
HEALTH COURTS?

PHILIP G. PETERS, JR.*

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This Article provides the first detailed critique of the Common Good/Harvard School of Public Health proposal to replace medical malpractice jury trials with adjudication before specialized health courts. I conclude that the modest benefits likely to be produced by the current health court proposal are more than matched by the risks of bias and overreaching

* Philip G. Peters, Jr., Ruth L. Hulston Professor of Law, University of Missouri-Columbia.

that these courts would also present. Missing from the plan is the doctrinal change most likely to improve patient safety – hospital enterprise liability. Without enterprise liability, the health court proposal is unlikely to achieve its patient safety goals and, as a result, simply does not offer patients a sufficient quid pro quo to justify their loss of the right to a trial before a jury of their peers.

INTRODUCTION

Momentum is gathering to take medical malpractice cases out of civil courts and assign them to administrative health courts. Both houses of Congress have held hearings on legislation that would authorize the creation of specialized health courts.¹ Similar legislation has also been proposed in half a dozen states.² Experiments with health courts have also been recommended by the Institute of Medicine and the American Medical Association.³

Although administrative health courts have been proposed in the past, the current proposal has progressed farther in the legislative process than any that have come before it. Furthermore, the current proposal has much wider support among industry stakeholders than either of the two most prominent proposals of the 20th century. Part of that increase in support probably stems from the surge in energies dedicated to improving patient safety following the Institute of Medicine's 2000 report *To Err is Human*.⁴ For patient safety advocates, specialized health courts are not so much a means of taking malpractice cases away from juries, as physicians have long demanded; health courts are a vehicle for redesigning medical injury adjudication so that it supports, rather than impedes, efforts to reduce iatrogenic injury through greater professional candor about medical error.

The current proposal also benefits from the identity of its principal sponsors. The public interest organization Common Good, which describes itself as bipartisan, has partnered with the respected health policy experts at the Harvard School of Public Health and the equally respected Robert Wood Johnson Foundation to draft a plan for specialized health courts and sell it to lawmakers.⁵ They have already assembled a long list of supporters, ranging from conservative Senator Bill Frist to the more liberal Progressive Policy Institute.⁶

¹ See Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. § 2 (2006); Medical Liability Procedural Reform Act of 2005, H.R. 1546, 109th Cong. (2006).

² See *infra* notes 40-54 and accompanying text.

³ See generally INST. OF MED., FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS 10 (Janet M. Corrigan et al. eds., 2002).

⁴ See generally INST. OF MED., TO ERR IS HUMAN (2000).

⁵ Jeanne Lenzer, *Medical Courts Could Ease US Malpractice Crisis, Group Says*, 330 BRIT. MED. J. 382 (2005).

⁶ *Progressive Policy Institute Endorses Special Health Courts*, COMMON GOOD, Feb. 17, 2005, <http://cgood.org/healthcare-newscommentary-inthenews-224.html>; *Senate Majority*

Because congressional testimony is presented in a format that stresses partisan positions, none of the testimony presented to Congress offered a disinterested and thoughtful sorting of the strengths and weaknesses of health courts. Instead, proponents gave the strongest possible case in favor of health courts and opponents listed all conceivable shortcomings.⁷ This Article fills that gap, separating the strong arguments from the weak, identifying the most important uncertainties, and recommending safeguards to reduce some of the risks.

The greatest weakness of the current proposal lies not in what it provides, but in what it omits. Missing from the plan is the doctrinal change most likely to improve patient safety – hospital enterprise liability. Even the Harvard researchers currently working on the health courts plan have conceded this point many times in the past.⁸ Without enterprise liability, the health courts proposal is dramatically less likely to achieve its patient safety goals and, as a result, simply does not offer patients a sufficient quid pro quo to justify the loss of their right to a trial before a jury of their peers.

Part I of the Article describes the central features of the health courts plan currently being proposed by Common Good and researchers from the Harvard School of Public Health. The next Part examines the likelihood that health courts will improve the system of malpractice adjudication as measured by the following five criteria: more just outcomes (Part II.A), fewer frivolous claims and more legitimate ones (Part II.B), greater efficiency (Part II.C), more defensible awards for pain and suffering (Part II.D), and better deterrence (Part II.E). Part III then defends my claim that lawmakers should not create a system of health courts unless the legislation also imposes hospital enterprise liability.

As they are currently conceived, the very modest benefits that a system of health courts would likely confer are balanced by the genuine risks of bias and overreaching by the courts. The addition of enterprise liability would shift that balance because it would greatly improve the likelihood that malpractice law will serve as an engine for patient safety improvements, while simultaneously taking individual physicians out of the line of fire. Enterprise liability could

Leader Bill Frist Calls for the Creation of Special Health Courts, COMMON GOOD, July 19, 2004, <http://cgood.org/healthcare-newscommentary-inthenews-140.html?>. For more detailed information on endorsements for health courts see Common Good, Endorsements, <http://cgood.org/learn-people-endorsements.html> (last visited Jan. 31, 2008).

⁷ See, e.g., *Innovative Solutions to Medical Liability: Hearing Before the Subcomm. on Health of the Comm. on Energy and Commerce*, 109th Cong. 26-27 (2006) (statement of Michelle Mello); *Medical Liability: New Ideas for Making the System Work Better for Patients: Hearing of the Comm. on Health, Education, Labor, and Pensions*, 109th Cong. 44, 45 (2006) (statement of Philip K. Howard, Founder and Chair, Common Good; Professor of Law, Columbia Law School).

⁸ See, e.g., PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 144-52 (1993) [hereinafter WEILER ET AL., A MEASURE OF MALPRACTICE].

allocate the costs of liability insurance more fairly among physicians, while improving the system's capacity to weather the periodic storms generated by the insurance cycle. Without these benefits, especially the improvements in patient safety, the benefits of health courts are too modest and too speculative to justify abrogating the patient's right to a trial by a jury of her peers.

I. THE 21ST CENTURY HEALTH COURT PROPOSAL

Under the Common Good/Harvard School of Public Health plan, medical malpractice cases would be taken out of the judicial system and handled by an administrative process similar to workers' compensation claims.⁹ Patients seeking to make a claim arising out of a hospital stay would start the process by filing their claim at the hospital or with its liability insurer.¹⁰ No lawyer or judicial paperwork would be required.

A group of medical experts convened by the hospital would then evaluate the claim to decide whether the care given to the patient met the standard of care.¹¹ All significant injuries caused by a physician's failure to follow "best practices" would be compensable.¹² This new and tougher standard of care would be called an "avoidability" standard because it would permit patients whose injuries could have been avoided using state-of-the-art medicine to recover.¹³

Either party would be entitled to appeal the panel's decision. In addition, the patient would be allowed to appeal the size of the monetary offer made by the defendant's liability insurer and would not need a lawyer to do so.¹⁴ In the event of an appeal, an administrative law judge specializing in health court adjudications would review the claim *de novo* using all available materials, including a live hearing, if requested.¹⁵ After input from a court-appointed medical expert, the health court judge would render a verdict and produce a written opinion with precedential authority.¹⁶

The sponsors of this plan believe that it has several important advantages over the current judicial process. First, cases will be resolved more quickly because the adjudicative process will be streamlined and some claims will automatically qualify for compensation under an *ex ante* schedule of

⁹ For the most recent and complete account of this, see generally Michelle M. Mello et al., "*Health Courts*" and Accountability for Patient Safety, 84 MILBANK Q. 459 (2006).

¹⁰ *Id.* at 464. Under one possible claims process, the hospital would be required to report the event to the insurer and would be surcharged if the insurer learned of the incident from the patient. *Id.*

¹¹ *Id.*

¹² *Id.* at 466.

¹³ *Id.*

¹⁴ *Id.* at 464. Claimants without lawyers could also ask the health court to evaluate the settlement offer made by the insurer. *Id.*

¹⁵ *Id.* at 464-65.

¹⁶ *Id.* at 464.

"accelerated-compensation events" (ACEs).¹⁷ Second, average payouts would be reduced because pain and suffering recovery would be capped according to the severity of the injury, the collateral source rule would not apply (meaning that payouts would be reduced by the amount collected from other sources, such as insurance), and periodic payment of future damages would be permitted.¹⁸ Third, the cost of litigating will go down because the process will be simplified and many claimants will proceed without counsel.¹⁹ Fourth, verdicts and settlements will be more rational and more fair because health courts will rely on specialized judges, "neutral" experts, written precedents, and ex ante ACEs.²⁰ Fifth, health courts will better serve the goal of compensating injured patients because the simplified claims procedure and the state-of-the art standard of care will provide recovery to more of the patients who are unnecessarily injured by their medical care.²¹

Finally, health courts will better promote patient safety.²² By taking fault terminology out of the standard of care and transferring decision making from juries to specialized judges guided by independent expert witnesses, health courts, say sponsors, will reduce physician defensiveness and make physicians less reluctant to speak openly about the sources of medical error.²³ Health courts will also promote safer clinical practices by giving physicians better ex ante guidance about the standard of care. Perhaps most exciting to public health scholars, the health court would serve as a central repository for claims information that could be studied to improve patient safety standards.²⁴

This long list of potential benefits has generated an equally long list of supporters.²⁵ On it are ten university presidents and eleven medical school deans. Two highly distinguished health policy experts are also included – Paul M. Ellwood and Alain C. Enthoven.²⁶ Their presence is noteworthy because one is a fellow at the conservative American Enterprise Institute and the other

¹⁷ *Id.* at 467, 476.

¹⁸ *Id.* at 467-68, 470.

¹⁹ *Id.* at 462-63.

²⁰ *Id.* at 464; Common Good, Frequently Asked Questions About Health Courts, <http://cgood.org/f-healthcourtsfaq.html> (last visited Jan. 31, 2008).

²¹ *Innovative Solutions to Medical Liability*, *supra* note 7, at 26-27 (statement of Michelle Mello). This might magnify tort law's deterrent signal. Mello et al., *supra* note 9, at 471 (arguing that improvements in the system's accuracy should clarify the deterrent signals to providers). The effectiveness of the deterrent will depend on whether this effect is offset by the reduction in compensable damages.

²² Mello et al., *supra* note 9, at 470-71. In addition, doctors may be more willing to disclose and discuss errors under a standard of care that does not imply negligence. *Id.* at 471-74.

²³ *Id.* at 471-74.

²⁴ *Id.* at 476.

²⁵ *More than 80 Prominent Leaders Endorse Special Health Courts*, COMMON GOOD, Feb. 7, 2005, <http://cgood.org/healthcare-newscommentary-inthenews-218.html>.

²⁶ *Id.*

at the more liberal Brookings Institute.²⁷ Paul Weiler, the lead legal investigator of the famous Harvard study of New York hospitals, is a supporter.²⁸ So are Dr. Louis Sullivan, the former Secretary of Health & Human Services, and Dennis O'Leary, President of the Joint Commission on Accreditation of Healthcare Organization (the JCAHO).²⁹ Other organizational sponsors include the AARP, the Democratic Leadership Council, the National Committee for Quality Assurance, and six major academic medical centers.³⁰ Supportive editorials have appeared in the New York Times,³¹ the Economist,³² and USA Today.³³ Endorsements range from medical societies, like the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists, to consumer groups, like Consumers Advancing Patient Safety.³⁴ On June 26, 2007, the American Medical Association reaffirmed its support and outlined the principles that should guide the creation of a health courts system.³⁵

Lawmakers have noticed. Senators Max Baucus (D-Mont.) and Michael B. Enzi (R-Wyo.) introduced Senate Bill 1481, the Fair and Reliable Medical Justice Act,³⁶ to fund ten innovative pilot projects to improve the resolution of medical malpractice disputes, including a pilot program of health courts.³⁷ A similar bill was introduced in the House by Representatives Jim Cooper (D-Tenn.) and William "Mac" Thornberry (R-Tex.).³⁸ Both bills were supported by Common Good.³⁹

In addition, legislation to create health courts or small pilot experiments has been introduced in several states, including Maryland,⁴⁰ New York,⁴¹

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Patient Safety & Health Care Quality Leaders Support Health Court Pilot Projects*, COMMON GOOD, July 5, 2006, <http://cgood.org/healthcare-newscommentary-inthenews-321.html>.

³⁰ Common Good, Who Supports Health Courts?, <http://cgood.org/forgendorsements.html> (last visited Jan. 31, 2008).

³¹ Editorial, *Malpractice Mythology*, N.Y. TIMES, Jan. 9, 2005, § 4, at 12 (calling for pilot projects, including health courts, to promote tort reform).

³² Editorial, *Scalpel, Scissors, Lawyer*, ECONOMIST, Dec. 14, 2005, at 70.

³³ Editorial, *'Health Courts' Offer Cure*, USA TODAY, July 4, 2005, available at http://www.usatoday.com/news/opinion/editorials/2005-07-04-our-view_x.htm.

³⁴ Common Good, Who Supports Health Courts?, *supra* note 30.

³⁵ See generally AM. MED. ASS'N, HEALTH COURT PRINCIPLES (2007), available at http://www.ama-assn.org/ama1/pub/upload/mm/378/healthcr_principles.pdf

³⁶ Fair and Reliable Medical Justice Act, S. 1481, 110th Cong. § 1 (2007).

³⁷ *Id.* § 3.

³⁸ Fair and Reliable Medical Justice Act, H.R. 2497, 110th Cong. § 1 (2007).

³⁹ Common Good, Legislative Activity on Health Courts, <http://cgood.org/f-healthcourtslegislation.html> (last visited Jan. 31, 2008).

⁴⁰ See S. 508, 422d Gen. Assem., Reg. Sess. (Md. 2007) (establishing a medical liability division in circuit courts); H.B. 779, 422d Gen. Assem., Reg. Sess. (Md. 2007) (creating a

Oregon,⁴² Pennsylvania,⁴³ and Virginia.⁴⁴ Common Good attorney Paul Barringer testified that additional state legislative activity was expected.⁴⁵ Initiatives are also reportedly underway in Wyoming, Colorado, Michigan, and Massachusetts.⁴⁶

The momentum behind this proposal contrasts sharply with the lukewarm reception given to a similar proposal made by the American Medical Association in 1988.⁴⁷ Like the current proposal, it would have taken medical malpractice cases out of the courts and placed them in specialized health courts.⁴⁸ Unlike the current health court proposal, however, it would have replaced private plaintiffs' attorneys working on a contingency fee with lawyers from the staff of the new administrative agency.⁴⁹ In short, it called for a physician's utopia. Juries would be replaced by specialized administrative law judges, contingent fee plaintiff's attorneys would be replaced by agency attorneys who would screen out the "frivolous" claims, and full compensation for negligently injured patients would be replaced with

Task Force to study the creation of a medical liability division within the Maryland circuit courts on the model of an existing, separate case management system for business and technology cases); H.B. 338, 422d Gen. Assem., Reg. Sess. (Md. 2007) (establishing a task force to study administrative compensation programs for birth-related neurological injury); H.B. 48, 422d Gen. Assem., Reg. Sess. (Md. 2007) (creating a medical malpractice review board of trained judges with the authority to hire neutral experts).

⁴¹ See S. 4149, 2007 Leg., 230th Sess. (N.Y. 2007) (authorizing health court pilot projects within the court system), available at <http://cgood.org/assets/attachments/S4149.pdf>.

⁴² See S. 655, 74th Leg., Reg. Sess. (Or. 2007), available at http://cgood.org/assets/attachments/OR_SB655.pdf.

⁴³ See S. 678, 2007 Gen. Assem., Reg. Sess. (Pa. 2007) (authorizing a demonstration program to examine an administrative medical liability system), available at <http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2007&sessInd=0&billBody=S&billTyp=B&billnbr=0678&pn=0725>.

⁴⁴ See S. J. Res. 90, 2006 Sess. (Va. 2006), available at http://cgood.org/assets/attachments/Va_Joint_Resolution_90.pdf; H.R.J. Res. 183, 2006 Sess. (Va. 2006) (providing for continuance of the Joint Subcommittee to Study Risk Management Plans for Physicians and Hospitals, which is investigating the feasibility of establishing a pilot health court and subsequently a system of health courts), available at http://cgood.org/assets/attachments/Va_Joint_Resolution_183.pdf.

⁴⁵ Innovative Solutions to Medical Liability, *supra* note 7, at 49 (statement of Paul Barringer, General Counsel, Common Good).

⁴⁶ See Mello et al., *supra* note 9, at 460.

⁴⁷ See AMA/SPECIALTY SOC'Y MED. LIAB. PROJECT, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED, ADMINISTRATIVE SYSTEM 1 (1988); Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1367 (1989).

⁴⁸ AMA/SPECIALTY SOCIETY MEDICAL LIABILITY PROJECT, *supra* note 47, at 17.

⁴⁹ *Id.* at 21-23.

highly restricted damages.⁵⁰ Because it was so one-sided, the AMA proposal attracted little support and was quickly overshadowed by a more promising proposal for fundamental malpractice reform.⁵¹

In 1991, a Reporter's Study for the American Law Institute (ALI) suggested that the fault-based system now in use be replaced with a no-fault system of compensation for medical injuries – similar to workers' compensation insurance – and that hospitals, rather than individual physicians, be responsible for buying the necessary insurance.⁵² In drafting this report, Paul Weiler built upon the work of scholars like Havighurst, Tancredi, Keeton, and O'Connell, who had proposed medical no-fault plans in the early 1970s.⁵³ Despite its radical proposals, the call for no-fault enterprise liability gradually accumulated the support of many health policy experts because it directly tackled the most serious shortcomings of the malpractice system, such as inadequate deterrence, infuriated physicians, and excessive transaction costs, while avoiding the usual preoccupation with the system's fictitious shortcomings, such as pro-plaintiff juries and excessive damages awards.⁵⁴ No-fault liability promised to reduce blaming and, thus, rancor, while at the same time protecting more of the patients who are injured by their medical care.⁵⁵ The proposals sought to reduce litigation time and expense by eliminating the element of fault, thereby increasing the fraction of premium dollars going to injured patients.⁵⁶ Enterprise liability aimed to improve the safety of care given to future patients by shifting the focus from individual competence to system-wide safety precautions.⁵⁷ Although the ALI proposal, like the AMA proposal that preceded it, would move malpractice adjudication

⁵⁰ *Id.* at 67-78, 145-46.

⁵¹ 2 AM. LAW INST., REPORTERS' STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 112 & n.5 (1991); WEILER ET AL., A MEASURE OF MALPRACTICE, *supra* note 8, at 144.

⁵² 1 AM. LAW INST., REPORTERS' STUDY, *supra* note 51, at ch. 10 (discussing medical injury); 2 *id.* at chs. 4, 15 (discussing medical malpractice and elective no-fault medical liability; Paul Weiler was the Chief Reporter of the study); *see also* PAUL WEILER, MEDICAL MALPRACTICE ON TRIAL (1991). Weiler's book was originally written as an ALI background paper and Chapter 6 was the basis for ALI chapter 15 on no-fault medical liability. 2 AM. LAW INST., REPORTERS' STUDY, *supra* note 51, at 487.

⁵³ See, e.g., Clark C. Havighurst & Lawrence R. Tancredi, "Medical Adversity Insurance" – A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 MILBANK Q. 125, 125-26 (1973); Robert E. Keeton, Compensation for Medical Accidents, 121 U. PA. L. REV. 590, 616-17 (1973); Jeffrey O'Connell, Expanding No-Fault Beyond Auto Insurance: Some Proposals, 59 VA. L. REV. 749, 827 (1973).

⁵⁴ See *infra* notes 439-446 and accompanying text.

⁵⁵ 2 AMERICAN LAW INSTITUTE, REPORTERS' STUDY, *supra* note 51, at 111-13.

⁵⁶ *Id.* at 119.

⁵⁷ *Id.* at 123, 512.

from civil courts to administrative health courts, its bipartisan spirit and content were dramatically different from the AMA proposal.⁵⁸

Two years later, the team of researchers who undertook the famous Harvard Study of Medical Practice in New York hospitals added their support to the ALI combination of no-fault and enterprise liability.⁵⁹ Weiler was on the project as well, as were several faculty members from the Harvard School of Public Health.⁶⁰ For the next decade, those public health scholars and their colleagues lobbied vigorously and compellingly, but unsuccessfully, for a small scale experiment with enterprise liability and no-fault recovery.⁶¹ Health care organizations and lawmakers were simply too frightened by the possible costs to carry out an experiment.

