HEALTH COURTS?

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This Article critiques the proposal from Common Good and the Harvard School of Public Health to replace medical malpractice jury trials with adjudication before specialized health courts. Professor Peters concludes that the modest benefits likely to be produced by the current health court proposal are matched by the risks of bias and overreaching that these courts would also present. Missing from the plan is the doctrinal change mostly 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 sufficient benefits to justify the risks.

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. Furthermore, it has much

2 See infra text at notes 25-30.
3 See INSTITUTE OF MEDICINE, FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS 10 (Janet M. Corrigan et al. eds., 2002) (recommending demonstration projects testing both reform proposals).
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.* 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, as they 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. They have already assembled a long list of supporters, ranging from conservative Senator Bill Frist to the more liberal Progressive Policy Institute.

Because congressional testimony is presented in a format that stresses partisan positions, none of the testimony presented to Congress attempted to offer 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. 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.

However, 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 mostly 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. Without enterprise liability, the health courts

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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 five Parts examine the likelihood that health courts will improve the system of malpractice adjudication as measured by the following five criteria: more just outcomes (Part II), fewer frivolous claims and more legitimate ones (Part III), greater efficiency (Part IV), more defensible awards for pain and suffering (Part V), and better deterrence (Part VI). Part VI then defends my claim that lawmakers should not create a system of health courts unless the legislation also imposes hospital enterprise liability.

Without enterprise liability, the very modest benefits that a system of health courts is likely to confer are closely matched by the genuine risks of bias and overreaching that they also present. The addition of enterprise liability would shift that balance. It would greatly improve the likelihood that malpractice law will serve as an engine for improvements in patient safety, while simultaneously taking individual physicians out of the line of fire. It has the potential to 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 the risk of bias posed by physician-guided health courts and too thin to warrant abrogation of 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 claims
Health Courts?

for workers compensation benefits. 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. 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. All significant injuries caused by a physician’s failure to follow “best practices” would be compensable. 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.

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. 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. After input from a court-appointed medical expert, the health court judge would render a verdict and produce a written opinion with precedential authority.

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 “accelerated-compensation events (ACEs)” 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

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6 The most recent and complete account is contained in Michelle M. Mello et al., “Health Courts” and Accountability for Patient Safety, 84 MILBANK Q. 459 (2006).
7 Id. at 464.
8 Id.
9 Id. at 466.
10 Id.
11 Id. at 464. Claimants without lawyers could also ask the health court to evaluate the settlement offer made by the insurer.
12 Id. at 464-65.
13 Id. at 468, 476.
Health Courts?

would not apply, and periodic payment of future damages would be permitted.\textsuperscript{14} Third, the cost of litigating will go down because the process will be simplified and many claimants will proceed without counsel.\textsuperscript{15} 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.\textsuperscript{16} 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.\textsuperscript{17}

Fifth, health courts will better promote patient safety.\textsuperscript{18} 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, reduce physician defensiveness and make them less reluctant to engage in open conversations about the sources of medical error.\textsuperscript{19} Health courts will also promote safer clinical practices by giving physicians better ex ante guidance about the standard of care. Perhaps most exciting to the public health scholars, the health court would serve as a central repository for claims information that could be studied to improve patient safety standards.

\textsuperscript{14} Id. at 467-68, 470.
\textsuperscript{15} Id. at 462-63 (noting that the “process would be designed to ensure that legal counsel would generally not be necessary but it might be desirable in some cases” as where the circumstances were complex).
\textsuperscript{16} The Common Good , at http://cgood.org/f-healthcourtsfaq.html; Mello et al., \textit{supra} note 7, at 464 (noting better consistency).
\textsuperscript{17} Michelle M. Mello, Testimony Before the Subcommittee on Health of the House Committee on Energy and Commerce at the Hearing Entitled “Innovative Solutions to Medical Liability,” at 6-7 (July 13, 2006) (transcript available at The Common Good, \textit{House Committee Hearings on Health Courts}, http://cgood.org/healthcare-events-67.html). This might magnify tort law’s deterrent signal. Mello et al, \textit{supra} note 8, at 471 (noting that improvements in the system’s accuracy should clarify the deterrent signals to providers). That will depend on whether this effect is offset by the reduction in compensable damages.
\textsuperscript{18} Mello et al., \textit{supra} note 7, at 470, 471. In addition, doctors may be more willing to disclose and discuss errors under a standard of care that does not imply negligence. \textit{Id.} at 471-74.
\textsuperscript{19} \textit{Id.} at 471-74.
Health Courts?

This long list of potential benefits has generated an equally long list of supporters. On it are 10 university presidents and 11 medical school deans. Two highly distinguished health policy experts are also included—Paul M. Ellwood and Alain C. Enthoven. Their presence is noteworthy because one is a fellow at the conservative American Enterprise Institute and the other at the more liberal Brookings Institute. Paul Weiler, the lead legal investigator of the famous Harvard study of New York hospitals, is a supporter. So are Dr. Louis Sullivan, the former Secretary of Health & Human Service and Dennis O’Leary, President of the Joint Commission on Accreditation of Healthcare Organization (the JCAHO). Other organizational sponsors include the AARP, the Democratic Leadership Council, the National Committee for Quality Assurance, and six major academic medical centers. Supportive editorials have appeared in the New York Times, the Economist, and USA Today. 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. 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.21

Lawmakers have noticed. Senator Max Baucus (D-Mont.) and Michael B. Enzi (R-Wyo.) introduced S. 1481, the Fair and Reliable Medical Justice Act of 2007, to fund ten innovative pilot projects to improve the resolution of medical malpractice disputes, including a pilot program of health courts.22 A similar bill was introduced in the House by Representatives Jim Cooper (D-Tenn.) and William “Mac” Thornberry (R-Tex.).23 Both bills were supported by Common Good.24

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Health Courts?

In addition, legislation to create health courts or small pilot experiments has been introduced in several states, including Maryland, New York, Oregon, Pennsylvania, and Virginia. Common Good attorney Paul Barringer testified that additional state legislative activity was expected. Initiatives are also reportedly underway in Wyoming, Colorado, Michigan, and Massachusetts.

The momentum behind this proposal contrasts sharply with the lukewarm reception given to a similar proposal made by the American Medical Association in 1988. Like the current proposal,


31 See Mello et al., supra note 7, at 460.

Health Courts?

it would have taken medical malpractice cases out of the courts and placed them in specialized health courts. 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. 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 highly restricted damages. 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.

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. 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. 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. It promised to

33 REPORTERS’ STUDY, AMERICAN LAW INSTITUTE, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, Vol. I, Chapter 10 (Medical Injury) & Vol. II, Chapter 4 (Medical Malpractice) & Chapter 15 (Elective No-Fault Medical Liability) (1991) (Paul Weiler was the Chief Reporter); see also PAUL WEILER, MEDICAL MALPRACTICE ON TRIAL (1991) (written originally as an ALI Background Paper). Chap 6 of the Weiler book was the basis for ALI chap. 15 on no-fault medical liability.


35 See infra text at notes *.
reduce blaming and, thus, rancor while at the same time protecting more of the patients who are injured by their medical care. It sought to reduce litigation time and expense by eliminating the element of fault and, thereby, increasing the fraction of premium dollars going to injured patients. It aimed to improve the safety of care given to future patients by shifting the focus from individual competence to system-wide safety precautions through the replacement of individual liability with hospital enterprise liability. Although the ALI proposal, like the AMA proposal that preceded it, would move malpractice adjudication from civil courts to administrative health courts, its bipartisan spirit and content were dramatically different from the AMA proposal.

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. Weiler was on the project as well, as were several faculty members from the Harvard School of Public Health.36 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.37 Health care organizations and lawmakers

36 PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993). See also HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990) (the original report to the State of New York, which had commissioned the study). 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.

37 Faculty members Troyen Brennan, Joseph Newhouse, Lucian Leape, and David Studdert wrote many articles on the subject, including the following (listed in chronological order and with all authors noted): Joseph P. Newhouse and Paul C. Weiler, Medical Malpractice: A Proposal for Reform, 14 REGULATION 78 (1991); Paul C. Weiler, Joseph P. Newhouse, and Howard H. Hiatt, Proposal for Medical Liability Reform, J. AM. MED. ASSN. 2355 (1992); William G. Johnson, Troyen A. Brennan, Joseph P. Newhouse, Lucian L. Leape, Ann G. Lawthers, Howard H. Hiatt, and Paul C. Weiler, The Economic Consequences of Medical Injuries: Implications for A No Fault Insurance Plan, 267 J. AM. MED. ASSN. 2487 (1992); PAUL C. WEILER, HOWARD H. HIATT, JOSEPH P. NEWHOUSE, TROYEN A. BRENNAN, LUCIAN L. LEAPE, & WILLIAM G. JOHNSON, A MEASURE OF MALPRACTICE: A
Health Courts?

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. However, they continued to make the case for exclusive enterprise liability because they rightly believed that enterprise liability had more potential than any other tort reform to produce improvements in patient safety. Then in 2006, their public advocacy of 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 specialized health courts. This, too, was presumably a concession to perceived political realities.

As a result, the phoenix arising 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. Although the current health court plan contains substantial improvements on the AMA proposal that make it more even-handed, the plan nevertheless sets upon a quixotic journey. The sponsors hope to achieve the kind of administrative cost savings found in no-fault compensation systems, yet liability under the new system would still be fault-based. The plan is also motivated by a sincere desire to generate the

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

39 Id.


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

42 See, e.g., Mello, supra note 19, at 6 (using such compensation systems as examples of efficiency claims resolution).
kind of improvements in patient safety that could be expected from a system of hospital enterprise liability, 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 the likely benefits and the potential risks.

