Announcing Remedies for Medical Injury: A Proposal for Medical Liability Reform Based On the Patient Protection and Affordable Care Act

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ANNOUNCING REMEDIES FOR MEDICAL INJURY:
A PROPOSAL FOR MEDICAL LIABILITY REFORM BASED ON THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT

Steven E. Raper, M.D., J.D.

ABSTRACT

Recently reaffirmed, the Patient Protection and Affordable Care Act holds the promise of sweeping change in many critical aspects of the United States’ system of delivering health care. Indeed, medical liability reform is embedded into the DNA of the Obama presidency. Further, a Sense of the Senate statement raised a number of concerns over the current medical malpractice regime. These concerns led to the enactment of a small but conceptually important provision of the Affordable Care Act. Congress intends, however, to allow the states to develop liability reform through the allocation of 50 million dollars for State Demonstration Projects.

From a patient’s standpoint, the current medical liability regime is deeply flawed. Fear of lawsuits degrade the venerable physician-patient relationship. Fear of lawsuits also drives physicians to engage in behaviors known as defensive medicine. Such behaviors may be negative, leading to shortages of physicians or needed services or positive, leading to the ordering of tests, procedures or consultations that are not medically necessary. Lastly, the current medical malpractice system is inefficient, taking too long to provide compensation to too few patients sustaining medical injury.

This paper sets forth a detailed proposal for a novel approach to medical liability reform; that of announcing a schedule of remedies for patients sustaining medical injury. First, I discuss the development of the schedule of injuries for which compensation should be provided. Considerations include a mandate for disclosure of medical injuries to patients and their families, the types of claims to be covered, the compensation standard, and compensation package are discussed. The concept of injury threshold is advanced, and well as how such a proposal should be financed.

Next, building on work by Samuel Bray and others, I discuss principles of announcing remedies as an alternative to tort litigation. Medical injury, in particular, is a good candidate for announcing. One benefit is the ability to tie enhanced patient safety and quality to compensation. This allows experience rating to occur, identifying healthcare provider with a record of claims. Filing and adjudication of contested claims are important elements in a Patient’s Compensation program. There is a need for informed consent in, any such
program, which in parallel to the early worker’s compensation experience should be voluntary.

Lastly, other aspects of the Affordable Care Act’s provisions are discussed; including the effects on and possible elimination of the collateral source rule. Additional consideration of the Affordable Care Act’s provisions required of a successful proposal, including scope of jurisdiction and other factors to be given preference in the successful award of such a grant. Regardless of fault, the Patient’s Compensation program proposed here goes a long way towards remedying the problems patients face in the aftermath of medical injury.
Announcing Remedies for Medical Injury: A Proposal For Medical Liability Reform Based on the Patient Protection and Affordable Care Act

Introduction................................................................................................................................................1

The Affordable Care Act’s Approach to Liability Reform........................................................................4

Affordable Care Act Provisions and Alternatives to Current Medical Tort Litigation. ..................5

Patients are Not Well-Served by the Prevailing Medical Malpractice Regime .......................................8

Degradation of the Physician-Patient Relationship ..............................................................................9

Patients Bear the Brunt of Positive and Negative Defensive Medicine ............................................14

Negative Defensive Behaviors ..................................................................................................................15

Positive Defensive Behaviors..................................................................................................................18

Inefficiency of the Medical Malpractice System....................................................................................24

Patient’ Compensation Insurance: Proposal for a State Demonstration Project..............................29

A Proposal for Patient’s Compensation Insurance...............................................................................30

Scheduling Remedies for Medical Injury. ...............................................................................................32

Mandate for Disclosure ............................................................................................................................34

Types of Claims ......................................................................................................................................35

Compensation Standard ..........................................................................................................................37

Financing ................................................................................................................................................38

Compensation Package ...........................................................................................................................39

Establishing an Injury Threshold. ...........................................................................................................42

Announcing Remedies for Patients Suffering Medical Injury ..............................................................43

Announcing Remedies as an Alternative to Medical Malpractice .....................................................44

Uniting Patient Safety Enhancements and Compensation ......................................................................49

Experience Rating of Physicians and Health-care Organizations..........................................................49

Medical Reviews of Physicians and Hospitals Should Be Rigorous.....................................................50

Filing Method and Adjudication ...............................................................................................................51

Informed Consent for Patients Admitted to Hospitals ..........................................................................53

Eliminating the Collateral Source Rule, and Other Insurance Considerations ......................................54

Other Administrative Requirements of the Affordable Care Act .....................................................56

Scope of Jurisdiction .............................................................................................................................58

Preference in Awarding Demonstration Grants. ....................................................................................59

Conclusions...............................................................................................................................................60
Announcing Remedies for Medical Injury: A Proposal For Medical Liability Reform Based on the Patient Protection and Affordable Care Act

Introduction

From a patient’s standpoint, change is needed in the current medical liability system of compensation for medical injury. Liability reform is embedded in the DNA of the Obama Presidency, as initially shown by two attempts at reform. First was creation of an Executive branch program for liability reform prior to specific Congressional approval. Second, a Legislative branch provision in the landmark Patient Protection and Affordable Care Act also acknowledges the need for liability reform. With regard to the first attempt, on September 9, 2009, President Obama directed the Secretary of Health and Human Services to establish a grants initiative to help States and health care systems tie patient safety to medical liability reform; reducing preventable injuries, enhancing communication between doctors and their patients, ensuring patients with medical injuries are compensated in a fair and timely manner, reducing the incidence of frivolous lawsuits, and reducing liability premiums.

To implement this directive, in June 2010, the Agency for Healthcare Research and Quality (AHRQ, a Sub-Agency of the Department of Health and Human Services) announced $23.2 million in funding for seven demonstration grants to operate through

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1 Frank A. Sloan & Lindsey M. Chepke, Medical Malpractice 18 (The MIT Press, 2008)(defining medical injury as injury attributable to the provision of medical care to patients).
June 2013 and thirteen one year planning grants. AHRQ terminated funding
opportunities for both the demonstration grants and planning grants as of March 6, 2012. The funding opportunity was terminated because the Agency has no further appropriated funds to support these grants. In its place, medical liability reform was addressed in a small but conceptually important part of the recently affirmed Patient Protection and Affordable Care Act as discussed infra.