By 2002, the Harvard Public Health researchers had reached the reluctant conclusion that no-fault liability was not politically feasible.⁶² However, they continued to make the case for exclusive enterprise liability because they rightly believed that enterprise liability had more potential to improve patient safety than any other tort reform.⁶³ Then, in 2006, the researchers' public advocacy for enterprise liability also ceased, as the Harvard School of Public Health joined forces with Common Good and the Robert Wood Johnson Foundation to craft and lobby for a system of administrative recovery through

⁵⁸ Compare *id.* ch. 15, with AMA/SPECIALTY SOC'Y MED. LIAB. PROJECT, *supra* note 47, at 3-12.

⁵⁹ HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 11-9 (1990). That team included two Harvard scholars who had helped write the earlier ALI study. Paul Weiler, a Harvard law professor, was both the Chief Reporter of the ALI report and the senior legal investigator on the Harvard Study. Troyen Brennan, a faculty member at the Harvard Schools of Medicine and Public Health, also served on both projects.

⁶⁰ See generally WEILER ET AL., A MEASURE OF MALPRACTICE, *supra* note 8.

⁶¹ Faculty members Troyen Brennan, Joseph Newhouse, Lucian Leape, and David Studdert have written extensively on the subject, including the following: WEILER ET AL., A MEASURE OF MALPRACTICE, *supra* note 8; Joseph P. Newhouse & Paul C. Weiler, *Reforming Medical Malpractice and Insurance*, 14 REG. 78 (1991); William G. Johnson, Troyen A. Brennan, Joseph P. Newhouse, Lucian L. Leape, Ann G. Lawthers, Howard H. Hiatt & Paul C. Weiler, *The Economic Consequences of Medical Injuries: Implications for a No-Fault Insurance Plan*, 267 JAMA 2487 (1992); David Studdert & Troyen Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217 (2001); David M. Studdert, Eric J. Thomas, Brett I.W. Zbar, Joseph P. Newhouse, Paul C. Weiler, Jonathan Bayuk & Troyen A. Brennan, *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1 (1997); David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225 (2001); Paul C. Weiler, Joseph P. Newhouse & Howard H. Hiatt, *Proposal for Medical Liability Reform*, 267 JAMA 2355 (1992).

⁶² Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1625, 1628 (2002).

⁶³ *Id.* at 1629.

specialized health courts.⁶⁴ This, too, was presumably a concession to perceived political realities.

As a result, the phoenix rising from the ashes of the ALI/Harvard School of Public Health proposal for no-fault enterprise liability is, instead, a revived and amended version of the AMA proposal for a fault-based, individual liability regime residing in specialized administrative health courts.⁶⁵ Although the current health court plan substantially improves on the AMA proposal by being more even-handed, the plan nevertheless sets upon a quixotic journey.⁶⁶ The sponsors hope to achieve the kind of administrative cost savings found in no-fault compensation systems,⁶⁷ yet liability under the new system would still be fault-based. The plan is also motivated by a sincere desire to generate the kind of improvements in patient safety that could be expected from a system of hospital enterprise liability,⁶⁸ yet liability would continue to reside in individual physicians. As a result, the benefits produced when this plan is put into operation are destined to be disappointing. Furthermore, the attempt to squeeze these benefits from a plan lacking such crucial ingredients creates troubling new risks. The rest of this Article assesses both these likely benefits and the potential risks.

II. RISKS AND BENEFITS OF THE HEALTH COURTS PROPOSAL

Health courts proponents offer five primary arguments in favor of their proposal: fairer outcomes, a better mix of claims filed, improved efficiency, more consistent damage awards, and improved patient safety. While each of these arguments has merit, important weaknesses inherent in the proposal could significantly undermine the benefits of health courts. Moreover, health courts proponents have predicated their proposal on several erroneous assumptions. For health courts to beneficially reform medical malpractice adjudication, these assumptions must be dealt with.

In its current state, the risks inherent in the health courts proposal would likely outweigh the potential benefits. First, several features of the health court plan are likely to produce bias in favor of physicians. These risks negate the reform's modest potential for improving the accuracy of adjudicated outcomes. The judicial system already does a remarkably good job of sorting the strong cases from the weak and producing fair outcomes. Second, the problems of over-claiming and under-claiming are as likely to get worse as to get better. Third, health courts proponents hope to eliminate certain procedural safeguards to streamline the administrative process. Without these safeguards, the

⁶⁴ Common Good, Frequently Asked Questions About Health Courts, *supra* note 20.

⁶⁵ See *supra* notes 1-7, 37-46 and accompanying text.

⁶⁶ The improvements include a heightened standard of care, a schedule of damages, and reliance on private plaintiff's attorneys.

⁶⁷ See, e.g., Mello et al., *supra* note 9, at 465-67.

⁶⁸ See, e.g., *id.* at 471; More Than 80 Prominent Leaders Endorse Special Health Courts, *supra* note 25.

administrative tribunal will undo a century of judicial reforms designed to insure that cases are decided fairly on the merits. Fourth, the proposal to award pain and suffering damages according to a schedule, while theoretically appealing, would work great harm if the schedule is used simply to reduce recoveries. Fifth, health courts are unlikely to deliver the improvement in patient safety that proponents seek most: greater physician disclosure of errors. Most importantly, the health courts proposal does not include a provision for enterprise liability – I address that shortcoming in Part III.

A. *The Prospects for Producing Fairer Outcomes*

Supporters of malpractice reform charge that the existing system of malpractice adjudication reaches irrational and unjust outcomes.⁶⁹ Juries, they claim, are easily hoodwinked by shrewd plaintiffs' lawyers, unscrupulous "hired gun" expert witnesses, and sympathetic plaintiffs.⁷⁰ Frightened by the prospect of a jury decision, malpractice insurance carriers and their insureds supposedly agree to unwarranted settlement payments. In the words of one famous study, the civil justice system is just an "expensive sideshow."⁷¹ The main event is the coercion of unwarranted settlements from innocent physicians. President George W. Bush stated the charge this way:

Doctors and hospitals realize . . . it's expensive to fight a lawsuit, even if it doesn't have any merit. And because the system is so unpredictable, there is a constant risk of being hit by a massive jury award. So doctors end up paying tens of thousands, or even hundreds of thousands of dollars to settle claims out of court, even when they know they have done nothing wrong.⁷²

Although these charges hardly exhaust the complaints that are lodged against the civil justice system and its handling of medical malpractice cases, they constitute the heart of the case that is conveyed to the public and to lawmakers. Injustice is a powerful justification for reform.

⁶⁹ See, e.g., STEPHEN DANIELS & JOANNE MARTIN, CIVIL JURIES AND THE POLITICS OF REFORM 1-2 (1995).

⁷⁰ See *id.*; NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS 122-23 (1995). Both the AMA and the Physician Payment Review Commission have concluded that lay juries reach different decisions than physicians would. VIDMAR, *supra* at 162; see also PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS 186 (1992); AMA/SPECIALTY SOC'Y MED. LIAB. PROJECT, *supra* note 47, at 7-11; Johnson et al., *supra* note 47, at 1370-71.

⁷¹ Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1967 (1996).

⁷² TOM BAKER, THE MEDICAL MALPRACTICE MYTH 13 (2005) (quoting President George W. Bush, Speech in Collinsville, Ill. (Jan. 2005)).

Advocates for health courts often repeat these charges,⁷³ suggesting that health courts would produce better outcomes. Several components of the health court proposal, they believe, have the potential to make claims resolution more just. Among these are the use of specialist judges, guidance from neutral medical experts, and greater reliance on practice guidelines to provide the standard of care.⁷⁴ Each of these changes has potential to improve the decision-making process and, thus, deserves thoughtful consideration. However, the foundational assumption that the civil justice system routinely produces irrational or unfair outcomes is simply not supported by the evidence.

In fact, the charge of irrational outcomes is the weakest of the many charges made against the current tort system. Both jury verdicts and settlements are surprisingly congruent with assessments made by other physicians. To the extent that litigation outcomes and peer assessments diverge, litigation outcomes are more likely than peer assessments to favor physicians over patients who sue them.

1. The Fairness of Jury Verdicts

Three decades of research provide a substantial evidentiary basis for evaluating jury decision-making.⁷⁵ The four key findings that emerge from that research are strikingly different from popular perception.⁷⁶ First, negligence matters. The stronger the plaintiff's evidence of negligence, the greater the likelihood of a plaintiff's verdict.⁷⁷ Plaintiffs win 10% to 20% of the cases that reviewers feel they should lose,⁷⁸ 20% to 30% of the cases rated as toss-ups,⁷⁹ and roughly 50% of the cases deemed by expert reviewers to have strong evidence of negligence.⁸⁰

Second, the agreement rate between juries and experts is better than physicians typically have with each other.⁸¹ In cases with weak evidence of negligence, as judged by physician evaluators, defendants win 80% to 90% of the jury verdicts.⁸² The resulting discrepancy rate of 10% to 20% is better than the 30% or higher rate of disagreement that physicians typically have when

⁷³ See, e.g., Troyen A. Brennan & Philip K. Howard, *Heal the Law, then Health Care*, WASH. POST, Jan. 25, 2004, at B7.

⁷⁴ See *id.*

⁷⁵ Philip G. Peters Jr., *Doctors & Juries*, 105 MICH. L. REV. 1453, 1454 (2007).

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.* at 1476 (citing Bryan A. Liang, *Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department*, 7 CORNELL J.L. & PUB. POL'Y 121 (1997)).

⁷⁹ *Id.*

⁸⁰ *Id.* at 1464.

⁸¹ *Id.* at 1478. In addition, some of these disagreements can probably be attributed to reviewer bias in favor of physicians and to jury access to more complete and stronger evidence of medical negligence. *Id.* at 1478-79.

⁸² *Id.* at 1464.

they are evaluating the performance of other physicians.⁸³ A 30% disagreement rate is also typical of performance evaluations in other professions.⁸⁴

Thus, it is disappointing that Philip Howard, the founder of Common Good, stated that a jury trial “resembles Russian Roulette” and “would not be considered a tolerable risk in other comparable professional activities.”⁸⁵ That contention is simply wrong because it treats every disagreement between the jury and the reviewer as a jury error, rather than an instance of predictable and inescapable inter-rater disagreement. And, it wrongly assumes that health courts would have far fewer of them. In truth, the rate of agreement between juries and reviewers is remarkably good – better than physicians typically have with each other.

A third conclusion justified by the jury studies is that juries are much more likely to depart from the opinions of the expert reviewers when doing so will exonerate a defendant physician than when doing so would result in a verdict for the patient. Doctors consistently win about 50% of the cases which physician reviewers have concluded they should lose and 70% to 80% of the cases with unclear or ambiguous evidence of negligence.⁸⁶ This extraordinary success rate suggests the presence of factors that systematically favor medical defendants in the courtroom.⁸⁷

There are several plausible explanations for the jury’s unexpected reluctance to hold negligent physicians liable. First, juries may be skeptical of patients who sue their doctors. This is consistent with social science research finding that prospective jurors have been listening to the unrelenting complaints of physicians and politicians over the past twenty years and sympathize with

⁸³ See, e.g., Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199, 204-05 (1991) (finding 30% disagreement or ambiguous findings); A. Russell Localio et al., *Identifying Adverse Events Caused by Medical Care: Degree of Physician Agreement in a Retrospective Chart Review*, 125 ANNALS INTERNAL MED. 457, 457 (1996) (finding a similar disagreement rate on both negligence and causation); Ralph Peeples et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 WAKE FOREST L. REV. 877, 884 (finding that reviewers disagreed in 34.3% of the cases).

⁸⁴ See Shari Seidman Diamond, *Order in the Court: Consistency in Criminal-Court Decisions*, in 2 THE MASTER LECTURE SERIES: PSYCHOLOGY AND THE LAW 119, 125 (C. James Scheirer & Barbara L. Hammonds eds., 1983) (finding a disagreement rate among scientists engaged in peer review of 25%, among employment interviewers of 30%, among psychiatrists diagnosing psychiatric illness of 30%, and among physicians diagnosing physical illness of between 23% and 33%).

⁸⁵ *Medical Liability: New Ideas for Making the System Work Better for Patients: Hearing of the Comm. on Health, Education, Labor, and Pensions*, *supra* note 7, at 44-45 (statement of Philip K. Howard).

⁸⁶ Peters, *supra* note 75, at 1492.

⁸⁷ *Id.* at 1493.

them.⁸⁸ Second, the preliminary evidence, though meager, suggests that defendants are much more likely than plaintiffs to have experienced attorneys and distinguished experts.⁸⁹ Thus, defendants' hired guns are more skilled than plaintiffs'. Third, juries may take the burden of proof very seriously in medical malpractice cases, giving physicians the "benefit of the doubt" when the experts for both sides are credible.⁹⁰ In some combination, these factors probably explain why it is quite difficult for malpractice plaintiffs to win even their strongest cases.

To the extent that jury bias in favor of plaintiffs is the perceived danger, these findings should be reassuring. From the perspective of defendants, jury performance is quite good. Although the civil justice system has many drawbacks – including its limited ability to screen out meritless cases early, its cost, and its failure to provide relief to the great majority of patients who are harmed by medical negligence – jury bias against physicians is not one of them.

2. The Fairness of Settlement Outcomes

Lobbyists for malpractice insurers and physicians have successfully cultivated the popular belief that liability insurers are regularly forced to accede to the outlandish settlement demands of plaintiffs with dubious claims in order to avoid the "lottery" of a jury trial.⁹¹ The public has been convinced that malpractice defendants are forced to pay exorbitant settlements to malpractice plaintiffs whose claims are dubious in order to avoid the risk of an irrational jury verdict.⁹² The actual settlement outcomes paint a very different picture.

Numerous studies confirm that the *odds* of a plaintiff receiving a settlement payment are directly related to the strength of the plaintiff's case.⁹³ The stronger the evidence of negligence, the more likely the plaintiff is to receive a settlement payment. In addition, the *size* of the settlement payment is directly correlated with the strength of the patient's case.⁹⁴ Here, too, the studies show that the amount paid to a plaintiff varies inversely with the quality of care provided to the patient.

⁸⁸ *Id.* at 1484.

⁸⁹ *Id.* at 1489.

⁹⁰ *Id.* at 1491.

⁹¹ See Brennan et al., *supra* note 71, at 1963; Philip G. Peters, Jr., *What We Know About Malpractice Settlements*, 92 IOWA L. REV. 1783, 1819 (2007) [hereinafter Peters, *Settlements*]; David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2025 (2006) [hereinafter Studdert et al., *Claims*]. See generally HARVARD MEDICAL PRACTICE STUDY, *supra* note 59.

⁹² See Peters, *Settlements*, *supra* note 91, at 1819.

⁹³ *Id.* at 1787-95 (synthesizing several studies).

⁹⁴ *Id.* at 1788-1801.

Between 80% and 90% of the claims rated by expert reviewers as lacking evidence of negligence are dropped or dismissed without payment.⁹⁵ Furthermore, the amount paid to claimants in the remaining cases is often only a token amount, such as the forgiveness of unpaid doctor's bills.⁹⁶ By contrast, cases with strong evidence of negligence settle at a much higher rate (77% to 95%), and the average payment is much larger.⁹⁷ Borderline cases fall in the middle.⁹⁸

A recent study by David Studdert and his colleagues found a strong correlation between the merits of malpractice claims and the outcomes of litigation.⁹⁹ The authors divided the claims into six categories based on the strength of the plaintiffs' evidence of negligence. The authors then determined how often defendants paid plaintiffs in each category of claims.¹⁰⁰ They found that the probability of a payment was directly tied to the strength of the plaintiff's case: Payment was made in 19% of the claims with “[l]ittle or no evidence” of error; 32% of the claims with “[s]light-to-modest evidence”; 52% of claims deemed a “[c]lose call” but less than 50-50 probability; 61% of those rated as a “[c]lose call” but greater than 50-50; 72% of the claims with “[m]oderate-to-strong evidence”; and 84% of the claims with “[v]irtually certain evidence.”¹⁰¹ As a result, the authors concluded that “the malpractice system performs reasonably well in its function of separating claims without merit from those with merit and compensating the latter.”¹⁰²

When a settlement does occur, its size is also driven by the merits.¹⁰³ While the great majority of plaintiffs with weak cases receive nothing at all, those who do recover tend to settle for much less than similarly injured plaintiffs with more meritorious claims.¹⁰⁴ As would be expected, claimants with cases of uncertain merit receive more than claimants with low-odds cases, and plaintiffs with strong cases receive the largest settlements, though not necessarily the full amount of the damages they suffered.¹⁰⁵

⁹⁵ *Id.* at 1804 fig.2.

⁹⁶ *Id.* at 1813.

⁹⁷ *Id.* at 1797, 1801.

⁹⁸ *Id.* at 1802; *infra* note 101.

⁹⁹ Studdert et al., *Claims*, *supra* note 91, at 2031.

¹⁰⁰ *Id.* at 2029 fig.2. To do this, they used a one-to-six scale to measure the reviewer's level of confidence for a determination of fault, ranging from “little or no evidence” to “[v]irtually certain evidence.” *Id.*

¹⁰¹ *Id.* These numbers exclude claims with dignitary injuries only (nine), no injuries (thirty-seven), and no-error judgments (two). *Id.* Roughly 6% of the cases in which payment was made followed a plaintiff's verdict (50 of the 798). *Id.* at 2030 tbl.2.

¹⁰² *Id.* at 2031.

¹⁰³ Peters, *Settlements*, *supra* note 91, at 1796-1801.

¹⁰⁴ *Id.* at 1813.

¹⁰⁵ *Id.* at 1817-18.

Thus, both the odds of a settlement and the size of any payment are driven by the merits of the case. Considered separately, each type of discount seems fair. Weak claims should fare worse, and they do. Yet, the presence of both discounts appears to produce a greater total discount than the merits necessitate.

The double effect is seen most clearly in the data on “toss-up” cases, i.e., those cases in which the evidence of negligence is ambiguous and the verdict at trial could go either way. Negotiation theory predicts that nearly all of these 50-50 cases will settle for about half of the plaintiffs’ damages.¹⁰⁶ That happens in 60% of the cases. In the other 40% of the cases, however, defendants are able to escape without making any payment at all.¹⁰⁷ Thus, borderline cases are discounted twice: once in the reduced amount paid to the claimants who receive settlement offers, and again in the 100% discount defendants get when no payment is needed to dispose of the cases. The ability of malpractice defendants to escape payment in 40% of the toss-up cases suggests that they have a significant advantage in bargaining power. This conclusion is also supported by the evidence that the amounts paid to settle malpractice cases fall short of expected value.¹⁰⁸

In hindsight, evidence that settlements are closely tied to the merits should come as no surprise. Insurers, like claimants, have an economic incentive to evaluate their cases accurately and to shape their settlement strategies accordingly. Insurers accomplish their objectives by undertaking a form of peer review in which they obtain multiple expert evaluations and rely on them heavily.¹⁰⁹ In addition, the empirical findings show that insurers possess the bargaining power to insist that settlements be consistent with those expert assessments. As Peeples and his colleagues have noted, it is ironic that physicians see the absence of peer review as the major flaw in the current system of malpractice adjudication.¹¹⁰ Peer review is precisely what the settlement process currently provides.

What explains this discrepancy in negotiating power? One likely source of this advantage lies in asymmetric stakes that give defendants the incentive to fiercely fight low-odds claims.¹¹¹ Another source involves asymmetric risk

¹⁰⁶ See FRANK A. SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE 220 (1993) (explaining that settlements, unlike trials, will discount the damages to reflect the probability of failure); Stephen J. Spurr & Sandra Howze, *The Effect of Care Quality on Medical Malpractice Litigation*, 41 Q. REV. ECON. & FIN. 491, 502-04 (2001).

¹⁰⁷ Peters, *Settlements*, *supra* note 91, at 1806 fig.4, 1814-16.

¹⁰⁸ See Farber & White, *supra* note 83, at 207-08; Walter Orlando Simmons, *An Economic Analysis of Mandatory Mediation and the Disposition of Medical Malpractice Claims*, 6 J. LEGAL ECON. 41, 51-52 (1996); cf. Stephen J. Spurr & Walter O. Simmons, *Medical Malpractice in Michigan: An Economic Analysis*, 21 J. HEALTH POL. POL’Y & L. 315, 337 (1996) (presenting consistent, but not statistically significant, findings).

¹⁰⁹ See Peeples et al., *supra* note 83, at 884-85, 891-93.

¹¹⁰ *Id.* at 892.

¹¹¹ See Peters, *Settlements*, *supra* note 91, at 1819-22.

tolerance, which prompts plaintiffs to settle their cases at a discount.¹¹² Third, both parties know that plaintiffs actually win very few jury trials and that cases resulting in plaintiff's verdicts often settle for significantly less than the jury award.¹¹³ Finally, the defendant has superior access to useful resources.¹¹⁴ Together, these factors appear to push the amounts actually paid in settlements below the value of the claims based on their underlying merits.