II. THE PROSPECTS FOR PRODUCING FAIRER OUTCOMES

Supporters of malpractice reform charge that the existing system of malpractice adjudication reaches irrational and unjust outcomes. Juries, they claim, are easily hoodwinked by shrewd plaintiffs’ lawyers, unscrupulous “hired gun” expert witnesses, and sympathetic plaintiffs. 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.” The main event is the coercion of unwarranted settlements from innocent physicians.

President George W. Bush stated the charge this way:

43 See, e.g., Common Good, at http://cgood.org/healthcare-newscommentary-inthenews-218.html; Mello et al., supra note 7, at 468-69 (noting the provisions of the health court plan intended to improve upon the weak deterrence signal currently sent by tort law).
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.47

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.

Advocates for health courts often repeat these charges,48 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. 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 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.

A. The Fairness of Jury Verdicts

Three decades of research provide a substantial evidentiary basis for evaluating jury decision-making. The four key findings that

48 See, e.g., Troyen A. Brennan & Philip K. Howard, Heal the Law, then Health Care, WASH. POST, Jan. 25, 2004, at B6 (“Doctors who did nothing wrong . . are often hit with huge verdicts”).
Health Courts?

emerge from that research are strikingly different from popular perception. First, negligence matters. The stronger the plaintiff’s evidence of negligence, the greater the likelihood of a plaintiff’s verdict. Plaintiffs win ten to twenty percent of the cases that reviewers feel they should lose, twenty to thirty percent of the cases rated as toss-ups, and roughly fifty percent of the cases deemed by expert reviewers to have strong evidence of negligence.

Second, the agreement rate between juries and experts is better than physicians typically have with each other. In cases with weak evidence of negligence, as judged by physician evaluators, defendants win eighty to ninety percent of the jury verdicts. The resulting discrepancy rate of 10 to 20 percent is better than the 30 percent or higher rate of disagreement that physicians typically have when they are evaluating the performance of other physicians. A thirty percent disagreement rate is also typical of performance evaluations in other professions.

50 Id. at 1478. (reviewing the literature on agreement rates). 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 1478-1479.
51 Id. at 1464.
52 See, e.g., Henry S. Farber & Michelle J. White, Medical Malpractice: An Empirical Examination of the Litigation Process, 22 Rand J. Econ. 199, 203, 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 Ann. Intern. Med. 457, 457 (1996) (finding a similar disagreement rate on both negligence and causation); Ralph Peeples, Catherine T. Harris & Thomas Metzloff, 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). In addition, some of these disagreements can probably be attributed to reviewer bias in favor of physicians and jury access to more complete and stronger evidence of medical negligence.
53 See Shari S. 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 34%).
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.” That contention is simply wrong. It wrongly 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 fifty percent of the cases which physician reviewers have concluded they should lose and seventy to eighty percent of the cases with unclear or ambiguous evidence of negligence. This extraordinary success rate suggests the presence of factors that systematically favor medical defendants in the courtroom.

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 the social science research finding that the prospective jurors have been listening to the unrelenting complaints of physicians and politicians over the past twenty years and sympathize with them. Second, the preliminary evidence, though scanty, suggests that defendants are much more likely than plaintiffs to have experienced attorneys and distinguished experts. Their hired guns are more skilled than those of the plaintiffs. Third, juries may take the burden of proof very seriously in medical malpractice cases, giving

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54 Philip K. Howard, Testimony before the U.S. Senate Health, Education, Labor and Pensions Committee, June 22, 2006 <http://cgood.org/healthcare-reading-cgpubs-speeches-19.html> (stating that one in four “baseless” claims result in payment, conceding that “the system is reasonably effective in sorting the good from the bad,” but concluding that “from the standpoint of a doctor, one out of four resembles Russian Roulette”).
55 Peters, Juries, supra note 49, at 1492.
56 Id. at 1493.
57 Id. at 1484.
58 Id. at 1489.
physicians the “benefit of the doubt” when the experts for both sides are credible.\(^{59}\) 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.

B. 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.\(^{60}\) The actual settlement outcomes paint a very different picture. Instead, they show that malpractice insurers negotiate from a position of power and employ that power in a hard-nosed, business-like manner.\(^{61}\)

Numerous studies confirm that the odds of a settlement payment being made are directly related to the strength of the plaintiff’s case.\(^{62}\) 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 cases.\(^{63}\) Here, too, the studies show that the amount paid to a plaintiff varies inversely with the quality of care provided to the patient.

Between 80 and 90 percent of the claims rated by expert reviewers as lacking evidence of negligence are dropped or dismissed

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\(^{59}\) Id. at 1491.

\(^{60}\) Brennan et al., supra note 46, at 1963. See generally HARVARD MEDICAL PRACTICE STUDY, supra note 35.

\(^{61}\) See Philip G. Peters, Jr., What We Know About Malpractice Settlements, 92 IOWA L. REV. 101 (forthcoming August 2007) [hereinafter Settlement].

\(^{62}\) Id. at 120-28 (synthesizing the studies).

\(^{63}\) Id. at 129-30 (synthesizing the studies).
Health Courts?

without payment. 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. By contrast, cases with strong evidence of negligence settle at a much higher rate (75 to 90%) and the average payment is much larger. Borderline cases fall in the middle.

The findings of a recent study by David Studdert and his colleagues are illustrative. The authors divided the claims into six categories based on the strength of the plaintiffs’ evidence of negligence. The authors then determined how often a settlement had been paid in each category of claims. They found that the probability of a payment was directly tied to the strength of the plaintiff’s case, as shown in Figure 1.

**Figure 1. Studdert et al., Settlement Rate by Confidence in Determination of Error**

![Figure 1](image-url)

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64 *Id.* at 121 fig. 2.
65 *Id.* at 129-20.
66 *Id.* at 120-30.
67 *Id.*
69 *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 “virtually certain evidence.”
The weaker the plaintiff’s case, the lower the probability that a settlement payment would be made. 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.”

When a settlement does occur, its size is also driven by the merits. While the great majority of plaintiffs with weak cases receive nothing at all, those who do recover tend to settle for a much smaller amount than a claimant with similar injuries and a stronger case on the merits. Often the settlement is simply a face-saving gesture, such as forgiveness of unpaid medical bills. 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.

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 total discount that is greater than required by the merits of the case.

The double effect is most clearly seen by looking at the data on “toss-up” cases, i.e. those cases 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. That happens in 60% of the cases. In

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70 Payment was made in 19% of the claims with “little or no evidence” of error, 32% of the claims with “slight to modest evidence”, 52% of claims deemed a “close call” but less than 50-50 probability, 61% of those rated as a “close call” but greater than 50-50, 72% of the claims with “moderate-to-strong evidence,” and 84% of the claims with “virtually certain evidence.” Id. at 2029 fig.2 (noting that these numbers exclude claims with dignitary injuries only (nine), no injuries (thirty-seven), and no-error judgments (two)). Roughly 6% of the cases in which payment was made followed a plaintiff’s verdicts (50 of the 798). Id. at 2030 tbl.2.
71 Id. at 2031.
72 Peters, Settlement, supra note 61, at 129-30.
73 Id. at 137.
74 See FRANK A. SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE 220 (1993 (noting that settlements, unlike trials, will discount the damages to reflect the probability of success); Stephen J. Spurr & Sandra Howze, The Effect of Care Quality on Medical Malpractice Litigation, 41 Q. REV. ECON. & FIN. 491,502-04 (2001).
the other 40%, however, defendants are able to escape without making any payment at all.\textsuperscript{75} Thus, borderline cases are discounted twice—once in the reduced amount paid to the claimants who do receive a settlement offer and again in the 100% discount defendants get when no payment at all is needed to dispose of the case. The ability of malpractice defendants to escape payment altogether in 40% of the toss-up cases suggests a significant advantage in bargaining power. The presence of superior bargaining power is also supported by the evidence that the amounts paid to settle malpractice cases fall short of expected value.\textsuperscript{76}

In hindsight, the 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 objective by undertaking a form of peer review in which they obtain multiple expert evaluations and rely on them heavily.\textsuperscript{77} 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 adjudicating malpractice cases.\textsuperscript{78} Peer review is precisely what the settlement process currently provides.

What explains this discrepancy in negotiating power? The most likely sources of the defendants’ advantage lie in asymmetric stakes that give defendants an incentive to fight low-odds claims fiercely,\textsuperscript{79} asymmetric risk tolerance that prompts plaintiffs to settle at a discount,\textsuperscript{80} shared knowledge that plaintiffs actually win very few jury trials and that cases resulting in plaintiff’s verdicts routinely are

\textsuperscript{75} Peters, \textit{Settlement}, supra note 61, at 123 fig. 4.
\textsuperscript{77} See Peeples et al., \textit{supra} note 52, at 884-85, 891-93.
\textsuperscript{78} \textit{Id.} at 892.
\textsuperscript{80} \textit{Id.} at 140-41.
settled for significantly less than the jury award,\textsuperscript{81} and the defendant’s superior access to useful resources of several kinds.\textsuperscript{82} Together, these factors appear to push the amounts actually paid in settlement 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 unrelated to the quality of care received by the claimant, such as witness appeal.\textsuperscript{83} The role played by strategic factors is disturbing because it substantiates complaints that the system is irrational and unfair. However, the current evidence suggests that its impact is largely confined to the uncertain cases.\textsuperscript{84} 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 producing settlements that are fair. As currently structured, the litigation process gives defendants, rather than the plaintiffs, an edge. When it errs, it tends to err on the side of the physician defendant.