Why do both the Executive and Legislative branches of government feel compelled to champion medical liability reform? Viewed from the perspective of the patient, there are three major deficiencies in the way medical injury is currently compensated. First, the current medical malpractice regime leads to degradation of the physician-patient relationship. Second, it is the patient that must directly bear the practice of defensive medicine, or tests, procedures and subspecialty consults done to avoid lawsuits. Lastly, inefficiencies in the prevailing medical malpractice regime lead to

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5 Medical Liability Reform and Patient Safety Initiative Progress Report http://www.ahrq.gov/qual/liability/mediabrep.htm (Last accessed Sept. 13, 2012)(instituting a grant program for states and health care systems willing to undertake medical liability reforms)(The demonstration projects can be placed in three categories. The first category, Preventing Harm Through Best Practices, seeks to improve care in clinical areas that frequently are the subject of a large number of medical malpractice claims, testing whether implementing new ways to prevent medical injury can simultaneously improve patient safety and reduce the number of malpractice lawsuits. A second category, Improving Communication With Patients, seeks to test whether better communication can lead to fewer lawsuits, fairer and faster compensation, and improved patient safety. Lastly, one project, Alternative Methods of Dispute Resolution is trying to improve dispute resolution after a malpractice claim has been filed; through the use of an expanded and enhanced “judge-directed negotiation” program in New York courts, coupled with a new hospital early disclosure and settlement model.)


7 E-mail from Karen J. Migdail, Senior Policy Advisor, Agency For Healthcare Research & Quality to Steven E. Raper, Associate Professor of Surgery, Perelman School of Medicine (Sept. 13, 2012, 14:31:00 EDST)(on file with the author).

8 Natl. Federation of Independent Business v. Sebelius, Nos. 11-393, 11-398 and, 11-400, 2012 BL 160004 (U.S. June 28, 2012)(concluding that the individual mandate to purchase health insurance must be construed as imposing a tax on those who do not have health insurance).
underclaiming and undercompensation for the medically injured as well as long times between injury and case resolution.\(^9\)

Liability reform and the problems borne by patients can be ameliorated by a Patient’s Compensation program as discussed infra. The Patient’s Compensation program proposed here is different than any of the proposals funded under the original Obama initiative.\(^10\) There are two main features of the proposed Patient’s Compensation program. First is scheduling a defined set of injuries for which there is consensus that medical care is the cause of the injury. Given the generally accepted notion that faulty systems of care and not individual negligence cause medical injury, it is not necessary for a patient to prove negligence, only that the injury is one of those on the schedule. Further, the schedule of injuries is stratified by severity, so that only meaningful injuries are compensated. The conceptual model for the medical injury compensation schedule is the Federal Sentencing Guidelines. Second, to enhance patient safety and access to the information patients need to know, the schedule of remedies for medical injury will be announced.

Announcing remedies – ex ante determination and declaration of the precise remedy - for injuries sustained as a result of medical care holds the promise of three important patient benefits.\(^11\) First, there is greater equality; an injured patient’s right to compensation is not constrained by factors such as race, socioeconomic status, or what a plaintiff’s attorney would consider to be a ‘valuable’ case. Second, announcing remedies

\(^10\) AHRQ summary, supra note 4.
for medical injury holds the promise of greater compliance with rules such as those designed to enhance patient safety, as well as decrease positive and negative defensive medicine behaviors. Lastly, announcing such remedies decreases the costs of recovering from medical injury, or hedonic adaptation. Hedonic adaptation is an important process for letting patients recover from injury. Telling a successful story in a medical malpractice setting impairs such recovery.  

There are two basic approaches to improving the method by which patients injured by medical care are compensated; first is to apply various reforms to tort-based medical malpractice, such as caps on pain and suffering, and second, to abandon negligence in favor of an administrative model. Although commentators have put forth many arguments both supporting and opposing various forms of medical liability reform, they have proposed relatively few models for its revision. This article will discuss an administrative approach to liability reform different than any funded to date. Part I will explain the Affordable Care Act’s guidance in the development of State Demonstration Programs. Part II will summarize the negative impact of the current medical liability regime of patients who suffer medical injury. Part III will address how a Patient’s Compensation program would ameliorate many of the problems with the current approach to medical liability. Although modest in scope and ambition, such a novel alternative to compensating medical injury is a viable and much needed option to traditional tort reform.

The Affordable Care Act’s Approach to Liability Reform

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Affordable Care Act Provisions and Alternatives to Current Medical Tort Litigation.

Congress clearly senses that the current medical malpractice system needs improvement, as noted in the Affordable Care Act’s Sense of the Senate Regarding Medical Malpractice. The United States Senate noted that the existing civil litigation system could be improved with regard to patient safety, reduction of medical errors, more efficient resolution of disputes, increased availability of prompt, fair resolution of disputes, and access to liability insurance. In enacting the Affordable Care Act, Congress appears content to stay out of a leadership role in creating meaningful reform, instead working through the States. The Public Health Service Act 42 U.S.C 280g et seq. was amended by adding § 399V–4; State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation. Selected provisions are worth noting in the context of their strong adherence to a States-based emphasis on tort reform. The amended section authorized the Secretary of Health and Human Services to award, not to exceed a 5 year period, demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care providers.

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14 § 6801 (2), 124 Stat. 119, at 805 (“States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court; . . .”)
15 § 6801 (3), 124 Stat. 119, at 805 (“Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.”)
17 § 10607, 124 Stat. 119, 1010.
organizations. For purposes of funding such grants, Congress authorized $50 million dollars. However, the funds have not been appropriated to date. To be eligible for a demonstration program, states must show that an alternative to tort litigation allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations and promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to resolved disputes.

The alternative to a State’s current tort litigation should address a number of points: first, make the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes; second, encourage the efficient resolution of disputes; third, encourage the disclosure of health care errors; fourth, enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; fifth, improve access to liability insurance; sixth, fully inform patients about the differences in the alternative and current tort litigation; seventh, provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative; eighth, would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and lastly, would not limit

18 § 10607, 124 Stat. 119, 1010.
19 § 10607 (k), 124 Stat. 119, 1015.
20 E-mail from Karen J. Migdail, Senior Policy Advisor, Agency For Healthcare Research & Quality to Steven E. Raper, Associate Professor of Surgery, Perelman School of Medicine (Sept. 13, 2012, 14:31:00 EDST)(on file with the author).
or curtail a patient’s existing legal rights, ability to file a claim in or access a State’s legal system, or otherwise abrogate a patient’s ability to file a medical malpractice claim.\textsuperscript{22}

Each State proposing a demonstration project is required to identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation.\textsuperscript{23} The scope of jurisdiction of the demonstration project could be Statewide, a designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations.\textsuperscript{24} The scope of jurisdiction could not be based on a health care payer or patient population.\textsuperscript{25} States are also required to demonstrate how patients would be notified that they are receiving health care services that fall within such scope, and the process by which they may opt out of or voluntarily withdraw from participating in the alternative.\textsuperscript{26}

