



PATIENT SAFETY,  
JUST COMPENSATION AND  
MEDICAL LIABILITY REFORM

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## I. EXECUTIVE SUMMARY

The debate over medical liability reform has been a long-running lobbying battle. The lines are clearly drawn between organized medicine pushing for limits on liability and trial attorneys defending the tort system. Patients injured in the course of their medical care and their families are caught in the middle. Left out of the debate entirely are the vast majority of patients—those who are not injured, yet whose safety is at risk and whose medical fees and premiums fund the entire liability system. Against the backdrop of the current, well-publicized medical liability insurance “crisis,” the heated rhetoric of the tort reform debate continues to obscure the complexities of how to make medical care safer, improve provider-patient relations, and provide fair compensation to injured patients.

The issues of medical liability, patient safety, and fair compensation for the medically injured seem to be caught in a vicious cycle. The law aims to “deter” substandard practice, but does not send clear or consistent signals, and undercuts the evolution of effective safety cultures in health care institutions. In today’s litigious climate, practitioners are reluctant to openly discuss and learn from errors or slips. So too many patients suffer preventable injury, which their caregivers may be hesitant to disclose or discuss. Thus many injured patients with legitimate claims do not learn about them, and even after bringing a claim face significant barriers to redress.

Legal reform and improved patient safety seem inextricably intertwined. Yet none of the traditional approaches to liability reform—including caps on awards of legal damages, limits on plaintiff lawyers’ contingency fees, and reduction of awards by amounts received from “collateral sources” like health insurance—aim to break this cycle. Instead, they all primarily seek to help medical professionals and their liability insurers rather than patients and patient safety improvement efforts. And even successful enactments often set the stage for continued efforts to overturn them in court, work around them in practice, and lobby endlessly for their repeal, especially once the immediate insurance crisis has passed.

Some proposals for non-traditional alternatives to the current medical liability system attempt to make compensation fairer and more predictable or to improve transparency and safety incentives. Such approaches include exclusive enterprise liability, systematic medical error disclosure, summary jury trials, early-offer reform, and scheduled compensation. Other non-traditional alternatives would require broader systems change and are generally expected to regularize, if not increase, the number of compensable claims and to be more congruent with systems approaches to patient safety. Such broad changes include medical courts, fault-based administrative systems, preventable-event reforms using avoidable classes of events, “no-fault” compensation systems that hold providers strictly accountable for preventable injury, and implementation of any of these reforms by private contract. These potential approaches may retain similarities to liability but call for fundamental changes to process or standards of recovery.

Solutions that seek to promote an open culture of safety in which errors and injuries are more transparent to patients must embrace dispute-resolution mechanisms that transcend our traditional fault-based system. For the majority of medical malpractice claims, the ethical imperative to hold providers accountable for the quality of care need not depend upon a system that is contentious and counterproductive to establishing a safety culture. Solutions that seek to promote access to fair compensation for those injured by the health care system must enable legitimate claimants to overcome the barriers that many encounter today. Expensive and adversarial litigation is not the

only means of resolving medical injuries and has not shown itself to be particularly effective in reducing errors or injuries—certainly not if compared with a system that could “surface” more problems and facilitate learning for prevention.

What is needed for progress is to replace finger-pointing and name-calling with a rational dialogue among major stakeholders about patient safety and fair compensation in health care. That will represent the first step on a long path to meaningful change in today’s under-performing medical liability system.

## II. BACKGROUND

The debate over medical liability reform heated up again in 2002, as many states faced shortages of liability insurance coverage and even more saw very high premium increases, threatening patient access to care. These events have reactivated a long-running lobbying battle, begun during earlier insurance crises.<sup>1</sup> The opposing camps are organized medicine and its insurers, who push for limits on liability, as against trial attorneys and some consumer representatives, who defend the existing tort system. Doctors blame high malpractice insurance rates on greedy lawyers, a large number of “frivolous” law suits, and damage awards escalating out of control. Trial lawyers argue that large damage awards provide the only effective deterrent to medical negligence that can protect patients from careless and incompetent providers, citing the Institute of Medicine and other publicity about inadequate patient safety.<sup>2</sup> Patients injured in the course of their medical care and their families are caught in the middle. Left out of the debate are the vast majority of patients—those who are not injured, yet whose safety is at risk and whose medical fees and premiums fund the entire liability system. The debate’s overblown rhetoric<sup>3</sup> continues to obscure the complexities of how best to make medical care safer, improve provider-patient relations, and provide fair compensation to injured patients.

Today’s perceptions of crisis have brought new urgency to demands for “tort reform,” especially caps on awards, to reduce the frequency of claims and the amounts of payouts.<sup>4</sup> As in the mid-1970s and -80s crises, insurance problems have provoked new attention to liability reform not only in severely affected states but also, more than ever before, in Congress and the White House.<sup>5</sup> There is also new appreciation of the need to improve quality and safety, and of the impediments to safety initiatives posed by legal fears, a new form of “defensive medicine.” An Institute of Medicine committee has urged the Administration to support patient-centric, patient-safety-friendly reform of medical liability.<sup>6</sup> In this climate, a window of opportunity is opening for more fundamental reform.

Concerns also exist about whether the current system of liability law and insurance constitute a good social value. The overall expense of malpractice insurance premiums (including alternative risk-bearing mechanisms) is not high—probably in the range of one percent of aggregate national physician and hospital costs.<sup>7</sup> However, the burden on individual practitioners is large for high-rated specialties like obstetrics, particularly in litigation hot spots, and the effectiveness of liability as a deterrent is questionable. Fear of liability helps promote some new precautions, but it is also a strong disincentive for medical professionals to report, discuss, and learn from errors—through traditional means like autopsies and peer review as well as newer ones like reporting systems for incidents and “close calls.”<sup>8</sup> Moreover, the “throughput” of compensation to patients is low: Few injured patients make claims, even fewer recover, compensation is slow and highly variable in similar cases, and the cost of administration (mainly lawyers’ fees) is very high.

There is promise of better ways to prevent injury. The Institute of Medicine (IOM) Committee on Quality of Health Care in America report *To Err Is Human: Building a Safer Health System* propelled the patient safety issue to the forefront of America’s health care quality agenda.<sup>9</sup> The IOM committee highlighted the large number of preventable medical injuries that occur in the nation’s health care system as well as the legal and cultural barriers that impede safety improvement. It described how taking a systems approach to safety works better than focus on blaming individuals. The report did not take a position on alternative compensation systems that might facilitate building a culture of openness about error and cooperation in safety promotion. The report greatly increased public awareness of quality and safety problems. It also won increasing acceptance among risk-

management professions and institutional administrators. However, public opinion polls showed general belief that the IOM had recommended tougher medical liability laws and physician discipline.<sup>10</sup> This is quite different from the report's actual emphasis on systems solutions as the best safety policy.

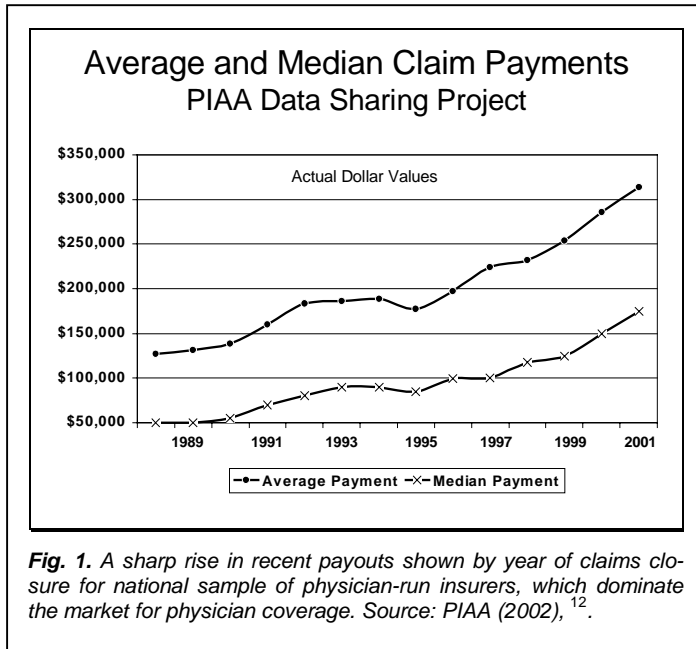
In March 2001, the same IOM committee released a second report, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, which describes the U.S. health care system as fundamentally in need of change. The *Chasm* report contends that improvement is needed in six dimensions of performance: care should be safe; care should be effective; care should be patient-centered; care should be timely; care should be efficient; and care should be equitable.<sup>11</sup> Because the prevailing liability system can impede quality improvement, the report suggests, both regulatory and legal reforms are essential components of an overall strategy for transforming the health care system.

In this paper we explore how patient safety improvement efforts and access to fair compensation for medical injury are helped or hindered by the current malpractice liability system. We then describe problems with the current system and discuss potential reforms. We identify the incremental "tort reforms" often implemented and explore more comprehensive alternatives and their pros and cons. We do not suggest which reform schemes should be pursued, but rather urge that future medical liability reform efforts seek to promote a culture of safety and fairer compensation.

### III. INSURANCE CRISIS AND OPPORTUNITY

Beginning in 2001, a number of states have found their markets' liability coverage in crisis—with departure or contraction by traditional insurers and sharp rises in prices<sup>12</sup> at a time when medical providers are struggling financially because of reimbursement stringency. A number of practitioners unable to afford high liability insurance premiums say that they have gone into early retirement, closed their practices, or moved to locations with lower rates. Hospital services for trauma and obstetrics are similarly at risk. Physicians remaining in practice in these markets also report taking defensive measures—such as limiting the scope of their practices or dropping procedures that put them at higher risk of litigation. Specialties at particularly high risk include neurosurgery, obstetrics, and orthopedics. Emergency rooms face not only high premiums for hospital liability coverage but also cutbacks in the supply of doctors willing to pay for ER coverage, and many have threatened closure, causing headlines in a number of states.<sup>13</sup> As a result, patient access to care may be jeopardized.

