

Elements of a System of Medical Justice

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"Liability and Patient Health"

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REFORMING AMERICA'S LAWSUIT CULTURE

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I. Possible Elements of a Reliable System of Medical Justice

“[T]he American legal system often is unjust—not, by and large, in its rules and official decisions, but because the complexity, fearsomeness, and unpredictability of its processes often deter the assertion of meritorious legal claims and compel the compromise of meritorious defenses. Adversarial legalism inspires legal defensiveness and contentiousness, which often impede socially constructive cooperation, governmental action, and economic development, alienating many citizens from the law itself.”

Robert A. Kagan,
Adversarial Legalism (Harvard 2001) p.4 (Tab 1)

“There’s only one cure for America’s ailing health-care system: We must create a reliable system of medical justice. Only then can we restore the trust essential to making sensible health-care choices. What’s required is not a thick rule book, but the key element of any effective legal system: a public institution with the authority to make rulings of right and wrong.”

Philip K. Howard, “Legal Malpractice,”
The Wall Street Journal, January 27, 2003 (Tab 2)

A. Knowledgeable decision makers

A majority of other civil law jurisdictions use non-jury courts to hear medical malpractice claims. Neither France, Germany nor Japan use civil juries. The requirement for use of a civil jury in personal injury cases was eliminated in England in 1883. The court has the power to order use of a jury but English case law makes clear that should be done “(if at all) only in exceptional circumstances.” In Canada, any party may make a motion to declare a case complex and the jury dismissed, and such motions are frequently granted in malpractice and product liability cases.

Gary T. Schwartz, “Product Liability and Medical Malpractice in Comparative Context,”
in *The Liability Maze*, Peter W. Huber and Robert E. Litan, Eds.,
The Brookings Institution (1991) p. 64 (Tab 3)

Sixty-two percent of Americans favor having medical malpractice cases tried in special courts presided over by medical professionals and other experts to review and decide injury cases, according to a recent Wall Street Journal, Harris Interactive Poll.

Wall Street Journal/ Harris Interactive Poll, February 2003 (Tab 4)

B. Consistent Judgments on Standards of Care

1. Participants can rely on prior decisions going forward

“Even under the best of circumstances, juries can never be as effective as specialized of fact at deciding malpractice cases because jurors are exposed to the medical issues only once; consequently, they cannot develop an institutional memory to aid them in deciding a specific dispute. This lack of exposure to medical issues not only impairs jurors’ ability to decide each case, but also increases costs and the likelihood of inconsistency across different cases. Furthermore, since juries are not required to articulate reasons for their findings and award determinations, their decisions cannot be scrutinized by insurers, lawyers, and claimants to establish reliable predictions for future claims.”

Kirk B. Johnson, *et al.*, “A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims,” 42 *Vand. L. Rev.* 1365, 1371 (1989) (Tab 5)

“Negligence . . . [is] a standard of conduct, a standard which we hold the parties bound to know beforehand, and which in theory is always the same upon the facts and not a matter dependent upon the whim of the particular jury or the eloquence of the particular advocate.”

Oliver Wendell Holmes, Jr., “Law in Science and Science in Law,” 12 *Harv. L. Rev.* 443, 458 (1899)

2. Impartial experts

The “battle of the experts” is unknown in malpractice and product liability cases in many European civil law jurisdictions. There:

“it is the judge who will probably examine the expert; for that matter, the judge may well be the person who designates those experts who will testify. (For example, the Dutch judge hearing a product case involving the sleeping medication Halcion resolved to decide the case by arranging for a committee of three experts). And even when a party is allowed to select his own expert, for that party’s lawyer to interview the expert before trial might be regarded as an impropriety.”

Schwartz (1991), p. 66 (Tab 3)

“The medical and legal professions have a tradition of mutual wariness that has impeded effective cooperation in developing consistent standards for medical testimony. The courts need help from the medical profession to help them strengthen the role of medical testimony in litigation. The medical community should respond by correcting misrepresentations of medical practice and assisting in the development of standards that encourage thoughtful and informed consideration of medical testimony by judges and juries.”

Jerome P. Kassirer and Joe S. Cecil, “Inconsistency in Evidentiary Standards for Medical Testimony: Disorder in the Courts,”
Journal of the American Medical Association,
Vol. 288, No. 11, September 18, 2002, p. 1387 (Tab 6)

3. Standard-setting authority in a court or other body could provide guidance and incentives to innovate

A demonstration project in Maine in the 1990s experimented with the idea that compliance with standards of care and risk management protocols could be used as an affirmative defense to a claim of medical negligence. Standards were as established by four medical specialty advisory committees representing four specialties: anesthesiology, emergency medicine, gynecology and radiology.

“An official of the Maine Medical Association indicated that the project grew out of discussions of a coalition of business, labor, insurance, and health interests, all concerned about alarming increases in the cost of health insurance. The coalition was especially concerned about defensive medicine, which was identified as one of the factors leading to increased health care costs. The coalition believed that physicians are motivated by the unfavorable liability climate, but cannot be expected to change their practice patterns unless given some protection from litigation.”

GAO Report, “Medical Malpractice: Alternatives to Litigation,” (1992) p. 10 (Tab 7)

“Similar to Maine, legislation in Minnesota cites adherence to approved practice guidelines as an absolute defense to malpractice charges, allowing physicians to employ them to support a defense of care rendered within standards but prohibiting their use by plaintiffs to evince substandard care. Florida included liability protection in its clinical guideline statute as an effort to reduce the expense of defensive medical practices. Maryland specifically prohibits either plaintiff or defendant from citing practice guidelines in malpractice cases, while the state of Washington specifically encourages the use of guidelines as evidence in medical liability cases.”

William J. Oetgen and Mary Jo Wiley,
“Medical Practice Guidelines: Is Cookbook Medicine Here?” 1996, p. 4 (available at <http://www.afip.org/Departments/legalmed/openfile96/guidelines.pdf>)

At the national level, no legislation exists that links practice guideline adherence to protection against claims of negligence, however, federal legislation with similar intent

(HR 5830) was introduced by Nancy Johnson (R. Connecticut) in 1990. The Act would have limited physician liability for those doctors who follow practice guidelines promulgated by the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality (AHRQ)).

National Health Policy Forum
Issue Brief No. 579, “Medical Liability Reform,
Is there a Role for the Federal Government?”

4. Recognizes complexities inherent in the concept of a “standard of care”

In many circumstances no single standard of care may exist. The need for human judgment, and our imperfect understanding of science and medicine are inevitable ingredients in any health-care related dispute. Research and thinking on this issue underline the need for knowledgeable decision makers experienced in healthcare related disputes.

“Under current practice, both experts try to ‘cull a single standard of care from the cacophony of opinion.’ By refuting the incorrect contention that a single standard exists, the empirical evidence will transform the [decision maker’s] inquiry away from a search for ‘the real’ standard of care, into a reflection on how to decide cases in which no single standard of care exists.”

Philip G. Peters, Jr., “Empirical Evidence and Malpractice Litigation,” 37 Wake Forest L. R. 757, 773 (2002) (Tab 8)
(quoting, Michelle M. Mello, “Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation,” 149 U. Oa, L. Rev. 645 (2001)

“[I]t is important to stress that the fallibility of experts and the variations in community practices do not mean that experts and practitioners are inadequate or arbitrary, much less petty, dumb, or greedy. The fundamental problem here is that human biology, diseases, and medicine are phenomenally complex, and the complexity simply exceeds the capabilities of human subjective reasoning. . . . Recognizing this fact does not imply disrespect, it implies confidence that we all want to provide the best care possible, and that there is no way to correct a problem without facing it.”

