

Windows of Opportunity

State-Based Ideas for Improving
Medical Injury Compensation and
Enhancing Patient Safety



Windows of Opportunity

Part of a National Campaign

The recommendations in this report are designed to help frame public policy debate and to promote health system improvements that benefit both patients and health care providers. The approach detailed in this report has generated substantial interest from a wide array of stakeholders across the political spectrum and across the country. Demonstration projects are urgently needed at the state level to begin to test the feasibility of many new promising ideas.

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For additional copies of this report – or for more details about the health court proposal, model legislation, and/or existing legislative proposals – please contact Common Good at 202-293-7450, extension 16.

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"[T]he value of a question is determined not only by the specificity and richness of the answers it provides but also by the quantity and quality of the new questions it raises."

Neil Postman, The End of Education

Executive Summary

The ideas in this report are presented to help states improve their medical injury dispute resolution and compensation processes, while enhancing health quality. State leadership in the area of medical liability reform has great potential to accomplish these goals. Moreover, the creation of demonstration projects to test promising new models for resolving disputes and compensating injuries at the state level could send a strong message to Congress and other leaders across the country about the viability of new reform proposals.

This report is part of a broader national campaign to advocate for new approaches to medical liability reform. The debate over medical liability issues is very polarized, and tends to be driven — both at the national and state levels — by proponents and opponents of capping non-economic damage awards. Sorely needed are innovative reform proposals that can enhance quality of care, promote consistency in justice, and facilitate improved compensation for injured patients.

The proposal, analysis, and recommendations described in this report stem from outreach undertaken by the national non-profit organization Common Good and research conducted by Professors David Studdert, Michelle Mello, Troy Brennan and their colleagues at the Harvard School of Public Health over the last two years, in an effort supported by the Robert Wood Johnson Foundation to refine and develop support for a conceptual model for the development of “health courts” — special courts to handle medical injury litigation. This work has involved extensive consultation with a broad range of stakeholders and study of a number of existing administrative medical injury compensation systems in the U.S. and overseas.

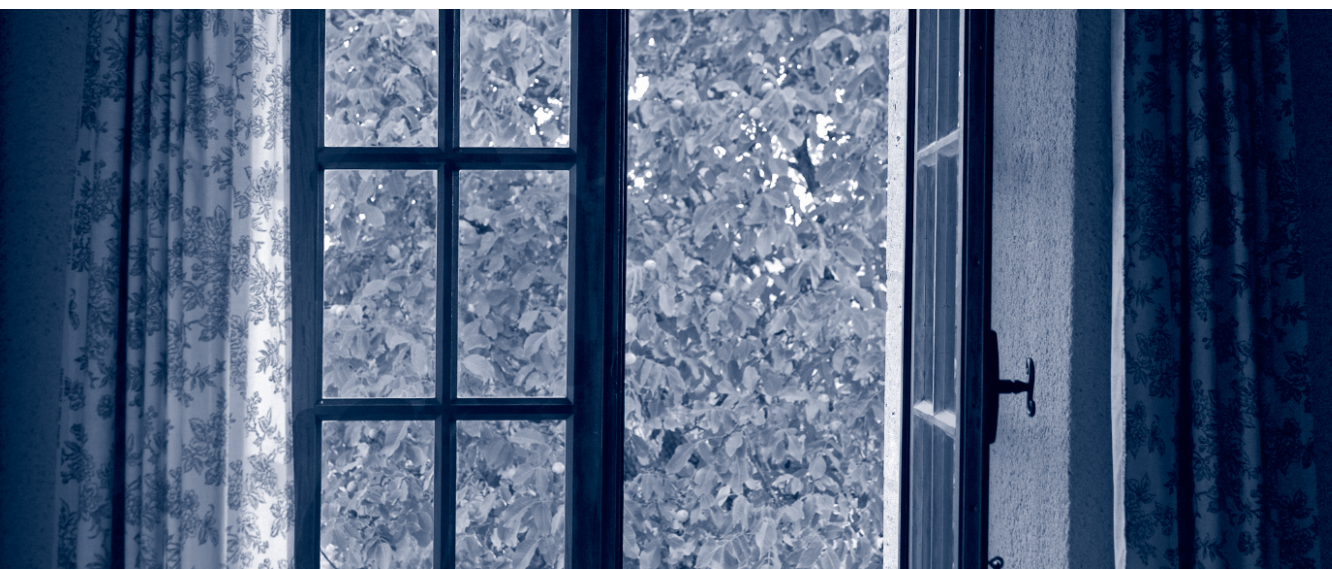
Health Courts: The Essentials

The health court model has the following core features:

- ★ **Trained Judges, Neutral Experts.** Judges with expertise in adjudicating medical injury disputes would consult with neutral medical experts to determine the standard of care in medical injury cases. They would issue written rulings of their decisions.
- ★ **Evidence-Based, Expedited Proceedings.** Experts would review the best available evidence about how adverse events occur and the extent to which they are preventable, and develop compensability recommendations for health court judges. Clear-cut cases would be fast-tracked for compensation, and early offers of compensation would be encouraged.
- ★ **New Compensation Standard.** Compensation would be based not on negligence but ‘avoidability’ — whether injuries could have been prevented if best practices had been followed. Avoidability is broader than negligence, but does not amount to strict liability for every adverse treatment outcome.
- ★ **Scheduled Non-Economic Damages.** A schedule of non-economic damages would specify a range of values for specific kinds of injuries.
- ★ **Patient Safety Enhancements.** Information from the adjudication process would be made available for root cause analyses by providers, and standardized reporting would facilitate development of preventive practices by safety authorities. This data on unanticipated events would be utilized to improve quality of care and enhance patient safety.

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Incremental Potential

The evolving health court model offers a vision of how America's medical liability system *ought* to work; it is in this respect very much a *transformative* reform proposal. Of course, most reforms in social policy tend to advance in an incremental way, and health courts are no exception.

In this regard, policymakers at the state level have to date advanced — or are developing — a number of reform proposals that incorporate one or more components of the health court model. More ambitiously, these include proposals to create health court or administrative compensation “demonstration projects” — limited trials to assess the feasibility of the approach. These demonstration projects would likely be of relatively limited jurisdiction (e.g., limited by geographic or clinical area). More modestly, proposals to create legislative task forces or commissions to study the feasibility of creating such demonstration programs have been advanced in a number of states; in several states such groups are currently undertaking this type of review.

In addition, a number of other types of proposals have been advanced or are in development that have the potential to promote greater consistency in medical justice — and in one way or another incorporate elements of the health court model. These include specialized education or training programs for judges, efforts to facilitate the retention of neutral experts in injury proceedings, designated case management processes or civil court divisions for medical injury cases, and other incremental reforms. See summary at right in Table 1.

As interest in the health court concept continues to grow, policy leaders in Washington, D.C. and around the country are likely to continue to consider and debate a number of these proposals. Our hope is that this report can contribute positively to the discussion.

Table 1
Health Courts, Administrative Compensation, and Enhanced Consistency in Medical Justice

To date, policy makers have proposed or discussed the following approaches for translating the health court model into policy.

-
- ✦ Create a pilot administrative compensation system at hospital, health system, or liability carrier, with “avoidability” standard and safety linkages
-
- ✦ Designate a specialized trial court for handling medical injury proceedings
-
- ✦ Implement a specialized case management program for medical injury cases
-
- ✦ Provide specialized education for judges who adjudicate medical injury proceedings in the existing system
-
- ✦ Facilitate retention of neutral expert witnesses in medical injury proceedings
-
- ✦ Charge a legislative task force with considering the feasibility of implementing a system of health courts in the state
-

Introduction

A Call for Innovation

America’s approach to resolving medical liability disputes and compensating medical injuries greatly needs improvement. Fortunately, promising new model proposals exist that can guide state policymakers in addressing critical system failings. As translated into policy initiatives, these injury compensation models may help to enhance system performance, and to improve health care delivery.

Today, America’s medical liability system works poorly, both for health care providers and for patients. Substantial and growing malpractice insurance premiums strain physicians and hospitals, threatening access to health services in some areas. Today’s system compensates few injured patients and has high administrative costs. Moreover, it subjects patients and providers to an adversarial process that has corrosive effects on health care. Evidence suggests that it also impacts health care quality, by discouraging reporting information about errors and near misses in treatment.

Notwithstanding the substantial and well-documented failings of the current system, little political consensus for reform has developed. To the contrary, debate over medical malpractice reform remains very polarized, with most Republicans calling for caps on non-economic damages and most Democrats equally vocal in protesting that caps will hurt injured patients.

Fresh policy approaches to malpractice reform are needed. In this context, the idea of creating “health courts” — special courts for medical injury cases — has emerged as a promising new alternative. The non-profit advocacy organization Common Good has been very active for several years in promoting the development of health courts. Supported by the Robert Wood Johnson Foundation, Common Good has been collaborating with Professors David Studdert, Michelle Mello, and Troy Brennan and their colleagues at the Harvard School of Public Health over the last two years to refine and cultivate support for a health court proposal.

The health court proposal features judges with training and expertise in health care, neutral experts retained and compensated by the court, judges making decisions about the standard of care, and a schedule of non-economic damages to ensure predictability and horizontal equity. In practice, the proposed health court system promises better to compensate injured patients, increase predictability and consistency of claims outcomes for providers, and facilitate (rather than impede) initiatives to enhance quality of care.

Interest and Support

The evolving health court proposal has generated broad interest and support from consumer groups, health care quality organizations, right- and left-leaning public policy institutes, organized medicine, and others who appreciate the potential for enhanced compensation, improved efficiencies, and greater consistency in justice. The media has taken note as well, with editorial endorsements in *USA Today*, the *Economist*, and a number of other publications.¹

As stakeholder support for the health care proposal has grown, so too has legislative interest. Legislation (in many cases bipartisan) to facilitate the creation of health court demonstration projects has been proposed in the U.S. Senate, the U.S. House of Representatives, and a number of state legislatures. Proposals are currently under development in many other states. See summary below in Table 2.

Table 2
Legislative Activity on Health Courts

The health court concept has been of substantial interest to legislators at both the federal and state levels. Legislative proposals to date include the following:

Federal Proposals

S 1337 - (2005) - Fair and Reliable Medical Justice Act - introduced by Senators Michael Enzi (R-WY) and Max Baucus (D-MT) - would facilitate the creation of state demonstration projects.

HR 1546 - (2005) - Medical Liability Procedural Reform Act - introduced by Representative Mac Thornberry (R-TX) - would authorize grants to states to create health court demonstration projects.

Selected State Proposals

Illinois - SB 151 - (2005) - would have created a separate circuit court within each appellate district solely for medical malpractice actions.

Maryland - HB 816 - (2006) - would have modified the screening panel process to incorporate judicial education, neutral experts, and patient safety linkages; HB 1136 - (2006) - would have established a legislative task force to study the feasibility of creating a medical malpractice division within the circuit court structure.

New Jersey - S 2910 - (2005) - would have created a Medical Malpractice Court to handle medical malpractice cases.

Pennsylvania - SB 1231 - (2006) - would establish pilot projects for administrative compensation system in medical liability cases involving hospitals.

Virginia - SJR 90 and HJR 183 - (2006) - continued the Joint Subcommittee to Study Risk Management Plans for Physicians and Hospitals, and specifically directed the Subcommittee to investigate the feasibility of establishing a pilot health court and system of health courts in Virginia.

Wyoming - HB 1010 - (2003) - directed the Wyoming Health Care Commission to consider the feasibility of establishing an administrative compensation system for compensating medical injuries in the state.

