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Commentary: Looking for a Better Way

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Many veterans of past attempts to scrap the current tort-based approach to medical malpractice have been wounded in their efforts to substitute something “better,” like enterprise liability or no-fault or MICRA-style reforms. We begin this issue of Forum with the ambitious goal of outlining the current state of malpractice reform and providing a true forum for disparate points of view and methodologies.

Most observers agree that the present malpractice system of fault finding and blame assessment does not constitute a social good. It takes much too long, has high frictional cost, and does not reimburse many injured patients. Perhaps even more important, the goals of the current system are unclear: to some, it acts as a deterrent to bad medicine and negligent providers; to others, it constitutes an opportunity to collect a significant amount of money to ease a bad outcome. It does neither well.

Nationally, malpractice consumes billions of dollars of direct insurance costs. If the CRICO experience is any indication, then approximately 23 percent goes to defense costs (primarily attorneys). In those cases that result in a payment (about 30 percent of cases filed), roughly 37 percent of the payment goes to plaintiff attorneys. When you look at total indemnity payments, 80 percent of dollars go toward six percent of all claims that are filed and 20 percent of all claims that are paid. Stated another way, approximately six percent of the people who file a claim get 80 percent of the dollars paid, they wait about four years to receive a payment, and then turn over more than a third of it to their attorney.

Malpractice also has indirect costs, such as defensive medicine, providers who change specialties or leave practice altogether after a suit (we have a number of real life examples), overburdened court systems, and the potential to inhibit efforts to improve patient safety.

So why do we cling to this inefficient system? Why have so many intelligent and well thought out attempts at reform simply turned to dust? The answer lies in two areas. First, most attempts at reform happen in response to some crisis, inhibiting the time for dialog and crafting a viable solution. Second, the reforms are often presented in isolation rather than as part of a systematic attempt to coordinate them with other aspects of health care.

For example, look at obstetrics, a major area of indemnification. Often, a newborn’s injuries have no identifiable cause (from a scientific viewpoint) but they evoke tremendous sympathy from the jury. What we, as a society, end up with is each jury deciding what it costs to provide a lifetime of care—even taking a position on how long that lifetime is likely to be. The question then becomes do we, as a society, want a “lottery” structure that supports the few plaintiffs who succeed in court with fantastic sums of money? Or, do we want to provide a guaranteed benefit to gravely impaired children and their families, based on actual lifetime needs?

And even if it were equitable, should the malpractice system be what’s used to keep providers from rendering negligent care? Does the threat of malpractice act as a governor on what would otherwise be grossly negligent behavior on the part of uncaring physicians? There is little real basis for this point of view. Indeed, a tiny percentage of providers may be impaired or not technically competent, but their behavior is not altered by the threat of malpractice suits. Again, the current system falls short. Would we not be better off with quality and outcome measures driving patient safety initiatives?

So, what is to be done, what are the options? As you read this Forum, weigh the benefits and negatives of what has been proposed—and in some states implemented—and join us in considering, and promoting a more effective, more patient-centered approach to compensation.
Medical Malpractice Tort Reform Across America: An Overview

Mary Schaefer, RN, MEd, ARM, JD and Jessica Bradley, MPH

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Since the malpractice insurance crisis of the mid-1970s, almost every state, including Massachusetts, has enacted some type of tort reform in an effort to discourage frivolous lawsuits. In spite of most state tort reform measures, skyrocketing jury awards are once again evident. From 1999 to 2000, the national median jury award for medical malpractice claims increased 43 percent, from $700,000 to $1 million. Such awards have grown at seven times the rate of inflation and settlement payments grew at three times the inflation rate.1

Over-inflated payouts are endangering health care quality across the United States. Higher payments are followed by higher malpractice insurance premiums, which, in some jurisdictions, threaten the public’s access to care—most recently in Florida, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia.1 (Massachusetts health care providers have managed to avoid exorbitant verdicts, but jury verdicts and settlements are notably higher, particularly in failure-to-diagnose cases. 2)

In response to increasing jury verdicts, rising physician insurance premiums, and impediments to accessing care, states are once again looking to legal reforms in hopes of preventing further erosion of the professional liability insurance market.3 Most states already have statutes of limitations that shorten the period after an injury in which a suit can be brought forward. Some have specific discovery rules, which provide that the time limitation on filing a suit does not begin until the injury is discovered. Florida has a two-year statute that begins from the date of discovery; however, in Maryland, a claim must be filed within three years from discovery and no later than five years.4 Shorter discovery limitations can limit a provider’s risk of potential liability.3

More recently, the reformers’ attentions have been focused on financial limitations. Several states are seeking to limit attorney fees, the premise being that a reasonable cap on attorney fees can help injured patients receive their fair share of damages. One tactic is to place a flat percentage maximum on attorney fees; another is to construct a sliding scale conferring to lawyers a diminished percentage as the size of the award increased. For example, in Illinois, fees are limited to 33 percent of the first $150,000; 25 percent of the next $850,000; and 20 percent of amounts above $1 million.5 Massachusetts has a similar scale (see sidebar page 4).

Despite these and other efforts to curb medical malpractice costs, the majority of states have found little success. The American Medical Association lists only six states that have “escaped the current crisis” of rising malpractice premiums: California, Wisconsin, New Mexico, Indiana, Colorado, and Louisiana.6 Each of those states has some form of cap on non-economic damages (i.e., damages that include pain and suffering), loss of marital companionship, and loss of consortium.7

Although damage caps can help stabilize liability insurance prices by restraining excessive damage awards, those caps are not always enforced by the courts.8 In some cases, state judges have substituted their own views of what tort law should be, a practice their critics believe has nullified public-supported legislative policymaking.8 As the majority of states struggle with effective tort reform measures, advocates are looking to the federal government for meaningful national legislation that would render state-level reforms, such as capping, less unpredictable.

Federal Reforms

At the federal level, the House of Representatives passed HR 4600, the HEALTH (Help Efficient, Accessible, Low-cost Timely Healthcare) Act of 2002, which is designed to reduce medical malpractice insurance premiums. Modeled after California’s successful statute, HR 4600 would impose limits on medical malpractice litigation in state and federal courts by:

1) limiting non-economic damages, including pain and suffering, to $250,000;
2) imposing a sliding scale on attorney fees;
3) limiting punitive damages to $250,000, or twice economic damages, whichever is greater;

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4) eliminating joint and several liability; and
5) reducing the statute of limitations.9

Economic damages, e.g., medical expenses, lost income, would remain uncapped.9 The bill is likely to be high on the Congressional agenda for 2003.

