., Eugene C. Grochowski, *Ethical Issues in Managed Care: Can the Traditional Physician-Patient Relationship Be Preserved in the Era of Managed Care or Should It Be Replaced By a Group Ethic?*, 32 U. MICH. J.L. REFORM 619, 651-52 (1999) ("Bedside rationing is opposed by the codes of ethics of many-perhaps all-major medical organizations. In addition, it is nearly universally condemned by medical ethicists ...") (citation omitted). Grochowski is an associate professor of medicine at Johns Hopkins University School of Medicine.

297 Hyman & Silver, *supra* note 211, at 937.

298 *Id.*, quoting Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1606 (2002).

299 *Id.* at 938.

300 See Mello & Brennan, *supra* note 298, at 1607.

301 See BAKER, *supra* note 224, at 118-39.

302 *Id.* at 129.

303 *Id.* at 134.

304 *Id.* at 140.

305 *Id.* at 146-47.

306 Hyman & Silver, *supra* note 211, at 939-41 (quoted language at 941).

307 *Id.* at 941.

308 *Id.* (footnote omitted).

309 BAKER, *supra* note 224 at 152.

310 *Id.* at 140-41.

311 *Id.* at 97.

312 Hyman & Silver, *supra* note 211, at 914.

313 *Id.*, citing Lucian L. Leape, *Reporting of Adverse Events*, 347 N. ENG. J. MED. 1633, 1635 (2002).

314 BAKER, *supra* note 224, at 97.

315 Hyman & Silver, *supra* note 211, at 925-26 (citations omitted).

316 *Id.* at 947-48 (citations omitted).

317 JOAN M. GILMOUR, PATIENT SAFETY, MEDICAL ERROR AND TORT LAW: AN INTERNATIONAL COMPARISON 198 (Health Canada Project No. 6795-15-203/5760003 2006) (citation omitted).

318 Hyman & Silver, *supra* note 211, at 897-98 (citations omitted).

319 *Id.* at 925, quoting Steven Lubet, Review Essay, *Like a Surgeon*, 88 CORNELL L. REV. 1178, 1195 (2003).

320 Hyman & Silver, *supra* note 211, at 898-99.

321 *Id.* at 917.

322 See Alex Azar, Gen. Counsel, Dep't of Health and Human Servs., Remarks at the AEI-Brookings Joint Center: Liability and Patient Health (Mar. 4, 2003), available at http://www.kaisernet-work.org/health_cast/uploaded_files/030403_aei_welcome.pdf#search=%22%22common%20good%22%20%22anesthesiologists%22%22 (last visited Nov. 1, 2006).

- 323 Hyman & Silver, *supra* note 211, at 920.
- 324 *Id.* at 921 (emphasis in original).
- 325 *Id.* at 916 (emphasis in original).
- 326 PAUL C. WEILER, JOSEPH P. NEWHOUSE, & HOWARD H. HIATT, A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 133 (1993).
- 327 Hyman & Silver, *supra* note 211, at 916, citing Weiler et al., *supra* note 233, at 127, 132.
- 328 Hyman & Silver, *supra* note 210, at 1131.
- 329 Hyman & Silver, *supra* note 211, at 991 (citation omitted).
- 330 Hyman & Silver, *supra* note 210, at 1130 (emphasis added).
- 331 BAKER, *supra* note 224, at 94.
- 332 *Id.* at 95 (citations omitted).
- 333 Robert J. Blendon et al., *Patient Safety: Views of Practicing Physicians and the Public on Medical Errors*, 347 N. ENG. J. MED. 1933 (2002).
- 334 *Id.* at 94-95 (observing that surveys show that doctors continue to think that malpractice lawsuits are a more serious problem in health care than medical mistakes and injuries).
- 335 See text accompanying note 201 *supra*.
- 336 See text accompanying note 38, *supra*.
- 337 See Patricia M. Danzon, *Liability for Medical Malpractice*, in HANDBOOK OF HEALTH ECONOMICS 1339, 1369 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (placing insurance overhead costs at about 20 percent of total system costs).
- 338 *Id.*
- 339 See, e.g., JAMES S. KAKALIK & NICHOLAS M. PACE, COSTS AND COMPENSATION PAID IN TORT LITIGATION vi-vii (1986).
- 340 Gerard F. Anderson et al., *Health Spending in the United States and the Rest of the Industrialized World*, 24 HEALTH AFFAIRS 903, 910 (2005).
- 341 This is a fair assumption. Cf. Vidmar, *supra* note 243, at 1232; LESTER BRICKMAN, MICHAEL HOROWITZ, & JEFFREY O'CONNELL, RETHINKING CONTINGENCY FEES 58 n.41 (1994).
- 342 Studdert et al., *supra* note 212, at 2031 tbl.3. The careful reader will discover the following statement in this study: "The combination of defense costs and standard contingency fees charged by plaintiffs' attorneys (35 percent of the indemnity payment) brought the total costs of litigating the claims in our sample to 54 percent of the compensation paid to plaintiffs." *Id.* This statement is correct, given their data, but it is also misleading, because defense costs do not come out of the indemnity payment. 54 percent is, therefore, not a fair measure of the (in)efficiency of the system. If total litigation costs are considered as a ratio to total system costs, one gets the figure 46 percent, meaning that the efficiency of the system (as defined in the text of this report) is 54 percent. Thus, the statement quoted here is consistent with the statement made in the text of this report, although the latter is the more meaningful statement.
- 343 KAKALIK & PACE, *supra* note 339, at xi fig.S.1.
- 344 *Id.* at xiii fig.S.2.
- 345 *Id.* at x.
- 346 *Id.* at xiii fig.S.2.
- 347 *Id.* at x.
- 348 See *id.* at xi, xiii (indicating that, relative to an augmented total system cost, the cost of plaintiff and defendant time spent on litigation are 3% and 9%, respectively, for all torts; 2% and 6%, respectively, for auto torts; and 2% and 12%, respectively, for non-auto torts, including medical malpractice). Data for defendants was not highly reliable for various reasons, see *id.* at 61-62, and no specific estimates for medical malpractice were reported.

- 349 There is, for example, some evidence that recoveries for non-economic damages may be too small on average. *See, e.g.,* Bovbjerg, Sloan, & Blumstein, *supra* note 30, at 928.
- 350 The effect remains but is reduced to the extent that a courts’ award of reasonable attorneys’ fees would be lower than current contingent fees. Similarly, the effect remains but is reduced if the converse rule—that successful defendants could recover their attorneys’ fees—were also part of the system. And the effect remains but is reduced if recoverability of attorneys’ fees depended on some sort of finding of an unreasonable refusal to settle by the losing party.
- 351 The PPI suggests allowing plaintiffs to recover attorneys’ fees (*see* PPI Report, *supra* note 35, at 11), but one need not adopt health courts in order to achieve this particular increase in system efficiency.
- 352 Hyman & Silver, *supra* note 211, at 952.
- 353 *Medical Guesswork*, BUS. WK., May 29, 2006.
- 354 *Id.*
- 355 Hyman & Silver, *supra* note 211, at 908-09 (citations omitted).
- 356 *Id.* at 952.
- 357 Frank A. Sloan, *Policy Implications*, in *SUING FOR MEDICAL MALPRACTICE 219* (Frank A. Sloan et al. eds., 1993).
- 358 *See, e.g.,* PPI Report, *supra* note 35, at 1-2.
- 359 *See* Anderson et al., *supra* note 340, at 910. This figure does not include “indirect costs” such as the costs of defensive medicine, for which no reliable estimates are available. *Id.*
- 360 BAKER, *supra* note 224, at 9.
- 361 Randall R. Bovbjerg & Robert A. Berenson, *Surmounting Myths and Mindsets in Medical Malpractice*, URB. INST. HEALTH POLY BRIEF 5 (Oct. 2005).
- 362 Anderson et al., *supra* note 340, at 904.
- 363 Marc A. Rodwin, Hak J. Chang, & Jeffrey Clausen, *Malpractice Premiums and Physicians’ Income: Perceptions of a Crisis Conflict with Empirical Evidence*, 25 HEALTH AFF 750 (2006).
- 364 *Id.* at 752 (Exhibit 1).
- 365 *Id.* at 757.
- 366 *Id.* at 751.
- 367 *Id.* at 752 fig.1.
- 368 *Id.* at 757.
- 369 *Id.* at 752 (Exhibit 2), 753 (Exhibit 3).
- 370 *Id.* at 754-55. The authors of the study acknowledge that the national and regional data available to them might conceal problems occurring at the state level but give reasons for believing that state-based data would not present a substantially different picture. *Id.* at 755-57.
- 371 *Id.* at 755. With regard to the decline in physician revenues in the period 1996 to 2000, the authors add: “Our data do not provide information regarding why physician revenue declined. Possible causes include reduction in physician payment rates as a result of the policies of third-party payers; decreased physician revenue as a result of physicians’ financial risk sharing; reduction in the volume of services provided as a result of utilization review; and decreases in the number of services provided by each physician, as a result of an increase in the number of physicians practicing.” *Id.*
- 372 Mello, *supra* note 12, at 4.
- 373 Bovbjerg & Tancredi, *supra* note 5, at 479.
- 374 Hyman & Silver, *supra* note 210, at 1111-12.
- 375 *Id.* at 1129.
- 376 REPUBLICAN POLICY COMMITTEE, *supra* note 46, at 1.
- 377 Heritage Foundation, *supra* note 43, at 13.

