

ADMINISTRATIVE COMPENSATION FOR MEDICAL MALPRACTICE INJURIES: RECONCILING THE BRAVE NEW WORLD OF PATIENT SAFETY AND THE TORTS SYSTEM

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I. INTRODUCTION

The medical malpractice tort system is a failure. Judged on economic terms, more than fifty percent of the dollars are lost to transaction costs, and the instability of the market disrupts the orderly delivery of medical care. Judged on public health terms, it not only fails to provide incentives for better medical care, but its irrationality actually impedes the adoption of better medical care practices in several important situations. Most damning, judged on justice terms, it provides inadequate or non-existent compensation to most injured patients and undeserved windfalls to others, while forcing good doctors to subsidize the errors of incompetent physicians, who thus gain a market edge. Medical malpractice has been very good for the pocketbooks and political aspiration of lawyers, but it has failed the public and health-care providers alike.

The magnitude of the failure of the tort system has been documented in a series of studies of substandard medical care, starting with the New York Study¹ in the 1980s and culminating in the 1999 Institute of Medicine Study (the IOM study), *To Err is Human*,² and the sequel, *Crossing the Quality Chasm*.³ These studies claimed that each year as many as 98,000 Americans die and many more suffer significant injuries from medical mistakes, making malpractice one of the leading causes of death.⁴ The New York Study also echoed the finding of previous studies that most injured patients did not sue for medical malpractice, and among those who did, the severity of their injuries and not the scientific merits of their claim determined their compensation.⁵

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¹ A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Practice Study III*, 325 N. ENG. J. MED. 245 (1991).

² COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 2000).

³ COMM. ON QUALITY HEALTH CARE IN AM., INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH CARE SYSTEM FOR THE 21ST CENTURY* (2001).

⁴ See *TO ERR IS HUMAN*, *supra* note 2, at 1.

⁵ Localio, *supra* note 1, at 248–50.

Implicitly recognizing the failure of the states to deal with patient safety, the federal government is moving forward with a national system for reviewing the quality of medical care and disciplining errant providers.⁶ While the authors believe that the fundamental motivation for this patients' system is to save money through controlling the delivery of medical care,⁷ nonetheless, it can be the core of an alternative to the torts system. This article explores an integrated quality credentialing and administrative compensation system for medical negligence. The authors argue that such a system must replace the tort system. Current efforts to impose federal quality standards while tinkering with concepts such as enterprise liability and no-fault compensation as adjuncts to the tort system will only perpetuate the injustice of the current system.

II. THE FAILURE OF THE TORT SYSTEM

It is important to take a hard look at the tort system and its role in medical care. There are many powerful interests that defend the tort system in general and the medical malpractice system in particular.⁸ It both compensates persons injured through negligence and deters dangerous behaviors. At the same time, it is recognized that administrative law systems have several major flaws.⁹ State boards of medical examiners are the administrative agencies currently charged with assuring the quality of medical practice, and, with few exceptions, they have wholly failed to address substandard medical care.¹⁰ Yet we believe that even an imperfect administrative compensation system will be an improvement over the existing medical malpractice system.

A. *Is there a Deep Pocket?*

The primary purpose of the tort system is to provide compensation for persons who are injured through the negligent or intentional actions of others who have a legal duty to

⁶ The term that best describes this evolving system is "Quality Credentialing." In the past, penalties have focused on fraudulent acts by providers. Under the new system, whether the government or private contractors reward or punish will turn on the number of errors or near misses that are identified in a physician's outcomes. See *infra* notes 107–38 and accompanying text.

⁷ Patient safety is the public face of the effort because it is much more politically acceptable than admitting that the federal government is setting up a national managed care system to control the provision of medical care. See generally Thomas R. McLean, *The Implications of Patient Safety Research & Risk Managed Care*, 26 S. ILL. U. L.J. 227 (2002).

⁸ Thomas R. McLean, *Stealth v. Health: The Complexity of Tort Reform*, 12 LEGAL MED. PERSP. (2003), at www.aclm.org/publications/lmp.asp.

⁹ See, e.g., Ronald A. Cass, *Models of Administrative Action*, 72 VA. L. REV. 363 (1986). Administrative law systems are antidemocratic in that decisions are made by government employees rather than jurors, and these decisions are very difficult to contest because courts give great deference to agency decision-making. *Id.* at 363. Agencies can make rules which have the force of law, and use these rules to further limit the ability of regulated parties to contest agency actions in court. *Id.* at 380–83. Agencies are subject to bias and it is much harder to disqualify a biased agency judge than a state or federal court judge. Most fundamentally, agencies are criticized because they violate our notions of separation of powers by having the same agency, and often the same people, act as investigator, prosecutor, and judge. *Id.*

¹⁰ In some cases this is because unorthodox practitioners have powerful friends in the legislature and get laws passed limiting the board's authority. See TO ERR IS HUMAN, *supra* note 2, at 70–71; CROSSING THE QUALITY CHASM, *supra* note 3, at 24–25.

avoid such injuries.¹¹ There are two critical limitations on the tort system as a method of compensation. First, a tort-based compensation requires that the negligent party have adequate resources to pay the claim, either personally or through his own insurance. In many automobile accident cases the negligent party does not have adequate insurance because the cost of a serious injury greatly exceeds the \$10,000 to \$20,000 maximum coverage provided by most automobile liability insurance policies.¹² While the news media focuses on huge verdicts, the truth is that in many automobile accident cases the tort system cannot provide adequate compensation, or any compensation at all, because the defendant is inadequately insured or not insured.

Similarly, malpractice coverage is often inadequate for compensating the most serious injuries. Medical malpractice coverage is generally purchased by a provider for the minimum limits mandated by statute or by the hospital at which the provider practices. For the most part, such policies are limited to \$1,000,000 per incident and \$3,000,000 total coverage per year.¹³ As discussed in the following section on transaction costs, the plaintiff is unlikely to get more than \$500,000 to \$750,000 of a \$1,000,000 award. This has to cover both past medical bills, future lost earnings, and future medical care. Serious injuries that require long-term medical care will have future costs in the millions of dollars.¹⁴ In almost all cases, multi-million dollar awards come from institutional providers, usually hospitals.¹⁵ Average settlement payments by physicians in medical malpractice cases have increased from \$232,000 to \$324,000 between 1998 and 2002, and the instances of multi-million dollar payments by institutional providers has also increased.¹⁶ Relying on institutional providers to pay large claims further limits the cases where adequate compensation is available. Hospitals are usually not liable for the

¹¹ Mark Geistfeld, *Negligence, Compensation, and the Coherence of Tort Law*, 91 GEO. L.J. 585, 585 (2003).

¹² See Insurance Information Institute, *Auto Insurance Expenditures by State*, at <http://iii.org/media/facts/statsbyissue/auto> (last visited Nov. 6, 2004).

¹³ U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO-03-702, *MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 6* (2003) (Report to Congressional Requesters), available at <http://www.gao.gov/new.items/d03702.pdf> [hereinafter *MEDICAL MALPRACTICE INSURANCE: REPORT*]; see also U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO-04-128T, *MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES* (2003) (Testimony Before the Subcommittee on Wellness and Human Rights, Committee on Government Reform, House of Representatives), available at <http://www.gao.gov/new.items/d04128t.pdf> [hereinafter *MEDICAL MALPRACTICE INSURANCE: TESTIMONY*]

¹⁴ There is one exception, in that Louisiana has an administrative compensation system for future medical costs that assures that the injured person is cared for. This is still a tort based system, but once the court determines that the plaintiff is entitled to future medical care, the responsibility for that care is shifted to a state compensation board. There is no damage award but the board pays for future care. This assures that care is available and reduces the transaction costs because the attorneys do not share in the money paid for future care. See generally *Kelty v. Brumfield*, 633 So. 2d 1210 (La. 1994).

¹⁵ See Berkeley Rice, *Hospitals Feel the Malpractice Pain*, MED. ECON., Oct. 10, 2003 at 37.

¹⁶ Gail Garfinkel Weiss, *Malpractice: Don't Wait For a Lawsuit to Strike*, MED. ECON., March 22, 2003, at 83; Press Release, Physician Insurers Association of America, PIAA, NPDB Data Show Medical Malpractice Costs Still Rising; NPDB Puts Total Payout Increase at 8% (May 4, 2004), available at http://www.thepiaa.org/pdf_files/20040504.

negligence of medical staff members.¹⁷ More fundamentally, the trend for years has been to move medical care out of the hospital and into the physician's office.

The most important limitation on tort compensation is that it is only available, even in a limited fashion, when there is negligent treatment and that negligence causes injury. While the initial IOM study claims up to 98,000 deaths a year and many more injuries from substandard care, there are two important caveats in translating that into tort compensation. First, and most important, the IOM does not distinguish between the death of an otherwise healthy person who might have lived for many more years and the death of a critically ill patient who, in the absence of substandard care, might have lived only a few days. Second, the IOM's notion of substandard care is not necessarily the same as negligent care. Substandard care can be due to inadequate community resources, limitations on medical insurance coverage, and other factors that are failings of the health care system, not health-care provider negligence. The vast majority of complications from medical treatment, even the most devastating complications, are the unpreventable consequences of non-negligent treatments for serious diseases.

There is no compensation for unavoidable complications other than the individual's own medical and disability insurance coverage, so-called "first person insurance." Because many people do not have this coverage, either because they cannot afford it or because they choose not to buy it, serious illness and treatment complications often result in financial ruin. This is a tragedy that is not addressed by the tort system. It is also one that subverts the tort system because juries are often swayed by the stories of severely injured persons who are in need, even when the scientific facts do not support their claim that the injuries were due to negligence.