States with demonstration projects are required to submit an annual report evaluating the effectiveness of funded activities including the impact of the activities on patient safety and on the availability and price of medical liability insurance.\textsuperscript{27} Health and Human Services is also required to submit to Congress a report examining any

\textsuperscript{23} Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10607(c)(3), 124 Stat. 119, 1011 (2010)(funding sources could be public or private, or a combination of sources. Funding methods were encouraged to provide financial incentives for activities that improve patient safety, as well as compensation for plaintiffs.)
\textsuperscript{25} § 10607(c)(4)(A) 124 Stat at 1011.
\textsuperscript{26} Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10607(c)(4)(B), 124 Stat. 119, 1011 (2010)(Further, the decision of the patient whether to participate or continue participating in the alternative process shall be made at any time and shall not be limited in any way.)
differences that result from such activities in terms of the quality of care, number and
nature of medical errors, medical resources used, length of time for dispute resolution,
and the availability and price of liability insurance.\textsuperscript{28} Further, an evaluation of the State
demonstration program is required, and should include a number of specific measures.\textsuperscript{29}
Congress authorized to be appropriated section, $50,000,000 to carry out the State
demonstration programs for five years beginning with fiscal year 2011.\textsuperscript{30} Section 10608
also dealt briefly with medical malpractice by inserting after “to an individual”: “or an
officer, governing board member, employee, or contractor of a free clinic shall in
providing services for the free clinic.”\textsuperscript{31}

\textbf{Patients are Not Well-Served by the Prevailing Medical Malpractice Regime}

Viewed from the perspective of the patient, there are three major problems with
the current medical malpractice regime: a degradation of the physician-patient
relationship, the practice of \textit{defensive medicine} to avoid lawsuits, and inefficiencies in the
malpractice process leading to underclaiming and undercompensation for the medically

\textsuperscript{28} Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10607(e)(2), 124 Stat. 119,
1012-13 (2010).
\textsuperscript{29} Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10607(g)(3), 124 Stat. 119,
1014 (2010). (Measures include an analysis and comparisons on the basis of: the nature and number of
disputes over injuries allegedly caused by health care providers or health care organizations; the nature and
number of claims in which tort litigation was pursued despite the existence of an alternative; the disposition
disputes and claims, including the length of time and estimated costs to all parties; the medical liability
environment; health care quality; patient safety in terms of detecting, analyzing, and helping to reduce
medical errors and adverse events; patient and health care provider and organization satisfaction with the
alternative and with the medical liability environment; and impact on utilization of medical services,
appropriately adjusted for risk.)
\textsuperscript{30} Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10607(k), 124 Stat. 119,
1015 (2010).
injured. Each of these problems can be ameliorated by a Patient’s Compensation program.

Degradation of the Physician-Patient Relationship

Physicians’ fears of malpractice are disrupting a most venerated relationship; that of physician and patient. One well-respected commentator likened medical malpractice - through the eyes of physicians - to Melville’s *Moby Dick* “… evil, ubiquitous, and seemingly immortal.” Malpractice lawsuits attempt to hold physicians and other health care providers individually or collectively responsible for some medical injuries. “Once an injury happens, someone bears the responsibility” is a widely held belief. In a Pew Charitable Trust study of Pennsylvania, liability concerns replaced doctors’ “previously ‘warm, fuzzy relationship with patients’ with hard-nosed scrutiny of the patient’s litigiousness . . .” Eighty one percent of physicians surveyed during the last Pennsylvania malpractice crisis responded that because of concerns about malpractice liability, every patient was viewed as a potential malpractice lawsuit. Further, 91% of specialists surveyed said that the malpractice system limits doctors’ ability to provide the highest-quality medical care. To maintain revenue, 75% of specialist physicians stated they were likely to increase patient volume. The relationship between volume and quality

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35 Id. at 117.
37 Id. at 48.
38 Id. at 49.
39 Id. at 50.
suggests that practices with a full patient load may have difficulty caring for more patients without compromising quality.  

Fears of being sued cause physicians to view the current system of medical malpractice as damaging personally and professionally. A nationwide survey of physicians found high levels of concern about the “dread risk” of malpractice litigation in a variety of geographic areas, practice settings, and specialties. Physicians’ fear of the litigation process has led to the emergence of a medical malpractice stress syndrome. Regardless of outcome, malpractice litigation has personal consequences for physicians that include burnout and suicidal ideation. Closed claims review of surgical malpractice claims has shown that most technical and judgment errors occur during care provided by competent physicians, which means all physicians are at risk of being sued. Physicians’ fear of being sued for malpractice is worsened by a lack of knowledge about the actual risk of being named in a lawsuit; physicians responding to a survey estimated that one in five of their colleagues will be sued in a given year; an estimate three times higher than the actual closed claims rate in New York state.

40 Id. at 49.
41 Ian S. Metzler & John G. Meara, Medical Liability Reform: Evidence for Legislative and Alternative Approaches, 97 BULL. AM. C. SURGEONS 6, 6 (2012).
42 Emily R. Carrier, James D. Reschovsky, Michelle M. Mello, Ralph C. Mayrell & David Katz Physicians’ Fears Of Malpractice Lawsuits Are Not Assuaged By Tort Reforms, 29 HEALTH AFFAIRS 1585, 1591 (2010).
Physician mistrust and resistance of the malpractice paradigm is due in large part to contemporary concepts of patient safety and error reduction approaches to the problem of medical injury that focus on “fixing the system, not fixing blame”. These adversarial and very personal claims against physicians occur despite accumulating evidence that most errors are multifactorial, or “systems” errors. The conceptual leap made in the Institute of Medicine’s landmark report *To Err is Human* was the need to understand medical injuries as systems errors rather than the negligent acts of individuals. Based largely on precepts gleaned from *To Err*, intensive efforts on the part of healthcare organizations have decreased medical injuries. One such effort was the national 5 Million Lives Campaign. A recent Commonwealth Fund report provided ten case studies felt to hold promise for further improving patient safety. Critics note that annual surveys have documented improvements in medical care and decreases in patient morbidity and