\textbf{C. The Impact of Specialized Judges}

Health court cases will be decided by a judge, rather than a jury. That judge will specialize exclusively in medical malpractice cases and will receive guidance from a neutral expert witness that he or she appoints. These reforms, say sponsors of the proposal, will produce more defensible outcomes in malpractice disputes.\textsuperscript{85}

The largest weakness of this claim is its assumption that the existing process produces a substantial number of unjust outcomes.

\textsuperscript{81} Id. at 141-44.
\textsuperscript{82} Id. at 146-49.
\textsuperscript{83} See, e.g., Thomas B. Metzloff, \textit{Resolving Malpractice Disputes: Imaging the Jury’s Shadow}, 54 LAW \& CONTEMP. PROBS. 43, 74-75 & n. 126 (finding that insurers had fought settlement in meritorious cases whenever the claimants were deemed “undesirable”); Paul L. Ogburn, Jr. et al., 33 J. REPROD. MED. 608, 608 (1988) (finding that defendants had settled several defensible cases because the insured physician was a bad witness, a fetal monitor tracing had been lost, or the providers had kept poor medical records)
\textsuperscript{84} 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, \textit{Settlement, supra} note 61, at 146-49 (discussing unequal attorney experience and litigation resources).
\textsuperscript{85} Mello et al., \textit{supra} note 7, at 468.
Health Courts?

As explained above, that premise is mistaken, at least insofar as it assumes that defendants bear the brunt of the injustice. Trial verdicts, in particular, already favor defendants more than they should. 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 most famous and largest of these studies was undertaken by Harry Kalven and Hans Zeisel, who found that the judge and jury agreed in roughly eight of every ten personal injury cases. When the judge and jury disagreed, the jury was nearly as about as likely to have favored the defendant as the plaintiff. To put these data into perspective, 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%). These reassuring findings are consistent with the many surveys which have found that judges generally hold a positive view of the jury.

87 Id. at 64 n.12.
88 KALVEN & ZEISEL, supra note 86, at 63–65 (10% v. 12%). Heuer and Penrod did a similar analysis with similar results. In the cases on which judge and jury had disagreed (thirty-seven percent of the total set of cases), judges disagreed with jury defense verdicts (nineteen percent) as frequently as they disagreed with jury verdicts for plaintiffs (eighteen percent). Heuer & Penrod, supra note 88, at 48 tbl.13.
89 A more recent, but much smaller, study by Larry Heuer and Steven Penrod found agreement in sixty-three percent of the cases. Larry Heuer & Steven Penrod, Trial Complexity: A Field Investigation of Its Meaning and Effects, 18 LAW & HUM. BEHAV. 29, 48 tbl.13 (1994). In addition, researchers have found similar rates of judge-jury agreement in criminal trials. See, e.g., KALVEN & ZEISEL, supra note 86, at 58 tbl.12 (78%); Heuer & Penrod, supra, at 48 tbl.12 (73%). In addition, two other surveys of judicial opinion have found similar or higher estimates of the rate of judge-jury agreement. See John B. Attanasio, Forward: Juries Rule, 54 SMU L. 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].
90 See supra note 53.
91 In the Kalven and Zeisel study, for example, the judges typically believed that a jury that decided the case differently had reached a reasonable decision. 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
Health Courts?

In addition, researchers have found that greater case complexity does not produce more disagreement between juries and presiding judges. 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.”

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 fifty percent of their bench trials, but only twenty-nine percent of

94% of the judges felt the jury understood the case and 87% believed that juries are not pro-plaintiff. Sentell, Federal Bench, supra note Error! Bookmark not defined., 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. Over 97% of both groups said that they agreed with jury verdicts more often than was reported in the Kalven and Zeisel study. Id. at 115 tbl.14.


Kalven & Zeisel, supra note 8686, at 157 (“While, as we can see, jury disagreement is greater in close cases than in clear ones, there is virtually no difference between the frequency of disagreement when the case is easy and when the case is difficult.”). 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) (reviewing the literature); Joseph Sanders, Scientifically Complex Cases, Trial by Jury, and the Erosion of Adversarial Processes, 48 DEPAUL L. REV. 355, 365 (1998) (concluding that the research shows jurors have trouble comprehending complex evidence). The most clearly established 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 (1988) (finding that mock jurors underestimated the Bayesian significance of statistical evidence about blood typing); 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 (reviewing the literature). This could cause them to overestimate, in hindsight, the riskiness of a physician’s. However, the data on agreement rates suggests that this risk is offset by other factors that favor malpractice defendants.
their jury trials. Using 2001 data from the country’s seventy-five largest counties, the Bureau of Justice Statistics similarly found that medical malpractice plaintiffs won fifty percent of their bench trials but only twenty-six percent of their jury trials. Thus, malpractice plaintiffs appear to win 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. These findings raise the possibility that juries are more deferential to physicians and more skeptical of patients who sue them 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. While it would be a mistake to give too much weight to comparisons of bench and jury trial outcomes because malpractice attorneys may systematically direct a different mix of malpractice cases to judges than to juries, the findings certainly cast doubt on the likelihood that physicians will find bench trials to be an improvement.

In addition, several obstacles could impede the achievement of 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. Second, judges are not immune from normal human sympathy. Finally, state health court administrative judgeships are not likely to be sought by the most successful malpractice lawyers from either side. Administrative judgeships are

94 Id. at 1137.
96 See Kevin M. Clermont & Theodore Eisenberg, Trial by Jury or Judge: Transcending Empiricism, 77 Cornell L. Rev. 1124, 1137 (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 (twenty-four compared to fourteen percent). COHEN, supra note 95 (finding sixty-five versus fifty-one percent in civil litigation generally).
97 See text supra at notes 49-59.
Health Courts?

typically less highly paid and less prestigious than trial or appellate court judgeships and are not filled by the most successful lawyers.\textsuperscript{99} The applicant pool would 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.\textsuperscript{100} The more closely the administrative court resembles a civil court of general jurisdiction, the higher the pay and prestige. All of these factors suggest that the improvement in outcomes will be marginal at most.

In addition, the very nature of a specialized tribunal poses risks of its own. In a specialized court, the advantages enjoyed by repeat players can be substantial. In a health court system that advantage would accrue to malpractice defendants. Most importantly, they are more often represented by experienced attorneys and claims agents.\textsuperscript{101} In addition to their own superior experience, repeat players benefit from appearing regularly before the same judge or panel of judges. Relationships of familiarity and trust become established. Shared lunches and shared conferences can add to this foundation. The perspective of the judges is also likely to be influenced by the appointed-experts (\textit{i.e.} physicians) with whom they will work with on a daily basis. Those physicians will bring a physician’s perspective of malpractice liability. In addition, 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.\textsuperscript{102} Perhaps, this is why

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\textsuperscript{100} \textit{Id.} at 343, 358.
\textsuperscript{101} See, \textit{e.g.}, SLOAN ET AL., \textit{supra} note 74, at 208, 216 (finding that specialists constitute a minority of plaintiffs’ attorneys and recommending specialty certification); Marc Galanter, \textit{Why the “Haves” Come Out Ahead: Speculations on the Limits of Legal Change}, 9 L. & SOC’Y REV. 95, 110 (1974) (noting that, in general, personal injury insurers are typically repeat players, while personal injury plaintiffs are not); Catherine T. Harris, Ralph Peebles & Thomas B. Metzloff, \textit{Who Are Those Guys? An Empirical Examination of Medical Malpractice Plaintiffs’ Attorneys}, 58 SMU L. REV. 225, 241 (2005) (reporting that defense counsel in the study sample had handled an average of over twice as many malpractice cases as had their counterparts).
\textsuperscript{102} Bruff, \textit{supra} note 100, at 331.
\end{flushleft}
Tom Baker has called the plan a bald attempt by physicians to “capture the judges.”\textsuperscript{103}

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. Our use of juries reflects deep-seated democratic values.\textsuperscript{104} Its democratic importance prompted Blackstone to call the jury the “the glory of the English law.”\textsuperscript{105} 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.” For this reason, both state and federal courts have generally held that legislatures must provide aggrieved parties with a quid quo pro when they replace jury trials with administrative proceedings.\textsuperscript{106} Workers compensations plans, for example, were

\textsuperscript{103} Kristin Eliasberg, Malpractice Fix, BOSTON GLOBE, August 21, 2005 (quoting Tom Baker); see Carl W. Tobias, Health Courts: Panacea or Palliative, 40 U. RICH. L. REV. 49, 51 (2005) (noting the risk of capture).


\textsuperscript{105} Dimick v Schiedt, 293 U.S. 474, 485 (1935) (quoting SIR WILLIAM BLACKSTONE, 3 COMMENTARIES ON THE LAWS OF ENGLAND 379).

\textsuperscript{106} See, e.g., Atlas Roofing v. OSHA, 430 U.S. 442 (1977) (finding that an alternative forum could be created if it offered injured workers new rights); Lucas v. U.S., 757 S.W.2d 687 (Tex. 1988); Wright v. Central DuPage Hosp. Assoc., 347 N.E.2d 736 (Ill. 1976); Simon v. St. Elizabeth Med. Ctr., 355 N.E.2d 903 (Ohio 1976); Amy Widman, Why Health Courts Are Unconstitutional, 27 PACE L. REV. 55, 74-80 (2006)(collecting and discussing the cases); Howard Alan Learner, Restrictive Medical Malpractice Compensation Schemes: A Constitutional “Quid Pro Quo” Analysis to Safeguard Individual Liberties, 18 HARV. J. LEGIS. 143 (1981) (same). 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); see also Granfinaciera SA v. Paul C. Nordberg, Creditor Trustee, 492 U.S. 33, 42(1989) (affirming and applying this rule in a dispute over bankruptcy court jurisdiction and stating that “private tort, contract, and property cases” are encompassed by the doctrine). 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.” Nearly all states have similar constitutional provisions. See Widman, supra note, at 84.
Health Courts?

permitted because they gave injured workers a substantial new right. Under these plans, workers were entitled to immediate and guaranteed compensation without the need to prove that their employer was at fault.\textsuperscript{107}

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 as well.