Even the best-designed tort reforms are likely to falter unless the medico-legal culture undergoes a parallel shift toward encouraging and rewarding health care professionals and institutions for identifying, reporting, and analyzing errors. Non-punitive models, such as no-fault compensation systems, could enhance reporting and collection of medical error data because they would enable health care providers to discuss and resolve disputes without fear of legal liability. Another innovative, non-judicial approach with promise is the “early offers” program, in which the provider (i.e., the potential defendant) would offer early compensation for economic loss to patients who are injured as a result of medical error.10

Patients, by agreeing to accept an early offer, would provide caregivers and health care institutions the control necessary to achieve successful and prompt resolution of medical injury claims. This would ultimately help to create an environment that encourages hospitals and caregivers to identify errors, evaluate causes, and take steps to prevent future injuries.10

Conclusion

Whether reform occurs through federal tort reform legislation, individual state reform, or through the adoption of non-judicial models, the challenge confronted by all three methods is the same: to create a system that balances the competing interests of health care providers and patients alike. Injured patients deserve fair and swift compensation, while health care providers deserve to practice in a non-punitive environment that encourages medical error reporting and disclosure. ■

Notes and References


2. Cunningham J. Failure to diagnose cases are on the rise. Massachusetts Lawyers Weekly. 2001;30:3323.


Massachusetts Law on Medical Malpractice Actions and Tort Damages

Limitation on Attorney Fees (M.G.L. c.231 §60I)

Attorney fees may not exceed the following a) 40 percent of first $150,000 recovered; b) 33.3 percent of the next $150,000 recovered; c) 30 percent of the next $200,000 recovered; and d) 25 percent of any amount by which the recovery exceeds $500,000.

Pre-Judgment Interest (M.G.L. c.231 §68)

Massachusetts law allows pre-judgment interest to accrue at 12 percent per annum from the date upon which the action was commenced.

Award of Damages and Itemization of Amount (M.G.L. c.231 §60F)

Damages are itemized by the jury into: 1) amounts intended to compensate for damages incurred prior to the verdict, and 2) amounts intended to compensate for future damages. Periodic payment plan for future economic damages is not required.

The damages that are compensable are so-called special damages that include medical expenses, lost earnings, and loss of earning capacity; and so-called general damages, which are often referred to as pain and suffering. Pain and suffering includes not only physical pain and suffering, but any loss of function, any loss of ability to perform recreational or household activities, embarrassment, and mental anguish caused by an injury.

Collateral Sources: Reduction of Award (M.G.L. c.231, §60G)

The trial judge may deduct from a damage award the amount received by the plaintiff from collateral sources.

Joint and Several Liability

Under the doctrine of joint and several liability, defendants may be found jointly liable for the entire amount of the plaintiff’s damages, regardless of each defendant’s proportion of fault in the case, so long as that defendant’s negligence is found to be a substantial contributing factor in causing the injury.

Comparative Negligence (M.G.L. c.231, §85)

Massachusetts has adopted the doctrine of modified comparative negligence in which a plaintiff whose own negligence contributes to cause his or her own injury is not absolutely barred from any recovery from the defendant unless his or her own negligence exceeds the negligence of the defendant. However, the amount of damages allowed to that plaintiff is diminished in proportion to the amount of negligence attributable to him or her.

Damage Caps (M.G.L. c.231, §60H)

Non-economic damages limited to $500,000, but can be without limitation if there is substantial or permanent loss or impairment of a bodily function or substantial disfigurement, or other special circumstances in the case that would deprive the plaintiff of just compensation for the injuries sustained.

Statutory Limitations on Recovery (M.G.L. c.260 §4)

Medical malpractice actions must be brought within three years after the cause of action accrues, but in no event brought more than seven years after occurrence of the act or omission occurred, except where the action is based upon the leaving of a foreign object in the body.

In the case of minors, a medical malpractice action must be brought within three years from the date the cause of action accrues, except that a minor under the full age of six years shall have until his ninth birthday in which the action may be commenced, but in no event filed more than seven years after occurrence, except where the action is based upon the leaving of a foreign object in the body. (M.G.L. c.231 §60D)
No-fault Birth-related Neurologic Injury Compensation: Perhaps Its Time Has Come, Again

by John M. Freeman MD, and Andrew D. Freeman JD

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Under the current tort system, 60 percent of malpractice premiums paid by obstetricians go to cover suits for alleged birth-related cerebral palsy (CP). Yet less than 10 percent of children born with CP receive any compensation. Even those who do receive compensation receive less than 40 cents of every dollar spent on insurance premiums—the rest goes for lawyers, experts, insurance administrators, and other transaction costs.¹

A report published in 1988 concluded that the tort system contributed to an adversarial patient/physician relationship, encouraged the practice of purely defensive medicine, left nine out of ten malpractice victims uncompensated, and expended more than half of its income in overhead and transaction costs while producing widely differing monetary awards for comparable victims.² A new report, issued in July 2002 by the U.S. Department of Health and Human Services, reiterates that the tort system remains unpredictable, costly, and slow; does not accurately identify negligence; does not deter bad conduct; and does not provide justice.³⁴

Perhaps it is time to revisit the no-fault malpractice tort reform proposal we published in 1988.¹ This was a true no-fault insurance designed to compensate all children born with cerebral palsy in proportion to the severity and expense of their disability. For less than the cost of malpractice insurance, this no-fault insurance could pay all children born with CP and their families for all expenses not covered by medical insurance or other government programs. No one would need to determine causation or fault, but “plaintiffs” would not receive compensation for pain and suffering. The program would achieve economic balance by foreclosing the option for suits alleging birth-related malpractice.

Background

In the late 1980s, Virginia and Florida, adopted what were inaccurately termed “no-fault” systems, limited to obstetrical cases that had resulted in severe injury to the brain or spinal cord due to lack of oxygen or to mechanical injury.³⁵ Under these plans, the most severely injured children were to be removed from the tort system to a workers’ compensation-type system that assured payment and care for the duration of the child’s life. However, the Virginia law required evidence that the injury was due to oxygen deprivation, and covered only the most seriously impaired children who were “permanently non-ambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living.” Virginia also required that both the obstetrician and the hospital be enrolled in the compensation plan.

As we predicted at the time, few children entered the system.³ The law did not decrease the cost of malpractice insurance and has been difficult and expensive to administer. The Richmond Times-Dispatch found that—in 14 years—only 75 children were admitted to the plan, that many families have had to endure years of hearings to determine eligibility, and that the program has serious fiscal problems.⁷ The Florida program has had similar problems.