Insurance problems have recurred because the supply of liability insurance has dropped, while demand is up, partly owing to the insurance cycle, partly to legal and other trends. A distinctive feature of this crisis is that the downturn in insurers' prospects was preceded not by an unexpected run-up in numbers of claims, as in the 1970s and 1980s, but by unexpectedly high growth in "severity" of claims (payout levels) starting in the late 1990s. These trends show most credibly in data from the association of physician-run insurers (Fig.1).<sup>14</sup> Average payouts nearly doubled between 1995 and 2001, in nominal dollars, a period of relatively low inflation.<sup>15</sup> While this trend represents all claims, particularly troublesome to insurers is that high-end payouts rose even faster. Claims payments of \$1 million and above rose from about 3% of the total in 1995 to almost 8% in 2001.<sup>16</sup>

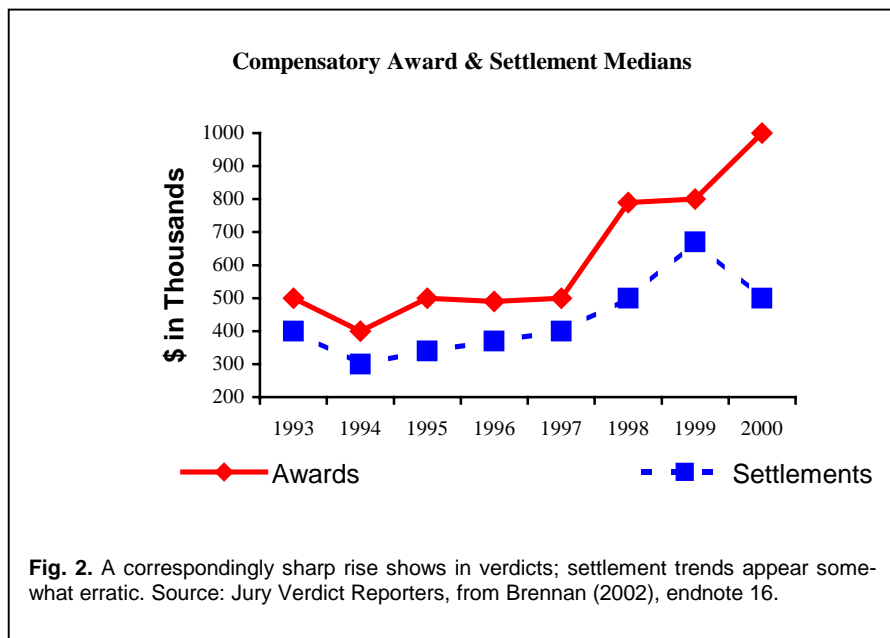


The ultimate source of valuation for claims is the jury verdict (occasionally the judge serves as the factfinder and issues the verdict). Only a very small share of claims ever goes to trial, fewer still go to verdict, and somewhat fewer are settled for the verdict amount. Nonetheless, parties' expectations of what a jury might find strongly influence the settlements that resolve almost all cases.

Some national information on verdicts suggests nearly a tripling in the malpractice verdict medians during 1995-2000 (Fig. 2). However, this graphic relies on the oft-cited publication *Jury Verdict Reporter (JVR)*, a national compilation of local reporters.<sup>17</sup> *JVR* reporting comes from voluntary submissions by trial attorneys and to an unknown degree is

thought to over-represent large cases that attorneys want to publicize.<sup>18</sup> In recent years, *JVR* has sought to include reports of out-of-court settlements as well as verdicts, but likely includes an even smaller share of them. This may partly explain the divergence in reported trend between settlements and verdicts.

Severity of insurance claims payouts had historically risen steadily. This predictable trend caused insurance premium rises without shocks to the insurance market. Starting in 2001, however, insurers experienced large underwriting losses, which were no longer offset by high investment returns. This was a sharp departure from the better-than-expected experience of the late 1980s and early 1990s that had boosted profits and attracted more competitors.



Intense competition lowered prices, which were for a time sustainable owing to high investment returns and reserve redundancies within some insurers. The late 1990s and early 2000s, however, saw an exodus of capacity as some large insurers failed, retrenched or voluntarily withdrew. The most consequential departure was that of The St. Paul

Companies, the largest writer of medical malpractice in the world.<sup>19</sup> The St. Paul Companies had weathered earlier crises, staying in for the long haul, unlike many commercial insurers that pulled out in earlier decades. Entering 2003, many providers appear to face continuing shortages of willing sellers; this constitutes an insurance crisis for some specialties, in some locations, for area-specific reasons.

#### IV. DOES THE CURRENT SYSTEM SUPPORT A CULTURE OF SAFETY?

Relatively few medical errors result from incompetence, carelessness, or intentional misconduct by caregivers—contrary to the popular stereotype promoted by defenders of tort liability.<sup>20</sup> Social yearning for simple explanations of how something has gone wrong tends to blame individuals most seemingly responsible. However, most errors instead result from simple human shortcomings and slips or lapses made under time pressure within complex systems of care that have not been designed to prevent errors. Accordingly, intensified blaming from liability claims and disciplinary action do little to improve outcomes. What is needed instead is thoroughgoing study of the systems within which errors occur, to make it easier to do the right thing, to reduce the likelihood that any residual errors will reach patients, and to intervene promptly with remediation should injuries nonetheless occur. *To Err Is Human* therefore urged a transformation in the response to errors, which it called moving to a culture of safety. This means fixing problems rather than fixing blame, as the report explains at some length. Thus the renewed “patient safety movement” launched in the mid-1990s achieved national recognition and front-page media coverage in a very short period.<sup>21</sup>

The primary external accountability systems of liability law and medical licensure and discipline threaten to sanction errors that become public, thereby discouraging patient safety’s emphasis on disclosure, learning, feedback, and improvement. As quality leader Don Berwick puts it, “the tort system poisons the openness and honesty that are preconditions to safety improvement,”<sup>22</sup> in particular root cause analyses and other uses of data on adverse events and “close calls.” Such data are often discoverable in legal and disciplinary proceedings.<sup>23</sup>

Why is liability such a roadblock to safety? Fears of liability exacerbate the traditional medical culture of secrecy.<sup>24</sup> The atmosphere of care delivery is overshadowed by the threat of litigation, as fears of making a mistake and of being sued looms large in the minds of providers. Survey evidence suggests that doctors drastically overestimate the likelihood of suit from patients suffering preventable injury.<sup>25</sup> The potential adverse consequences of a malpractice suit include: adverse publicity and emotional stress, substantial loss of time from practice for depositions and other adjuncts of litigation, and investigation by peer review or institutional management—all starting from the initiation of suit. If found liable by settlement or verdict, the physician faces mandatory reporting to the National Practitioner Data Bank and often the medical society, financial responsibility for any portion of an award not covered by liability insurance, increased risk of disciplinary action by state authorities, and exclusion from managed-care networks. Access to liability coverage in the future may also be compromised after significant awards. Fears of uncovered losses are plausibly much worse in jurisdictions where tort awards remain unlimited and malpractice verdicts can reach \$100 million.<sup>26</sup>

Keeping quiet can seem an effective “defense” to claims, as most medical injuries are not obvious to patients. In general, even mandated disclosure of medical problems fails to elicit full reporting in various contexts—to the FDA for drug and device problems, to the National Practitioner Data Bank for physician malpractice settlements, and to state regulators about in-hospital errors.<sup>27</sup>

However, a Veterans Affairs hospital's experience suggests that more openness about problems might not greatly increase the number of cases compensated and could greatly reduce litigiousness and very large awards.<sup>28</sup>

## V. HOW WELL DOES THE CURRENT SYSTEM PERFORM?

Few would argue against the right of patients to an accountable health care system. Patients injured by negligent medical care have a right to compensation. Patients, families, and society at large are entitled to know that responsible medical institutions and caregivers will strive to avoid similar problems in the future. However, the current fault-based system for resolving medical malpractice claims is seriously flawed on both grounds. Consider compensation first.

### **Shortcomings in Compensation**

#### *Few people even seek compensation*

To begin with, only a small share of patients estimated to have valid legal claims actually bring claims against health care providers—perhaps as few as 3 percent and no more than approximately 30 percent.<sup>29, 30</sup> The large Harvard Medical Practice Study estimated that only one in fifteen actual cases of medical negligence resulting in serious injury or death in New York state in 1984 was eventually litigated.<sup>31</sup>

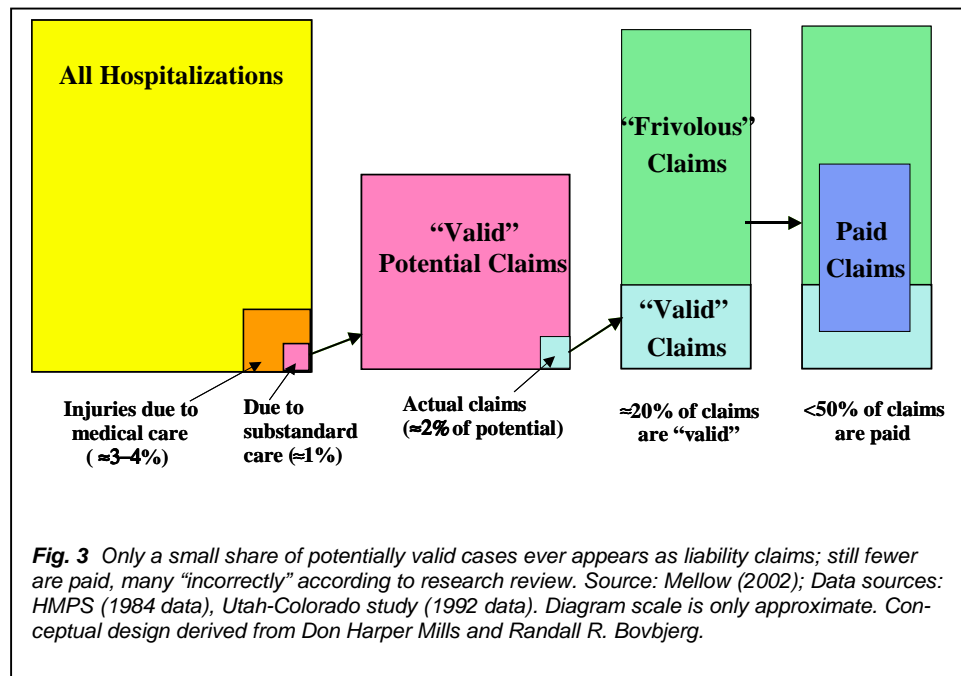
Several theories have been offered as to why many injured patients do not file lawsuits. Patients may often be unaware that they have suffered an injury and may not be informed of the adverse event by their provider.<sup>32</sup> Most medical injuries by definition occur to people already under care for some injury or illness, and harm due to medical error is typically hard to distinguish from that due to the underlying condition. This is quite different from auto accidents or other torts, in which previously healthy people are hurt. Moreover, as the Insurance Information Institute notes, studies find that many medical accidents result only in minor or short-term disability, for which patients' medical care expenses are covered by their health plan.<sup>33</sup>