D. 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.\textsuperscript{108} The use of court-appointed experts has much more potential than the shift from juries to judges 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 be asked not only to provide guidance on individual disputes, but also to clear up the question of legal liability in areas of clinical practice which frequently end up in court and which must be decided anew each time because jury verdicts do not create binding precedent. In the area of toxic torts, panels of court-appointed experts have helped courts sort out and bring closure to several highly contested medical issues. Perhaps, something similar could occur in medical malpractice cases such as those involving the causation of cerebral palsy in newborns.

At the same time, however, 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 is conflicting. On the one hand, the physicians who served as reviewers for medical malpractice carriers and for university researchers studying jury

\textsuperscript{107} See PROSSER AND KEETON ON THE LAW OF TORTS 573 (W. PAGE KEETON ED., 5\textsuperscript{th} ED. 1984). Workers are offered a guarantee of immediate compensation for injuries arising from the workplace in return for their loss of a jury decision on causation and damages.

\textsuperscript{108} Mello et al., supra note 7, at 464.
Health Courts?

verdicts were roughly twice as likely as juries to judge the performance of another physician to be negligent. 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 and lesser deference to the judgment of the physician defendant. Whatever the reason, physicians who serve in the role of private consultant are less parsimonious in their assignment of error than juries are. If the court-appointed physicians are as demanding as these reviewers have been, then medical courts will rule in favor of claimants more often than juries currently do.

On the other hand, other studies have found that physicians are reluctant to label another physician as negligent. 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.” That finding is fully consistent with widely-shared perception that neither the hospital peer review process nor state licensure boards are willing to take action against incompetent physicians. It is also consistent with the reports of efforts by physician specialty groups to punish specialists who give testimony they dislike. The risk of biased testimony will be even more serious if, as suggested by one health court proponent, appointed experts can also be punished by the health court for failure to give “objective” testimony. Finally, the risk of bias will be heightened by the public setting in which these experts will testify. That alone will place considerable pressure on them 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 they are more willing to judge other doctors negligent than juries are. 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

109 See supra text at notes 49-59.
110 WEILER ET AL., supra note 35, at 125.
Health Courts?

absolutely must collect the data needed to evaluate the willingness of the appointed physicians to criticize defendants who have failed to meet the standard of care.

E. Reforms to Produce More Predictable and Consistent Outcomes

Sponsors also hope that several additional features of the health courts proposal will improve eventual consistent outcomes by making the standard of care more clear and the verdicts more consistent. First, judges will issue written opinions that will serve both as guidance for future clinical practice and as a precedent for the decision in future legal disputes. Second, where evidence-based practice guidelines have been issued by credible medical authorities, those guidelines will define the standard of care. Finally, the administrative staff of the health courts will identify common mishaps for which compensation would be presumptively available (“accelerated compensation events” (ACEs)). 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 enable the health courts to render more consistent decisions post hoc.

Each of these reforms has the potential to improve upon the status quo. Although a number of difficult details will need to be resolved, they don’t appear to be insurmountable. Because practice guidelines or something very like them are commonly drafted by health care entities of all shapes and sizes, ranging from individual practice groups, to national specialty boards, the enabling legislation for health courts will need to specify the criterion by which the legally-binding guidelines are to be identified. In addition, physicians should be warned not to expect this reform to work a fundamental change in malpractice litigation. 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

112 Mello et al, supra note 7 at 464.
113 Id. at 461.
114 Id. at 465.
115 Id at 467.
Health Courts?

during the impeachment of an opposing expert.\textsuperscript{116} Furthermore, the data on the jury verdicts suggests that juries exonerate doctors who clearly comply with professional norms. The difficult cases are those in which the parties dispute whether the doctor fully complied with the applicable guideline or whether the guidelines apply in circumstances like those of the plaintiff. Those disputes will not be eliminated by the reforms contained in the new health court plan.

Practice guidelines are of most value in simple cases.\textsuperscript{117} Yet simple cases are not the ones in which physicians are most uncertain about either medical or the legal standard of care. The clear cases are the ones that juries and settlement negotiators are likely to resolve correctly even without health courts. The worrisome cases are those in which the standard of care is disputed or ambiguous and those in which the evidence of what happened to the patient are least clear. These are the cases whose outcomes are most subject to argument and manipulation. Yet, they won’t be governed by practice guidelines and the ACEs in a new health court system.

Conceivably, some of this uncertainty could be reduced overtime by the written opinions of the health court when it decides these cases. 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, Holmes argued the 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.”\textsuperscript{118} After his appointment to the U.S. Supreme Court, Justice Holmes convinced a unanimous Court to

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\item[116] See, e.g., \textsc{Barry R. Furrow et al.}, 1 \textit{Health Law} 363-64 (1995) (noting that the source of the guideline determines its weight).
\item[118] \textsc{Oliver Wendell Holmes, The Common Law} 111-12 (1981).
\end{itemize}
\end{footnotesize}
adopt his view. 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. “[W]hen the standard is clear,” wrote Holmes, “it should be laid down once and all by the Courts.” Seven years later, Holmes had retired and Justice Cardozo convinced the Court to abandon the “stop, look, and listen” rule. General rules, wrote Cardozo, fail to leave room for individual circumstances. Holmes’ rule, for example, did not take into account the specific facts of an individual case, such as whether getting out of the car at that location would be ineffective or whether getting out and then rushing back to the car would have been even more dangerous than simply listening for the sound of a train and then proceeding cautiously. 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 are more successful than Holmes was will turn on the susceptibility of common malpractice changes to \textit{ex ante} resolution.

On balance, the combination of written opinions, binding guidelines, and ACEs have 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, there is simply a limit to the detail with which legal standards of conduct can be articulated in advance. Nonetheless, a pilot experiment testing these provisions would be worthwhile.

\textbf{F. Synthesis}

The research on medical malpractice verdicts shows that juries treat physicians very fairly, perhaps with too much deference. 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

\begin{itemize}
\item See, e.g. David M. Eddy, \textit{Variations in Physician Practice: The Role of Uncertainty}, \textit{3 Health Aff.}, Summer 1984 (explaining the many causes of uncertainty); John Wennberg, \textit{Dealing with Medical Malpractice Variations: A Proposal for Action}, \textit{3 Health Aff.}, Summer 1984, at 6,7 (noting that physician practices vary widely, even within narrow geographic areas).
\end{itemize}
Health Courts?

adjudication system that will have a substantially higher agreement rate in cases with weak evidence of negligence. At most, modest improvements may be possible through careful refinements, such as the appointment of an expert who answers only to the court.

The data on settlement outcomes is similarly reassuring. To the extent that juries and settlements err, the error is more likely to favor the defendant physician than the plaintiff patient. 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. 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 wishes 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. Any experiment with health courts absolutely must include an evaluation component to determine whether the new tribunals are yielding just outcomes.

Others 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. These reforms are likely to make the legal standard of care more concrete and to yield verdicts that are more consistent over time. 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. 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 the right to a jury trial. That is a topic to which I return after examining the other risks and benefits of the health court proposal.
III. 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 claim that the judicial system disposes poorly of the claims that enter the courthouse, they charge that the current system prompts the wrong patients to sue. On the one hand, very 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 reduce either of these problems substantially.

A. Impact on Under-claiming

Too few malpractice claims are filed. Few serious scholars dispute that. Only 2-3% of the patients who are injured by medical negligence ever file a claim.\textsuperscript{123} Some of the under-claiming results because the injuries were relatively minor. Yet, one highly respected scholar estimates that only about 3-5% of the patients whose injuries are serious make a claim.\textsuperscript{124} As a result, the current legal regime is widely believed to do a poor job of protecting the rights and welfare of negligently injured patients.

Sponsors of the health court plan believe that simplification of the claims process will increase the claiming, thus improving the system’s ability to provide just compensation and also strengthening its deterrent signal.\textsuperscript{125} Their willingness to recognize this problem and to look for solutions is a demonstration of 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. Initiation of the process might be as simple as requesting and completing a claims form at the hospital. In addition, the potential

\textsuperscript{123} A. Russell Localio et al., \textit{Relation Between Malpractice Claims and Adverse Events Due to Negligence}, 325 NEW ENG. J. MED. 245, 247 (1991).
\textsuperscript{124} See Mello, \textit{supra} note 18, at 6 (“Less than 5% of the patients with serious injuries due to negligence ever become claimants.”)
\textsuperscript{125} Mello et al., \textit{supra} note 7, at 471.
Health Courts?

speed and relative simplicity of the claims resolution process may reduce patient reluctance to initiate it. 126

Nevertheless, many of the factors that currently limit claiming 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. Many will still lack advisors or confidents who can help them understand their rights. Because physicians will still be individually liable, they are unlikely to assist patients in making claims, as they reportedly do in Sweden. 127

Furthermore, the planned abrogation of the collateral source rule will more than offset the benefits of claims simplification. Today, minor and even moderate injuries are typically not worth pursuing because of the costs of malpractice litigation are so high and odds of success before a jury are long. Abrogation of 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. Its impact will be limited by two factors. First, insurers traditionally resist paying legitimate patient claims until the patient demonstrates her seriousness by hiring a lawyer or a medical expert. 128 Second, the sponsors of health courts have underestimated the extent to which the fair resolution of complex medical malpractice claims requires an equally complex dispute resolution process. As will be explained in Part IV, accurate decision-making in complex

126 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
127 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. In fact, neither they nor their hospitals pay premiums for liability insurance. Instead, that insurance is funded out of tax revenues. Furthermore, claims that are made against the fund do not name individual defendants. These factors produce a climate of cooperation that is justly envied by health safety advocates in the U.S. Id. at 460.
128 See infra text at note *.  