“There is widespread agreement that the current system of tort liability is a poor way to prevent and redress injury resulting from medical injury.”

Institute of Medicine, 2002



Key Design Questions

As state policymakers contemplate the ways in which the health court model can be translated into specific policy proposals, key questions and design choices they confront include the following:

- ✦ What specifications should exist for judges, administrative decision-makers, and expert witnesses in the health court system?
- ✦ How can the jurisdiction of a health court pilot project be most appropriately delineated? By geographic or clinical area, or both? Can a “demonstration” program be created to assess the feasibility of the approach?
- ✦ What procedural mechanisms can be employed in the health court system to expedite compensation and resolution of claims — while protecting the rights of individual claimants?
- ✦ How can legal and regulatory barriers (including constitutional concerns about the right to a jury trial as well as separation of powers) be best addressed, either in the context of a proposed pilot project or with respect to a broader program?
- ✦ What standard of liability should apply in the health court system: negligence or the broader “avoidability” standard?
- ✦ How can a schedule for compensating claimants’ non-economic damages best be constructed and operationalized? What considerations should guide the valuation of payment levels at various tiers in the schedule?
- ✦ What appeal rights will claimants have in a health court system?
- ✦ How will the administrative compensation processes be coordinated with existing or proposed disciplinary and safety processes? How can data from the adjudication process best support quality enhancement initiatives?
- ✦ How can a health court system best be financed?

This report is intended to provide educated guidance to policymakers as they consider these and a host of other design choices and issues. To do so, it provides contextual information about existing administrative compensation programs in the U.S. and overseas, outlines in detail the key elements of the health court model, and — based on various state proposals to date and in development — details a number of specific ways in which state policymakers might incorporate elements of the health court model into reform proposals.

Of course, the ideas here are only a sampling of potential approaches to enhancing the functioning of the medical liability system. And while this report specifies educated recommendations, it does not provide any single “right” answer with respect to most design questions/issues. Given the political, legal, and economic realities in individual states, there are numerous routes which different states may choose to take.

The fundamental goals of improving health care quality, preserving access to vital health care services, and protecting the rights of injured patients are shared ones, spanning ideological and political lines. In that spirit, we hope that the ideas presented in this report can assist policymakers in considering the potential benefits and pitfalls of various reform alternatives.

Persistent System Shortcomings

Through both stable and unstable times, there remains enduring dissatisfaction with America's medical liability system. In particular, concerns about the system consistently include its poor efficiency, limited deterrent effects, inconsistent standards, and inequitable compensation processes.

The medical liability system has been much in the news in recent years. However, liability reform has not been a public policy issue through recent decades to generate consistent interest from either legislators or the public. Instead, its prominence has tended to fade periodically and then reappear, as a sort of “Rip Van Winkle of health policy.”²

Three crises in medical liability have occurred since the 1970s. As a general rule, increases in premiums in periodic crisis intervals have tended to bring out the most vocal calls for reform, while periods of relative stability have generated less pressure for system changes.

Availability and Affordability Crises: 1970s and 1980s

For a variety of reasons, the late 1960s and early 1970s saw a major increase in malpractice litigation against physicians. Coupled with economic difficulties triggered by the OPEC oil embargo, many of the commercial insurers that had provided professional liability insurance withdrew from the market and left a large number of physicians without coverage. In response to this “crisis of availability,” favorable legal reforms were passed in state capitals around the country. These included California’s Medical Injury Compensation Reform Act (MICRA), a law which limited non-economic damages in malpractice cases to \$250,000.³ Physicians in many states also contributed capital to support efforts by state medical associations, hospital associations, and others to create mutual (i.e. physician-owned) malpractice insurance companies. As many as 100 such companies were started across the country; today they insure about 60 percent of U.S. physicians in private practice.⁴

About 10 years later, the second medical malpractice crisis occurred. The primary characteristic of this “crisis of affordability” was a substantial increase in the cost of malpractice insurance premiums, associated with increased claiming and a difficult investment climate for insurers. Physicians’ ability to pass along some of their increased professional liability insurance costs in the reimbursement rates they charged to public and private payors helped them weather this crisis.⁵

Medical Liability Today

The third medical malpractice crisis began in the late 1990s. Malpractice insurance rates have increased dramatically in recent years, particularly for certain specialties such as obstetrics and emergency medicine. There is evidence that the sizes of both the average and the largest payouts have risen substantially. At the same time, many malpractice insurers have experienced financial difficulties, due to low interest rates (about 80 percent of the typical malpractice carrier’s investment portfolio is invested in high-grade bonds) and a difficult reinsurance climate after the September 11th terrorist attacks. Moreover, competition in the malpractice insurance market in the 1990s contributed to some carriers offering policies that did not fully cover the costs of future claims associated with these policies — and to some insurance companies exiting the market as a result of these difficulties.⁶

With health plans today exerting a great degree of control over provider reimbursement rates, physicians are much less able to pass along increased overhead costs to payors than they were in the 1980s. This has led to strong pressure from health care providers for reform, including implementation of a federal cap on non-economic damages. Some states have heeded their call, yet at the national level political gridlock has stalled momentum for the enactment of caps.⁷

Polarized Perspectives

Disagreeing with much of the foregoing, some consumer advocates claim that there has been no explosion in the severity of claims, that problems in the market are due to insurance cycles rather than increased claiming, and that the pressure exerted by physicians and insurance companies on political leaders with respect to these issues represents simply an effort to seek an even more favorable legal climate. Indeed, the very legitimacy of using the word “crisis” is strongly challenged.

The best available evidence suggests that both increases in average claims payouts and shifts in investment returns have played a role in driving up liability costs.⁸ Nonetheless, the only point in the medical liability debate around which there is little dispute is the fact that physicians (especially in high-risk specialties) pay much more for malpractice insurance coverage today than several years ago.





Broader System Performance Issues

Unfortunately, problems in America's medical liability system have broader adverse consequences. In particular, today's medical liability system fails in four fundamental ways: (1) it compensates few injured patients; (2) it has high administrative costs (which means less money reaches injured patients); (3) it provides little deterrent effect for substandard practices; and (4) it affects the culture of medicine and hinders quality improvement initiatives by discouraging reporting of information about errors by health care providers.

Few Are Compensated. First, a primary goal of the tort system is — as it should be — to compensate adequately and fairly those who have been injured by substandard care. However, notwithstanding high rates of iatrogenic injury,⁹ research suggests that the system fails to achieve this goal. According to the oft-cited 1991 Harvard Medical Practice Study, fewer than 2 percent of patients injured as the result of provider negligence file a malpractice claim. Because the claiming rate is low and about a quarter of meritorious claims go unpaid,¹⁰ it is rare that patients injured by negligence are actually compensated. The system also lacks horizontal equity, in that some claimants receive awards that appear generous compared with injury severity while many others receive nothing. Even within jurisdictions, awards for similar injuries can vary substantially.¹¹

It Has High Administrative Costs. The current system is very inefficient. Close to 60 percent of total system costs pays for attorneys' fees, expert witnesses, and other administrative costs.¹² Less than half, therefore, ends up in the hands of injured patients. This represents a very high rate of transaction costs, especially when compared with administrative injury compensation programs such as workers' compensation or Social Security Disability Insurance. In addition, most claims drag on for years through court proceedings before the injured patient is compensated. Studies indicate that most malpractice cases take from three to five years to reach a resolution.¹³

Deterrent Effects Are Limited. The current medical liability system provides little deterrent effect to physicians, because it does a poor job in distinguishing between care that is and is not negligent. The current legal standard of liability is negligence, but not infrequently compensation is awarded to patients regardless of that standard, and a poor outcome is often a key factor in the determination of awards. In fact, while plaintiffs who have experienced negligent care are relatively more likely to receive compensation, plaintiffs nonetheless receive compensation in about a quarter of the cases where independent experts would say that no negligence occurred.¹⁴

It Affects the Culture of Medicine. Medical malpractice litigation also has adverse impacts on the culture of medicine and health care quality. In particular, the malpractice climate has helped to create what some observers have termed a "culture of silence" in medicine that discourages health care providers from disclosing information about mistakes because of fears of litigation and damaging their reputations. All doctors make mistakes at one time or another, but the existing system does little to promote learning from these mistakes. Rather, today's liability system tends to limit the flow of information about adverse events in treatment that experts identify as important for reducing errors, improving the quality of care, and saving lives.¹⁵ This can also affect efforts such as adverse event reporting which are intended to help identify why errors happen. This is unfortunate, since the growing patient safety movement depends on transparency of information — which the medical liability system tends to make less accessible.

It Encourages Adversarialism and Defensive Medicine. The "name and shame game" in the existing approach to resolving medical injury disputes seeks to assign blame to individual practitioners for injuries that have occurred in treatment. This ignores the growing awareness about the role that breakdowns in *systems* of care — as opposed to individual errors — have in leading to most treatment injuries. Moreover, studies indicate that injured patients who have experienced medical injury most want a sincere explanation and apology from their doctors.¹⁶ However, doctors are generally reluctant to admit any failures or disclose information about errors when that information could be used against them in court. Doctors are also much more likely to practice costly defensive medicine in this context, recommending unnecessary treatment and procedures that they believe will minimize their exposure to liability. The empirical evidence as to the costs of defensive medicine is not definitive, but research does clearly suggest that defensive practices are virtually ubiquitous in medical practice. In this context, health care cost containment is very difficult, since the legal system will not consistently uphold reasonable decisions about costs contained.¹⁷

Interest in Alternatives

Just as attention to medical liability has increased and decreased with each crisis and subsequent period of relative stability over the last 30 years, so too has interest waxed and waned in exploring alternatives to the medical liability system. While there have been some bold initiatives at the state level — for example, the creation in the 1980s of Birth-Related Neurological Injury Compensation programs in Florida and Virginia — there has been no fundamental reform at the national level.

Although the polarization of interest groups remains strong today, the current pressures for medical liability reform are somewhat different than in past crises. In particular, a new factor figures prominently in current reform discussions: patient safety.

Since the beginnings of the current medical malpractice crisis in the late 1990s, the concepts of patient safety and health care quality have become increasingly important drivers in health policy. Perhaps no single event galvanized public interest in health care quality and patient safety more than the Institute of Medicine’s 2000 publication of its landmark report, *To Err is Human: Building a Safer Health System*. In this report, the IOM revealed that as many as 98,000 people die unnecessarily every year in American hospitals because of medical errors. The report concluded that most errors are caused not by individual providers but rather by breakdowns in larger systems of care.¹⁸ This report stimulated significant political interest in health care quality, and has led to the development and introduction of numerous legislative initiatives to address these issues.¹⁹

As interest in patient safety has increased, so too has awareness that health care quality and the medical liability system are connected. To better prevent medical errors, experts say, more information needs to be disclosed about errors and near-misses (those errors that do not result in any harm).²⁰ Only with such data can hospitals and providers analyze the patterns and frequencies of medical error and focus on fixing the system-wide breakdowns that lead to errors. However, fear of litigation in the current system impedes open exchange of information about errors and near-misses.

Significantly, the Institute of Medicine identified the legal system as a major impediment to improved quality in a 2002 report titled *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*. The report went on to recommend that Congress charter demonstration projects to explore alternatives to the existing approach to resolving medical injury cases.²¹

Growing out of the Institute of Medicine’s recommendations, support has continued to increase for experimenting with new approaches to resolving medical malpractice disputes. In this context, health courts offer a number of desirable components, particularly given their potential to enhance patient compensation, improve efficiencies and consistency, and facilitate patient safety initiatives.