David M. Eddy, “The Use of Evidence and Cost Effectiveness by the Courts: How Can It Help Improve Health Care?” Kaiser Permanente Southern California, 26 J. Heath Pol. & L. 396 (2001) (Tab 9)

C. Predictable Outcomes

1. Encourages rational settlements

A system that produces predictable, consistent outcomes encourages efficient, rational settlements between the parties. Japan's Traffic Accident Resolution System exemplifies this. In Japan:

“fewer than 1 percent of automobile accidents involving death or an injury result in tort litigation. In the United States, the comparable figure is 21.5 percent. The disparity does not stem from passivity on the part of Japanese accident victims. They commonly make claims based on tort law and they receive compensation from negligent drivers and their insurance companies. The litigation rate is low because Japan provides nonlitigious methods of assessing fault, advising victims of their legal rights, and determining the appropriate level of compensation. . . . [B]efore a court case is filed in Japan, contested claims are generally resolved by *nonlitigious dispute resolution mechanisms*. [The system] work[s] because the Japanese legal system works hard at developing *clear rules that guarantee virtually automatic, predictable and moderate compensation* for victims.”

Kagan (2001) p. 135 (Tab 1)

2. Provides a backdrop for innovative processes such as Early Offers

Such a reliable system could provide a backdrop for innovative settlement processes such as Early Offers. The Early Offers mechanism attempts to provide incentives to defendants and claimants to settle claims quickly when an injury occurs. For claimants, the primary incentives to accept Early Offers are quick resolution and compensation for all economic losses. Claimants are also encouraged to accept Early Offers because “if a qualifying offer is made and the potential claimant rejects it and goes to court, the resulting litigation would be conducted under rules that were less favorable to the plaintiff.” This element of the Early Offers mechanism also provides incentives to potential defendants to make offers, because they will be better positioned should the case go to court. Specifically,

“A plaintiff who refuses a qualifying offer would be subject to a higher burden of proof (clear and convincing evidence) and a different standard of liability (intentional or wanton misconduct) for recovery of noneconomic damages.”

Committee for Economic Development,
Breaking the Litigation Habit: Economic Incentives for Legal Reform (2000) pp. 17-18

See also, Jeffrey O'Connell, “Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives,”
49 *Law & Contemporary Probs.* 125 (1986)

D. Creates Incentives for Quality Improvement at Enterprise Level

“[O]ur data also confirms the widespread perception that incentives for POs [physicians organizations] to improve quality are uncommon: 32% of organizations reported having no incentives and 74% had 2 or fewer of 7 incentives surveyed to improve quality of care. . . . Our data support policy recommendations by the IOM and others that POs should be given incentives to improve quality and support for developing clinical IT [information technology] systems.”

Lawrence Casalino, M.D., Ph.D., *et al.*, “External Incentives, Information Technology, and Organized Processes to Improve Health Care Quality for Patients with Chronic Diseases,” *JAMA*, January 22/29, 2003, p. 440 (Tab 10)

“Society should strive to find a third way, a more productive approach that blends external accountability and internal learning and improvements within health-care organizations. This last is the most important of all – better performance calls for harmonizing professional sanctions with patient safety systems, boosting market pressures for safety so as to improve on vague fears of a lawsuit as a source of motivation to improve care and patient safety.”

Randall R. Bovbjerg *et al.*, “Paths to Reducing Medical Injury: Professional Liability and Discipline vs. Patient Safety,” *J. Law, Medicine & Ethics* 369, No. 29 (2001)

1. Creates financial incentives

“The workers’ compensation system that has been in place in the United States throughout most of this century also gives companies strong incentives to make workplaces safe. Premiums for workers’ compensation, which employers pay, exceed \$50 billion annually. Particularly for large firms, these premiums are strongly linked to their injury performance. Statistical studies indicate that in the absence of the workers’ compensation system, workplace death rates would rise by 27 percent. This estimate assumes, however, that workers’ compensation would not be replaced by tort liability or higher market wage premiums. The strong performance of workers’ compensation, particularly when contrasted with the command-and-control approach of OSHA regulation, has led many economists to suggest that an injury tax be instituted as an alternative to the current regulatory standards.”

W. Kip Viscusi, “Job Safety,” *The Concise Encyclopedia of Economics*, available at <http://www.econlib.org/library/Enc/JobSafety.html>

“To the extent that it is common for potential tortfeasors to shift risk onto insurers they may avoid facing sufficient costs to induce appropriate care. A range of measures can mitigate these concerns, including experience-rated premiums and co-payments/deductibles. An alternative third-party payer may be the individual’s employer (*e.g.* a clinician’s hospital). Under such ‘enterprise liability schemes’ (a version of which has existed in the UK NHS since 1990), the hospital may seek to shift risk onto an insurer and issues similar to those above arise. Of course, in order to ensure that employers have incentives to supply care, the enterprise will need to have mechanisms in place to monitor, record, investigate and, possibly, punish any acts for which it is held liable. Even if this is possible, it will entail some measure of cost, so justification of such schemes requires that benefits exist to offset this. These may include the hospital being the appropriate risk-bearer for systemic risks (as opposed to case-level ones): it designs the risk management systems and is responsible for their operation.”

Paul Fenn, Alastair Gray, Neil Rickman, Robert Young,
“Deterrence and Liability for Medical Negligence:
Theory and Evidence,” presented at the 19th Annual Conference
of the European Association of Law and Economics (2002) p. 7

2. Avoids rigid thinking about recommended practices

“There will never be complete evidence for everything that must be done in medicine. The prudent alternative is to make reasonable judgments based on the best available evidence combined with successful experiences in health care. While some errors in these judgments are inevitable, we believe they will be far outweighed by the improvements in patient safety that will result.”

Lucian L. Leape, M.D., *et al.*, “What Practices Will Most Improve Safety?:
Evidence-Based Medicine Meets Patient Safety,”
Journal of the American Medical Association, July 24/31, 2002, p. 507 (Tab 11)

E. Eliminates Culture of Blame

“[W]e need to learn from errors. Our current culture emphasizes an approach often referred to as ‘name you, blame you, shame you.’ We know that such approaches only encourage clinicians to hide their mistakes. As the IOM report notes, we can learn from the experience of the aviation industry in this regard. Once fraught with accidents, the aviation industry today can serve as a model for how to build a safe system. The key to their success was abandoning a ‘blame the individual’ approach. Abandoning that approach led to an increase in reporting of errors and ‘near misses.’ They rigorously analyze those events and re-engineer the plane’s systems and processes, using human factors analysis and applying teamwork, guidelines, automation, simplification, and standardization to as many functions as possible. Our health care system must take similar steps. By creating an environment where clinicians can

share their mistakes, we can begin to develop systems that will ensure that these errors will not be repeated.”

Testimony on Patient Safety and Medical Errors
John M. Eisenberg, M.D., Director, AHRQ
Before the Senate Health Education Labor Pension Committee
Montpelier, Vermont, February 16, 2000

“In 1998 the Veterans Administration formed the Expert Advisory Panel for Patient Safety System Design to obtain expert advice to enhance the design of the VA’s reporting systems. . . . They advised us that an ideal reporting system: a) must be non-punitive, voluntary, confidential and de-identified; b) must make extensive use of narratives; c) have interdisciplinary review teams; and d) most importantly, focus on identifying vulnerabilities rather than be a counting exercise. . . .

To complement our internal system, an agreement to establish the Patient Safety Reporting System (PSRS), a complementary, de-identified voluntary reporting system, was finalized . . . with NASA. The PSRS is patterned after the highly successful Aviation Safety Reporting System that NASA operates on behalf of the FAA. It is external to the VA and allows all physicians, nurses, pharmacists, laboratory personnel, and others to report unsafe occurrences without fear of administrative or other action being taken against them.