B. Transaction Costs

The transaction costs of the tort system are the second reason for its failure. They consume most of the dollars paid for medical malpractice insurance, and they also make it economically impossible for the majority of persons injured through negligence to seek compensation through the tort system. There are three major transaction costs in tort based medical negligence compensation:

- 1) Contingent fees, expenses, and plaintiff's attorney opportunity costs;
- 2) Defense lawyer's costs; and
- 3) Costs of health-care provider's direct and indirect expenses.

¹⁷ Most medical staff members are independent contractors and the hospital will only be liable for their negligence if the hospital itself was negligent in allowing the physician to join or remain on the medical staff, or if a hospital employee such as a nurse was also negligent. *See, e.g.,* Schlotfeldt v. Charter Hosp. of Las Vegas, 910 P.2d 271, 274 (Nev. 1996); Candler Gen. Hosp., Inc. v. Persaud, 442 S.E.2d 775, 776-77 (Ga. Ct. App. 1994). *See also* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS, ch. 6 (4th ed. 2001).

Plaintiffs' attorneys' fees and costs have received the most media attention. Contingent fees can run up to fifty percent of the award if the case is appealed. Some states, such as California and Illinois, have capped contingent fees.¹⁸ Contingent fees are only part of the costs of case preparation. Case investigation often requires the work of many professionals other than the attorneys, and there are costs for copying records, traveling to talk to witnesses, and the single largest expense, paying physician expert witnesses. In most contingent fee contracts the plaintiff is responsible for the costs even if there is no recovery, although many attorneys waive the costs if there is no recovery and the client is not well off.¹⁹ These costs can run up to many thousands of dollars, sometimes as much as \$50,000 to \$100,000 in a complex case taken to trial.

Because there is no direct recovery of attorney fees in tort cases in most states, the fees and costs must come from the plaintiff's proven damages, assuring that unless there is a large pain and suffering award, the plaintiff's actual recovery after all costs and fees will be a fraction of the real damages. The combination of costs and contingent fees—even in a state like California that caps fees—can consume most of the award. If there is an inadequate award the attorney loses the value of the time spent preparing the case, so that the potential recovery must be great enough to pay the costs, give the attorney a fair return on his time, and leave enough money to benefit the client.

Defense costs receive much less public scrutiny, but can equal or exceed plaintiffs' attorneys' costs because they are incurred in all cases, unlike plaintiffs' attorneys' fees which are only paid in cases where there is a settlement or a plaintiff's jury verdict. Defense costs include attorney time, almost always billed at an hourly rate, costs of case-related services such as copying and travel, and expert witness costs. Defense costs increase as the case gets closer to trial, with costs rising dramatically in the weeks before trial as attorneys prepare for and then participate in the trial. Early settlements or dismissals limit defense costs, but also limit the revenue of the defense lawyers, creating potential conflicts. It is not unusual for defense costs to exceed \$200,000 in cases litigated to a verdict, which means even a win for the defense is a significant loss to the medical malpractice insurer or to the corporate defendant paying its own attorneys.

Health care providers involved in medical malpractice litigation have significant direct and indirect costs that are not covered by medical malpractice insurance. Direct costs include lost time from practice while participating in the preparation and trial of the case, retaining a personal lawyer to oversee the case if there is a chance the verdict will exceed the insurance limits, and potential loss of business due to adverse publicity. The emotional cost is also very high. For many physicians, the lawsuit becomes the single

¹⁸ California caps contingent fees at forty percent of the first \$50,000, thirty-three and one-third percent of the next \$50,000, twenty-five percent of the next \$500,000, and fifteen percent of any amount that exceeds \$600,000. CAL. BUS. & PROF. CODE § 6146 (West 2004).

¹⁹ Samuel R. Gross, *We Could Pass a Law . . . What Might Happen if Contingent Legal Fees Were Banned*, 47 DEPAUL L. REV. 321, 321–22 (1998). This is an important issue, since the majority of claims do not result in any payout.

focus of their lives for years, disrupting all other aspects of their lives. Some even commit suicide.²⁰

C. *The Impact of Transaction Costs*

Transaction costs for medical malpractice compensation impact the fairness of the system. Most plaintiffs who get a recovery receive fifty percent or less of the actual settlement or verdict. The recovery of non-economic damages—pain and suffering—is a response to the problem, allowing the jury to top off the award so that the plaintiff takes home closer to the real costs of compensation. This is not the case with settlements, however, which are usually at a discount to the patient's true compensation needs. For plaintiffs who get little or no recovery, the process of spending several years focused on the lawsuit, with considerable personal sacrifice in many cases, is embittering and only complicates their getting recovery.

The second impact is that plaintiffs with smaller claims cannot afford representation. While the cutoff for an economically valid claim under the contingent fee system is, at best, an apocryphal number, conventional wisdom is that a claim must have provable damages of at least \$100,000, and many specialist firms want damages in the \$500,000 range.²¹ As with most types of injury data, the most severe injuries are only a small part of the total number of injuries. Data from the New York study showed that few cases of iatrogenic injuries lead to legal claims.²² The most important determinate was the severity of the injury.²³ While the less severe injuries would support smaller awards, their frequency would make the total payouts much larger in a system with smaller transaction costs.²⁴

Thus, there are two powerful incentives to maintain high transaction costs. First, the lawyers on both sides have little interest in any reform that would lower lawyer costs. Second, the medical malpractice insurers have no incentive to lower transaction costs in any way that would make it cheaper to bring a claim. As plaintiffs' lawyers rightly complain, all the efforts at tort reform are aimed at reducing the number of claims and reducing the potential awards for a given claim, not increasing the justice of the system for plaintiffs.

D. *Deterrence*

²⁰ For an interesting look at the emotional cost of medical malpractice cases on both physicians and plaintiffs, see SARA C. CHARLES & EUGENE KENNEDY, *DEFENDANT: A PSYCHIATRIST ON TRIAL FOR MEDICAL MALPRACTICE* (1986).

²¹ Ironically, while there is much discussion of frivolous claims, as if plaintiffs with minor problems are flooding the court system, law firms seldom bring claims unless there are major injuries. The conflict is whether the injury was caused by the care, and the appropriate standard of care.

²² Localio, *supra* note 1, at 247.

²³ *Id.* at 249.

²⁴ See generally Don Harper Mills, *Medical Insurance Feasibility Study: A Technical Summary*, 128 W. J. MED. 360, (1978).

Defenders of the tort system argue that deterrence plays an important role in improving medical care. Tort law can deter activities which are not economically viable when their profits are offset by the internalization of the cost of the injuries they cause. Compensation through tort law serves to internalize the cost of injuries caused by an activity. More accurately, deterrence happens when the profits of an activity are offset by the combination of the cost of compensation and the transaction costs associated with claims for compensation. Sometimes deterrence is based on the cost of compensation paid out. More commonly, deterrence is really due to the actions of public regulators, such as the Consumer Product Safety Commission or the Department of Transportation. While tort claims may bring problems to the attention of regulators, just as often, regulators bring problems to the attention of the tort bar. In some cases, the cost of defending unfounded claims can drive a safe drug from the market, as happened with Bendectin, a drug to manage severe nausea in pregnant women.²⁵ Deterrence also acts through the fear of insurers. If insurers are concerned that an activity will attract litigation, they will refuse to insure it.

Opponents of tort reform and alternatives to the tort system argue that deterrence is very important to encourage health-care providers to practice better medicine. The best, and perhaps only significant example was the use of litigation fears to hasten the adoption of monitoring standards for general anesthesia, in particular the use of oximetry and capnography.²⁶ In this case the deterrence theory was that lawyers would convince courts that such monitoring was the standard of care and that anesthesiologists who did not use the monitors would be impossible to defend. This contributed to the rapid adoption of monitoring standards,²⁷ with a dramatic reduction in medical malpractice claims against anesthesiologists and the lowering of their medical malpractice insurance rates. The interesting lesson from this was that there was no litigation over failure to use these devices at the time the standards were adopted. The tort lawyers were used as bogymen to hasten the adoption of the new standards by the anesthesia professional organizations.²⁸

This is an isolated example. The introduction of fetal monitoring for pregnant women led to the opposite result, a significant increase in legal claims.²⁹ In some cases there have been changes in the behavior of medical care providers, but no evidence that this has improved the quality of medical care. The best example may be the extensive paperwork that physicians must complete to apply for state licensure or medical staff privileges.

²⁵ Once Malignant Morning Sickness Drug Preparing for Comeback, Oct. 10, 2000, available at <http://archives.cnn.com/2000/HEALTH/women>. For an example of one of the many lawsuits, see *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993).

²⁶ STANDARDS OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS (1987). See also Jay B. Brodsky, *What Intraoperative Monitoring Makes Sense?*, 115 CHEST 101S, 102S (1999);

²⁷ HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990).

²⁸ This was orchestrated through the Anesthesia Safety Counsel, a group of experts including Professor Richards, which was funded by the major manufacturer of oximeters. The manufacturer wanted to improve patient safety, but also wanted to sell its machines. It was very successful at both efforts.

²⁹ See generally Edward P. Richards & Charles Walter, *How Effective Safety Devices Lead to Secondary Litigation*, 10 IEEE ENG'G IN MED. & BIOLOGY 66 (1991).

This usually includes references from every position that the physician held since medical school, and it is repeated by every institution that the physician deals with. While it may have eliminated a few imposters, there is no evidence that it has improved the quality of medical care. It has just increased the cost of care.

More generally, the dark side of deterrence is defensive medicine. Defensive medicine is the ordering of diagnostic tests and the hospitalization of patients because the physician fears that failing to do so will lead to litigation if the patient's course is not as predicted. What physicians fear is that they will be second guessed for failing to make the correct diagnosis, and that ordering extra tests or putting the patient in the hospital will show that they did everything possible.³⁰ There is little support for the effectiveness of defensive medicine, but many physicians are convinced that they must do it.³¹

E. Why does Deterrence Fail?

Deterrence fails for three reasons. First, the timeframe is wrong. Medical malpractice claims are paid years after negligent actions, making it very difficult for physicians to make the link between their behavior and the payout. More importantly, if the unsafe behavior is one that increases the profits of the physician, the hospital, or the managed care plan, changing the behavior today costs real dollars, while the cost of potential claims in the future is only a theoretical risk: the discount rate of future claims to net present day value is very high. This behavior is economically rational because in many cases the potential profits from the practice patterns that create the litigation risk are higher than the incremental tort risk.