Further, malpractice cases are hard to win and expensive to prepare, including the cost of expert witnesses, evidence gathering, depositions, and testimony. Therefore, it may be difficult for a patient to find an attorney willing to take a case on a contingency-fee basis unless it is highly likely to win or to win a large award<sup>34</sup>—or both—which eliminates many cases of slight or moderate injury. Other authors suggest that it is difficult for patients to determine whether their injury was actually the result of negligence.<sup>35</sup> Injured patients can face significant hurdles in establishing causation, one of four elements that a plaintiff must prove to the satisfaction of the trier of fact in a medical malpractice case.<sup>36</sup> A large majority of injured patients does not sue, perhaps taking other action such as changing their doctor, filing a complaint, or engaging a lawyer but deciding not to proceed.<sup>37</sup>

Most claimants receive no compensation

Even among those bringing a claim, most do not win (Fig. 3).<sup>38</sup> Many claims are found non-meritorious (or too hard to prove) during pre-trial investigation (or “discovery”) and are dropped before trial. An even higher share of cases completing a trial ends with a jury verdict against the claimant. Overall, only 43% of claimants won some compensation in physician malpractice claims closed in 1984, according to the last nationally representative study.<sup>39</sup>

Accordingly, by far the main source of compensation for medical injury is not liability insurance. Rather, almost all support for medical injuries come from all other forms of compensatory insurance and public programs—from sick leave to Medicare disability coverage.<sup>40</sup> Even within states, there are major variations by locality in rates of claiming and in plaintiffs’ awards, which flow through into the liability insurance premiums charged.<sup>41</sup> Presumably, these variations reflect differences in cultural attitudes, as the basic law of malpractice is the same within any one state.



**Fig. 3** Only a small share of potentially valid cases ever appears as liability claims; still fewer are paid, many “incorrectly” according to research review. Source: Mellow (2002); Data sources: HMPS (1984 data), Utah-Colorado study (1992 data). Diagram scale is only approximate. Conceptual design derived from Don Harper Mills and Randall R. Bovbjerg.

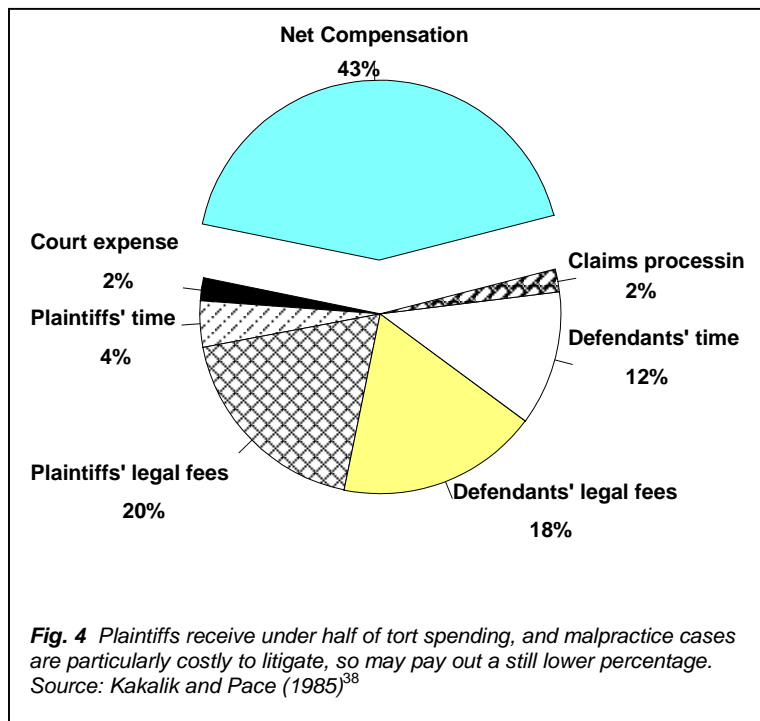
Liability delivers compensation inefficiently

In part because the tort system must litigate each claim of eligibility for compensation, the system is very slow and costly to administer.

According to the closed-claims study from the United States General Accounting Office,<sup>42</sup> the typical physician claim took about 14 months to be filed (the low was under one month, the high,

over 18 years). The median time to resolution from filing was 23 months for paid claims, 17 for unpaid (the fastest was under one month, the slowest about 13 years). Average times were higher than medians, and high-severity cases took longer than lesser injuries. According to Jury Verdict Research, average litigation time for medical malpractice was 45 months in 2000, as measured from incident date to trial date.<sup>43</sup>

A careful analysis of compensation paid in state and federal tort litigation in 1985 found that 43% (of the total) went to plaintiffs, net of tort system spending and not counting liability insurers' profits (Fig. 4).<sup>44</sup> The net payout for malpractice plaintiffs might well be lower than for other types of litigation. Insurance companies spend proportionately twice as much on defense in malpractice cases as in Workers' Compensation, for example, itself widely considered too costly to administer. These observations support the common assertion that only forty percent or less of medical liability premium dollars go to plaintiffs, the rest to lawyers, insurer costs, and court system costs.<sup>45</sup> One sometimes sees statements that only 20% or less of malpractice insurance premiums compensate claimants; such figures generally exclude liability compensation that duplicates health insurance or other sources even though in most jurisdictions claimants are entitled to such collections.



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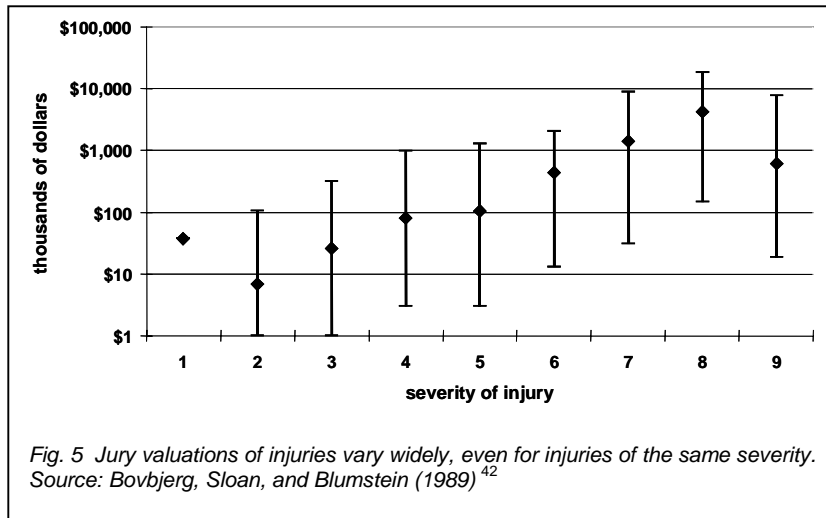
Liability payments often over- or under-compensate for monetary losses

Within the current liability system there is often a disconnect between compensation and the loss actually suffered. Many studies of medical and other forms of liability have documented that relatively minor injuries tend to be over-compensated relative to economic loss and more serious injuries under-compensated.<sup>46</sup> One study carefully matched severely injured obstetrical and emergency room claimants with the medical literature's indications on need for care. It found significant under-compensation for these severe cases.<sup>47</sup> Under-compensation is not surprising because most cases settle before trial, so the payment levels are naturally discounted for present payment, for the certainty of recovery rather than taking one's chances at trial, and for avoiding the costs of going forward to trial.

On the other hand, some cases receive far larger awards than seem justified by the monetary losses sustained. Small cases may be overcompensated in settlement because the insurer wants to avoid the even higher cost of defending at trial. Large cases may win mega-awards as a result of jury sympathy for the claimant or antipathy for the defendant, even if punitive damages are not formally awarded. (Punitive damages are very rare in malpractice cases.) Some argue that the potential for mega-awards leads to a "jackpot" mentality in which plaintiffs and their attorneys are encouraged to bring weak or frivolous cases because "rolling the dice" is worthwhile with even a slim chance of a mega-recovery.<sup>48</sup>

*Non-monetary losses are imprecisely defined and tremendously variable in practice*

Liability law provides very little constructive guidance to factfinders on how to value non-monetary,



intangible losses like “pain and suffering.”<sup>49</sup> Accordingly, overall valuations vary considerably, even for cases of similar severity (Fig. 5). Juries and judges have no way of knowing what values have been assigned in other similar cases—unlike valuations in any private market or judicial valuations of fair market value, for example—so liability law has no way to seek similar results in similar cases.