Statement of James P. Bagian, M.D., P.E., Director, National Center for Patient Safety and Jonathan B. Perlin, M.D., Ph.D., M.S.H.A., Chief Quality and Performance Officer, Veterans Health Administration before the House Veterans’ Affairs Subcommittee on Investigation, July 27, 2000

F. Balances the Predicament of the Victim with Broader Societal Interests

There is a zero sum conflict between compensation for past mistakes and funds available for future health care:

“Who’s in charge today? No one. No judge, legislature, or agency is making deliberate judgments of what is reasonable care and what is not. No one is making rulings of who can sue for what. No one is balancing the needs of a victim against the needs of the rest of society. No one even acknowledges the interest of the common good—that every award to a victim raises the costs (or reduces the care) to sick people in a comparable amount.”

Philip K. Howard, “Legal Malpractice” (Tab 2)

The Vaccine Injury Compensation Model is an example of a system that successfully balances the needs of injured children against society’s need for an adequate supply of vaccines:

“The vaccine injury compensation bill is a rare instance in which Congress passed a [tort] replacement antiligation reform. Though the replacement

mechanism is quasi-judicial, it clearly differs significantly from traditional tort litigation. Individual vaccine makers are no longer on trial, negligence is no longer an issue, specialized decision makers preside rather than jurors, and payments are made from a government trust fund. Vaccine injury compensation has been moved from an adversarial legal model, where decision making rested in the hands of juries and judges across the nation interpreting vague, varied, and evolving rules, to something closer to the bureaucratic model, where centralized, specialized “special masters” apply a comparatively clear set of standards. . .

[T]he liability climate for the manufacturers appears to have been transformed by the compensation law [The Vaccine Injury Compensation Program]. The number of lawsuits filed against makers of DPT, by far the largest category of vaccine litigation, has declined precipitously. Thanks in part to this change in the liability climate, research and development of vaccines has exploded. The “whole cell” version of DPT has been replaced by the less troublesome acellular version, a change for which the parents group had long campaigned. . . . The head of Merck’s vaccine unit has called this the ‘best time’ for vaccine research in decades, with vaccines being developed for more than twenty diseases, including such scourges as childhood ear infections, malaria, gastric ulcers, and AIDS. The vaccine law, according to one pharmaceutical company official, has ‘turned the industry around,’ encouraging biotech companies to enter what had been a dead-end field.”

Thomas F. Burke, *Lawyers, Lawsuits and Legal Rights*
(University of California Press 2002), p. 163-64 (Tab 12)

G. Deliberate Judgments About Compensation

“Paradoxical as it may seem, one of the commonest tasks of a judge sitting in a civil court is also one of the most difficult. This is the assessment of general damages for pain, suffering or loss of the amenities of life. Since no monetary award can compensate in any real sense, these damages cannot be assessed by a process of calculation. Yet whilst no two cases are ever precisely the same, justice requires that there be consistency between awards.”

Lord Donaldson of Lynton, Forward to First Edition
Guidelines for the Assessment of General Damages
in *Personal Injury Cases*, (Oxford University Press 2002) (6th Ed), p. ix (Tab 13)

“[W]e find that people have a hard time in arriving at consistent, predictable judgments *when using the scale of dollars*—even when their moral judgments are both consistent and predictable. We show that in personal injury cases, people’s moral evaluations are shared, but their dollar judgments are erratic. We also show that a major source of this unpredictability comes from the fact that people do not know how to ‘translate’ their moral judgments into dollar amounts.

Why is the task of translation so difficult? One reason is that the legal system does not provide a standard, or *modulus*, by which to make sense of various points along the dollar scale. Imagine, for example, that an individual or company has committed some reckless act, perhaps by permitting an unsafe product to go on the market. Should the damages awarded be \$50,000? Or \$200,000? Or \$500,000 Or \$10 million? The legal system does not give people a sense of how to measure, in dollars, different moral evaluations of cases. Without a standard or modulus, different individuals, and different juries, will naturally come to very different conclusions about appropriate dollar awards, even when their moral judgments are entirely consistent.”

Cass R. Sunstein, “From Outrage to Dollars,”
Punitive Damages: How Juries Decide (U. Chicago Press 2002), p. 29

“Damage awards in [US] tort cases thus emerge from an intensive investigation of very particularized circumstances – an investigation that is evaluated under only the most general of guidelines. Moreover, no reservoir of experience accumulates to guide juries and judges. There is simply no judicial analogue to the guidance of common law and the role of precedent when judges and juries turn to the quantification of damages.”

Randall R. Bovbjerg, Frank A. Sloan, & James F. Blumstein,
“Valuing Life and Limb in Tort: Scheduling ‘Pain and Suffering,’”
83 N.W. U. L. Rev. 908 (1989) (Tab 14)

1. Treats like cases alike

“The desire for a measure of consistency in the award of noneconomic damages is ‘an expression of the belief in equal treatment of like cases as an ultimate value of justice.’”

Peter Cane, Editor, *Accidents, Compensation and the Law* (5th ed.)

“Few who suffer personal injuries as the result of the negligence of others, particularly injuries with permanent effect, will feel that the general damages that they are advised to accept or that they are awarded, adequately compensate them for their pain, suffering, and disability. If, despite this, victims of negligence are to feel that justice has been done, they must be treated consistently.”

Lord Phillips of Worth Matravers, Master of the Rolls,
Forward, *Guidelines for the Assessment of General Damages*, p. vii (Tab 13)

“Germans find the variation in our damages awards totally unacceptable. To them the point is not that we give too much money for pain and suffering and they give too little. The point is that whatever amount we decide to give for 30 minutes of pain before death (\$1000 or \$100,000), we should give the same amount to people for the same kind of injury. The Germans enforce a semblance of order with respect to pain and suffering damages by collecting together all the damage awards produced in every trial court in Germany in a given year. This book, called the *Tabellen*, is published and used by judges and lawyers to estimate what a damage award in a new case should be.”

Anthony J. Sebok, “How Germany Views U.S. Tort Law: Duties, Damages, Dumb Luck, and the Difference in the Two Countries’ Systems.” *Findlaw* July 23, 2001

2. Possible use of schedules or damage compilations to award noneconomic damages

○ In England, the Guidelines for the Assessment of Damages, compiled by the Judicial Studies Board, serves as a non-binding reference point for judges and lawyers in the assessment of damages. It is divided into nine sections, each dealing with a particular category of injury, most sub-divided into type of injury within a category and degrees of seriousness. For example, the sixth edition recommends an award of between £165,000 and £205,000 for injury resulting in quadriplegia and notes:

“The top bracket will be appropriate only where there is significant effect on senses or ability to communicate. It will also involve significant brain damage.” [£205,000 = ~ \$325,000]

Guidelines for the Assessment of General Damages in Personal Injury Cases (6th ed, Judicial Studies Board 2002) p. 3 (Tab 13)

○ In Austria, pain and suffering damages are awarded in the form of a lump sum for all pain and suffering sustained. In making their judgments, judges consult statistical evidence compiled in a regularly published record of awards, called the *Schmerzensgeld* which contains average rates of compensation determined according to the severity of pain as well as its duration. These tables serve as guidelines for the assessment of damages, which are typically far less generous than in Germany. The largest amount granted for pain and suffering damages in an obstetric negligence case was \$137,400.

Michael Faure and Helmut Koziol eds,
Cases on Medical Malpractice in a Comparative Perspective,
Springer-Verlag-Wien, 2001, New York p. 74

○ In Belgium, the judge begins his calculation of damages by consulting an indicative *tariff* which is “an unofficial, non-binding but actually much-applied set of guidelines, which was elaborated and regularly updated by the National Federation of Magistrates in the Courts of First Instance and the Royal Federation of the Justices of the Peace and Police Courts.” The Judge then adapts this *tariff* to the facts of the case. The maximum award for pain and suffering arising from total impairment is roughly \$800,000.

Faure and Koziol, p. 96

○ In France there is no table or guideline with statutory or judicial authority. French judges normally allow reference to both previous awards and use of guidelines published by a variety of private agencies to determine the size of awards. Medical experts are consulted who use tables to calculate noneconomic damages (*echelles de prejudices moraux*). However, judges have broad and final discretion to grant noneconomic damages, which has made awards less predictable than in other European countries. The sizes of damages are roughly in line with those in Germany. One notably large award for pain and suffering was a grant of \$370,000. There are no limits on recovery in France.