Second, medical malpractice insurance provides very little incentive to change individual behavior. Most malpractice insurance is not individually rated. All of the physicians practicing the specialty in a given community pay the same rate, and share the losses. In a classic “commons” problem, there is little personal incentive for a physician to change his behavior.³² In fact, since physicians usually do not pay based on the volume of their work, there is an incentive to do as many risky but profitable procedures as possible, since that increases the income for the same malpractice insurance payment.³³ Thus all

³⁰ Defensive medicine causes injuries, but a detailed discussion is beyond the scope of this article. *See generally* Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1 (2001); Edward P. Richards & Thomas R. McLean, *Physicians in Managed Care: A Multidimensional Analysis of New Trends in Liability and Business Risk*, 18 J. LEGAL MED. 443 (1997). *See also* Richard Hayward, *VOMIT (Victims of Modern Imaging Technology)—An Acronym for Our Times*, 326 BRIT. MED. J. 1273 (2003), available at <http://bmj.bmjournals.com/cgi/content/full>.

³¹ Because someone will be paid for doing those tests or for time the patient spends in the hospital, there are other incentives for institutions to encourage this belief in the necessity of defensive medicine. One never hears of physicians saying that they have to spend more time talking to patients to prevent litigation, although this is perhaps the single most important way to reduce claims.

³² There is some adjustment based on which invasive procedures are performed, for example, family practitioners who deliver babies will pay a much higher rate than those who do not.

³³ One of the interesting provisions of the Virginia birth injuries compensation program discussed herein is that it is paid for by a per birth charge. While not discussed in the legislative analysis noted in the article,

neurosurgeons pay very high malpractice insurance rates because some of them do a lot of unnecessary back surgery, which results in malpractice claims. Surgeons who do not do unnecessary procedures subsidize the medical malpractice insurance for surgeons who do.

The third reason deterrence fails is the large number of medically unfounded claims that are brought and settled, or in which plaintiffs get a jury verdict. As discussed previously, in the analysis of transaction costs plaintiffs' attorneys have powerful financial incentives to not bring medical malpractice cases unless the patient has major injuries.³⁴ However, if the client has a major injury with long-term consequences, a skillful attorney can persuade a jury to overlook technical issues such as whether the physician followed the standard of care or whether the injuries were caused by the physician's actions at all.

This is a critical point: the legal notion of a frivolous claim is profoundly different from what physicians think of as a frivolous claim. In the legal world, any claim you can win without violating the code of professional conduct is a valid claim and you are obliged to bring it on behalf of your client—if you undertake the client's representation.³⁵ This is the source of much cognitive dissonance in the medical legal world.³⁶

The breast implant litigation is an archetypical example. By all scientific criteria, the litigation was unfounded and frivolous.³⁷ By professional legal criteria it was perfectly ethical. None of the expert testimony used by the plaintiffs was credible in the scientific world, but since judges are allowed to use their own version of science in admitting testimony, these cases were allowed to go to trial and sympathetic juries awarded millions of dollars.³⁸ As long as the duty of an advocate is to find an expert to support his client's case, not to find an impartial expert, medical malpractice law will send a hopelessly muddled deterrence signal.³⁹ Thus, claims are settled for various reasons,

this might explain why many physicians do not participate; large volume practices might find conventional insurance, which is not rated by the number of births, cheaper, even though their risk is much higher.

³⁴ See *supra* text accompanying notes 20–24.

³⁵ MODEL RULES OF PROF'L CONDUCT R. 3.1 ("Meritorious Claims and Contentions"); see FED. R. CIV. P. 11; see also MODEL RULES OF PROF'L CONDUCT R. 1.16 (discussing declining or terminating representation).

³⁶ This is why the current tort reform proposal to bar claims by attorneys who have filed three frivolous claims is unworkable. The legal system already has sanctions for attorneys who file frivolous claims. FED. R. CIV. P. 11. Adding new sanctions does not address the problem that it is not unethical to bring a claim you can win, even if the science is against you.

³⁷ See Gina Kolata, *Panel Confirms No Major Illness Tied to Implants*, N.Y. TIMES, June 21, 1999, at A1. The final settlement exceeded 4 billion dollars. *Id.*

³⁸ See David S. Caudill & Richard E. Redding, *Junk Philosophy of Science?: The Paradox of Expertise and Interdisciplinarity in Federal Courts*, 57 WASH & LEE L. REV. 685, 715–16 (2000). While *Daubert* is seen by many as reducing the admission of bad science, this is not necessarily the case. See *id.* The only cases that are seen on appeal are those where evidence has been excluded, i.e., where *Daubert* works. If the evidence is admitted, it is much more difficult to appeal the case, creating a profound selection bias against seeing cases where *Daubert* fails.

³⁹ Judges bear most responsibility here. Most state codes and the *Federal Rules of Civil Procedure* allow judges to appoint special masters, neutral experts on technical matters, but judges almost never do this. See FED. R. CIV. P. 53. This would be a powerful check on the duty of zealous advocacy. See *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 149 (1997) (Breyer, J., concurring).

including the difficulty in explaining to the jury that the physician's wrongful act did not cause the plaintiff's injury; because the defendant has a difficult personality that the jury will dislike; or because juries typically rule for children whom they see as deserving, or any combination of reasons. All of these are perfectly acceptable legal reasons to bring a claim. All lead to the payment of medically unfounded claims.⁴⁰ The aggregate effect of these false positive and false negative signals from the medical malpractice system is to convince physicians that medical malpractice claims are random events.⁴¹ Secondly, paying verdicts and settlements which are based on medically unsound practices or scientifically unsupported claims sends a message to health-care providers and the public that such practices are acceptable. An important example is unfounded claims that childhood vaccines cause injuries such as autism. While there is no evidence to support such claims, the massive media attention to such claims and their pervasive presence on websites supported by plaintiffs' attorneys has even convinced some health-care providers that vaccinations are dangerous and should be avoided.⁴² Thus, rather than a deterrent, the tort system often encourages the worst sort of anecdotal claims and runs contrary to all principles of scientifically based medical practice.⁴³

The example of oximetry to reduce anesthesia injuries and negligence claims against anesthesiologists, compared to efforts to reduce obstetric medical malpractice claims, illustrates a key point in this error signal theory of deterrence failure. As the anesthesiologist who was one of the developers of pulse oximetry explained it, oximetry is so simple even a surgeon can understand it. What he meant was that most anesthesia accidents, of whatever cause, had the common effect of injuring the patient through reducing the oxygen in the patient's blood. The oximeter of those days was a simple device that measured oxygen in the patient's blood in real time, and beeped when it was too low. Everyone in the operating room could hear the beep, including the surgeon, who would know what it meant and could then make sure that the anesthesiologist checked on the patient.⁴⁴ This was a simple, relatively inexpensive technological fix that promised to reduce claims by reducing injuries, and, conversely, to increase claims if it was not used because it would be so easy for the plaintiff's attorney to claim it was negligent to not use it.

⁴⁰ It is important to note that plaintiffs also suffer under this system. Plaintiffs who are unsympathetic to a jury are at a disadvantage. Defense attorneys are subject to the same ethical rules as plaintiffs' attorneys and also use scientifically unfounded evidence to support their cases.

⁴¹ See William Meadow et al., *Physicians' Experience with Allegations of Medical Malpractice in the Neonatal Intensive Care Unit*, PEDIATRICS, May 1997, at 1. Moreover, it must be recognized that what limited data is available on medical malpractice claims is suboptimal because of selection bias of the reporting sources.

⁴² See Steve P. Calandrillo, *Vanishing Vaccinations: Why Are So Many Americans Opting Out of Vaccinating Their Children?*, 37 U. MICH. J.L. REFORM 353, 353 (2004).

⁴³ Some states have attempted to limit these unfounded claims by using medical review panels. To the author's knowledge, none of these laws make the panel's finding binding, i.e., the plaintiff is not allowed to bring an unfounded claim or the defendant cannot defend a valid claim. They do encourage the settlement of claims that the panel finds meritorious. This creates a selection bias in the cases that are tried, making it look like the panels are biased against plaintiffs because the only cases seen on appeal are ones in which the plaintiff lost at the panel.

⁴⁴ This was important because a major source of anesthesia injuries was anesthesiologists who were inattentive or even out of the room.

In contrast, there is no easily detected common cause of birth injuries, which are the biggest cause of obstetric claims. Scientific evidence shows that many birth injuries that result in huge jury awards are not due to the obstetrician's negligence at all, but are the result of chronic conditions of the placenta or other unpreventable events.⁴⁵ There is no simple solution to birth injuries which obstetricians can be frightened into using through fears of litigation. This is much more typical of medical negligence than the simple technical fix of oximetry.

Ironically, there is a way to reduce birth injury claims, but because it does not address any single simple problem, the tort system does not provide a clear signal to use it. Advanced Medical Systems has developed a structured system of patient records and patient information materials to deliver prenatal care.⁴⁶ It assures that all necessary prenatal tests and examinations are conducted, and, as importantly, documents this in a clear and unambiguous record.⁴⁷ The result is that even if there is a birth injury, it is very difficult to show any negligence because it is easy to show the jury that everything was done correctly and that the patient was properly informed at all times. Physicians using this system have claims at the rate of about 1/100,000 deliveries, dramatically lower than those who do not use the system.⁴⁸ The lack of attention to this and other structured approaches to prenatal care, in the face of huge problems with obstetric medical malpractice claims, is perhaps the best evidence of the failure of deterrence.