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47 **WILLIAM C. RICHARDSON ET AL.,** *Chapter 8: Creating Safety Systems in Health Care Organizations in To ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 179 (Linda T. Kohn, et. al., eds., Institute of Medicine, Committee on Quality of Health Care in America 2000).
49 RICHARDSON, *supra* note 47, at 179.
50 What did the 5 Million Lives accomplish? [http://www.ihi.org/offerings/Initiatives/PastStrategicInitiatives/5MillionLivesCampaign/Pages/default.aspx](http://www.ihi.org/offerings/Initiatives/PastStrategicInitiatives/5MillionLivesCampaign/Pages/default.aspx) (Last accessed Sept. 25, 2012)(on file with author)(documenting *The 5 Million Lives Campaign*, which at its formal close in December 2008, had enrolled 4,050 hospitals, with more than 2,000 facilities pursuing each of 12 Campaign interventions to reduce infection, surgical complication, medication errors, and other forms of unreliable care. Eight states enrolled all hospitals in the Campaign, and 18 states enrolled over 90% of their hospitals in the Campaign. The Campaign documented, among other signs of progress, 65 hospitals going a year or more without a ventilator-associated pneumonia, and 35 reported going a year or more without a central line-associated bloodstream infection in at least one of their ICUs. Active Campaign hospitals in Rhode Island reported a 42% decrease in central-line associated bloodstream infections from 2006 – 2007, and New Jersey reported a 70% reduction in pressure ulcers through the work of 150 healthcare organizations.)
mortality, but such improvements have not been uniformly successful. A decade after *To Err* was released, much has been accomplished in making patients safer, leading one eminent patient safety scholar to upgrade systemic efforts from a C+ to a B-. Medical injuries continue to occur despite a decade of improvements in patient safety; morbidity and mortality occur due to the ever more complex nature of medical treatment.

Balancing a systems-based approach resisting the natural tendency to blame individuals for errors against accountability for blameworthy behavior is a recent development. The mental model for patient safety in the first five years was “no blame and shame”; a mantra that helped engage reluctant providers and undoubtedly generated substantial progress towards improving patient safety. Currently, it has become clear that consequences for failure to adhere to safety rules need to be enhanced. One model for differentiating injuries due to systems errors which should be managed with systems re-engineering from willful, blameworthy acts is that of the *just culture* advocated by

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52 Fifth Annual Patient Safety in American Hospitals Study
http://www.healthgrades.com/media/dms/pdf/patientsafetyinamericanhospitalsstudy2008.pdf (last visited July 18, 2011)(on file with the author)(finding that substantial progress continues to be made; for example, 249 Distinguished Hospitals for Patient Safety achieving, on average, 43 percent less patient harm. However, as all hospitals do not achieve at the Distinguished Hospitals for Patient Safety level, an additional 220,000 incidents and 37,000 deaths among hospitalized Medicare patients during 2004 through 2006 could have potentially been prevented.)


54 HealthGrades Eighth Annual Patient Safety in American Hospitals Study March 2011
https://www.cpmhealthgrades.com/CPM/assets/File/HealthGradesPatientSafetyInAmericanHospitalsStudy2011.pdf (last visited Sept. 25, 2012)(on file with author)(Reporting that from 2007 through 2009 667,828 Medicare beneficiaries experienced 708,642 patient safety events and $7.3 billion of excess cost. Medicare patients sustaining at least one patient safety event post-operatively had approximately a one-in-ten chance of dying as a result of the event. There were 79,670 in-hospital deaths that occurred among patients who experienced patient safety events.)


David Marx. Physicians have not yet embraced sanctions against such acts even for willful violations of reasonable safety standards such as hand hygiene.

A Patient’s Compensation model holds promise for improving the physician-patient relationship by restoring trust, by improving quality of care, and by compensating patients without regard to negligence. There is some empiric data to support this contention. In the Swedish no-fault system, physicians participate personally in the filing of 60% of claims. Physicians are committed to improving the safety and well-being of patients. By placing the responsibility for eliminating medical injury in the hands of the providers who care for patients, acceptance of an administrative compensation regime would engender less animosity. Less physician defensiveness is noted in systems that do not require the patient to prove negligent care. In the Virginia Neurological Birth-injury Compensation program, 62 physicians may have avoided lawsuits due to the program’s existence and did not have to endure the professional and emotional expense.

57 DAVID MARX, PATIENT SAFETY AND THE “JUST CULTURE”: A PRIMER FOR HEALTH CARE EXECUTIVES (Columbia University, 2001) (discussing individual accountability and four behavioral categories - human error, negligence, intentional rule violations, and reckless conduct - used to describe blameworthy conduct and the need for disciplinary action by authorities to deter such conduct.) see also Allan S. Frankel, Michael W. Leonard, & Charles R. Denham, Fair and Just Culture, Team Behavior, and Leadership Engagement: The Tools to Achieve High Reliability 41 HSR: HEALTH SERVICES RES. 1690, 1693 (2006) (defining a just culture as one in which each individual is accountable for their actions, but is not blamed for work environment system faults beyond their control.)


involved in responding to a lawsuit.\textsuperscript{62} Further, since the birth injury program is a no-fault program, the physicians’ names and case information are not reported to the National Practitioner Data Bank, which tracks all malpractice settlements.\textsuperscript{63} Being reported to the NPDB is uniformly considered as a major concern for practicing physicians; yet the American Medical Association believes that such medical liability claims data is a poor indicator of quality.\textsuperscript{64}

In Florida, NICA payments help to fund the benefits for children while prohibiting malpractice litigation on covered claims; the substantial benefits of increased protection from costly litigation and a resulting freedom to focus on patient care make full participation in the NICA Plan a positive for many obstetricians.\textsuperscript{65} Although only obstetricians and gynecologists have direct coverage, the malpractice premiums for all Florida physicians have been lower for many years because most of the truly catastrophic claims were covered by NICA - not the tort system.\textsuperscript{66}

\textit{Patients Bear the Brunt of Positive and Negative Defensive Medicine}

From the patient’s point of view, medical tests, procedures, or specialty consultations performed in attempts to decrease the risk of malpractice claims are undesirable; such physician behavior is known as defensive medicine.\textsuperscript{67} Defensive

\begin{thebibliography}{99}
\bibitem{63} Id.
\bibitem{66} Id.
\bibitem{67} There are several definitions of defensive medicine. see David M. Studdert, Michelle M. Mello, William M. Sage, Catherine M. DesRoches, Jordon Peugh, Kinga Zapert, Troyen A. Brennan, \textit{Defensive Medicine}
medicine is thought to become more prevalent when physicians perceive heightened malpractice risk. There are two different types of physician behaviors which are considered defensive medicine; both types have the potential to negatively impact the patient. **Negative defensive medicine** includes behaviors in which physicians refuse to perform high risk procedures, enter high risk specialties, or care for high risk patients. **Positive defensive medicine** occurs when physicians perform procedures and order tests or other services to reduce adverse outcomes, deter patients from filing medical malpractice claims, or enhance documented evidence that the physician is practicing standard of care, so that if, in the future, legal action is initiated, liability can be preempted. None benefit the patient, some may lead to harm, and all are attempts by individual physicians to decrease the risk of being sued for malpractice.