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Health Courts?

cases often requires both significant pretrial discovery and multiple expert witnesses. 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, the proposed plan is more likely to exacerbate under-claiming than to relieve it.

B. 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. In the most recent study, David Studdert and his colleagues found that 37 percent of all claims in the sample lacked evidence of medical error.

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 that they received. Furthermore, the huge majority of unwarranted claims are dropped or dismissed without payment. When patients insist on bringing them to trial, defendants rarely lose a jury verdict.

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. For physicians, being drawn in the

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129 See Part IV, infra, for a defense of this conclusion.
130 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.
131 Studdert, supra note 68, at 2024.
132 Studdert, supra note 68, at 2030-2031. Many claims are difficult to evaluate without hearing the recollections of the physicians and nurses who provided the patient’s care. Typically, they will not talk to the patient’s attorneys unless the patient files suit and takes their depositions. Thus, filing a lawsuit is often a necessary part of investigating the merits of her claim. Until some form of “pre-lawsuit” discovery is crafted to provide the necessary information, these lawsuits will continue.
133 Peters, Settlement, supra note 61, at 48 (reviewing the empirical data).
134 Peters, Juries, supra note 49, at 1459-1460 (reviewing the empirical data).
Health Courts?

process is itself a form of punishment. Even if we discount their complaints to account for their thin skins and their sense of entitlement, there are credible reasons for believing that medical malpractice defendants suffer more from unwarranted lawsuits than do defendants in other routine tort actions, such as automobile accident and product liability cases.

Some of the factors that distinguish medical malpractice cases 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. Second, while automobile drivers are as likely to be plaintiffs as defendants, 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 average automobile driver. 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.\textsuperscript{136} Physicians, on the other hand, are sued as individuals and predictably “take malpractice suits very personally.”\textsuperscript{137} 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.”\textsuperscript{138}

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.\textsuperscript{139} 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.\textsuperscript{140} Insurers and hospitals routinely go

\textsuperscript{136} Weiler et al., supra note 35, at 126.


\textsuperscript{138} Id.

\textsuperscript{139} Id.

\textsuperscript{140} 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
even farther, demanding disclosure of every claim made against the doctor, regardless of its disposition. As one physician 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.”

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

Lucian L. Leape, MD, 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. “One result is that physicians, not unlike test pilots, come to view error as a failure of character.” Once human error is transformed into a failure of character, every unwarranted charge of negligence is experienced as a viciously libel.

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 to view it as an attack on her competence and self-worth, than, for example, a grocery store janitor whose delay in cleaning a broken pickle jar results in a customer injury. The magnitude of personal anguish is revealed regularly in the priority that they place on malpractice reform and in the deep anger and distress that physicians express individually in ordinary conversations about the topic. They are elite and powerful professionals who often base much of their personal identity and self-

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physicians have been less likely to settle claims since introduction of the NPDB in 1990, especially for payments less than $50,000).


Health Courts?

worth on their professional status. As a result, they suffer from a charge of negligence in a different way than does, for example, 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 tell their children not to practice medicine, to think of retiring early, and to stop seeing patients whom they perceived to be more likely to sue. The sued physicians were also much more likely to report severe depressed mood, inner tension, anger, and frustration than the nonsued physicians. In fact, a strong reaction of anger was “pervasive” among sued physicians (88%). They perceived themselves as scapegoats of the legal profession. Yet, only 24.8% of the sued doctors had paid settlements. 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.

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 the 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, punishment is inflicted upon the innocent and guilty alike. Under these circumstances, the fact that roughly 40 percent of all malpractice claims lack merit is highly damning and fuels the perception that the system is irrational. These

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144 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 causes suffering in them and their families. Id. at 440.
145 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.
147 Id. at 565.
148 Charles et al., supra note 144, at 438 (18.5% settled with doctor’s permission and 6.3% settled without).
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, \textsuperscript{149} these measures do not appear to have produced a significant improvement.\textsuperscript{150} 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. Under the health court plan, patients could make these “what the heck” claims without the filtering that occurs when they attempt to find a lawyer who will take their case.

A better way to protect physicians from the pain inflicted simply by 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 VII.

To sum up, 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.


\textsuperscript{150} \textit{See, e.g.}, \textsc{Furrow et al.}, \textit{supra} note 116, at 531-32 (discussing the mixed success of screening panels).
IV. THE QUEST FOR IMPROVED EFFICIENCY THROUGH PROCEDURAL SIMPLIFICATION

Health court advocates believe that their proposed administrative process will make the resolution of malpractice claims both faster and less costly. In some states, medical malpractice cases currently linger for years before they are settled or tried. 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 the resolution of pretrial motions run the bill up even further. As a result, less than 50 cents of every dollar paid by physicians for their malpractice insurance ultimately goes to injured patients. Most of the rest is consumed by the process of deciding which patients should receive a payment. 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 percent of workers compensation premiums reach injured workers and 85 to 90 percent of the premiums paid for disability insurance reach disabled policyholders.

As a consequence, malpractice litigation’s time and expense pose a very serious problem. Medical malpractice litigation shares this problem with other areas of technically or scientifically complex fault-based litigation, such as disputes over defective product design. There, too, creative solutions are badly needed.

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. 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. Although

151 Mello, supra note 18, at 6.
152 Id.
Health Courts?

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.

Unfortunately, cutting these steps of 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.\textsuperscript{153} 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 \textit{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 \textit{issues}, like 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.

A. 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

\textsuperscript{153} Troyen A. Brennan & Michelle M. Mello, \textit{Patient safety and medical malpractice: a case study}, 139 ANN INTERN MED 267 (2003) (acknowledging that the administrative cost savings produced by no fault programs come “largely by minimizing the role of the lawyers”).
Health Courts?

liberal discovery and significant motion practice. At the other, are administrative processes that provide only minimal due process, such as license suspension proceedings, where citizens are simply given notice and an opportunity to tell their stories. Most administrative tribunals fall between those two models. The location that health courts occupy 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. In the federal system, 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. However, the independent tribunals created by Congress are quite different from the agency-associated tribunals.

Independent Article I courts, such as the Tax Court and the Court of Federal Claims, are created by Congress as freestanding bodies and strongly resemble judicial trial courts. The bankruptcy courts are even annexed to the federal district courts. 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. Parties rarely proceed without a lawyer. Substantial pretrial discovery and motion practice are the norm. Each side calls both fact and expert witnesses and cross-examination is a matter of right. Except for the absence of a jury, litigation before these administrative courts is very much like litigation in traditional civil courts. 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. 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). These

154 See infra text following note 155.
155 See infra text at notes 158-70
Health Courts?

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. Because these tribunals have close ties to an executive branch agency, their proceedings are often called agency adjudications or, less commonly, Article II proceedings because of their close connection to the executive branch.

If lawmakers choose to use an agency adjudication model for health courts, then they also must decide whether to make the tribunal subject to the jurisdiction’s Administrative Procedure Act (APA). Tribunals that are not governed by 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. No tribunal-assisted discovery takes place and the tribunal can bar attorneys. The hearing officers have lower pay and less prestige than the administrative law judges who sit in tribunals governed by the APA. 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. As one observed noted, these informal tribunals are often staffed by lower-caliber judges “who can tolerate

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156 Bruff, supra note 100, at 360
157 Id. at 329 (calling them “Article II executive adjudicators”).
159 See generally Aman & Mayton, supra note 158, at 254-62 (stating, at 254, that agency procedures for informal actions range from “no procedure at all” to “procedures that begin to approximate, but not quite duplicate, those set forth in [the APA]”).
160 In tribunals governed by the APA, the decision-maker is an “administrative law judge.” Pierce et al., supra note 124, 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.
161 Bruff, supra note 100, at 326 (describing a controversial policy in the social security disability benefits program).
life on the assembly line.” 162 This model would satisfy neither doctors nor their patients.

Adjudicative proceedings that are subject to the APA (also called “formal” proceedings) 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.163 Social security eligibility proceedings fit this model.

Although APA 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 an APA proceeding if the hearing officer feels that doing so is necessary “for a full and true disclosure of the facts.”164 In practice, most agencies place material limits on cross-examination.165 Furthermore, testimony before the tribunal often is submitted in written form, rather than by personal appearance.166 In addition, the APA does not require any opportunity for pretrial discovery.167 As a result, agencies can set their own policies over discovery and those policies vary widely.168

The next difference is that the rules of evidence do not apply in administrative hearings.169 Instead, administrative tribunals freely admit hearsay evidence and commonly take judicial notice of facts

162 Id. at 331.
163 5 U.S.C.A. § 553(c), 554(c)(2) (1982); AMAN & MAYTON, supra note 158, at 220.
164 5 U.S.C.A § 556(d) (1982); AMAN & MAYTON, supra note 158, at 220.
165 AMAN & MAYTON, supra note 158, at 221.
166 See, e.g., Walter Gellhorn, Rules of Evidence and Official Notice in Formal Administrative Hearings, 1971 DUKE L.J. 1, 37; PIERCE ET AL., supra note 158, at 311.
168 AMAN & MAYTON, supra note 158, at 219-20.
169 Id. at 221-34; PIERCE ET AL., supra note 158, at 310-11;
170 AMAN & MAYTON, supra note 158, at 229-30 (also noting that the APA requires that parties be given the opportunity “to show the contrary”); PIERCE ET AL., supra note 158, at 311.
Health Courts?

that are not in the record. Finally, administrative law judges are less independent, less well-paid, and less respected than trial court judges.