Michael Cannarsa, “Compensation for Personal Injury in France.” Available at <http://www.jus.unitn.it/cardozo/Review/2002/Cannarsa.pdf>

Faure and Koziol, p. 121

○ In Germany, judges calculate pain and suffering damages by consulting the *Schmerzensgeldtabellen*, a catalogue of more than thirty years of civil decisions which includes detailed information on the circumstances of injury and the nature of compensation. The largest awards for pain and suffering made in cases of severe mental and physical disability currently range from €200,000 to €250,000 euros. (€250,000 = \$270,000 dollars)

Faure and Koziol, p. 52

○ In the Netherlands, courts have the right to freely fix compensation taking into account the circumstances of the case. However, in practice the courts take into account recent trends in compensation both at home and abroad. Lists of damages awarded for pain and suffering are published every three years in the journal *Verkeersrecht*. Pain and suffering damages range from as little as a hundred dollars to a maximum of roughly \$150,000.

Faure and Koziol, p. 160

○ Compensation for noneconomic loss in Sweden is paid in accordance with certain fixed tables which are adjusted annually for inflation. Compensation for pain and suffering is less in Sweden than in other countries, but social insurance benefits are very generous. A large pain and suffering award for severe disability would not exceed \$50,000 dollars.

Faure and Koziol, pp. 197-200

○ South African judges may refer to several sets of guidelines in determining damages, including Kemp's Quantum of Damages and the Road Accident Fund's Guidelines, but precedent is the prime determinant. The highest award payments for pain and suffering according to the former would be about \$150,000.

South African Road Accident Commission Report, 2002, pp. 1109-1117

H. Values Truth Seeking Over Adversarial Procedures

“There are two fundamental differences between German and Anglo-American civil procedure, and these differences lead in turn to many others. First, the court rather than the parties' lawyers takes the main responsibility for gathering and sifting evidence, although the lawyers exercise a watchful eye over the court's work. Second, there is no distinction between pretrial and trial, between discovering evidence and presenting it. Trial is not a single continuous event. Rather, the court gathers and evaluates evidence over a series of hearings, as many as the circumstances require. . . Adversary control of fact-gathering in our procedure entails a high level of conflict between partisan advantage and orderly disclosure of the relevant information. Marvin Frankel put this point crisply when he said that ‘it is the rare case in which either side yearns to have the witnesses, or anyone, give the whole truth.’ . . .

The case against adversary domination of fact-gathering is so compelling that we have cause to wonder why our system tolerates it. Because there is nothing to be said in support of coached witnesses, and very little to be said in favor of litigation-biased experts, defenders of the American status quo are left to argue that the advantages of our adversary procedure counterbalance these grievous, truth-defeating distortions.”

John H. Langbein, “The German Advantage In Civil Procedure,”
52 U. Chi. L. R. 823, 826, 832, 841 (1985) (Tab 15)

I. Provides Appropriate Accountability for Reckless or Intentional Acts

1. Provides effective authority over credentialing and licensing of individual practitioners

“State medical boards, composed of doctors, lawyers, and public representatives, have evolved into the primary public institutions responsible for disciplining physicians in the United States. The history of state medical boards, like that of other public agencies, is one of constant adjustment to changing political, social, and economic conditions. This is particularly true in the field of health care where the shift from professional monopoly to corporate oligopoly has disrupted long-standing ties.”

Carl F. Ameringer, *State Medical Boards and the Politics of Public Protection* (Johns Hopkins, 1999) pp?

“Marilynn Rosenthal, a sociologist at the University of Michigan, has examined how medical communities in the United States, Great Britain, and Sweden deal with problem physicians. She has gathered data on what happened in more than two hundred specific cases, ranging from a family physician with a barbiturate addiction to a fifty-three-year-old cardiac surgeon who continued operating despite permanent cerebral damage from a stroke. And nearly everywhere she looked she found the same thing. It was a matter of months, even years, before colleagues took effective action against a bad doctor, however dangerous his or her conduct might have been. People have called this a conspiracy of silence, but Rosenthal did not find plotting so much as a sorry lack of it. In the communities she has observed, the dominant reaction was uncertainty, denial and dithering, feckless intervention—very much like a family that won’t face up to the fact that the grandma needs to have her driver’s license taken away.”

Atul Gawande, *Complications: A Surgeon’s Notes on an Imperfect Science* (New York: Metropolitan Books, 2002), p 94-95

In 1988, the AMA/Specialty Society Liability Project put forth a comprehensive administrative proposal for liability reform. The group was composed of the American Medical Association, thirty-one national medical specialty societies, and the Council of Medical Specialty Societies. The proposal was intended to be enacted in one or more states on an experimental basis, and set forth the parameters of a fault-based, administrative system that would replace the tort system for adjudication of claims of medical malpractice, incorporating and enhancing the policing function of the medical boards:

“It is clear from every study done on the incidence of medical negligence that there are more instances of iatrogenic injury than there are claims of medical malpractice. There also is evidence that the threat of liability is not a very effective deterrent to inadequate medical care. This evidence suggests that no system of liability determination and compensation can, by itself, effectively identify, retrain, and discipline physicians who are providing substandard care. For these reasons, the Liability Project chose to integrate its proposal for an administrative fault-based claim process into a specialized medical practices agency. This specialized medical practices agency will have significantly strengthened educational, disciplinary, and licensing powers and increased resources to permit the Board to perform the expanded functions.

The proposed system also is designed to enhance deterrence of substandard practices. Under the proposal, the two types of state regulation of the quality of medical care—resolution of malpractice claims and direct oversight of physician practices—would be combined in the jurisdiction of the Board and thereby coordinated more effectively. In addition, the proposal imposes greater requirements upon physicians to continue their medical education and adopt risk management measures. Finally, the Board would be given greater authority than existing state agencies generally have to monitor physician performance and respond to substandard or unprofessional practices. The effectiveness of this enhanced authority will be ensured by the proposal’s provisions for sufficient staff and resources to carry out this new authority.”

Kirk B. Johnson, *et al.*, “A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims,” 42 Vand. L. Rev. 1365, (1989), p. 1378-79 (Tab 5)

2. Provides meaningful data on errors and success rates

“All of the participants in the health care system -- HMOs and third-party insurers, physicians and patients -- require meaningful information about quality of care. If the data being collected and analyzed are incomplete, the conclusions are not meaningful, and can produce disastrous consequences. Entire patient populations can be left without options. Good doctors can make bad decisions to manipulate data that is not truly connected to quality.”

Jennifer Obel, “Uncalculated Risks
Medical Outcome Data, if Misused, Can Deprive Patients of the Care They Need,”
The Washington Post, January 14, 2003.

“The National Practitioner Data Base [a Congressionally mandated database that collects and disseminates information on malpractice payments, judgments, and other sanctions levied against physicians and other licensed health care professionals] does not give flexibility in thinking through whether the doctor was at fault. The legislation was trying to use the actual exchange of dollars as a proxy. When a payment is made in a medical malpractice case—that’s when the physician’s name goes into the data bank. This criterion and its impact on individual practitioners have come up for years. The law doesn’t make allowances for a lot of the health-care quality issues that are now being raised.”

William Robinson, M.D., M.P.H.,
Director, Center for Quality, Health Resources and Services Administration,
telephone interview, February 13, 2003

J. Administratively Efficient

“The [US] tort system is highly inefficient, returning less than 45 cents on the dollar to claimants. Breaking down costs, Tillinghast [an actuarial consulting firm] found that an estimated 20 cents go to litigants for their actual (economic) losses, and 22 cents to compensate for pain and suffering. Of the remaining 56 cents, 17 cents pays for claimants’ lawyers, 16 cents for defense costs, and 25 cents for administrative costs.