- 378 PPI Report, *supra* note 35, at 10.
- 379 Debate Club, *supra* note 204. See also Common Good Draft Proposal, *supra* note 61, at 1 (“[c]ompensation decisions based on ‘avoidability,’ a standard that is broader than negligence but does not approach strict liability”).
- 380 Bovbjerg & Tancredi, *supra* note 5, at 489.
- 381 Common Good Draft Proposal, *supra* note 61, at 9.
- 382 *Id.* at 5.
- 383 *Id.*
- 384 PPI Report, *supra* note 35, at 4.
- 385 Harvard Press Release, *supra* note 58.
- 386 PPI Report, *supra* note 35, at 4.
- 387 *Id.* at 12.
- 388 *Id.* at 12-13.
- 389 Common Good Draft Proposal, *supra* note 61, at 5.
- 390 PPI Report, *supra* note 35, at 10 (“A robust administrative level of service will be essential to ensure that a health court system delivers speedy, affordable justice.”).
- 391 *Id.* (“For patients, a reliable system has to be one that can provide compensation for people wrongly injured by the medical system without years of legal wrangling and without costs that now consume roughly one-half of the awards.”). See also Howard, *supra* note 50 (“To reduce legal fees and emotional toil, proceedings would be expedited, so that injured patients would be able to keep more of any award.”).
- 392 Tancredi & Bovbjerg 1992, *supra* note 5, at 187.
- 393 Havighurst & Tancredi, *supra* note 1, at 137, n.3.
- 394 Bovbjerg & Tancredi, *supra* note 5, at 486.
- 395 PPI Report, *supra* note 35, at 10 (emphasis added). The report adds that “[t]his broader, more liberal standard of recovery goes beyond the current haphazard standard that is based on individual negligence.” *Id.* The report does not explain what it means by a standard based on “individual negligence” nor how its standard is different.
- 396 *Id.* at 12.
- 397 Havighurst & Tancredi, *supra* note 1, at 138 (emphasis added).
- 398 Tancredi, *supra* note 137, at 935 (emphasis added).
- 399 Model Act, *supra* note 71, §6-101(a).
- 400 See, e.g., RESTATEMENT (SECOND) OF TORTS §282 (1965) (“negligence is conduct which falls below the standard established by law for the protection of others against *unreasonable* risk of harm” (emphasis added)).
- 401 REPUBLICAN POLICY COMMITTEE, *supra* note 46, at 5 (emphasis added) (citation omitted).
- 402 Tancredi & Bovbjerg 1992, *supra* note 5, at 185.
- 403 Tancredi & Bovbjerg, *supra* note 133, at 207.
- 404 *Id.* at 206.
- 405 *Id.*, tbl.2.
- 406 See text accompanying notes 133-135, *supra*.
- 407 Common Good Draft Proposal, *supra* note 61, at 9-10.
- 408 *Scalpel, Scissors, Lawyer*, THE ECONOMIST, Dec. 17-23, 2005, at 32.
- 409 Tancredi & Bovbjerg 1992, *supra* note 5, at 186.
- 410 Bovbjerg & Tancredi, *supra* note 5, at 486.
- 411 Tancredi & Bovbjerg 1992, *supra* note 5, at 191-93 (citation omitted).
- 412 *Id.* at 185.
- 413 The experts are described as “nationally recognized medical experts from each specialty examined.” Laurence R. Tancredi & Randall R. Bovbjerg, *Creating Outcomes-based Systems for Quality and Malpractice Reform: Methodology of Accelerated Compensation Events (ACEs)*,

- 70 MILBANK MEMORIAL FUND Q. 183, 185 (1992). There is no information on who they are, what qualifies them as being “nationally recognized experts,” how they would be chosen, or how many there would be.
- 414 Lars Noah, *Medicine’s Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373, 420 (2002) (citation omitted).
- 415 *Id.* at 421, citing David M. Eddy, *Clinical Policies and the Quality of Clinical Practice*, 307 NEW ENG. J. MED. 343, 345 (1982).
- 416 *Id.* at n.204, citing Charles E. Phelps, *The Methodologic Foundations of Studies of the Appropriateness of Medical Care*, 329 NEW ENG. J. MED. 1241, 1244 (1993).
- 417 Tancredi & Bovbjerg, *supra* note 133, at 203.
- 418 Tancredi & Bovbjerg 1992, *supra* note 5, at 193.
- 419 *Id.*
- 420 *Id.* at 200.
- 421 *Id.*
- 422 Lawrence R. Tancredi, *Designated Compensable Events: A No-Fault Approach to Medical Malpractice*, 10 L., MED. & HEALTH CARE 200, 202 (1982).
- 423 PPI Report, *supra* note 35, at 12.
- 424 Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform*, 5 HEALTH MATRIX 369, 376 (1995).
- 425 Noah, *supra* note 414.
- 426 John D. Ayres, *The Use and Abuse of Medical Practical Guidelines*, 15 J. LEGAL MED. 421, 441 (1994), *quoted in* Noah, *supra* note 414, at 421.
- 427 Noah, *supra* note 414 (citation omitted). *See also* Steven H. Woolf et al., *Clinical Guidelines: Potential Benefits, Limitations, and Harms of Clinical Guidelines*, 318 BRIT. MED. J. 527, 529 (1999) (“Guideline development groups often lack the time, resources, and skills to gather and scrutinize every last piece of evidence.”).
- 428 Noah, *supra* note 414, at 423. *See also* Niteesh K. Choudhry et al., *Relationships Between Authors of Clinical Practice Guidelines and the Pharmaceutical Industry*, 287 JAMA 612 (2002) (survey results illustrate “considerable interaction” between pharmaceutical companies and the authors of clinical practice guidelines); Jodi M. Finder, *The Future of Practice Guidelines: Should They Constitute Conclusive Evidence of the Standard of Care?*, 10 HEALTH MATRIX 67, 111-13 (2000) (discussing the influence of insurers on practice guidelines).
- 429 Noah, *supra* note 414, at 424. *See also* Paul G. Shekelle et al., *Validity of the Agency for Healthcare Research and Quality Clinical Practice Guidelines: How Quickly Do Guidelines Become Outdated?*, 286 JAMA 1461 (1999). In a 2001 survey, researchers discovered that approximately 75% of the guidelines reviewed were outdated. *Id.* at 1466. Furthermore, the researchers calculated the average lifespan of guidelines to be approximately 5.8 years. *Id.*
- 430 Additionally, there is potential for conflict between insurers and health courts. *See* Arnold J. Rosoff, *Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines*, 26 J. HEALTH POL. POLY & L. 327, 333 (illustrating a hypothetical situation in which an HMO requires physicians to follow one set of guidelines while a national organization follows another set of guidelines).
- 431 *See* Woolf et al., *supra* note 427, at 530 (“[C]linicians often find them [practice guidelines] inconvenient and time consuming to use.”); Laxmaiah Manchikanti et al., *The Role of Guidelines in Interventional Pain Medicine: Let Us Separate Apples and Oranges*, 4 PAIN PHYSICIAN 13, 16 (2001) (“[P]hysicians who are expected to use the guidelines but are not familiar with the evidence upon which they are based, are unlikely to follow the guidelines.”).