At the same time, there is troubling evidence that some settlement outcomes are strongly influenced by strategic factors such as witness appeal, which are unrelated to the quality of care received by the claimant.¹¹⁵ The role played by strategic factors is disturbing because it substantiates complaints that the system is irrational and unfair. However, while the current evidence suggests that the impact of strategic factors is largely confined to uncertain cases,¹¹⁶ its incidence is unknown.

When the jury studies and the settlement studies are considered collectively, they justify the conclusion that the judicial system does a remarkably good job of sorting the strong cases from the weak and of producing settlements that are fair. As currently structured, the litigation process gives defendants, rather than plaintiffs, an edge. When it errs, the current system tends to err on the physician-defendant's side.

3. The Impact of Specialized Judges

Health court cases will be decided by a judge, rather than a jury.¹¹⁷ The judge will specialize exclusively in medical malpractice cases and will receive guidance from a neutral expert witness whom he or she appoints.¹¹⁸ These reforms, say sponsors of the proposal, will produce more defensible outcomes in malpractice disputes.¹¹⁹

The largest weakness of this claim is its assumption that the existing process produces a substantial number of unjust outcomes. As explained above, that premise is mistaken, at least insofar as it assumes that defendants bear the brunt of the injustice.¹²⁰ Trial verdicts, in particular, already favor defendants

¹¹² *Id.* at 1824-25.

¹¹³ *Id.* at 1825-28.

¹¹⁴ *Id.* at 1828-31.

¹¹⁵ See, e.g., Thomas B. Metzloff, *Resolving Malpractice Disputes: Imaging the Jury's Shadow*, 54 LAW & CONTEMP. PROBS. 43, 74-75, 83 n.126 (1991); Paul L. Ogburn, Jr. et al., *Perinatal Medical Negligence Closed Claims from the St. Paul Company, 1980-1982*, 33 J. REPROD. MED. 608, 610 (1988).

¹¹⁶ With the significant exception of attorney experience (which strongly favors malpractice defendants), we don't yet know whether strategic factors tend to favor one side more often than the other. See Peters, *Settlements*, *supra* note 91, at 1829-31.

¹¹⁷ Mello et al., *supra* note 9, at 460.

¹¹⁸ *Id.* at 464.

¹¹⁹ *Id.* at 468.

¹²⁰ See *supra* Part II.A.1.

more than they should.¹²¹ Health courts cannot treat physicians any more deferentially without demonstrating unconscionable bias in favor of defendants.

Furthermore, researchers have found that judges usually agree with jury decisions. The largest and most famous of these studies was undertaken by Harry Kalven and Hans Zeisel,¹²² who found that the judge and jury agreed in roughly eight out of every ten personal injury cases.¹²³ When the judge and jury disagreed, the jury was almost as likely to have favored the defendant as the plaintiff.¹²⁴ To put these data into perspective,¹²⁵ the judge-jury agreement rate in tort cases, despite the common presence of dueling experts, is higher (78%) than the inter-reviewer agreement rate observed in the medical malpractice studies (around 70%).¹²⁶ These reassuring findings are consistent with the many surveys finding that judges generally hold a positive view of the jury.¹²⁷

¹²¹ See *id.*

¹²² HARRY KALVEN, JR. & HANS ZEISEL, THE AMERICAN JURY (1966).

¹²³ *Id.* at 64 n.12.

¹²⁴ *Id.* at 63-65 (finding that the jury, but not the judge, favored the defendant in 10% of cases, while the jury alone favored the plaintiff in 12% of cases). Heuer and Penrod did a similar analysis with similar results. In the cases on which the judge and jury had disagreed (37% of the total set of cases), judges disagreed with jury defense verdicts (19%) as frequently as they disagreed with jury verdicts for plaintiffs (18%). Larry Heuer & Steven Penrod, *Trial Complexity: A Field Investigation of Its Meaning and Its Effects*, 18 LAW & HUM. BEHAV. 29, 48 tbl. 13 (1994).

¹²⁵ In addition, researchers have found similar rates of judge-jury agreement in criminal trials. See, e.g., KALVEN & ZEISEL, *supra* note 122, at 58 tbl.12 (finding 78% agreement); Heuer & Penrod, *supra* note 124, at 48 tbl.12 (finding 71% agreement). Other surveys of judicial opinion have found similar or higher estimates of the rate of judge-jury agreement. See John B. Attanasio, *Foreword: Juries Rule*, 54 SMUL. REV. 1681, 1684 (2001); R. Perry Sentell, Jr., *The Georgia Jury and Negligence: The View from the Bench*, 26 GA. L. REV. 85, 97-98 (1991); R. Perry Sentell, Jr., *The Georgia Jury and Negligence: The View from the Federal Bench*, 27 GA. L. REV. 59, 70-71 (1992) [hereinafter Sentell, *Federal Bench*].

¹²⁶ See Diamond, *supra* note 84, at 125 tbl.1.

¹²⁷ In the Kalven and Zeisel study, for example, the judges typically believed that juries that decided cases differently had reached reasonable decisions. See Neil Vidmar, *The Performance of the American Civil Jury: An Empirical Perspective*, 40 ARIZ. L. REV. 849, 853 (1998). A Georgia survey of state and federal judges found 94% of the judges felt that the jury understood the case, and 87% believed that juries are not pro-plaintiff. Sentell, *Federal Bench*, *supra* note 125, at 116 tbls.16 & 17. All of the federal judges and 98% of the state judges felt that jury performance was satisfactory or would be if some procedural reforms were adopted. *Id.* at 117 tbl.18. At least 97% of both groups reported agreeing with jury verdicts more than eight times out of ten, the approximate figure from the Kalven and Zeisel study. *Id.* at 115 tbl.14.

In addition, researchers have found that greater case complexity does not produce more disagreement between juries and presiding judges.¹²⁸ As a result, Kalven and Zeisel concluded that their findings of strong judge-jury agreement were “a stunning refutation of the hypothesis that the jury does not understand.”¹²⁹

The only studies that shed light specifically on medical malpractice cases are the few that have compared the outcomes in bench trials with the outcomes in jury trials. When Kevin Clermont and Theodore Eisenberg looked at the win rates for all federal civil trials between 1979 and 1989, they found that malpractice claimants won 50% of their bench trials but only 29% of their jury trials.¹³⁰ Using 2001 data from the country’s seventy-five largest counties, the Bureau of Justice Statistics similarly found that medical malpractice plaintiffs won 50% of their bench trials but only 26% of their jury trials.¹³¹ Thus, malpractice plaintiffs appear to win about half as often in front of juries as they do in front of judges.

Moreover, this discrepancy is atypical of personal injury litigation generally. In most civil litigation, other than malpractice and product liability litigation, bench and jury success rates are roughly the same.¹³² These findings raise the

¹²⁸ See, e.g., Shari Seidman Diamond & Mary R. Rose, *Real Juries*, 1 ANN. REV. L. & SOC. SCI. 255, 271 (2005) (collecting and reviewing the studies); Neil Vidmar & Shari Seidman Diamond, *Juries and Expert Evidence*, 66 BROOK. L. REV. 1121, 1126, 1174, 1177 (2001).

¹²⁹ KALVEN & ZEISEL, *supra* note 122, at 157. At the same time, other studies have documented the limitations of a lay jury in complex cases. See, e.g., Joe S. Cecil et al., *Citizen Comprehension of Difficult Issues: Lessons from Civil Jury Trials*, 40 AM. U. L. REV. 727, 755-60 (1991); Joseph Sanders, *Scientifically Complex Cases, Trial by Jury, and the Erosion of Adversarial Processes*, 48 DEPAUL L. REV. 355, 365 (1998). The most clearly established juror weakness lies in the comprehension and application of probabilistic evidence. For example, people tend to overestimate the significance of some low probability risks. See David L. Faigman & A.J. Baglioni, Jr., *Bayes' Theorem in the Trial Process: Instructing Jurors on the Value of Statistical Evidence*, 12 LAW & HUM. BEHAV. 1, 13-14 (1988); Brian C. Smith et al., *Jurors' Use of Probabilistic Evidence*, 20 LAW & HUM. BEHAV. 49, 60-70 (1996). See generally Cecil et al., *supra*, at 755-60. This could cause them to overestimate, in hindsight, the riskiness of a physician's treatment. However, the data on agreement rates suggest that this risk is offset by other factors that favor malpractice defendants.

¹³⁰ Kevin M. Clermont & Theodore Eisenberg, *Trial by Jury or Judge: Transcending Empiricism*, 77 CORNELL L. REV. 1124, 1137 tbl.3 (1992).

¹³¹ THOMAS H. COHEN, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, TORT TRIALS AND VERDICTS IN LARGE COUNTIES, 2001, at 4 tbl.3 (2004), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/tvlc01.pdf>.

¹³² See Clermont & Eisenberg, *supra* note 130, at 1137 & tbl.3 (1992). The Bureau findings also suggest that malpractice litigation is unusual. The judge-jury discrepancy rate was much larger in medical malpractice cases than it was in civil litigation generally (24% compared to 14%). COHEN, *supra* note 131, at 4 tbl.3 (finding, for civil litigation generally, a 65% win rate in bench trials versus a 51% win rate in jury trials).

possibility that juries are more deferential to physicians and more skeptical of patients who sue than judges are. This finding squares neatly with the finding that juries are less likely than independent physician reviewers to conclude that a negligent physician should be liable.¹³³ Because malpractice attorneys may systematically direct a different mix of malpractice cases to judges, it would be a mistake to give too much weight to these comparisons of bench and jury trial outcomes. Nonetheless, these findings certainly cast doubt on the likelihood that physicians would find bench trials to be an improvement.

In addition, replacing juries with state health court administrative judges creates new obstacles that could impede even marginal improvement. First, judges are vulnerable to the same kinds of cognitive biases that can affect juries, such as the framing and hindsight biases.¹³⁴ Second, judges are not immune from normal human sympathy. Finally, these judgeships are not likely to be sought by the most successful malpractice lawyers from either side. Administrative judgeships are typically less highly paid and less prestigious than trial or appellate court judgeships and are usually not filled by the most successful lawyers.¹³⁵ All of these factors suggest that the improvement in outcomes would be marginal at most.

By its very nature, a specialized tribunal poses its own set of risks. First, repeat players in a specialized court can enjoy substantial advantages. In a health court system, that advantage would accrue to malpractice defendants, who also happen to be represented by experienced attorneys and claims agents more often than plaintiffs.¹³⁶ These repeat players would benefit from appearing regularly before the same judge or panel of judges. Continuing interactions establish relationships of familiarity and trust. Shared lunches and

¹³³ See *supra* text at notes 86-90 (exploring the reasons for jury bias in favor of defendants).

¹³⁴ See, e.g., Chris Guthrie et al., *Inside the Judicial Mind*, 86 CORNELL L. REV. 777, 796-97, 801-03 (2001); Jennifer K. Robbennolt, *Evaluating Juries by Comparison to Judges: A Benchmark for Judging?*, 32 FLA. ST. U. L. REV. 469, 491-93, 497-98 (2005).

¹³⁵ See Harold H. Bruff, *Specialized Courts in Administrative Law*, 43 ADMIN. L. REV. 329, 331 (1991). However, the intellectual challenge presented in Tax Courts may help attract able judges. *Id.* at 337. The applicant pool would likely improve substantially if health courts were created at the federal level, because federal court judgeships are much more prestigious than state positions. Even in the federal system, however, administrative law judges are paid far less than federal district court judges. *Id.* at 352.

¹³⁶ See, e.g., SLOAN ET AL., *supra* note 106, at 207-08, 216 (finding that specialists constitute a minority of plaintiffs' attorneys and recommending specialty certification); Marc Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change*, 9 LAW & SOC'Y REV. 95, 107 fig.1, 110 (1974) (explaining that personal injury insurers are typically repeat players, while personal injury plaintiffs are not); Catherine T. Harris et al., *Who Are Those Guys? An Empirical Examination of Medical Malpractice Plaintiffs' Attorneys*, 58 SMU L. REV. 225, 237 (2005) (reporting that defense counsel in the study sample had handled, on average, more than twice as many malpractice cases as compared to their counterparts).

conferences can add to this foundation. Second, the appointed experts (i.e., physicians) who will work with the judges on a daily basis will probably influence the judges' perspective. Those physicians will have a physician's perspective of malpractice liability. Finally, the narrow range of issues faced by a specialized court increases the incentive for interest groups to seek influence in the process of selecting judges.¹³⁷ Perhaps this is why Tom Baker has called the plan a bald attempt by physicians to "capture the judges."¹³⁸

Another important risk presented by health courts is that administrative judges may not share the values of the public. For this reason, common law cases in the United States have historically been tried before juries. Our use of juries reflects deeply ingrained democratic values.¹³⁹ Its democratic importance prompted Blackstone to call the jury "the glory of the English law."¹⁴⁰ More recently, the United States Supreme Court stated that "[m]aintenance of the jury as a fact-finding body is of such importance and occupies so firm a place in our history and jurisprudence that any seeming curtailment of the right to a jury trial should be scrutinized with the utmost care."¹⁴¹ For this reason, both state and federal courts have generally held that legislatures must provide aggrieved parties with a quid pro quo when they replace jury trials with administrative proceedings.¹⁴² Workers' compensation plans, for example, were permitted because they gave injured workers a

¹³⁷ Bruff, *supra* note 135, at 331-32.

¹³⁸ Kristin Eliasberg, *Malpractice Fix*, BOSTON GLOBE, Aug. 21, 2005, at E1 (quoting Tom Baker); *see also* Carl W. Tobias, Essay, *Health Courts: Panacea or Palliative?*, 40 U. RICH. L. REV. 49, 51 (2005) (observing the risk of capture).

¹³⁹ See KALVEN & ZEISEL, *supra* note 122, at 6-7; Stephen Landsman, *The History and Objectives of the Civil Jury System*, in VERDICT: ASSESSING THE CIVIL JURY SYSTEM 22, 29-39 (Robert E. Litan ed., 1993).

¹⁴⁰ WILLIAM BLACKSTONE, 3 COMMENTARIES *374.

¹⁴¹ Dimick v. Schiedt, 293 U.S. 474, 486 (1935).

¹⁴² See, e.g., *Atlas Roofing Co. v. Occupational Safety & Health Review Comm'n*, 430 U.S. 442, 455 (1977); *Wright v. Cent. Du Page Hosp. Ass'n*, 347 N.E.2d 736, 741 (Ill. 1976); *Simon v. St. Elizabeth Med. Ctr.*, 355 N.E.2d 903, 904 (Ohio 1976); *Lucas v. United States*, 757 S.W.2d 687, 691-92 (Tex. 1988); Howard Alan Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. LEGIS. 143, 155-66 (1981); Amy Widman, *Why Health Courts Are Unconstitutional*, 27 PACE L. REV. 55, 74-81 (2006). On the federal right to trial by jury, see *Crowell v. Benson*, 285 U.S. 22, 51 (1932) (holding that private rights may not be removed from Article III courts) and *Granfinanciera, S. Am. v. Nordberg*, 492 U.S. 33, 42, 51 (1989). The Seventh Amendment provides: "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law." U.S. CONST. amend. VII. Nearly all states have similar constitutional provisions. See Widman, *supra*, at 84.

substantial new right: workers were entitled to immediate and guaranteed compensation without needing to prove their employers were at fault.¹⁴³

Given the historic importance of a claimant's right to have her grievance heard by a jury of her peers, the modest potential for improved decision-making associated with the use of specialized judges is too small a benefit, standing alone, to justify the loss of a peer decision, especially when the risk of pro-physician bias is taken into account. However, the health court plan offers other potential benefits.

4. The Impact of Court-Appointed Expert Witnesses

Under the proposed health court plan, health court judges will appoint their own expert witnesses to guide their deliberations.¹⁴⁴ Compared to the shift from juries to judges, the use of court-appointed experts has much more potential to improve the accuracy of malpractice verdicts, although it is important to remember that the room for improvement is quite modest.

Conceivably, these court-appointed experts could provide guidance on more than individual disputes. In the area of toxic torts, for example, panels of court-appointed experts have helped courts sort out and bring closure to several highly contested medical issues.¹⁴⁵ Perhaps something similar could occur in medical malpractice cases, such as those involving the causation of cerebral palsy in newborns. The experts for health courts could also be asked to write guidelines for the resolution of frequently recurring fact patterns so that recurring cases won't be decided anew each time they arise.

At the same time, judicial reliance on a single court-appointed doctor to evaluate the conduct of another physician in the same specialty or subspecialty could produce verdicts that unfairly favor physicians. The evidence on this issue, however, is conflicting. On the one hand, the physicians who have served as reviewers for medical malpractice carriers and for university researchers studying jury verdicts were roughly twice as likely as juries to find the performance of another physician to be negligent.¹⁴⁶ The reason for this is unclear, but it could easily be caused by a combination of the reviewer's superior ability to determine when testimony of the defendant's hired expert lacked credibility, or by a lesser deference to the judgment of the physician defendant. Whatever the reason, physicians who serve as private consultants are less parsimonious in assigning error than juries are. If the court-appointed

¹⁴³ See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 573 (5th ed. 1984). Workers are guaranteed immediate compensation for injuries arising from the workplace in return for the loss of a jury decision on causation and damages.

¹⁴⁴ Mello et al., *supra* note 9, at 464-65.

¹⁴⁵ Troyan A. Brennan, *Helping Courts with Toxic Torts: Some Proposals Regarding Alternative Methods for Presenting and Assessing Scientific Evidence in Common Law Courts*, 51 U. PITTS. L. REV. 1, 13-18 (1989).

¹⁴⁶ See *supra* text at notes 75-90.

physicians are as demanding as these reviewers have been, medical courts will rule in favor of claimants more often than juries currently do.

On the other hand, studies have found that physicians are reluctant to label another physician as negligent, indicating that court-appointed physician experts might favor physicians over claimants. One study found that physicians are so unwilling to label another physician's care as negligent that they refuse to do so even when the treatment given to the patient was "clearly erroneous."¹⁴⁷ This finding is consistent with the widely-shared perception that neither hospital peer review processes nor state licensure boards are willing to take action against incompetent physicians.¹⁴⁸ It is also consistent with reports of efforts by physician specialty groups to punish specialists who give testimony they dislike.¹⁴⁹ Finally, the risk of bias might also be influenced by the public setting in which these experts will testify,¹⁵⁰ which may place considerable pressure on the experts to demonstrate their loyalty to the profession.

There is an obvious tension between the findings that physicians are loath to indict one another and the evidence that physicians who review medical charts for liability insurers are more willing than juries are to judge other doctors negligent. In some contexts, they can be pressed to reveal their honest impressions. Setting and role seem to matter. At present, we can only guess how the role of court-appointed experts will affect their willingness to be candid and even-handed. As a result, any initial experiment with health courts absolutely must collect the data needed to evaluate the appointed physicians' willingness to criticize defendants who have failed to meet the standard of care.

5. Reforms To Produce More Predictable and Consistent Outcomes

Sponsors also hope the health courts proposal will improve medical malpractice outcomes by clarifying the standard of care and increasing the consistency of verdicts.¹⁵¹ There are several reasons for this hope. First, judges will issue written opinions that will both guide future clinical practice and set precedent for future legal disputes.¹⁵² Second, where evidence-based practice guidelines have been issued by credible medical authorities, those guidelines will define the standard of care.¹⁵³ Finally, the administrative staff of the health courts will identify common mishaps for which compensation

¹⁴⁷ WEILER ET AL., *supra* note 8, at 125.

¹⁴⁸ Mello et al., *supra* note 9, at 473.

¹⁴⁹ See, e.g., Steve Ellman, *Medical Associations Step Up Scrutiny of Doctors Who Testify for Medical Malpractice Plaintiffs*, DAILY BUS. REV., June 25, 2003, <http://www.dailybusinessreview.com/AwardStories/CodeOfSilence.html>.

¹⁵⁰ See Mello et al., *supra* note 9, at 472.

¹⁵¹ *Innovative Solutions to Medical Liability*, *supra* note 7, at 46.

¹⁵² *Id.*

¹⁵³ *Id.* at 47.

would be presumptively available (“accelerated compensation events” (ACEs)).¹⁵⁴ This combination of written opinions, binding practice guidelines, and ex ante identification of common compensable events could make it much easier for physicians to conform their clinical practices to the standard of care and also could enable health courts to render more consistent decisions post hoc.