In 1950, only 20 [US] civil trials in federal courts lasted longer than 20 days. By 1981, the number of comparably lengthy trials had multiplied ninefold. The National Center for State Courts, in the most comprehensive study of court delay ever undertaken, found that median processing time in 1989 for all tort cases in the 25 urban trial courts studied was 441 days. Median times for tort cases varied greatly, ranging from 215 days in Wichita to 953 days in Boston. Median times in civil cases disposed of by jury trial ranged from 356 days in Fairfax, Virginia, to almost five years in Providence. The study also found that there is no statistical correlation between the size of a judge’s caseload and case processing time. Data from Jury Verdict Research suggest that the delays have continued through the 1990s. In 2000, it still took about 38 months from the time of the incident for a trial to begin in vehicular accidents, about the same as in 1994 and 45 months in medical malpractice cases, a drop of 16 months from 1994.”

Insurance Information Institute (www.iii.org)

Adjudication system features and rules can have a drastic effect on administrative efficiency. The difference between the Wisconsin and New Jersey workers' compensation systems illustrates:

“A 1988 study by the Workers Compensation Research Institute found that in permanent partial disability claims in New Jersey, dueling attorneys were involved in 100 percent of the cases and dueling doctors in 79 percent; the total ‘friction costs’ expended on those professionals were equal to 46 percent of total payments to the injured workers. . . . [For] ‘functional impairment’ claims in Wisconsin, friction costs had been reduced to merely 14 percent of compensation payments, attorneys involved in only 32 percent of cases and dueling physicians in only 6 percent.” [Wisconsin achieved this by employing a number of] “techniques, each of which reduced adversarial control and increased hierarchical control over processes and outcomes.”

Kagan (2001) 237-38 (Tab 1)

“A shift to detailed procedural rules for tort cases may bring the benefits of an administrative process. Such a system of case management was proposed by the Woolf Report to reduce the costs and delay in litigation. Its key features are:

- early communication between claimants and defendants, and target dates for disclosure of medical records;
- both parties to make realistic and prompt settlement offers with premium damages for defendants who fight on, lose and face an award above the offer;
- scheduled costs of elements of care for severely injured patients, to avoid case-specific calculations;
- use of a single (jointly instructed) expert witness for smaller more straightforward cases, with meetings between experts where they were separately instructed;
- fast track for cases up to £10,000 with strict time and cost limits.”

Adrian Towse and Patricia Danzon, Medical Negligence and the NHS: An Economic Analysis, in *Health Econ.* 8: 93-101 (1999), 98 (citing H. Woolf, *Access to Justice: Final Report to the Lord Chancellor on the Civil Justice System in England and Wales* 1996)

“[T]akao Tanase estimates that in Japan legal fees comprise only 2 percent of the total compensation paid to injured persons and that mediating and claims process costs amount to about 0.2 percent of the total amount paid to injured persons. In the United States, according to an in-depth survey in the late 1980s, 24 percent of individuals hurt in motor vehicle accidents involving potential defendants hire a lawyer, which generally compels the defendant to employ a lawyer too; the figure goes up to 57 percent of claimants with ‘serious injuries’ (defined as fractures, burns, or worse). . . . The resulting costs are shocking. According to a Department of Transportation nationwide study of motor vehicle accident tort claims (not just lawsuits) in 1968, lawyers for both sides were paid 47 percent of the total personal injury benefits. . . . In the words of Peter Bell and Jeffrey O’Connell, ‘No one wants to compensate injured people with a bucket brigade of money that wastes every second bucket.’ “

Kagan 2001 p. 137 (Tab 1)

K. Accessible to Patients

“The Vaccine Injury Compensation Program claimants may also recover ‘reasonable’ attorney’s fees and costs, and attorneys may not charge a fee in excess of what is awarded under the Program. The Program also permits attorney fee awards to be made when a claim is otherwise denied, as long as it had a reasonable basis in fact and was pursued in good faith. This latter feature may be unprecedented among public benefit programs.”

*The Vaccine Injury Compensation Program:
An Overview* (Department of Justice, February 2003)

The Swedish Patient Compensation Insurance (PCI) and the Pharmaceutical Insurance (PI) are designed to be accessible to patients. The programs:

“[A]re best understood as supplementary insurance that builds on the comprehensive network of other social and collective insurances in Sweden, including a tax-financed, publicly operated health care system. Most of these programs existed when the PCI and the PI were established in 1975 and 1978, respectively. . . .

An injured patient completes a simple form that is available in all clinics and hospitals, typically with the help of hospital personnel. This form is filed with the insurance consortium. The insurers’ claims adjuster reaches a decision without expert medical advice in about half the cases, depending on the adjuster’s experience. The adjuster may consult with a member of a panel of medical experts on issues of avoidability and extent of marginal damage.

The patient may appeal to the Patient Claims Panel for up to one year from the insurer’s decision. Appeals relate both to compensability and, increasingly, to the amount of compensation. The Panel, which meets

monthly, consists of six members—a chairman, two patient representatives, one medical expert appointed by the government, and two members appointed by the health care authorities. A representative of the insurers serves as an advisor on the settlement principles and insurance issues, but does not participate in the decision. Evidence is usually in writing; the patient may present his or her case orally with the consent of the Panel, but this occurs in only 10% of Panel hearings.”

The AMA/Specialty Society Liability Proposal also incorporates accessibility features:

“Patients who believe they have suffered injuries because of inadequate health care will be able to initiate administrative claims by filling out a simple form identifying the circumstances that serve as the basis for their claims. Claims forms will be readily available throughout the state and patients will be able to file the forms without the assistance of an attorney. In the event patients do experience difficulties in completing the form, the state will provide a toll-free telephone number for patients to call for help.”

Kirk B. Johnson, *et al.*, “A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims,” 1384-85 (Tab 5)

L. Provides a Comprehensive, Exclusive and Final Remedy

1. Prevents end run litigation

Many US systems designed to be comprehensive nonetheless tend to devolve into litigation over definitional issues or other, related issues used as an escape hatch from what was designed to be an exclusive remedy. In Florida, for example, where a no-fault program for perinatal injury cases has been in place for a decade, research shows parents try to obtain relief within the program and sue as well. The current problems with the US workers’ compensation system illustrate the problem of increasing end-run litigation:

“A problem is erupting under the modern state-based workers’ compensation system: workers’ compensation has moved away from its original goals of uniformity, efficiency, predictability, and fairness to a current state of disarray amidst inconsistent state case law and federal regulation. . . . [A]n evolving body of state common law is the first cause of the erosion of the exclusive remedy doctrine. Judicially-created exceptions to the exclusive remedy doctrine give injured workers the ability to circumvent the workers’ compensation system and sue employers in tort for on-the-job injuries.... The ADA [Americans With Disabilities Act] and the FMLA [Family and Medical Leave Act] provide relatively new federal protection to injured workers and leave employers with conflicting obligations. The exclusive remedy doctrine does not foreclose ADA or FMLA claims because those statutes pre-empt state workers’ compensation laws. Now, not only must employers determine if injured workers are entitled to workers’ compensation benefits, they must

also determine if the employee is ‘disabled,’ as defined by the ADA, or suffers from a ‘serious health condition’ under the FMLA. When a work-related injury qualifies as a disability or ‘serious medical condition,’ the employer is exposed to tort damages and conflicting state and federal remedies.”