- 432 Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 681-82 (2001) (summarizing the major studies of physician compliance with clinical practice guidelines).
- 433 *Id.* at 683.
- 434 U.S. AGENCY FOR HEALTHCARE QUALITY & RESEARCH, NATIONAL GUIDELINE CLEARINGHOUSE, DISCLAIMER, available at <http://www.guideline.gov/about/disclaimer.aspx> (last visited Nov. 2, 2006).
- 435 PPI Report, *supra* note 35, at n58.
- 436 Noah, *supra* note 414, at 426 (citation omitted).
- 437 *Id.* at 425-26. See also Cynthia M. Boyd et al., *Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases: Implications for Pay for Performance*, 294 JAMA 716 (2005). In a 2005 study, researchers examined nine clinical practice guidelines for the most common chronic diseases. *Id.* The researchers discovered that only four of the nine clinical practice guidelines addressed additional factors such as age and other comorbidities. *Id.* at 718. In conclusion, the researchers stated that following CPGs may have “undesirable effects” when treating elderly patients with multiple ailments. *Id.* at 716.
- 438 PPI Report, *supra* note 35, at 9.
- 439 *Id.* (citations omitted).
- 440 See Mello, *supra* note 432, at 710.
- 441 The Progressive Policy Institute’s report is typical: “According to studies of medical malpractice in several states, only 2 percent of patients injured by negligent care in a hospital file malpractice claims.” PPI Report, *supra* note 35, at 1 (citations omitted).
- 442 See text accompanying note 63, *supra*.
- 443 Common Good Draft Proposal, *supra* note 61, at 17 (“If the health court overturns the hospital’s decision and makes a finding that the case was clearly compensable, it may impose a financial penalty on the hospital. (A penalty would also be imposed if it came to light that the hospital or its health care providers failed to disclose information known about the injury to the patient/family.)”; Model Act, *supra* note 71, §4-103(e) (If the Medical Injury Court judge finds that the Medical Professional Liability Claim Review Panel made a clear error in the provider’s favor in reviewing the claimant’s claim, or that the health care facility or health care provider failed to disclose information known about the injury to the claimant in accordance with §4-102(c), it shall assess a penalty on the health care facility or health care provider in the amount of \$<some minimum amount>. This amount shall be paid to the Medical Injury Court Fund.”).
- 444 Hyman & Silver, *supra* note 210, at 1113-14 (citations omitted).
- 445 See MO. REV. STAT. § 516.105 (2005), NEV. REV. STAT. § 11.190 (2005), TEX. CIV. PRAC. & REM. § 16.003 (2005) OHIO REV. CODE ANN. § 2305.113 (2003), MINN. STAT. § 541.076 (1999), IND. CODE ANN. § 34-18-7-1 (1998).
- 446 See text accompanying note 166, *supra*.
- 447 Bovbjerg & Tancredi, *supra* note 5, at 489-92 (emphasis added).
- 448 Bovbjerg & Raymond, *supra* note 47, at 19.
- 449 Common Good Draft Proposal, *supra* note 61, at 16.
- 450 Cf. Randall R. Bovbjerg, Laurence R. Tancredi & Daniel S. Gaylin, *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265 JAMA 2836 (1991) (concluding that ACEs would probably cover two-thirds of claims currently paid, based on an obstetrics sample).
- 451 Milbank, *supra* note 108, at 469 (citation omitted).
- 452 Bovbjerg & Raymond, *supra* note 47, at 19.

- 453 Milbank, *supra* note 108 at 474 (“avoidability” is a “less loaded notion” than negligence and “brings with it fewer moral connotations than negligence has; avoidable means suboptimal but not substandard”).
- 454 *Id.*
- 455 See Section VI.A.
- 456 Milbank, *supra* note 108, at 474 (“avoidability” is a “less loaded notion” than negligence and “brings with it fewer moral connotations than negligence has; avoidable means suboptimal but not substandard”).
- 457 *Id.* at 473 (citation omitted).
- 458 *Id.* at 485.
- 459 Bovbjerg & Raymond, *supra* note 47, at 13.
- 460 Milbank, *supra* note 108, at 485-86.
- 461 *Id.* at 475.
- 462 Cf. Milbank, *supra* note 108, at 486 (“Hospitals’ investigations of particular injuries or patterns of injuries reported out of the health court system might generate concerns that would merit a restriction or suspension of a physician’s privileges. Hospitals would retain their current discretion to take such action.”).
- 463 Bovbjerg & Tancredi, *supra* note 5, at 486.
- 464 Tancredi & Bovbjerg 1991, *supra* note 133, at 166.
- 465 Bovbjerg & Tancredi, *supra* note 5, at 493.
- 466 PPI Report, *supra* note 35, at 13.
- 467 Common Good Draft Proposal, *supra* note 61, at 3.
- 468 Tancredi & Bovbjerg 1991, *supra* note 133, at 168.
- 469 *Id.*
- 470 See text accompanying note 402, *supra*.
- 471 Tancredi & Bovbjerg 1992, *supra* note 5, at 190.
- 472 Bovbjerg & Tancredi, *supra* note 5, at 486.
- 473 Tancredi & Bovbjerg 1991, *supra* note 133, at 168.
- 474 Bovbjerg, Tancredi, & Gaylin, *supra* note 450, at 2836.
- 475 See, e.g., *Low v. United States*, 795 F.2d 466 (5th Cir. 1986) (liability for depressed skull fracture following use of forceps); *Garhart v. Columbia/Healthone*, 95 P.3d 571 (Colo. 2004) (liability for injury to brachial plexus following use of forceps).
- 476 See Common Good Draft Proposal, *supra* note 61, at 17 (“The final disposition of the case is recorded by the health court administrative staff and all written decisions in the case stored in health court’s [sic] database”); Model Act, *supra* note 71, §2-104 (calling for establishment of a “searchable electronic database to receive data from the Medical Injury Court relating to claims and decisions”), §4-103(d) (“The Medical Injury Court Board of Qualifications shall develop a standardized reporting form which the Medical Injury Court judge shall employ to report information about such decisions to the <state Department of Health> pursuant to §2-104 of this Act.”).
- 477 PPI Report, *supra* note 35, at 4.
- 478 Catherine T. Struve, *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, Pew Charitable Trusts 70 (2003), available at http://pewtrust.com/pdf/medical_malpractice_101603.pdf (last visited Oct. 29, 2006).
- 479 *Id.*
- 480 PPI Report, *supra* note 35, at 9 (emphasis added).
- 481 See generally FREDERICK SCHAUER, *PLAYING BY THE RULES: A PHILOSOPHICAL EXAMINATION OF RULE-BASED DECISIONMAKING IN LAW AND LIFE* (1991); LARRY ALEXANDER & EMILY SHERWIN, *THE RULE OF RULES: MORALITY, RULES, AND THE DILEMMAS OF LAW* (2001).
- 482 Hyman & Silver, *supra* note 210, at 1130.

- 483 Bovbjerg & Raymond, *supra* note 47, at 3.
- 484 *Scalpel, Scissors, Lawyer*, THE ECONOMIST, Dec. 17-23, 2005, at 32.
- 485 PPI Report, *supra* note 35, at 11.
- 486 Hyman & Silver, *supra* note 210, at 1111.
- 487 BAKER, *supra* note 224, at 66-67.
- 488 *Id.* at 45. Similar explanations, with some additional factors particular to Texas, are given in Bernard Black, Charles Silver, David A. Hyman, & William M. Sage, *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 J. EMPIRICAL LEG. STUD. 207, 253-55 (2005).
- 489 See text accompanying notes 171-172, *supra*.
- 490 See PPI Report, *supra* note 35, at 1; BAKER, *supra* note 224, at 68-70.
- 491 See *supra*, text accompanying note 246.
- 492 This reduction can be crudely modeled using the data for paid claims distributions in Texas between 1988 and 2002 provided in Black et al., *supra* note 488, at 225 tbl.4, augmented with paid claims between \$1 and \$10,000 as indicated there (*id.*, 224-25). If one assumes that a 28-fold increase in paid claimants would be proportionately distributed among the payment range categories below \$250,000 (i.e., no new paid claims over \$250,000) and that mean payments within each payment range would remain constant, then the mean paid claim would go down to about 30% of its actual value under the tort system.
- 493 See Baker, *supra* note 224, at 31-33, 36.
- 494 Milbank, *supra* note 108, at 466.
- 495 The effect would be analogous to a shift from American party-dominated proceedings to continental official-dominated systems, a shift that would entail significant expansion of public spending on the court system as well as reduced spending on private attorneys. See John H. Langbein, *The German Advantage in Civil Procedure*, 52 U. CHI. L. REV. 823 (1985); John C. Reitz, *Why We Probably Cannot Adopt the German Advantage in Civil Procedure*, 75 IOWA L. REV. 987 (1990).
- 496 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, 240 (2001) (footnote omitted).
- 497 See David M. Studdert et al., *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1 (1997).
- 498 PPI Report, *supra* note 13, at 10 ("A robust administrative level of service will be essential to ensure that a health court system delivers speedy, affordable justice.").
- 499 Milbank, *supra* note 108, at 470 (citations omitted).
- 500 REPUBLICAN POLICY COMMITTEE, *supra* note 46, at 9.
- 501 In the following discussion, we set aside questions of social savings and costs in the form of potentially reduced defensive medicine and reduced deterrence for malpractice. As discussed elsewhere, the relative sizes of these impacts are hard to determine and, in any event, only indirectly affect the direct system costs that determine premium rates.
- 502 See PPI Report, *supra* note 35, at 7.
- 503 See notes 340-342 and accompanying text. The calculation is as follows. Let C = total direct system costs; T = transaction costs (administrative overhead); $N = C + T$ = net recoveries by claimants. Under the tort system, $T = .5C = N$, approximately. Now reduce transaction costs from T to T' , and let C' = new total direct system costs in which transaction costs are only $T' = .25C'$, but $N' = C' + T' = N$, that is, net recovery is held constant. Notice that $T'/N = T'/N' = 1/3$. Then $C'/C = (T' + N')/(T + N) = (N/3 + N)/(2N) = 2/3$. Or, $C' = .67C$. The present assumption that health courts would consume 25% of total system costs (i.e., $T' = .25C'$) seems to be comparable to, but more optimistic than, what even health court proponents have assumed. See Studdert et al., *supra* note 497, at 30-31 (taking 30% overhead costs to be a good estimate).