Although each of these reforms has the potential to improve upon the status quo, a number of difficult details will need to be resolved. Health court legislation will need to specify the criteria by which the legally binding guidelines are to be identified. Currently, practice guidelines, or something very like them, are drafted by a diverse range of health care entities, ranging from individual practice groups to national specialty boards. Meanwhile, physicians should be informed that this reform will not work a fundamental change in malpractice litigation. Indeed, it is already common for defendants and plaintiffs alike to tell the jury about applicable practice guidelines, either through the testimony of their own expert witness or during the impeachment of an opposing expert.¹⁵⁵ Furthermore, the data on jury verdicts suggest that juries exonerate doctors who clearly comply with professional norms.¹⁵⁶

While legally binding practice guidelines are likely to improve malpractice adjudication, their adoption will not resolve all cases involving practice guidelines. The difficult cases commonly arise in two circumstances: where the parties dispute whether the doctor fully complied with the applicable guideline, and where the parties dispute whether the guidelines even apply in the plaintiff’s case. Those disputes will not be eliminated by the reforms contained in the new health court plan.

Practice guidelines are most valuable in simple cases. But, simple cases are the ones in which physicians are most certain about the appropriate medical or legal standard of care, and are the ones that juries and settlement negotiators are likely to resolve correctly even without health courts. Worrisome cases, on the other hand, arise when the standard of care is disputed or ambiguous and when the evidence of what happened to the patient is unclear. The outcomes of these cases are most subject to argument and manipulation. In a new health court system, however, such cases would not be governed by practice guidelines and the ACEs.

Conceivably, written opinions by the health court could reduce some of this uncertainty over time, and the value of these decisions as precedent will turn in large part on the extent to which they are tied to the unique facts of the case before the court. Once again, however, it will be important to avoid undue expectations. That is the lesson taught by the debate between Justices Holmes and Cardozo nearly a century ago. In his famous lectures on the common law,

¹⁵⁴ *Id.*

¹⁵⁵ See 1 BARRY R. FURROW ET AL., HEALTH LAW 363-64 (1995) (commenting that the source of the guideline determines its weight).

¹⁵⁶ See *id.* at 362-66.

Holmes argued that judges should gradually replace juries in deciding the negligence issue because experienced judges would come to know community standards and be able to formulate them in a set of concrete rules. Otherwise, the jury would be left “without rudder or compass.”¹⁵⁷ After his appointment to the Supreme Court, Justice Holmes convinced a unanimous Court to adopt his view.¹⁵⁸ “[W]hen the standard is clear,” wrote Holmes, “it should be laid down once [and] for all by the Courts.”¹⁵⁹ Seven years later, Holmes had retired and Justice Cardozo convinced the Court to abandon Holmes’s view.¹⁶⁰ General rules, Cardozo argued, fail to leave room for individual circumstances¹⁶¹ and that Holmes’s view did not take into account the specific facts of an individual case.¹⁶² Since then, American courts have only rarely articulated specific rules for the decision of negligence cases. Instead, they allow juries to consider the overall facts of each case. Whether health courts will be more successful than Holmes will turn on the susceptibility of common malpractice charges to ex ante resolution.

On balance, the combination of written opinions, binding guidelines, and ACEs has some potential to make the legal standard of care more concrete and to make verdicts more consistent. However, any improvements they produce are likely to be modest. Given the many sources of uncertainty in medical practice,¹⁶³ there is simply a limit to the detail with which legal standards of conduct can be articulated in advance.

6. Synthesis

The research on medical malpractice verdicts shows that juries treat physicians very fairly (perhaps with too much deference).¹⁶⁴ Given the limits of human capacity to reconstruct past events and the inevitable subjectivity of judgments about the quality of past performance, it is probably not possible to design a fault-based adjudication system that will have a substantially higher agreement rate in cases with weak evidence of negligence.¹⁶⁵ At most, modest

¹⁵⁷ OLIVER WENDELL HOLMES, JR., THE COMMON LAW 111-12 (Little, Brown & Co. 1945) (1881).

¹⁵⁸ Balt. & Ohio R.R. v. Goodman, 275 U.S. 66, 70 (1927). The Court ruled that a person driving a car across a railroad track who cannot see whether a train is approaching must “stop and get out of his vehicle” to check for trains. *Id.* at 69-70.

¹⁵⁹ *Id.* at 70.

¹⁶⁰ Pokora v. Wabash Ry. Co., 292 U.S. 98, 103-05 (1934).

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ See, e.g., David M. Eddy, *Variations in Physician Practice: The Role of Uncertainty*, 3 HEALTH AFF. 74, 75 (1984); John Wennberg, *Dealing with Medical Malpractice Variations: A Proposal for Action*, 3 HEALTH AFF. 6, 7 (1984).

¹⁶⁴ See *supra* notes 75-90 and accompanying text.

¹⁶⁵ See *supra* notes 93-116 and accompanying text.

improvements may be possible through careful refinements, such as the appointment of an expert who answers only to the court.¹⁶⁶

The data on settlement outcomes are similarly reassuring. To the extent that juries and settlements err, the error is more likely to favor the defendant physician than the plaintiff patient.¹⁶⁷ This evidence rebuts the claim that health courts are needed to escape an irrational adjudicative process.

To the extent that health courts actually do provide more just decisions, physicians are unlikely to appreciate the improvement. That is because the greatest room for improvement in jury decision making lies in cases with strong evidence of negligence.¹⁶⁸ Juries too often decide those cases in favor of defendants. Physicians presumably do not expect health courts to correct this injustice. If, instead, they expect to win even more cases, then satisfaction of their wish can only occur if health courts are even more biased in favor of physicians than the civil justice system.

Because health court judges will rely heavily on the opinions of their approved physicians to reach decisions, pro-physician bias is a genuine danger.¹⁶⁹ Any experiment with health courts absolutely must include an evaluation component to determine whether the new tribunals are yielding just outcomes.

Other provisions of the health court plan are less worrisome. The combination of written opinions, binding guidelines, and ACEs, for example, has the potential to improve the fairness of judicial outcomes.¹⁷⁰ These reforms are likely to make the legal standard of care more concrete and yield verdicts that are more consistent over time.¹⁷¹ Nevertheless, improvement will be moderated by the fact that there is a limit to the detail with which legal standards of conduct can be articulated in advance.¹⁷² Still, a pilot test of these provisions would be valuable. Whether or not this pilot can legally be undertaken, however, will turn on whether injured patients have received a sufficient quid pro quo to justify abrogation of their right to a jury trial.¹⁷³ That is a topic to which I return after examining the other risks and benefits of the health court proposal.

B. *Impact on the Mix of Claims Filed*

Health court supporters routinely charge that the current system for handling medical accidents treats both patients and physicians unfairly. In addition to their charge that the judicial system poorly disposes of the claims that enter the

¹⁶⁶ See *supra* notes 144-150 and accompanying text.

¹⁶⁷ See *supra* notes 75-90, 93-116 and accompanying text.

¹⁶⁸ See *supra* notes 86 and 87 and accompanying text.

¹⁶⁹ See *supra* notes 147-150 and accompanying text.

¹⁷⁰ See *supra* notes 151-154 and accompanying text.

¹⁷¹ See *supra* notes 151-154 and accompanying text.

¹⁷² See *supra* notes 157-163 and accompanying text.

¹⁷³ See *supra* Part II.A.5.

courthouse, health court supporters charge that the current system prompts the wrong patients to sue. On the one hand, few of the patients who are injured by medical negligence ever make a claim. In this respect, the system cheats patients. On the other hand, physicians suffer from an avalanche of unwarranted claims. Both of these charges have merit. Unfortunately, a system of administrative health courts is unlikely to substantially reduce either of these problems.

1. Impact on Under-Claiming

Too few malpractice claims are filed. Few serious scholars dispute that.¹⁷⁴ Only 2-3% of patients injured by medical negligence ever file a claim.¹⁷⁵ Some of the under-claiming is because the injuries are relatively minor. Yet, one highly respected scholar estimates that only about 3-5% of patients with serious injuries make a claim.¹⁷⁶ As a result, many scholars believe the current legal regime does a poor job of protecting the rights and welfare of negligently injured patients.¹⁷⁷

Sponsors of the health court plan believe that simplifying the claims process and “mandating” disclosure to patients will increase the number of claims, thus improving the system’s ability to provide just compensation while also strengthening its deterrent signal.¹⁷⁸ The sponsors’ willingness to recognize this problem and to look for solutions demonstrates an evenhandedness that is uncommon among tort reformers. A system of administrative health courts could conceivably reduce the problem of under-claiming by making the process of filing a claim less daunting to injured patients. Initiating the process might be as simple as requesting and completing a claim form at the hospital, and the potential speed and relative simplicity of the claims resolution process may reduce patient reluctance to initiate it.¹⁷⁹ In addition, the prospect of an insurance surcharge could conceivably lead some hospitals to push harder than they currently do for physician openness.

Nevertheless, many of the factors currently limiting claims will continue to operate. Patients are still likely to have difficulty distinguishing medically induced injury from the unfortunate progression of their disease or an unlucky complication.¹⁸⁰ Many will still lack advisors or confidantes who can help

¹⁷⁴ See *Innovative Solutions to Medical Liability*, *supra* note 7, at 21; Weiler et al., *supra* note 61, at 2355.

¹⁷⁵ A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence*, 325 NEW ENG. J. MED. 245, 247 (1991).

¹⁷⁶ See, e.g., *Innovative Solutions to Medical Liability*, *supra* note 7, at 26 (statement of Michelle Mello).

¹⁷⁷ See, e.g., *id.*; Johnson et al., *supra* note 47, at 1366.

¹⁷⁸ Mello et al., *supra* note 9, at 471.

¹⁷⁹ In addition, the “state-of-the-art” standard of care might prompt more claims by making it easier for patients to determine whether they have a justified claim.

¹⁸⁰ See BAKER, *supra* note 72, at 91.

them understand their rights.¹⁸¹ Because physicians will still be individually liable and apparently not subject to the surcharge, they are unlikely to assist patients in making claims, as physicians reportedly do in Sweden.¹⁸²

Furthermore, the planned abrogation of the collateral source rule will dilute the benefits of claim simplification. The collateral source rule states that the amount of damages paid to a plaintiff by a defendant will not be reduced by payments received by the plaintiff from other sources, such as medical insurance.¹⁸³ Today, minor and even moderate injuries are typically not worth pursuing because the costs of malpractice litigation are so high and the odds of success before a jury are low.¹⁸⁴ Abrogating the collateral source rule will extend this de facto immunity to much more severe injuries because it will preclude recovery for expenses that have been reimbursed by a third party payor, such as disability coverage, sick leave, and health insurance. This change will make patients with disability or health insurance even less likely to make a claim than they are today.

Procedural simplification will soften this impact, but only marginally. Two factors in particular will limit this suggested simplification's impact. First, insurers traditionally resist paying legitimate patient claims until the patient demonstrates her seriousness by hiring a lawyer or a medical expert.¹⁸⁵ Second, health courts sponsors have underestimated the extent to which fairly resolving complex medical malpractice claims requires an equally complex dispute resolution process. As will be explained in Part II.C, accurate decision making in complex cases often requires both significant pretrial discovery and multiple expert witnesses.¹⁸⁶ Thus, the simplicity of the claims process will evaporate relatively quickly.

For all of these reasons, the new administrative claims process is unlikely to experience a substantial net increase in legitimate claims. As long as it abrogates the collateral source rule,¹⁸⁷ the proposed plan is more likely to exacerbate under-claiming than to relieve it.

¹⁸¹ See *id.*

¹⁸² See Patricia M. Danzon, *The Swedish Patient Compensation System: Myths and Realities*, 14 INT'L REV. L. & ECON. 453, 454 (1994). In Sweden, physicians are not named as individual defendants. *Id.* at 455-56. In fact, neither the physicians nor their hospitals pay premiums for liability insurance. *Id.* at 455. Instead, that insurance is funded out of tax revenues. *Id.* Furthermore, claims made against the fund do not name individual defendants. *Id.* at 460. These factors produce a climate of cooperation that is justly envied by health safety advocates in the U.S. See generally *id.*

¹⁸³ BLACK'S LAW DICTIONARY 238 (5th ed. 1979).

¹⁸⁴ See *Innovative Solutions to Medical Liability*, *supra* note 7, at 27-28 (statement of Michelle Mello).

¹⁸⁵ See Peters, *Settlements*, *supra* note 91, at 1828.

¹⁸⁶ See *infra* Part II.C for a defense of this conclusion.

¹⁸⁷ This is not meant to suggest that abrogation of the collateral source rule is never appropriate; that would be essential in a system of no-fault recovery and patients would receive a fair quid pro quo.

2. Impact on Over-Claiming

Physicians fairly complain that too many malpractice claims lack legal merit. Somewhere between one-third and one-half of all medical malpractice claims turn out to be baseless.¹⁸⁸ In the most recent study, David Studdert and his colleagues found that 37% of all claims in the sample lacked evidence of medical error.¹⁸⁹

Defenders of the civil justice system point out that many of these claims, perhaps most, are filed by patients who need to use the tools of pretrial discovery in order to evaluate the quality of care they received.¹⁹⁰ Furthermore, the huge majority of unwarranted claims are dropped or dismissed without payment.¹⁹¹ When patients insist on bringing them to trial, defendant physicians rarely lose a jury verdict.¹⁹²

However, defenders of the civil justice system underestimate the emotional and financial cost that physicians bear while waiting for the system to do its filtering.¹⁹³ For physicians, being drawn into the process is itself a form of punishment.¹⁹⁴ Thus, there are credible reasons for believing medical malpractice defendants suffer more from unwarranted lawsuits than do defendants in other routine tort actions, such as automobile accidents and product liability cases.

Some of the factors that distinguish medical malpractice cases from other tort actions are structural. First, medical malpractice claims are more likely to lack merit than automobile negligence claims, perhaps because they are much harder for the plaintiff to evaluate accurately.¹⁹⁵ Second, while automobile drivers are as likely to be plaintiffs as defendants,¹⁹⁶ physicians are always defendants in medical malpractice litigation. This lack of reciprocity surely contributes to their widely-shared sense of victimization. Third, physicians are much more likely to be drawn into court repeatedly than, for example, the

¹⁸⁸ Studdert et al., *Claims*, *supra* note 91, at 2024.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.* at 2030-31. Many claims are difficult to evaluate without hearing the recollections of the physicians and nurses who provided the patient's care. See BAKER, *supra* note 72, at 91-92. Typically, they will not talk to a patient's attorneys unless the patient files suit and takes their depositions. See *id.* at 90. Thus, filing a lawsuit is often a necessary part of investigating the merits of a claim. See *id.* at 91-92. Until some form of "pre-lawsuit" discovery is crafted to provide the necessary information, these lawsuits will continue.

¹⁹¹ Peters, *Settlements*, *supra* note 91, at 1475.

¹⁹² *Id.* at 1459-60 (finding that of the cases where liability was not admitted and liability was a legitimate issue only 11% of the plaintiffs received a significant award of damages).

¹⁹³ See Charles M. Yablon, *The Good, the Bad, and the Frivolous Case: An Essay on Probability and Rule 11*, 44 UCLA L. REV. 65, 102 (1996).

¹⁹⁴ Sara C. Charles et al., *Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation*, 141 AM. J. PSYCHIATRY 563, 565 (1984).

¹⁹⁵ See O'Connell, *supra* note 53, at 756.

¹⁹⁶ See BAKER, *supra* note 72, at 18.

average automobile driver.¹⁹⁷ While product manufacturers are even more likely to be repeat defendants than physicians are, the target defendant in products cases is typically a large corporation.¹⁹⁸ Physicians, on the other hand, are sued as individuals, and predictably “take malpractice suits very personally.”¹⁹⁹ As one physician explained, “[r]ather than being seen as a ‘fact of life’ or a ‘cost of doing business,’ malpractice suits often threaten the core of a physician’s self-esteem.”²⁰⁰

A fourth difference arises out of the realities of the medical industry. A charge of incompetence follows physicians for life, resurfacing whenever they seek or renew their liability insurance, managed care contracts, licensure, and hospital privileges.²⁰¹ Their obligation to report settlements in any amount to the National Practitioner Data Bank (“NPDB”) makes even a token payment a permanent part of their history.²⁰² Insurers and hospitals routinely go even farther, demanding disclosure of every claim made against the doctor, regardless of its disposition.²⁰³ As one physician, Dr. Elliot Perlman, noted after the case against him was dropped:

The lawyers advised me to forget it, but it’s not that simple. Every year I have to fill out forms from my malpractice insurer, hospital staffs, and state licensing boards. I’m asked whether I’ve ever been convicted of a felony and whether a malpractice claim has ever been brought against me. So it’s OK to have been accused of murder – but not of malpractice.²⁰⁴

As Perlman correctly laments, doctors who are simply accused of error acquire a record that follows them for life.

Lucian L. Leape, M.D., one of the pioneers in health quality research, points out a fifth unique aspect of malpractice litigation that arises out of the culture of medical practice. In everyday practice, the norms of medicine send the clear message that mistakes are unacceptable.²⁰⁵ “One result is that physicians, not unlike test pilots, come to view an error as a failure of character . . .”²⁰⁶ Once

¹⁹⁷ *Id.*

¹⁹⁸ WEILER ET AL., *supra* note 8, at 126.

¹⁹⁹ Richard E. Anderson, *Billions for Defense: The Pervasive Nature of Defensive Medicine*, 159 ARCHIVES INTERNAL MED. 2399, 2400 (1999).

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² See Teresa M. Waters et al., *Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims*, 40 INQUIRY 283, 283 (2003) (finding that physicians have been less likely to settle claims since introduction of the NPDB in 1990, especially for payments less than \$50,000).

²⁰³ Elliott M. Perlman, *Well-Managed Case Gets Caught in Malpractice Fervor*, AM. MED. NEWS, Feb. 21, 1994, at 14.

²⁰⁴ *Id.*

²⁰⁵ Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1851 (1994).

²⁰⁶ *Id.*

human error is transformed into a failure of character, every unwarranted charge of negligence is experienced as a vicious libel.²⁰⁷

Of these differences, the most important is almost certainly the personal nature of a charge of medical negligence. When a physician is sued, she is much more likely than an automobile driver who is sued for negligence to view it as an attack on her competence and self-worth. The magnitude of personal anguish is revealed regularly in the priority that physicians place on malpractice reform and in the deep anger and distress that they express individually in ordinary conversations about the topic.²⁰⁸ They are elite and powerful professionals who often base much of their personal identity and self-worth on their professional status.²⁰⁹ As a result, physicians suffer from a charge of negligence in a different way than does an errant driver in a no-injury collision.

One fascinating set of studies found that physicians who had been sued were significantly more likely to think of retiring early, to stop seeing patients whom they perceived to be more likely to sue, and to tell their children not to practice medicine.²¹⁰ The sued physicians were also much more likely to report severe depressed mood, inner tension, anger, and frustration than the nonsued physicians.²¹¹ In fact, a strong reaction of anger was “pervasive” among sued physicians (87.9%),²¹² and they perceived themselves as scapegoats of the legal profession.²¹³ Yet, only 24.8% of the sued doctors had paid settlements.²¹⁴ For the three-quarters who made no payment, it was the burden of being charged and the task of exonerating themselves that had produced their anger.²¹⁵

On balance, therefore, unfounded malpractice claims do seem to carry unique social and personal costs. They also impose costs on the legal system beyond the expenses associated with filtering weak claims. When the mere fact of being charged with negligence is seen as a form of punishment, then tort law’s deterrent signal is badly distorted. From this perspective,

²⁰⁷ See *id.* at 1852.

²⁰⁸ See, e.g., Brennan & Howard, *supra* note 73, at B7; Perlman, *supra* note 203, at 14.

²⁰⁹ See Samuel R. Gross & Kent D. Syverud, *Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial*, 90 MICH. L. REV. 319, 365 (1991).

²¹⁰ Sara C. Charles et al., *Sued and Nonsued Physicians’ Self-Reported Reactions to Malpractice Litigation*, 142 AM. J. PSYCHIATRY 437, 437-38 (1985). They were also significantly more likely to say that litigation caused suffering to them and their families. *Id.* at 440.

²¹¹ *Id.* at 438. When they interviewed nonresponders, the researchers learned that many had not completed the questionnaire because doing so was too emotionally disruptive. *Id.* at 440.

²¹² Charles et al., *supra* note 194, at 564 tbl.1, 565 (1984).

²¹³ *Id.* at 565.

²¹⁴ Charles et al., *supra* note 210, at 438.

²¹⁵ Charles et al., *supra* note 194, at 565.

punishment is inflicted upon the innocent and guilty alike: the fact that roughly 40% of all malpractice claims lack merit is highly damning and fuels the perception that the system is irrational.²¹⁶ These facts make the initial claims process the weak link in the present adjudicatory process.