Joan T. A. Gabel, “Escalating Inefficiency in Workers’ Compensation Systems: Is Federal Reform the Answer?” 34 Wake Forest L. Rev 1083, 1083-85 (1999) (Tab 16)

The recent decision by the Second Circuit holding that patients can sue health plans for injuries resulting from the company’s refusal to approve “medically necessary treatment,” may indicate that claims against HMOs would quickly become an “end-run” around any system of medical justice unless that system contemplates the claims:

“How can one object to the result reached by the court in this case? Taking its inspiration from some words in *Pegram v. Herdrich*, 530 U.S. 211 (2000), the majority elegantly skirts the boundary of ERISA preemption to avoid an outrageous outcome. Appellants allege that Mr. Cicio might well have survived, had not the plan administrator negligently denied coverage for Mr. Cicio’s treatment. Under the circumstances, it seems no more than just to allow his widow’s suit for malpractice to proceed in state court, as the majority does. And I certainly share in the majority’s “skepticism of a line of reasoning that would draw from a ‘comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans,’ the elimination of protective standards of professional conduct.”

Yet in the end I cannot reconcile the majority’s holding with the Supreme Court’s precedents and with the structure of ERISA itself, given those precedents. Nor do I believe that the majority opinion somehow “fixes” the problem with the ERISA caselaw. The conclusion that my colleagues have reached today is a band-aid on a gaping wound. It may provide justice to Mrs. Cicio, and I’m glad for that, but the injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end.”

Cicio v. Vytra Healthcare, ___ F3d. ___ (2d Cir.)
(February 17, 2003) Calabresi, J., Dissenting in Part

2. Authority for finality

Other societies accept a greater degree of authority and finality from tribunals.

“In the Dutch, German, and British informal tribunals, legitimacy and the feeling of neutrality are enhanced by a combination of hierarchy, representation, and expertise. The tribunals are not mediators, as in many American alternative dispute resolution procedures. They are hierarchical decision makers whose decisions have a high degree of finality. The panels of adjudicators are somewhat representative in that they include lay people. The panels are specialized by subject matter, which makes them more expert. The adjudicators also take the initiative to draw out the facts and explain their decisions—unlike American judges, who sit passively while competing lawyers attempt to discredit opposing litigants and reshape the truth, and unlike American juries, which do not interact with the disputants and do not explain their decisions.”

Kagan (2001) p. 237 (Tab 1)

M. Possible limitation on Contingency Fees

“A variant of Early Offers could be applied to create strong economic incentives to protect plaintiffs from paying contingency fees that are not commensurate with the risk and effort undertaken by the lawyer. . . . The possibility that the plaintiff would have to pay excess contingency fees can be used to increase the incentives for settlement. At no additional cost to the defendant, more money can be made available to the plaintiff by limiting unwarranted contingency fees. Defendants could make a settlement offer (as fashioned by them and independent of the formula for a qualifying Early Offer) within a short time after a claim was made. The lawyer’s contingent fee on the amount of the settlement offer, whether accepted or rejected and subsequently recovered through settlement or litigation, would be limited to hourly charges or to some percentage (*e.g.*, 10 percent of the settlement offer) that would be substantially less than the percentage that would otherwise be permitted (usually 33 percent or more). This could be accomplished by court rule or legislation. Because more of the settlement offer would be available for the plaintiff, settlement would be more likely.”

Committee for Economic Development,
Breaking the Litigation Habit: Economic Incentives for Legal Reform (2000) p. 19

II. Possible Structures for a Reliable System of Medical Justice

“There is widespread agreement that the current system of tort liability is a poor way to prevent and redress injury resulting from medical error. Most instances of negligence do not give rise to lawsuits, and most legal claims do not relate to negligent care. Many injured patients do not know they have suffered an injury resulting from error, and those who go through the legal process often do not even recover the cost of their continued health care. A few plaintiffs and their attorneys, however, win large sums that may be disproportionate to their injuries or unrelated to the defendant’s conduct. Prolonged, adversarial haggling over claims by plaintiffs’ attorneys and liability insurers alienates both providers and patients, and generates legal fees and administrative expenses that consume more than half the cost of liability insurance premiums. The apparent randomness and delay associated with this pattern of accountability not only prevent severely injured patients from receiving prompt, fair compensation, but destabilize liability insurance markets and attenuate the signal that liability is supposed to send health care providers regarding the need for quality improvement.”

Institute of Medicine, “Liability: Patient-Centered and Safety Focused, Nonjudicial Compensation,” Janet M. Corrigan *et al.* eds., *Fostering Rapid Advances in Health Care* (National Academy Press 2002) p.82 (Tab 17)

There are three structural decision points for building a reliable system of medical justice: the kind of tribunal that will hear cases; the possible bases for compensation of injured patients, and the identity of the risk bearer. The systems could have national, sub national or local jurisdiction.

A. Possible Forums

1. Judicial: Special Medical Court

The United States Congress has created a number of special “legislative courts” to hear certain categories of cases in a non jury setting including the Court of Federal Claims (used to hear cases under the Vaccine Injury Compensation Program); the Customs Courts, the Court of Appeals for Veterans Claims, the Tax Court, the Court of International Trade and the US Court of Appeals for the Armed Services.

“The Supreme Court has held that ‘. . . Article III [of the Constitution] does not express the full authority of Congress to create courts, and that other Articles invest Congress with powers in the exertion of which it may create inferior courts and clothe them with functions deemed essential or helpful in carrying those powers into execution.’”

Special Courts, U.S. Government Manual

None of these “legislative courts” uses a civil jury.

“To be sure, the [US Supreme] Court has been more than vigorous in its protection of the jury trial in the absence of a congressional directive to the contrary. When, however, Congress has clearly enunciated that use of a civil jury is incompatible with the accomplishment of its legislative goals, the Court has, for the most part, turned and run faster than a defeated army in retreat.”

Martin H. Redish & Daniel J. La Fave,
”Seventh Amendment Right to Jury Trial in Non-Article III Proceedings,”
4 Wm. & Mary Bill Rts. J. 407, 408 (1995)

Congress may also create exclusive trial level jurisdiction in an existing federal court as it did in the recent Terrorism Risk Insurance Act of 2002 (HR 3210, Sec. 107(a)), or create exclusive appellate level jurisdiction as it did in 1982, when it gave the Federal Circuit exclusive jurisdiction over patent appeals.

2. Administrative Tribunal

The 1988 AMA/Specialty Society Liability Project proposal was designed to be enacted in one or more states on an experimental basis, and set forth the parameters of a fault-based, non jury, administrative system that would replace the tort system for adjudication of claims of medical malpractice.

As described by its creators:

“The proposal first calls for an administrative hearing process to replace the civil jury system in deciding claims of medical malpractice. Second, while fault is retained as the basis for liability, the proposal modifies several of the other legal rules for determining liability. These first two elements of the proposal are designed to bring greater rationality, equity, and efficiency to the tort system’s goal of compensation. The proposal also includes reforms of the processes for educating, credentialing, and disciplining physicians. These changes will ensure that physicians are of a high quality which, ultimately, is the purpose of deterrence in the current malpractice system.”

The proposal relies on the “quid pro quo” rationale for eliminating the civil jury, as does the workman’s compensation scheme:

“[T]he proposed system will not pass constitutional muster unless it is a reasonably just substitute for the current jury system. Changes in the legal rules for malpractice will provide part of the quid pro quo for the elimination of the jury trial. The overall design in formulating the revised rules has been to serve the fundamental goals of professional liability reform: fair compensation to injured patients, deterrence of substandard medical care, and an efficient allocation of scarce resources. In some instances, choices have been made overtly to benefit patients. On the other hand, the system is not one-sided. The current insurance availability problems are attributable to weaknesses in the current legal rules, especially those used to award damages. Thus, modifications in those rules that benefit physicians and insurers clearly are warranted to limit the pressure of insurance rate increases.”