*The system often compensates the wrong cases*

According to a number of studies, valid cases can fail to be compensated, especially at trial.<sup>50</sup> Conversely, invalid ones can receive compensation. The data presented in Fig 3 above portray the tort system as particularly inaccurate; some other studies find much better correspondence between expert medical assessments of cases and their liability outcomes.<sup>51</sup> Juries can make mistakes in both directions. Mistakes favoring claimants may be more common than many doctors would like because the decision rule for malpractice cases is proof to a standard of “more probable than not” as opposed to “clear and convincing evidence” or proof “beyond a reasonable doubt.” The latter is the standard in criminal trials, and sometimes doctors assert that it should apply in medical liability as well. However, such a higher standard would cause many more valid cases to be denied—akin to the understanding in criminal justice that it is better for nine guilty defendants to go free than for one innocent one to be convicted. Such unequal treatment of doctors and patients in personal injury lawsuits would probably be socially unacceptable.

**Shortcomings in deterrence**

*Features of the tort system undercut the prospects for good deterrence*

The liability system does not address the large majority of avoidable injuries. Because the “enforcement rate” is low, under-deterrence is likely. Liability standards are not clear in advance, making it hard for providers to take appropriate precautions—unlike auto rules of the road, where enforcement may be rare but penalties are high and standards clear. Moreover, medical providers perceive that law’s case-by-case determinations are haphazard, often related as much to personal characteristics or to courtroom performance as to medical standards of care. Thus, any deterrent signal is undercut by what Gaba calls tort’s lack of sensitivity and specificity—“it cannot or does not detect the vast majority” of cases and “cannot or does not ‘punish’ only those who are negligent, but [also] ... a significant number of ‘good practitioners.’”<sup>52</sup>

Further, the fiscal incentive meant to be created by making a negligent provider pay is undercut by liability insurance, which not only pays for any award but also pays for and organizes the defense of cases.<sup>53</sup> Loss of direct financial incentive could be made up for by “experience rating,” as in auto and other lines of coverage, but malpractice cases are so infrequent, and the losses so concentrated in a small share of very large payments, that actuarial prediction is unreliable. In practice, physician insurers have traditionally done little experience rating.<sup>54</sup> Potential deterrent impact may still occur because physicians greatly overestimate the actual chance of facing a lawsuit; significant adverse claims experience can make physicians uninsurable at conventional rates, forcing them to seek limited and expensive “surplus lines” liability coverage; hospitals are usually experience rated; and the uninsured costs of liability are considerable, especially costs of lost practice time, productivity, and psychic stress. A final qualitative point on deterrence is that most providers think that courtroom theatrics and other scientifically extraneous factors determine trial results and that many pre-trial settlements represent economic compromises rather than valid determinations.<sup>55</sup> Thus, the very group whose behavior is meant to be influenced by tort results is typically unwilling to seek to learn from liability experience.

*Over-deterrence or “defensive medicine” can also occur*

Providers have long asserted that they engage in large amounts of unproductive “defensive medicine,” medical practice decisions made more for legal reasons than for medical benefit to a patient.<sup>56</sup> “Positive” defensiveness means providing or ordering extra services (e.g., extensive radiological work-ups) not justified by medical indications. “Negative” defensiveness means deciding not to provide needed services or even not to serve needy patients (e.g., ceasing to perform high-risk surgery) where liability risks seem high. In such cases, liability incentives are believed to over-deter as well, motivating the wrong kind of response. How much defensive medicine may exist is disputed,<sup>57</sup> as is the extent to which social policy can reduce it. One line of research by two authors has found significant Medicare savings with no change in patient outcomes for states with consequential tort reform compared to those without.<sup>58</sup>

Extreme forms of defensiveness include dropping out of a specialty (or a state) altogether, actions often reported in provider surveys or news accounts. Non-cooperation with patient safety initiatives out of fear of liability is another form of negative defensiveness. Because the appropriate standards to follow are unclear to individual physicians at risk of litigation, over-deterrence of defensive medicine may coexist with under-deterrence of inadequate prevention of injury.

*Empirical evidence that deterrence is weak*

Many tracts have been written about deterrence, citing theoretical grounds for thinking that liability sanctions logically should elicit appropriate responses or citing anecdotes where legal liability was followed by adoption of loss-prevention efforts, at least at the facility level (e.g., introduction of sponge counts during surgery, bed rails in nursing homes, standards for avoiding wrong-site surgery). It can also be noted that the success of patient safety standards for anesthesia, even the founding of the National Patient Safety Foundation and the creation of the IOM Committee on Quality of Health Care in America, were in part prompted by adverse liability findings.<sup>59</sup> Yet specific empirical evidence that more liability creates better results is very weak, even for automobile liability, where causation and standards are much clearer.<sup>60</sup> Mello and Brennan reviewed empirical data of adverse events in hospitals and malpractice claims, and concluded that the proportion of internalized cost is small, and that the financial deterrent effect of the tort system is limited and weak.<sup>61</sup>

## VI. WHAT PATIENTS SEEK IN LITIGATION

Although most patients are not litigious, failures of a clinician or provider institution to establish trust, empathy, and open communication can create fertile ground for litigation.<sup>62</sup> Research by Vincent et al. usefully categorizes four major reasons why some patients sue: 1) accountability—to hold an individual or organization responsible; 2) explanation—to find out what happened and why it happened; 3) standards of care—to assure that the organization is taking action to prevent similar events in the future; and 4) compensation—to obtain reparation for financial loss, pain and suffering.<sup>63</sup> Any alternative injury-resolution and compensation system needs to address these concerns of injured patients and their families.

■ *Accountability*—Accountability in the context of medical ethics and law relates to one’s preparedness to account for professional judgements, acts, and omissions.<sup>64</sup> Accountability also entails responsiveness. For injured patients and their relatives, accountability often translates to the willingness of a provider or institution to explain or justify what occurred and why. They may also want to know that the staff involved in the incident receives disciplinary action or remedial training when appropriate. They want an individual and/or institution to accept responsibility for negligence or misjudgments that contributed to an adverse event.

■ *Explanation*—Open communication and honesty are vital to injured patients and families. The lack of such dialogue has been attributed to increased propensity to seek legal recourse. A survey conducted by Loma Linda University found that 97% of patients wanted acknowledgement of even minor errors.<sup>65</sup> Malpractice litigation research suggests that poor provider communication and/or withheld information are factors triggering decisions to sue. In this regard, litigation is used as a discovery tool after other means of getting satisfactory answers have failed.

One review of depositions from settled malpractice suits identified problematic physician-patient relationship issues in 71% of the cases.<sup>66</sup> The issues included failure to be available or “deserting” the patient; devaluing patient and/or family views; poor communication skills; and failing to understand the patient and/or family perspective. The researchers concluded that “the consulting physician has an important role in shaping the patient and/or family understanding of what creates a bad outcome and potentially influences the enthusiasm with which a patient or family member considers initiating a suit”.

Unrealistic expectations of the outcome of treatment can be another factor in the decision to sue. The importance of communication between the physician and patient about critical issues related to treatment, including possible complications and the chance of failure should not be underestimated. For example, several authors suggest that the efficacy of early detection and treatment of breast cancer<sup>67</sup> is largely overstated to the public, giving rise to unrealistic expectations of medical science for this disease.<sup>68, 69, 70</sup> Regarding breast cancer screening and treatment, Spratt and Spratt assert that “widely publicized screening and follow-up recommendations are often the source of the grievances. Even when the recommendations are followed exactly, bad outcomes are still associated with incurable cancer even though fatal outcome is inevitable”.

■ *Improving Standards or Processes for Future Care*—Many medically injured patients want assurance that what happened to them will not happen to others. Vincent et al. conclude “That patients and relatives wish to prevent future incidents can be seen both as a genuine desire to safeguard others and as an attempt to find some way of coping with their own pain or loss. The pain may be

ameliorated if they feel that, because changes were made, then at least some good came of their experiences.”<sup>71</sup>

■ *Compensation*—Injured patients and their families want fair and prompt compensation. Some patients are simply seeking to recoup the monetary losses associated with their injury. Others want a noneconomic award for “pain and suffering” or “emotional distress”. Still others want those responsible to pay for the losses so as to deter others from engaging in like conduct or even seek punitive damages to punish the defendants.

## VII. ALTERNATIVE APPROACHES TO INJURY RESOLUTION AND COMPENSATION

### *The elements of a compensation system*

Any mechanism or system for compensating personal injuries comprises a number of elements: (1) a definition of the compensable event, (2) a set of decision rules for valuing injuries, (3) a process for evaluating a particular claimant’s claim of entitlement and a particular level of compensation for injury, (4) a mechanism for resolving disputes if a claimant is not satisfied with the compensation offered, if any, and (5) a means of paying compensation to the claimant at the appropriate time(s), and (6) funding method(s) to finance the compensatory payments and expenses of running the system.

All alternatives to the liability system for compensating injured patients need to include each of these elements. Alternatives vary according to how much they differ from traditional tort remedies on each element. The following discussion starts with the traditional tort system, then changes to that system, other fault-based systems, and finally, compensation alternatives not based on fault-finding.

As a general rule, some approaches simply try to cut back on what are perceived as the excesses of unreformed tort liability law and process, narrowing the grounds for or likelihood of recovery or cutting back on compensation by limiting awards. Other reforms are more thoroughgoing, generally making monetary compensation available to more people, but with less expansive definitions of non-monetary losses and more consistent payouts across cases. Relatively few reforms feature an explicit tie to patient safety. In general, more reform proposals have addressed eligibility for compensation than have spelled out just how valuations would occur.

## **Traditional, Fault-Based, Judicially Determined Tort Law**

### *The Basic Tort Law Paradigm*

The elements of the tort system can be briefly recapitulated as a starting point: The compensable event is a negligent harm to a patient. Eligibility for compensation is thus based on defendant behavior, not claimant's circumstances or need. Valuation is conducted under rules of tort damages, based on the rationale that an innocent victim of blameworthy conduct should be "made whole." This means restoring a claimant as nearly as can be done with money to the state of life they enjoyed before the injury, accounting for all circumstances and needs.