Under both the Virginia and Florida laws, the overly restrictive definitions of covered children result in the exclusion of many children with birth injuries deemed insufficiently severe, but whose injuries are otherwise similar to those who are covered. Those definitions also provide an opportunity for some families who want to sue to opt out, and fail to eliminate the need for lengthy and costly hearings regarding the cause of the children’s birth defects.

During the 1990s the malpractice “crisis” abated. Insurance premiums rose less sharply, due in part to an increase in the insurance industry’s investment income, increased competition, and the capping of awards for pain and suffering. Recently, however, the crisis has returned, with dramatic premium increases, especially for obstetricians and emergency medicine specialists. Once again, many physicians are stating that the insurance is not affordable; some are leaving the practice of medicine or shifting their location or area of practice. Access to obstetrical care and, in some places, to emergency care, is limited or not available.⁵ As we address this current crisis, we should revisit the approaches taken in the 1980s and learn from those mistakes.

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Some states, and the Congress, are currently considering caps on awards for pain and suffering, as were adopted by several states during the 1980s. While caps do reduce some of the cost of lawsuits, they do so inequitably, by limiting recoveries only for the most severely injured. Moreover, caps are unlikely to reduce defensive medicine, which is practiced to avoid being sued, not to avoid an award of more than a certain amount.

Shifting away from the tort system for children born with cerebral palsy seems especially appropriate in light of recent research showing that a very small percentage of CP results from malpractice. In 1988, Dr. Karin B. Nelson found that most CP was unrelated to birth asphyxia, and that in less than eight percent of cases was it even possible to have prevented the CP. Subsequent studies show that even that number was far too high. As Nelson more recently states, “It is often not possible to conclude with confidence the cause of CP in an individual case.... It is far less possible to determine if the CP was preventable.”

She also states, “Increasing evidence indicates that much of the CP previously ascribed to hypoxic injury may be due to intrauterine infection. That infection is currently not detectable prior to or at the time of birth, and its effects are not currently preventable.” Thus, the resultant CP cannot be attributed to obstetrical fault.

Cerebral palsy sometimes can be due to birth trauma and to birth asphyxia, but these are rare causes of neurological injury. Whatever its cause, CP remains an expensive tragedy. The more than 90 percent of children with CP who receive no compensation from the tort system have the same needs as the few children who receive multimillion dollar awards. Quick, efficient, and equitable compensation to allow the child and family the best possible quality of life should be society’s goal. The current tort system does not achieve this, nor do the Florida and Virginia “no-fault” laws. Capping payments for pain and suffering as recently proposed will reduce a small portion of the cost of the current tort system, but will produce neither fairness nor any compensation for most sufferers. Only a true no-fault system could achieve that.

True No-fault

What are the goals of the tort system?

■ To identify causation? Since fault is difficult or impossible to determine in most cases, a tort system that determines causation by pitting “expert” against “expert” in an adversarial forum before lay juries is both inaccurate and inefficient.

■ To determine fault? If, in the majority of cases, we cannot even determine causation, the determination of fault is even more difficult. The retrospective determination of whether a different course of obstetrical management was appropriate, and whether it would have resulted in a different outcome for the baby, is a matter of opinion, not of fact.

■ To compensate the injured victim? The current system awards large monetary damages to a small proportion of identically handicapped children.

■ To punish offending physicians? On very rare occasions obstetricians (and other physicians) commit blatant malpractice. They may fail to appear at the delivery until too late, they may be drunk, drugged, incompetent, or ill informed. However, the current system of justice lumps them together with competent practitioners involved in an adverse event. A better system must be found to punish the egregious offenders and encourage (without the fear of civil suits) other physicians, nurses, and hospitals to more readily report, investigate, and address malpractice.

A true no-fault insurance system for children with cerebral palsy would compensate all children for their excess handicap-related medical expenses, would be more equitable than the current tort system, and would avoid the current costly litigation. It would be less expensive than obstetrical malpractice insurance and would avoid defensive medicine and improve access to care. Perhaps it is an idea whose time has come.
The Patient Safety Case for No-fault Compensation*

David Studdert, LLB, ScD, MPH and Troyen A. Brennan, MD, JD, MPH

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The Institute of Medicine’s (IOM) recent report on error in medicine introduced a wide audience to the alarming extent of morbidity and mortality due to preventable adverse events in American hospitals.1 The publicity that surrounded the report, particularly attention given to iatrogenic death rates, has stirred interest among policy makers at both the state and federal levels.2,4

Leading policy responses promote two key strategies for enhancing patient safety: 1) design and implementation of “systems approaches” to reducing errors; and 2) improved tracking of incidents involving unintended harms. Scientific and regulatory goals are well-aligned here. Experts generally agree that both systems-oriented interventions and data gathering are vitally important to any significant advances in patient safety.5-10

Unfortunately, because access to compensation for medical injury in our health care system hinges on blame and individual provider fault, the patient safety reforms spurred by the IOM Report are on a collision course with the medical malpractice system. In the short term, that collision is likely to stymie much-needed attempts to make American hospitals safer. In the long term, it will substantially restrict the scope of public health gains that are achievable through error prevention efforts. The challenge of addressing error in medicine demands a thorough reconsideration of the legal mechanisms currently used to deal with harms in health care.

A System at Odds with Improvements in Patient Safety

Harmful accidents in health systems frequently involve human error, but their causes and effects cannot be meaningfully understood by examining provider behavior alone.7,8 Hence, the most promising patient safety initiatives seek to identify and correct latent errors, and to avoid what James Reason has called the “blame trap.”9 A focus on individual provider judgment may not only limit the effectiveness of error-prevention efforts, but will actually exacerbate underlying causes of error. Punitive environments appear to chill providers’ willingness to generate information about errors—information that could be used to understand the causes of error and design effective prevention strategies.10-13

Similarly, system-oriented approaches to reform are fundamentally at odds with the medical malpractice dispute resolution system. At its core, malpractice law involves a set of adversarial proceedings, beginning with a patient’s allegation of negligence against an individual provider.14 Processes of care are relevant only insofar as they may prove or disprove the defendant’s negligence.

In short, malpractice litigation induces silence and bitterness. Physicians do not believe it contributes to the quality of care,15,16 except perhaps when targeted at institutions such as managed care organizations.17 Hospital executives appear to share providers’ skepticism, an outlook exemplified by the fact that many hospitals continue to conceive of risk management and quality improvement as substantively different enterprises.18 The need for openness and dispassion about errors in the current malpractice environment constitutes a troubling deadlock for the patient safety movement. Although some commentators continue to hold out hopes that the existing system may adapt, clearly, alternative approaches to patient compensation must be seriously considered.