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 where individual fault is an important issue, such as those involving tax compliance.

B. The Risks of Simplification

When advocates of health courts extol the simplicity and efficiency of their proposed claims process, they treat modern procedural protections as if they were objectionable Victorian relics, meant only to enrich attorneys and enrage physicians. The truth is very different. These safeguards were established to produce more just outcomes. They were, in fact, a reaction to the unfairness associated with more streamlined Victorian processes.

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. The pleadings used to initiate a lawsuit had to be highly detailed. This probably reduced the risk of frivolous lawsuits. Unfortunately, it also led to the dismissal of many meritorious cases. The problem of unjust outcomes was especially great when key evidence lay in the possession of the defendant or his associates.

172 See CHARLES ALAN WRIGHT & ARTHUR R. MILLER, 5A FEDERAL PRACTICE AND PROCEDURE; CIVIL 3D, §331, at 467 (2004) (hereinafter, “Wright & Miller”) (noting 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 discover then in effect).
Concern about unjust outcomes prompted enactment of the Federal Rules of Civil Procedure (FRCP) in 1938. Their express goal was to decide more cases on their true merits. Among other things, the FRCP marked the introduction of a less detailed form of pleading called “notice pleading” and the blossoming of court-sanctioned discovery. 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. The new system relies much less on the pleadings to identify the issues and to weed 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. As a result, trial judges rarely dismiss a case before considerable discovery has taken place. 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.” 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.

Administrative tribunals depart from this judicial model. They have streamlined their procedures in order to process a large volume of claims at a manageable cost. Literally millions of disputes over government benefits are decided by administrative tribunals every year. A streamlined adjudicative process enables the agencies to process these disputes efficiently and, as long as the claims tend to be

173 See FRIEDENTHAL ET AL., CIVIL PROCEDURE, 245, 253 (4th ed. 2005) (also noting that most states then followed suit).
174 FED. R. CIV. P. 8(a)(2).
175 See WRIGHT & MILLER, supra note 172, at 469.
176 Hospital Bldg. v. Trustees of Rex Hosp., 425 U.S. 738, 746 (1976) (“We have held that ‘a complaint should not be dismissed for failure to state a claim unless it appears beyond a doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.’”)
177 See FLEMING JAMES, JR., ET AL., CIVIL PROCEDURE 287 (5th ed. 2001).
178 See KENNETH CULP DAVIS & RICHARD J. PIERCE, JR, Vol. 1 ADMINISTRATIVE LAW TREATISE 378-79 (3d ed. 1994) (noting that government “would collapse of its own weight” if full judicial process were required).
Health Courts?

routine, at a tolerable risk of error. A more expensive process is not typically warranted by the stakes. In some instances, it would make claims resolution unavailable to many citizens.¹⁷⁹ In most of these expedited adjudicative processes, no determination of individual fault needs to be made.

C. Streamlining in Medical Malpractice Cases

An abbreviated administrative process would not be appropriate for the resolution of controverted 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. Mishaps are omitted.¹⁸⁰ In addition, many cases are tainted by suspicions that the chart has been altered.¹⁸¹ 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. As a result, patients often must file a lawsuit just to find out what went wrong.¹⁸² The Physician Payment Review Commission acknowledged this information asymmetry in its 1995 report to Congress, stating that “[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.”¹⁸³ Malpractice defendants make powerful use of the information

¹⁸² See Gerald B. Hickson et al., Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries, 267 J. OF AM. MED. ASSN. 1359 (1992) (finding that patients often sue to obtain information).
asymmetry that typically exists. One study found that settlement offers were rarely made when patients used a hospital’s voluntary, informal complaint process. Instead, the hospital 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.” Another study found that settlement of cases with severe injuries never occurred prior to the filing of a lawsuit. Often the defendant makes no offer until the patient has retained an expert who will testify that the defendant breached the standard of care. Nonlitigious patients are rarely compensated—not even when the hospital believes that the patient has been injured by medical negligence. 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 them to obtain information from recalcitrant witnesses. In addition, parties are given the right to cross-examine adverse witnesses and to offer witnesses of their own, including experts. Because patients who sue their doctors lack the social and political influence of the doctors whom they sue, their rights are also protected by placing the civil justice system in its own independent branch of government and by insisting that verdicts

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185 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).
186 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.”)
188 Id.
189 See Farber & White, supra note 185, at 795. The goal is to avoid settling with the “peaceful” patients who will not file suit. Id.
190 See Mello et al., supra note 7, at 465.
be rendered by a jury of their 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 to 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. They have even suggested that patients whose claims are initially rejected by an insurer will appeal their decisions to the health court without the assistance of counsel.\(^{190}\) Apparently, they assume that 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.” No similar cap is proposed for the fees of defense counsel. 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 percent when they win. Thus, a cap is likely to diminish the quality of lawyers willing to represent malpractice plaintiffs and reduce the thoroughness of representation that these attorneys are able to provide.\(^{191}\) Counsel will be less likely than they are today to accept cases that require substantial investigation in order to evaluate their merits. Caps on attorneys’ fees, in short, would be unjust to injured

\(^{190}\) Patricia Munch Danzon and Lee A. Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. LEG. STUD. 345, 363 (1983) (finding that fees cannot be reduced without also reducing attorney effort and that “the evidence is more consistent with contingent fees yielding only competitive returns at the margin.”)
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. Occasionally, however, their personal clinical choices will not coincide with the “best practices” required by the avoidability standard of care. Hearing multiple expert opinions will help the trial judge construct a 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.

D. Synthesis

Health courts should not be created until the sponsors provide concrete assurances that they 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 that cases are decided on the merits.

Unfortunately, this level of procedural protection will substantially reduce the reduction in time and cost that proponents hope to obtain from health courts. If reformers want a considerably faster and less adversarial process, then 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

193 However, an argument could certainly be made for a separate, more simplified process for handling of small claims.
Health Courts?

need not prove that their injuries were caused by anyone else’s fault. This eliminates protracted litigation to determine the appropriate standard of care, often involving the depositions of multiple experts scattered across the country. It also eliminates the extended fact-finding that is often necessary to determine which provider, if any, failed to comply with that standard. When litigation over the issue of fault is eliminated, large administrative savings are possible. As long as it 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 the inclusion of these safeguards will reduce the cost savings achieved, their inclusion will repay those financial costs with superior justice.

V. PRODUCING MORE CONSISTENT DAMAGE AWARDS THROUGH SCHEDULING

The health court proposal would create a schedule for pain and suffering damages in which the size of the plaintiff’s recovery for noneconomic harm would be calibrated to match the severity of her injuries. This reform has the potential to greatly improve the consistency and horizontal fairness of damage awards because damage awards in malpractice cases are currently highly inconsistent. Under the proposed schedule, like cases would be treated more alike. 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.

A damages schedule would also satisfy critics who think that a ceiling must be set on pain and suffering recovery in order to prevent “excessive” awards. Unlike state tort reforms that impose a single

194 See Mello, supra note 7, at 468 (crediting a proposal by Bovbjerg, Sloan, and Blumstein in 1989).
painless and suffering cap for all injuries, however, a damages schedule would take severity into account. This is a considerable improvement.

Nevertheless, the task of producing the schedule will be fraught with all of 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 the 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 will create the risk that materially different cases will be treated as if they were alike. Too much discretion will introduce the risk that awards in cases involving injuries will vary considerably from judge to judge. Despite the difficulty of the task, however, the potential benefits justify the risks.

The most troubling danger posed by the adoption of a damages schedule 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. To prevent these two problems, drafters should 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.” This is a genuinely frightening idea that completely misunderstands the role and function of compensatory damages.

As with other tort recoveries, malpractice awards are designed to accomplish corrective justice by making the negligently injured patient whole. These recoveries are not paid out of tax revenues and, thus, are not subject to legislative judgments about allocation of

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196 See Joanne Doroshow, The Health Courts Façade, 42 TRIAL, Jan. 2006, at 20, 22 (noting that these plans fail to fully compensate even for lost pre-injury income and noting that statutory damage schedules are subject to reduction over time by legislature)
197 Mello, supra note 7, at 470.
Health Courts?

general revenue. Instead, the judges and juries resolving tort disputes are deciding 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. Through the capping of recovery, this regime would force negligently injured patients to subsidize the cost of health care 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. As a result, any verdict on this reform must await concrete details about the size and basis for the contemplated awards.

VI. 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. Indeed, patient safety is the benefit that they emphasize most. This emphasis is not misplaced. Several of the proposed changes have the potential to produce improvements in 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. However, the plan is unlikely to deliver the safety benefit that patient safety advocates covet most—greater physician disclosure of errors. To accomplish that fundamental objective will require either a paradigm shift 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 that the threat of malpractice liability gives physicians a concrete incentive to provide
Health Courts?

competent care. Yet, there is no reliable evidence to substantiate this assumption despite several attempts to detect a deterrent impact. Though these efforts are beset with methodological obstacles, it is nonetheless both disappointing and telling that no reliable evidence of safety improvements has surfaced.198

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,199 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. 200 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. 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. 201 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. 202 Patient safety advocates persuasively argue that open discussion of errors is a necessary precursor to systematic safety improvements.