More must be done to eliminate the baseless cases quickly and to reduce the emotional, financial, and professional costs borne by physicians as they await eventual exoneration. Although lawmakers in several states have enacted reforms intended to reduce this problem (such as statutes requiring plaintiffs to obtain the support of a medical expert prior to filing their lawsuit or soon thereafter, and statutes creating pretrial screening panels),²¹⁷ these measures do not appear to have produced significant improvements.²¹⁸ Creative new ideas are badly needed.

Unfortunately, the health court plan does not address this problem directly. At best, it will speed up the process of reaching a final judgment. In fact, the simplified claims process could make the problem of over-claiming worse because it will offer patients a quick and easy way to obtain a free evaluation of their claims, just as the creation of nonbinding malpractice screening panels reportedly did in some states.²¹⁹ Under the health court plan, patients could make these “what the heck” claims without the filtering that occurs when they seek a lawyer who will take their case. A better way to protect physicians from the pain inflicted by simply being drawn into the judicial process is to eliminate individual liability and replace it with hospital enterprise liability. This idea, called exclusive enterprise liability, was proposed over twenty years ago and is discussed at greater length in Part III.

The health courts claims process is unlikely to materially reduce the level of under-claiming. In fact, the proposed restrictions on damage recovery are likely to make the problem worse. In addition, the plan is simply not designed to reduce the level of over-claiming. Here, too, the reform is more likely to make the problem worse, than to make it better.

C. *The Quest for Improved Efficiency Through Procedural Simplification*

Health court advocates believe their proposed administrative process will resolve malpractice claims more quickly and cheaply.²²⁰ In some states, medical malpractice cases currently linger for years before they are settled or

²¹⁶ See Charles et al., *supra* note 210, at 440.

²¹⁷ E.g., FLA. STAT. § 766.104(1) (2006) (requiring that the attorney filing the action has a good faith belief that there has been negligence in the treatment of the claimant); GA. CODE ANN. § 9-11-9.1(a) (1998) (requiring a plaintiff to file with the complaint an expert's affidavit setting forth at least one negligent act or omission).

²¹⁸ See, e.g., FURROW ET AL., *supra* note 155, at 531-32.

²¹⁹ *Id.* at 532.

²²⁰ Mello et al., *supra* note 9, at 467-68.

tried.²²¹ These long delays extract an emotional toll on both the claimants and the defendant physicians. The delays also put some plaintiffs under substantial financial pressure to settle quickly (and thus, cheaply) in order to pay their accumulating medical and household bills. A faster process would be a welcome improvement if it could also deliver fair outcomes.

Medical malpractice litigation is also extremely expensive. Lawyers and expert witnesses for both sides must be paid, along with the insurer's claims management staff. Court-ordered discovery and resolution of pretrial motions run the bill up even further. As a result, less than fifty cents of every dollar paid by physicians for their malpractice insurance ultimately goes to injured patients.²²² Most of the rest is consumed by the process of deciding which patients should receive a payment.²²³ This compares poorly with the fraction of payments that go to injured parties in fields where the claimant need not prove fault. For example, 70-80% of workers' compensation premiums reach injured workers and 85-90% of the premiums paid for disability insurance reach disabled policyholders.²²⁴ And medical malpractice litigation shares this problem with other areas of technically or scientifically complex fault-based litigation, such as disputes over defective product design.²²⁵ There, too, creative solutions are badly needed.²²⁶ As a consequence, malpractice litigation's time and expense pose a very serious problem.

The health court plan tackles the dual problems of long delay and high cost by substituting an administrative claims process for the complicated judicial process that currently handles malpractice lawsuits.²²⁷ Preliminary coverage determinations will be made by the insurer as they currently are, but appeals will go to specialized health court judges who are assisted by court-appointed experts.²²⁸ Although few other details of this administrative process have thus far been revealed, the new regime cannot produce the savings that proponents desire without a marked reduction in the costs associated with hired expert witnesses, pretrial discovery, motion practice, and lawyer preparation. Only by cutting these costly activities can the fault-based health court plan approach the low level of administrative costs found in no-fault claims resolutions processes, such as those used for workers' compensation and disability insurance claims.²²⁹

²²¹ See *Innovative Solutions to Medical Liability*, *supra* note 7, at 26 (statement of Michelle Mello).

²²² *Id.* at 19 (statement of Michelle Mello).

²²³ *Id.* at 24-27 (statement of Michelle Mello).

²²⁴ *Id.* at 26 (statement of Michelle Mello).

²²⁵ O'Connell, *supra* note 53, at 752.

²²⁶ See *id.* at 826-29.

²²⁷ Mello et al., *supra* note 9, at 462-65.

²²⁸ *Id.* at 464.

²²⁹ See *Innovative Solutions to Medical Liability*, *supra* note 7, at 26-27 (statement of Michelle Mello).

Unfortunately, cutting this pretrial preparation in a fault-based system is a risky business. No-fault systems, such as workers' compensation insurance, drastically reduce administrative costs because they eliminate the need to prove or defend against allegations of fault.²³⁰ The elimination of that issue dramatically reduces the money spent on expert witnesses and attorneys. It also materially reduces the acrimony and emotional cost associated with the claims process.

Fault-based systems, by contrast, must provide both parties with a fair opportunity to explore the strengths and weaknesses of the claimed breach of duty. Any attempt to produce the economies found in no-fault disputes within a fault-based claims system will inevitably increase the risk of unjust verdicts. Trimming procedural safeguards, such as the opportunity to do full discovery and the opportunity to present favorable expert witnesses, is materially different from the cost-savings produced by trimming issues, such as fault, and, for obvious reasons, is far more likely to produce incorrect decisions. Given the complexity of medical malpractice disputes, a fair process will require most of the procedural protections that currently make malpractice litigation expensive and lengthy.

1. The Important Choice Among Administrative Models

The fairness of the procedural protections provided by health courts will turn on the choice that lawmakers make among the many administrative models currently in use. At one end are the tribunals that resemble traditional trial courts and provide opportunities for liberal discovery and significant motion practice.²³¹ At the other end are administrative processes that provide only minimal due process, such as license suspension proceedings, where citizens are simply given notice and opportunities to tell their stories.²³² Most administrative tribunals fall between those two models. Where health courts fall on this continuum will help determine both the accuracy of their outcomes and the savings, if any, that accrue from the switch to health courts.

Administrative courts are typically created as either the adjudicative arm of an administrative agency, like the tribunals that adjudicate social security disputes under the Social Security Administration, or as an independent governmental entity, like the Court of Federal Claims.²³³ In the federal system,

²³⁰ Troyen A. Brennan & Michelle M. Mello, *Patient Safety and Medical Malpractice: A Case Study*, 139 ANNALS INTERNAL MED. 267, 267 (2003) (acknowledging that the administrative cost savings produced by no-fault programs come "largely by minimizing the role of the lawyers").

²³¹ ALFRED C. AMAN, JR. & WILLIAM T. MAYTON, ADMINISTRATIVE LAW 173-74 (2d ed. 2001).

²³² See AMAN & MAYTON, *supra* note 231, at 252-62; *infra* text accompanying notes 246-255.

²³³ 26 U.S.C. § 7441 (2000); 1 KENNETH CULP DAVIS & RICHARD J. PIERCE, JR., ADMINISTRATIVE LAW TREATISE 90-91 (3d ed. 1994); 17 CHARLES ALAN WRIGHT, ARTHUR

both kinds of tribunals are sometimes called Article I courts because they are created by Congress under Article I of the Constitution and are not part of the judicial branch created under Article III.²³⁴ However, the independent tribunals created by Congress are quite different from the agency-associated tribunals.

Independent Article I courts, such as the Court of Federal Claims,²³⁵ are created by Congress as freestanding bodies and strongly resemble judicial trial courts. Indeed, the bankruptcy courts are even annexed to the federal district courts.²³⁶ Such courts have detailed rules of procedure patterned on the Federal Rules of Civil Procedure or, in the case of bankruptcy courts, procedures extensively tailored to the unique character of the disputes it decides.²³⁷ Substantial pretrial discovery and motion practice are the norm.²³⁸ Each side calls both fact and expert witnesses and cross-examination is a matter of right.²³⁹ Except for the absence of a jury, litigation before these administrative courts is very much like litigation in traditional civil courts.²⁴⁰ It seems unlikely that the backers of health courts have this kind of administrative tribunal in mind because this model would not be materially cheaper or faster than civil courts.²⁴¹ Nor would it be any less adversarial.

The second group of administrative courts is attached to an administrative agency, such as the Social Security Administration or the Occupational Health and Safety Administration (OSHA).²⁴² These tribunals resolve disputes arising out of the business of the affiliated agency, such as disputes over eligibility for social security or the violation of workplace safety rules.²⁴³ Because these tribunals have close ties to an executive branch agency, their proceedings are often called agency adjudications²⁴⁴ or, less commonly, Article II proceedings.²⁴⁵

If lawmakers choose an agency adjudication model for health courts, then they also must decide whether to subject the tribunal to the formal adjudication

R. MILLER & EDWARD H. COOPER, FEDERAL PRACTICE AND PROCEDURE § 4101 (2d ed. 1988).

²³⁴ DAVIS & PIERCE, *supra* note 233, at 90.

²³⁵ WRIGHT, MILLER & COOPER, *supra* note 233, at § 4101.

²³⁶ *Id.* § 4106.

²³⁷ *Id.*

²³⁸ BENJAMIN WEINTRAUB & ALAN N. RESNICK, BANKRUPTCY LAW MANUAL ¶ 6.04, at 6-8 to -10 (1980).

²³⁹ *Id.* at 6-9 to -10.

²⁴⁰ *Id.* at 6-8.

²⁴¹ See, e.g., *Innovative Solutions to Medical Liability*, *supra* note 7, at 26-27 (statement of Michelle Mello); Mello et al., *supra* note 9, at 462-65.

²⁴² Bruff, *supra* note 135, at 345-47.

²⁴³ *Id.* at 346-47.

²⁴⁴ *Id.* at 359.

²⁴⁵ *Id.* at 329.

procedures under the Administrative Procedure Act (APA) or the equivalent state statute.²⁴⁶ Tribunals that are not governed by the formal adjudication procedures of a state or federal APA ordinarily provide fewer procedural safeguards – sometimes no more than notice of the proceeding, an opportunity to present evidence (though not necessarily in person), and an unbiased decision maker.²⁴⁷ No tribunal-assisted discovery takes place and the tribunal can bar attorneys.²⁴⁸ The hearing officers have lower pay and less prestige than the administrative law judges who sit in formal tribunals governed by the APA.²⁴⁹ They also have less independence from agency pressures, such as the pressure to move a large caseload quickly or to limit the number of claims allowed.²⁵⁰ As one commentator observed, these informal tribunals are often staffed by lower-caliber judges “who can tolerate life on the assembly line.”²⁵¹ This model is unlikely to satisfy either doctors or their patients. In contrast, adjudicative proceedings subject to the APA’s formal adjudication procedures tend to have higher stakes and more procedural safeguards. Unlike informal proceedings, the parties are entitled to a formal hearing and can be accompanied by an attorney.²⁵² Social security eligibility proceedings fit this model.²⁵³

Although APA formal adjudication proceedings have more procedural protections than informal proceedings, they lack many of the procedural protections that are provided by the judicial process. For example, counsel can only cross-examine an adverse witness in a formal adjudication proceeding if the hearing officer feels that doing so is necessary “for a full and true disclosure of the facts.”²⁵⁴ In practice, most agencies place material limits on cross-examination.²⁵⁵ Furthermore, testimony before the tribunal is often

²⁴⁶ Congress determines whether the federal APA applies. RICHARD J. PIERCE, JR. ET AL., ADMINISTRATIVE LAW AND PROCESS 304 (4th ed. 2004). At a minimum, the process must include notice, an opportunity to present evidence, and an unbiased decision-maker. *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 546 (1985); *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 13 (1978); AMAN & MAYTON, *supra* note 231, at 173-74.

²⁴⁷ See AMAN & MAYTON, *supra* note 231, at 254-62.

²⁴⁸ *Id.* at 173, 219.

²⁴⁹ In tribunals governed by the APA, the decision-maker is an “administrative law judge.” PIERCE ET AL., *supra* note 246, at 308. “Informal” adjudication not governed by the APA is presided over by an “administrative judge.” *Id.* at 309. The latter have much less independence from the agency and lower pay. *Id.* at 309-10.

²⁵⁰ Bruff, *supra* note 135, at 349 (describing a controversial policy in the social security disability benefits program).

²⁵¹ *Id.* at 331.

²⁵² 5 U.S.C. § 554(c)(2) (2000); AMAN & MAYTON, *supra* note 231, at 220.

²⁵³ See AMAN & MAYTON, *supra* note 231, at 220.

²⁵⁴ 5 U.S.C. § 556(d) (2000); AMAN & MAYTON, *supra* note 231, at 220.

²⁵⁵ AMAN & MAYTON, *supra* note 231, at 221.

submitted in written form rather than by personal appearance.²⁵⁶ In addition, the APA does not require any opportunity for pretrial discovery²⁵⁷ and the Federal (or State) Rules of Evidence do not apply in administrative hearings.²⁵⁸ Instead, administrative tribunals freely admit hearsay evidence and commonly take judicial notice of facts that are not in the record.²⁵⁹ Consequently, agencies can set their own policies over discovery and those policies vary widely.²⁶⁰

Thus, administrative tribunals vary substantially in the procedural protections they provide. The simpler the issue to be resolved and the larger the volume of claims to be handled, the more simplified the decision-making process tends to be. The higher the stakes and the more complex the issues to be decided, the more that the administrative process resembles the judicial process, especially in disputes like those involving tax compliance, where individual fault is an important issue.

2. The Risks of Simplification

When advocates of health courts extol the simplicity and efficiency of their proposed claims process, they fail to recognize the importance of procedural protections. Procedural protections were established to produce more just outcomes.²⁶¹ They were, in fact, a reaction to the unfairness associated with more streamlined Victorian processes.²⁶²

Until the middle third of the 20th century, American litigation had many of the efficiencies sought today by the proponents of health courts. Virtually no court-assisted discovery was permitted, expert witnesses were relatively uncommon, and trial dates came quickly.²⁶³ The pleadings used to initiate a lawsuit had to be highly detailed.²⁶⁴ This probably reduced the risk of

²⁵⁶ See, e.g., Ernest Gellhorn, *Rules of Evidence and Official Notice in Formal Administrative Hearings*, 1971 DUKE L.J. 1, 37; PIERCE ET AL., *supra* note 246, at 311.

²⁵⁷ AMAN & MAYTON, *supra* note 231, at 219-20. Discovery is not constitutionally required in administrative proceedings. Silverman v. Commodity Futures Trading Comm'n, 549 F.2d 28, 33 (7th Cir. 1977); NLRB v. Interboro Contractors, Inc., 432 F.2d 854, 857-58 (2d Cir. 1970), cert. denied, 402 U.S. 915 (1971).

²⁵⁸ AMAN & MAYTON, *supra* note 231, at 221-34; PIERCE ET AL., *supra* note 246, at 310-11.

²⁵⁹ AMAN & MAYTON, *supra* note 231, at 229-30 (stating that the APA requires parties be given the opportunity "to show the contrary" under 5 U.S.C. § 556(e) (2000)); PIERCE ET AL., *supra* note 246, at 311.

²⁶⁰ AMAN & MAYTON, *supra* note 231, at 219-20.

²⁶¹ See Stephen N. Subrin, *How Equity Conquered Common Law: The Federal Rules of Civil Procedure in Historical Perspective*, 135 U. PA. L. REV. 909, 922-25 (1987).

²⁶² *Id.* at 944.

²⁶³ *Id.* at 919.

²⁶⁴ See 5A CHARLES ALAN WRIGHT & ARTHUR R. MILLER, *FEDERAL PRACTICE AND PROCEDURE* § 1331, at 467 (3d ed. 2004).

frivolous lawsuits.²⁶⁵ Unfortunately, it also led to the dismissal of many meritorious cases.²⁶⁶ The problem of unjust outcomes was especially great when key evidence was possessed by the defendant or his associates.²⁶⁷

Concern about unjust outcomes prompted enactment of the Federal Rules of Civil Procedure (FRCP) in 1938.²⁶⁸ The express goal of the rules was to decide more cases on their true merits.²⁶⁹ Among other things, the FRCP introduced “notice pleading,”²⁷⁰ and court-sanctioned discovery blossomed.²⁷¹ Both of these reforms were designed to delay the final disposition of a claim until each of the parties had the opportunity to learn all of the facts known by the other.²⁷² The new system relies much less on the pleadings as a means of identifying the issues and weeding out nonmeritorious cases, and much more on greatly expanded discovery, summary judgment, and the pretrial conference.

Under the modern rules, courts are still expected to identify and dispose of unwarranted claims, but they do so more slowly, convinced that full investigation of the facts leads to more informed and more just settlements and verdicts.²⁷³ As a result, trial judges rarely dismiss a case before considerable discovery has taken place.²⁷⁴ As explained by the Supreme Court in a 1976 antitrust case, where ““the proof is largely in the hands of the [defendants], . . . dismissals prior to giving the plaintiff ample opportunity for discovery should be granted very sparingly.”²⁷⁵ These reforms of pleading and discovery made it possible to redress wrongs that previously had been immunized by the inability to reach evidence in the hands of the defendant.²⁷⁶

Administrative tribunals depart from this judicial model. They have streamlined their procedures to process a large volume of claims at a manageable cost.²⁷⁷ Literally millions of disputes over government benefits

²⁶⁵ See Subrin, *supra* note 261, at 917-18.

²⁶⁶ See WRIGHT & MILLER, *supra* note 264, at 467.

²⁶⁷ See *id.* (commenting that these rules kept many meritorious suits out of court because the pre-litigation investigation required to ascertain the necessary facts was impossible under the limited rules of formal discovery then in effect).

²⁶⁸ See FRIEDENTHAL ET AL., CIVIL PROCEDURE 253 (4th ed. 2005) (observing that most states then followed suit).

²⁶⁹ *Id.* at 255.

²⁷⁰ FED. R. CIV. P. 8(a)(2).

²⁷¹ See WRIGHT & MILLER, *supra* note 264, at 469.

²⁷² See FRIEDENTHAL ET AL., *supra* note 268, at 254.

²⁷³ See *id.* at 254-55.

²⁷⁴ See *id.*

²⁷⁵ Hosp. Bldg. v. Trs. of Rex Hosp., 425 U.S. 738, 746 (1976) (quoting Conley v. Gibson, 355 U.S. 41, 45-46 (1957)).

²⁷⁶ See FLEMING JAMES, JR. ET AL., CIVIL PROCEDURE 287 (5th ed. 2001).

²⁷⁷ DAVIS & PIERCE, *supra* note 233, at 90-91.

are decided by administrative tribunals every year.²⁷⁸ A streamlined adjudicative process enables the agencies to process these disputes efficiently and, as long as the claims tend to be routine, at a tolerable risk of error. A more expensive process is not typically warranted by the stakes.²⁷⁹ In some instances, it would make claims resolution unavailable to many citizens.²⁸⁰ In most of these expedited adjudicative processes, no determination of individual fault needs to be made.²⁸¹

3. Streamlining in Medical Malpractice Cases

An abbreviated administrative process would not be appropriate for the resolution of controversial medical malpractice disputes. Court-assisted discovery, in particular, is essential. An abbreviated discovery process would inevitably rely far too heavily on the written medical records. Yet, lawyers on both sides know that the hospital chart is often incomplete.²⁸² Mishaps are omitted.²⁸³ In addition, many cases are tainted by suspicions that the chart has been altered.²⁸⁴ A truncated adjudicative process would exacerbate the already strong temptation to doctor the records.

In addition, the doctors and nurses who treat a patient usually know far more about the circumstances in dispute than the patient does. Yet, doctors and their staff are notoriously unwilling to talk to their patients about adverse events.²⁸⁵ As a result, patients often must file a lawsuit just to find out what went wrong.²⁸⁶ The Physician Payment Review Commission acknowledged this information asymmetry in its 1995 report to Congress, stating “[i]t is often difficult to judge at a case’s inception whether it is likely to be successful, because key information often is not available in the medical record and must be obtained through the legal process.”²⁸⁷ Malpractice defendants make

²⁷⁸ See *id.* at 378-79 (opining that government “would collapse under its own weight” if full judicial process were required).

²⁷⁹ See *id.*

²⁸⁰ See AMAN & MAYTON, *supra* note 231, at 118 n.3. Undue proceduralism could deplete the resources intended for program beneficiaries. See *Richardson v. Perales*, 402 U.S. 389, 406 (1971).

²⁸¹ DAVIS & PIERCE, *supra* note 233, at 379.

²⁸² See Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 LANCET 309, 312 (1997).