The No-fault Approach

Compensation programs that do not rely on negligence determinations are popularly referred to as “no-fault” systems.19 The workers compensation plans in operation in all states are a prominent example of the no-fault model. A number of states also have no-fault components embedded in their programs for compensating automobile injury; claimants must prove that they have suffered an injury that was caused by an accident, but need not show that the third party acted in a negligent fashion.

No-fault compensation systems are not completely unknown to medicine—several are in operation abroad.20 Among the international models, the Swedish approach is perhaps the most attractive. Patients who believe they have been injured as a result of medical care in Sweden are encouraged to apply for compensation using forms available in all clinics and hospitals. Physicians and other health care personnel are actively involved in approximately 60 to 80 percent of claims, alerting patients to the possibility that a medical injury has occurred, referring the patient to a social worker for assistance, even helping patients to lodge claims.21 Physicians in Sweden tend to regard the facilitation of medical injury claims as a natural extension of their therapeutic responsibility to safeguard patients’ best interests.

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The Patient Safety Case for No-fault Compensation (continued)

Once a claim is made, the treating physician prepares and files a written report about the injury. An adjustor makes an initial determination of eligibility and then forwards the case for final determination to one or more specialists who are retained to help judge compensability. The process is relatively fast, with the average claim taking six months from initiation to final determination. Approximately 40 percent of claims receive compensation. The key element of the compensation criteria in the Swedish model is the concept of avoidability. System designers recognized that compensating all injuries arising from medical care would be prohibitively expensive. Thus, only a subset of medical injuries are eligible for compensation. Successful claims are paid in a uniform manner using a fixed benefits schedule, and include compensation for both economic and non-economic (pain and suffering) losses.

The Fresh Case for No-fault
In comparisons with medical malpractice, the capacity of no-fault systems to compensate injured patients is usually touted as their major strength. The two chief criticisms traditionally leveled against no-fault are that 1) the costs of achieving effective compensation are prohibitive; and 2) removal of fault-based determinations will have a deleterious impact on deterrence goals. Recent empirical findings and new patient safety imperatives debunk the rationale for both criticisms.

Affordability Through Flexibility
By combining data on the incidence and types of adverse events in Colorado and Utah in 1992 with estimates of the losses stemming from those adverse events, we calculated the costs of three different compensation models:

- one that would compensate all medical injuries;
- one extending payment only to medical injuries attributable to negligence; and
- one that compensated injury according to Swedish avoidability criteria.

The calculations use a compensation package with standard components for each injury, including lost income, household production, health care costs, and compensation for pain and suffering associated with the medical injury.

Figure 1 summarizes our results. Estimates show that many more injured patients may be compensated under no-fault than tort within budgets that are similar to or less than the costs of the current system. We believe that these data provide a strong case for the potential affordability of no-fault schemes.

Deterrence Reconsidered
Critics of no-fault have generally equated a shift to no-fault with abandonment of opportunities to use the compensation system to leverage positive influences on provider behavior. How can a system that jettisons individual blame for errors create incentives for careful behavior? Setting aside the questionable role of deterrence in malpractice law, we see ample evidence that no-fault systems can be structured to promote safety. Indeed, new insights into the causes of medical injury suggest that they are actually far better placed to promote safety than negligence-based litigation.

The best example of deterrence in no-fault programs comes from the field of workers’ compensation where a variety of “experience rating” methods are used to create financial pressure on employers to pursue safety in the workplace. Experience rating means that firms or individuals with higher rates of injury pay higher premiums. W. Kip Viscusi and others have demonstrated the capacity for this kind of incentive structure to deter injuries.

Linking a shift to no-fault with the adoption of “enterprise liability” would provide an opportunity to train the safety incentives of experience rating on the problem of medical injury. In its sharpest form, enterprise liability...
means that individuals do not directly bear the costs associated with an accident. Instead, the enterprise—whether it be a large group practice, a hospital with an integrated medical staff, or a health plan—would be “strictly liable” in both a legal and economic sense, by meeting the costs of liability premiums for all affiliated staff.\textsuperscript{30,31} Premium levels could then be experience rated. For instance, a hospital would pay more following a rash of avoidable injuries and less if quality improvement initiatives curtailed the incidence of such events.

In addition to its deterrence promise, enterprise liability is thoroughly consistent with system-oriented quality improvement efforts.\textsuperscript{1,31} If the aberrant behavior of individual providers is a relatively infrequent explanation for harm, as a growing body of empirical literature suggests, then the greatest potential for patient safety advances must lie in institutional, not individual, accountability.\textsuperscript{1}

\textbf{An Incremental Approach to Reform}

Most hospitals and physicians are not prepared for a rapid shift to a no-fault model, much less enterprise liability, and the unanticipated outcomes of such a major transition should be studied. In addition, a number of important design issues must be worked through, including:

\begin{itemize}
  \item the status of the compensation authority (private or public),
  \item the role of existing malpractice insurers,
  \item institutional oversight to guard against cover-ups of injuries,
  \item informed consent for patients cared for in a no-fault framework,
  \item the extent of attorney involvement (if any),
  \item appeal rights, and
  \item the tensions that will inevitably emerge between no-fault and the coexisting tort regime.\textsuperscript{32}
\end{itemize}

Rather than wholesale replacement of the tort systems with no-fault, we advocate enabling legislation at the state level that would allow selected organizations to experiment with no-fault-enterprise liability models. We believe that institutions participating in a no-fault-enterprise liability program would quickly outstrip their competitors both in terms of their attractiveness to patients and their ability to bring about safety interventions.

More importantly, the combination of no-fault and enterprise liability would provide institutions with carrots to pursue error prevention efforts, in the form of a less punitive environment and instructive data, and sticks, in the form of experience rated premiums. Our view is certainly optimistic. But it is a social experiment worth undertaking if we are to decrease significantly the number of injuries caused by medical errors.