Table 3
Benefits of Health Courts

Element of Health Court Proposal	Potential Benefit
Trained Adjudicators	Greater expertise brought to resolution of injury cases
Neutral Experts	Avoids dueling experts for hire, which cause delay, increased cost
Judges Deciding Standards of Care	Enhances consistency in adjudication of like cases
Scheduled Damages	Promotes horizontal equity among similarly situated claimants
Avoidability Standard	Reduces emphasis on blaming individual providers
Patient Safety Linkages	Promotes an environment where health care providers can learn from mistake



Existing Compensation Systems

Administrative models for compensating medical injuries exist today both in the U.S. and overseas. These examples shed light on the potential benefits of an administrative approach to compensating medical injuries, and illustrate the issues that should be considered by policymakers interested in adopting such an approach in their state.

The health court model draws on elements of a number of administrative dispute resolution and compensation systems in the U.S. and overseas. These include injury compensation programs in New Zealand and several Scandinavian countries, as well as the Birth-Related Neurological Injury Compensation programs in Virginia and Florida. These programs all feature several or more key elements that would be incorporated into a health court system, such as trained adjudicators, neutral experts, damage schedules, and linkages to patient safety initiatives.

The experience and relative performance of these respective systems offer considerable insight as to the potential benefits of an administrative approach, as well as important system design considerations. This section outlines the essential elements of these respective systems, with emphasis on the benefits and weaknesses of the programs.

New Zealand's Comprehensive System

New Zealand has a comprehensive social welfare system, with universal health coverage. As part of this system of government-sponsored benefits, compensation is provided for accidental injuries, including injuries that are caused by medical treatment. In exchange for access to this government-provided compensation, injured patients give up their right to sue in court (except in certain egregious cases).

Patients who are injured due to medical treatments seek compensation not through a lawsuit, but rather by filing a claim with the quasi-governmental Accident Compensation Corporation (ACC), which was set up in the 1970s to provide coverage for all types of accidents.²²

Coverage. ACC administers the system, which provides coverage for any “personal injury caused by treatment.”²³ In essence, this standard comes closest of any injury compensation system around the world to true “no-fault” since it compensates all injuries regardless of the rarity or severity of the injury, and whether or not care was negligent.

The program covers rehabilitation and treatment for those who have been injured, survivor support for spouses and minor children, and loss of earnings. As much as 80 percent of earnings at the time of injury may be covered, although there is some concern that compensation can be inadequate for some injured patients, particularly those who are unemployed at the time the injury occurs. The program also can provide a single payment to claimants of up to \$100,000.00 NZ (roughly \$70,000.00 U.S.) to cover other miscellaneous expenses associated with the injury.²⁴

There is no coverage where the injury was not caused by the treatment at issue; in other words, not every bad outcome is compensable. Nor are those injuries covered which are an ordinary side effect of treatment (e.g. hair loss after chemotherapy).

Navigating the System. The system is simple to navigate, with basic claims processed in a matter of weeks and virtually all claims resolved within nine months. Damages for injuries are paid pursuant to a schedule of benefits, to ensure that similarly situated claimants receive similar amounts. About three in every five claims results in a compensation award.

Damages in certain cases may amount to a very small amount of money, or merely to a prescription for covered health services. For example, with a minor back injury, a patient’s “compensation” could be coverage for extra physical therapy sessions.²⁵

System Financing. Funding for the medical injury portion of ACC coverage is through general tax revenues, as well as levies on employers and self-employed individuals. The annual cost of the program is approximately \$50,000,000 (in U.S. dollars).

From New Zealand’s population of roughly 4 million, there are about 3,000 claims a year. Experts believe that this represents a relatively low claiming rate compared with the numbers of medical injuries that are believed to occur annually. Of course, the low claiming rate helps to control program costs, as do the program’s low administrative costs (roughly 10 percent of total expenses) and the use of a compensation schedule. Cost control within the program itself is also helped by the fact that the country’s extensive social welfare system covers costs associated with many of the damages routinely at issue in a U.S. malpractice case.²⁶

Impact on Safety. New Zealand's system has been designed to support improvements in patient safety, and ACC is making efforts to use data collected through the claims process to drive safety improvements at the institutional level. Admittedly, there is little evidence to suggest that New Zealand hospitals are substantially safer (or more dangerous than) those in peer countries like Australia or the United Kingdom.²⁷ However, all claims are recorded in a database that can be accessed by hospitals, and that is used by ACC for safety analyses. If ACC identifies a threat to safety (including a specific provider), it reports that information to the appropriate regulatory authority. ACC can also ask the government to order providers to adopt certain clearly effective, low-cost safety improvements.

To ensure appropriate accountability for medical professionals, the New Zealand government in 1990 established the Health and Disability Commissioner (HDC) to promote patients' rights and to mediate and/or investigate cases in which patients have filed complaints about their treatment, independently of the ACC claims process. The HDC also disseminates lessons learned through investigations.

Overall Assessment. In reducing adversarialism and promoting prompt and equitable compensation with low administrative costs, New Zealand's injury compensation system has achieved major successes. The system also has the information and the power to drive enhancements in safety and quality.

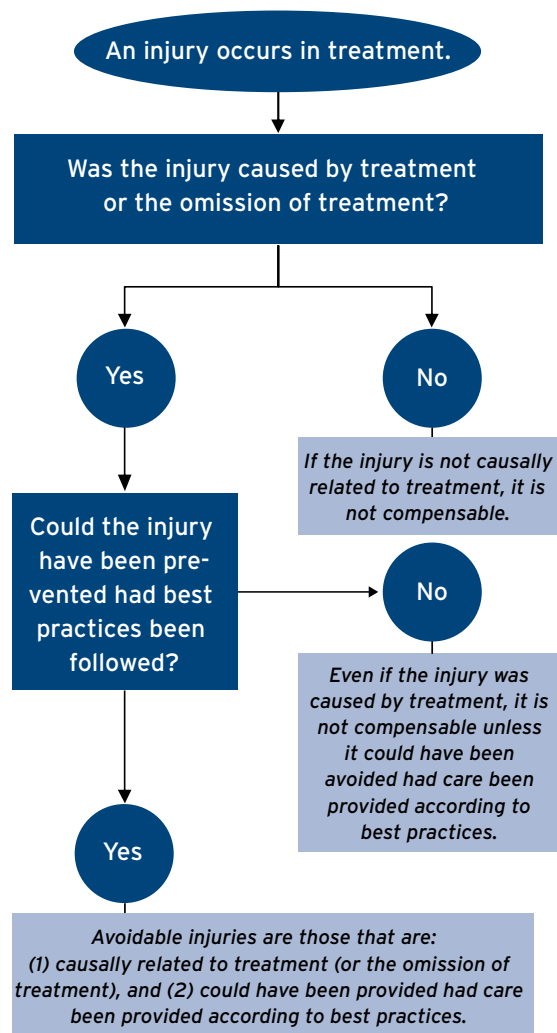
The Scandinavian Experience: Avoidable Harm

Like New Zealand, the five Nordic countries (Sweden, Denmark, Finland, Norway, and Iceland) provide a range of social welfare benefits, including universal health coverage. Within each country's social welfare system, compensation is provided for injuries sustained in connection with medical treatment. Sweden pioneered this approach to medical injury compensation in 1975, and the respective systems in each country bear strong similarities.²⁸ (The description below is primarily based on Sweden.)

The Scandinavian systems are administrative in nature and generally are operated by governmental and non-governmental entities with regulatory oversight. As in New Zealand, patients injured through medical treatment in these countries seek compensation through an administrative process, not through civil litigation.

Coverage. The systems in each country rely on a standard of liability known as "avoidability" that is broader than negligence but that does not approach true "no-fault," or strict liability. Under the avoidability standard, injuries are eligible for compensation if they were caused by treatment and could have been prevented (or "avoided," hence the "avoid"-ability term) had best medical practices been followed (See Figure 1). The exact definition and application of the avoidability standard varies somewhat among the five countries, as does coverage for some additional injuries in certain additional circumstances, but the basic idea is to tie determinations of liability to whether or not providers adhered to best medical practices.²⁹ In so doing, the avoidability standard captures all those injuries which are due to negligent care, as well as some additional injuries. However, it does not capture every bad medical outcome, or outcomes relating to the underlying medical condition.

Figure 1
Determining Whether An Injury Was Avoidable





Navigating the System. The systems are simple to navigate. In each country, a patient injured due to medical treatment files his or her claim form with an adjuster who, working with an independently retained expert, assesses the claim's validity. In Sweden, about 40 to 45 percent of claims filed result in compensation. The rate of compensability of claims varies across the other countries, from Finland (31 percent) to Iceland (50 percent). Most claims in Sweden and Denmark are resolved within six to nine months of submission.³⁰

The process is generally non-adversarial. This is due in part to the use of the avoidability standard, which is intended to reduce the sense of culpability associated with negligent claims. Indeed, administrators in Sweden describe their system not as “no-fault,” but rather as “no-blame.” In as many as 80 percent of claims in Sweden, physicians help their patients file claims for compensation.³¹

Claims in each country are paid according to a uniform schedule of benefits that specifies a range of values for particular injuries. It also provides certain deductibles that exclude small claims from the system. In Sweden, for example, claims are not eligible for compensation unless they involve an individual spending ten or more days in the hospital, or being sick for 30 or more days.³²

Several levels of administrative appeal are generally available to claimants. In Sweden, this includes appeal to civil courts of general jurisdiction, although this option is rarely exercised due to the relative generosity of the administrative benefit system and the difficulty of winning a medical injury case at trial.

System Financing. The systems are primarily government financed. In Sweden, for example, the system is funded by regional governmental councils, with contributions also made by consortia of health care providers. Administrative costs are relatively low (approximately 15-20 percent of total expenses in the systems in Denmark and Sweden).³³

Impact on Safety. Administrators of these systems have taken steps to promote patient safety. In both Sweden and Denmark, for example, information from the adjudication process is logged in a database and made available to external researchers. In some cases this information is aggregated and provided to health care providers, particularly when there are variations in error rates among facilities. Authorities continue to expand and improve patient safety activities.

These administrative programs are intentionally distanced from physician disciplinary processes, under the premise that punishing physicians who are providing information about injuries will lead to diminished willingness on the part of physicians to be candid about errors and near misses that have occurred in treatment. In so doing, the programs acknowledge the greater role that systems of care — as compared with individual fault — have in leading to most medical injuries. To ensure that “no-fault” does not equate to “no accountability,” each country has administrative processes for disciplining physicians.³⁴

Overall Assessment. Work remains to be done to recognize the full safety-enhancing potential of the Scandinavian injury compensation systems. However, these programs offer a number of benefits, including expedited compensation, reduced adversarialism, and enhanced system fairness.

Florida and Virginia Birth-Injury Programs

Several limited non-tort programs for compensating medical injuries exist today in the United States. In particular, both Virginia and Florida have programs that provide compensation for certain birth-related injuries through an administrative alternative to the tort system. Virginia's Birth-Related Neurological Injury Compensation Program was created in 1987; Florida's Birth-Related Neurological Injury Compensation Association (NICA) was created in 1988 to manage a similar program, the Birth-Related Neurological Injury Compensation Plan.