- 504 See text accompanying notes 171-172, *supra*.
- 505 Common Good Draft Proposal, *supra* note 61, at 11.
- 506 The debate over the collateral source rule continues in the states. For useful contemporary analyses, see Joel K. Jacobsen, *The Collateral Source Rule and the Role of the Jury*, 70 OR. L. REV. 523 (1991) (endorsing the view that the collateral source rule should be retained, as a rule of damages, to the extent that it protects a person's contractually obtained insurance benefit, but not as a rule of evidence); Christian D. Slain, *Preserving the Collateral Source Rule: Modern Theories of Tort Law and a Proposal for Practical Application*, 47 CASE. W. RES. L. REV. 1075 (1997) (arguing that the deterrence benefits of the collateral source rule, together with other considerations, argue in favor of retaining the rule but adopting measures to facilitate subrogation claims).
- 507 Common Good Draft Proposal, *supra* note 61, at 11.
- 508 See *infra*, notes 648-649 and accompanying text.
- 509 See Mello, *supra* note 12, at 9-10.
- 510 Common Good Draft Proposal, *supra* note 61, at 10.
- 511 See Vidmar, *supra* note 249, at 322 (describing the Milliman Report, commissioned by the Florida Hospital Association), 326-27 (raising questions about the reliability of the 75% figure). A more reliable and recent study of closed claim files from Texas puts noneconomic damages at 47% of total damages awarded by jury verdict for cases with payouts exceeding \$25,000. See Hyman, et al., *supra* note 262, at 18 tbl. 5.
- 512 See Studdert et al., *supra* note 497, at 18-34.
- 513 The figures stated in the text are based on consolidating the data for Utah and Colorado that appear in the published study. *Id.* at 28 tbl.3. From that table, one can calculate that, if an 8-week deductible were applied, together with the elimination of all "pain and suffering" damages, but not eliminating lost household production recoveries, then the total payouts under the hypothesized Swedish-style "avoidability" standard would be \$107 million. The authors compared the figures in Table 3 to total malpractice premiums paid in the two states, although the figures for the latter are not adequately explained. *Id.* at 31. (The latter appear to be figures for some later year deflated to 1992 dollars.) In any event, total hypothesized payouts cannot be usefully compared to total malpractice premiums paid until one adjusts for insurers' overhead and profit (about 20% of premiums) as well as defense costs (about 24% of premiums), neither of which come out of paid claims. (See Section V.H.) With these adjustments, aggregate 1992 payouts for Utah and Colorado under the tort system would be about \$99 million, 8 percent less than the hypothesized figure of \$107 million for the Swedish-style compensation system. (It should also be noted that the hypothetical calculations presented in the cited article are built on a number of simplifying assumptions, including in particular: (1) that all persons with a legitimate claim would file and be compensated, an assumption that exaggerates health court system costs and is so noted by the authors (*id.* at 23-24); and (2) that no persons without a legitimate claim would file or be compensated, an assumption that understates the health court system costs but is not noted by the authors.)
- 514 See, e.g., PPI Report, *supra* note 35, at 3 ("The system would be similar to the one that handles workers' compensation claims.").
- 515 Bovbjerg & Tancredi, *supra* note 5, at 483 (citing National Childhood Vaccine Injury Act of 1986 as existing version of compensation by administrative agency).
- 516 *Id.* at 484.
- 517 Press Release, Harvard School of Public Health, No-Fault Compensation for Medical Injury Proposed as Incentive for Reporting and Correcting Hospital Error, Improving Patient Safety (July 10, 2001), available at <http://www.hsph.harvard.edu/press/releases/press07102001.html> (last visited Nov. 19, 2006).

- 518 PPI Report, *supra* note 35, at 7.
- 519 Danzon, *supra* note 337, at 1379.
- 520 Martha T. McCluskey, *Efficiency and Social Citizenship: Challenging the Neoliberal Attack on the Welfare State*, 78 IND. L.J. 783, 864 (2003), describing MICHAEL J. GRAETZ & JERRY L. MASHAW, TRUE SECURITY: RETHINKING AMERICAN SOCIAL INSURANCE 83-85 (1999).
- 521 Joan T.A. Gabel, *Escalating Inefficiency in Workers' Compensation Systems: Is Federal Reform the Answer?*, 34 WAKE FOREST L. REV. 1083, 1089 (1999) (citations omitted).
- 522 Martha T. McCluskey, *The Illusion of Efficiency in Workers' Compensation "Reform,"* 50 RUTGERS L. REV. 657, 681 (1998) (citations omitted).
- 523 *Id.* at 845 (citations omitted).
- 524 Bovbjerg & Tancredi, *supra* note 5, at 484.
- 525 42 USCS § 300aa-21.
- 526 Gilmour, *supra* note 317, at 198.
- 527 ALLIANCE FOR JUSTICE, HEALTH COURTS UNDER A MICROSCOPE 7 (March 2006).
- 528 Milbank, *supra* note 108, at 468 ("Many features of the health court's design suggest that it would be not only procedurally fair but also more likely to result in a favorable outcome for an injured patient than the present system.").
- 529 Hyman & Silver, *supra* note 210, at 1112.
- 530 Struve, *supra* note 478, at 73 (citation omitted).
- 531 See Howard, *supra* note 32.
- 532 Struve, *supra* note 478, at 74 (citation omitted).
- 533 PPI Report, *supra* note 35, at 9.
- 534 Model Act, *supra* note 71, at Appendix 1, § __-102(b).
- 535 Lockwood, *supra* note 70.
- 536 Tancredi & Bovbjerg, *supra* note 5, at 185.
- 537 The American Association of Neurological Surgeons has been operating a procedure for peer review of expert testimony since 1983. DAVID H. KAYE, DAVID E. BERNSTEIN & JENNIFER MNOOKIN, THE NEW WIGNORE: A TREATISE ON EVIDENCE: EXPERT EVIDENCE § 10.4.2, at 359 (2004). "Of the various complaints heard by the association of neurologists over the past 20 years, all but one have involved expert testimony given on plaintiff's behalf." *Id.* at 361. See *Austin v. Am. Ass'n of Neurological Surgs.*, 253 F.3d 967 (7th Cir. 2001) (affirming trial court's summary judgment motion against disciplined expert witness who challenged the peer review system as against public policy; explaining away the data as possibly the result of the willingness of disgruntled defendant doctors to file complaints).
- 538 *Id.* at 192 (emphasis added).
- 539 Bovbjerg & Tancredi, *supra* note 5, at 490 (emphasis added).
- 540 Havighurst & Tancredi, *supra* note 1, at 137-38.
- 541 See text accompanying note 63, *supra*.
- 542 As one of the present authors has written, "[i]n order to be a true proponent of patient interests, an advocate must be able to employ all lawful means of patient protection. This means that they can answer correctly the following four questions: 1) Who is your boss? 2) Is it within the scope of your employment to recommend to patients in appropriate circumstances that they hire attorneys and sue their physicians or hospitals? 3) After you make such a recommendation to a patient, do you feel comfortable informing your employer that you have done so? 4) After you inform your employer, does the employer say: 'Well done!?' Only if the respondent can answer the first question 'the patient,' and not 'the hospital' or 'the managed care organization,' and then answer 'yes' to the remaining three questions would she qualify as a real advocate for patients." Maxwell J. Mehlman, *Medical Advocates: A Call for a New Profession*, 1 WIDENER L. SYMP. J. 299, 320 (1996). It should be added that the advocate also would keep her job.