\textbf{Notes and References}

14. The pursuit of specific providers is especially true in Massachusetts, where not-for-profit health care institutions are covered by a charitable immunity limit of $20,000.
From the late 1960s into the 1970s, physician professional liability insurance in California had shown increases of 300-400 percent; in some instances almost 1000 percent. In January of 1975, a major southern California malpractice carrier notified approximately 2,000 physicians that their coverage would not be renewed. At that same time, approximately 4,000 northern California physicians were notified that their premiums were going up 380 percent. The legislature responded with the Medical Injury Compensation Reform Act of 1975 (MICRA), which included this preamble:

“...[T]here is a major healthcare crisis in the State of California attributable to skyrocketing malpractice premium costs and resulting in a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial to access for the economically marginal, and deploration of physicians such as to substantially worsen the quality of healthcare available to citizens of this state. ...[T]his statutory remedy herein provided is intended to provide an adequate and reasonable remedy within the limits of what the foregoing public health and safety considerations permit now and into the foreseeable future.”

The legislature sought a balance between ensuring Californians would have access to care and at the same time protecting individuals who may be harmed through some act of medical negligence or malfeasance. Although MICRA’s $250,000 cap on non-economic damages tends to receive most of the attention, the Act had goals which go well beyond this single purpose. They are:

- The establishment of a specific statute of limitations, with a special statute for minors.
- Specific limits on attorneys fees.
- The requirement for advance notice in order to give both parties the opportunity to resolve issues before the expense and time lost to litigation.
- Periodic payment for future losses. This provision applies to awards of $50,000 or more. Periodic payment does not apply for the present value award of future non-economic damages. Also periodic payment for wage loss does not terminate on the plaintiff’s death, although future payment of medical expenses does.
- California Civil Code section 3333.1 also provides that in medical malpractice cases defendants may introduce evidence of payment of plaintiff’s medical expenses by other sources such as social security, government income, disability, workers’ compensation coverage, plaintiff’s health or disability insurance, accident insurance providing income or medical payment benefits, or health plan. Juries are not obligated to take into consideration in awarding damages the existence of collateral sources of payment. Opponents of MICRA have argued that this provision allows defendants to avoid their obligation with respect to the damages incurred by an injury.
- Limits on punitive damages and provisions requiring court approval to make a claim for punitive damages before proceeding.

One of the most significant outcomes from the enactment of MICRA has been a limitation on the growth of malpractice premiums without inhibiting continued access and availability of medical care. California physicians pay, on average, one half to one third of the premium paid in most other populous states (see Figure 1), without effecting access to the courts nor compensation for the non-economic losses plaintiff may incur for such things as the cost of ongoing care, rehabilitation, and lost earnings.

Since 1975, malpractice insurance premiums have risen 168 percent in California while rising approximately 420 percent nationwide. An obstetrician in California pays approximately $45,000 in annual liability premium,
whereas the average liability premium for obstetricians in other large states is twice that.  
Justice Cruz Reynosa, now retired California Supreme Court Justice and on the court that upheld the constitutionality of MICRA in 1986, recently stated, “MICRA has reached a balance between the interest that plaintiffs have and the interest of providing reasonable insurance and medical attention.”

Plaintiff Awards

Despite MICRA, however, the average cost of a medical malpractice claim in California has outpaced the rate of inflation, increasing from about $10,000 in 1976 to approximately $120,000 in 1996. Many would argue that, in spite of MICRA’s cap on non-economic damages, plaintiffs awards for damages necessary to compensate for those costs that can be attributed to medical negligence have been adequate and reasonable.

The history of MICRA is replete with challenges to its constitutionality and the constitutionality of individual provisions. In American Bank and Trust Company vs. Community Hospital, the court upheld the periodic payment provisions of the Act. In Barme vs. Wood, the court upheld the collateral source provisions of the Act. In Roa vs. Lodi Medical Group, the court upheld the constitutionality of the limitations on legal fees provisions. In Fein vs. Permanente Medical Group, the court upheld the provisions of MICRA limiting non-economic damages to $250,000. More recently there have been attacks on MICRA from different quarters, including attempts to avoid the limits of MICRA by alleging causes of action that purportedly preclude impositions of MICRA limits. One example is elder abuse, in which plaintiff attorneys attempt to turn events of potential medical negligence into a claim of elder abuse in order to avoid the MICRA limits and have access to unlimited attorney fees.

Two cases significant to MICRA are now on appeal. At issue in American Continental Insurance Company, et al. vs. Shirley Allen, et al. vs. Los Alamitos Medical Center, et al. and Terry Lathrop and Douglas Lathrop vs. Health Care Partners is whether a physician's group is a “health care provider” and, therefore, afforded the protections of MICRA. The trial courts in Orange County and San Francisco County decided that the Medical Groups are not covered and cannot avail themselves of MICRA’s $250,000 limit on non-economic damages. The current tactic of the plaintiffs’ bar is not to attack MICRA directly, but to avoid MICRA by attacking its application in certain circumstances. Many believe the success of this argument would effectively negate the benefits accrued to Californians in general as a result of MICRA.

Health care in California remains in crisis. The good news is that professional liability insurance—although not without its problems—is not contributing materially to that crisis. Given its stated purpose, MICRA has achieved its goals.

Notes and References
3. California Civil Code section 333.2.
5. The Doctors Company Report.
11. Terry Lathrop and Douglas Lathrop vs. Health Care Partners, venue California Appeals Court, 1st District, Division 5.
Medical malpractice is again causing a crisis in health care in the United States. Women are having difficulty obtaining obstetrical care; trauma surgery and neurosurgical care are limited in some areas of the country. A survey of hospitals by the American Hospital Association revealed that the current professional liability crisis has caused 20 percent of the association’s 5,000 member hospitals to cut back services and six percent have eliminated some units. The cost of professional liability insurance for physicians has been rising significantly for several years. In 2002, premiums for internists and general surgeons rose (on average) 25 percent; for obstetricians the increase averaged 20 percent. Physicians are finding that the rising cost and/or availability of professional liability insurance are forcing them to limit their practice to less risky procedures, abandon specialty practices, move to other states, “go bare,” or retire prematurely.

What is the Cause of this Crisis?
We have a flawed system of dealing with medical injury in the United States. Indeed, it is difficult to imagine a system worse than the one we now have. Consider the following:

- Fewer than one in 16 patients who are negligently injured ever receive compensation. This is totally unacceptable as a compensation mechanism, providing financial relief to far fewer injured parties than any other form of insurance. That includes property and casualty insurance, disability insurance, and workers’ compensation insurance, where virtually all people who suffer an injury or loss are compensated.

- More than 55 percent of the premiums paid by physicians is consumed by what we euphemistically refer to as “overhead” but, in reality, are legal fees. This is far more than any other form of commercial insurance.

- Individuals who litigate may have to wait five to seven years before receiving compensation. This can result in severe hardship to the truly injured patient.