F. The Medical Malpractice Insurance Business

The medical malpractice insurance system causes problems far beyond its contribution to the costs of health care. While reliable numbers are difficult to come by, the total cost of medical malpractice insurance premiums has never exceeded one to two percent of the total medical care budget.⁴⁹ Even the most inflated estimates of defensive medicine do not raise the total to more than five percent of the medical care budget.⁵⁰ Yet physicians claim they are leaving practice because of insurance costs and others claim to be leaving states such as Mississippi because of insurance cost and availability.⁵¹ How can such a small part of the health care budget have such a disproportionate effect on physicians?⁵²

⁴⁵ Patricia King Urbanski, *Placental Evaluation: Pregnancy's Black Box?*, AWHONN LIFELINES, April 1997, at 54–55.

⁴⁶ ADVANCED MED. SYS., INC., *PRENATAL CARE—A SYSTEMS APPROACH*, at <http://www.amsintl.com> (Last visited Nov. 8, 2004)

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ See U.S. GEN. ACCOUNTING OFFICE, PUB. NO GAO-03-836, *MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTHCARE* 26–29 (2003).

⁵⁰ See generally *id.*

⁵¹ *Id.* 30–36; see also FRED J. HELLINGER & WILLIAM E. ENCINOSA, *THE IMPACT OF STATE LAWS LIMITING MALPRACTICE AWARDS ON THE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS* (2003) (prepared for the Agency for Healthcare Research and Quality (AHRQ)), at <http://www.ahrq.gov/research/tortcaps>.

⁵² In part, the disproportionate effect on Medical Doctors is related to two decades of managed care and Medicare cuts which has made the profit-margins of some physicians razor thin. See Thomas R. McLean,

The cost of medical malpractice insurance is not evenly distributed across the participants in the health-care delivery system. Under recent United States Supreme Court case law,⁵³ medical care insurers, through which most of the private money in health care flows, have almost complete immunity from medical malpractice claims.⁵⁴ Conversely, physician practices, which account for only about 25% of the health care budget, bear most of the costs of the medical malpractice system.⁵⁵ Among physicians, rates are set state-by-state and are based on specialty practice, certain procedures, and geographic areas.⁵⁶ As the number of physicians in a rating group decreases, the averaging effect decreases, increasing the volatility of the rates.⁵⁷ The level and quality of the state's insurance commission affects the volatility of the rates, as do issues such as the accuracy of risk estimation by the insurer, the rate of return on money invested by the insurer to cover future claims, the cost of reinsurance and the actual claims paid out on the groups of physicians.⁵⁸ Rates are also affected by state tort law practices and tort reform laws, although GAO studies do not demonstrate any consistent pattern for the effect of the reforms.⁵⁹ While most physician groups point to California's tort reform package as having stabilized rates in that state, it is impossible to sort out the influence of other factors, especially the size of the state and the huge physician base over which the claims can be averaged.⁶⁰

Rates alone are only part of the problem. The most acute problem is availability of insurance. Major medical malpractice insurance carriers have a pattern of leaving states when the insurance cycle turns down, reducing the profitability of their product.⁶¹ This was less of an issue in the 1970s when most coverage was written as occurrence policies, i.e., if you were insured in 1975 and a claim was made against you in 1979, it was paid for by your 1975 policy.⁶² This created a long tail on claims because the insurer had to

Using the Market to Regulate Health Care Price: Why Heart Hospitals Will Have a Competitive Advantage in the World of Post-Diagnostic Related Group Pricing, 2 AM. HEART HOSP. J. 165, 165 (2004).

⁵³ *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2502 (2004). This freedom from liability is in part related to the complex nature of this case and the complex functions (medical oversight and risk dispersion) that the HMO had taken on.

⁵⁴ Thomas R. McLean & Edward P. Richards, *The "Aetna Health" Ruling*, NAT'L L.J., Aug. 30, 2004, at 12; Thomas R. McLean & Edward P. Richards, *Health Care's "Thirty Years War": The Origins and Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283, 316–17 (2004). This remains true despite the reality that many practices that lead to patient injuries are the result of managed care financial policies.

⁵⁵ The usual structure of hospital staffs keep the physicians as independent contractors, so the hospitals are only liable for the small group of employed physicians, for the actions of their staff that are done at the direction of a physician, and for failing to properly credential medical staff members.

⁵⁶ See MEDICAL MALPRACTICE INSURANCE REPORT, *supra* note 13.

⁵⁷ *Id.*; see also HELLINGER & ENCINOSA, *supra* note 51.

⁵⁸ See MEDICAL MALPRACTICE INSURANCE: REPORT, *supra* note 13.

⁵⁹ See generally *id.*

⁶⁰ There are also informal reports that the claims frequency is rising in California, which may destabilize the rates in the long term.

⁶¹ MEDICAL MALPRACTICE INSURANCE: REPORT, *supra* note 13, at 37–38.

⁶² *Id.*

predict the cost of covering claims in the future, making it difficult to set rates.⁶³ One of the responses to the 1970s medical malpractice insurance rate crises was to change coverage to claims made policies.⁶⁴ Claims made insurance only pays claims that are brought within the effect date of the policy.⁶⁵ Thus, you have to keep buying insurance, even if you are no longer in practice or even alive. If you stay with the same insurer for all of your practice years, you only notice the difference between claims made and occurrence insurance when you leave practice or change states. At that point you have to buy tail coverage, an additional policy that covers any claims made for care rendered during your primary policy coverage. Depending on the company's policy, the cost of tail coverage can be inexpensive or can cost several times a single year's premium.

The problem is that tail coverage costs are not regulated effectively in many states, so that if an insurer leaves the state, its policy holders will have to buy tail coverage as a high and unexpected expense. The alternative is to pay a surcharge to the successor insurer⁶⁶ so that the new insurer will cover claims based on care rendered under the previous policy. As with the tail coverage, this surcharge comes as a large and unexpected expense. In the worst case, there will not be any insurers in the state willing to write coverage, leaving the physician bare and unable to continue practice since most hospitals require insurance for hospital medical staff privileges.

Thus, the medical malpractice insurance system has two major flaws. First, even when it is working well and the rates are stable and reasonably related to physician's income, it provides little incentive for individual physicians to practice risk management.⁶⁷ While private insurers will refuse to write coverage for physicians with a lot of losses, that is a sufficiently remote threat that has little impact on the day-to-day practice of the insured.⁶⁸ Second, over the long run, it has proven to be unstable because of the insurance cycle. This leaves physicians facing unexpected rate increases or surcharges, and even leaves them with the threat of no coverage.

III. ALTERNATIVES TO THE TORT SYSTEM

Physicians and hospitals are the major proponents of tort reform, so it is not surprising that most tort reform efforts attempt to affect the insurance side of the problem by

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ This is commonly known as nose coverage.

⁶⁷ There are some exceptions. The COPIC Insurance Company in Colorado, which was formed by physicians in Colorado in response to the uncertainty of the insurance market in the state, developed risk management standards in several important areas and required their insured to follow the standards. *See Copiscope Newsletter, available at* <http://callcopic.com/publications/copiscope.htm> (COPIC's risk management newsletter published bi-monthly).

⁶⁸ Many states have state managed alternatives to private medical insurance for physicians who cannot get coverage in the private market, thus removing even the threat of non-coverage. In Louisiana, for example, the state fund is limited to charging a small surcharge for physicians with a bad claims history, making it difficult to remove such physicians from the insurance system. *See* LA. REV. STAT. ANN. § 1299.44 (West 2001).

limiting the potential awards, by using screening panels to reduce the cost of dismissing scientifically unfounded cases, and by limiting the time to bring the cases.⁶⁹ There are three other major alternatives which have been proposed by researchers and by business groups. While none of these has gained much support, it is important to understand why they are not effective alternatives to administrative compensation.

A. *Binding Arbitration*

Binding arbitration is used extensively to control litigation costs in other industries. While some states putatively ban arbitration agreements for medical malpractice cases, such bans have been rejected by the United States Supreme Court as preempted by the Federal Arbitration Act.⁷⁰ Arbitration can limit unfounded claims and scientifically implausible claims and can eliminate outlier jury awards. Arbitration can reduce the transaction costs, but only if plaintiffs' attorneys adjust their fee agreements and defense attorneys do not prepare the cases as if they were going to trial. Some health-care providers have used arbitration to reduce the cost of managing negligent injuries.⁷¹

The biggest hurdles to binding arbitration are physician fears, which are encouraged by defense attorneys who are skeptical of binding arbitration. Physicians are frightened of arbitration because it is seen as always trying to give something to both sides. The almost uniform adoption of arbitration by securities dealers seems to indicate that this is not a significant monetary problem, but the requirement that malpractice settlements be reported to the National Practitioner Database makes physicians unwilling to accept a system that is seen as more likely to give an award.⁷² Insurers are ambivalent about arbitration because of data which shows that reducing the transaction costs will increase overall payments. Since their interest is in controlling overall payments, not in assuring fair compensation, cost effective arbitration would be a threat to their bottom line. Arbitration might improve the deterrence signal if it reduced awards without scientific merit, but since it has not been used extensively in medical malpractice cases there is not empirical support for its effect on deterrence.

B. *Enterprise Liability*

Enterprise liability is the liability of businesses and other organizations for the negligent acts of their employees. It is a well established concept that is very important in other areas of tort law. Outside of health care, torts against businesses almost always involve enterprise liability through the doctrine of *respondeat superior*, under which the

⁶⁹ Caps on plaintiffs' attorney's fees do shift a bit more money to the injured person, but at the potential cost of further limiting the claims that can be economically litigated.

⁷⁰ 9 U.S.C. § 2 (2000); *see also* Doctor's Assocs., Inc. v. Casarotto, 517 U.S. 681, 686–87 (1996) (preempting Montana state statute); Perry v. Thomas, 482 U.S. 480, 490–491 (1987) (preempting California labor law); Southland Corp. v. Keating, 465 U.S. 1, 16–17 (1984) (preempting California state statute).