**Negative Defensive Behaviors**

Specialist physicians’ fear of lawsuits leads many to restrict the scope of their practices to exclude high-risk services such as obstetrics and spine surgery, with smaller among High-Risk Specialist Physicians in a Volatile Malpractice Environment. 293 JAMA 2609, 2609 (2005)(defining defensive medicine as “a deviation from sound medical practice . . . induced primarily by a threat of liability . . .”) see also U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice, OTA-H-6-O-2* (Washington, DC: U.S. Government Printing Office, July 1994)(On file with author)(defining defensive medicine as “when doctors order tests, visits or procedures, or avoid certain high-risk patients or procedures primarily (but not solely) because of concern about malpractice liability.”

68 Studdert, *supra* note 67 at 293.
numbers discontinuing patient care or relocating to states with lower malpractice costs.\textsuperscript{71}

There is data to support the assertion that physicians engage in a number of types of negative defensive behavior; one well-studied example of avoiding a high risk procedure is the decline in rates of vaginal birth after cesarean section (VBAC).\textsuperscript{72} Since the 1990s, nationwide rates of VBAC have decreased sharply and rates of cesarean section have increased sharply; both trends are consistent with clinical behavior aimed at reducing obstetricians’ exposure to malpractice litigation.\textsuperscript{73} Neurosurgery represents another discipline in which spinal surgery procedures - perceived by neurosurgeons as one of a series of ‘high-risk’ procedures - are correlated with higher rates of litigation.\textsuperscript{74} Lastly, the decision by Centers for Medicare and Medicaid Services (CMS) to deny payment for


\textsuperscript{72} Clarissa Bonanno, Marilee Clausing, Richard Berkowitz, \textit{VBAC: A Medicolegal Perspective}, 38 CLINICAL PERINATOLOGY 217, 223 (2011)(quoting from Dr. Richard N. Waldman’s American College of Obstetrics and Gynecology Presidential Inaugural Address “Each one of us enters the labor and delivery room shoudering our concern for our two patients and weighing down by the yoke of liability.”) see also Emily R. Carrier, James D. Reschovsky, Michelle M. Mello, Ralph C. Mayrell, and David Katz, \textit{Physicians’ Fears Of Malpractice Lawsuits Are Not Assuaged By Tort Reforms} 29 HEALTH AFFAIRS 1585, 1587 (2010)(finding that individual physicians’ malpractice concerns are pervasive and correlate across specialties reflecting underlying risk.)

\textsuperscript{73} Y. Tony Yang, Michelle M. Mello, S. V. Subramanian, David M. Studdert, \textit{Relationship Between Malpractice Litigation Pressure and Rates of Cesarean Section and Vaginal Birth After Cesarean Section}, 47 MEDICAL CARE 234, 239 (2009)(estimating that a $10,000 decrease in malpractice premiums would correspond to approximately 3600 fewer primary cesarean sections, 6000 fewer total cesarean sections, and 1600 more VBACs. Further, other tort reforms including caps on noneconomic damages and pretrial screening panels were associated with higher rates of VBAC and lower rates of cesarean section.).

services treating complications that could be ‘reasonably prevented’ has led to concerns that hospitals may choose not to provide high-risk service lines or procedures.\textsuperscript{75} 

In addition to the VBAC example noted above, other data exist to show that physicians might perform cesarean sections out of fear of litigation regardless of geographic area or liability climate.\textsuperscript{76} Two well-designed studies have found that greater malpractice risk - measured by premiums or claims frequency in the area - was associated with a statistically significant increase in the incidence of cesarean sections.\textsuperscript{77} Other studies have had mixed results, with some providing corroborating evidence\textsuperscript{78} but others finding no difference in cesarean rates.\textsuperscript{79} One study even showed that non-economic damage caps (marker of decreased malpractice pressure) increased c-section utilization.\textsuperscript{80}

\textsuperscript{75} Rocco Ricciardi, Nancy N. Baxter, Thomas E. Read, Peter W. Marcello, David J. Schoetz, Patricia L. Roberts, \textit{Surgeon Involvement in the Care of Patients Deemed to have “Preventable” Conditions}, 209 J. AM. COLL. SURGEONS 707, 710 (2009).

\textsuperscript{76} Katherine Baicker, Elliot S. Fisher, & Amitabh Chandra, \textit{Malpractice Liability Costs and the Practice of Medicine in the Medicare Program}, 26 HEALTH AFFAIRS 841, 852 (2007).


\textsuperscript{79} Michael Frakes, \textit{Defensive Medicine and Obstetric Practices}, 9 J. EMPIRICAL LEGAL STUD. 457, 457 (2012)(documenting no change in C-sections, but reduction in use of episiotomy with adoption of non-economic damage caps.) see also Roger A. Rosenblatt, Randall R. Boivbjerg, Amanda Whelan, Laura-Mae Baldwin, L. Gary Hart, & Constance Long, \textit{Tort Reform and the Obstetric Access Crisis. The Case of the WAMI States}, 154 WEST. J. MED. 693, 699 (1991)(noting “review of legislation shows that all four states enacted “strong” tort reforms at about the same time that declining obstetric care availability became a major political issue . . .”) but see Laura-Mae Baldwin, L. Gary Hart, Michael Lloyd, Meredith Fordyce, Roger A. Rosenblatt, \textit{Defensive Medicine and Obstetrics}, 274 JAMA 1606, (1995)(study showing no “. . . association between the malpractice experience or exposure of individual physicians and an increase in the use of prenatal resources or cesarean deliveries for the care of low-risk obstetric patients.”)

Although difficult to comprehensively analyze, there is also data to suggest that physicians avoid practicing in states with high malpractice premiums. In a survey of resident physicians in rural Florida, 411 of 981 physicians decreased or eliminated health care services due to liability costs. The problem of rural flight was also noted in a study correlating high malpractice rates with a per capita decrease in rural MDs. Physicians also choose to avoid on-call duties due to fears of being sued for malpractice; the American College of Surgeons and the American Association of Neurologic Surgeons have reported that one third of survey respondents had been sued by emergency room patients. One survey of neurosurgeons showed that 38% limit provision of trauma services due to, inter alia, liability concerns.