²⁸³ See *id.* (implying that not all medical errors are recorded in medical charts).

²⁸⁴ See Michael J. Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 WM. & MARY L. REV. 693, 709 (1994).

²⁸⁵ See Gerald B. Hickson et al., *Factors that Prompted Families To File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1361 (1992).

²⁸⁶ See *id.*

²⁸⁷ PHYSICIAN PAYMENT REVIEW COMM’N, ANNUAL REPORT TO CONGRESS B-19 (1995) (on file with author).

powerful use of the information asymmetry that typically exists.²⁸⁸ One study found that settlement offers were rarely made when patients used a hospital's voluntary, informal complaint process.²⁸⁹ Instead, hospitals used the process "to learn about the litigiousness of specific patients" and used "the filing of lawsuits as a hurdle that patients must overcome in order to convince the hospital that they are sufficiently litigious to justify a high settlement."²⁹⁰ Another study found that settlement of cases with severe injuries never occurred prior to the filing of a lawsuit.²⁹¹ Often the defendant makes no offer until the patient has retained an expert who will testify that the defendant breached the standard of care.²⁹² Non-litigious patients are rarely compensated – not even when the hospital believes that the patient has been injured by medical negligence.²⁹³ Their limited access to information and the hurdles that they face in obtaining attorneys and experts place injured patients at a significant disadvantage.

The civil justice system attempts to balance the scales. Claimants have the right to representation by counsel and are encouraged to use it. Contingent fees are allowed in order to give low-income patients equal access to counsel and to justice. Modern discovery rules help plaintiffs pierce the veil of secrecy surrounding the events that produced their injuries, enabling patients to obtain information from recalcitrant witnesses. In addition, parties have the right to cross-examine adverse witnesses and to offer witnesses of their own, including experts. Because patients who sue generally lack the social and political influence of the defendant doctors, the patients' rights are also protected by having the civil justice system in its own independent branch of government and by insisting that verdicts be rendered by a jury of the patients' peers. Each of these protections is likely to be weakened or eliminated in the proposed shift from civil courts to administrative health courts.

Like court-assisted discovery, the role afforded plaintiffs' counsel will be very important. Proponents of the health court plan have occasionally expressed their hope and expectation that patients will be able to resolve their claims without an attorney.²⁹⁴ They have even suggested that patients whose

²⁸⁸ See Lucian Arye Bebchuk, *Litigation and Settlement Under Imperfect Information*, 15 RAND J. OF ECON. 404, 409 (1984).

²⁸⁹ Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777, 789 (1994) (37 of 355 claims).

²⁹⁰ *Id.* at 778. These "empirical results are consistent with an information structure in which patients initially are poorly informed about the quality of medical care and the hospital initially is poorly informed about how litigious patients are." *Id.* at 806.

²⁹¹ Roger A. Rosenblatt & Andy Hurst, *An Analysis of Closed Obstetric Malpractice Claims*, 74 OBSTETRICS & GYNECOLOGY 710, 711 (1989).

²⁹² *Id.* at 712.

²⁹³ See Farber & White, *supra* note 185, at 795. The goal is to avoid settling with the "peaceful" patients who will not file suit. *Id.*

²⁹⁴ See Mello et al., *supra* note 9, at 462-63.

claims are initially rejected by an insurer will appeal their decisions to the health court without the assistance of counsel.²⁹⁵ Apparently, proponents assume the health court judge, with assistance from the court-appointed expert(s), will be able to rule fairly on the claim using the record prepared by the insurance company. This assumption is breathtakingly naïve. Physicians, hospitals, and malpractice insurers will, of course, be represented by experienced counsel and insurance adjusters. They will use this advice to design their initial claims procedures and also their strategy before the health court. Unfair overreaching will be routine if patients are not encouraged to retain counsel themselves.

Proponents would also like to cap the fees of legal counsel who represent plaintiffs. Thus, a brochure promoting health courts says that attorneys' fees will be "held to 20 percent."²⁹⁶ No similar cap is proposed for the fees of defense counsel.²⁹⁷ This proposal is presumably premised on the assumption that plaintiffs' attorneys will have far less work to do in the new regime and, thus, will be unable to justify their high contingent fees. However, the process of investigating and proving a malpractice claim is unlikely to become so inexpensive and risk-free that experienced and successful plaintiffs' attorneys will be willing to stay in a field that offers them zero payment when they lose and only 20% when they win. Thus, a cap will likely diminish the quality of lawyers willing to represent malpractice plaintiffs and reduce the thoroughness of representation provided by these attorneys.²⁹⁸ Counsel will be less likely to accept cases that require substantial investigation to evaluate their merits. Caps on attorneys' fees, in short, would be unjust to injured patients. If justice is the goal, then thorough representation by experienced counsel should be strongly encouraged.

Finally, the parties should be permitted to call a limited number of their own experts. The physicians asked to serve as court-appointed experts are likely to use their own clinical practices as the benchmark against which others should be judged.²⁹⁹ Occasionally, however, their personal clinical choices will not coincide with the "best practices" required by the "avoidability" standard of care.³⁰⁰ Hearing multiple expert opinions will help the trial judge construct a

²⁹⁵ See *id.* at 465.

²⁹⁶ COMMON GOOD INST., AN URGENT CALL FOR SPECIAL HEALTH COURTS 6 (2005), available at <http://cgood.org/assets/attachments/130.pdf>.

²⁹⁷ See generally Mello et al., *supra* note 9.

²⁹⁸ Patricia Munch Danzon & Lee A. Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. LEGAL STUD. 345, 363 (1983).

²⁹⁹ See William Meadow, *Operationalizing the Standard of Medical Care: Uses and Limitations of Epidemiology To Guide Expert Testimony in Medical Negligence Allegations*, 37 WAKE FOREST L. REV. 675, 676 (2002) (calling this "so obvious as to almost go without saying"); Tim Cramm et al., *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 711 (2002) (stating that physicians do this "covertly").

³⁰⁰ Meadow, *supra* note 299, at 688.

more accurate and sophisticated picture of existing medical opinion. In addition, the risk that court-appointed experts will be biased in favor of their fellow physicians provides an independently sufficient reason to allow plaintiffs to call a limited number of expert witnesses.

4. Synthesis

Health courts should not be created until the sponsors provide concrete assurances that such courts will employ procedures like those used in full Article I administrative courts. These protections should include the opportunity to do meaningful discovery, to present witnesses (including at least one expert on liability) and to cross-examine all adverse witnesses including court-appointed experts. It is impossible to overstate the importance of these provisions. Without these safeguards, the transfer of medical malpractice claims to a streamlined administrative tribunal will undo a century of judicial reforms designed to insure cases are decided on the merits.

Unfortunately, this level of procedural protection will substantially reduce the time and cost savings proponents hope health courts will provide.³⁰¹ If reformers want a considerably faster and less adversarial process, they will need to eliminate the element of fault. In a no-fault system, like first-party disability insurance and third-party workers' compensation coverage, claimants need not prove that their injuries were caused by anyone else's fault.³⁰² Foregoing proof of fault eliminates protracted litigation to determine the appropriate standard of care, which often requires deposing multiple experts scattered across the country.³⁰³ A no-fault system also eliminates the extended fact-finding often necessary to determine which provider, if any, failed to comply with that standard.³⁰⁴ Eliminating litigation over the issue of fault makes large administrative savings possible. But as long as litigation over the issue of fault is retained, only a very modest amount of streamlining will be possible.

The accuracy and fairness of a health court regime will turn heavily on the procedural protections that it incorporates. The stronger the procedural protections, the stronger the claim that health courts provide a fair alternative to civil courts. Although including these safeguards will reduce the cost savings achieved, their inclusion will repay those financial costs with superior justice.

D. *Producing More Consistent Damage Awards Through Scheduling*

The health court proposal creates a schedule for pain and suffering damages which calibrates the size of the plaintiff's recovery for non-economic harm to

³⁰¹ However, an argument could certainly be made for a separate, more simplified process for the handling of small claims.

³⁰² See *supra* note 52 and accompanying text.

³⁰³ See Keeton, *supra* note 53, at 594.

³⁰⁴ See *id.*

match the severity of her injuries.³⁰⁵ This reform has the potential to greatly improve the consistency and horizontal fairness of damage awards because like cases would be treated more alike.³⁰⁶ While lawmakers could simply impose this reform onto the existing court structure, that idea currently has little legislative support. As a result, the health courts proposal would provide a welcome opportunity to test the idea.

In addition, a damages schedule would satisfy critics who think that a ceiling must be set on pain and suffering recovery in order to prevent "excessive" awards.³⁰⁷ Unlike state tort reforms that impose a single pain and suffering cap for all injuries, however, a damages schedule would account for severity.³⁰⁸ This is a considerable improvement.

Nevertheless, the task of producing the schedule will be fraught with all the difficulties that have bedeviled the drafters of uniform sentencing laws. Hard decisions will need to be made about the criteria to consider when classifying the severity of injuries, the amount of damages to allow for each classification, and the permissibility of departing entirely from the approved verdict range in extreme or unique cases. Too little discretion creates the risk that materially different cases will be treated as if they were alike. Too much discretion introduces the risk that awards will vary considerably from judge to judge. The most troubling danger a damages schedule poses is the risk that the level of damages will be unconscionably low. The woefully incomplete recoveries provided under most state workers' compensation plans illustrate the danger.³⁰⁹ Drafters should therefore base their initial schedules on the size of jury awards in cases with similar injuries and then include an annual inflation adjustment.

Even then, however, the adequacy of these awards will be vulnerable to erosion every time physicians march on the state capital. Surprisingly, the authors of the health court plan seem to anticipate and welcome this kind of revision: through periodic legislative assessment, they state, "we can ensure that the amount we spend on medical injury compensation matches social judgments about how much we should be spending."³¹⁰ This is a genuinely frightening idea that completely misunderstands the role and function of compensatory damages.

³⁰⁵ See Mello et al., *supra* note 9, at 468 (crediting a damages proposal by Bovbjerg, Sloan, and Blumstein in 1989).

³⁰⁶ E.g., David W. Leebron, *Final Moments: Damages for Pain and Suffering Prior to Death*, 64 N.Y.U. L. REV. 256, 259 (1989) (arguing that awards for pain and suffering vary significantly and inexplicably).

³⁰⁷ See, e.g., Mello et al., *supra* note 9, at 467-68.

³⁰⁸ *Id.* at 468, 470.

³⁰⁹ See Joanne Doroshow, *The Health Courts Facade*, 42 TRIAL 20, 22 (2006) (explaining that these plans fail to fully compensate even for lost pre-injury income and lamenting that statutory damage schedules are subject to reduction over time by legislation).

³¹⁰ Mello et al., *supra* note 9, at 470.

As with other tort recoveries, malpractice awards are designed to accomplish corrective justice by making the negligently injured patient whole. Judges and juries resolving tort disputes decide whether the costs associated with an injury should be born by the injured individual or by the person who caused the injuries. When the harm has been caused by someone's negligence, then our norms and laws currently dictate that the negligent party should bear the loss, rather than an innocent victim. Capping recovery below full compensation would unfairly shift the costs of health care accidents away from the individuals and organizations that negligently cause them and onto the innocent patients who suffer them. By capping recovery, a damages schedule would force negligently injured patients to subsidize health care costs for the rest of us, producing both an underinvestment in safety and unfair allocation of accident costs. As long as the system is fault-based, physicians ought to make their innocent victims whole, at least insofar as the harm caused can be fairly ascertained in monetary terms.

The risk that damage levels will be set far too low casts a shadow on an otherwise worthy idea. Despite the difficulty of the task, however, the potential benefits of a damages schedule justify a pilot experiment. A final verdict on this reform must await concrete details about the size and basis of the contemplated awards.

E. *The Likelihood of Spurring Improvements in Patient Safety*

Proponents of the Common Good health court plan strongly believe that the shift from trial courts to health courts will lead to significant improvements in the safety of medical care.³¹¹ Indeed, patient safety is the benefit that they emphasize most.³¹² This emphasis is not misplaced. Several of the proposed changes have the potential to improve patient safety. These include the adoption of a new and tougher standard of care, the centralized collection of accident data, and the production of clearer *ex ante* standards of care.³¹³ However, the plan is unlikely to deliver the safety benefit that patient safety advocates covet most – greater physician disclosure of errors.³¹⁴ To accomplish that fundamental objective will require either an increase in the willingness of physicians to participate in organization-wide safety efforts or the adoption of hospital enterprise liability – perhaps both.

Courts and legal scholars have long assumed the threat of malpractice liability gives physicians a concrete incentive to provide competent care.³¹⁵ Despite several attempts to detect a deterrent impact there is no reliable

³¹¹ See, e.g., *id.*

³¹² *Id.*; *Innovative Solutions to Medical Liability*, *supra* note 7, at 45 (statement of Paul Barringer, General Counsel, Common Good).

³¹³ Mello et al., *supra* note 9, at 468-71.

³¹⁴ See Hickson et al., *supra* note 285, at 1361-62.

³¹⁵ See Mello & Brennan, *supra* note 62, at 1597-98.

evidence to substantiate this assumption.³¹⁶ Though these efforts are beset with methodological obstacles, it is nonetheless both disappointing and telling that no reliable evidence of safety improvements has surfaced.³¹⁷

There are probably several explanations for the weakness of deterrence in the field of medical malpractice. First, physicians buy malpractice insurance to insulate themselves from tort damages. Because their premiums are not ordinarily experience-rated,³¹⁸ this insurance immunizes them from the direct consequences of a jury award. Second, very few negligently injured patients file claims, diluting the legal incentive to adopt best practices.³¹⁹ Third, the judicial system fails to give doctors clear guidance about the clinical practices that will satisfy the legal standard of care, making it difficult for them to comply even if they want to do so.³²⁰ Finally, and most importantly, most physicians believe that the odds of being sued are unrelated to the quality of treatment provided and the legal system does not recognize or exonerate the practice of good medicine.³²¹ Given the lack of concrete evidence that malpractice liability leads to improvements in patient safety and the widespread uncertainty about what the law requires, policy makers are obliged to take seriously the claim that health courts can do better.

The Institute of Medicine goes further, arguing not only that malpractice law fails to encourage good medicine, but also that it discourages physician cooperation with patient safety initiatives.³²² Patient safety advocates persuasively argue that open discussion of errors is a necessary precursor to systematic safety improvements.³²³ They believe the fear of lawsuits discourages doctors from disclosing their own errors and participating in these discussions.³²⁴ In addition, the perception that lawsuits are random makes it hard to convince physicians that safety initiatives will pay legal dividends.³²⁵ These realities have prompted most patient safety advocates to conclude that

³¹⁶ See *id.*

³¹⁷ See *id.* at 1607-13.

³¹⁸ *Id.* at 1616.

³¹⁹ *Id.* at 1618. In addition, the combination of a very low claims rate among people with valid claims and a high number of baseless claims sends a distorted deterrence signal to providers. *Id.* at 1620. Moreover, insufficient claiming insufficiently internalizes for physicians the damages caused by poor medicine. *Id.*

³²⁰ See Mello et al., *supra* note 9, at 469.

³²¹ See Mello & Brennan, *supra* note 62, at 1619 (discussing the “incredibly small overlap between the group of patients injured by negligence and the group who brought suit”).

³²² INST. OF MED., TO ERR IS HUMAN 43 (2000).

³²³ Mello et al., *supra* note 9, at 472 (“[H]onesty about potential problems will both promote overall discussion and reiterate to the professional that the patient’s well-being is the first objective.”).

³²⁴ *Id.* at 473.

³²⁵ See WEILER ET AL., *supra* note 8, at 129.

malpractice reform is an essential predicate to fundamentally improving patient safety.³²⁶

To rebut this argument, opponents of malpractice reform typically point to the dramatic safety improvements made in anesthesiology over the past twenty years.³²⁷ They cite these improvements as proof that the incentives created by malpractice liability can and do improve patient safety.³²⁸ Premiums in that specialty went from the high end of the industry to the low end as the result of a concerted effort to reduce both accidents and lawsuits.³²⁹

The transformation of anesthesiology was certainly a splendid illustration of tort's deterrent power. Sadly, it is also a rare one. Furthermore, that transformation would not have taken place if the Harvard teaching hospitals had not adopted a voluntary version of enterprise liability. Part III explains why enterprise liability is far more likely to lead to safety improvements than individual liability. Individual physician liability has yet to produce any similarly striking examples of malpractice-motivated patient safety improvement.

The health court plan proposes to end this drought not by incorporating enterprise liability, but by making several other changes to existing tort law. The first is a shift in the standard of care from customary medical practice to state-of-the-art practice.³³⁰ The drafters call this standard an "avoidability" standard because it will allow recovery by all patients whose injuries could have been avoided by the use of best practices.³³¹ Second, health courts will provide physicians with better ex ante guidance about the clinical practices that are required by the new standard of care, making it easier for physicians to respond appropriately to tort law's incentives.³³² Third, sponsors believe that the simplified claims process associated with their plan will make claiming easier and, thus, make malpractice law's deterrent signal more robust.³³³ Fourth, proponents believe reliance on specialized judges and neutral experts will erode physicians' fears about undeserved liability and, thus, lead them to more openly discuss their medical mistakes and to cooperate with system-wide

³²⁶ Mello et al., *supra* note 9, at 470-71.

³²⁷ John H. Eichhorn et al., *Standards for Patient Monitoring During Anesthesia at Harvard Medical School*, 256 JAMA 1017, 1020 (1986).

³²⁸ See *id.*

³²⁹ See *infra* text accompanying notes 406-411.

³³⁰ *Innovative Solutions to Medical Liability*, *supra* note 7, at 43-47 (statements of James M. Wootton & Paul Barringer).

³³¹ *Id.* at 43, 46, 47 (statements of James M. Wootton & Paul Barringer). That label is used because it imposes liability whenever the injuries suffered by the patient could have been avoided using state-of-the-art practices. Mello et al., *supra* note 9, at 474.

³³² *Innovative Solutions to Medical Liability*, *supra* note 7, at 47 (statements of James M. Wootton & Paul Barringer).

³³³ *Id.* at 46 (statements of James M. Wootton & Paul Barringer).

efforts to prevent medical accidents.³³⁴ Finally, the claims data that will be gathered by the health court can be used to detect recurring problems and to design ways to prevent them.³³⁵ Each of these potential improvements will be addressed in turn.

1. The Avoidability Standard of Care

The proposed change from a custom-based standard of care to a state-of-the-art standard is intended to raise the level of quality that physicians expect of themselves.³³⁶ Proposing this change was politically brave; studies repeatedly show that practicing physicians are slow to adopt important improvements in treatment.³³⁷ However, the new standard's clinical effect will likely be tempered by one of the obstacles that also limits the deterrent effect of existing malpractice law. Under the health courts plan, individual physicians will bear liability, rather than the larger health care enterprises in which physicians function.³³⁸ Yet, liability insurance for physicians is not experience-rated.³³⁹ As a result, the legal incentive for physicians to raise their level of practice will be tempered significantly. While the proposed "avoidability" standard is a welcome reform, its impact on clinical practices and patient safety is likely to be tempered by these shortcomings.

2. Better Ex Ante Guidance

The health court plan aims to improve patient safety by giving practicing physicians a clearer idea of the clinical practices that will satisfy the legal standard of care.³⁴⁰ Physicians will then be able to conform their practices to the legal standard, producing both state-of-the-art medical care and a marked reduction in malpractice exposure.³⁴¹ Several features of health courts are intended to contribute to this goal.³⁴² One is that all health court decisions will be published and will be binding precedents in future cases.³⁴³ These past decisions will provide physicians with valuable guidance about the way similar

³³⁴ See Mello et al., *supra* note 9, at 472-73.

³³⁵ *Innovative Solutions to Medical Liability*, *supra* note 7, at 46 (statements of James M. Wootton & Paul Barringer).

³³⁶ See John E. Wennberg & Philip G. Peters, Jr., *Unwarranted Variations in the Quality of Health Care: Can the Law Help Medicine Provide a Remedy/Remedies?*, 37 WAKE FOREST L. REV. 925, 938 (2002).

³³⁷ See, e.g., *id.* at 927-28 (citing as an example the systematic under use of beta-blockers).

³³⁸ See, e.g., Johnson et al., *supra* note 47, at 1387 & n.116.

³³⁹ See Mello & Brennan, *supra* note 62, at 1617-18.

³⁴⁰ See Mello et al., *supra* note 9, at 461.

³⁴¹ See *Innovative Solutions to Medical Liability*, *supra* note 7, at 46-47 (statement of Paul Barringer).

³⁴² See Mello et al., *supra* note 9, at 468-69.