⁷¹ Broughton v. Cigna Healthplans of Cal., 988 P.2d 67, 71 (Cal. 1999).

⁷² Joseph T. Hallinan, *Attempt to Track Malpractice Cases is Often Thwarted*, WALL ST. J., Aug. 27, 2004, at A1. Because there is no evidence that the National Practitioner Databank really provides useful information about claims payments, its benefits may be outweighed by the adverse effect on more efficient claims settlement procedures. *Id.*

employer is responsible for the negligent acts of the employee or agent when those actions are within the course and scope of employment or further the interests of the enterprise.⁷³ Enterprise liability greatly increases the chance that there will be enough money to pay a claim. It also provides a corporate defendant who is usually less sympathetic to the juror than the individual plaintiff. Enterprise liability does enhance deterrence for claims which the company can cheaply control by controlling its workforce. In most cases this means screening out workers who pose a risk, such as those who have been convicted of crimes. It also encourages businesses to assure that employees obey laws such as those against drunk driving on company time.⁷⁴ Enterprise liability only addresses the transaction costs in the tort system if it is coupled with modifications in the standards for proving liability. For example, most states have reduced the burden of proving a case against the manufacturer of a product.⁷⁵ This was done as a form of enterprise liability, in that the enterprise was the manufacturing sector.⁷⁶ The rationale was that making tort cases for defective products easier to prove would reduce the cost of the cases for plaintiffs, shifting the cost of injury to manufacturer.⁷⁷ If there were significant savings in the products liability system, few were passed on to the plaintiffs. More generally, enterprise liability does not affect the portion of tort costs going to injured persons, and exemplifies the disconnect between awards and the standard of care of the underlying medical care.

Traditional enterprise liability is very limited in health care. The major institutions in health care are hospitals and nursing homes, but in most cases they do not employ the physicians who practice there. Historically state laws against the corporate practice of medicine prevented physicians from working for hospitals and other lay-run medical businesses. Instead, they are treated as independent contractors. A hospital is only liable for negligence of a medical staff member when the hospital was itself negligent in admitting the physician to the medical staff, allowing the physician to remain on the medical staff, or when an actual hospital employee is negligent.⁷⁸ If the physician works for a group practice or a managed care company, that employer is liable.⁷⁹

Paul C. Weiler and Kenneth S. Abraham proposed a system of vicarious liability in which hospitals, the major enterprise in the medical system, would be responsible for iatrogenic

⁷³ WILLIAM A. KLEIN ET AL., BUSINESS ASSOCIATIONS: CASES AND MATERIALS ON AGENCY, PARTNERSHIPS, AND CORPORATIONS 47–80 (5th ed. 2003).

⁷⁴ See *EEOC v. Exxon Corp.*, 203 F.3d 871, 872 (5th Cir. 2000). The Exxon Valdez case may be the largest award against a company for a simple negligent act, although it is not clear that the Americans with Disabilities Act would have allowed Exxon to have disciplined the captain to prevent the accident.

⁷⁵ JERRY J. PHILLIPS ET AL., PRODUCTS LIABILITY: CASES, MATERIALS, PROBLEMS 101–20, 147–269 (2d ed. 2002).

⁷⁶ *Id.*

⁷⁷ *Id.* Reducing the standard of proof in products injury cases had the unintended consequence of encouraging unfounded claims, such as those against the breast implant and vaccine manufacturers. See *supra* text accompanying notes 37–42.

⁷⁸ *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 256–57 (Ill. 1965).

⁷⁹ *Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.*, 958 F. Supp. 1137, 1149–50. (E.D. Va. 1997).

adverse events.⁸⁰ This would require fundamental changes in the legal relationship between hospitals and physicians. It makes some economic sense in that the hospitals account for a larger share of health spending and thus could better bear the cost of the malpractice insurance. However, it ignores the trend to move care out of hospitals and into ambulatory care centers, which has accelerated since the paper was written. Even the notion of hospitals has changed with the advent of specialty care hospitals⁸¹ which avoid the community care obligations of traditional hospitals.⁸² An alternative system, which is at the root of the no-fault proposals, is to treat the entire health care system as the enterprise and thus spread the cost of compensation over the industry. If this were done as a general tax on health care it would address the problem of the availability of medical malpractice insurance, but not the other problems with a tort based compensation system.

Some of the researchers who did the IOM Study argue that increasing enterprise liability⁸³ will increase the deterrence effect of tort law and cause these institutions to discipline physicians to reduce patient injuries. This presupposes that there is a deterrence effect from tort law, and that this effect would be more powerful for institutions. The major reasons that physicians do not feel a deterrence effect—the wrong timeframe and mixed signals—are, if anything, more significant for institutions. Major businesses of all kinds, including health care institutions, do their financial planning on short timeframes. There is pressure to show profits each quarter, and a year is a very long time in a rapidly changing business like health care. Since payouts on medical malpractice claims happen years after the incident, and there is no direct link between risk management efforts and insurance rates, health-care enterprises put a high net present day discount on any efforts to prevent future medical malpractice claims. If the physicians who are putting the institution at risk are also generating significant billing for the hospital, any long term savings will be more than offset by short term losses. Unlike dealing with the driving habits of low level employees, disciplining high risk but high grossing physicians has real short term costs that make it unlikely that enterprises will be any more susceptible to deterrence than individual physicians. If the institution is under significant financial pressure, which is the case for many health-care institutions, all concerns about long term risks tend to be subsumed by the pressure to keep the doors open day-to-day.

C. *No-Fault Compensation*

⁸⁰ Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 393–94 (1994).

⁸¹ These specialty hospitals, which are often owned by the same physicians who operate in them, may end up under enterprise liability because of the identity between control and medical practice.

⁸² Thomas R. McLean, *Cybersurgery: Innovation or a Means to Close Community Hospitals and Displace Physicians*, 20 J. MARSHALL J. COMPUTER & INFO. L. 495, 497 (2002). Not only are hospitals going to become few in years to come but with the rise of specialty hospitals, the hospital system is atomizing. Thomas R. McLean, *The Rise of the Heart Hospital and the Fall of the House of Usher*, 1 AM. HEART HOSP. J., 223, 223 (2003).

⁸³ This would be done both through forcing physicians to work for large health care businesses and by limiting the independent contractor defense for hospitals.

The third alternative to tort compensation is no-fault compensation (NFC) for medical malpractice injuries. This is the major focus of several research groups and has been proposed since the early 1970s.⁸⁴ No-fault compensation is in the workers' compensation system for workplace injuries, and several states have used limited no-fault compensation for automobile accidents.⁸⁵ The federal compensation systems for railroad workers,⁸⁶ longshore and harbor workers,⁸⁷ and seamen⁸⁸ use a modified no-fault system which depends on showing a very small amount of fault. None of the proposed systems for no-fault coverage for medical malpractice injuries effectively address the fundamental difference between medical practice and the areas where no-fault has been used. In medicine, most patients have something wrong with them when they seek treatment, something that under the best of circumstances may not get better. In contrast, an automobile accident no-fault system, or a worker's compensation system is generally dealing with injuries that are clearly attributable to the accident. While both of these systems have to deal with injuries to persons who had pre-existing problems similar to those attributed to the accident, they represent a small fraction of the claims.

Medical injuries cannot be separated from unpreventable complications without a finding of fault and causation.⁸⁹ The majority of medical malpractice claims involve injuries that might be the natural consequence of the disease or an unpreventable complication of the treatment. In many cases there may be questionable treatment, but it has nothing to do with the injury, i.e., there is no causation. Causation is only an issue in other no-fault systems when the patient has a pre-existing illness that resembles the claimed injury. Yet even establishing causation is not enough.⁹⁰ If the question is just whether the treatment caused the injury, then every patient who suffered a complication of treatment would be eligible for compensation. Under such a system a significant fraction of all patients would be entitled to compensation. To avoid having all complications become compensable, a medical compensation system must include a finding of improper adherence to medical standards, i.e., fault.

Advocates of current no-fault compensation systems assert that no-fault coverage uniquely provides financial incentives to eliminate adverse medical events.⁹¹ This seems

⁸⁴ Clark C. Havighurst & Laurence R. Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 MILBANK Q. 125, 128 (1973).

⁸⁵ There are various opt out provisions for serious injuries, and pre-existing injuries.

⁸⁶ 45 U.S.C. § 51 (2000).

⁸⁷ 33 U.S.C. §§ 901–06 (2000).

⁸⁸ 46 U.S.C. app. § 688 (2000).

⁸⁹ For an excellent critique of the no-fault proposal from the Harvard Study, which is the genesis of the IOM proposal, see Maxwell J. Mehlman, Saying "No" to No-Fault: What the Harvard Malpractice Study Means for Medical Malpractice Reform, Address Before the Special Committee on Medical Malpractice, New York State Bar Association (Jan. 1991).

⁹⁰ The best analogy is workers' compensation coverage for diseases with an occupational component, such as stress related heart disease. While states have taken different approaches to determining compensation for such diseases, all of them depend on some type of analysis which moves away from simple no-fault to an evaluation of the contribution of the workplace conditions to the patient's overall health.

⁹¹ David M. Studdert et al., *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L. REV. 1643, 1675 (2000); David M. Studdert et

unlikely. If the current system, which focuses on physicians, does not provide workable incentives to reduce injuries and thus claims, spreading the risk over an even larger group would seem to further undermine the incentive.