*Positive Defensive Behaviors*

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82 Eugene H. Shively & Susan A. Shively, Threats to Rural Surgery, 190 AM. J. SURGERY 200, 201 (2005) citing Robert G. Brooks, Nir Menachemi, Cathy Hughes, Art Clawson, Impact of the Medical Professional Liability Insurance Crisis on Access to Care in Florida, 164 ARCHIVES OF INTERNAL MED. 2217, 2219 (2004) (documenting elimination of services as greatest for general surgeons (78.6%) and surgical specialists (73.6%)).

83 Katherine Baicker & Amitabh Chandra, The Effect of Malpractice Liability on the Delivery of Health Care, in Frontiers of Health Policy Research, D. Cutler and A.M. Garber eds. p. 17, 18 (Cambridge, Mass.: MIT Press, 2005) (documenting a 1% decrease in per capita rural MDs (2% for older rural MDs) for every 10% increase in malpractice premiums.)


The conventional behavior described as defensive medicine has also been called *positive defensive* behavior.\(^86\) Teasing out the effect of malpractice risk on physician behavior can be difficult because physicians may have more than one rationale for ordering a test, referral, or procedure; the desire to avoid malpractice claims as well as the intention to see that the patient receives an accurate diagnosis and correct treatment regardless of cost.\(^87\) The Office of Technology Assessment’s comprehensive study on *Defensive Medicine and Medical Malpractice* stated the problem bluntly: “... accurate measurement of the extent of this phenomenon is virtually impossible.”\(^88\) As a result, it has been hard to determine the pervasiveness, cost, and consequences of defensive assurance behavior, and yet, a number of commentators have made such estimates.

A 2003 survey of high-risk specialists in Pennsylvania found that 93 percent reported that they sometimes or often engaged in at least one of six positive defensive behaviors.\(^89\) Using data on Medicare spending for Part A and Part B services and hospitals’ total expenditures, reductions in the cost of medical liability were found to

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\(^{88}\) Id., at 4.

\(^{89}\) David M. Studdert, Michelle M. Mello, William M. Sage, Catherine M. DesRoches, J Peugh, Kinga Zapert, Troyen A. Brennan, *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA (2005)(Assurance behaviors studied included ordering more diagnostic tests than were medically indicated; unnecessary referrals to specialists; prescribing more medications than were medically indicated; and suggesting unnecessary invasive procedures such as biopsies to confirm diagnoses. Physicians who were not confident about the adequacy of their liability coverage and physicians who perceived their insurance premiums to be very burdensome were significantly more likely to report these behaviors.)
lower health care expenditures.\textsuperscript{90} Several types of medical liability reform lowered health plan costs offered by self-insured employers due in part to decreases in malpractice premiums.\textsuperscript{91}

States enacting tort reforms such as caps on medical malpractice damages experienced slower growth in expenditures for elderly patients admitted with heart disease.\textsuperscript{92} Kessler and McClellan, in a much discussed early study, studied the relationship of medical liability and health care expenditures for acute myocardial infarction and ischemic heart disease in a Medicare population.\textsuperscript{93} The analysis showed that direct liability reforms - those with caps on damage awards, punitive damages, mandatory prejudgment interest, or collateral source rule - reduced hospital expenditures five to nine percent.\textsuperscript{94}

The Kessler/McClellan study used Medicare claims data to examine whether patients in states without tort reforms received more health care services than patients with the same diagnoses in states that had such reforms; hypothesizing that the difference would approximate defensive medicine behaviors.\textsuperscript{95} This study has been somewhat controversial because the authors attempted to extrapolate national defensive-medicine


\textsuperscript{92} Daniel Kessler & Mark McClellan, \textit{Do Doctors Practice Defensive Medicine?} 111 \textit{Q. J. ECON}. 353, 358 (1996).

\textsuperscript{93} \textit{Id.}

\textsuperscript{94} \textit{Id.}

\textsuperscript{95} \textit{Id.}, at 354-55.
costs from these two diagnoses. The study’s findings are probably not generalizable to all conditions or all patients, but its estimates for the two diseases for which data were analyzed appear statistically accurate. It has been suggested on reanalysis of the Kessler/McClellan data that medical management does a better job of reducing overuse of costly and invasive medical technology.

Similar evidence of positive defensive behaviors have been documented in order rates for imaging studies, such as mammograms for breast cancer screening and computed tomograms for neurologic injury. Rates of screening mammography were shown to increase significantly in the setting of increased malpractice awards. Compared to states without medical liability reform laws, states with laws that limited monetary damages, mandated periodic award payments, or specified collateral source offset rules had an approximately 40% lower likelihood of imaging to assess neurologic injury. A survey performed by the Massachusetts Medical Society showed that physician’s liability concerns directly impacted patients, and defensive testing and referrals cost in excess of 280 million per year. Further, professional liability concerns had a substantial effect on the scope of physicians’ practices with 38% of physicians

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98 Katherine Baicker & Amitabh Chandra, The Effect of Malpractice Liability on the Delivery of Health Care, in Frontiers of Health Policy Research, D. Cutler and A.M. Garber eds. 19 (Cambridge, Mass.: MIT Press, 2005)(documenting a 4% increase in mammography for every 10% increase in the average malpractice award.)
reducing the number of high risk services and 28% of physicians reducing the number of high-risk patients they saw.\textsuperscript{101}

In summary, although methodological challenges make it unlikely that there will ever be a completely accurate picture of the extent of defensive medicine, the studies cited above find that defensive behaviors exist.\textsuperscript{102} The Congressional Budget Office recently concluded that “the weight of the empirical evidence now demonstrates a link between tort reform and the use of healthcare services.”\textsuperscript{103} But arguments about whether or not malpractice reforms decrease defensive behaviors miss the point; from a patient’s perspective, defensive medicine occurs, and it is the patient who must endure it.