Kirk B. Johnson, *et al.*, “A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims,” 1394 (Tab 5)

Congress has created numerous federal administrative tribunals to hear special categories of cases:

“An even more profuse and variegated flowering of special and specialized adjudicative tribunals and agencies is the product of the coming of, first, the industrial and, then, the administrative state. An important—and, it turns out, prototypical—forerunner was a development at the level of state rather than federal government; workmen’s compensation. The creation of workmen’s compensation boards to supplant the jurisdiction of the common law courts to administer compensation to workers injured in industrial accidents was responsive to the felt need to create modest, high-volume, specialized tribunals, using informal and expeditious procedures to assure rapid and inexpensive justice to a class of litigants without meaningful access to the ordinary modes of litigation. When, later, workmen’s compensation became a federal program (for admiralty workers), Congress readily followed the state law precedents by adopting a method of adjudication designed for the ‘prompt, continuous, expert and inexpensive’ resolution of ‘the thousands of cases’ involved: it created a specialized administrative compensation tribunal rather than resorting to the ordinary article III courts.”

Paul M. Bator, “The Constitution as Architecture: Legislative and Administrative Courts Under Article III,” 65 *Ind. L.J.* 233, 237 (1990). (Tab 18)

3. Private: Contract-Based System

“In 1975, the California *Code of Civil Procedure* was amended to permit the contractual use of binding arbitration to resolve disputes of medical malpractice (*CCC section 1295*). Current law provides that health care plans must give notice in the contract clarifying that when both parties enter into a contract, they give up their constitutional right to have the dispute decided in a court of law before a jury, and instead accept the use of arbitration. Consumers enrolled in California health maintenance organizations (HMO) are also required under state law (*Health and Safety Code section 1363 (a) (10) and 1373*) to be notified by their health care plans of the types of disputes that are subject to arbitration, and how to initiate the process.”

Marcus Nieto and Margaret Hosel, *Arbitration in California Managed Health Care Systems*, California Research Bureau, California State Library, December 2000, 4.

“In entering into contracts for medical services with patients, some HMOs mandate the use of arbitration with binding decisions for medical malpractice disputes. Two such HMOs, Ross-Loos and Kaiser Permanente, require about 6.5 million subscribers—1 million for Ross-Loos and 5.5 million for Kaiser—to arbitrate claims arising from care received through their health care plans. Ross-Loos, located in southern California, includes arbitration in all its contracts. Kaiser plans enroll about 6.5 million people in 16 states. While Kaiser includes mandatory arbitration in healthcare contracts in only 5 states, these plans cover about 85 percent of the total enrollees. All enrollees in the Ross-Loos and Kaiser health care plans, regardless of the source of payment for the coverage—Medicare, Medicaid, and federal and nonfederal employee health benefit programs—are required to use arbitration if it is included in the health care contract. . . .

Plaintiffs in California challenged the (1) legality of requiring subscribers to health care plans to arbitrate claims and (2) constitutionality of an agreement that waives the right to a jury trial without express consent. However, the California supreme court found that such contracts were not illegal and did not violate the right to a jury trial [*Madden v. Kaiser Found. Hosp.*, 552 P.2d 1178 (Cal. 1976)].”

1992 GAO Report (Tab 7)

The Swedish systems for compensating medical and pharmaceutical injury are voluntary, contract-based compensation systems. Most participants opt into the systems because the tort system in Sweden operates under rules that make it very difficult for a plaintiff to recover:

“Whereas interest in tort reform in the United States is driven by the high cost of the traditional negligence system, the underlying concern in Sweden in the early 1970s was lack of access to adequate compensation, because of the explicit and implicit obstacles faced by tort plaintiffs. Only about 10 patients per year received compensation for medical malpractice. The impetus to develop the contractual, administrative insurance schemes for medical and pharmaceutical injuries came from legislative proposals that threatened to significantly expand tort liability of medical providers. Thus, although tort liability was not a significant burden on providers at the time, these voluntary insurance schemes were established to preempt a statutory expansion of tort liability that could have been more burdensome. Similarly, the Pharmaceutical Insurance was adopted in 1978 by voluntary agreement between the pharmaceutical manufacturers and the insurance consortium, under threat of statutory expansion of tort liability, which was thereby preempted.”

Patricia M. Danzon, “The Swedish Patient Compensation System: Lessons for the United States,” 15 J. Legal Med. 199, 204 (1994)

B. Bases for Compensation

Any system for adjudicating health-care related disputes must make a deliberate decision at the outset regarding what kinds of injuries will be compensated: only injuries caused by negligence (a fault-based system); all injuries arising from medical treatment (a true no-fault system, similar to the US workers’ compensation, and like the Vaccine Injury Compensation Program); health-care related injuries that are “avoidable” (a “no-fault” variant used in the Swedish systems) or all injury regardless of where it occurred (social insurance, such as the existing Social Security disability system). Each is discussed briefly below.

1. Fault-Based: Fault, Causation and Nature of Injury

The existing US tort system requires that a plaintiff prove causation and fault (negligence) in order to recover. The AMA/Specialty Society Liability Project administrative proposal is a fault-based model. The proposal retains fault as a basis for compensation, but proposes a number of changes to the liability rules, as described above.

2. “No-Fault” – Causation (or Avoidability) and Nature of Injury only

The Vaccine Injury Compensation Program is a no-fault program:

“The Program is ‘no-fault.’ That is, claimants need not establish that the vaccine was defective, or that any degree of negligence was involved in its administration. The only liability-related question is causation — did the vaccine cause the injury for which compensation is sought.”

*The Vaccine Injury Compensation Program:
An Overview* (Department of Justice, February 2003)

The Swedish systems used an “avoidability” analysis:

“An injury is compensable if (1) by ‘the preponderance of the evidence’ it was caused by medical care, and (2) either the treatment was not medically justified or the injury could have been avoided, given customary care. The PCI (Patient Compensation Insurance) requires no proof of fault or negligence of an individual provider. Thus from the physician’s perspective, the PCI is truly no fault. From the patient’s perspective, however, the criteria of compensability are quite similar to traditional custom-based tort standards. Medical causation is a necessary but not a sufficient condition. Normal, and even most abnormal, risks of standard medical care are explicitly not compensable. The criteria for compensability are defined in some detail in writing and are revised periodically, balancing pressures for compensation against cost control.”

Patricia M. Danzon, “The Swedish Patient Compensation System: Myths and Realities,” 14 *Int’l Rev. L. & Econ.* 453, [] (1994)

New Zealand utilizes another “no fault” variant:

“The types of medical misadventure claims accepted under the scheme are limited, and there appears to be little recourse to claimants via the civil courts. As such, there does not seem to be as much pressure on the cost of medical malpractice insurance in NZ, as has been witnessed in Australia. The basis of the ACC is a no-fault system of compensating members of the public for injury. It replaces the right to sue for damages. Statutory damages for medical misadventure have effectively determined the ‘bar;’ parties whose injuries do not meet the criteria of the ACC would be very unlikely to win damages via the courts. It should be noted that there is potential for claims for exemplary or punitive damages (which do not form part of the statutory damages awards) to be awarded in certain circumstances through the courts. However, it appears, based on recent decisions that even gross medical negligence is unlikely to lead to a damages award in the absence of conscious wrong-doing.”

Elayne Grace and Jean-Marc Queau,
“What’s Happening in Medical Malpractice Around the Globe?”
presented at The Institute of Actuaries of Australia
Sixth Accident Compensation Seminar, October 2002, p. 24 (Tab 19)

3. Social Insurance: Fact and Nature of Injury Only

A system that compensates all injury regardless of causation would be a form of social insurance similar to the US Social Security Disability program or the social insurance programs for the economic cost of medical care in many non-US jurisdictions.

C. Risk Bearer

1. Doctor/ Clinician

Individual practitioners are the first risk bearers in the US system, as they were in the UK before 1990 when the UK switched to an enterprise liability system. Many health care experts believe that a system that focuses on the individual provider as the risk bearer will not provide appropriate deterrence and quality improvement:

“Writing almost twenty years ago, Mark F. Grady recognized in the legal context that negligence is not actually a simple matter of personal deficiency or inattentiveness. Rather, as those in the field of engineering have long recognized, all human beings are prone to mistakes. The key is to put systems in place to prevent or mitigate these mistakes. Adopting a systems focus changes our view of the role of negligence. Because the system is designed to prevent or mitigate the effects of instances of individual negligence, the occurrence of an injury due to negligence reflects a systems failure as well as an individual failure.”