The major values of a workable no-fault coverage system would be increased fairness to injured patients and the spreading of costs over the entire health care system.⁹² Such a plan will not necessarily be less expensive.⁹³ Because no-fault coverage would *theoretically* eliminate the need to prove negligence, it would facilitate the filing of smaller dollar-value cases. Not surprisingly, even the advocates of no-fault coverage are having difficulty demonstrating the cost-effectiveness of medical no-fault coverage.⁹⁴

There are two no-fault plans for primary medical malpractice injuries in the United States. Both deal with birth injuries, an area where lovable plaintiffs with long term injuries increase the chance that juries will make huge awards, even in the absence of clear medical negligence. Both are administrative compensation systems modeled after workers' compensation systems. The Virginia plan uses a workers' compensation model and has the workers' compensation board make the determination of whether a baby meets the criteria for compensation under the plan.⁹⁵ The Virginia plan is voluntary for physicians and hospitals, with only about 75% of the babies born in the state covered by the plan.⁹⁶ If the physician or hospital participates in the plan, it preempts any tort claims for the covered injuries.⁹⁷ If the baby qualifies under the plan, he or she can receive all necessary care, which often exceeds the total value of awards under the capped Virginia tort system before the attorney's fees and insurance subrogations are deducted from the tort awards.⁹⁸ The plan seems to be much more fair than the tort system in that most of the award goes to the plaintiff and because there is no cap on the necessary care. Not all physicians participate because it is not necessarily cheaper than medical malpractice insurance, and because all physicians still have to insure against injuries that are not covered by the fund. This plan, and the cap on the tort system, seems to have stabilized medical malpractice insurance rates for birth injuries, but this was at a time when rates were generally stable in most states.

al., *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1, 25–29 (1997); David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 221 (2001).

⁹² McLean, *supra* note 8.

⁹³ See generally Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991) (recognizing various costs associated with negligence in hospitalized patients).

⁹⁴ Studdert et al., *Beyond Dead Reckoning*, *supra* note 91, at 1677.

⁹⁵ JOINT LEGISLATIVE AUDIT & REVIEW COMM'N OF THE VA. GEN. ASSEMBLY, REVIEW OF THE VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM, ii (Jan. 2003), *available at* <http://biotech.law.lsu.edu/policy/Rpt284.pdf>.

⁹⁶ *Id.* at 48.

⁹⁷ *Id.* at 5.

⁹⁸ *Id.* at ii–iii.

The Florida plan is very different, primarily because it is not an exclusive remedy.⁹⁹ In effect, the plan has a narrow definition of injury, which is also the extent of the preemption.¹⁰⁰ The plan includes a requirement that the plaintiff prove causation, and filing with the plan tolls the statute of limitations.¹⁰¹ If the plaintiff is turned down by the plan, the fact that the plaintiff does not have a covered injury means that the plaintiff's claim is also not preempted and the plaintiff can file a medical malpractice claim.¹⁰² The result is that while the plan has been fairer for the participating plaintiffs, it has had little effect on the number of birth injury claims filed in Florida.¹⁰³

To the extent that these plans work, it is because they use standard criteria and an administrative review process. They are limited to a very narrow range of injuries but, within these limits, the Virginia plan seems to be fairer than the tort system for both patients and physicians. The Florida plan is good for patients but has only increased the compensation and medical malpractice costs because it is not an exclusive remedy. Virginia is a better model, but it is a reminder that equitable compensation for injuries is expensive. Neither plan addresses deterrence by requiring risk management strategies to prevent or reduce birth injuries.¹⁰⁴

IV. THE ADVENT OF FEDERAL QUALITY CREDENTIALING

⁹⁹ David M. Studdert et al., *The Jury Is Still In: Florida's Birth-Related Neurological Injury Compensation Plan After a Decade*, 25 J. HEALTH POL. POL'Y & L. 499, 517 (2000).

¹⁰⁰ The injury must be (1) to the brain or spinal cord of a (2) live infant (3) weighing at least 2,500 grams at birth. It must be (4) caused by oxygen deprivation or mechanical injury and (5) occur in the course of labor, delivery, or resuscitation in the immediate postdelivery period (as opposed to genetic or congenital abnormality). The birth must take place (6) in a hospital. Finally, as a consequence of the injury, the infant must have been (7) rendered permanently and substantially mentally and physically impaired.

Id at 503.

¹⁰¹ *Id.*

¹⁰² *Id.* at 517–19.

¹⁰³ *Id.* at 504.

¹⁰⁴ It would have been an interesting experiment to have required the use of a structured pre-natal care system as a condition of participation to find out if doing so could have reduced injuries.

Our proposal for an administrative compensation system for medical malpractice injuries assumes that the IOM, working through CMS at the federal level, will successfully implement a national medical quality credentialing system. While the IOM's proposed system does not assign fault in individual cases, it does assign fault based on the physician's aggregate behavior. The plan will be based on guidelines that are equivalent to legal findings of standard of care which can be used as the basis for administrative compensation.¹⁰⁵

Perhaps the most challenging hurdle to improving health quality and cost is the need for a methodology to objectively rank physicians. Certainly, no one wants an error-prone physician providing care to a family member. On the other hand, high quality physicians who rarely commit medical errors or have adverse outcomes need to be identified, not only to reward the physicians' good behavior, but also so we might all learn from these master healers.

A. *Traditional Method*

Currently, there are two crude methods of measuring medical outcomes. First, physicians have been rated by various consumer groups such as Public Citizen.¹⁰⁶ Consumer group rankings generally suffer because they are based on negative outcome, *i.e.* how often a physician has been sued or disciplined by a board of medical examiners. Such rating systems not only fail to identify quality providers, but can also be misleading. Consumer group data is not normalized by the volume of patients a physician cares for in a given time period. Thus a physician with 3 claims in 5 years might be a part time physician who has treated relatively few patients, or a front line physician in a major hospital's trauma department treating several times as many patients. Consumer data also fails to account for the severity of the patient's underlying illness. A physician might have a high death rate because he or she is recognized in the community as the best hope for complicated patients and treats only the sickest patients. Conversely, a surgeon with a very low complication rate for a difficult procedure may be operating on people who are not sick enough to need the procedure, and thus are much more likely to survive.

B. *Managed Care Method*

The second crude method of rating physicians is by economic credentialing. A widely used definition of economic credentialing is a system for ranking physicians "solely on economic factors which are unrelated to the individual's ability" as determined by peer review.¹⁰⁷ Basically, under this system, the least cost-efficient physicians are deemed to be of the lowest quality. Physicians eschew economic credentialing because it is conceptually possible to avoid having an adverse outcome if only they could do

¹⁰⁵ See Eleanor D. Kinney, *Administrative Law Approaches to Medical Malpractice Reform*, 49 ST. LOUIS U. L.J. § III(b) (forthcoming Jan. 2005).

¹⁰⁶ See Public Citizen, Latest Public Citizen Publications, <http://www.citizen.org/publications> (last visited Nov. 2004).

¹⁰⁷ American College of Medical Quality, Professional Policies, Policy 19: Economic Credentialing, <http://acmq.org/profess/policy19.htm> (last visited Nov. 1, 2004).

everything possible. Moreover, when hospitals engage in economic credentialing there are anti-kickback concerns.¹⁰⁸ Unfortunately, economic credentialing is hard to fight because the traditional alternative of peer-review as the sole method for judging physicians does not work as an objective yard stick of physician quality.¹⁰⁹

C. Patient Safety Method

It was against this background that the IOM published *To Err is Human*.¹¹⁰ In this monograph the IOM called for the development of clinical practice guidelines. This clarion call has been recently taken up by the National Quality Forum (NQF).¹¹¹ More specifically, the NQF is recommending that the health-care industry adopt clinical practice guidelines which are being developed from scientific data collected by the Agency for Healthcare Research and Quality (AHRQ) and the Leapfrog Group to minimize iatrogenic injury.¹¹² The power behind the NQF's recommendations comes from two sources. First, the NQF is a consensus organization whose membership spans all facets of the health-care industry.¹¹³ Members vary from individuals concerned with improving health care to Fortune 500 companies. Because the NQF's recommendations represent the consensus of its membership, it is reasonable to assume that the individual members will adopt these recommendations as their own. When a Fortune 500 company, or other large purchaser of health care, adopts the NQF's recommendations, it is likely that these recommendations will be incorporated into the employer's health plans. This of course has an important implication: if a medical service is not provided in accordance with the NQF's recommendations, it is possible that the medical service rendered will not be considered properly payable.

The second power source behind the NQF's recommendations is an act that is little known in health care circles: the National Technology Transfer and Advancement Act of 1995 (NTTAA).¹¹⁴ Enacted to facilitate information transfer in the electronic and telecommunication industries, nothing prevents NTTAA from being utilized in the health care industry. NTTAA directs government organizations that elect to develop objective standards to adopt, absent a compelling reason to the contrary, the objective standards of an industry if they are articulated by a "consensus organization."¹¹⁵ Although "consensus organizations" is a defined term, Dr. Ken Kizer, CEO of NQF, stated publicly that, not only does the NQF meet the definition of a consensus organization, but was also

¹⁰⁸ Paul Danello, *Economic Credentialing: Where is it Going?* (2003), available at <http://articles.corporate.findlaw.com/articles/files/00989/009358>.

¹⁰⁹ Thomas R. McLean, *Medical Rationing: The Implicit Result of Leadership by Example*, 36 J. HEALTH L. 325, 337 (2003).

¹¹⁰ See generally *TO ERR IS HUMAN*, *supra* note 2.

¹¹¹ NAT'L QUALITY FORUM, *SAFE PRACTICES FOR BETTER HEALTH CARE*, v (2003), available at www.qualityforum.org/txsafeexecsumm+order6-8-03PUBLIC.pdf.

¹¹² *Id.* at v-vi.

¹¹³ National Quality Forum, About the National Quality Forum, www.qualityforum.org/about/home.htm.

¹¹⁴ Pub. L. No. 104-113, 110 Stat. 775 (codified as amended at 15 U.S.C. § 3701 (2000)).