A major goal underlying both programs was to help ensure the continued affordability of malpractice insurance coverage to obstetricians. In fact, malpractice insurance premiums for obstetricians/gynecologists (OB/GYNs) fell in both Virginia and Florida after creation of the programs, although the precise extent to which the programs precipitated this result is impossible to determine. Program evaluations in Virginia have suggested that the program continues to facilitate access to liability coverage for OB/GYNs. The impact is less clear in Florida which, at baseline, has a very unfavorable liability climate for obstetrical care.³⁵

Coverage. Each state's plan pays for the care of infants who are born with specific neurological injuries. The programs are a mandatory avenue of compensation for patients cared for by participating physicians and they offer exclusive remedies, meaning that injuries deemed eligible for compensation under the program may not be pursued in tort. For successful claimants, the programs provide a range of lifetime benefits. Both programs were designed to be “no-fault” in the sense that eligibility criteria do not include provider fault or negligence.

The Virginia plan covers medical care, rehabilitation, economic losses, and other benefits. In some cases, the program will pay claimants' attorneys' fees. Similarly, the plan in Florida covers medical and other related expenses. It also provides coverage for reasonable filing expenses (including attorneys' fees), an infant death benefit of \$10,000, and a one-time cash award of up to \$100,000 to the infant's parents or guardians (conceptually similar to a non-economic damage award).³⁶

Each program narrowly defines the events that are compensable: severe neurological birth-related injuries to newborns. To be eligible for the Virginia program, a child must have suffered a birth-related neurological injury (as defined by Virginia law) that resulted from oxygen deprivation or mechanical injury during labor, delivery, or the period immediately following delivery. The Florida plan is similarly restricted to children who have suffered a brain or spinal cord injury (again, as defined by state law) that was caused by oxygen deprivation or mechanical injury during labor, delivery, or during the period immediately following delivery. Florida also has a minimum birthweight requirement. In each program, the child must have been delivered by a participating health care professional, or at a participating hospital. All eligible children must have suffered a certain minimum level of disability. Only live births are eligible.³⁷

Navigating the System. In Virginia, the state Workers' Compensation Commission adjudicates claims. Claimants begin the process by filing a petition to enter the program with the Commission. Upon submission of the petition, it is reviewed by an expert panel and by the program's administrators. An initial hearing as to eligibility is held by a Workers' Compensation Commission administrative law judge within 120 days. After the judge issues his or her decision, either party may appeal to the full Commission and then to the state Court of Appeals and the state Supreme Court.³⁸ While legal representation is not required, most claimants retain an attorney to assist with filing the petition, and surveys suggest that most claimants tend to learn about the program from a lawyer, not from a health care provider.³⁹

In the Florida plan, a petition is filed with the Florida Division of Administrative Hearings. NICA reviews these petitions for compensability, and coordinates medical review of children seeking entry into the program. NICA renders an initial determination as to whether the child is eligible, and then submits this decision to the Division, where an Administrative Law Judge makes the final determination regarding eligibility. Where claims are disputed, there is an evidentiary hearing within the Division. Significantly, NICA is an exclusive remedy only if the injury meets the tightly prescribed eligibility criteria.⁴⁰

Research suggests that the programs have significant advantages from a claimant standpoint. For example, a legislative review commission in Virginia found that children in the program fared better than they would have in the state's tort system.⁴¹ In addition, more than two thirds of parents would have chosen the program over a malpractice lawsuit, and the administration of the program was considerably faster than tort. More than half of these families would not have been compensated under the tort system. Similarly, research suggests that the Florida program has compensated patients on a more expedited basis than could have been expected in the tort system, and with far greater efficiency.⁴²

Each program also has drawbacks. In Virginia, the program does not compensate mothers for injuries suffered during birth (a separate action must be pursued), and patients' flexibility in spending awards is limited. However, the major problem in each program is the narrowness of current eligibility standards. The programs have admitted relatively few children since inception (171 in Florida as of November 2003; 110 in Virginia as of March 2006). With restrictive eligibility criteria, the programs can capture only a relatively small number of cases. Particularly in Florida, a number of claims of the type described in the original statute continue to be addressed in the tort system.⁴³ Of course, additional financing would be required to permit the programs to expand eligibility standards while remaining solvent.

System Financing. Each state's program is funded by assessments on hospitals and physicians. Physician participation in each program is optional, although large majorities of physicians delivering obstetrical care in the states elect to participate (about 80 percent in Florida, and 72 percent in Virginia). Participating physicians pay \$5,000 per year, while hospitals pay \$50 per live birth up to a cap of \$150,000 annually. Non-participating physicians contribute \$250 annually. Virginia also has a levy on liability insurers. Both programs have relatively low administrative costs compared with the tort system (between 8-10 percent of total expenses).⁴⁴

Each program was designed to be self-funding. Florida's program, which was initially capitalized with a \$20 million appropriation, has achieved this goal and is financially sound. Its statutory charter permits it to stop accepting new claims if its liability for existing claims reaches a certain percentage of total assets, as well as to assess casualty insurers (although it has taken neither step to date).



Virginia's program, by contrast, is currently in an actuarially unsound condition, although it has enough resources to pay expenses for at least the next 25 years. A substantial factor contributing to the program's financial condition is its assessment structure. In particular, state law permits assessments to be temporarily reduced, and this was done in the early years of the program. Had this not been done, the program's financial condition would today be far more secure.⁴⁵

Impact on Safety. The programs were not established primarily for safety-enhancing purposes, and they have done little to facilitate safety enhancements or risk management. Neither program explicitly incorporates information about how past claims were resolved into the process for adjudicating new claims, nor does either program disseminate information about rulings on current cases to practicing physicians.

In Florida, the Division of Medical Quality Assurance reviews all claims to determine whether the conduct of the physician rises to a level warranting disciplinary action. Similarly, participating physicians and hospitals in Virginia agree to review to claims by the Department of Health and the Board of Medicine, and a participating physician can be barred from the program for multiple claims or injury awards. However, evidence suggests that neither of these organizations does so very often, largely because of high thresholds for action (i.e. the physician's actions needed to have been grossly negligent, presented a danger to patient safety, or have been part of a larger pattern of behavior).

Overall Assessment. In short, the birth-injury compensation programs have a number of strengths and several shortcomings. In enhancing safety and expanding patient compensation, the programs have had minimal effectiveness, largely because they were not designed for this purpose and no effort has been made to deploy them toward this end. The programs, particularly Virginia's, have faced challenges with financing stability and the restrictiveness of eligibility standards. However, the programs have succeeded in expediting compensation and improving efficiencies. They also have helped (at least to some degree) to stabilize state markets for medical liability insurance.

As the best existing examples of administrative compensation in the U.S., these programs represent important models for efforts in other states. Indeed, legislative proposals to create birth-injury funds have been advanced in many states over the last two decades. Moving forward, the programs' strengths and weaknesses can help to guide design choices in other reform efforts to establish administrative compensation programs at the state level.

The Health Court Model

The experience and relative performance of existing administrative compensation systems in the U.S. and overseas provide a strong foundation upon which to develop a model for a new approach to resolving medical injury disputes: one that can expand compensation to injured patients, improve system efficiencies, and enhance consistency of justice.

The health court model draws upon lessons learned from the systems described in the previous pages, but goes well beyond these to address key failings in today's system for resolving medical liability disputes and compensating injuries. As described in previous pages, it is characterized by the following elements:

Administrative Process. Compensation decisions in the health court system would be made outside the regular court system by trained adjudicators. An explicit record of decision making would be kept in order to provide greater clarity in key areas (for example, expected levels of compensation, or what constitutes acceptable/optimal care) to improve reliability of decision making.

New Liability Standard. Compensation decisions in the system would be based on a standard of care that is broader than the negligence standard, but that would not equate to strict liability for all unexpected medical outcomes.

Scientific Basis. Compensation criteria would be "evidence-based," in the sense that they would be grounded in experts' interpretations of the leading scientific literature. To the maximum extent feasible, compensation decisions would be guided by *ex ante* determinations about the preventability of common medical adverse events made through a process of deliberation and review of scientific evidence involving clinical experts and other key stakeholders. Certain kinds of injuries would be "fast-tracked" for expedited compensation.

Predictability. Guidelines for compensating non-economic losses would be created for the system and applied to each claim that is judged eligible for compensation. Valuations of non-economic damages would be made using explicit, rational, and consistent methods.

Safety. De-identified information from the adjudication process would be made available to caregivers for root cause analysis and development of preventive practices. Such data would be utilized at the institutional level to enhance safety. In addition, information would also be extracted from standardized event reporting for epidemiological analysis by researchers and regulatory authorities.

These broad principles admit considerable flexibility in specific design choices, including choices with respect to key design choices and issues, such as jurisdiction, the role of experts and judges, claimant rights and appeals, the appropriate standard of liability, damages, system financing, and the relationship to patient safety structures. The following analysis presents a range of educated options with respect to these key issues, and provides insights as to what course of action may be most workable.

Jurisdiction

Key Questions

- ✦ How should the range of covered disputes be defined?
- ✦ If a demonstration project is established, should it be government or institutionally based?
- ✦ Should it cover all clinical areas or select clinical areas?
- ✦ Should jurisdiction be mandatory or voluntary in nature?

Possible Alternatives

- ✦ Administration of the program could be through a statewide mandatory system, or through a demonstration project with voluntary participation of one or more liability insurers or hospitals.
- ✦ All clinical areas could be covered, or coverage could be limited to select clinical areas such as obstetrics and/or surgery/anesthesia.

As a starting point, a voluntary demonstration project would likely be the most feasible alternative. States would likely be more comfortable with an approach in which insurers/provider organizations elected to participate, rather than one in which participation was mandatory statewide. There may also be an opportunity to develop a demonstration program through a state agency, such as the state Department of Health. In either case, individual hospitals or health care systems would opt into the program, along with their insurer. Patients would need a mechanism for opting into the program as well. A patient's choice would need to be made in advance of the injury, and preferably prior to commencement of the treatment relationship in which the injury occurred.

If a demonstration project approach based on voluntary participation is chosen, it would be preferable to start with just a few clinical areas in which the types and causes of adverse outcomes are relatively well understood. Clinical areas that allow prospective consent on the part of the patient would be preferable, as the patient would most likely have to be offered the opportunity to participate. Based on these two parameters, anesthesia and obstetrics make the most sense. The claims arising from these two areas are relatively homogeneous, and in many cases, there is ample time before the event in which providers can seek informed consent from the patient to participate in the demonstration project.

Any such demonstration project should cover ordinary medical injury claims only. Intentional tort claims, medical product liability claims, and mixed coverage/treatment claims against managed care organizations should remain in the jurisdiction of the tort system.

Judges & Experts

Key Questions

- ✦ Who should serve as the decision maker in the health court?
- ✦ What qualifications should judges or other decision makers have, and how should the appointment or selection process be handled?
- ✦ What qualifications should experts have, and should there be designated panels of experts from which judges can draw in each case?
- ✦ Should the health court be located within the judicial or executive branch of government?

Possible Alternatives

- ✦ A panel of medical and/or claims experts at the involved hospital or insurer could operate under state oversight and with discretion constrained by a legislative mandate to apply pre-established decision aids and/or a damages schedule.
- ✦ An administrative law judge with some medical expertise — but no formal medical credentials — could specialize in the adjudication of medical injury claims, and be supported by independent medical experts.
- ✦ A state-appointed judge with some amount of medical expertise could be designated.

A combination of the above alternatives would probably be most reasonable, depending upon the individual state. In the most likely scenario, a judge who specializes in health court claim adjudication would be assisted by medical experts with relevant expertise who come from a panel selected by the court. Ideally the health court would feature an administrative decision maker; however, a variety of legal, regulatory, and political considerations may make it preferable to locate the health court within the judicial branch. In either case, a training curriculum to educate judges about issues faced in medical injury cases should be developed. There should be pre-designated panels of expert witnesses from which judges or administrative decision makers could draw; medical specialty societies in the state could assist in developing standards for credentialing neutral expert witnesses.