- 543 Erin Ann O’Hara & Douglas Yarn, *Note & Comment: On Apology and Consilience*, 77 WASH. L. REV. 1121, 1186 (2002).
- 544 Erin Ann O’Hara, *Apology and Thick Trust: What Spouse Abusers and Negligent Doctors Might Have In Common*, 79 CHI.-KENT L. REV. 1055, 1076-77 (2004) (citation omitted).
- 545 *Id.* at 1077.
- 546 O’Hara & Yarn, *supra* note 543, at 1187.
- 547 Common Good Draft Proposal, *supra* note 61, at 8.
- 548 PHYSICIAN INSURERS ASSOCIATION OF AMERICA, ONLINE MEMBERSHIP DIRECTORY & PROFESSIONAL SERVICES SECTION, at <http://www.piaa.us/directory/public/details.asp?cid=108&st=member&mt=primary&loc=usa&sid=> (last visited Nov. 9, 2006).
- 549 *A Success Story*, COPIC’S 3RS [SIC] PROGRAM NEWSL., Mar. 2004, at 2.
- 550 *Id.* at 4. The Milbank article innocently refers to this as “communication training.” Milbank, *supra* note 108, at 462.
- 551 Personal communication from Lee Albert, May 3, 2006.
- 552 Gail Weiss, *Should You Apologize?*, 83 MED. ECON. 50 (Apr. 21, 2006).
- 553 COPIC, FREQUENTLY ASKED QUESTIONS, at <http://www.callcopic.com/customer-service/frequently-asked-questions/#3rs> (last visited Nov. 9, 2006).
- 554 COPIC, *supra* note, 549 at 2 (“Payments are not reportable to the Colorado Board of Medical Examiners because patients are not required to sign a waiver of their right to sue. Similarly, payments are not reported to the National Practitioner Data Bank because they are not made in response to a written demand for monetary compensation.”).
- 555 *Id.* at 1.
- 556 SORRY WORKS! COALITION, EXECUTIVE SUMMARY, at <http://www.sorryworks.net/WhatIs.phtml> (last visited Nov. 3, 2006).
- 557 Bovbjerg & Tancredi, *supra* note 5, at 490.
- 558 Dep’t of Veterans Affairs, Disclosure of Adverse Events to Patients, VHA Directive 2005-049 (Oct. 27, 2005), available at http://www.va.gov/ETHICS/docs/policy/VHA_Directive_2005-049_20051027_Disclosing_Adv_Events.pdf (last visited July 19, 2006).
- 559 Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANN. INT. MED. 963, 966-967 (1999).
- 560 Milbank, *supra* note 108, at 470.
- 561 See Model Act, *supra* note 71, §5-104(b)(1).
- 562 COPIC, *supra* note 553.
- 563 See, e.g., Studdert et al., *supra* note 497, at 26-27 (reporting lost household production in Utah and Colorado in 1992 valued at nearly twice the gross wage losses).
- 564 See *id.* at 28 tbl.3, 30.
- 565 Bovbjerg, Tancredi & Gaylin, *supra* note 450, at 2842.
- 566 *Id.*
- 567 Common Good Draft Proposal, *supra* note 61, at 11.
- 568 *Id.*
- 569 Karen E. Jenni & George Loewenstein, *Explaining the “Identifiable Victim Effect”*, 14 J. RISK & UNCERTAINTY 235, 236 (1997).
- 570 See, e.g., ROBERT COOTER & THOMAS ULEN, LAW AND ECONOMICS 167 (4th ed. 2004).
- 571 See text accompanying notes 114-118, *supra*.
- 572 See 8 LARSEN’S WORKERS COMPENSATION LAW § 133.01 (2004).
- 573 Bovbjerg, Tancredi, & Gaylin, *supra* note 450, at 2842.
- 574 See, e.g., Vidmar et al., *supra* note 249, at 329-31; Studdert et al., *supra* note 212, at 2027.
- 575 That is, if 6% represents the inflation adjusted market interest rate on an investment, any given individual might value spending his money more than investing it at 6% for subsequent consumption.

- 576 See PROSSER AND KEETON ON THE LAW OF TORTS ch. 25 (W.P. Keeton gen. ed., 5th ed. 1984/2004).
- 577 Obtaining data on relatively small case settlements is difficult. One study of closed claim files in Texas shows that 22.8% of all paid claims between 1995 and 2002 involved payments less than or equal to \$10,000 (in 1988 dollars), and that 33.7% of all paid claims in this period involved payments less than or equal to \$25,000 (in 1988 dollars). Black et al., *supra* note 488, at 246 (calculations based on Table 13). *Cf. id.* at 227 tbl.5 (from which these figures can be calculated as 24.4% and 36%, respectively). The authors do note a decline in small payment claims over time (*id.* at 233-34), but even as late as 2002, 18% of paid claims were less than or equal to \$10,000 and 27.4% of paid claims were less than or equal to \$25,000 (again, in 1988 dollars). *Id.* at 246 (calculations based on Table 13).
- 578 Consider the following analogy: a law prohibiting anyone with an annual income below \$25,000 from purchasing a car costing over \$100,000. It may be true that few individuals with such low incomes would be able to purchase cars at such prices. But in a free society, there is a big difference between discovering that the market for cars places certain cars out of one's reach and discovering that the state's public policy is not to allow one to make such a purchase.
- 579 See text accompanying notes 380-389, *supra*.
- 580 See Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137 (2006).
- 581 *Strauss v. Biggs*, 525 A.2d 992, 1000 (Del. 1987).
- 582 *Id.* at 998.
- 583 33 Cal. Rptr. 2d 6, 7 (Cal. Ct. App. 1994).
- 584 *Id.* at 9.
- 585 No. 87C-SE-171-1-CV, 1989 Del. Super. LEXIS 51, at **1-2 (Del. Sup. Ct. Feb. 2, 1989). The financial incentives were fee-withhold arrangements in which a portion of the physician's fees would be returned depending on the referral practices of all of the physicians in the managed care network. *Id.* at (4). The court upheld the trial court's refusal to award punitive damages because the patient's own expert refused to attribute her physician's behavior to financial motives, because there was no evidence that the managed care plan had advised the physician that he was making too many referrals, and because the plaintiff did not show that the physician had failed to make other necessary referrals in the past. *Id.* at **11-12, **14-15.
- 586 *Menaugh v. Resler Optometry Inc.*, No. 56297, 1990 Mo. App. LEXIS 405, at **1-2 (Mo. Ct. App. 1990).
- 587 David Rosenzweig, *Fraud Case Filed Against Doctor: Operator of Clinics in L.A. and Orange Counties Is Accused of Improperly Treating AIDS Patients, Bilking Insurers and Medicare*, L.A. TIMES, July 21, 2005 at B1. The indictment charged the doctor with cheating Medicare and insurance companies out of \$1.2 million in this way between 1995 and 2001.
- 588 569 F.2d 1221, 1222-24 (3d Cir. 1977).
- 589 See Lockwood, *supra* note 70, at 2 ("Compensation would be uniform, fair, and codified. For example, all victims of cerebral palsy as a result of medical negligence would be paid on a sliding scale, according to severity").
- 590 Havighurst & Tancredi, *supra* note 1, at 134-35.
- 591 Common Good Draft Proposal, *supra* note 61, at 7.
- 592 See RESTATEMENT (SECOND) TORTS § 8A, cmt. B (1965) ("As the probability that the consequences will follow decreases, and becomes less than substantial certainty, the actor's conduct loses the character of intent, and becomes mere recklessness").
- 593 Bovbjerg & Tancredi, *supra* note 5, at 492.
- 594 *Id.* at 493.

- 595 Milbank, *supra* note 108, at 484 (“This history raises the question of whether a health court should follow a similar approach, making information on paid claims available to licensure and disciplinary authorities. In addition, should such information be reported to the state department of public health, particularly if it involves hospital care? Should it be reported to medical specialty boards? Finally, should paid claims in a health court trigger a report to the NPDB? The experience of other countries suggests that the answers to these questions should generally be no.”).
- 596 Common Good Draft Proposal, *supra* note 61, at 14.
- 597 Milbank, *supra* note 108, at 486.
- 598 Tancredi & Bovbjerg 1992, *supra* note 5, at 198.
- 599 See text accompanying note 588, *supra*.
- 600 Bovbjerg, Tancredi, & Gaylin, *supra* note 450, at 2837.
- 601 Common Good Draft Proposal, *supra* note 61, at 6.
- 602 *Id.*
- 603 Model Act, *supra* note 71, §2-103(a)(3).
- 604 See, e.g., Bryan Lee, *Recent Developments in Health Law: American Journal of Law & Medicine and Harvard Law & Health Care Society: Managed Care: Health Providers’ Bill of Rights Now Law in California*, 31 J.L. MED. & ETHICS 157 (2003) (“... a recent survey by the University of California-San Francisco found that only 58 percent of California doctors are accepting new HMO patients, meaning that some privately insured patients are struggling to find physicians. If plans cannot compel the addition of new patients, insured consumers may not have significant physician choice”) (citation omitted); Robin Toner, *Harry and Louise Were Right, Sort Of*, N.Y. TIMES, Nov. 24, 1996, at D1 (finding that among mid-size employers 52% now offer their workers only one plan).
- 605 See text accompanying notes 516, 524, *supra*.
- 606 Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CINN. L. REV. 53, 100 (1998) (“The vast majority of physicians delivering babies participate in the programs, over ninety percent.”).
- 607 See Studdert et al., *supra* note 497, at 6.
- 608 46 C.F.R. §46.101(a) (2006).
- 609 T.D. et al. v. New York State Office of Mental Health, 626 N.Y.S.2d 1015, 1023 (Sup. Ct. 1995) (“... all Federally funded research is subject to the Federal regulations promulgated by the United States Department of Health and Human Services (HHS) for the protection of human subjects (see, 45 CFR part 46, subpart A—Basic Policy for Protection of Human Research Subjects)”). HHS regulations define “research” to mean “a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.” 45 C.F.R. §46.102(d) (2006). The regulations include an exception for “[r]esearch and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine [p]ublic benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.” 45 C.F.R. §46.101(b)(5)(2006). But this exception, which has been applied to welfare program experiments (see, e.g., C.K. v. New Jersey Dep’t of Health and Human Services, 92 F3d 171, 189 (3d Cir. 1996)), would not apply to a health court demonstration project since health courts are not a public benefit or service program.
- 610 45 C.F.R. §116 (2006).