198 See Mello & Brennan, supra note 39, at 1607-13 (concluding that there is currently no reliable evidence of systematic safety improvements due to tort law).
199 See Mello & Brennan, supra note 39, at 1616 (noting that experience-rating is rare for individual physicians because claims are too stochastic to be a credible indicator of physician quality or risk).
200 See Mello & Brennan, supra note 39, at 1618 (noting the distorted signal sent by the combination of very low claims rate among people with valid claims and a high number of baseless claims), 1618 (noting that insufficient claiming produces insufficient internalization of the damages caused by poor medicine), & 1620 (explaining the role of certainty of detection).
201 See Mello & Brennan, supra note 39, at 1619 (discussing the poor fit between payment and poor medicine).
202 INSTITUTE OF MEDICINE, TO ERR IS HUMAN (2000).
They believe that fear of lawsuits discourages doctors from disclosing their own errors and participating in these discussions. In addition, the perception that lawsuits are random makes it hard to convince physicians that safety initiatives will pay legal dividends. These realities have prompted most patient safety advocates to conclude that malpractice reform is an essential predicate to fundamental improvement in patient safety.

To rebut this argument, opponents of malpractice reform typically point to the dramatic safety improvements made in anesthesiology over the past twenty years. They cite these improvements as proof that the incentives created by malpractice liability can and do improve patient safety. 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.

The transformation of anesthesiology was certainly a splendid illustration of tort’s deterrent power. Sadly, it 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 VI 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. 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. 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. Third, sponsors believe that the simplified claims process associated with

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203 See Mello et al., supra note 7, at 473.
204 See infra text at notes 244-47.
205 Mello & Brennan, supra note 7. 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. Id.
their plan will make claiming easier and, thus, make malpractice law’s deterrent signal more robust. Fourth, proponents believe that 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 efforts to prevent medical accidents. Finally, the claims data that will be gathered by the health court can be used to detect recurring problems and design ways to prevent them. Each of these potential improvements will be addressed in turn.

**A. 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. Proposing this change was politically brave; studies repeatedly show that practicing physicians are slow to adopt important improvements in treatment. However, the clinical effect of this new standard is likely to be tempered by one of the obstacles that also limits the deterrent effect of existing malpractice law. Under the health courts plan, liability will be borne by individual physicians, rather than the larger health care enterprises in which physicians function. Yet, liability insurance for physicians is not experience-rated. As a result, the legal incentive for physicians to raise their level of practice will be tempered significantly. For this reason, it seems reasonable to welcome the proposed avoidability standard of recovery while also concluding that its impact on clinical practices and patient safety is too uncertain to predict.

**B. 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. 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. Several features of health courts are intended to contribute to this goal. One is that all health court decisions will be published and

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

207 See Mello et al., supra note 7, at 468-69.
Health Courts?

will be binding precedents in future cases. These past decisions will provide physicians with valuable guidance about the way that similar 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 of the malpractice cases in a given jurisdiction will be decided by a single judge or set of judges. 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. 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.

C. 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. 208 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, 209 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. 210

D. Centralized Data Collection

Specialized health courts would also improve patient safety by creating a central repository of information about iatrogenic injury. 211 Malpractice claims files could potentially provide public health

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208 See Mello et al., supra note 7, 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’s not clear why this would be so, unless we assume that physicians and nurses will guide patient’s 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 margin or weak claims will become legally compensable.

209 See supra text at notes 123-30.

210 Id.

211 See Mello et al., supra note 7, at 476-82.
Health Courts?

researchers with detailed information about the kinds of injuries and clinical practices that most often produce significant iatrogenic injury. This 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 number of hospitals have their own reporting requirements, none have been able to generate the volume of data desired by patient safety advocates.

Public health researchers are understandably hungry to collect this data. Better information about the causes of medical injury will lead to improvements in patient safety.\textsuperscript{212} Because most doctors are unwilling to disclose their medical accidents and errors voluntarily, the lawsuits filed against them could provide a useful substitute.

However, the usefulness of this 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 has apparently been useful in other countries.\textsuperscript{213} As a result, it is possible, that this data set could be used to reduce iatrogenic injuries here.

E. Fostering Disclosure by Physicians

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

\textsuperscript{212} \textit{Id.} at 474-75 (indicating that hospitals will be obliged to do a hospital root-cause analysis following each claim)

\textsuperscript{213} See Mello et al., \textit{supra} note 7, at 478-82 (contending that benefits have accrued in other countries which have adopted administrative claims processes).
Health Courts?

Health court backers also believe that the new avoidability standard of care will make it easier for physicians to talk about their mistakes. When patients sue, they will merely allege that an “avoidable” injury occurred, not that the physician was negligent or incompetent. 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. In addition, supporters believe that specialized health courts, by virtue of their expertise, will reduce the nearly universal distrust that physicians have towards the system of justice. This distrust produces a culture of defensiveness that impedes efforts to improve quality. As a consequence, 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.

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. Physician silence is produced by many factors and nearly all of them will remain in place after health courts are established. As a result, it will take a far more dramatic change in the law to bring about that disclosure—something approaching legal immunity.

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

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214 See id. at 474.
215 See id. at 474. 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.
216 Howard, supra note 54 (testimony at a Congressional hearing).
217 42 U.S.C § 299b-22 et seq. (2005); Public Law 109-41 (signed by President George W. Bush on July 29, 2005).
legal reform requested by the patient safety movement was legislation to make these disclosures confidential. Congress promptly responded, giving physicians precisely the assurances they had requested. Yet, the new law did not solve the problem of physician silence. As a result, frustrated patient safety advocates are now searching for a better way to shake physicians out of their fortress mentality.

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. Errors threaten their self-esteem and expose them to the risk of stigmatization by peers and of loss of autonomy and authority. Even before the emergence of modern malpractice litigation in the 1960s, those dangers made physicians very reluctant to report mishaps.

Interestingly, these professional barriers also operate in countries that have not experienced an expansion of malpractice litigation similar to ours. Canadian physicians, for example, are sued approximately one quarter as frequently as American doctors. Yet, Canadian physicians are only somewhat more supportive of disclosing serious errors to patients than U.S. physicians are, and they are no more likely to report having actually disclosed any. When patients from the two countries were asked about disclosure, they were equally likely to report the failure of their doctors to disclose a medical mistake. The researchers concluded that “U.S. 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

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218 See, e.g., Harris et al., supra note 102 (finding that insurers paid settlements in nearly half of the cases in which physicians denied liability to the researchers).
219 Thomas H. Gallagher et al., Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients, 166 ARCH. INTERN. MED. 1585, 1585 (2006).
220 See Mello et al., supra note 7, at 473.
221 Thomas H. Gallagher et al., US and Canadian Physicians’ Attitudes and Experiences Regarding Disclosing Errors to Patients, 166 ARCH. INTERN. MED. 1605, 1606, n. 21-23 (2006).
222 Id. at 1609.
223 Id. at 1605, 1607.
224 Gallagher et al., supra note 217, at 1592.
determinant” of physician reluctance to disclose. Instead, disclosure practices “may relate to the norms, values, and practices that constitute the culture of medicine.”

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. In order for a legal reform to have that effect, it will need to offer physicians considerably greater insulation from the costs of liability 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.

F. Synthesis

Several provisions in the health court plan have the potential to make a contribution toward the goal of 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

\[225\] Gallagher et al., supra note 221, at 1609.

\[226\] Id.


\[228\] 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.
from the simplified claims procedure are likely to be offset by the disincentives to claiming associated with abrogation of the collateral source. 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 the adoption of hospital enterprise liability—perhaps both.

VII. 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 produce significant improvements in patient safety than any aspect of the current health court plan. It is also more likely than they are to reduce the extraordinary fear and anger that physicians feel today. As a result, the absence of 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. Today, physicians who are not hospital-based are ordinarily treated as independent contractors, rather than agents or employees of the hospital.229 As a result, hospitals 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.230 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 the lawsuit, they are routinely represented and held harmless by

229 See BARRY R. FURROW, HEALTH LAW 374 (2000) (describing the traditional independent contractor relationship). 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.

230 See, e.g. DAN B. DOBBS, THE LAW OF TORTS 910-17 (2000) (noting that the negligence must occur within the scope of employment).
their employer.\textsuperscript{231} As a result, 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 employees.\textsuperscript{232} Physicians have long favored this categorization because they value the independence they associate with this status. 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.\textsuperscript{233} They have resisted corporate influence ever since—most recently in their successful alliance with patients to limit the power of managed care organizations. However, their independence has a cost. Physicians are named as defendants far more often than people who work in any other trade or profession.

Health care’s unique structural arrangements produce two significant drawbacks that are relevant here. First, hospitals don’t have the same legal incentive to minimize accidents that other businesses do, like airlines and auto manufacturers.\textsuperscript{234} Second, the absence of exclusive organizational liability deprives physicians of the buffer that protects most workers from the financial and emotional burdens of being a target defendant.\textsuperscript{235} The predictable result is that 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 of today’s patient safety advocates on building safer medical systems, rather focusing exclusively on the performance of individuals. Safety advocates believe that the greatest improvements in patient safety will

\textsuperscript{231} I base this statement on my experience as a tort defense attorney.

\textsuperscript{232} See Furrow et al., supra note 229, at 374, 376; see also Dobbs, supra note 230, at 917 (describing the usual absence of vicarious liability for the torts of independent contractors).