³⁴³ *Id.* at 465.

cases will be decided in the future. By contrast, jury verdicts come with no explanation and, at any rate, do not bind future juries. In addition, all malpractice cases in a given jurisdiction will be decided by a single judge or set of judges.³⁴⁴ More consistent and predictable outcomes may well result. Finally, the sponsors also propose that health courts give more weight to specialty board practice guidelines than trial courts currently do.³⁴⁵ Together, these features could make it easier for practicing physicians to discern the standard of care in advance and to match their behavior to it.

3. Claiming by More Victims of Negligence

Health courts could also improve deterrence by increasing the number of claims made by deserving patients. Proponents believe that simplification of the claims process will produce more claims, thus strengthening the deterrent signal.³⁴⁶ Once again, the authors of the health court proposal deserve to be congratulated for honestly addressing a serious shortcoming of the current system, even though doing so could cost them some support from physicians. As the earlier discussion of under-claiming explained,³⁴⁷ however, any net increase in claiming and recovery by negligently-injured patients is likely to be modest because the elimination of recovery for expenses paid by collateral sources will make the claims process less attractive and less realistic for many injured patients.³⁴⁸

4. Centralized Data Collection

Specialized health courts would also improve patient safety by creating a central repository of information about iatrogenic injury.³⁴⁹ Malpractice claims files could provide public health researchers with detailed information about the kinds of injuries and clinical practices that most often produce significant iatrogenic injury. These data could then be examined to identify root causes and fix them. No similar data bank currently exists in the United States. Although the national hospital accrediting agency, several states, and a

³⁴⁴ See *Innovative Solutions to Medical Liability*, *supra* note 7, at 46-47 (statement of Paul Barringer).

³⁴⁵ See *id.* at 47.

³⁴⁶ Mello et al., *supra* note 9, at 471. This rosy scenario also seems to assume that patients will be better able to sort legitimate claims from unwarranted ones. Otherwise, the extra claims would simply produce more static. It is not clear why this would be so, unless we assume that physicians and nurses will guide patients' decisions. I explain in the text why this is unlikely to occur as long as providers risk individual liability. The new standard of care will, of course, mean that an unknown fraction of currently marginal or weak claims will become legally compensable.

³⁴⁷ See *supra* text at notes 175-187.

³⁴⁸ See *supra* text at notes 175-187.

³⁴⁹ See Mello et al., *supra* note 9, at 476.

number of hospitals have their own reporting requirements,³⁵⁰ none have been able to generate the volume of data desired by patient safety advocates.³⁵¹

Public health researchers are understandably hungry to collect these data. Better information about the causes of medical injury will improve patient safety. Because most doctors are unwilling to disclose their medical accidents and errors voluntarily,³⁵² the lawsuits filed against them could provide a useful substitute.

However, the usefulness of these data should not be overstated. It will only shed light on the small subset of negligently-inflicted injuries that result in the filing of a claim for damages. This is a notoriously tiny and unrepresentative subset of iatrogenic injuries and it contains no information whatsoever about practices that commonly produce “near-misses.” Still, similar data have apparently been useful in other countries.³⁵³ As a result, it is possible that this data set could be used to reduce iatrogenic injuries here.

5. Fostering Disclosure by Physicians

It seems reasonable to assume that creating a new health court system could initially reduce physician anxiety about the fairness of malpractice adjudication. Specialized judges would replace juries.³⁵⁴ Court-appointed, independent medical experts would either replace or supplement experts hired by the parties.³⁵⁵ Credible practice guidelines would be given binding authority.³⁵⁶ Written judicial decisions would provide concrete guidance for future clinical practice.³⁵⁷ Damages would be capped.³⁵⁸ All of these things could improve physician confidence. The sponsors of the health courts proposal hope this confidence will lead to greater physician participation in safety improvement efforts, including more open disclosure of errors.³⁵⁹

Health court backers also believe the new “avoidability” standard of care will make it easier for physicians to talk about their mistakes.³⁶⁰ When patients sue, they will merely allege that an “avoidable” injury occurred, not

³⁵⁰ See *Innovative Solutions to Medical Liability*, *supra* note 7, at 44, 54, 55, 76 (statements of Paul Barringer, Margaret VanAmringe, and Joanne Doroshow); WEILER ET AL., *supra* note 8, at 33-59.

³⁵¹ See *Innovative Solutions to Medical Liability*, *supra* note 7, at 44, 54, 55.

³⁵² See *id.* at 27.

³⁵³ See Mello et al., *supra* note 9, at 478-82 (contending that benefits have accrued in other countries which have adopted administrative claims processes).

³⁵⁴ *Id.* at 464.

³⁵⁵ *Id.* at 465.

³⁵⁶ *Id.* at 461, 471.

³⁵⁷ *Id.* at 465.

³⁵⁸ *Id.* at 467-68.

³⁵⁹ *Id.* at 472-74.

³⁶⁰ See *id.* at 474.

that the physician was negligent or incompetent.³⁶¹ Because the “avoidability” standard lacks any explicit reference to culpability – indeed, it lacks any moral connotation whatsoever – patient safety advocates hope that it will produce less psychological resistance to the disclosure of bad outcomes.³⁶² Supporters also believe that specialized health courts, by virtue of their expertise, will reduce the nearly universal distrust that physicians have towards the system of justice.³⁶³ This distrust produces a culture of defensiveness that impedes efforts to improve quality.³⁶⁴ Consequently, health court backers believe that physician resistance to the open disclosure of accidents and near misses will loosen substantially once their liability is governed by the proposed health court plan.³⁶⁵

Sadly, these hopes are unlikely to bear fruit. Health court advocates ignore strong evidence that a far more dramatic transformation in either physician culture or malpractice doctrine will be necessary to prompt physicians to talk freely about their mistakes.³⁶⁶ Yet, health court advocates hardly waited for the ink to dry on this law before ramping up their efforts to enact health court legislation.³⁶⁷ This impatience suggests deep pessimism about the likelihood that the new safe harbor for safety discussions will shake physicians out of their fortress mentality.

The most powerful evidence supporting this pessimistic conclusion is the failure of the Patient Safety and Quality Improvement Act³⁶⁸ to remedy the nondisclosure problem. In its exhaustive and crucial study of medical mistakes, *To Err Is Human*,³⁶⁹ the Institute of Medicine concluded medicine would not enjoy the degree of disclosure necessary for substantial improvements in patient safety until practicing physicians were certain their disclosures could not be used against them by tort plaintiffs.³⁷⁰ As a result, the first legal reform requested by the patient safety movement was legislation to

³⁶¹ See *id.*

³⁶² See *id.* It is also possible that an adverse verdict under the new standard will not lead to the same harmful professional consequences associated with a finding of negligence. *Id.*

³⁶³ *Medical Liability: New Ideas for Making the System Work Better for Patients*, *supra* note 7, at 41, 42 (statement of Philip K. Howard).

³⁶⁴ Mello et al., *supra* note 9, at 473.

³⁶⁵ *Id.* at 473-74.

³⁶⁶ Thomas H. Gallagher et al., *Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1585, 1591-92 (2006) [hereinafter Gallagher et al., *Choosing Your Words Carefully*].

³⁶⁷ Congress passed the Patient Safety Quality Improvement Act in 2005. Pub. L. No. 109-41, 119 Stat. 424 (codified at 42 U.S.C.A. §§ 299b-22 to 299c (2007)). A revamped Health Courts proposal came out the next year. See generally Mello et al., *supra* note 9.

³⁶⁸ Pub. L. No. 109-41.

³⁶⁹ INST. OF MED., TO ERR IS HUMAN (2000).

³⁷⁰ *Id.* at 87.

make these disclosures confidential.³⁷¹ Congress promptly responded, giving physicians precisely the assurances they had requested.³⁷² Yet, the new law did not solve the problem of physician silence; frustrated patient-safety advocates are now searching for a better way to make physicians talk.³⁷³

This failure is hardly surprising. Medical sociologists and psychologists have found that physicians have difficulty recognizing their own errors, much less disclosing them to others.³⁷⁴ Errors threaten physicians' self-esteem and potentially expose them to peer stigma and loss of autonomy and authority.³⁷⁵ Even before modern malpractice litigation emerged in the 1960s, those dangers made physicians very reluctant to report mishaps.³⁷⁶ Interestingly, these professional barriers also operate in countries where malpractice litigation has not expanded like ours. Canadian physicians, for example, are sued approximately one quarter as frequently as American doctors.³⁷⁷ Yet, Canadian physicians are only somewhat more supportive of disclosing serious errors to patients than U.S. physicians are,³⁷⁸ and they are no more likely to report having actually disclosed any.³⁷⁹ When patients from the two countries were asked about disclosure, they were equally likely to report that their doctors failed to disclose a medical mistake.³⁸⁰ The researchers concluded that "US tort reform, while potentially desirable for other reasons, may have limited effect on physicians' disclosure attitudes and practices" because "the malpractice environment may not be the major determinant" of physician reluctance to disclose.³⁸¹ Instead, disclosure practices "may relate to the norms, values, and practices that constitute the culture of medicine."³⁸²

It will take more than a specialized, nonjury tribunal to transform physician disclosure practices. Ideally, the change will be triggered by a paradigm shift in medical culture.³⁸³ In order for a legal reform to have that effect, it will

³⁷¹ See 42 U.S.C.A. §§ 299b-22 to 299c (2005).

³⁷² See *Id.* § 299b-22.

³⁷³ See generally Mello et al., *supra* note 9.

³⁷⁴ See, e.g., Ralph Peeples, Catherine T. Harris & Thomas Metzloff, *Settlement Has Many Faces: Physicians, Attorneys, and Medical Malpractice*, 41 J. HEALTH & SOC. BEHAV. 333, 341 (2000).

³⁷⁵ Gallagher et al., *Choosing Your Words Carefully*, *supra* note 366, at 1585.

³⁷⁶ See Mello et al., *supra* note 9, at 473.

³⁷⁷ Thomas H. Gallagher et al., *US and Canadian Physicians' Attitudes and Experiences Regarding Disclosing Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1605, 1606 (2006) [hereinafter Gallagher et al., *US and Canadian Physicians*].

³⁷⁸ *Id.* at 1609.

³⁷⁹ *Id.* at 1605, 1607.

³⁸⁰ Gallagher et al., *Choosing Your Words Carefully*, *supra* note 366, at 1592.

³⁸¹ Gallagher et al., *US and Canadian Physicians*, *supra* note 377, at 1609.

³⁸² *Id.*

³⁸³ Gallagher et al., *Choosing Your Words Carefully*, *supra* note 366, at 1592. 50% of physicians deny that systemic errors cause most medical errors. See Gallagher et al., *US*

need to offer physicians considerably greater insulation from liability costs than health courts do. Something like exclusive hospital enterprise liability will be needed if we really want physicians to talk openly about errors. Even then, however, the psychological, cultural, and professional costs associated with disclosure will continue to make disclosure painful. Given that reality, the shift from jury trials to specialized health courts simply will not be sufficient to produce a material change in physician disclosure, no matter how benign the label given to the new standard of care.³⁸⁴

6. Synthesis

Several provisions in the health court plan could potentially improve patient safety. Most promising among them are the state-of-the-art standard of care, the centralized collection of data on medical accidents, and clearer ex ante standards of care. However, the deterrence benefits expected from the simplified claims procedure will likely be offset by the disincentives to claiming associated with abrogation of the collateral source rule. Furthermore, health courts are unlikely to lead to more robust disclosure of medical errors by physicians. That change will require either a major transformation of physician culture or adoption of hospital enterprise liability – perhaps both.

III. THE ADVANTAGES OF ENTERPRISE LIABILITY

The most disappointing aspect of the health courts proposal is not what it includes, but what it omits. Hospital enterprise liability has far more potential to significantly improve patient safety than does any aspect of the current health court plan. Enterprise liability is also more likely than health courts are to reduce the extraordinary fear and anger that physicians feel today. As a result, enterprise liability is truly the elephant in the room.

Enterprise liability would change existing law by making hospitals vicariously liable for the torts of physicians working within the hospital.³⁸⁵ Today, physicians who are not hospital-based are ordinarily treated as

and Canadian Physicians, *supra* note 377, at 1610. Others studies have confirmed the widespread perception that physicians resist the modern tools of quality improvement such as outcome reviews, data sharing, and collective design of safer systems. Anne-Marie J. Audet et al., *Measure, Learn, and Improve: Physicians' Involvement in Quality Improvement*, 24 HEALTH AFF. 843, 850 (2005); see also Michael D. Cabana et al., *Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement*, 282 JAMA 1458, 1458 (1999); Arnold Milstein & Nancy E. Adler, *Out of Sight, Out of Mind: Why Doesn't Widespread Clinical Quality Failure Command Our Attention?*, 22 HEALTH AFF. 119, 124 (2003).

³⁸⁴ Under a health courts regime, physicians would still buy their liability insurance and would still be individually liable for injuries they inflict. Their disclosures of error to hospital or national quality improvement programs would be no more confidential than they already are.

³⁸⁵ Newhouse & Weiler, *supra* note 61, at 81.

independent contractors, rather than as agents or employees of the hospital.³⁸⁶ Hospitals therefore escape vicarious liability for the errors of most attending physicians.

In most other fields of tort law, such as manufacturer liability for defective products and merchant liability for slip-and-fall accidents, the business entity that delivers the services is vicariously liable for the errors of its workforce.³⁸⁷ Home gardeners who are hurt by a defective weed-eater sue the manufacturer, not the assembly line worker whose mistake caused the malfunction. Shoppers who fall on a slippery floor in the grocery store typically sue the store, not the janitor. In the rare instances when individual workers are named in lawsuits, their employers routinely represent them and hold them harmless.³⁸⁸ Liability for individual error is not merely shared by the worker with the enterprise; it is shifted entirely from the individual to the larger business entity.

Health care has always been different. Unlike assembly line workers and even highly-trained professionals like airline pilots, physicians have historically been treated by the law as independent contractors, not as employees.³⁸⁹ Physicians have long favored this categorization because they value the independence associated with this status.³⁹⁰ A century ago, when physicians feared that corporate employment of physicians would threaten the prevailing model of private practice, they successfully lobbied for enactment of “corporate practice” prohibitions.³⁹¹ They have resisted corporate influence ever since – most recently in their successful alliance with patients to limit the power of managed care organizations.³⁹² However, their independence has a cost. It seems reasonable to suspect that physicians are named as defendants far more often than people who work in most other trades or professions.

Health care’s unique structural arrangements produce two significant drawbacks that are relevant here. First, hospitals do not have the same legal incentive to minimize accidents that other businesses do, like airlines and auto manufacturers.³⁹³ Second, the absence of exclusive organizational liability

³⁸⁶ See FURROW ET AL., *supra* note 155, at 374-76. Some, but not all, states have begun to impose vicarious liability on hospitals for the conduct of physicians who are exclusively hospital-based and who are selected by the hospital, rather than the patient – such as many emergency medicine doctors and anesthesiology departments – using a theory of ostensible or apparent agency. *Id.* at 377-78. However, that legal theory won’t support liability for the torts of physicians who are chosen by patients outside of the hospital. *Id.* at 376.

³⁸⁷ See, e.g., DAN B. DOBBS, THE LAW OF TORTS 910-17 (2000) (explaining that the negligence must occur within the scope of employment).

³⁸⁸ I base this statement on my experience as a tort defense attorney.

³⁸⁹ See FURROW ET AL., *supra* note 155, at 374, 376; see also DOBBS, *supra* note 387, at 917.

³⁹⁰ 2 AM. LAW INST., REPORTERS’ STUDY, *supra* note 51, at 125-26.

³⁹¹ See Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 445-46 (1988).

³⁹² *Id.*

³⁹³ See 2 AM. LAW INST., REPORTERS’ STUDY, *supra* note 51, at 118 n.14.

deprives physicians of the buffer protecting most workers from the financial and emotional burdens of being a target defendant.³⁹⁴ Predictably, practicing physicians bear an animosity toward tort law and plaintiffs' lawyers that is unmatched in any other trade or profession.

Juxtaposed against this history of individualism is the emphasis today's patient safety advocates place on building safer medical systems, rather than focusing exclusively on the performance of individuals. Safety advocates believe that the greatest improvements in patient safety will come from greater attention to the processes by which health care is delivered.³⁹⁵ They point out that a large fraction of the injuries that occur in hospitals are due to system breakdown.³⁹⁶ Greater attention to the system of delivery, rather than individual errors, would enable hospitals and safety researchers to identify those stages of the process at which errors are most common and to redesign those stages to make errors both less common and more swiftly corrected. Accomplishing this objective requires both the capacity and the willingness to look at the entire delivery system, from patient arrival to patient departure. Hospitals are better situated to accomplish this than individual physicians.³⁹⁷ Yet, today's system of individual physician liability greatly reduces the hospital's legal incentive to take the necessary steps and then weather the inevitable backlash from physicians about interference with their discretion. Exclusive hospital enterprise liability could produce that incentive.³⁹⁸

The existing hole in the law governing medical accidents not only limits its deterrent effect, but also impairs its ability to justly compensate patients whose accidents were avoidable. As long as physician liability is an individual matter, patients who are injured in medical accidents that could have been avoided through state-of-the-art cooperation between the providers and the hospital will continue to lack a legal remedy. Enterprise liability will close that hole.

In addition, the deterrent effect of enterprise liability is less subject to dilution by the purchase of liability insurance than is individual physician

³⁹⁴ See *id.* at 121.

³⁹⁵ See Mello & Brennan, *supra* note 62, at 1623.

³⁹⁶ See *id.*

³⁹⁷ Hospital enterprise liability is, therefore, consistent with models favored by legal economists, like Guido Calabresi, who suggested that the law should impose liability on the party best positioned to see safety issues, including the relevant trade-offs, and to take appropriate measures to prevent accidents or to induce others to prevent accidents. See GUIDO CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 135-73 (1970). He called parties in this position "the cheapest cost avoiders." *Id.* at 135 n.1. Hospitals undoubtedly play this role in the delivery of in-patient health care.

³⁹⁸ There is limited empirical evidence suggesting that hospitals are more responsive than physicians to the deterrence signals transmitted by tort law. See Troyen A. Brennan, *The Role of Regulation in Quality Improvement*, 76 MILBANK Q. 709, 721 (1998).

liability. Hospitals, unlike individual physicians, can be experience-rated.³⁹⁹ Experience-rating creates a powerful incentive to reduce accidents. In the field of workers' compensation insurance, for example, it has reduced the number of workplace fatalities by more than 25%.⁴⁰⁰ Health care causes far too many accidental injuries to waste this potential.

Enterprise liability would also more optimally use the resources that hospitals can bring to the patient-safety mission. Michelle Mello and Troyen Brennan offered the following frank assessment: "only institutions can muster the resources to bring about systematic improvements in patient safety."⁴⁰¹ Enterprise liability would give institutions an incentive to do so.

Other industries, like aviation and automobile manufacture, have responded to this incentive by making extraordinarily successful use of modern quality improvement theory and its emphasis on systems design, rather than individual fault.⁴⁰² Each has focused on system-wide strategies such as better monitoring of errors, thorough data analysis, examination of hand-offs and multi-person processes, and the accommodation of foreseeable human error.⁴⁰³ As a practical matter, each of these industries operates under the incentives of a system in which the enterprise bears all of the costs of legal liability. Thus, "no-one expects that the pilots or machinists working for an airline firm would personally pay a substantial premium for insurance against their own instances of careless behavior."⁴⁰⁴ By contrast, "roughly three-quarters of all malpractice claims are now brought against physicians and other individual providers."⁴⁰⁵

Enterprise liability's deterrent power is most poignantly illustrated by the miraculous reduction in anesthesia accidents that occurred at the end of the twentieth century. It happened because all of the physicians in Harvard Medical School's Department of Anesthesia were insured by Harvard's own medical malpractice insurance company.⁴⁰⁶ Anxious to bring down the payouts being made for injuries occurring in the anesthesia departments of Harvard's nine teaching hospitals, the insurer's risk managers asked the

³⁹⁹ 2 AM. LAW INST., REPORTERS' STUDY, *supra* note 51, at 123-24; Mello & Brennan, *supra* note 62, at 1617-18, 1633.

⁴⁰⁰ 2 AM. LAW INST., REPORTERS' STUDY, *supra* note 51, at 506-07 (citing MICHAEL J. MOORE & W. KIP VISCUSI, COMPENSATION MECHANISMS FOR JOB RISKS: WAGES, WORKERS' COMPENSATION, AND PRODUCT LIABILITY 133-35 (1990)); see also JOSEPH V. REES, REFORMING THE WORKPLACE: A STUDY OF SELF-REGULATION IN OCCUPATIONAL SAFETY 72-80, 114-18 (1988) (offering a case study in the influence of workers' compensation premiums and employer safety policy).