- 611 *Id.*
- 612 *Id.* at §116(a)(8).
- 613 Alexander Morgan Capron, *Social Experimentation and the Law*, in ETHICAL AND LEGAL ISSUES OF SOCIAL EXPERIMENTATION 127, 143 (Alice M. Rivlin & P. Michael Timpane eds., 1975).
- 614 Edward M. Gramlich & Larry L. Orr, *The Ethics of Social Experimentation*, in ETHICAL AND LEGAL ISSUES OF SOCIAL EXPERIMENTATION 105-06 (Alice M. Rivlin & P. Michael Timpane eds., 1975).
- 615 *Id.* at 106.
- 616 AM. BAR ASS'N HOUSE OF DELEGATES, RECOMMENDATION 103 (Feb. 13, 2006), available at http://www.abanet.org/leadership/2006/midyear/daily_journal/103.doc (last visited Nov. 5, 2006).
- 617 Wall St. J. Online & Harris Interactive Res., *National Survey Shows that More than Half of Adults Americans Support Medical Malpractice Reform*, WALL ST. J. ONLINE, Mar. 6, 2003, available at http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2003vol2_iss2.pdf (last visited Nov. 1, 2006).
- 618 *Id.* at 2-3.
- 619 Hyman & Silver, *supra* note 210, at 1122 (citations omitted).
- 620 JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS, HOSPITAL ACCREDITATION STANDARDS (2004).
- 621 Am. Med. Ass'n, Council on Ethical & Judicial Affairs, Code of Medical Ethics Opinion E-8.12, available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-8.12.HTM&rs_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-7.05.HTM&nxt_pol=policyfiles/HnE/E-8.01.HTM (last visited Nov. 3, 2006).
- 622 See text at notes 558-559, *supra*.
- 623 Kramen & Hamm, *supra* note 559, at 965-66.
- 624 See, e.g., FED. R. EVID. 409. (Similar rules exist in all states).
- 625 See, e.g., FED. R. EVID. 408. (Similar rules exist in all states).
- 626 ARIZ. REV. STAT. § 12-2605 (2005), COLO. REV. STAT. § 13-25-135 (2003), CONN. GEN. STAT. § 52-184D (2005), DEL. CODE ANN. tit. 10, § 4318 (2006), GA. CODE ANN. § 24-3-37.1 (2005), 735 ILL. COMP. STAT. 5/8-1901 (2005), LA. REV. STAT. ANN. § 13:3715.5 (2005), ME. REV. STAT. ANN. TIT 24, § 2908 (2005), MD. CODE ANN., CTS. & JUD. PROC. § 10-920 (2004), OHIO REV. CODE ANN. § 2317.43 (2004), OKLA. STAT. TIT. 63, § 1-1708.1H (2004), UTAH CODE ANN. § 78-14-18 (2006), WYO. STAT. ANN. § 1-1-130 (2004). To be sure, none of these rules cloaks the underlying error; that is, if a provider admits taking a certain action, the patient would be able to admit evidence, other than the provider's unsworn acknowledgment, that such an action was taken. This limit is necessary to prevent health care providers avoiding all liability by simply informing patients of their negligence.
- 627 See, e.g., R. Penchansky & C. Macnee, *Initiation of Medical Malpractice Suits: A Conceptualization And Test*, 32 MED. CARE 813 (1994).
- 628 See Maria R. Lamari, *The Role of Alternative Dispute Resolution in Government Construction Contract Disputes*, 23 HOFSTRA L. REV. 205, 216 (1994). See also Charles Silver, *Does Civil Justice Cost Too Much?*, 80 TEX. L. REV. 2073, 2107-12 (2002), COMM. FOR ECONOMIC DEV., BREAKING THE LITIGATION HABIT: ECONOMIC INCENTIVES FOR LEGAL REFORM 17-19 (2000).
- 629 Hyman & Silver, *supra* note 210, at 1123.
- 630 AM. BAR ASS'N HOUSE OF DELEGATES, RECOMMENDATION, *supra* note 616.
- 631 See, e.g., PPI Report, *supra* note 35, at 5 (under health court system, malpractice insurers "would more frequently pay limited compensation for injuries that receive nothing today").

- 632 UK Department of Health, NHS Redress: Statement of Policy (<http://www.dh.gov.uk/assetRoot/04/12/32/82/04123282.pdf>) (last visited Nov. 9, 2006).
- 633 See, e.g., Dale A. Nance, *Rules, Standards, and the Internal Point of View*, 75 *FORDHAM L. REV.* 1287 (2006).
- 634 REPUBLICAN POLICY COMMITTEE, *supra* note 46, at 4.
- 635 See Bovbjerg et al. *supra* note 30, at 924.
- 636 See, e.g., PROSSER AND KEETON ON TORTS § 36 (5th ed. 1984).
- 637 For an extensive, if not definitive, discussion of some of these issues, see Mello, *supra* note 432 (arguing that clinical practice guidelines should be admissible by either party but only through expert testimony that uses them to corroborate the customary standard of practice as applied to the particular case).
- 638 See PROSSER & KEETON ON TORTS, *supra* note 636, §§ 39, 40.
- 639 See, e.g., CHARLES H. WHITEBREAD & CHRISTOPHER SLOBOGIN, *CRIMINAL PROCEDURE* 668 (4th ed. 2000).
- 640 See Sections VI.B and VI.C.
- 641 See Maxwell J. Mehlman, *Bad "Bad Baby" Bills*, 20 *AM. J.L. & ETHICS* 129, 143-44 (1994) (discussing potential use of practice guidelines); Maxwell J. Mehlman, *Assuring the Quality of Medical Care: The Impact of Outcome Measurement and Practice Standards*, 18 *L. MED. & HEALTH CARE* 368 (1990).
- 642 Common Good Draft Proposal, *supra* note 61, at 10.
- 643 See, e.g., Danzon, *supra* note 337, at 1374.
- 644 *Id.* See, e.g., ALA. CODE § 6-5-543 (2005), ALASKA STAT. §§ 09.17.040 (1986), 09.55.548(a) (1976), CAL. CIV. CODE § 667.7 (1975), C.R.S. 13-64-204 (2001), GA. CODE ANN. § 51-13-1 (2005), 735 ILL. COMP. STAT. 5/2-1705 (2005), MONT. CODE ANN. § 25-9-403 (1987), N.M. STAT. ANN. § 41-5-7(D) (1978), OHIO REV. CODE ANN. § 2323.55 (2003), WASH. REV. CODE ANN. § 4.56.260 (1986).
- 645 Compare, e.g., ALASKA STAT. §§ 09.17.040 (1986), 09.55.548(a) (1976) (providing for inheritable periodic payments in lieu of lump sum payments), with MICH. COMP. LAWS ANN. § 600.6307 (providing for defendant's purchase of annuity for the benefit of plaintiff, the benefits of which presumably cease at plaintiff's death), and N.M. STAT. ANN. § 41-5-7(D) (1978) (providing for an award of periodic payments of future medical expenses to be determined by supplemental proceeding as they accrue, which payments presumably cease at death).
- 646 Accounting problems related to time-discounts for future losses have caused serious constitutional issues, as have problems associated with the provision of adequate security for future payment, and problems of inequity in treating malpractice cases differently from other tort cases. See, e.g., *Smith v. Myers*, 887 P.2d 541 (Ariz. 1994); *Carson v. Maurer*, 424 A.2d 825, 838 (N.H. 1980); *Galayda v. Lake Hosp. Sys., Inc.*, 644 N.E.2d 298, 301-02 (Ohio 1994).
- 647 Common Good Draft Proposal, *supra* note 61, at 11.
- 648 ALA. CODE § 6-5-545 (2005), ALASKA STAT. § 09.55.548 (1976), ARIZ. REV. STAT. § 12-565 (1984), CAL. CIV. CODE § 3333.1 (1975), DEL. CODE ANN. tit. 18, § 6862 (1998), IND. CODE ANN. § 34-44-1-2 (1998), IOWA ADMIN. CODE § 668.14 (1987), ME. REV. STAT. ANN. tit. 24, § 2906 (1989), MASS. GEN. LAWS ANN. ch. 231, § 60G (1986), MICH. COMP. LAWS § 600.6303 (1961), N.Y. C.P.L.R. § 4545 (1984), OHIO REV. CODE ANN. § 2315.20 (2005), PA. STAT. ANN. tit. 40, § 1303.508 (2002), R.I. GEN. LAWS § 9-19-34.1 (1986), TENN. CODE ANN. § 29-26-119 (1979), UTAH CODE ANN. § 78-14-4.5 (1985), WASH. REV. CODE § 7.70.080 (2005), WIS. STAT. § 893.55 (1979).
- 649 COLO. REV. STAT. § 13-21-111.6 (1986), CONN. GEN. STAT. § 52-225a (1986), FLA. STAT. ch. 768.76 (1986), IDAHO CODE § 6-1606 (1990), ILL. COMP. STAT. 5/2-1205 (1984), MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-06 (1976), MINN. STAT.