This standard calls for, first, paying for all documentable (or projectable) costs related to the injury, for past, current, and future needs. The main elements of such monetary loss are wage losses and medical expenses, but other expenses may be included as well. In addition, non-pecuniary losses are recognizable to whatever extent the factfinder deems appropriate for the injury. These are considered within many different categories, notably including "pain and suffering" and "loss of enjoyment of life," as described by verbal formulae meant to capture the emotional or other non-monetary values of uninjured status. Payments are made under a negotiated settlement or court judgment, normally as a lump sum at time of resolution. Funding for the system comes largely from physicians' and hospitals' liability insurance or alternative risk mechanisms.

### *Tort reform changes to the liability system*

In response to medical liability insurance crises and intense medical lobbying, most states have enacted some form of medical liability reform. Enactments address substantive legal rules as well as processes for filing and resolving lawsuits. Some reforms seek to promote "alternative dispute resolution" (ADR), such as mediation and arbitration, which seek to resolve tort claims outside of the judicial system. They apply different processes but are based on the same basic principles of defendant responsibility and valuation of injury for compensation. ADR can occur without specific medical liability reform, as some is voluntary

Four tort reforms are most strongly sought by medical interest groups in the states and in a pending federal bill that passed the House of Representatives in 2002.<sup>72</sup> All four were part of the Medical Injury Compensation Reform Act (MICRA) legislation passed in California in the mid-1970s, finally upheld on judicial review in the mid-1980s. Most observers credit MICRA for California's moving from the very top of the national distribution in price of physician premiums to the middle of the pack, but the plaintiffs bar and some consumer groups disagree.<sup>73</sup> The provisions are (1) Caps on awards limit either the non-pecuniary component of compensation or the total recovery. (2) "Collateral-source offset" provisions require or allow the judge or jury to reduce liability awards by the amounts of other compensation. (3) Shorter "statutes of limitation" limit time after an injury within which a claimant must file suit. (4) Limits on plaintiff attorneys' compensation seek to increase net compensation to claimants' compensation and reduce the attorneys' incentive to seek huge awards.

These and almost all other tort reforms seek to cut back on liability and compensation—reducing the frequency or severity of claims, so as to keep liability insurers in the market and bring premium increases under control (see Appendix A, Notable Conventional Tort Reforms). They do not address concerns about fairness of compensation or promoting a culture of safety. Other reforms adopted during prior crises addressed issues of access to liability insurance, information about insurance, and matters of medical quality oversight. Sometimes, today too, tort reform measures are

coupled with plans to boost patient-safety reporting, as in recent Pennsylvania legislation and in President Bush's reform proposals.<sup>74</sup>

The tort reforms that have been legislated to date are almost exclusively state law<sup>75</sup> (see Appendix B, Conventional Tort Reform Measures by State). These state reforms are largely mandatory changes in tort rules or process; some are applied at the discretion of the court or by voluntary agreement between the parties involved.<sup>76</sup>

In 2002, two federal malpractice liability reform bills—one in each chamber—were introduced during the 107<sup>th</sup> Congress. In the House of Representatives, Congressman Jim Greenwood introduced H.R. 4600, the “Help Efficient, Accessible, Low-cost, Timely Health Care (HEALTH) Act”. The house passed this bill on September 26, 2002. Senator John Ensign (R-NV) introduced S. 2793, the companion legislation of the same name in the Senate. The bill has not been voted on by the Senate, which has consistently failed to pass medical liability reform in the past.

The components of these federal bills include:

- Putting a cap non-economic damages at \$250,000
- Limiting contingency fees paid to attorneys
- A three year statute of limitation for filing lawsuits
- Limiting punitive damages awards to the greater of two times economic damages or \$250,000
- Prohibiting collateral source benefits—such that plaintiffs may not collect payment from defendants that are already paid by their health insurance or other sources
- Permitting payment of larger awards over time
- Exclusion of joint and several liability (defendants are responsible only for their “fair share” of an award, based on their proportion of responsibility).

The major provisions of HR 4600.S. 2793 are similar to the medical liability reform positions outlined by the Bush Administration in a report issued by the Department of Health and Human Services in July 2002.<sup>77</sup>

Many tort reforms are controversial and have faced repeated challenges to their constitutionality as well as judicial interpretations that reduce their impact.<sup>78</sup> The New York Times in 1999 reported that at least eighty-seven state court decisions have overturned all or vital provisions of state liability reform efforts.<sup>79</sup> Reform legislation typically passes at the height of a medical liability insurance crisis, and erosion of reforms often occurs after the symptoms of crisis subside. Some courts have explicitly ruled that reforms are only valid if needed to avert a crisis; others have held that reforms are valid “on their face” (i.e., at time of enactment) but not “as applied” (i.e., later, when deemed to inappropriately delay judicial resolutions or undercut judicial prerogatives). Nevertheless, by one count, the Supreme Courts in 21 states and the District of Columbia have upheld tort reforms.<sup>80</sup> A thorough analysis in 1989 found that caps were most subject to being overturned, with almost half not surviving judicial challenge as of that time.<sup>81</sup>

### **Non-traditional Tort Reforms**

The following are other alternatives that modify the traditional tort system. Some are in use but none has truly supplanted conventional rules or process. Most are ways to address particular aspects of the tort system, e.g., how eligibility for compensation is determined, what level of compensation to pay, or who should pay. This category of potential reform is broader than convention tort reform, especially in that many of these ideas attempt to make compensation fairer and more predictable or to improve transparency and safety incentives.

■ *Exclusive Enterprise Responsibility* has been proposed to make hospitals or other medical institutions responsible for insuring and defending practitioners who practice within them.<sup>82</sup> Hospitals already face various forms of direct and indirect (“vicarious”) responsibility for acts and omissions of physicians arguably under their control, but the individuals remain “jointly and severally” liable, so that all must have their own coverage and resolve their own cases. The reform would consist in making only institutions liable; providers could not be named as defendants (though they would clearly be witnesses). During the Clinton health reform discussions, some sought to make what they were calling “accountable health plans” also accountable for liability, but that idea did not last even as long as the overall proposal. An integrated health system today, or a large physician group, has de facto enterprise responsibility, as insurance and defense are jointly provided, but individuals are still named defendants—and potentially reportable to the National Practitioner Data Bank.

Potential benefits of exclusive enterprise responsibility include better access to liability coverage based on group principles and a more stable risk pool, easier access to alternative liability insurance markets, streamlined and coordinated defense of claims that reduces “divide and conquer” stratagems of plaintiffs’ attorneys, as well as improved enterprise risk management and patient safety. Potential disadvantages include giving attorneys a deeper pocket to claim against, unknown influences on the doctrinal development of tort liability and jury attitudes, and the possibility that coordinated defense could promote a conspiracy of silence to squelch claims rather than patient safety efforts to prevent injury. Note that enterprise responsibility is just a mechanism for bearing and managing risk. It can apply equally under a fault-based or non-fault basis of responsibility, with various dispute resolution mechanisms and with any method for valuation of claims for compensation

■ *Greater Disclosure* of injuries to patients and their families—sometimes called “transparency”—has been proposed as a way to improve resolution of injury resolution under liability or any other system of compensation.<sup>83</sup> Many support disclosure as a matter of ethical obligation or good medical practice for enhancing patient-provider trust.<sup>84</sup> Some support it as a practical risk-management strategy, and disclosure in other spheres has had some positive impacts.<sup>85</sup> There is much anecdotal information about medical disclosure policy (Hamm & Kraman 2001), but no systematic information about the extent and nature of implementation “in the field,” or about how to categorize the true extent of change, to measure links to systems improvement, or to assess impacts on liability and quality/safety (Connolly 2001).<sup>86</sup> Proponents hope to speed compensation and improve patient relations, reduce litigiousness, and encourage better patient safety and provider cooperation with learning from problems.

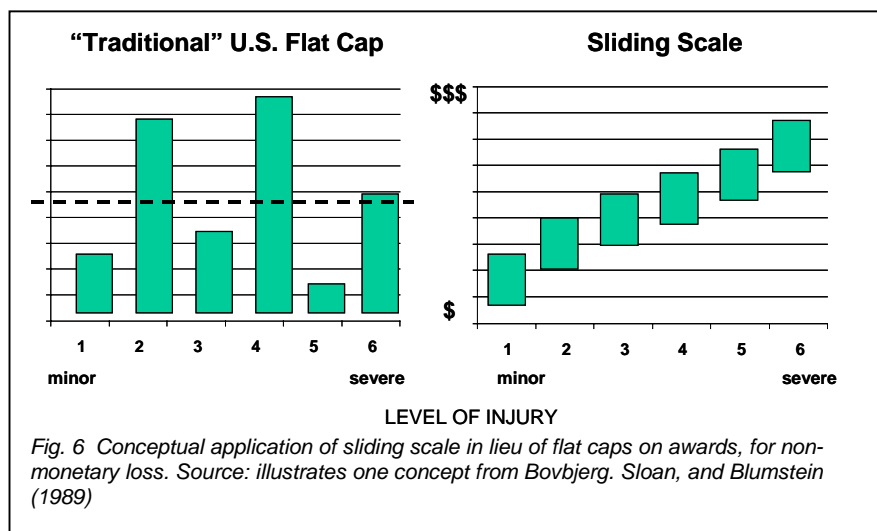
■ *Summary Jury Trials*—Such mini-trials are run by agreement of parties, typically in a complex or expensive case as a way of estimating the strength of each side’s case and promoting pre-trial settlement or a private “high-low” agreement that trial will proceed but any award will be constrained by the agreement. Summary jury trials feature abbreviated presentation of evidence and arguments to a mock jury, typically lasting no more than one day. Expert witnesses are limited or not allowed. The mock jury’s findings are not admissible in court if the case later goes to trial.<sup>87, 88</sup>

■ *“Early-offer” reform*—Another proposed reform seeks to promote prompt private settlements soon after an injury occurs.<sup>89</sup> This proposal calls for medical providers to respond promptly to medical injuries by making early offers of settlement to pay all future monetary losses, net of receipts from other insurance. Limited non-pecuniary losses would be included, such as loss of unpaid services like care for children. Calculation of damages is facilitated by having liability payments made as losses accrue, without having to guess about the future. The early offer approach could be

implemented voluntarily at time of offer (any party is free to make any offer), but many think that stronger motivation is needed, as there is fear that potential plaintiffs could see an offer as an admission of liability and hence see a lawyer to seek higher damages in court. Implementation could also occur in advance, through contracts, between health plan and enrollees or between medical providers and patients. Contracts might work best where care is planned in advance or a medical relationship is long-standing, such as chronic treatment or prenatal care. Alternatively, early offer could be enabled by statute curtailing tort remedies by law when qualifying offers are made promptly after an injury. An enabling statute could be very simple, increasing its chances of making it through the legislative process in its original form.