- A malpractice suit frequently causes severe emotional damage to the physician and his or her family, even when the physician is later acquitted by the courts.

- The current system promotes the practice of defensive medicine, the cost of which has been estimated to be as high as $50 billion per year.

- Our current litigation system impedes the development of a patient safety system which requires the self-reporting of errors.

The first crisis in professional liability occurred in the mid-1970s and, as a result, all 50 states passed legislation to deal with the crisis. However, most of these legislative reforms did very little to improve the system. The most effective legislation, passed in California, was the Medical Injury Compensation Reform Act of 1975 (MICRA), the essential components of which were a cap on pain and suffering at $250,000, the mandating of proportionate liability, collateral source offset, reduction in the statute of limitations, structured awards over $50,000, limitation of legal contingency fees, and a required 90-day notice of intent to sue. While MICRA did moderate the rate of increase in the cost of professional liability insurance for California physicians, it did little to materially change the system. Most of the flaws described above persist today in California as in the rest of the nation.

What is the Answer to Our Flawed System?
For many years, I have advocated a form of medical injury insurance. I would like to change our fault-based system to an insurance-based system. Instead of spending a great deal of time and energy trying to determine fault, I would like to see a system which identifies those injuries that qualify and compensates them as they would be with other forms of insurance. Americans are accustomed to purchasing insurance for disability, for death and dismemberment, for injuries sustained at work, in an automobile, airplane or boat. Why not purchase insurance when one has to undergo the complex and sometimes risky treatments available today to deal with medical illness? The system would cover all out-of-pocket expenses and lost wages for a compensable event. Here is how it might look:

- A list of compensable events would be developed by an expert panel composed of health care professionals and representatives of the public.

- Claims could be filed by a physician, patient, or hospital.
■ All medical injury claims would first have to be submitted to the medical injury insurance company. If the injury were deemed to be non-compensable, patients could bring suit in the usual manner.
■ This insurance would be purchased by the consumer as part of a health and accident policy.
■ The cost of this insurance would be approximately one-and-a-half percent of a typical comprehensive health and accident policy.

A similar plan was enacted by the federal government in 1986 in response to a crisis when the few remaining vaccine manufacturers informed the government that they would cease manufacture of childhood vaccines unless the government solved the liability problem. The government’s response was the National Childhood Vaccination Injury Act of 1986. A list of compensable events was developed and if a child experienced such an event following vaccination, a claim could be filed and, if appropriate, payment made through a compensation fund. This fund was established by placing a small surcharge on every dose of vaccine sold. The plan has worked well and has allowed manufacturers of childhood vaccines to continue production.

The medical injury insurance plan would work in a similar manner. It would compensate greater numbers of patients in a more timely, efficient, and fair manner than our current system. It would be non-adversarial and would significantly reduce the cost of defensive medicine. It would take the financial pressure off many high-risk specialists and relieve the pending crisis of access to care for many Americans. It would promote the reporting of medical errors and near misses resulting in a meaningful patient safety system. For many years, similar alternatives to the tort system have been in effect in Sweden, Australia, and New Zealand, and appear to work well.

For more than 25 years, attempts have been made by all 50 states and the federal government to reform our current medical liability system. These reforms have been aimed at the consequences of a flawed system and not the underlying defective system itself. We must change the focus of our thinking when compensating a medical injury toward an insurance based model. The public would favor this type of solution. A recent poll of the public by The Health Care Liability Alliance (HCLA) showed that, by an overwhelming margin, Americans favor medical liability reform because they are concerned that skyrocketing liability costs could limit access to care and that medical liability litigation is one of the primary forces driving the increase in health care costs.

Conclusion

We have a fundamentally flawed system of dealing with medical injury that is having a profound effect on our health care system. We recommend a paradigm shift from a fault-based system, which compensates few injured patients at a great cost to physicians, both financially and emotionally, to an insurance-based system where far more patients are compensated and where the system is funded by those who receive the benefits.

This insurance-based system would:
■ Remove from physicians the omnipresent and pervasive fear of litigation allowing physicians to engage in “best practice” rather than “safe practice,”
■ Reduce the cost of defensive medicine, and
■ Promote the self-reporting of medical errors and “near misses” resulting in improved patient safety and thus a safer health care system.

The question that remains is: Can the will of the American people overcome the powerful and pervasive influence of the trial bar on federal and state legislation so that this much-needed reform can be enacted.

Notes and References
4. Tillinghast-Towers Perrin - as described in AMA testimony to Congress June 12, 2002.
5. For data related to the cost of defending claims filed against clinicians insured through Harvard’s Controlled Risk Insurance Company (CRICo), see CRICo President Jack McCarthy’s Commentary (page 2).
9. See Michael Evans article on MICRA in this issue (page 10).

“We have a flawed system of dealing with medical injury in the United States. Indeed, it is difficult to imagine a system worse than the one we now have.”

Charles SE. Malpractice suits; their effect on doctors, patients, and families. Journal of the Medical Association of Georgia. 1987;76:268-72.
Physicians have long been concerned about medical malpractice lawsuits. It is not the possibility of being held accountable that is troublesome—many physicians believe that if a doctor makes a mistake then the patient is entitled to be compensated for his or her injuries. Rather, what many physicians object to is how the court system goes about determining liability. At the center of their concern is the American constitutional commitment to lay juries and the adversarial process.

Those interested in changing the malpractice system often focus on the litigation process. Many so-called “tort reform” measures have had a procedural component, looking to promote alternative methods for determining physician liability. One potentially attractive alternative is the use of binding arbitration. Is it attractive enough that, soon, a large percentage of malpractice disputes will be decided by arbitrators instead of by juries?

From Whence it Came
For decades, arbitration has been used routinely in several commercial contexts—such as disputes between companies. Unlike mediation, which is intended to assist the parties in a voluntary settlement of the dispute, arbitration is an adjudicative process designed to produce a binding decision on the merits. Ideally, it is also efficient. One manifestation of that interest is in the limited right to appeal an arbitration result. Absent a manifestly unjust result, arbitration decisions will not be overturned even in cases with substantial question as to whether or not the arbitrator correctly applied the substantive law. In part, this is justified by the belief that arbitrators should be more flexible in incorporating non-legal norms, such as common commercial practices, in making their decisions.

The arbitration process itself is not strictly structured, and can be subject to negotiation among the parties. Thus, it would be possible for the parties to develop innovative approaches to such variables as 1) the selection of the arbitrator(s); 2) the amount of discovery or investigation to be permitted; and 9) the ground rules for the hearing itself. While the parties sometimes conduct the arbitration themselves, many parties retain an entity such as the American Arbitration Association (AAA).