The debate about defensive medicine has generally centered on whether malpractice liability reform will decrease health care costs. Most defensive-medicine studies have failed to demonstrate any real evidence on defensive medical practices arising from higher malpractice premiums.\textsuperscript{104} This debate, however, misses the fact that patients are the ones sustaining the burden of defensive medicines, tests, procedures, and care. A patient’s compensation program, scheduling and announcing the remedies for medical injury would decrease defensive medicine behaviors. A defensive-medicine

\textsuperscript{101} Id., at 15.


response to perceived malpractice risk is essentially overdeterrence, rather than true deterrence of substandard care.105

Another advantage of a Patient’s Compensation approach would be to encourage greater integration of physicians into health-care organizations as employees. Traditionally, physicians are licensed, independent practitioners who are credentialed and privileged by healthcare facilities but subject to limited authority.106 Hammer notes the fact that physicians are independent practitioners and the formal relationship between physicians and hospitals has been cast as one in which “corporate ownership of hospitals’ physical assets strictly separated from control over physicians’ specialized human capital.”107

The advantages of physicians as employees are obvious. If the hospital employs its physician staff, then component parts are legally incapable of conspiring with each under the Copperweld doctrine.108 Physicians, however, are not typically employees nor investor-owners of hospital facilities; they participate in self-governing medical staffs with exclusive responsibility for many aspects of hospital quality.109 In practice, physicians were also hospitals’ real customers, since they acted as largely unconstrained purchasers for health insurers through their patients.110 A Patient’s Compensation model

108 HAMMER & SAGE supra note 107 at 92.
109 Id.
110 Id.
holds promise for improving physician trust and decreasing resistance by improving quality of care, and compensating patients without regard to negligence. There is some empiric data to support this contention; in the Swedish system, physicians assist their injured patients in the filing of over half of all claims.\footnote{Studdert & Brennan, supra note 59 at 230.}

**Inefficiency of the Medical Malpractice System**

If the medical system has not traditionally done its best for patients, neither has the legal profession. The current medical malpractice system is inefficient as judged by review of medical records and closed claims review. A very low rate of claiming behavior means many patients do not receive compensation for their injuries. Unless high rates of compensation occur, the health care system does not accept the correct level of moral accountability.\footnote{SANDRA M. GILBERT, Chapter 1: Writing/Righting Wrong 37 in ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM (Georgetown University Press 2004).} A trio of studies was responsible for the Institute of Medicine’s 2000 report To Err is Human.\footnote{WILLIAM C. RICHARDSON ET AL., Executive Summary in TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1, 2 (Linda T. Kohn, et al., eds., Institute of Medicine, Committee on Quality of Health Care in America 2000).} The California Medical Association study in a review of 20,864 medical charts showed that 4.65% of patients sustained a “potentially compensable event”.\footnote{Don H Mills, Medical insurance feasibility study - A technical summary. 128 W. J. MED. 360, 362 (1978)(defining a potentially compensable event as a disability caused by health care management).} Of these events, only 0.79% were considered as having had legal fault.\footnote{Id., at 363(defining a potentially compensable event as a disability caused by health care management).} In other words, only 17% of patients sustaining medical injury would be eligible for compensation. The Harvard Medical Practice Study reviewed 30,121 medical charts and noted 1278 injuries (3.7%).\footnote{Troyen A. Brennan, Lucian L. Leape, Nan M Laird, Liesi Hebert, A. Russell Localio, Ann G. Lawthers, Joseph P. Newhouse, Paul C. Weiler, & Howard H. Hiatt. Incidence of adverse events and negligence in}
Announcing Remedies for Medical Injury: A Proposal For Medical Liability Reform Based on the Patient Protection and Affordable Care Act

adjudged due to negligence. The HMPS did show that 38% of patients who sustained serious disabilities had negligent adverse events, compared to 20% if injuries were deemed non-negligent. Lastly, by matching a random sample of 31,429 medical charts with statewide data on medical malpractice claims, the identified a statewide ratio of negligence to malpractice claims of 7.6:1. A similar medical chart review was carried out in Utah and Colorado to validate the HMPS and showed the rate of adverse events to be 2.9% in both states. In Utah and Colorado, the rates of negligence contributing to adverse events were 32.6% and 27.5% respectively. The negligent adverse event to claims ratio was 5.1:1 and 6.7:1 in Utah and Colorado respectively.

Closed claims reviews have also been used to study the efficacy of malpractice claims since studies begun in 1984 by the American Society of Anesthesiologists. The

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117 Id.


120 Eric J. Thomas, David M. Studdert, Helen R. Burstin, E. John Orav, Timothy Zeena, Elliott J. Williams, K. Mason Howard, Paul C. Weiler, & Troyen A. Brennan, Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado. 38 MED. CARE 261, 265 (2000) see also Atul A. Gawande, Eric J. Thomas, Michael J. Zinner, MD, & Troyen A. Brennan, MD. The Incidence and Nature of Surgical Adverse Events in Colorado and Utah in 1992. 126 SURGERY 66, 71 (1999)(noting the incidence of adverse events to be the same in surgical and non-surgical care.

121 Thomas, et. al. supra note 120 at 265 (2000)


medical specialties of anesthesia, obstetrics, emergency medicine, family medicine, and surgery have been the richest source of closed claims data.\textsuperscript{124} Although relatively small in number, the surgery closed claims data are instructive; a follow-up to the Utah and Colorado study showed that 66\% of all adverse events were surgical.\textsuperscript{125} Closed claims data analysis has several advantages over medical chart reviews: physician fears of frank disclosure leading to sanction or litigation were already addressed; most of the compensated claims in these reports involve serious to catastrophic injuries; claims files contain richer information about the medical injury – in addition to the medical record, evidence, deposition transcripts, interrogatories and answers, claims manager reviews, and complaints and answers by opposing attorneys.\textsuperscript{126}

Two groups of researchers have published a series of recent studies analyzing surgical closed claims data. One group consisted of members of Harvard-affiliated Departments of Surgery and the School of Public Health.\textsuperscript{127} The other group consisted of the American College of Surgeons’ Committee on Patient Safety and Professional

\textsuperscript{124} A PubMed.gov search using the search terms “closed claims” and “closed malpractice claims” with limits of 1980 forward and U.S. studies returned 95 articles. 76 (80\%) were from the disciplines of anesthesia (50), emergency medicine (9), obstetrics (7), family medicine (5) and surgery (5).


\textsuperscript{126} F. Dean Griffen & Richard H. Turnage, \textit{Reviews Of Liability Claims Against Surgeons: What Have They Revealed?}, 43 ADVANCES IN SURGERY 199, 207 (2009).

Liability. The two groups analyzed closed claims from different vantage points. The ACS group sought to determine whether or not injuries were preventable by individual surgeons. The Harvard study examined the role of human and systems factors and errors in surgical practice.

The Harvard group reviewed 444 surgery claims - closed between 1986 and 2004 - from malpractice insurance companies based throughout the United States. The claims covered 21,000 physicians, 46 acute care hospitals, and 390 outpatient facilities. The four most common types of operations that were the subject of this study included gastrointestinal surgery (22%), spinal surgery (14%), nonspine orthopedic surgery (10%), and cardiothoracic surgery (9%). Of the 444 claims studied, 422 involved injuries, and of these injuries, 258 (61%) were attributed to error and 39% were not due to error. Errors were found to occur most often in commonly performed operations by experienced surgeons where patient complexity or systems failure were present.