⁴⁰¹ Mello & Brennan, *supra* note 62, at 1623.

⁴⁰² *Id.*

⁴⁰³ Leape, *supra* note 205, at 1855 (discussing the aviation industry).

⁴⁰⁴ 2 AMERICAN LAW INSTITUTE, REPORTERS' STUDY, *supra* note 51, at 118 n.14.

⁴⁰⁵ *Id.* at 115.

⁴⁰⁶ See generally John H. Eichhorn et al., *supra* note 327.

hospital's anesthesiologists to investigate why their collective experience was so poor.⁴⁰⁷ The group devised new techniques and equipment to lower the risk of mishap.⁴⁰⁸ At the same time, high malpractice premiums and bad publicity prompted the American Society of Anesthesiologists to do an intensive study of the causes of anesthesia-related injuries and to develop better protocols.⁴⁰⁹ The improved standards and tools that resulted from these combined efforts have since become standard across the country.⁴¹⁰ As a result, mortality rates dropped from 1 in 10,000-20,000 to 1 in about 200,000, a ten- to twenty-fold improvement.⁴¹¹ Liability insurance premiums for the specialty of anesthesiology went from being among the highest in medicine to among the lowest.⁴¹²

The successful transformation of anesthesiology was prompted in significant part by the de facto system of exclusive enterprise liability operating at the Harvard medical facilities. Like most medical schools, Harvard protected its physicians from the threat of liability by purchasing insurance on their behalf.⁴¹³ Having done so, Harvard had a strong incentive to look for ways to bring down the cost of that insurance. The fruits of this incentive are harvested each time a patient awakens from anesthesia unharmed.

The benefits to be gained from enterprise liability are also suggested by the identity of the institutional leaders in the patient safety movement. Many promising safety initiatives are led by hospitals and managed care organizations which already operate under a system of de facto exclusive enterprise liability.⁴¹⁴ For example, the Wall Street Journal recently reported that the Veterans Administration and managed-care giant Kaiser Permanente are leading an effort to improve diagnostic accuracy by using new tools, like computer decision-support systems, to help order correct tests, institute proper follow-up plans, obtain complete medical histories, and perform adequate physical exams.⁴¹⁵ The two hospitals at the forefront of the movement to voluntarily disclose errors – the VA hospital in Lexington, Kentucky and the

⁴⁰⁷ *Id.* at 1017.

⁴⁰⁸ *Id.* at 1018-20.

⁴⁰⁹ See David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 919-20 (2005) (describing the history of anesthesia quality improvement).

⁴¹⁰ Lucian L. Leape, *Error in Medicine*, in MARGIN OF ERROR: THE ETHICS OF MISTAKES IN THE PRACTICE OF MEDICINE 95, 107 (Susan B. Rubin & Laurie Zoloth eds., 2000).

⁴¹¹ Hyman & Silver, *supra* note 409, at 918.

⁴¹² *Id.* at 918-20.

⁴¹³ Eichhorn et al., *supra* note 406, at 1017.

⁴¹⁴ Tom Baker calls this "enterprise insurance." BAKER, *supra* note 72, at 174-78. Others call it insurance "channeling." See, e.g., WEILER, *supra* note 52, at 126.

⁴¹⁵ Laura Landro, *The Informed Patient: Preventing the Tragedy of Misdiagnosis*, WALL ST. J., Nov. 29, 2006, at D1.

teaching hospital at the University of Michigan – also employ and insure their attending physicians.⁴¹⁶

Exclusive enterprise liability, whether de jure or de facto, also has the potential to modestly increase physician participation in patient safety initiatives along with physician willingness to disclose medical errors to patient safety committees.⁴¹⁷ By eliminating individual liability, enterprise liability will make it easier for hospitals to institute a “blame-free” culture that encourages open discussion of errors. Unlike confidentiality rules and damages caps, however, it accomplishes this objective without depriving injured patients of the redress to which they are entitled.⁴¹⁸

The likelihood that enterprise liability will allow physicians to discuss errors and near misses more freely is suggested not only by common sense, but also by studies which have found that independent practicing physicians are less likely to support the disclosure of errors than physicians who work for an institution.⁴¹⁹ Private physicians are more likely to see disclosure proponents as naïve; they are “reluctant to do anything that might precipitate a lawsuit.”⁴²⁰ This attitude predictably stems from physicians’ personal exposure to malpractice liability, a risk physicians don’t face when protected by large insured institutions.⁴²¹ Little wonder that the leaders in the movement for greater disclosure were large, self-insured institutions whose physicians had much less concern about malpractice insurance availability and premiums.⁴²²

Enterprise liability also has advantages unrelated to patient safety. For example, exclusive enterprise liability would save litigation costs by consolidating the defense of the hospital and all its providers.⁴²³ According to one report, about 25% of all medical malpractice cases have two or more defendants.⁴²⁴ Second, exclusive enterprise liability places the burden of purchasing liability insurance on a corporate entity that is more likely than an individual physician to plan ahead for the peaks and troughs of the insurance

⁴¹⁶ *Id.*

⁴¹⁷ For a discussion of reasons why legal reforms are destined to have limited effect, see *supra* text accompanying notes 374-384.

⁴¹⁸ See Randall R. Bovbjerg, *Reform of Medical Liability and Patient Safety: Are Health Courts and Medicare the Keys to Effective Change?*, 9 J. HEALTH CARE L. & POL'Y 252, 254 (2006).

⁴¹⁹ See Gallagher et al., *US and Canadian Physicians*, *supra* note 377, at 1610; see also Gallagher et al., *Choosing Your Words Carefully*, *supra* note 380, at 1591.

⁴²⁰ Thomas H. Gallagher & Wendy Levinson, Commentary, *Disclosing Harmful Medical Errors to Patients: A Time for Professional Action*, 165 ARCHIVES OF INTERNAL MED. 1819, 1819 (2005).

⁴²¹ *Id.*

⁴²² *Id.*

⁴²³ BAKER, *supra* note 72, at 178.

⁴²⁴ 2 AM. LAW INST., REPORTERS' STUDY, *supra* note 51, at 119.

cycle and to weather them relatively smoothly.⁴²⁵ More than any other single factor, the periodic spikes of the insurance cycle precipitated the malpractice insurance and political crises of the 1970s, 1980s, and 2001.⁴²⁶ Any malpractice reform that hopes to end these crises must temper the impact of these inevitable premium spikes on individual physicians.⁴²⁷ Enterprise liability has played this role in other social-enterprise fields;⁴²⁸ it could do the same in health care. Without enterprise liability, the current health court proposal offers nothing to soften the insurance cycle's impact on individual physicians' pocketbooks.

Third, enterprise liability removes the unfair penalty currently imposed on physicians who practice in a high-risk specialty, like obstetrics, neurosurgery, or emergency medicine.⁴²⁹ Physicians who practice in these high-risk specialties play a vital role in our health care system, yet they pay far higher premiums than their colleagues in lower-risk specialties.⁴³⁰ Some reformers have suggested that the state, or other providers, give these specialties financial assistance. Enterprise liability provides an even more elegant solution. It shifts to the hospital the burden of insuring against injuries that occur in the hospital and its clinics and, to this extent, removes the financial penalty currently associated with high-risk practice.⁴³¹ Once again, this is a lesson learned decades ago in other industries; neither airline pilots nor fuselage welders are required to buy their own liability insurance.⁴³²

Of course, enterprise liability has its own set of potential disadvantages. For example, eliminating individual physician liability could theoretically dilute the effort physicians make to avoid patient injuries. Yet, that signal is already badly diluted by the availability of liability insurance that is not experience-rated and by widespread physician disbelief that the malpractice system rewards competence. The legal incentive to reduce iatrogenic injury that enterprise liability places on hospital systems is likely to produce more powerful and more productive pressures on individual physicians than individual liability.

Second, enterprise liability introduces the problem of defining the boundaries of hospitals' vicarious liability.⁴³³ Lawmakers will need to decide such issues as whether injuries occurring in outpatient facilities or those caused

⁴²⁵ See BAKER, *supra* note 72, at 165.

⁴²⁶ See *id.* at 51-52.

⁴²⁷ See *id.* at 67.

⁴²⁸ See *id.* at 163-64.

⁴²⁹ 2 AM. LAW INST., REPORTERS' STUDY, *supra* note 51, at 116.

⁴³⁰ *Id.* at 115-16.

⁴³¹ See BAKER, *supra* note 72, at 175.

⁴³² 2 AM. LAW INST., REPORTERS' STUDY, *supra* note 51, at 116 & n.14.

⁴³³ Furthermore, about 90% of the claims and payments now being made arise out of care given inside a hospital. *Id.* at 114.

by errors during office visits following hospitalization should be included.⁴³⁴ However, there is no reason to believe the task of defining these legal boundaries will be any more troublesome than countless others that lawmakers regularly tackle.

Third, the federal anti-kickback laws, as currently written, may make it illegal for hospitals that do not employ their treating physicians to voluntarily purchase insurance coverage for all the physicians on their staffs.⁴³⁵ However, that has yet to be determined. Furthermore, state legislation imposing enterprise liability would sidestep the problem.⁴³⁶

Finally, in cases involving patient injuries caused by individual carelessness, not poor system design, exclusive enterprise liability will insulate the morally responsible person from legal responsibility. This dilution of corrective justice is a serious cost. However, liability insurance already weakens the link between victim and tortfeasor, especially in the absence of experience rating.⁴³⁷ Furthermore, the improved deterrence enterprise liability will likely produce offers patients an adequate quid pro quo. That is why lawmakers have tolerated de facto enterprise liability in so many other areas of tort liability.⁴³⁸ In addition, enterprise liability will enhance the system's ability to provide just compensation whenever responsibility for the patient's injuries lies as much or more in a poorly designed system as in an individual lapse of judgment.

Because the benefits of enterprise liability far outweigh its disadvantages, many respected health law scholars recommend it. They include Clark Havighurst,⁴³⁹ Paul Weiler,⁴⁴⁰ Troyen Brennan,⁴⁴¹ Michelle Mello,⁴⁴² David Studdert,⁴⁴³ Tom Baker,⁴⁴⁴ and William Sage.⁴⁴⁵ Although these scholars

⁴³⁴ *Id.* at 113-14.

⁴³⁵ See BAKER, *supra* note 72, at 176.

⁴³⁶ *Id.* at 176-77.

⁴³⁷ See WEILER ET AL., *supra* note 8, at 147-48; Mello & Brennan, *supra* note 62, at 1626.

⁴³⁸ See Mello & Brennan, *supra* note 62, at 1604-06.

⁴³⁹ Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J. L. & MED. 7, 8 (2000) (advocating vicarious liability for managed care plans).

⁴⁴⁰ Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 381 (1994); see also WEILER ET AL., *supra* note 8, at 114.

⁴⁴¹ Mello & Brennan, *supra* note 62, at 1598.

⁴⁴² *Id.*

⁴⁴³ See generally *supra* note 61.

⁴⁴⁴ BAKER, *supra* note 72, at 164-65 (recommending that hospitals be obliged to purchase "enterprise insurance" covering all claims against medical providers using hospital facilities). He believes that doctors and hospitals might more readily accept enterprise insurance than enterprise liability because formal liability is resisted by physicians. *Id.* at 175-76.

differ on a number of issues, like the choice between hospitals and managed care organizations as the responsible “enterprise,” they agree on the need for institutional, rather than individual, responsibility.⁴⁴⁶

Why then is enterprise liability missing from the package of reforms bundled together in the current health courts proposal? The answer almost certainly lies in the anticipated opposition of hospital associations and physicians groups. While hospitals have an obvious financial reason to resist the transfer of legal responsibility entirely onto their shoulders, the issue is more complex for physicians. On the one hand, exclusive enterprise liability would take them out of the shadow of tort liability and permit them to focus on their patients.⁴⁴⁷ On the other hand, physicians have traditionally opposed expanding hospital vicarious liability because they fear it will bring greater interference with their medical decision making.⁴⁴⁸ Yet, this objection, as the ALI notes, “evokes a health care world that has long since passed.”⁴⁴⁹ With rare exceptions, physicians already function as part of complex systems. Surely, physicians understand the importance of building those systems carefully. Furthermore, Tom Baker rightly observes that enterprise liability has existed in university hospitals and staff-model health maintenance organizations for many years without revolt.⁴⁵⁰

Sooner or later, tort law needs to adapt to this modern era.⁴⁵¹ In hindsight, it is now obvious that the law’s delay in doing so has been bad for both physicians and patients, keeping individual physicians on the front line of malpractice litigation and depriving patients of the safety systems that enterprise liability will produce. As a result, the absence of enterprise liability in the current health court proposal is a very serious weakness.

CONCLUSION

Any critique of the health court plan proposed by Common Good and the Harvard School of Public Health must acknowledge the good faith of its sponsors. They are genuinely driven by a desire to make both the legal system and the health care system better for physicians and patients alike. This orientation is both rare and refreshing.

⁴⁴⁵ William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J. L. & MED. 1, 1 (1994) (advocating vicarious liability for managed care plans).

⁴⁴⁶ See Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1979 (2003) (using economic analysis to show that managed care organizations should be vicariously liable even if they do not exert direct control over physicians).

⁴⁴⁷ See Mello & Brennan, *supra* note 62, at 1629.

⁴⁴⁸ 2 AM. LAW INST., REPORTERS’ STUDY, *supra* note 51, at 125.

⁴⁴⁹ *Id.*

⁴⁵⁰ BAKER, *supra* note 72, at 177.

⁴⁵¹ 2 AM. LAW INST., REPORTERS’ STUDY, *supra* note 51, at 126.

Yet, their plan is badly flawed by its omission of enterprise liability. To put the matter succinctly, they are reviving the wrong plan. The ALI model, even without no-fault liability, is far superior to the AMA model. By favoring the AMA approach, the sponsors of health courts seek the administrative efficiencies that a no-fault recovery regime would provide and the patient safety improvements that enterprise liability would produce without adopting either no-fault liability or enterprise liability. Without those features, the outcomes are very likely to be disappointing.

Is the proposal for health courts, nevertheless, good enough to warrant pilot tests? Answering that question requires a balancing of the plan's potential benefits against its risks. The principal point of the plan is to take medical malpractice cases away from juries and hired experts and turn them over to specialized judges and court-appointed experts, in the hopes of producing fairer outcomes and reducing physician distrust.⁴⁵² Yet, the data demonstrate that the judicial system does a remarkably good job of sorting the strong cases from the weak and producing fair settlements.⁴⁵³ The room for improvement is very limited. Furthermore, the data clearly reveal that physicians benefit from jury errors far more often than plaintiffs.⁴⁵⁴ As a result, physicians are unlikely to recognize or to appreciate a genuine improvement in the fairness of malpractice adjudication.

At the same time, the potential for modest improvement in the fairness of malpractice outcomes must be balanced against the risk that a specialized tribunal would be even less fair to injured patients than juries are. A specialized court is more vulnerable to capture by repeat players. In health courts, the repeat players will be the liability insurers and their counsel. In addition, the dependence of the health court judges on the guidance of court-appointed physicians could produce a pro-physician bias. The risk that trial judges will not share the values of the public is one important reason why common law cases in this country have historically been tried before juries.⁴⁵⁵ Insofar as fairer outcomes are the objective of the health court proposal, the risks of bias seem more significant than the modest potential for more accurate decisions. Should a jurisdiction decide to take these risks, however, it is crucial that it collect the data needed to determine whether appointed physicians are willing to criticize physician defendants.

Proponents believe that an administrative court model will be more efficient, processing claims more quickly and less expensively. However, great care will need to be taken when determining which of the procedural protections found in the civil courts should be abandoned in the new health courts. If complex medical malpractice cases are to be resolved as fairly as they are under the current system, health courts will need procedures that match those of the most

⁴⁵² See *supra* notes 117-119 and accompanying text.

⁴⁵³ See *supra* notes 91-116 and accompanying text.

⁴⁵⁴ See *supra* notes 86-87 and accompanying text.

⁴⁵⁵ See *supra* notes 139-143 and accompanying text.

formal administrative courts, such as the Court of Federal Claims.⁴⁵⁶ Although the robust procedural protections provided by those tribunals would strip health courts of the speed and cost advantages so highly touted by health court proponents, those strong procedural protections are necessary to insure that health court outcomes are as fair as those rendered today. Cut-rate decision making raises the risk of cut-rate justice. If reformers want a considerably faster and less adversarial process, then they will need to eliminate the element of fault.

Health courts are also likely to disappoint the hopes of sponsors who believe that the simplified claiming process will reduce the problem of under-claiming by patients who are injured by medical negligence. That is because the favorable impact of a simplified claims process will be more than offset by the plan's abrogation of the collateral source rule. By reducing compensable damages substantially, the plan will make it more difficult for many patients with meritorious cases to find attorneys.

At the same time, the plan lacks any reforms to reduce the number of meritless claims that are filed. Because unfounded malpractice claims impose serious social and personal costs, the initial claims process is the weakest link in the present adjudicative process. Yet, the health court plan does not address this issue.

In other respects, however, the health court plan has considerable promise. The combination of written opinions, binding *ex ante* guidelines, and ACEs, for example, has the potential to modestly improve the fairness of judicial outcomes. These reforms are likely to make the legal standard of care more concrete and to yield verdicts that are more consistent over time. At the same time, they do not appear to carry the same risk of bias as some of the plan's other provisions, like exclusive reliance on court-appointed physicians. Even though there is a limit to the detail with which legal standards of conduct can be articulated in advance, a pilot test of these provisions would be valuable.

The proposed damages schedule is also a very promising provision. That schedule has the potential to make non-economic damages more consistent and, thus, more fair, while simultaneously eliminating the issue of excessive awards. However, that beneficial potential will evaporate if the level of damages set by these schedules does not approximate current jury awards. If the levels of recovery are reasonable, then this reform warrants an experiment.

In addition, several provisions of the health courts plan could lead to improvements in patient safety. Most promising are the state-of-the-art standard of care, the centralized collection of data on medical accidents, and clearer *ex ante* standards of care. However, the improved deterrent signal that sponsors hope will result from the simplified claims procedure is likely to be offset by the barrier to claiming produced by abrogation of the collateral source rule and by the continued reliance of physicians on liability insurance that is not experience-rated. Furthermore, the transfer of malpractice cases

⁴⁵⁶ See *supra* note 235 and accompanying text.

from juries to specialized health courts is highly unlikely to produce greater openness among physicians about medical error. That change will require either a major transformation of physician culture or the adoption of hospital enterprise liability – perhaps both.

Without enterprise liability, the very modest benefits that the current health court proposal is likely to confer are closely matched by the genuine risks of bias and overreaching that they also present. On the positive side, some improvement in patient safety is likely to result from several of the plan's provisions, though the gains are likely to be far smaller than those reasonably expected from the adoption of enterprise liability.⁴⁵⁷ In addition, the provisions of the plan that make the standard of care more concrete have the potential to improve the fairness, predictability, and consistency of the adjudicated outcomes.

These potential benefits are matched, however, by serious shortcomings. Most troubling is the risk that specialized health courts and their purportedly neutral experts will, instead, be biased toward physicians. The promised streamlining of procedures is also likely to favor physicians over patients. Although this bias can be cured, the cure would sacrifice the financial savings currently promised by the proposal. Finally, the scheduling of damages comes with the risk – perhaps, the likelihood – that the caps will be set at levels that inadequately compensate injured patients. Given these shortcomings, the case for the current health court plan, with its failure to include enterprise liability, is unpersuasive.

The case for a pilot experiment would be enhanced if provisions were added to reduce the risk of unfair outcomes. Assurances of an adequate opportunity for discovery, protections against the selection of biased experts by the health courts (such as the use of multiple experts or a party-driven selection process similar to the selection of an arbitrator), explicit preservation of the ability of the parties to call their own expert witnesses, and a fair schedule for pain and suffering damages would reduce that risk. The stronger these protections are, the stronger the argument that health courts will provide a fair alternative to civil courts.

Even these improvements will not be sufficient, however, in the absence of enterprise liability. As a matter of both legislative policy and constitutional doctrine, any reform that eliminates the right to a jury trial should offer injured patients a reasonable quid pro quo. Without enterprise liability, the health court plan offers patients only the possibility of a small improvement in the safety of health care delivery systems. That is not enough.

⁴⁵⁷ These provisions include a tougher standard of care, the centralized collection of data on medical errors, and the clearer *ex ante* guidance provided by the combination of the new definition of the standard of care, the issuance of written opinions with precedential effect, the greater weight given to authoritative clinical guidelines, and the identification of ACEs in advance. Of course, the magnitude of the safety improvements is impossible to predict.