A virtue of this reform is its simplicity. It requires little change in substantive law and none in settlement process, and there is no need to value injury or the need for compensation in advance. Moreover, it bars no one from all recovery, and it offers a clear quid pro quo for curtailed tort remedies by strongly encouraging settlement offers to the vast majority of patients not helped at present. Weaknesses include that it seems unduly coercive to patients and relies on uncertain provider willingness to acknowledge responsibility. Providers might instead “game” the system by making offers only to badly injured people believed to be the most litigious, thus undercutting the intended new benefits. Further, the system might work “too well,” in that the large number of cases not now dealt with would have to be paid for. Early offer can be combined with other measures. For example, it has been proposed to make the reform more transparent by requiring or contractually promising to make early offers in all cases covered by an advance listing of avoidable events (considered further below).

■ *“Scheduling” of compensation*—Another approach to assessing damages (i.e., compensation) seeks to make damage awards by “scheduling” of awards, loosely adapting the term from Workers’ Compensation.<sup>90</sup> Like conventional tort reform, these are “patches” for the current liability system, not a full alternative. They do not, for example, deal with how claims are brought, nor the standards of responsibility for payment/eligibility for compensation.



The essence of such proposals is to improve consistency across cases, assuring that worse losses are paid more and lesser ones less—not necessarily to move awards up or down overall—by adopting a more systematic approach to assessing difficult-to-value losses, including non-pecuniary damages and future medical care. For example, arbitrary, flat caps on non-monetary losses could be replaced with

sliding scales for awards (Fig 6); several other approaches have been suggested, but not implemented. More consistent compensation across similar cases would promote horizontal equity and assuring that awards relate to severity would promote vertical equity—two key concerns of fairness. Those who favor the liability system argue that fairness dictates a full chance to argue one’s

unique circumstances to a jury and that no alternative system can better capture the nuances of important elements of loss. Forms of scheduling are commonly applied in accident law outside the U.S. and in disability insurance or workers' compensation here, but not in U.S. liability law. Scheduling could occur under the current system or under any alternative, but has not as yet attracted much political support.<sup>91</sup>

### **Broader Systems Change**

Finally, a number of alternatives require more systems change. They may retain similarities to liability but call for fundamental changes to process or standards of recovery. Such broad changes are generally expected to help regularize if not increase the number of compensable claims and to be more congruent with systems approaches to patient safety.

■ *Medical Courts*—Medical disputes could be handled exclusively by a system of special medical courts, probably but not necessarily federal courts operating nationally. The courts would be staffed by full-time judges who hear no other types of cases and who are chosen and trained for the technical expertise needed to evaluate and resolve complex medical disputes with much technical evidence. One current proposal cites the precedent of the specialized courts for patent law;<sup>92</sup> other examples include admiralty and tax courts. This idea has been proposed, but not tested, as an alternative to the current court system. 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. Simultaneously, other rules might or might not be changed about eligibility for and amounts of damages.

■ *A Fault-Based Administrative System*—The American Medical Association and Medical Specialty Societies (AMA/MSS) proposed in the late 1980s to cover more cases but resolve them more expertly through an administrative agency.<sup>93</sup> As for medical courts, the key rationale for the AMA/MSS plan was today's lack of expertise in medical dispute resolution—a standard rationale given in favor of creating an agency to regulate a particular area. The AMA/MSS proposed their plan for state-by-state legislative enactment. Fault was still to be the standard of responsibility/eligibility, but damage rules would have been clarified and non-pecuniary losses subjected to sliding-scale ceilings related to severity of injury (as under scheduling above). State-provided lawyers were to represent claimants, and the agency would be directed to work closely with the state disciplinary board as well. The proposal was a balanced and serious one, but despite its potential to help patients, it was never enacted. Organized medicine has ceased to promote this approach very actively, lobbying much more for conventional reform, especially a cap on awards.

■ *Preventable-Event Reforms using Avoidable Classes of Events (ACEs)*—The basic idea of the reform options using ACEs is to create better incentives to prevent avoidable adverse outcomes in medical care. ACEs are avoidable classes of events, adverse medical outcomes that are normally avoidable when patients receive good care. Lists of ACEs can be created in advance by experts and then be used to improve today's legal and quality-monitoring systems or to replace much or most of malpractice law. ACEs must meet three main criteria:

- The events are readily specified and distinct from non-ACEs that might appear similar.
- They are moderately or highly preventable as a class.
- Listing them does not distort medical decision-making.

Different uses of ACEs would emphasize different advantages for reform of liability, quality monitoring and incentives, and risk management. The ACE concept has been elaborated in a series of papers over some years.<sup>94</sup> The creation of ACEs relies on generalized expert judgment about statistical outcomes of medical care. In contrast, the current system relies on idiosyncratic testimony about allegedly faulty processes of care in particular cases, viewed retrospectively.

ACE listings could be used to “trigger” responsibility for providers to make an early offer of limited compensation (above), thus assuring that early offers would be made routinely rather than strategically to settle threatening tort cases. Alternatively, ACEs could be the basis for an administrative system that holds medical providers strictly accountable for promptly compensating patients experiencing any ACE, without regard to fault of the provider. (In this context, ACEs have also been called “accelerated compensable events”.) ACE listings would make determinations of eligibility more transparent to patients, encouraging more meritorious cases to be identified for compensation. ACE-based compensation should be far faster and less costly to administer than the tort system, allowing more people to be covered for the same level of funding. Most commentators suggest limiting compensation per case, in light of offering more certain payment in more cases.

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. ACEs do not cover all possible fault-based claims because not all medical injuries are preventable,<sup>95, 96</sup> and some non-ACE patients might still want to seek compensation. In keeping with the goal of making the compensation system less threatening to caregiver cooperation with patient safety efforts, non-ACE cases might be arbitrated rather than litigated. It 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.

■ *Virginia and Florida administrative compensation for severely injured newborns*—These are the main non-tort medical compensation systems in the U.S.<sup>97</sup> Virginia in 1987 barred tort claims for severe neurological, birth-related injuries, in order to take the most expensive childbirth injuries out of the tort system and keep liability insurance available to Virginia obstetricians. Instead of seeking recovery in tort, claimants have their net monetary losses covered through a non-fault, Workers’ Compensation-style state program run administratively. Assured that such high-cost cases would no longer be in court, insurers continued to do business in the state. The next year, Florida passed a very similar, but slightly more liberal law. The systems narrowly defined the compensable event: severe neurological, birth-related impairment to newborns not due to substance abuse or congenital injury. Funding comes from assessments on participating obstetricians and a lesser fee for all other doctors.

Compensation in Virginia is limited to monetary loss (“medically necessary and reasonable expenses” of medical, residential, and custodial care), and Florida is similar. All collateral sources are offset (public and private), and payments are made as expenses are incurred. Virginia makes allowance for lost earnings at working ages, scheduled at fifty percent of average wages, but not Florida. Neither state allows “pain and suffering” or other explicitly non-monetary loss, but Florida provides a one-time parental allowance of up to \$100,000, which may be thought of as compensation for non-pecuniary loss. Reasonable attorneys’ fees are also covered in both states.

A major assessment through 1997 found that no-fault kept liability coverage affordable, provided comparable levels of compensation to fault, but at much lower overhead cost, speeded up claims

resolution after claim, and achieved physician and claimant satisfaction similar to that of the tort system.<sup>98</sup> On the negative side, the programs were very small, even for their narrowly defined eligibility—too small to broadly improve compensation or deterrence—while the survival of tort for uncovered obstetrical injuries continued to encourage physician defensiveness, also likely inhibiting them from referring injuries to no fault, lest they wind up in court instead. Claimants uniformly reported that they had heard of the compensation program not from their physicians but from their lawyers. The programs have faced considerable legal and political challenges to their legitimacy.

■ *Alternative compensation systems for preventable injuries*, without the need to prove fault, are the most thoroughgoing alternative to tort litigation. This non-trial alternative makes medical providers strictly responsible for reimbursing losses due to preventable injury, completely eliminating the requirement for any injured patient to prove provider negligence in court, and hence has often been termed “no-fault.” Compensation is to be determined according to a payment schedule for medical injuries.

The main U.S. precedent for medical no-fault is Workers’ Compensation,<sup>99</sup> which operates as third party coverage (the employer pays for workers) under state mandates. Any employee injury on the job is entitled to be compensated administratively but not to sue in tort. Wage losses are typically covered up to a limited percentage of pre-injury earnings (e.g., two-thirds) up to a specified ceiling (e.g., 200% of state average wage) and for a limited time (e.g., 2 years). Medical expenses are covered indefinitely, originally on a fee-for-service, open-ended basis, but in recent years often subject to some utilization management controls. Similarly, auto no-fault in the 1960s proposed to cover all injuries arising from the operation of a motor vehicle through insurance rather than litigation. Auto no-fault, however, was a first party insurance policy (that is, each motorist covered their own injuries and those of their passengers). In practice, states have never completely replaced motor tort liability with the right to no-fault insurance recovery.