- §548.36 (1986), MONT. CODE ANN. §27-1-308 (1987), N.J. REV. STAT. § 2A:15-97 (1986), N.D. CENT. CODE §32-03.2-06 (1987), OKLA. STAT. tit. 21, § 142.10 (1981), W. VA. CODE §55-7B-9a (2003).
- 650 One analysis addressing this question, albeit incompletely, is: Joel K. Jacobsen, *The Collateral Source Rule and the Role of the Jury*, 70 OR. L. REV. 523 (1991).
- 651 The collateral source rule is a substantive rule of the measure of damages with evidentiary implications, not simply a rule of evidence, and constitutional problems here often concern statutes that attempt to repeal the collateral source rule by changing the rules of admissibility without changing the substantive rule, leaving the jury with no intelligible rule to follow with regard to the collateral payments that are evidenced. *See, e.g.*, Denton v. Con-Way S. Express Inc., 402 S.E.2d 269 (Ga. 1991); O'Bryan v. Hedgespeth, 892 S.W.2d 571 (Ky. 1995). Also of constitutional concern is treating malpractice cases differently than other tort cases. *See, e.g.*, Carson v. Maurer, 424 A.2d 825, 835-36 (N.H. 1980) (holding a collateral source offset provision unconstitutional under state law).
- 652 PPI Report, *supra* note 35, at 10.
- 653 Evidence on this point is mixed. A study of claims in Florida between 1990 and 2003, for example, found no evidence of escalating defense litigation expenses (attorneys' fees and expert fees). *See* Vidmar et al., *supra* note 249, at 350-52. A study of Texas closed claim files over a roughly similar period found defense litigation expenses per large paid claim rose between 4.2% and 4.5% per year in real terms. Black et al., *supra* note 488, at 241-46.
- 654 *See, e.g.*, Anthony Champagne, Daniel Shuman & Elizabeth Whitaker, An Empirical Examination of the Use of Expert Witnesses in American Courts, 31 JURIMETRICS J. 375 (1991); Daniel W. Shuman, Elizabeth Whitaker & Anthony Champagne, *An Empirical Examination of the Use of Expert Witnesses in the Courts - Part II: A Three City Study*, 34 JURIMETRICS J. 193 (1994). While these studies were not limited to malpractice cases, the authors still usefully conclude:
- [E]xpert testimony is not dominated by a cadre of highly paid professional expert witnesses who offer their services to the highest bidder. Our surveys find little use of advertisements, little evidence of disproportionate fees for testifying, and no large percentage of expert witnesses who learn most of their income from testifying. Indeed, most experts are paid about what one would expect, given their expertise and the demands of testifying.
- Id.* at 206.
- 655 PPI Report, *supra* note 35, at 9.
- 656 *Id.*
- 657 The state of our knowledge on this question is represented by the following comment: "While the vast majority of experts no doubt testify only when their genuinely held opinions comport with the side who has hired them, it is not far-fetched to believe that some experts will indeed say anything for the right price." KAYE, BERNSTEIN & MNOOKIN, *supra* note 537, § 10.3.1, at 341.
- 658 Consider an analogy not involving experts. Suppose a simple car accident case comes to trial, in which the plaintiff is supported by his testimony and the defendant is supported by her testimony. One need not believe that the jury is incompetent to decide, based on such conflicting testimony, whether the light at the intersection was red in order to agree that the jury could benefit from additional evidence like the testimony of a bystander who observed the collision, even if the bystander has some kind of bias, which could be explored during testimony, regarding car accidents in general. On the exaggerated role of jury distrust as a theory of evidence rules as well as the need to be alert to the value of evidence the parties may not present without judicial intervention, *see* Dale A. Nance, *The Best Evidence Principle*, 73 IOWA L. REV. 227 (1988).

- 659 It is important, in other words, not to reject the extreme view that all party-retained experts are charlatans, or at least unhelpful, only to embrace the opposite extreme view that court-appointed experts offer nothing additional because perfect neutrality and objectivity from experts is impossible. This rejection of Scylla for the sake of Charybdis is not uncommon in the literature on experts. See, e.g., Ned Miltenberg, *Myths About "Neutral" Scientific Experts*, 36:1 TRIAL 62 (Jan. 2000).
- 660 See Joe S. Cecil & Thomas E. Willging, *Accepting Daubert's Invitation: Defining A Role for Court-Appointed Experts in Assessing Scientific Validity*, 43 EMORY L.J. 995, 1006 (1994).
- 661 See, e.g., FED. R. EVID. 403, 611(a).
- 662 Being entitled to select experts does not necessarily entail that the parties should be able to engage in ex parte one-sided preparation of the expert. Procedures could be developed to avoid the untoward consequences of treating expert witnesses as if they are an agent of the party, even when the expert is selected by the party. See, e.g., Samuel R. Gross, *Expert Evidence*, 1991 WIS. L. REV. 1113, 1221-26.
- 663 See text accompanying notes 99-118, *supra*.
- 664 See KAYE, BERNSTEIN & MNOOKIN, *supra* note 537, § 10.4.1, at 347-48. A survey of state and federal trial judges, conducted in 1987, found that very substantial majorities favored the use of independent experts in cases involving technical or scientific issues, such as medical malpractice. *Judges' Opinions on Procedural Issues: A Survey of State and Federal Trial Judges Who Spend at Least Half of Their Time on General Civil Cases*, 69 B.U. L. REV. 731, 741 (1989).
- 665 See KAYE, BERNSTEIN & MNOOKIN, *supra* note 537, § 10.4.1, at 351.
- 666 See, e.g., *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 595 (1993); *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 149-50 (1997) (J. Breyer, concurring).
- 667 See, e.g., *Keyes v. Humana Hosp. Alaska, Inc.*, 750 P.2d 343 (Alaska 1988) (sustaining constitutionality of statute encouraging trial courts to appoint three-person expert advisory panel that presents a report admissible at trial and whose members are subject to cross-examination at trial).
- 668 *Court Appointed Scientific Experts: A Demonstration Project of the AAAS*, at <http://www.aaas.org/spp/case/case.htm> (last visited Sept. 23, 2006).
- 669 See Gross, *supra* note 662, at 1227-30.
- 670 See KAYE, BERNSTEIN & MNOOKIN, *supra* note 537, at 351.
- 671 In order to encourage voluntary reporting of errors, in 2005, Congress enacted the Patient Safety and Quality Improvement Act, Pub. L. No. 109-41, 119 Stat. 424 (2005), which authorizes the creation of a system of patient safety organizations. Reports of medical errors can be sent to these organizations, and will be kept confidential so that they cannot be used against the reporter in malpractice litigation. Hyman and Silver criticize the plan because it is not going to be adequately funded and because health care professionals have no significant incentive to make reports. See Hyman & Silver, *supra* note 211, at 988.
- 672 See, e.g., Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Practice for Malpractice Reform*, 80 TEX. L. REV. 1595, 1633 (2002).
- 673 Press Release, Institute for Healthcare Improvements, IHI Announces that Hospitals Participating in 100,000 Lives Campaign Have Saved an Estimated 122,300 Lives (June 14, 2006), available at <http://www.ihl.org/NR/rdonlyres/1C51BADE-0F7B-4932-A8C3-0FEFB654D747/0/UPDATED100kLivesCampaignJune14milestonepressrelease.pdf> (last visited Nov. 8, 2006) [hereinafter IHI Press Release].
- 674 *Id.*
- 675 *Id.*
- 676 INST. FOR HEALTHCARE IMPROVEMENTS, 100,000 LIVES CAMPAIGN - LIVES SAVED FAQs, at <http://www.ihl.org/NR/rdonlyres/0FC36040-53FB-4B06-A95E-7E2D5055A154/0/LivesSavedCalculationFAQ.doc> (last visited Nov. 8, 2006).