\textsuperscript{233} See Mark A. Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care cost Containment, 137 U. Pa. L. Rev. 431 (1988) (describing this and other ways in which physicians successfully enlisted the law to protect their independence and power).

\textsuperscript{234} See Reporters’ Study, supra note 33, Vol. II, at 118.

\textsuperscript{235} See Reporters’ Study, supra note 33, Vol. II, at 121.
come from greater attention to the processes by which health care is delivered. They point out that a large fraction of the injuries that occur in hospitals are due to system breakdown. 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. 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 has the potential to produce that incentive.

The existing hole in the law governing medical accidents not only limits its deterrent effect, but also impairs its ability to provide just compensation to 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 among 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 liability. Hospitals, unlike individual physicians,
Health Courts?

can be experience-rated. 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 percent. Health care causes far too many accidental injuries to waste this potential.

Enterprise liability would also make optimal use of the resources that hospitals can bring to the mission of patient safety. Michelle Mello and Troyen Brennan offered the following frank assessment: “Only institutions can muster the resources to bring about systematic improvements in patient safety.” Enterprise liability would give them 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. Each has focused on an entire system of production and delivery, making use of 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. As a practical matter, each 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 substantial premiums for insurance against their own instances of careless behavior.” By contrast, roughly three-quarters of all malpractice claims are now brought against physicians and other individual providers.

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239 REPORTERS’ STU DY, VOL. II, supra note 33 , at 123-24; Mello & Brennan, supra note 38, at 1617-18, 1633.
241 Mello & Brennan, supra note 38, at 1623 (“In addition to its deterrence promise, enterprise liability is thoroughly consistent with system-oriented quality”).
242 Lucian L. Leape, Error in Medicine, 23 J. AM. MED. ASSN. 1851, 1852 (1994) (discussing the aviation industry).
243 REPORTERS’ STU DY, supra note 33, at VOL. II, 118 n.14.
244 Id. at VOL. II, 115.
Health Courts?

The deterrent power of enterprise liability is most poignantly illustrated by the miraculous reduction in anesthesia accidents that occurred at the end of the 20th century. It happened because all of the physicians in Harvard Medical School’s Department of Anaesthesia were insured by Harvard’s own medical malpractice insurance company. 245 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 hospital’s anesthesiologists to investigate why their collective experience was so poor. The group devised new techniques and equipment to lower the risk of mishap. 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. 246 The improved standards and tools that resulted from these combined efforts have since become standard across the country. 247 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. 248 Liability insurance premiums for the specialty of anesthesiology went from being among the highest in medicine to among the lowest.

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. 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

248 Hyman & Silver, *supra* note 248, at 918.
Health Courts?

Many promising safety initiatives are led by hospitals and managed care organizations which already operate under a system of \textit{de facto} exclusive enterprise liability\footnote{Tom Baker calls this “enterprise insurance.” \textsc{Baker, supra} note 47, at *174-78. Others call it insurance “channeling.” See, e.g., \textsc{Weiler, supra} note 33 at 126.} 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.\footnote{Laura Landro, \textit{Preventing the Tragedy of Misdiagnosis}, \textsc{Wall St. J.}, Nov. 29, 2006, at D1.} The two hospitals at the forefront of the movement to voluntarily disclose errors—the VA hospital in Lexington, Kentucky and the teaching hospital at the University of Michigan—also employ and insure their attending physicians.

Exclusive enterprise liability, whether \textit{de jure} or \textit{de facto}, also has the potential to modestly increase physician participation in patient safety initiatives along with their willingness to disclose medical errors to patient safety committees.\footnote{For a discussion of reasons why legal reforms are destined to have limited effect, \textit{see supra} text at notes *.} 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.\footnote{\textit{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) (noting that the usual plea for “blame free” quality enhancement ignores the legitimate expectations of injured patients).}

The likelihood that enterprise liability will free physicians to discuss errors and near misses more freely is suggested not only by common sense, but also by studies which have found the independent practicing physicians are less likely than physicians who work for an institution to support the disclosure of errors.\footnote{\textit{See Gallagher et al., Attitudes and Experiences, supra} note 221, at 1605; \textit{Gallagher et al., Choosing Your Words Carefully, supra} note 219, at 1591 (finding medical specialists disclosed less information if they were in private practice).} Private physicians
Health Courts?

are more likely to see disclosure proponents as naïve; they are “reluctant to do anything that might precipitate a lawsuit.” This attitude is a predictable consequence of their personal exposure to malpractice liability, a risk that physicians don’t face when they are protected by large insured institutions. 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.

Enterprise liability also has advantages that are unrelated to patient safety. For example, exclusive enterprise liability would save litigation costs by consolidating the defense of the hospital and all its providers. According to one report, about 25 percent of all medical malpractice cases have two or more defendants. 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 cycle and to weather them relatively smoothly. More than any other single factor, the periodic spikes of the insurance cycle precipitated the malpractice insurance and political crises of 1970s, 1980s, and 2001. Any malpractice reform that hopes to end these crises must temper the impact of these inevitable premium spikes on individual physicians. In other fields of social enterprise, enterprise liability has played this role. It could do the same in health care. Without enterprise liability, the current health court proposal offers nothing to soften the impact of the insurance cycle on the pocketbooks of individual physicians.

Third, enterprise liability removes the unfair penalty currently imposed on physicians who practice in a high-risk specialty, like obstetrics, neurosurgery, or emergency medicine. Physicians who

255 Id. at 1819.
256 Id. at 1819.
257 BAKER, supra note 47, at 178 (noting reduction in expense and complexity of defending lawsuits
258 REPORTERS’ STUDY, supra note 33, Vol. II, at 119.
259 See BAKER, supra note 47, at 165 (noting that hospitals are “better able to manage the volatility of the insurance underwriting cycle”).
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. As a result, some reformers have suggested that these specialties be given financial assistance from the state or from other providers. 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. Enterprise liability places on hospital systems to reduce iatrogenic injury is likely to produce more powerful and more productive pressures on individual physicians than individual liability.

Of course, enterprise liability has its own set of potential disadvantages. For example, the elimination of individual physician liability could theoretically dilute the effort that 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 widespread physician disbelief that the malpractice system rewards competence. As a result, the legal incentive that enterprise liability places on hospital systems to reduce iatrogenic injury 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 the hospital’s vicarious liability. Lawmakers will need to decide such issues as whether injuries occurring in outpatient facilities should be included or those caused by errors during office visits following hospitalization. However, we have no reason to believe that the task of defining these legal boundaries will be any more troublesome than countless others that lawmakers regularly tackle.

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261 See BAKER, supra note 47, at 175 (noting that individual insurance policies place too much of the burden on physicians in high-risk specialties and high-risk locations).
262 Furthermore, about ninety percent of the claims and payments now being made arise out of care given inside a hospital. REPORTERS’ STUDY, supra note 33, VOL. II, at 114.
263 Id
Health Courts?

Third, the federal anti-kickback laws, as currently written, may make it illegal for hospitals which do not employ their treating physicians to voluntarily adopt a *de facto* system of enterprise liability by purchasing insurance to cover all of the physicians on their staff.\(^{264}\) However, that has yet to be determined. Furthermore, state legislation imposing enterprise liability would sidestep the problem.\(^{265}\)

Finally, in cases involving patient injuries that were 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. Furthermore, the improved deterrence likely to be produced by enterprise liability 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. 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,\(^{266}\) Paul Weiler,\(^{267}\) Troyen Brennan,\(^{268}\) Michelle Mello,\(^{269}\) David Studdert,\(^{270}\) William Sage,\(^{271}\) and Tom

\(^{264}\) See *Baker*, supra note 47, at 176.
\(^{265}\) *Id.* at 176-77.
\(^{266}\) Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 Am. J. L. & Med. 7 (2000) (advocating vicarious liability for managed care plans)
\(^{268}\) Mello & Brennan, *supra* note 38.
\(^{269}\) *Id.*
\(^{270}\) See *supra* note 37.
\(^{271}\) *Baker*, supra note 47, at 164-65 (recommending that hospitals be obliged to purchase “enterprise insurance” covering all claims against medical providers using the organization’s facilities). He believes that doctors and hospitals might more readily accept enterprise insurance than enterprise liability because formal liability is resisted by physicians.
Baker. Although these scholars 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. 

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. On the other hand, physicians have traditionally opposed the expansion of hospital vicarious liability because they fear it will bring greater inference with their medical decision-making. Yet, this objection, as Paul Weiler notes, “evokes a health care world that has long since passed.” 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 notes that enterprise liability has existed in university hospitals and staff-model health maintenance organizations for many years without revolt.

Sooner or later, tort law needs to adapt to this modern era. In hindsight, it’s 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.


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

274 REPORTERS’ STUDY, supra note 33, VOL. II, at 125.

275 BAKER, supra note 47, at 177.

276 Id at 126.
**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.

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. 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. The room for improvement is very limited. Furthermore, the data clearly reveal that physicians benefit from jury errors far more often than plaintiffs. 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 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. 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 formal administrative courts, such as the Tax Court and the Court of Federal Claims. 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.
Health Courts?

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 noneconomic 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 physician on liability insurance that is not experience-rated. Furthermore, the transfer of malpractice cases from juries to specialized health courts is highly unlike 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. 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, such as 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. 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 quo pro*. 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. Without enterprise liability,

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277 They 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.
Health Courts?

the benefits of health courts are too modest to justify the risk that physician-guided health courts will be biased and too thin to warrant abrogation of the patient’s right to a trial by a jury of her peers.