Prior to the mid-1980s, courts in many states looked with disfavor upon binding arbitration particularly if it involved consumers. Courts would approve arbitration agreements when they were negotiated after a dispute arose (because the parties at that point could assess whether they preferred arbitration to a jury trial), but they would not enforce arbitration agreements entered into before a dispute arose.

Beginning in 1985, however, the Supreme Court, in a series of decisions, has held that the Federal Arbitration Act, which provides that arbitration agreements should generally be enforceable, preempts contradictory state law provisions that purport to limit such agreements. For example, the state of Montana required that any contract with an arbitration clause have the arbitration provision prominently displayed in capital letters on the first page. The purpose of the provision was to help call the consumer’s attention to the fact that the contract had an arbitration clause. The United States Supreme Court held that this provision was preempted by the Federal Arbitration Act because it suggested a hostility to arbitration.

The Supreme Court’s signal favoring arbitration has been widely criticized by academics who believe that, in many situations, arbitration agreements between large corporations and consumers are inherently unfair. Despite this criticism, arbitration agreements are increasingly common. Many financial institutions, such as American Express, impose arbitration agreements in contracts with credit-card holders. Gateway Computer includes an arbitration clause in its sales contracts to those buying a computer. This rapid escalation in the number of entities imposing arbitration clauses on their customers has spawned active litigation to limit their use; to date, the Supreme Court has generally upheld the provisions.
Arbitration for Malpractice

Given that 1) the Supreme Court has sent a clear signal that arbitration agreements should be upheld and 2) many physicians would seem to favor arbitration over a jury trial, one might think that arbitration would have become—or at least soon would become—commonplace in malpractice cases. Has it?

Surprisingly, the answer is no. Arbitration has been widely used in the malpractice context only in California, one of the few states that actively encouraged arbitration (in part, in response to lengthy dockets in their courts) prior to the Supreme Court’s recent pro-arbitration stance. Most significantly, Kaiser Permanente, a large health maintenance organization with several million California members, mandated arbitration. Accordingly, since the early 1980s, hundreds of malpractice claims against Kaiser have been arbitrated. (Unfortunately, Kaiser did not permit access to performance statistics, thus making it impossible to assess how wide-spread arbitration might impact the disposition of malpractice claims.3)

A recent case has raised considerable concern about whether arbitration can work fairly in the malpractice context. In Engalla v. Permanente Medical Group,6 the California Supreme Court considered a case filed by a patient against Kaiser claiming that its arbitration system was unfair. Engalla alleged that he was dying as a result of the failure of Kaiser’s physician to diagnose cancer. Engalla wanted to complete the arbitration prior to his death. Kaiser’s attorney, however, did not move expeditiously to select the arbitrator and convene the hearing. Frustrated by the delays, Engalla filed suit claiming that the delays were unconscionable and that Kaiser had therefore forfeited any rights to insist on arbitration. The evidence showed that, in fact, most arbitrations under the Kaiser system were delayed. The California Supreme Court wrote a blistering opinion criticizing many aspects of the arbitration system employed by Kaiser. As a result, Kaiser implemented a series of changes to improve its method of operations.7

In general, plaintiffs’ attorneys are strongly opposed to binding arbitration. Insurers who attempt to impose such agreements in the medical context should expect a fight. This is largely a function of the comfort level that plaintiffs’ attorneys have with the current litigation process, especially with juries. Even though relatively few malpractice cases are actually tried before a jury (about 10 percent), the possibility of a jury trial greatly influences the settlement process. Thus, the plaintiffs’ bar

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Arbitration (continued)

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believes—rightly or wrongly—that their settlement leverage would be greatly reduced if the alternative to a settlement was an arbitration as opposed to a jury trial.

Several additional reasons explain why malpractice arbitrations are not yet common. Most malpractice insurers have not evidenced a strong interest in developing arbitration programs. Since malpractice insurers handle the defense of malpractice claims, arbitration will be seriously pursued only when they decide to do so. Insurers, perhaps, are reticent about committing to arbitration in part because they appreciate that, despite “conventional wisdom,” juries in fact often favor physicians. They may be concerned that arbitrators—sometimes accused of “splitting the baby”—will tend to find for plaintiffs more often than do juries. Also, given that arbitration may be cheaper to pursue, installing an arbitration system may tend to increase the number of claims. Second, physicians find discussing arbitration agreements with patients awkward; few doctors want to discuss what will happen if they make a mistake. Third, few organizations are geared up to handle malpractice arbitrations.

One of the most interesting recent events is the decision by the AAA to drop health care arbitrations. Perceiving a possibly important new growth opportunity, AAA developed a model set of arbitration procedures for health care disputes. Some notable health care providers, such as Duke Hospital which asks but does not require its patients to sign an arbitration agreement, had used AAA to arbitrate malpractice cases. As a result of criticism about the inherent unfairness of hospitals and physicians forcing patients (who lack bargaining power) to sign arbitration agreements, AAA has decided to exit the field, leaving few organizations with a track record available for handling malpractice arbitrations.

What then of the future? Despite the potential that arbitration might be a more efficient and fairer system for resolving malpractice claims, considerable expansion in the current context seems unlikely. Consumer advocates and plaintiffs’ attorneys are strongly contesting the growing use of arbitration. Without an easier path towards use of arbitration, it is more likely that its potential will continue to be unrealized.

Notes and References

4. For example, in Green Tree Financial Corp. v. Randolph, 531 U.S. 79, 121 S.Ct. 513 (2000), a divided Supreme Court refused to invalidate an arbitration agreement despite uncertain information as to how much it would cost a consumer (who had financed her mobile home purchase) to pursue an arbitration to collect an alleged improper $15 fee. The Court held that the burden was on the party who was challenging the arbitration to prove that they could not vindicate their rights in the arbitration setting.
6. 15 Cal.4th 951, 938 P.2d 903, 64 Cal.Rptr.2d 843 (Cal. 1997).
We do not have a crisis of runaway juries, we do not have a crisis of skyrocketing numbers of new malpractice cases, and we do not have a medical malpractice insurance crisis in Massachusetts. Juries are not overwhelmed by sympathy for plaintiffs, as evidenced by the rate at which physicians prevail in medical malpractice cases. This is all worth stating because those who propose to dismantle the present system need to show that any other system could accomplish the dual goals of deterrence and compensation more effectively. Any “reform” that seeks to deal with the problem by restricting patients’ rights, particularly for those who have been most seriously injured, would approach the situation from the wrong direction.