Non-fault-based medical compensation would not cover all harm occurring in medical care (unlike workers’ compensation coverage of all injuries on the job) because negative health outcomes naturally occur to patients receiving care; indeed, most deaths now occur in medical institutions. The compensable event for non-trial medical compensation is not *any* negative outcome in the course of medical care but rather *preventable* harm. One type of proposal would use a medical panel to determine preventability after the fact on a case-by-case basis, following the Scandinavian model.<sup>100</sup> Another would use Avoidable Classes of Events. Both seek to create an organized, consistent system that improves compensation and incentives for prevention.<sup>101</sup> Non-fault medical compensation systems are used in Denmark, Sweden, and Finland, while Australia and New Zealand have had non-fault systems to pay for all accidents. Medical non-fault compensation operates in a different funding context outside the U.S., as other advanced industrial countries have far more extensive social insurance and welfare programs that provide compensation for injuries and disability generally, not just from medical care.

■ *Reform by private contract*—Some reformers suggest leaving reform of any type to private contracts between purchasers and sellers of health care.<sup>102</sup> Rather than mandating that any particular reform apply to everyone, purchasers could be allowed to choose their own system for medical injury compensation. They could decide that they want a full panoply of legal protections, possibly going even beyond today’s tort rules—but they would then have to pay for it through that same contract. Alternatively, purchasers could opt for less elaborate remedies—perhaps with alternative dispute resolution administration and very limited damages—but possibly greater guarantees of patient

safety efforts. Under contracting, medical providers would have to indicate clearly how much less or more they would charge for services when exposed to less traditional liability or more patient safety. Or the contract could provide for some variant of no-fault, with the prospect that both medical consumers and providers might gain, at the expense of lawyers and other workers in the liability system.

Because it relies on private decision making, contracting has much appeal for supporters of individual choice, free markets, and limited government. However, contracting by individual patients has never had much practical appeal, especially since reformers have always seemed to want to reduce legal accountability without replacing it with any other accountability and to cut liability compensation without creating a more attractive system. Transaction costs of service-by-service contracting would be high, and conflicts among contracts could occur with care from multiple providers. Moreover, individuals are often seen as at a negotiating disadvantage relative to medical providers, certainly for emergency or life-saving care.

Contracting seems much more attractive when considered as an aspect of employment-group purchase of care or coverage. In particular, under some forms of dual option enrollment in managed care, consumers freely chose among alternative delivery systems and styles of care when they enroll each year. They could very logically also choose among associated different approaches to injury compensation and dispute resolution. Binding arbitration is part of Kaiser Foundation Health Plan contracts in many states, and even broader reforms could be introduced in this way. Especially if the alternative system(s) were generally perceived as fair and protective of patient safety, consumers and courts might well accept that plans could make liability alternatives part of their overall approach to financing and delivering medical care.

### **New IOM Proposal to Encourage State-Based Demonstrations of Two Broad Liability Reforms**

An IOM committee on Rapid Advance Demonstration Projects proposed in November 2002 that the federal government promote state-based demonstration projects in health system reform.<sup>103</sup> Proposed projects include liability reforms to address systems problems in patient safety and medical quality identified in two prior IOM books.<sup>104</sup> The proposal outlines two types of potential liability demonstration projects for implementation in 4 or 5 states as early as 2003. The liability reforms are intended to “create injury compensation systems outside of the courtroom that would provide timely, fair compensation to injured patients and promote apologies and nonadversarial discussions between patients and clinicians.” The federal government would encourage experimentation financially and through technical assistance.

The report sets forth two conceptual models for state demonstration projects.

■ *Option 1: Provider-Based Early Payments*—This approach called for self-insured or experience-rated provider groups to voluntarily agree to identify and promptly compensate patients for avoidable injuries. In return the state would protect participating provider organizations from tort liability in cases where prompt compensation is offered and the federal government would provide reinsurance. The Avoidable Classes of Events approach of prospectively setting limits on non-economic damages for identifiable classes of avoidable injuries is named as a model. The proposal appears to contemplate implementation in large part by private contract, evidently between health plans and employers negotiating group contracts on behalf of enrollees.

■ *Option 2: Statewide Administrative Resolution*—Here, states would grant all health care professionals and facilities, however organized, immunity from tort liability (under most circumstances). In exchange, all providers would be required to participate in a state-sponsored, administrative system established to provide non-fault-based compensation to patients who have suffered avoidable injuries. In cases of avoidable injury, providers or their liability carriers would pay capped and scheduled amounts determined by a state administrative system.

Under either option, participating states (and to a certain extent also provider groups) would be required to:

- establish and maintain “objective indicators of avoidable errors” and schedules for calculating limited economic and non-economic damages;
- create a legal environment to enable the malpractice reform and to protect individuals and organizations acting in good faith under the conditions of the demonstration project;
- set up a patient safety reporting system that features voluntary, confidential reporting of “near misses” (i.e., “close calls” where errors occurred but did not harm patients); and
- launch a campaign to educate the public about the cost-benefit tradeoffs of liability reform.

The IOM committee does not estimate the cost of these alternative systems, but assumes that there would be “modest, if any, increases in health care expenditures” under the pilot projects. The federal government would guarantee fiscal neutrality (no higher cost to demonstrators) and pay initial start-up and technical assistance costs. The federal government would also provide reinsurance for provider organizations participating in the early-offer avoidable-event demonstration projects to cover the highest layer of compensatory awards that providers cannot afford to cover on their own.

“The demonstrations,” the panel said, “would be designed to ascertain a reform’s effect on the number and nature of claims filed and associated total costs, as well as to permit comparison of claims and cost information across all of the demonstrations.” Many medical liability reform advocates feel that using states as laboratories can pioneer real change in the medical-legal environment, promoting fair and timely compensation for injured patients, while fostering patient safety. The IOM proposals are unique in so forthrightly asserting that the central goal is to help patients and promote patient safety, not to curb liability or protect defendants.

## VIII. CONCLUSION

The issues of medical liability, patient safety, and just compensation for the medically injured seem to be caught in a vicious cycle. In today’s litigious medical environment, providers are reluctant to openly discuss and learn from errors; without an environment that fosters an effective safety culture in health care delivery, too many patients suffer preventable injury; without liability reforms, many injured patients with legitimate claims encounter significant barriers to redress. The issues seem inextricably intertwined. Meanwhile, none of the traditional approaches to reform, including award caps, contingency fee limits, or collateral source rule reform aim to break this cycle because they all primarily seek to help medical professionals and their liability insurers rather than patients and patient safety improvements.

This paper has not fully assessed tort reforms, but many have noted how little such piecemeal efforts have done to improve patient safety, help injured people receive fair compensation, or reduce defensive medicine.<sup>105, 106, 107</sup> Where fully implemented, strong tort reform does keep

liability insurance available and hold down premium increases.<sup>108</sup> It does little or nothing, however, to transform the medical-legal culture of blame and secrecy into a culture of safety nor to promote fair compensation for legitimate claims. Liability insurance markets do need the calming that caps on awards can provide. Yet both fairness and long-run political and legal success in defending caps call for more patient-centered safety efforts, which can actually improve care and safety and also justify reduced legal prerogatives.

Solutions that seek to promote an open culture of safety must embrace dispute resolution mechanisms that transcend our traditional fault-based system. For the majority of medical malpractice claims, the ethical imperative to hold providers accountable for the quality of care need not depend upon a system that is contentious and counterproductive to establishing a safety culture. Incidents involving criminal acts, intentionally unsafe acts, or acts of impaired individuals should clearly be referred to proper legal or regulatory authorities. A new rationale and framework for accountability that promotes patient safety is needed for “A New Health System for the 21<sup>st</sup> Century”.

Solutions that seek to promote access to fair compensation for those injured by the health care system must enable legitimate claimants to overcome the barriers that many encounter today. Expensive and adversarial litigation need not be the only means of resolving medical injuries.

A rational dialogue among major stakeholders regarding the issues of patient safety and fair compensation in the context of medical liability reform would represent the first steps on a long path to meaningful change. Questions for discussion include:

*Fair Compensation*

- To what extent does fairness in compensation call for consistency and equity in results across the system as opposed to an individualized fair hearing for each dispute resolution?
- In considering fairness of compensation, should one benchmark from averages under the current tort system, from privately purchased compensatory insurance (e.g., for disability, health), or from social insurance or public welfare programs in the U.S. and abroad?
- Does fairness in compensation require that everyone be in the same system or is some choice socially acceptable?
- What are reasonable processes for determining fair compensation? Do private insurers, public administrators, and courts have equal claims to fairness?
- Under what circumstances does fair compensation include non-pecuniary aspects of loss?
- Should punitive damages be part or compensation or handled differently for purposes of deterrence and accountability?
- What are the attributes of reforms that promote fair compensation?

*Practical issues of implementation*

- What are the economic implications of expanding access to fair compensation to a greater proportion of the medically injured?
- How can any expansions to compensation be funded? How will an alternative system relate to “collateral” sources?
- How can the various reform proposals be made consistent with constitutional rights?
- What are the barriers and enablers to medical liability reform?

*Justice, Safety, and Accountability*

- What are the attributes of reforms that promote safety culture?
- Should funding for compensation be part of accountability?
- Can a consensus be reached on an accountability continuum of provider behaviors (i.e., from intentional wrong-doing at one end of the continuum to ordinary human error at the other)?
- How can the culture of patient safety (fix problems, not blame; drive fear out of the system; accept human fallibility and make systems error-resistant) be squared with expectations of accountability (having to show good performance to independent outsiders)?

The public and political leaders need to understand better the nature of current liability system's problems. They also need to understand why comprehensive systems change is needed to promote fair compensation, medical quality, and patient safety. Powerful interest groups and substantial inertia support the current system, with or without modifications.