Administrative Processes

Key Questions

- ✦ What procedural and structural methods could increase efficiency, reduce administrative costs, and streamline the procedures and time to final decisions about compensability of claims?
- ✦ How should the system best be harmonized with disclosure and early offer programs at the institutional level?
- ✦ How should rulings on standards of care and compensation provide guidance in future cases?

Possible Alternatives

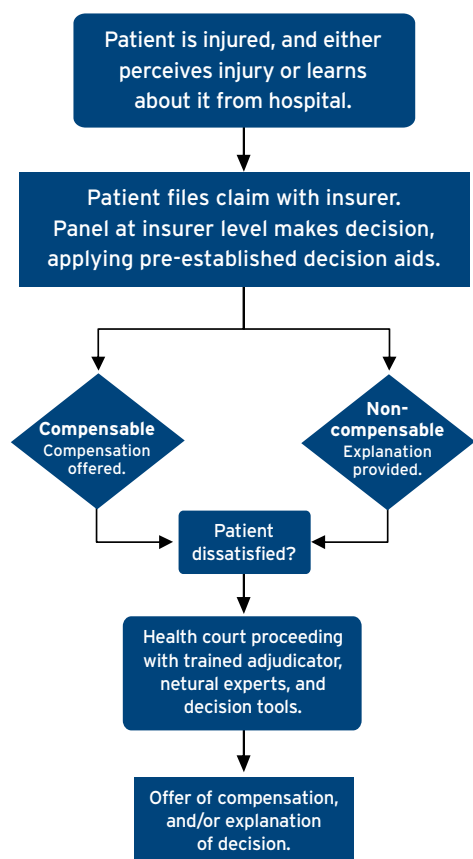
- ✦ Claims could be reviewed at the institutional level to encourage quick settlements.
- ✦ A health court hearing could be held for all claims.

Ideally, the first level of review in the health court system would be an internal process at the involved hospital or insurer. This level of review would not be a neutral adjudicatory process, but rather a formal mechanism for encouraging expeditious settlement of claims. A panel of experts convened by the involved hospital or insurer would review the event and, using decision aids and schedules make an early offer of compensation within four weeks. This would be done in concert with disclosure of the event by the caregivers. Counseling for patients would proceed along the lines of the “3-R” program developed by COPIC, the Colorado liability insurer, in an effort to resolve as many claims in this early stage (See Figure 2).⁴⁶

Priorities in this stage ought to be placed on disclosure of the error or injury, and, if appropriate, an apology made by the health care provider to the patient. In addition, consistent with the safety activities described later in this section, the institution ought to explain the steps that would be taken to prevent the incident from occurring in the future. To increase the likelihood of ensuring that such review reduces adversarialism and promotes expeditious resolution of claims, these processes ought to be focused on meeting and exceeding the real and *perceived* needs of patients, as early as reasonably possible in the process.

If the early offer did not lead to resolution, then a health court hearing would be held promptly. In the hearing, the judge or administrative decision maker would consult with one or more neutral expert witnesses to determine the applicable standard of care. The judge would also rely on guidance from past cases and lists of accelerated compensation events. Review would be *de novo*; the deliberations of the institutional review process would not bear on the determination of the health court. Compensation would be paid, as appropriate, with respect to the process described below.

Figure 2
Health Courts: Claims Process



Claimant Rights

Key Questions

- ✦ What information about incidents of injury should be disclosed to claimants?
- ✦ What notice and consent procedures should be developed for patients?

Possible Alternatives

- ✦ Information disclosed to claimants could be limited to the materials available under existing peer review protections.
- ✦ The peer review privilege could be reduced in scope to allow access to peer review reports.
- ✦ Notice and consent provisions should conform to the requirements of state law.

Claimants should have full access to their medical records, and the opinion of the hospital or insurer panel at the first stage of review should be part of the claim record available to the claimant. Claimants should also have the right to be represented by an attorney, although representation ideally might not be necessary if the health court process was designed in a consumer-friendly way.

In the context of a system in which an initial decision about a claim is made by the involved hospital or insurer, patients should have access to any materials used in a peer-review investigation (as they do under current law). Since any peer-review committee report would likely influence the decision made on the claim, it might also be desirable to allow patients to access any sections of such a report related to their own injury. Note that this would represent a limited reduction in peer-review protection as compared to present law.

Notice and consent requirements would vary by state, although any such requirements should be satisfied to the extent that patients voluntarily opt into the program. If a demonstration program is conducted in coordination with a health plan, consent might be provided through the plan's subscriber agreement. In this context, the patient would be deemed to have consented to participate in the program if proper notice was provided.⁴⁷



Appeals

Key Questions

- ✦ What should be the scope of appeal rights?
- ✦ What structures should exist for hearing appeals of the administrative health court's decisions?

Possible Alternatives

- ✦ Appeals from health court proceeding could be made to an administrative appellate court.
- ✦ Appeals from proceedings could be made to a regular appeals court.

Claimants and providers should have a right of appeal, and appeals either to the existing state appeals court or a new medical administrative appellate court may be feasible. However, such judicial review is not intended to be a *de novo* review. Anything but a rather high standard for review would very likely lead to large administrative costs and attorneys' fees at the appeals level. Consequently, an "arbitrary and capricious" standard for review from the health court would be preferable.

Compensation Standard

Key Questions

- ✦ What liability standard should govern determinations as to compensability of claims?
- ✦ What common adverse events should be pre-designated as compensable based on expert consensus?
- ✦ How could the system best relate to evidence-based standards of practice in determining liability and compensation?

Possible Alternatives

- ✦ There could be strict liability for defined treatment outcomes shown to be causally related to medical management.
- ✦ "Avoidable" events — plus pre-designated accelerated compensation events (ACEs) — could be compensable.

"Avoidable" injuries are those that are caused by treatment (or omission of treatment) and that could have been avoided had care been provided according to best practice. In other words, an injury is deemed avoidable if it might have been prevented had a better system of care been in place. The concept of avoidability occupies a middle ground between the concepts of strict liability (all injuries caused by medical care are compensable) and negligence (only events due to provider fault are compensable).

The avoidability standard is desirable because it moves away from the notion of individual fault and the negative connotations that the medical profession associates with negligence. It comports with the notion of preventability, which is critical to the patient safety movement's insistence on lack of blame. But it does not have the onerous financial implications associated with a move to strict liability.

Ideally, the avoidability standard would be employed to determine compensability of claims in the health court. To obtain compensation, claimants would need to show that the injury would not have occurred if best practices had been followed. They would not need to meet the more exacting negligence standard and show that a defendant acted as "no reasonable practitioner" would have.

The decision as to whether an injury was avoidable would be made in light of the circumstances as known at the time care was delivered, and in light of resources available at the locus of care. In practice, this standard could be modified by additional criteria based on the injury's severity, its rarity, or a focus on particular types of outcomes (e.g., birth injuries).

To help define what events were avoidable, a series of "accelerated compensation events," or "ACEs," would be generated. The ACEs lists would describe injuries that were deemed presumptively avoidable based on review of the best available scientific evidence. The lists would be developed by an expert consensus process, relying on medical evidence about injury causation, frequency, and preventability, and the best available evidence-based standards of medical practice. Events that matched the specifications and clinical circumstances of an item on an ACE list would be eligible for expedited compensation.⁴⁸

To increase consistency of rulings from case to case, the system would incorporate guidelines and precedent by recording written determinations made by the judge or administrative decision maker in a searchable electronic database that could be accessed by adjudicators in future cases involving similar injuries. It would also include the pre-designated lists of ACEs.

Use of the avoidability standard may well be significant in helping to overcome constitutional challenges under jury trial provisions of many states' constitutions. That is because surviving this challenge in a number of states will require that the program provide a remedy — like avoidability — which is substantively distinct from a common law standard such as negligence.⁴⁹

Damages

Key Questions

- ✦ How could a schedule for claimants' non-economic damages best be designed and implemented?
- ✦ What should be the basis of dollar valuations or ranges assigned to the various tiers of such a schedule?

Possible Alternatives

- ✦ Values in a non-economic damage schedule could draw on existing jury verdict data.
- ✦ Values in a damage schedule could be based on public deliberations informed by academic research about utility losses.

A key element of the health court model is to enhance the consistency by which damages are determined. This is particularly the case with respect to non-economic damages, which in today's system can vary considerably for similarly situated claimants.⁵⁰

With respect to economic damages, valuations should be based on methods currently used in the tort system and compensated in full. An expert employed by the health court would make the valuation, based on information provided by the plaintiff. However, in order to be eligible for consideration by the health court, a claim ideally would need to involve economic losses above some minimum threshold amount (for example, 4-6 weeks lost work time or \$3,000-\$4,000 in out-of-pocket medical expenses). Payments would be made on a periodic basis, or perhaps paid over time as required by the patient's circumstances. Awards that include a future loss component would be re-examined every few years. An insurer or hospital would be subject to some financial penalty if it did not make a damages assessment in good faith.

With respect to non-economic damages, values should be based on public deliberation about reasonable compensation for the various levels of non-economic loss, as well as what the maximum total costs of the compensation system should be. Academic research into utility valuations could be used to inform public deliberation; jury verdict data might also be useful.

To determine specific values for the non-economic damages schedule, a matrix of levels of injury severity should be generated, based on age categories and the National Association of Insurance Commissioners' 9-point disability scale, the AMA Guides to the Evaluation of Permanent Impairment, and/or decision science research about utility losses associated with different health states. A dollar value range should be assigned to each cell in the matrix; the adjudicator would then select a value in the range with reference to the specific facts of the case compared with similar cases.

Financing

Key Questions

- ✦ How should the system be funded, including administrative costs and compensation costs?
- ✦ What relationship should it have with existing forms of liability insurance and the institutions that write this insurance?
- ✦ What financial issues would the use of the avoidability standard create?

Possible Alternatives

- ✦ The system would be financed through tax revenue from individual and/or corporate taxes (i.e. a social-insurance model).
- ✦ The system would be financed through existing insurance arrangements plus an annual surcharge to the state to finance the administrative costs of the system. An initial public appropriation would likely be required to cover the costs of getting the system up and running.

A privately-financed model that includes a modest annual surcharge for state administrative expenses is likely to be preferable, and more politically feasible. To the (limited) extent possible, financing should be experience-rated in order to provide institutions with incentives for reducing injury and claims rates.

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

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

Patient Safety

Key Questions

- ✦ How could an administrative process best promote safety and quality in health care?
- ✦ How could the system be integrated with other patient safety structures at the hospital, state, and federal levels?
- ✦ How should the system interact with state medical licensure boards and the National Practitioner Data Bank?

Possible Alternatives

- ✦ A state agency or agencies could be established or designated to process claims and foster safety improvement activities.
- ✦ De-identified claims data compiled by this agency could be shared with other patient safety regulatory bodies, including state offices of patient safety, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), research organizations; and purchasing/quality initiatives such as the Leapfrog Group and the National Committee for Quality Assurance (NCQA).
- ✦ Information on claims could be provided back to patient safety offices at hospitals.
- ✦ Drug and device related information could be shared with the FDA.