Historically, interest in “reforming the system” has coincided with a perceived crisis in malpractice insurance. And, while medical malpractice premiums in this state, as well as others across the country, have risen recently, the reasons do not cry out for “tort reform” so much as for “insurance reform.” The cycle is not a new one, and its causes have been known for at least 25 years. A recent study conducted by Americans for Insurance Reform made two important findings:

First, the amount that medical malpractice insurers have paid out, including all jury awards and settlements, directly tracks the rates of medical inflation; payments (in constant dollars) have been extremely stable and virtually flat since the mid-1980s.

Second, medical insurance premiums do not correspond to increases or decreases in payouts, but rather, increase or decrease in direct relationship to the strength or weakness of the economy.

Thus, the amount of premiums are more closely tied to the economy, the stock market, and the rate of medical inflation than they are to any change in claims experience.

The two most common suggestions made to change the system are: 1) a no-fault system which avoids the tort system altogether, and 2) measures designed to reduce the amount of damages injured patients can receive. Many commentators have recognized that a no-fault system could well be more expensive than our current system. Surely, physicians who are concerned about their premiums should not be drawn to a no-fault system for cost-saving reasons. The no-fault system in Florida for brain injured babies has fallen far short of its goal of compensating more patients in a more predictable way than the tort system. States that approach “tort reform” through caps on non-economic damages do so by discriminating against children, women, low wage earners and the elderly.

Deterrent Effect of Tort System

Any system of medical liability that fails to offer strong deterrence to malpractice should be viewed as an inadequate system. Professors Thomas H. Koenig and Michael Rustad recently undertook a review of the effects of the tort system that “revealed a large number of cases in which safety measures were instituted after a successful tort verdict.” These include:

- a hospital that adopted a sponge-count and surgical instruments policy,
- hospitals that developed a standard protocol for diagnosing the source of chest pain,
- implementation of a protocol to prevent misplaced catheters, and
- a revised protocol for an entire nursing home chain that protects Alzheimer patients from drowning in their own bathtubs.

Koenig and Rustad concluded that, “Tort damages provide a wake-up call to medical providers to change their practices or face the consequences. Hospitals are learning to avoid liability by error-proofing their practices and procedures. Sometimes it takes tragic cases and litigation to ‘overhaul equipment and policies.’”

Professor Paul Weiler, who co-authored the Harvard Medical Practice Study Group’s report on medical injuries on New York state, has written that, Malpractice law has played a valuable role in stimulating broad-based improvements in the institutional environment and procedures through which medical care is provided: the Harvard study provides revealing (though not impregnable) evidence that increasing the chances that a tort claim will be filed when negligence occurs in a hospital will reduce the danger of negligent injuries occurring in the first place.
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He has also stated:

I am satisfied that tort law has had a substantial effect on the way physicians now practice in this country. The somewhat more expensive mode of defensive medicine fortunately appears to have produced some of the hoped-for reduction in doctor negligence and patient injuries.”

The tort system is able to provide this important function because it offers a strong incentive for hospitals and medical providers to develop protocols that result in better patient care. These are not protocols imposed from the outside by a governmental agency; these are protocols developed by the hospitals and medical providers themselves when forced to deal with a problem.

Although the tort system cannot improve the performance of the most careful anesthesiologists in town, it can improve the performance of anesthesiologists generally. It does this by unearthing errors that would remain hidden, publicly exposing them (“Sunlight is said to be the best of disinfectants: electric light the most efficient policeman,” said Justice Louis D. Brandeis) and imposing monetary penalties. The combination gives business organizations powerful incentives to reduce errors as much as is feasible.

While errors cannot be eliminated, unnecessarily high error rates are unnecessarily costly. The tort system, therefore, encourages effective self-regulation, that is, regulation not by government agencies but by entities, including hospitals, that know their businesses best.

Certainly, the deterrent aspect of tort law could be strengthened by changes in the law that would place accountability more directly where it should lie, for example, permitting injured patients to sue managed care organizations (MCOs) directly, without the prohibitions in ERISA, in cases where the MCO played a significant role in determining the standard of care that was delivered. It would also make sense to allow “institutional” or “enterprise” liability, including the ability to hold hospitals or other medical institutions accountable for negligent acts that take place within their hospital or institution.

Conclusion

In the final analysis, the case for “tort reform,” whether by means of restricting patient rights directly in the tort system or establishing a no-fault system, has not been made. Restricting patients rights does not lower premiums appreciably; it primarily benefits the insurance industry. No-fault schemes are impractical, costly, and unpredictable. The current system of medical malpractice serves the crucial goal of deterring breaches from the standard of care, which is now more important than ever in the age of corporate managed care. It also compensates those who have been wrongfully harmed just as they would be compensated if they had been negligently harmed by anyone other than a medical provider. Any attempts to “reform” the system should be focused upon changes which would bring about greater deterrence and not upon changes which would serve to restrict the rights of those patients who have been the most seriously injured through negligence.

Notes and References

1. Massachusetts averages approximately 300 medical malpractice payouts per year; the average payout for 1999 was $384,000. See Special Report on Medical Malpractice Payments: Overview of Medical Malpractice Payments Reported to the Massachusetts Board of Registration in Medicine Commonwealth of Massachusetts. Board of Registration in Medicine, 1990 through 1998, p. 13 (available at www.massmed-board.org/mm2000.pdf).
2. Testimony of Joanne Doroshow, Executive Director of the Center for Justice & Democracy, during an Oversight Hearing of the Joint Committee on Insurance, Massachusetts, October 1, 2002.
3. “We continue to close 60 percent of all claims without payment, and of those cases we are forced to defend in court, we prevail in 90 percent.” Barry Manuel, MD, Chairman of the Board of ProMutual Group, Inc, 2001 Annual Report.
17. Ibid, p. 89.
Why is RMF Going Interactive?

Hazardous care delivery, skyrocketing malpractice awards, ever-increasing insurance costs—and the media fascination with it all—can result in a health care system unsafe for patients and providers.

As the industry and the public demand that professionals raise their awareness and understanding of patient safety, Risk Management Foundation (RMF) is responding. We’re building on core services that include unparalleled claims management, low medical malpractice premiums, resources for safe patient care, and risk management recommendations based on actual evidence. RMF will now deliver instant access to our knowledge base in order to address your growing time pressures and need for accurate and insightful information.

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—Luke Sato, MD
Vice President & Chief Medical Officer
Risk Management Foundation