The interest groups have clear visions of their preferred states of the world and promote them with appealing anecdotes and "stories." Trial lawyers say doctors and insurers have only themselves to blame—medical negligence hurts far too many people that only lawyers can help, and insurers' bad investments and business plans jeopardize insurance availability and price stability. Tort reformers say that lawyers and juries are out of control and must be reined in to keep premiums affordable and prevent insurers and doctors from withdrawing.

What is the right story for liability system reformers to promote fair compensation and patient safety? What clear, plausible, and attractive vision can be set forth? The Institute of Medicine's call for pro-patient and pro-safety reform offers a good springboard for discussion. Ultimately, constructive public deliberations involving the various points of view will be required to create and sustain the environment for change.

## APPENDIX A—NOTABLE CONVENTIONAL TORT REFORMS

The following brief overview describes frequently discussed conventional tort reforms. The first four are the most sought by defendants and most resisted by plaintiffs attorneys. All have been enacted in some number of states.

*Caps on Awards* limit the amount of compensation that a jury can award a plaintiff or allow the judge to reduce a jury award. Provisions vary somewhat in their workings, as do the dollar limits set. Monetary caps are typically applied to so-called “non-economic” damages like “pain and suffering,” for which there is no evidence of tangible expenses, but may also apply to the entire recovery in medical malpractice actions. One tabulation lists fourteen states that have enacted caps on the recovery of non-economic damages in medical malpractice actions and occasionally in other torts as well (Alaska, California, Florida, Hawaii, Idaho, Kansas, Maryland, Massachusetts, Missouri, Oregon, Utah, West Virginia, and Wisconsin).<sup>109</sup>

*Collateral-source Offset* reforms require or allow the judge or jury to reduce liability awards to the extent that claimants have received or will receive compensation from other sources. The law calls health insurance and other compensation “collateral” to its liability dispute resolution, but such other payments are central to compensation for medically injured people, providing the bulk of actual support for medical injury. Reforms overturn the traditional legal rule that evidence of “collateral sources” of compensation is not admissible at trial. Supporters of reform argue that “double recovery” is unjust and inefficient, as the overhead costs of delivering compensation through other means is so much lower than under the liability system. Opponents of reform object that it is unfair for culpable tortfeasors to benefit from claimants’ prudent purchase of their own compensation or to shift burdens of substandard practice to employers and governments who also fund compensation coverage or programs.

*Statute of Limitations*—Reduced “statutes of limitation” change the statutory amount of time that a claimant has after an injury to file a lawsuit (e.g., two years after the injury). Statutes and judicial interpretation have allowed minors, people suffering a hidden injury, and certain other cases to be brought many years after the fact.<sup>110</sup> Reformers seek to reduce claiming based on very old incidents, for which evidence is “stale” and contemporary medical standards are hard to reconstruct. Defenders of exceptions to the basic statute say it is needed to provide compensation to people who through no fault of their own cannot make a claim earlier.

*Limits on Lawyers’ Fees*—Restrictions on the size of plaintiff attorneys’ contingency fees seek to reduce the share of an award that is taken “off the top” by a winning lawyer, thus seeking to increase net compensation to injured claimants. Some provisions seek to re-energize judicial discretion to oversee the reasonableness of legal fees and expenses. More common are provisions for a “sliding” scale of maximum percentages—more for the first layer of compensation, progressively less for higher increments of recovery. Sometimes, adjustments are made for stage of dispute resolution, as less legal effort is needed to settle before trial than after. Supporters argue that open-ended contingency fees encourage plaintiffs’ attorneys to try too hard to win mega-awards that provide huge windfalls to attorneys (also perceived to help them finance development of new theories and techniques of litigation). Defenders note that contingency fees promote screening of cases and closely align the interests of lawyers with those of their clients.

Other reforms are also often sought and enacted.

*Alternative Dispute Resolution* is the term used to describe processes such as mediation and arbitration that seek to resolve legal claims outside of the judicial system. These processes are typically less expensive and quicker than court trials. Arbitration is a process of dispute resolution that occurs before an arbitrator or arbitration panel. Arbitration can be binding and judicially enforced or non-binding. Some states such as Florida have a system of voluntary binding arbitration for the determination of damages. Arbitration may occur under a special malpractice enabling statute or under general enabling statutes. Despite early pioneering by Kaiser and a few others, arbitration has never become popular and accounts for a very small share of claims resolutions. It has been argued that judicial hostility and lack of hard data on performance have hampered acceptance.<sup>111</sup> Mediation is a voluntary process in which a neutral party facilitates the negotiation of an agreement by the disputing parties themselves, often one adding non-traditional elements to conventional offers of payment, including an apology or indication of changed processes to protect patients.<sup>112</sup> Mediation may be voluntary or a mandatory step imposed by the court to attempt to resolve a dispute before trial.<sup>113</sup>

*Medical Review Panels* are widely used in workers compensation and have been used to resolve health insurance coverage disputes over medical necessity. The composition of a medical review panel typically includes experienced physician experts and may include non-physician experts as well. The role of the medical review panel is to interpret patient-specific data, scientific and medical evidence, and other data relevant to the dispute.<sup>114</sup> Some states require medical malpractice claims to be presented to a medical review panel before a complaint against a health care provider can be filed in court. Findings of the panel may or may not be admissible in subsequent proceedings. Some panels have had problems maintaining prompt hearings, and some are routinely waived by the parties who expect serious cases to go into litigation anyway.

*Periodic Payment* provisions allow awards for continuing, future losses to be paid on the “installment plan.” The liability insurer buys an annuity to make a controlled stream of regular payments over time (often limited to the lifetime of a claimant) rather than the traditional legal lump-sum payment of compensation made at the time of final judicial or voluntary settlement of the dispute. (Under either payment arrangements, lawyers are paid off the top.) Supporters note that structure assures continuing support and prevents incautious dissipation of an award and also allows the market to set the appropriate discount rate on future losses rather than inept juries. Opponents object that injured people need more control over their resources and that they should be able to invest their own funds. (Interestingly, a market has developed to allow claimants to undo structured settlements by contracting with a financial firm to exchange their right to future structured payments for a current lump-sum payment—for a fee, of course.)

**APPENDIX B—CONVENTIONAL TORT REFORM MEASURES BY STATE**

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|---|--|
| <p><b>DAMAGE CAPS</b></p> <p>Damages in liability cases are classified as economic and non-economic. Economic damages include actual monetary losses due to negligence such as medical bills and loss of future earnings. Non-economic damages refer to money awarded to a victim for unquantifiable losses such as pain and suffering or loss of consortium.</p> <p>Punitive damages may also be awarded with the intention of punishing an egregious offender. Many states have put a limit on non-economic damages. A few states have the total amount of possible damage award.</p> | <p>AK, CA, CO, GA, HI, ID, IN, KS, LA, ME, MD, MA, MI, MO, MS, MT, NE, NJ, NM, ND, NV, OK, PA, SD, TX, UT, VA, WV, and WI.</p> <p>Passed but later held unconstitutional in: AL, FL, IL, NH, SD, TX, and WA.</p> |
| <p><b>PERIODIC PAYMENT OF DAMAGES PERMITTED</b></p> <p>Periodic payment allows a defendant to pay a damage award over time as opposed to one lump payment. The argument for this reform is that it will prevent bankrupting providers who lose malpractice suits. Patient advocates argue that it is unfair to victims because it takes away the possibility of investing the large sum, which may be necessary in the case of a person severely disabled through medical negligence.</p>   | <p>AL, AK, AZ, AR, CA, CO, CT, DC, DE, FL, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MO, MS, MT, NH, NM, NV, NY, ND, PA, RI, SD, UT, VA, WA, WI and WY.</p>  |
| <p><b>COLLATERAL SOURCE RULE REFORM</b></p> <p>The collateral source rule prohibits juries from hearing evidence that claimants have been fully or partially compensated from other sources (e.g., medical insurance) for their injuries.</p>   | <p>AK, AZ, CA, CO, CT, DE, FL, ID, IL, IN, IA, ME, MA, MI, MN, MT, NE, NV, NJ, NY, ND, OR, PA, RI, SD, TN, UT, WA, and WI.</p> <p>Passed but later held unconstitutional in: AL, KS and KY.</p>                  |
| <p><b>LIMITING ATTORNEY CONTINGENCY FEES</b></p> <p>Attorneys for plaintiffs in tort cases almost always work on a contingency fee basis, receiving a percentage of the damage award. This arrangement makes it possible for people of all economic levels to bring suit for injuries resulting from negligence. Reformers argue that attorneys' fees are often excessive, take away from the victim's compensation, and encourage attorneys to bring frivolous suits.</p>  | <p>CA, CT, DE, FL, IL, IN, ME, MA, MI, NJ, NY, OK, TN, UT, WI, WY.</p>   |

**JOINT AND SEVERAL LIABILITY REFORM**

Joint and several liability is designed to protect victims in cases where more than one party has been found liable or responsible for the injuries inflicted by holding that each is completely responsible for the damages if any other party fails to pay its portion. This is designed to ensure that an injured person will receive his or her entire damage award, i.e., be “made whole,” even if one or more of the responsible parties fails to pay. The counter argument is that this rule encourages plaintiffs to sue hospitals or doctors with “deep pockets” or substantial insurance policies. The alternative is comparative or contributory negligence under which rule a jury is asked to apportion responsibility, each defendant paying its share of the damages.

AK, AZ, CA, CO, CT, FL, GA, HI, ID, IA, KS, KY, LA, MN, MS, MT, NE, NV, NH, NJ, NM, NY, ND, OR, SD, TN, TX, UT, WA, WI, WV and WY.

Passed but later held unconstitutional in: IL and MT.

Source: Advocacy Resource Center of the American Medical Association, “State Laws Chart I: Liability Reforms”, October 2002 (<http://www.ama-assn.org/ama1/pub/upload/mm/378/revisedstatechart1.doc>) October 2002 and the National Academy for State Health Policy ([www.nashp.org](http://www.nashp.org)), found in *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, p.10, July 2002

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