- 677 IHI Press Release, *supra* note 673.
- 678 *Id.*
- 679 *Id.*
- 680 *Id.*
- 681 Milbank, *supra* note 108, at 487.
- 682 Paul Mogin, *Why Judges, Not Juries, Should Set Punitive Damages*, 65 U. CHI. L. REV. 179, n.14 (1998).
- 683 Sorrell v. Thevenir, 633 N.E.2d 504, 510 (Ohio 1994) (citations omitted).
- 684 Jeanne v. Hawkes Hosp. of Mt. Carmel, 598 N.E.2d 1174, 1180 (Ohio Ct. App. 1991).
- 685 Etheridge v. Med. Ctr. Hosps., 376 S.E.2d 525, 529 (Va. 1989) (emphasis in original).
- 686 Johnson v. St. Vincent Hosp., 404 N.E.2d 585, 592 (Ind. 1980).
- 687 *Salem College & Academy, Inc. v. Employment Div.*, 695 P.2d 25, 30 (Or. 1985).
- 688 North Carolina ex rel. Morrow v. Califano, 445 F. Supp. 532, 535 (E.D.N.C. 1977), *aff'd mem.* 435 U.S. 962 (1978).
- 689 U.S. CONST. amend. VII.
- 690 Granfinanciera, S.A. v. Nordberg, 492 U.S. 33, 51 (1989), *citing* Atlas Roofing Co. v. Occupational Safety & Health Review Comm'n, 430 U.S. 442, 458 (1977).
- 691 Granfinanciera, S.A. v. Nordberg, 492 U.S. at 51-52.
- 692 *See* text accompanying notes 50-52, *supra*.
- 693 Cupp v. Commissioner, 65 T.C. 68, 86 (1975).
- 694 *See, e.g.,* Winans v. Adam, 56 U.S. 330, 338 (1854) (in patent infringement action, the question of whether the defendant constructed, used, or sold the patented thing "is a question of fact, to be submitted to a jury").
- 695 *See* Granfinanciera S.A. v. Nordberg, 492 U.S. 33 (1989) (right to jury trial in bankruptcy proceedings).
- 696 Carson v. Maurer, 424 A.2d 825, 830-31 (N.H. 1980). *Accord*, Brannigan v. Usitalo, 587 A.2d 1232, 1234 (N.H. 1991).
- 697 Sorrell v. Thevenir, 633 N.E.2d at 511. *Accord*, State ex rel. Ohio Academy of Trial Lawyers v. Sheward, 715 N.E.2d 1062, 1091 (1999).
- 698 *See, e.g.,* Mizrahi v. North Miami Med. Cent., Ltd., 761 So.2d 1040, 1042-1043 (Fla. 2000) ("the Legislature referred to and discussed the medical malpractice crisis and its adverse impact on the accessibility of health care Clearly, limiting claims that may be advanced by some claimants would proportionally limit claims made overall."); *Fein v. Permanente Med. Group*, 695 P.2d 665, 680, 683 (Cal. 1985) ("in enacting MICRA the Legislature was acting in a situation in which it had found that the rising cost of medical malpractice insurance was posing serious problems for the health care system in California;" "the Legislature clearly had a reasonable basis for drawing a distinction between economic and noneconomic damages, providing that the desired cost savings should be obtained only by limiting the recovery of noneconomic damage").
- 699 *See, e.g.,* Ferdon v. Wisconsin Patients Comp. Fund, 701 N.W.2d 440, 474, 483 (Wis. 2005) ("Based on the available evidence from nearly 10 years of experience with caps on noneconomic damages in medical malpractice cases in Wisconsin and other states, it is not reasonable to conclude that the \$ 350,000 cap has its intended effect of reducing medical malpractice insurance premiums. We therefore conclude that the \$ 350,000 cap on noneconomic damages in medical malpractice cases is not rationally related to the legislative objective of lowering medical malpractice insurance premiums"; "medical malpractice insurance premiums are an exceedingly small portion of overall health care costs"); *Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156, 168 (Ala. 1991) ("Not only does it appear that the element of damages awards composes but a fraction of the cost of malpractice insurance, but the study also revealed that malpractice insurance costs made up only 9 percent of the "total professional expenses" for self-employed physicians.");

- Arneson v. Olson, 270 N.W.2d 125, 136, 137 (N.D. 1978) (“the trial court made a finding that there did not appear to be an availability or cost crisis in this State. We cannot say that this finding is clearly erroneous, based upon the evidence in this case”; “the methods adopted have no reasonable relation to the attainment of the results desired”).
- 700 Additionally, courts have struck down caps as a violation of separation of powers and as impermissible special legislation (e.g., *Best v. Taylor Machione Works*, 689 N.E.2d 1057 (Ill. 1997)).
- 701 See *Moore v. Mobile Infirmary Ass’n*, 592 So.2d 156 at 169 (“the statute operates to the advantage not only of negligent health care providers over other tort-feasors”); *Carson v. Maurer*, 424 A2d at 836-37 (“the cap on damage recovery distinguishes not only between malpractice victims and victims of other torts but also “between malpractice victims with non-economic losses that exceed \$ 250,000 and those with less egregious non-economic losses”) (citation omitted).
- 702 See *Waggoner v. Gibson*, 647 F. Supp. 1102, 1106 (N.D. Tex. 1986); *Moore v. Mobile Infirmary Assn.*, 592 So. 156 at 169 (“The hardship falls most heavily on those who are most severely maltreated and, thus, most deserving of relief.”); *Wright v. Central Du Page Hosp. Ass’n*, 347 N.E.2d 736, 742 (Ill. 1976) (“Defendants argue that there is a societal *quid pro quo* in that the loss of recovery potential to some malpractice victims is offset by ‘lower insurance premiums and lower medical care costs for all recipients of medical care.’ This *quid pro quo* does not extend to the seriously injured medical malpractice victim”).
- 703 *Waggoner*, 647 F. Supp. at 1106.
- 704 See discussion in Section VII.C.
- 705 See discussion in Section VII.D. The Milbank article accordingly concedes that “[c]onstitutional requirements in many states would require that claims below this threshold be allowed to proceed in tort.” Milbank Article, *supra* note 108, at 467.
- 706 See text accompanying note 76, *supra*.
- 707 409 U.S. 57 (1972). See *Aetna Life Ins. Co. v. Lavoie*, 475 U.S. 813, 826 (1986) (applying *Ward* test in a case involving health insurance).
- 708 *Univ. of Miami v. Echarte*, 618 So.2d 189, 193 (Fla. 1993), quoting *Kluger v. White*, 281 So.2d 1, 4 (Fla. 1973).
- 709 *Kansas Malpractice Victims Coalition v. Bell*, 757 P.2d 251, 259-60 (Kan. 1988).
- 710 *Lucas v. United States*, 757 S.W.2d 687, 691 (Tex. 1988) (“It is significant to note that in two of the jurisdictions in which damages caps were upheld, the fact that alternative remedies were provided weighed heavily in the decisions.”).
- 711 *Wright v. Cent. Du Page Hosp. Ass’n*, 347 N.E.2d 736, 742 (“Defendants argue that there is a societal *quid pro quo* in that the loss of recovery potential to some malpractice victims is offset by ‘lower insurance premiums and lower medical care costs for all recipients of medical care.’ This *quid pro quo* does not extend to the seriously injured medical malpractice victim and does not serve to bring the limited recovery provision within the rationale of the cases upholding the constitutionality of the Workmen’s Compensation Act.”)
- 712 PPI Report, *supra* note 35; COMMON GOOD, AN URGENT CALL FOR HEALTH COURTS 4, available at <http://cgood.org/assets/attachments/130.pdf> (last accessed Nov. 3, 2006).
- 713 *New York Cent. R.R. Co. v. White*, 243 U.S. 188, 201 (1917).
- 714 *Lucas v. United States*, 757 S.W.2d 687, 691 (emphasis in original).
- 715 *Lucas*, 757 S.W.2d at 691.