Each of the above options has merit. Participating hospitals should share de-identified claims data with external patient safety organizations such as the Joint Commission on Accreditation of Healthcare Organizations, and the state should establish a claims database with standard reporting and data fields which would facilitate epidemiological analysis of the claims data by approved researchers. Indeed, many states have already established patient safety authorities and/or error reporting systems which may have capabilities for receiving such information. The Patient Safety Organizations (PSOs) to be established or designated under the 2005 federal patient safety legislation might also receive such information.⁵¹

Connected with the health court, either a local staff or external researchers could analyze the data for new prevention strategies. Ideally, there would be at least a modest health court administrative staff to maintain the database, coordinate with researchers about data requests, and disseminate analytical findings to hospitals and other health care providers. Marrying disclosure to full information, data should also be fed back to patient safety teams at each place of original occurrence so that they could undertake root cause analyses at the same time that patients were being informed. This information should be used to enhance safety efforts at the institutional level, and any institution participating in the pilot should have a demonstrable plan for how in fact this will occur.

However, the circumstances under which identifiable claims information would be shared with organizations responsible for physician discipline, licensure, and certification — such as state medical licensure boards and the National Practitioner Data Bank — should be carefully considered to ensure that disincentives for internal disclosure would be minimized. Policy makers may wish in this context to consider the ways in which aviation authorities have maximized incentives for reporting information about flight safety: by ensuring that such reporting is easy, confidential, non-punitive, and focused on safety-enhancement.

Patient safety activities. In addition to relaying critical and relevant information to the appropriate agencies, a health court system's administrative staff might undertake its own patient safety improvement activities. Many of the regulatory or research organizations working to improve patient safety often only can issue recommendations regarding best practices. In certain instances where a more immediate benefit to patient safety and welfare may be gained, consideration might be given to allowing the health court to require remediation or improvement in an underlying contributing factor. To the extent this is done, however, mandates for remediation or improvement should be made without placing blame on an institution or provider and generally kept confidential. Furthermore, disclosure should be made only in circumstances of egregious patient harm or if there is a failure to comply with a health court request.

Database maintenance. For purposes of patient safety, the health court administrative staff should maintain a database of all claims filed and all claims paid. With the presence of proper patient incentives for reporting, this database could serve as a repository for information of all medical injury for covered providers. This database would be searchable (many fields would be predetermined), permitting epidemiological research and periodic reports on medical injury. The health court administrative staff would also be able to monitor claims related to medications and devices. Whether paid or not, claim patterns might provide early warning of the dangers of medications and devices. If related to specific products, notification could be provided to the FDA.

Egregious professional misconduct. In cases of egregious provider misconduct, in which the health court determines that a risk of significant harm continues to exist for other patients or that this event was clearly outside of the bounds of professional behavior, the hospital would be exhorted to investigate and (as appropriate) report to regulatory authorities. To ensure accountability, the health court might itself notify the appropriate regulatory, disciplinary, or licensing agency in extreme cases. Because the intent of this system is to keep compensation decisions separate from decisions of discipline, responsibility and blame, however, disclosure should be permitted only in narrow circumstances where the danger to patient safety is clear, ongoing, and significant.

Providers with multiple paid claims. It might become apparent to the health court that a certain provider (either an entity or a person) has a pattern of claims or repeated injury. In these circumstances, the health court administrative staff might undertake an independent investigation by reviewing all of the claims made. If the investigation determines that the pattern rises to the level of egregious professional misconduct, action might be taken as described above. If the pattern of injury does not rise to that level, but demonstrates a need for further training or correction of a certain practice or risk, the health court could encourage such remediation to take place at the institutional level. This might dovetail especially well with the continuous competency proposals that have been advanced by the American Board of Medical Specialties (ABMS), the Federation of State Medical Boards (FSMB), and the Citizen Advocacy Center (CAC), among others.

Prioritization of patient safety measures. The health court might help overcome the problem of prioritizing patient safety measures. During investigations, questions regarding whether specific patient safety practices might have prevented the injury could be asked. Practices could be taken from Leapfrog measures, National Quality Forum measures, Agency for Healthcare Research and Quality practices, or patient safety standards from JCAHO. Based on the data gathered, recommendations could be made to individual institutions. These recommendations might come with deadlines for implementation.

Provider-specific information. At the request of a health care organization, the health court administrative staff might provide detailed claim and compensation information from that organization compared with that of all other claims. This would permit large organizations to initiate improvement activities in specific areas and to learn from organizations with lower rates of injury.

Periodic publications. The health court administrative staff might periodically publish de-identified claims information for the benefit of the public, researchers, providers, and/or payors. Some examples are types and rates of injuries reported and percentages compensated, relationships between volumes and rates of compensated injury at medical centers, and rates of unexpected deaths.

Translating Concept into Reality

The health court model described in previous pages is well-defined; however, translating this model into policy action is where the greatest potential lies for breakthrough system improvements. Fortunately, state policy makers interested in experimenting with health courts — and improving the functioning of the medical liability system — have a number of policy options at their disposal.

The health court model offers a transformative vision of how the medical liability system *ought* to work. In particular, it promises better to compensate patients who have been injured, improve system efficiencies, and help to set standards that both patients and health care providers can trust. Moreover, it offers real potential for facilitating improvements in the safety and quality of our health care system.

However, transformative changes in social policy rarely occur overnight. Creating a system of health courts will require time, effort, and consensus — all of which will likely necessitate a series of incremental steps over time. These may include modest reforms like designating legislative task forces or commissions to gauge the feasibility of creating such a system in individual states, more ambitious efforts like creating functioning pilot projects covering a limited geographic or clinical area, and a number of other potential intermediate steps.

This section outlines a number of concrete steps that state legislators could take to implement the health courts vision or key elements of the health courts approach.

Create an Administrative Compensation Demonstration Project

Proposed or in discussion in a number of states is the idea of creating a demonstration project at a hospital, health system, or liability carrier to compensate patients injured due to medical treatment through an administrative process rather than through civil litigation. Jurisdiction in such a program could be limited by geographic or clinical area (such as obstetrical care).

While actual proposals vary, a demonstration initiative at the institutional level might well be pursued in the following way:

- ✦ A state agency or commission could be directed to award demonstration grants, a stop-loss guarantee, or subsidized reinsurance to certain institutions.

- ✦ Institutions — hospitals, health systems, or liability carriers — could apply to participate in the program, with the agency or commission selecting the most eligible institutions. Preferably, participating hospitals or health systems would be self-insured, and physicians practicing within these institutions would need to agree to joint defense of claims with the facility. Also, there would need to be a strong commitment to risk management at the institutional level.
- ✦ Both patients and providers would agree to a uniform schedule for compensating non-economic losses. This schedule would be based on injury severity and patient circumstances. A process for allowing patient opt-in would be established at the institutional level. Patients would opt into the program prior to the point of care.⁵²
- ✦ Claimants would submit their claims to an independent administrator designated by the participating institutions, and could be represented by an attorney. The independent administrator would select neutral medical experts to determine compensability of injuries, based on the avoidable injury standard. Damages would be determined by reference to the uniform compensation schedule noted above.
- ✦ Appeals — at a relatively high standard of review — might be to the state appeals court, or to a new administrative appeals court.

Alternatively, an administrative demonstration program could also be created within an existing executive-branch agency — or a new agency — within state government. Such a demonstration program might be created in the following way:

- ✦ The program could be overseen by a branch of the state health department or workers' compensation agency (similar to the way in which the Workers Compensation Commission in Virginia manages that state's Birth-Related Neurological Injury Compensation Program).
- ✦ Through an application process, this agency could select one or more particular institutions (or a defined geographic area) as the location of the demonstration.
- ✦ Participating institutions would need to have well-functioning disclosure and early offer programs; the agency would establish an administrative process to adjudicate claims unresolved at the institutional level — and to compensate avoidable injuries.
- ✦ A training curriculum would be developed for adjudicators, drawing on established models of judicial education. Neutral experts would be retained by the adjudicators.

- ✦ A working group of academics and attorneys could develop the outline of a workable non-economic damage schedule, drawing on such resources as the NAIC's disability scale and the AMA's Guides to the Evaluation of Permanent Injury.
- ✦ The program should have strong linkages to patient safety initiatives, such as any state reporting initiatives within the state Department of Health.

Pennsylvania

A bi-partisan bill introduced in the Pennsylvania Senate in June 2006 would establish an administrative compensation system for medical liability cases. S.B. 1231 — the “Administrative Medical Liability System Demonstration Act” — would give a newly formed Administrative Medical Liability System Commission the authority to award grants to hospitals to participate in demonstration projects implementing administrative compensation systems for patient injuries. A self-insured hospital would be eligible to participate in the program if it agreed to a comprehensive risk management plan and to joint defense of claims with its medical staff, and if their insurance carriers were willing to participate. Patients suffering avoidable injuries — and who had opted into the program prior to treatment — would be compensated according to a uniform damages schedule. The demonstration program would be evaluated after several years on its safety-enhancing benefits, among other factors.


Establish a Specialized Trial Court for Medical Injury Disputes

A number of states have specialized courts for handling a range of different disputes, such as business disputes or complex litigation. Of these, perhaps the best known is Delaware's Court of Chancery, which has equitable jurisdiction over many corporate disputes. Such specialized courts have a long history of adjudicating particular types of cases appropriately and expeditiously.

Drawing on existing models of specialized courts within the judicial branch of government, a special trial court for medical injury cases might be developed in the following way:

- ✦ A judicial demonstration program could be created as a special division within the state's civil trial court system.
- ✦ A training curriculum could be created for judges, drawing on established models of judicial education. Those judges who choose voluntarily to specialize in medical injury cases could serve as the adjudicators in the medical injury division, similar to the way in which voluntarily specialized judges preside in science and technology proceedings in several states.
- ✦ Neutral experts would be retained in injury cases. Note that the right for judges to call court-appointed (neutral) expert witnesses is well-established; in many states, this right is granted in the state's Rules of Evidence (as a counterpart to Rule 706 of the Federal Rules of Evidence). Moreover, the right may be established under case law in states where there is no such provision in the evidentiary rules.
- ✦ A working group of academics and attorneys could develop the outline of a workable non-economic damages schedule, drawing on such resources as the NAIC's disability scale and the AMA's Guides to the Evaluation of Permanent Injury; alternatively, the working group might develop standardized guidance for judges to oversee jury awards.

A court such as this might be established without any legislative action, although the support of the judiciary would of course be essential. To the extent that the judges in this scenario are to decide the standard of care, employing the avoidability standard may well be essential to overcoming constitutional challenges.



On the other hand, a special medical court (or, as discussed below, case management program) might without any constitutional ramifications feature voluntarily specialized judges, the negligence standard, and court-appointed experts, while retaining the jury as the ultimate arbiter of fact. Greater predictability and consistency in decision making in this approach could also be promoted by facilitating the provision of more detailed jury instructions by judges to juries, and by adopting reforms intended to enhance jurors' ability to process and understand information. There very likely would be opportunities to tie this initiative to state error reporting and patient safety systems.

Designate a Case Management Program for Medical Injury Cases

Rather than creating a specialized trial court, another option is to develop a specialized case management system, or "track," for handling medical injury litigation. An analog to this are the special judicial tracks that some states have for handling business disputes; an even closer parallel is the special process that Maryland created several years ago for resolving science and technology disputes (see box at right for details). Such "tracks" or case management programs typically involve a particular docket within the court system to which cases involving specialized subject matter, multiple parties, or substantial damages can be assigned.