¹¹⁵ Pub. L. No. 104-113 (codified as amended at 15 U.S.C. § 272 (1996)).

specifically designed to exploit the power granted by NTTAA.¹¹⁶ Accordingly, if a governmental agency, such as CMS, is interested in adopting patient safety standards in health care, then the agency must consider NQF recommendations very strongly.¹¹⁷

There is no question the government is going to adopt guidelines because the greatest impediment to controlling health-care cost is the autonomous physician.¹¹⁸ In a recent GAO report on medical inflation, the government observed that the American economy is about to break under the weight of this important economic force.¹¹⁹ Accordingly, to tame medical inflation the GAO has called for a significant increase in individual provider-specific outcomes data.¹²⁰ With such data, the GAO argues that cost-efficient providers should be rewarded and cost-inefficient providers encouraged “to emulate [the] best practices” of other providers.¹²¹ The GAO goes on to add that individual providers, and especially physicians, need to have their practice pattern monitored; and where there is deviation from the best practice, the provider should be held accountable.¹²² In this regard the GAO observes that it will be necessary to develop “an authoritative source of reference for the public, providers, and payers on what constitutes effective care.”¹²³

In *Leadership by Example* the IOM encouraged the phasing in of guidelines for the 15 diseases that account for 85% of health-care costs.¹²⁴ Guidelines will create a bright line test to determine if a physician is delivering quality care. To illustrate, consider a guideline that states: if a 10 year child presents with a fever, a sore throat, and clinical findings consistent with a bacterial infection, the standard of care treatment is outpatient penicillin.¹²⁵ If a physician sees a 10 year old with a sore throat, the physician can comply with the guideline and prescribe penicillin or the physician can document a contra indication to penicillin, and treat with another antibiotic. If the physician follows the guideline and prescribes penicillin, the IOM would consider this to be quality care.¹²⁶

¹¹⁶ Ken Kizer, Address at the Cerner Millennium Conference, Kansas City, Mo. (Sept. 11, 2001).

¹¹⁷ Thomas R. McLean, *Application of Administrative Law to Health Care Reform: The Real Politik of Crossing the Quality Chasm* 16 J.L. & Health 65, 74 (2001–2002).

¹¹⁸ McLean, *supra* note 8,

¹¹⁹ U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO-04-793SP, HEALTH CARE: UNSUSTAINABLE TRENDS NECESSITATE COMPREHENSIVE AND FUNDAMENTAL REFORMS TO CONTROL SPENDING AND IMPROVE VALUE 25 (2004), available at <http://www.gao.gov/new.items/d04793sp.pdf>.

¹²⁰ *Id.* at 20.

¹²¹ *Id.* at 12.

¹²² *Id.* at 21.

¹²³ *Id.* at 17–18.

¹²⁴ COMM. ON ENHANCING FED. HEALTHCARE QUALITY PROGRAM, INST. OF MED., LEADERSHIP BY EXAMPLE: COORDINATING GOVERNMENT ROLES IN IMPROVING HEALTH CARE QUALITY [hereinafter LEADERSHIP BY EXAMPLE]. See also McLean, *supra* note 117, at 70–71.

¹²⁵ This would be standard treatment today; however, many physicians prescribe more expensive antibiotics. If a physician is asked why the more expensive antibiotic was prescribed, the standard answers are that it is as effective as penicillin and has fewer side effects. Assuming that the drug is as effective as penicillin, the reason the drug has few side effects is because the drug will be new to the market. Plus, if the physician does not prescribe this drug they will never receive any more favors from the drug reps who are pushing the more expensive drugs.

¹²⁶ COMM. ON DATA STANDARDS FOR PATIENT SAFETY, INST. OF MED., PATIENT SAFETY: ACHIEVING A NEW STANDARD FOR CARE 30 (Philip Aspden et al. eds., 2004) [hereinafter PATIENT SAFETY].

If the physician does not comply, automated data analysis programs scanning the required electronic medical records will flag the record for further review.¹²⁷

Non-compliance can result in two outcomes. First, if the non-complaint event was a significant deviation from the standard of care that potentially threatened injury to the patient, immediate remedial action would be set into place.¹²⁸ This might range from counseling to disciplinary action.¹²⁹ The reviewer might also determine that the physician properly documented a valid reason for the deviation and the case would be closed. Most deviations would not be acute threats to the patient but, in the aggregate, they would constitute substandard care. For example, assume that a physician violated the guideline for treating sore throats in children statistically more frequently than comparable physicians,¹³⁰ the physician would then be offered an opportunity to explain the deviation. If the physician has not properly documented that his patient population justifies different treatment, the physician will be subject to remedial actions, including limitations on the physician's right to care for federally funded patients or to practice in facilities which care for those patients.¹³¹ While not a finding of fault in an individual case, this will be a much more powerful deterrent than having the malpractice insurer pay a settlement or judgment, which does not affect the physician's ability to practice.

D. Value-Based Purchasing: Putting Teeth into Clinical Guideline

In *Leadership by Example*, the Institute of Medicine (IOM) encourages the federal government to use its unique purchasing power in the health-care sector to reform the system.¹³² In particular, the IOM recommends that the government adopt “value-based purchasing.”¹³³ Value-based purchasing rewards vendors who provide high quality goods and services.¹³⁴ Value-based purchasing is characterized by: “(1) disclosure of comparative quality information to encourage consumers and purchasers to choose the highest-quality providers, and (2) selective purchasing or payment incentives to providers and beneficiaries.”¹³⁵ According to the IOM, value-based purchasing would return the

¹²⁷ Robert A. Guyton, *Quo Vadimus?*, 78 ANNALS THORACIC SURGERY 391, 395 (2004).

¹²⁸ Even before the days of patient safety it was possible for a physician to order a drug in violation of a guideline and be immediately investigated. See *Lee v. Trinity Lutheran Hosp.*, No. 00-0716-CV-W-HFS, 2004 U.S. Dist. LEXIS 1800, at *3–4 (W.D. Mo. Jan. 29, 2004).

¹²⁹ Prior to the establishment of patient safety guidelines it was possible to summarily suspend a physician's privileges. See *Med. Staff of Sharp Mem'l Hosp. v. Superior Court of San Diego County*, 121 Cal. App. 4th 173, 176 (Cal. Ct. App. 2004).

¹³⁰ While a detailed discussion of statistics is not within the scope of this paper, it is sufficient to say that when there is a statistically significant difference between two physicians, this difference is not due to chance alone; i.e. there must be a reason.

¹³¹ A similar analysis can be done for surgical outcomes which are not subject to clinical practice guidelines. If the surgeon has too many complications the surgeon will have to explain why his or her patients do not fair as well. See generally McLean, *supra* note 8.

¹³² LEADERSHIP BY EXAMPLE, *supra* note 124, at 6.

¹³³ *Id.* at 67.

¹³⁴ *Id.*

¹³⁵ *Id.*

best price while creating the right incentives for health care providers to provide high quality (*i.e.*, error-free) medical services.¹³⁶

Moving to value-based purchasing will mean that safety data which is provider specific will need to be gathered. Safety data, as used here, is broadly defined to cover near misses as well as actual errors.

A *near miss* is defined as an act of commission or omission that could have harmed the patient but did not do so as a result of chance (e.g., the patient received a contraindicated drug but did not experience an adverse drug reaction), prevention (e.g., a potentially lethal overdose was prescribed, but a nurse identified the error before administering the medication), or mitigation (e.g., a lethal drug was overdosed was administered but discovered early and countered with an antidote).¹³⁷

Even without harm being caused to a patient a near miss will identify an event which may increase front-end cost (e.g., unnecessary testing) or back-end costs (e.g., litigation). Conversely, near misses may reveal methods to control cost on the front end (e.g. a more efficient way to care for patients) or the back end (e.g., a safer way to care for patients). It is hard to imagine a value-based purchasing system that would ignore this information. After all, the purpose of shifting health care to value-based purchasing is precisely to identify and reward good providers and weed out the bad providers.

The threat of weeding out sub-quality providers will be a strong incentive for physicians to conform to objective standards of care. Physicians will not be able to accumulate errors and near misses. If they do, their employers will have to conclude that they are not physicians of quality. Moreover, in a rational world one would expect that once an employer has concluded that a physician is not of quality, that employer would not renew the physician's contract.¹³⁸ In short, in the near future physicians will be credentialed based on quality. Such credentialing will not be solely economic, nor will it be a resection of peer review.

V. ELEMENTS OF AN ADMINISTRATIVE COMPENSATION SYSTEM

Federal quality credentialing removes both the deterrence and punishment aspects of tort law, leaving only compensation to be addressed.¹³⁹ Federalizing the standards for medical quality review is critical because it removes the rationale for jury determined

¹³⁶ *Id.*

¹³⁷ PATIENT SAFETY, *supra* note 126, at 30.

¹³⁸ Once quality credentialing is up and running, non-renewal of a physician's contract will be a fatal scarlet letter on the physician's resume. Non-renewal will signal that the physician inappropriately prescribes medical treatment at the very least, and may signal a deeper flaw such as alcoholism or criminal propensity. In a world looking for quality physicians, non-renewal will be a red flag to future employers.