Michelle M. Mello & Troyen A. Brennan,
”Deterrence of Medical Errors:
Theory And Evidence For Malpractice Reform”, Tex. L.R. 1595, 1626 (2002)

2. Hospital/ Health Plan: Enterprise Liability

“In its sharpest form, enterprise liability means that individuals do not directly bear the costs associated with an injury. Instead, the enterprise . . . would be “strictly liable” in both a legal and economic sense by meeting the costs of liability premiums for all affiliated staff. Premium levels could then be experience rated. For instance, a hospital would pay more in a given year if there was a rash of avoidable injuries and less if quality improvement initiatives curtailed the incidence of such events. In addition to its deterrence promise, enterprise liability is thoroughly consistent with system-oriented quality improvement efforts. If the aberrant behavior of individual providers is a relatively infrequent explanation for harm, as a growing body of empirical literature suggests, then the greatest potential for patient safety advances must lie in institutional, not individual, accountability. . . . Enterprise liability can effectively target financial incentives at institutions, even specific processes within institutions.”

David M. Studdert, Troyen A. Brennan,
“No-Fault Compensation for Medical Injuries:
The Prospect for Error Prevention” *Journal of the American Medical Association*.
Vol. 286 No. 2, July 11, 2001, p. 221.

“Another significant difference between the PCI ([Swedish] Patient Compensation Insurance) model and either [US] workers’ compensation or the proposed no-fault enterprise liability model for hospitals in the United States is the link between patient compensation and incentives for injury prevention (deterrence). Workers’ compensation in the United States imposes strict liability on an employer for injuries to its workers. To preserve deterrence incentives, workers’ compensation insurance premiums are experience-rated at the level of the individual firm, to the extent feasible. By contrast, from the provider’s perspective, the Swedish PCI is truly no-fault, no blame, and no liability. The PCI eliminates all personal liability of individual medical providers—physicians or hospitals—for injuries to their patients. Although the PCI is financed by premiums paid primarily by the Swedish county councils that provide medical care, the levy is a flat per capita amount unrelated to the claims experience of hospitals and physicians in each county. Thus, compensation for medical injuries is effectively financed by a tax on medical care, thereby internalizing costs to the medical care system (general deterrence); but there is no feedback from claims to specific institutions or individuals (specific deterrence).”

Patricia M. Danzon, “The Swedish Patient Compensation System:
Lessons for the United States,” 15 *J. Legal Med.* 199, 200 (1994)

3. Government (perhaps funded by special tax)

Post program claims under the Vaccine Injury Compensation Program are funded through a special tax on vaccines:

“[Henry] Waxman decided to fundamentally restructure the compensation program. He split it into two parts, one for compensating for injuries suffered before the program went into effect, the other for new injuries. The preprogram injuries were to be compensated out of general tax revenues, with \$80 million authorized for each of the program’s first four years. Claimants would be compensated for future unreimbursed medical and custodial expenses but could recover only a total of \$30,000 for attorney’s fees, lost earnings, and pain-and-suffering combined. Claimants with preprogram injuries were still eligible to choose tort litigation instead, and the new manufacturer defenses in the legislation would not apply to them. Waxman set a ceiling of 3,500 on claims that could be paid for preprogram cases. . . Postprogram claims were to be paid out of a surtax on vaccines. The tax was set at \$4.56 for the DPT vaccine, \$4.44 for the measles, mumps, and rubella vaccine, and 29 cents for the polio vaccine.”

Burke (2002) p. 159 (Tab 12)

“Medical malpractice insurance has been provided under the New Zealand (NZ) accident compensation scheme since 1974, administered by the government-owned Accident Compensation Corporation (ACC). The funding for medical misadventure claims under this scheme is not currently provided by medical practitioners, rather it is shared between the government and all New Zealanders in the paid workforce.”

What’s Happening in Medical Malpractice Around the Globe? p. 24 (Tab 19)

D. Federal Incentives to States to Innovate With Any of the Above Having Elements in Part I, Above

“Demonstration projects would likely build on existing liability reform proposals, such as ‘avoidable classes of events’, ‘early offers of settlement’, and ‘scheduled ranges of allowable noneconomic damages.’ States should engage in efforts to educate the public about trade-offs involved in liability reform, and help providers communicate more effectively with patients when errors occur.”

Fostering Rapid Advances, pp. 10-11 (Tab 1)

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Gary T. Schwartz, “Product Liability and Medical Malpractice in Comparative Context,” in <i>The Liability Maze</i> , Peter W. Huber and Robert E. Litan, eds., The Brookings Institution (1991)	3
Wall Street Journal/Harris Interactive Poll, February 2003	4
Kirk B. Johnson, Carter G. Phillips, David Orentlicher, and Martin S. Hatlie, “A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims,” 42 <i>Vand. L. Rev.</i> 1365, (1989)	5
Jerome P. Kassirer and Joe S. Cecil, “Inconsistency in Evidentiary Standards for Medical Testimony: Disorder in the Courts,” <i>Journal of the American Medical Association</i> , Vol. 288, No. 11, September 18, 2002.	6
General Accounting Office Report, “Medical Malpractice, Alternatives to Litigation.” (1992)	7
Philip G. Peters, Jr., “Empirical Evidence and Malpractice Litigation,” 37 <i>Wake Forest L. R.</i> 757, (2002)	8
David M. Eddy, Kaiser Permanente Southern California “The Use of Evidence and Cost Effectiveness by the Courts: How Can It Help Improve Health Care?” 26 <i>J. Health Pol. & L.</i> 396 (2001)	9
Lawrence Casalino, Robin R. Gillies, et al., “External Incentives, Information Technology, and Organized Processes to Improve Health Care Quality for Patients With Chronic Diseases,” <i>Journal of the American Medical Association</i> , Vol. 289, No. 4, January 22/29, 2003	10
Lucian L. Leape, Donald M. Berwick, and David W. Bates, “What Practices Will Most Improve Safety? Evidence-Based Medicine Meets Patient Safety,” <i>Journal of the American Medical Association</i> , Vol. 288, No. 4, July 24/31, 2002	11
Thomas F. Burke, <i>Lawyers, Lawsuits and Legal Rights</i> (Berkeley: University of California Press, 2002)	12

Lord Donaldson of Lymington, Forward to First Edition, “Guidelines for the Assessment of General Damages in Personal Injury Cases, Sixth Edition” (Oxford: Oxford University Press, 2002)	13
Randall R. Bovbjerg, Frank A. Sloan and James F. Blumstein. “Valuing Life and Limb in Tort: Scheduling ‘Pain and Suffering,” 83 Nw. U. L. Rev. 908, (1989)	14
John H. Langbein, “The German Advantage In Civil Procedure, 52 U. Chi. L. R. 823, (1985)	15
Joan T. A. Gabel, “Escalating Inefficiency in Workers’ Compensation Systems: Is Federal Reform the Answer?” 34 Wake Forest L. Rev 1083, (1999)	16
Janet M. Corrigan, Ann Greiner, and Shari M. Erickson, eds., “Liability: Patient-Centered and Safety-Focused, Nonjudicial Compensation,” in <i>Fostering Rapid Advances in Health Care</i> , Institute of Medicine, (Washington, DC, National Academies Press, 2002)	17
Paul M. Bator, “The Constitution As Architecture: Legislative and Administrative Courts Under Article III,” 65 Ind. L.J. 233, (1990)	18
Elayne Grace and Jean-Marc Queau, “What’s Happening in Medical Malpractice Around the Globe?” presented at The Institute of Actuaries of Australia Ninth Accident Compensation Seminar, October 2002	19