Again drawing on existing models, a program such as this might be established as follows:

- ✦ The case management program could be established on a demonstration basis within the state's civil trial court system.
- ✦ A training curriculum could be created for judges, with those judges choosing voluntarily to specialize in medical injury cases serving as the adjudicators.
- ✦ Neutral experts would be retained in injury cases, with credentialing standards developed by key stakeholders such as state medical specialty societies. As noted above, the right to call neutral (court-appointed) expert witnesses already exists in many states' Rules of Evidence, and/or in state case law.
- ✦ A working group of academics and attorneys could develop the outline of a workable non-economic damages schedule, drawing on such resources as the NAIC's disability scale and the AMA's Guides to the Evaluation of Permanent Injury; it might also develop standardized guidance for judges to oversee jury awards.

As with a specialized trial court, a case management process such as this might well be established without legislative action if the judiciary was supportive. Using the avoidability standard may well be a critical factor in surviving state constitutional challenges to the extent that the judges (rather than civil juries) are to make decisions about the standard of care in this scenario.

This type of case management program could, however, feature voluntarily specialized judges, court-appointed experts, and the negligence standard without any constitutional ramifications, so long as the jury was retained as the arbiter of fact. More detailed jury instructions could help to promote more consistent decision making in this approach, as could juror education.

Maryland's Program for Business and Technology Cases

Responding to the perception in the business community that Maryland has an anti-business environment, the Maryland General Assembly passed a bill in 2000 — as part of a broader plan to attract technology companies to the state — creating a task force to consider the feasibility of establishing a specialized court or process to handle technology-related disputes. In undertaking its deliberations, the task force consulted with a wide range of stakeholders, considered the experiences of other states, and weighed the likely benefits and costs of creating this new process. Based on its review, the task force recommended that a program be established to provide a designated process for science and technology disputes. However, rather than proposing the creation of a separate court "division," the task force instead suggested that a business and technology case management program be established in the state circuit courts to take advantage of the state's existing case management system. This has in fact been done, and today specialized judges are designated to hear eligible technology and business cases. Voluntary professional specialization is a key feature of the program; the judges who receive training are those who choose to do so. Cases are expedited, and written opinions of judicial rulings in these cases are published to promote consistency and transparency.

Provide Specialized Education for Judges Who Adjudicate Injury Cases

A key element of the health court proposal is the designation of specialized decision-makers to adjudicate injury cases. Within the existing court system, however, there are also opportunities to develop training curricula for judges who adjudicate injury cases. In a somewhat analogous way, the judiciary in Ohio has collaborated with the judiciary in Maryland to create a program for educating judges about complex scientific and technical issues (see box below). Although this approach does not address system efficiencies or patient safety, it could help to improve consistency in decision making and could represent an intermediate step in creating a health court or administrative compensation system.

The training curriculum could address such topics as:

- ✦ The use of clinical practice guidelines in medical treatment.
- ✦ Assessment of the qualifications of independent expert witnesses.
- ✦ Fundamentals of anatomy, pharmacology, pathology, surgical care, and preventive care.
- ✦ Changes in the medical standard of care concerning health conditions that often give rise to claims (e.g., the age at which women should first be given mammography screening for breast cancer).
- ✦ Other medico-legal issues.

This program could be established by the direct action of the judiciary, without legislative action. Establishing such a program would require working with appropriately trained institutions or professionals within the state, such as medical organizations, schools of medicine or nursing, or other entities providing medical education services.

ASTAR: Judicial Resources on Science and Technology

ASTAR — the Advanced Science and Technology Adjudication Resource Center, Inc. — is a consortium of the Supreme Court of Ohio and the Court of Appeals of Maryland. ASTAR identifies and trains “resource judges” — judges with specialized expertise — for adjudicating science and technology cases. ASTAR also sets standards and accreditation for several state resource judge programs. ASTAR has also held briefings on issues raised in medical injury cases.


Facilitate Retention of Neutral Expert Witnesses in Injury Proceedings

Another key element of the health court proposal is the availability of neutral expert witnesses to provide testimony in injury cases. An additional intermediate step for policy makers interested in the health court proposal, therefore, may be to promote the retention of neutral expert witnesses in injury cases. This might dovetail especially well with implementing tighter rules for the qualifications of each of the parties’ experts, and with other efforts to ensure accountability in the provision of expert testimony.⁵³

As noted previously, the right to call court-appointed expert witnesses is included in the Federal Rules of Evidence as well as in the rules of evidence and/or case law in many states. However, it is not common today for judges in medical injury cases to retain court-appointed experts. A new program in Tennessee, however, sheds light on how an initiative to promote retention of neutral experts might be established (see text box on page 24). The program in Tennessee — as yet untested — relies on a specific protocol for determining the admissibility of expert testimony.

The Tennessee protocol works in the following way:

- ✦ In a case where medical expert testimony is to be provided, testimony from experts for both the plaintiff and the defendant is submitted at least 120 days before trial.
- ✦ The judge decides whether or not the expert medical opinions are divergent; if so, he or she can ask the physician panel of the county Medical Society to provide the names of several expert physicians in the particular specialty at issue. The name of the physician defendant is not disclosed.
- ✦ The Medical Society panel provides the names of several physician experts, each of whom must be an acknowledged expert in the field at issue, live in a different state, and be insured through a different liability carrier. The judge chooses a name from the list supplied, and provides that to the attorneys for each party.
- ✦ A hearing can be held if either side objects to the physician selected; the judge makes the final determination on the expert selection after the hearing. The independent expert reviews the expert witness reports, and a hearing is scheduled sixty days before trial on the admissibility of the expert testimony. Either party can take the deposition of the expert witness.

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- ✦ The independent expert testifies at the hearing in regards to whether or not the expert testimony of plaintiff and defendant met these criteria: (1) whether scientific evidence has been tested, and the methodology with which it has been tested; (2) whether the evidence has been subjected to peer review or publication; (3) whether a potential rate of error is known; (4) whether the evidence is generally accepted in the scientific community; and (5) whether the expert's research in the field has been conducted independent of litigation.⁵⁴

As with the judicial education approach described above, this would not address system efficiencies or patient safety, but it could help to improve consistency in decision making, and represents an intermediate step in creating a full-blown health court system.

The Alliance Protocol

In spring 2004, Tennessee Circuit Court Judge Neil Thomas approached the Chattanooga Bar Association and the Chattanooga-Hamilton County Medical Society about participating in a dialogue to improve relationships between physicians and attorneys in Hamilton County, Tennessee. When the groups met shortly thereafter, medical malpractice litigation was a key issue of discussion. Both groups agreed on two points: (1) patients suffering injuries due to mistakes should be compensated, and (2) the admissibility of expert testimony should be determined well before trial. With respect to the latter point, the groups considered how judges might employ Rule 706 of the Tennessee Rules of Evidence, which permits trial judges to call an independent expert to assist in determining admissibility of testimony where opinions of the parties' experts diverge. The groups agreed that trial judges often were not in a good position to determine whether either party had offered expert testimony that should be determined inadmissible; they also agreed that trial judges are not typically well-equipped to identify possible court-appointed experts to assess opposing expert testimony. With those issues in mind, a protocol was adopted governing the use of Rule 706 in medical malpractice cases and in certain other cases involving medical injuries where expert opinions diverge and the trial judges cannot determine whether or not an opinion should be deemed admissible.

Convene a Legislative Task Force

In a number of states, legislatures have designated specialized commissions to consider the feasibility of establishing a health court or other administrative process for resolving medical liability disputes and compensating medical injuries (see text box on page 25). Such commissions provide only an initial first step, but can be a precursor to further legislative activity. The commissions typically draw on a range of stakeholders with an interest in medical liability reform and patient safety, seek input from the medical and legal communities, and provide recommendations to the legislature upon the conclusion of these deliberations.

A legislatively-chartered commission might consider the various legal, economic, and political factors implicated in the establishment of a demonstration project in the state. More particularly, this might include consideration of the following issues:

- ✦ The experience of other states in creating specialty courts and administrative processes for compensating patients with medical injuries.
- ✦ The operational aspects associated with establishing a health court or other administrative process.
- ✦ The costs associated with efficient operation of the court or process, including staffing needs.
- ✦ The criteria for determining the type and monetary thresholds for claim eligibility under the court or process, and the feasibility of developing schedules for non-economic damage awards.
- ✦ The level of expertise and training that should be required of adjudicators and the potential to utilize expert advisory panels.
- ✦ The development of statewide guidelines on the appropriate standards of medical care to be used by adjudicators, and the applicability of avoidability as the standard of care.
- ✦ The procedure for filing and assigning claims, and the feasibility of establishing an expedited appeals process for claims assigned to a medical malpractice court.
- ✦ The constitutionality of the system under the state constitution.

Legislative Task Forces or Commissions to Date

Among the states in which legislative task forces or commissions have been directed to consider the feasibility of creating health courts or administrative compensation systems are the following:

Wyoming – In the 2004 special session, the legislature directed that a new Wyoming Health Care Commission be established that would, among other responsibilities, consider the workability of creating a new compensation system as an exclusive remedy for damages resulting from health care errors.

Virginia – Joint resolutions were passed by both houses of the Virginia legislature in early 2006 that directed the “Joint Subcommittee to Study Risk Management Plans for Physicians and Hospitals” to investigate the feasibility of establishing a multi-jurisdictional pilot health court and subsequently a system of health courts in Virginia.

Pennsylvania – In 2003, the General Assembly directed the Joint State Government Commission (the research agency of the legislature) to assess the feasibility of establishing an alternative to the existing liability system for medical professional liability actions.

Massachusetts – In 2004, the state legislature directed that a study of the idea of health courts be undertaken.

Conclusion

Today, Congress and many states face a continued policy logjam over medical liability reform. At the same time, some evidence suggests that the crisis in malpractice insurance premiums may be abating. To help prevent future crises, the time today is ripe for reforms like health courts or administrative compensation programs that address system failings relating to patient compensation and inefficiency, as well as secondary impacts of the medical liability system on health quality and coverage.

A particularly beneficial aspect of the American governmental framework is that we have 50 individual state “laboratories” for policy experimentation. As such, the states provide the perfect opportunity to showcase the feasibility of the health court or administrative compensation model. By taking advantage of the existing support and energy for reform to develop new state demonstration efforts, state leaders today have the opportunity to have a significant impact on national policy making related to health quality and medical liability reform.

Creating health court or administrative compensation demonstration projects now could serve as a major catalyst leading to major breakthroughs across the country — since ideas that are successfully adopted in one state can spread to others. Doing so could also send a strong message to Congress, increasing the likelihood of federal action. Moreover, these reforms have substantial potential to promote the creation of health care environments where professionals can learn from their mistakes — and take steps to prevent such mistakes from re-occurring in the future. Most importantly, by showcasing new injury dispute mechanisms that better compensate patients, reduce administrative costs, and promote a culture of patient safety, these demonstration projects can also provide substantial benefits to the health care system as a whole.