¹³⁹ Since monetary awards, even big verdicts, are almost always settled within insurance limits for the physician, even a punitive damage award is not really a punishment. Limitations on medical practice, which can be imposed through quality credentialing, are a very real punishment.

standards of care. As happened in the federal preemption cases for medical devices,¹⁴⁰ a uniform federal standard for medical quality should preempt state tort law findings contrary to the federal standards.¹⁴¹ The federalizing of standards is critical because only the federal government can impose a uniform national system of administrative compensation. No state is prepared to move to pure administrative compensation.¹⁴² It is in the interest of the federal government to establish objective standards because it would be fairer to patients, which is consistent with the patient safety movement, and because it would eliminate the tension between federal practice guidelines and state tort efforts to undermine those guidelines, as has been seen with some state efforts to undermine private quality and cost controls.¹⁴³ The alternative is complete preemption of tort claims, as ERISA provides for health plans, which is far less fair than an administrative compensation system.¹⁴⁴

An administrative system to deal with compensation does not need to be perfect, only better than the tort system. There are four important lessons to draw from the tort system as a method for compensation for medical negligence injuries. First, the only compensation is for serious injuries. Second, most of the dollars in the system go to lawyers and the medical malpractice insurer. Even the plaintiff's settlement seldom nets more than sixty percent of the settlement value, and, in many cases, less than fifty percent of the gross settlement. Third, because of state collateral source rules, medical care and other insured costs are often paid twice. Fourth, the randomness in the tort system cuts both ways. Just as physicians sometimes lose claims that are medically unfounded, patients also lose claims that are medically founded.¹⁴⁵

But compensation does not have to work this way. The Virginia birth injury system shows that even a simple administrative compensation system will put more money in the hands of injured persons and less in transaction costs than the tort system. It demonstrates that by providing for flexible payments of future medical-care needs, the system assures long term care, one of the biggest failures of the tort system. The Virginia system also takes advantage of other available insurance, and only pays costs that are not

¹⁴⁰ *Brooks v. Howmedica, Inc.*, 273 F.3d 785 (8th Cir. 2001); *Martin v. Medtronic, Inc.*, 254 F.3d 573 (5th Cir. 2001); *Massachusetts v. Hayes*, 691 F.2d 57 (1st Cir. 1982).

¹⁴¹ Congress can give a federal agency the power to preempt state law. *See New York v. Fed. Energy Regulatory Comm'n*, 535 U.S. 1, 18 (2002) (“[A] federal agency may pre-empt state law only when and if it is acting within the scope of its congressionally delegated authority.”).

¹⁴² While trial lawyers are the visible opposition, such systems also threaten defense lawyers and the medical malpractice insurance industry. There is no push for administrative compensation by physicians because they fear the traditional problem of an explosion of claims if the system lowers the transaction costs.

¹⁴³ *See generally* *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), (forcing a managed care company to provide a medically unnecessary and costly procedure).

¹⁴⁴ *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2495 (2004).

¹⁴⁵ While there is no good data on this, it is likely that patients lose more deserving cases than physicians lose undeserving cases. Since medical malpractice defense is usually done by experienced attorneys with adequate working budgets, physicians generally get good representation. Patients who have the bad luck of picking an inexperienced lawyer who does not refer the case to an expert lawyer will often lose meritorious claims. Even experienced lawyers want to maximize their return on the work invested and will often drop a case if it looks difficult to win, even if it is meritorious.

otherwise insured. Implicit in the definition of a birth injury is the notion of a severe injury, which ensures that the system is not susceptible to swamping with low level claims that would not be compensated under the tort system.

While the Virginia birth injury compensation system provides useful lessons, it cannot be generalized because of the narrowness of its coverage.¹⁴⁶ A general compensation system could not have a listed set of compensable conditions because the potential variation is too large. The system will have to depend on expert review of claims. This is already done by medical review panels in several states, but these depend on the tort system to present the claims. A better parallel is the Social Security Disability system.

A. *The Social Security Disability Model*

A person making a claim for disability must fill out forms which show that the person is not gainfully employed or making more than the allowable limits for a disabled person.¹⁴⁷ The claimant must also provide medical records and physician's statements documenting the nature of the mental or physical condition that makes it impossible for the claimant to work.¹⁴⁸ These documents are reviewed by a disability examiner to determine if the claimant has a condition that has been legally determined to be disabling.¹⁴⁹ This list of conditions is established by administrative regulation or by statute.¹⁵⁰ If the person's condition is listed, then they are automatically determined to be disabled.¹⁵¹ If the condition does not fit a listed condition, then the examiner has a protocol to evaluate the claimant's overall condition and job skills to determine if they are otherwise disabled.¹⁵²

This review is done entirely on the written records submitted to the agency. If these records are insufficient, the agency can ask the person to submit to a physical evaluation by an independent physician, who will make a report to the agency to supplement the claimant's records.¹⁵³ If the claimant is turned down for benefits, he can require a hearing before an administrative law judge to contest the agency's findings.¹⁵⁴ This process was challenged as violating the claimant's right to due process because there was no right to a hearing before the initial agency determination.¹⁵⁵ The United States Supreme Court ruled that this process provided constitutionally adequate due process.¹⁵⁶ The court found that the cost of a hearing on all claims before the initial determination was not cost

¹⁴⁶ There are other limitations associated with the Virginia and Florida birth compensation systems. First, both systems allow an injured party to have the option of using the tort system. Second, despite these systems being termed no-fault coverage, they are, like tort law, fault-based.

¹⁴⁷ See *Mathews v. Eldridge*, 424 U.S. 319, 335–36 (1976).

¹⁴⁸ See *id.* at 336.

¹⁴⁹ *Id.* at 335.

¹⁵⁰ *Heckler v. Campbell*, 461 U.S. 458, 459–60 (1983).

¹⁵¹ *Id.* at 460.

¹⁵² *Id.*

¹⁵³ *Mathews*, 424 U.S. at 337.

¹⁵⁴ *Id.* at 339.

¹⁵⁵ See *id.* at 324–25.

¹⁵⁶ *Id.* at 349.

effective because it would not result in significantly more accurate determinations.¹⁵⁷ The right to be heard after the determination of disability was sufficient.¹⁵⁸

This same type of review could be done to determine whether a patient who received negligent care was injured by that care, and, if so, how much the patient is entitled to for compensation. The system could use uniform standards for economic losses and use independent experts as necessary. Such a review would be more accurate and more efficient than a judicial determination. Unlike medical malpractice cases, in which standards are based on the persuasiveness of experts and not scientific validity, these administrative panels could publish their standards so that the process would be transparent. The compensation review should be kept separate from the quality credentialing process, at least to the extent that whether there was a compensation award should not be considered as part of quality credentialing. Quality decisions must be made on the health care rendered, not the vagaries of the patient's reaction to the care. Conversely, quality credentialing information would be an important consideration in determining if the care fell below the acceptable standard and was thus compensable.

B. Controlling the Costs of Compensation

The first limitation on the system should be the level of compensation. As with the Social Security Disability system, the claimant should have to show significant injury, which could include large unpaid medical costs. The system should take into account all other insurance proceeds and social welfare programs, and only pay otherwise uncompensated costs. The payments should be tailored to provide adequate income for ordinary wage earners, not highly paid workers. There should be no compensation for emotional injuries in themselves, but compensation should include any treatments that might ameliorate the injuries. Highly paid workers who want to assure they will receive full compensation for injuries should be expected to purchase first-party insurance¹⁵⁹ to cover employment income or business losses and disability.¹⁶⁰ This shifts the burden of paying for extra protection to those who can best afford it and best determine the level of risk that they want to assume.¹⁶¹

Because the largest damage awards under such a system would be for medical care, especially future care for permanent injuries, as they are under the current tort system, broadening the reach of the medical insurance system would reduce the potential payouts. Under a single payor national health insurance system,¹⁶² all medical care costs would be

¹⁵⁷ *Id.* at 347.

¹⁵⁸ *Mathews*, 424 U.S. at 349.

¹⁵⁹ See Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453, 481 (2004);

¹⁶⁰ This might even be done on a per procedure basis, as is done with flight insurance.

¹⁶¹ George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1550–61 (1987); *but see* Jon D. Hanson & Kyle D. Logue, *The First-Party Insurance Externality: An Economic Justification for Enterprise Liability*, 76 CORNELL L. REV. 129 (1990).

¹⁶² See COMM. ON THE CONSEQUENCES OF UNINSURANCE, INST. OF MED., *INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS* 131 (2004); David U. Himmelstein & Steffie Woolhandler, *National*

removed from the compensation system. More generally, by eliminating the collateral source rule,¹⁶³ a national health system would eliminate the major damages in all tort cases, not just those under an administrative compensation system. Ironically, universal access to medical care coupled with an elimination of the collateral source rule would eliminate the major damage engine in tort law.¹⁶⁴

C. *Paying for the Costs of Compensation*

The fairest way to pay for compensation for medical negligence injuries under a working quality credentialing system would be as a tax on the proceeds of the health care system. Rich surgeons would pay more than poor pediatricians, and rich specialty hospitals would pay more than community hospitals that served the poor.¹⁶⁵ Even under the current system, shifting payment for compensation to a tax on profits would be much more fair than the current system where good physicians underwrite bad physicians who often make much more money through their shoddy and dangerous practices.

VI. CONCLUSIONS

While the debate over tort versus administrative compensation for medical negligence injuries is not new, what is new is the development of a national quality credentialing system for physicians and hospitals. This system implicitly recognizes the failure of tort law to provide useful deterrence signals, especially when cost of care is also a consideration.¹⁶⁶ By providing an independent system for assuring quality medical care, the federal government must be concerned with state tort actions that will undermine the effectiveness of the national system, both by second guessing the federal standards and by using them in unintended ways. Using the power of federal preemption to substitute an administrative compensation system would protect the federal standards for quality care. At the same time, it would redress the deep unfairness of the current tort system, which neither fairly compensates injured patients nor fairly allocates the cost of compensation across the health-care system.

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¹⁶³ This would be logical since the policy rationale for the rule is to encourage the purchase of insurance, which would no longer be relevant.

¹⁶⁴ This could have a profound effect on small auto accident cases and other cases where the major part of the recovery is usually based on the insurer paying at two to four times the cost of the medical care, which the attorney conspires to raise by working with friendly medical care providers who pile on unnecessary and sometimes dangerous care.

¹⁶⁵ The federal government pays about forty percent no matter how the system is structured because the federal government buys about forty percent of the health care in the United States. Stuart M. Gerson & Jennifer E. Gladieux, *Advice of Counsel: Eroding Confidentiality in Federal Health Care Law*, 51 ALA. L. REV. 163, 171 (1999).

¹⁶⁶ It also recognizes the failure of state medical licensing boards to enforce even rudimentary quality standards, thus supporting the argument of tort lawyers that that tort system is the only check on poor quality medical care.