Endnotes

- ¹ See “‘Health Courts’ Offer Cure.” USA Today. July 4, 2005. Available at: http://www.usatoday.com/news/opinion/editorials/2005-07-04-our-view_x.htm. The Economist has called health courts a “sensible idea.” “Scalpel, Scissors, Lawyer.” The Economist. December 14, 2005. See <http://cgood.org/healthcare-newscommentary-watch-833.html>. See also “Malpractice Mythology.” The New York Times. January 9, 2005. [“Experts have suggested a number of approaches, including special health courts with judges trained to deal with malpractice issues, required mediation, mandatory reporting of errors by doctors and prompt offers of compensation. But there is a lot of uncertainty about what would work best ... Congress should push for a wide range of demonstration projects aimed at solving the malpractice problem by actually cutting down on malpractice.”] For more media coverage, visit: <http://cgood.org/brochure-hcare-press.html>.
- ² See, e.g., Sage WM. Med-Mal: Health Policy’s Rip Van Winkle. Manhattan Institute PointofLaw.com online discussion, “Condition Critical?” November 14, 2005. Available at: http://www.pointoflaw.com/feature/condition_critical1205.php.
- ³ Sage WM. Medical Liability and Patient Safety. 22(4) Health Affairs 26-36 (2003). Note that MICRA’s cap is about \$920,000 in 2005 dollars (See Bureau of Labor Statistics. U.S. Department of Labor. CPI Inflation Calculator. Available at: <http://www.bls.gov/cpi/home.htm>).
- ⁴ See Sage WM. The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis. 23(4) Health Affairs 10, 12 (2004).; See also Smarr, LE. Testimony. Hearing on “Patient Access Crisis: The Role of Medical Litigation.” U.S. Senate Judiciary Committee, 108th U.S. Legislative Session, Washington, DC, Feb. 11, 2003.
- ⁵ Berenson RA, Kuo S, May JH. Issue Brief 68 Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places (Washington, DC: Center for Studying Health System Change, September 2003). Available at: <http://www.hschange.com/CONTENT/605/>.
- ⁶ Bonvino R. Leadership Forum: Why the St. Paul Company’s Actions are Important to New York State. January 2002.
- ⁷ American Medical Association. Medical Liability Reform – NOW! July 19, 2006: 26. Available at: <http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnow.pdf>; Higgins M. Broken System?. Washington Times. April 21, 2005: C8.
- ⁸ Mello MM. Report No. 10 Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms. The Robert Wood Johnson Foundation. May 2006: 15. Available at: http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf.
- ⁹ “Iatrogenic” injuries are those injuries that are caused by medical treatment.
- ¹⁰ Studdert DM, Mello MM, Gawande AA, Gandhi TK, Kachalia A, Yoon C, et al. Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. 354(19) New England Journal of Medicine 2031 (2006).
- ¹¹ Bovbjerg RR, Sloan FA, Blumstein JF. Valuing Life and Limb in Tort: Scheduling “Pain and Suffering.” 83 Northwestern Law Review 908–76 (1989).
- ¹² See Tillinghast-Towers Perrin. U.S. Tort Costs: 2003 Update. February 2003: 17. Note that the estimates of expenses devoted to administrative costs range among different value approaches.
- ¹³ Studdert DM, Mello MM, Gawande AA, Gandhi TK, Kachalia A, Yoon C, et al. Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. 354(19) New England Journal of Medicine 2031 (2006).
- ¹⁴ Ibid.
- ¹⁵ Palmisano, DJ. Testimony. Hearing on H.R. 5. U.S. House Judiciary Committee, 108th U.S. Legislative Session, Washington, DC, February 28, 2003.
- ¹⁶ See Dauer EA, Marcus LJ. Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement. 60(1) Law and Contemporary Problems 195 (1997).
- ¹⁷ See, e.g., Kessler D, McClellan M. Do Doctors Practice Defensive Medicine?. 111(2) Quarterly Journal of Economics 353-390 (1996). It is important to note that there are substantial variances in estimates of what defensive medicine costs the U.S. health care system. The article cited in this footnote represents perhaps the highest estimate, although the validity of this estimate has been challenged. There is little question, however, that defensive medicine does in fact occur. See Studdert DM, Mello MM, Sage WM, DesRoches CM, Peugh J, Zapert K, Brennan TA. Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment. 293 Journal of the American Medical Association 2609-2617 (2005).
- ¹⁸ Kohn LT, Corrigan JM, Donaldson MS, eds. To Err is Human: Building a Safer Health System. (Washington, DC: Institute of Medicine, National Academies Press, 2000).
- ¹⁹ See, e.g., The Patient Safety and Quality Improvement Act of 2005. P.L. 109-41, signed into law July 29, 2005.
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- ²¹ Corrigan JM, Greiner A, Erickson SM, eds. Fostering Rapid Advances in Health Care: Learning from System Demonstrations. (Washington, DC: Institute of Medicine, National Academies Press, 2002) 10.
- ²² Bismark M, Paterson R. No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety. 25(1) Health Affairs 278-283 (2006).
- ²³ Even though medical injury has been processed through ACC, it has been treated somewhat differently than other types of accidents over the years, and the medical injury portion of the program has been modified several times. Until 2005, the standard for coverage was such that patients could receive compensation if (1) an adverse event resulted from a provider’s ‘mishap’ (which amounted in practice to application of the negligence standard), or (2) the injury met certain rarity or severity criteria. In effect, patients were compensated when doctors were negligent, or when they suffered a very rare side effect that had substantial negative consequences for them. There was public and provider frustration over the arbitrariness of the application of the rare/severe criteria, and the *de facto* continuation of the negligence standard, so in May 2005 a new standard was implemented. With the new standard, any “personal injury caused by treatment” (PICT) is eligible for ACC compensation. In essence, PICT amounts to the closest any system around the world comes to being ‘no-fault,’ since it compensates all injuries regardless of the rarity/severity of the injury, and regardless of negligence. There is, however, no ACC coverage when the injury was not caused by the treatment at issue.
- ²⁴ Bismark M, Paterson R. No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety. 25(1) Health Affairs 280-281 (2006).
- ²⁵ Interview with Accident Compensation Corporation staff. March 24, 2005. Wellington, New Zealand. Notes on file with Paul Barringer, Common Good.
- ²⁶ Bismark M, Paterson R. No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety. 25(1) Health Affairs 281 (2006).
- ²⁷ Bismark M, Paterson R. No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety. 25(1) Health Affairs 282 (2006).
- ²⁸ See Erichsen M. The Nordic Patient Insurance Schemes. Working Paper (2005).

- ²⁹ Kachalia A, Mello MM, Brennan TA, Studdert DM. Beyond Negligence: Avoidability and Medical Injury Compensation. Harvard School of Public Health Working Paper (2006).
- ³⁰ Wyoming Health Care Commission Medical Errors Subcommittee. Report on Medical Errors and Medical Injury Compensation. October 1, 2005: 49. Available at: http://www.wyominghealthcarecommission.org/_pdfs/Medical_Errors_FinalDraft9-28-05.pdf.
- ³¹ Event Transcript. Administrative Approaches to Compensating for Medical Injury: National and International Perspectives. Common Good. Carnegie Endowment for International Peace, Washington, DC, October 31, 2005: 16, 22. Available at: http://cgood.org/assets/attachments/Transcript_-_October_31st_Event.pdf.
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- ³⁴ Espersson, C. Personal Interview. Stockholm, Sweden, May 26, 2005. Notes on file with Paul Barringer, Common Good. *See also Event Transcript*. Administrative Approaches to Compensating for Medical Injury: National and International Perspectives. Common Good. Carnegie Endowment for International Peace, Washington, DC, October 31, 2005: 20-30.
- ³⁵ Joint Legislative Audit and Review Commission. Review of the Virginia Birth-Related Neurological Injury Compensation Program. (Richmond, VA: Commonwealth of Virginia, 2003) iv. Available at: <http://jlarc.state.va.us/Reports/Rpt284.pdf>; Studdert DM, Fritz LA, Brennan TA, The Jury Is Still In: Florida's Birth-Related Neurological Injury Compensation Plan After a Decade. 25(3) Journal of Health Politics, Policy, and Law 499-526 (2000).
- ³⁶ *See* Florida Birth-Related Neurological Injury Compensation Association. Benefit Handbook 5-11, 26-27. Available at: http://www.nica.com/parents/CoverageGuidelines_Final.pdf; Eligibility, Benefits & Claims. Virginia Birth-Related Neurological Injury Compensation Program Website. November 1, 2006. <http://www.vabirthinjury.com/Eligibility_Benefits.htm>.
- ³⁷ Office of Program Policy Analysis and Government Accountability. Report No. 04-04 Special Report: NICA Eligibility Requirements Could Be Expanded, But the Costs Would Increase Significantly. January 2004: 2. Available at: <http://www.nica.com/downloads/OPPAGAreport.pdf>.
- ³⁸ Eligibility, Benefits & Claims. Virginia Birth-Related Neurological Injury Compensation Program Website. November 1, 2006. <http://www.vabirthinjury.com/Eligibility_Benefits.htm>.
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- ⁴⁰ Florida Birth-Related Neurological Injury Compensation Association. Benefit Handbook. 12-13, 22-25.
- ⁴¹ Joint Legislative Audit and Review Commission. Review of the Virginia Birth-Related Neurological Injury Compensation Program. iv-vi.
- ⁴² Office of Program Policy Analysis and Government Accountability. Report No. 04-04 Special Report: NICA Eligibility Requirements Could Be Expanded, But the Costs Would Increase Significantly. 5.
- ⁴³ Ibid, citing Sloan F, Whetton-Goldstein K, Kulas E, Stout E. The Road from Medical Injury to Claims Resolution: How No-Fault and Tort Differ (1997).
- ⁴⁴ Joint Legislative Audit and Review Commission. Review of the Virginia Birth-Related Neurological Injury Compensation Program. 9; Office of Program Policy Analysis and Government Accountability. Report No. 04-04 Special Report: NICA Eligibility Requirements Could Be Expanded, But the Costs Would Increase Significantly. 5.
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- ⁴⁶ The 3-R Program (the three "R"s are: Recognize, Respond, and Resolve) was initiated several years ago by COPIC, the Colorado physician-owned medical liability insurer. Physicians who participate in the program are encouraged to communicate with patients who have been injured, and, if appropriate, to apologize. COPIC pays for certain out-of-pocket expenses incurred by injured patients who choose to participate in the program, as well as lost work time.
- ⁴⁷ To the extent that this approach is followed, it likely would be helpful to have state legislation specifying the amount of notice that the institution needs to provide to patients for purposes of participation in the program.
- ⁴⁸ Clearly, delineating avoidable from unavoidable events will not be straightforward in all situations. On the other hand, the negligence standard is frequently not clear-cut. Moreover, compensation systems abroad have successfully implemented the avoidability/unavoidability distinction in thousands of cases.
- ⁴⁹ A full discussion of state constitutional issues is beyond the scope of this document, but it is worth noting that the constitutional analysis in many states as to the permissibility of an administrative injury compensation system will turn to some degree on the extent to which the administrative system provides an adequate substitute remedy for the system it replaces.
- ⁵⁰ Note that collateral source offsets and restrictions on subrogation activities could help contain the costs of a health court demonstration project. However, statutory amendments at the state level and possibly at the federal level will likely be required to preserve defendants' status as secondary or tertiary payer, due to Medicare and Medicaid secondary payer rules, and possible restrictions under the Employee Retirement Income Security Act.
- ⁵¹ *See* The Patient Safety and Quality Improvement Act of 2005. P.L. 109-41 § 924, signed into law July 29, 2005.
- ⁵² One option would be to create the demonstration project at the participating health care institution in collaboration with a health plan. In this scenario, patient participation would be determined through a clause in the plan's subscriber contract; the patient would be deemed to consent to participate in the demonstration if proper notice was provided. To the extent that this approach is followed, it likely would be helpful to have safe harbor legislation specifying the amount of notice that the institution needs to provide to patients for purposes of participation in the program.
- ⁵³ Such efforts include proposed requirements that medical experts in injury litigation be of the same specialty as the defendant in the matter at issue, or that such experts be board-certified and have a license to practice in the state.
- ⁵⁴ *See* *McDaniel v. CSX Transp.* 955 SW2d 257, 265 (1997); *see also* *Daubert v. Merrell Dow Pharmaceuticals.* 509 US 579, 593 (1993).

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