The ACS study collected data from 460 closed surgical claims at five malpractice insurance companies. Claims were excluded if no indemnity payment had been made and if the associated loss expense was less than $25,000. Injuries associated with care that fell below accepted standards were present in 64% of claims, and no deficiencies

129 Griffen & Turnage, supra note 126 at 206 (2009).
130 Id.
131 Rogers, et. al. supra note 127 at 27.
132 Rogers et. al. supra note 127 at 26.
133 Rogers et. al. supra note 127 at 28.
134 Rogers et. al. supra note 127 at 27.
135 Regenbogen, et. al. supra note 127 at 709 (Table 3).
136 Griffen, et. al. supra note 128 at 562.
137 Id.
were found in 36%. The incidence of closed claims in which no breach of the standard of care was identified was remarkably similar between the Harvard and ACS (39% and 36%, respectively) studies.

A more recent study of 1452 closed malpractice claims was analyzed whether a medical injury had occurred and if the injury was due to medical error. In 3 percent of the claims, medical injuries were not present, and 37 percent of claims for injuries did not involve errors. Although a low percentage of errorless claims led to compensation (28%, compared to 73% of claims with errors), error-free injuries accounted for 13% of total liability costs in the system.

Another measure of the inefficiency of the malpractice system is the time line for claims resolution. These are long periods for plaintiffs to await decisions about compensation and for defendants to endure the uncertainty, acrimony, and time away from patient care that litigation entails. Among the studied claims, the average time

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138 Id. at 565.
141 Id. at 2026.
142 Id. at 2027-28.
between injury and resolution was five years, and one in three claims took at least six years to resolve.¹⁴⁴

**Patient’ Compensation Insurance: Proposal for a State Demonstration Project**

Much has been written regarding the implementation of a State Demonstration Project advocating an alternative to tort-based reform.¹⁴⁵ Little has been done despite recommendations to implement state pilot programs for nearly 40 years.¹⁴⁶ To date funds have been awarded sparingly, if at all.¹⁴⁷ The Agency for Healthcare Research in Quality (AHRQ) has funded a number of demonstration projects outside of the Affordable Care Act, but none involves a scheduled approach to remedy for medical injury or other administrative compensation.¹⁴⁸ Any proposal for Patient’s Compensation insurance should take advantage of the experience of State programs which have already been enacted – in particular the Florida and Virginia birth injury compensation programs - to

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¹⁴⁵ The Patient’s Compensation program I propose has, in part, its roots in proposals suggested by a number of health care law specialists. see PATRICIA M. DANZON, CHAPTER 12 ALTERNATIVES: PRIVATE CONTRACT AND NO-FAULT in MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY. 213-17 (Harvard University Press 1985)(discussing largely the negatives of a no-fault approach.); PAUL C. WEILER, HOWARD H. HIATT, JOSEPH P. NEWHOUSE, WILLIAM G. JOHNSON, TROYEN A. BRENNAN, LUCIAN L. LEAPE, A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION. 149-152 (Harvard University Press 1993)(highlighting the advantages of a voluntary program as an initial step towards a no-fault approach); TOM BAKER, THE MEDICAL MALPRACTICE MYTH, 163-64 (University of Chicago Press, 2005)(part of a proposed Patient Protection and Healthcare Responsibility Act includes a Patient Compensation Program for injuries not currently compensated, and specifically designed to avoid conflict with common law tort).


learn what has worked and what has not. It may be desirable – but not necessary - to enact a Patient’s Compensation program in a state which has existing legislation capping non-economic damages. For instance, Virginia has adopted a total cap on damages in medical malpractice litigation; the total amount available under the cap is similar to that available through the state’s birth injury program, so there is little to be gained by avoiding Virginia BICP jurisdiction. The Virginia eligibility standard is also more permissive in some ways, making establishing eligibility for compensation easier than under common law tort action. Conversely, claimants in Florida have an incentive to try and circumvent jurisdiction of the Florida birth injury program and pursue tort remedies for claims that may have a high probability of success as a negligence action. In 2003, caps on malpractice awards began in Florida; but no systematic study of the effect of the complex sliding scale formula for non-economic damages currently exists.

**A Proposal for Patient’s Compensation Insurance**

Success in obtaining a grant for Patient’s Compensation Insurance (Patient’s Compensation program) would be enhanced by emphasizing three main elements in the grant; all explicitly set forth in the Affordable Care Act. First, a Patient’s Compensation program should be subjected to substantive consultation with relevant

150 *Id.*
151 *Id.* at 500.
152 *Id.* at 499.
153 *Id.*
154 E-mail from Karen J. Migdail, Senior Policy Advisor, Agency For Healthcare Research & Quality to Steven E. Raper, Associate Professor of Surgery, Perelman School of Medicine (Sept. 13, 2012, 14:31:00 EDST)(on file with the author)(To date, although the Affordable Care Act authorized funds for such state demonstration projects, no funds have been appropriated.)
stakeholders, including health care providers, patient advocates, and health care organizations, attorneys with expertise in representing malpractice plaintiffs as well as defendants, medical malpractice insurers, and health care quality and patient safety experts.\footnote{Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10607(c)(5), 124 Stat. 119, 1011 (2010).} Second, the Patient’s Compensation Insurance grant should attempt to enhance patient safety by incorporating mechanisms detecting, analyzing, and reducing medical injuries.\footnote{Id.} Third, the proposal should improve access to liability insurance.\footnote{Id.}

In addition to the considerations mentioned above, two goals would be necessary for such a tort reform grant to be successfully funded. First, the proposed alternative should resolve disputes over injuries caused by health care providers or health care organizations.\footnote{Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10607(c)(1), 124 Stat. 119, 1010 (2010).} This may be the most important of the elements Congress enacted. There are three possibilities by which patients can sustain bad outcomes: progression of the patient’s underlying disease, non-negligent injuries, and negligent injuries. A Patient’s Compensation program, to comply with the Affordable Care Act’s requirements, must be able to distinguish the first possibility from the second and third.

One approach would be to adapt the worker’s compensation formula, in which a patient would recover for any injury more likely due to treatment received than underlying illness. However, such a comprehensive definition could make the goal of dispute resolution difficult to accomplish. In particular, failure of early diagnosis, some infections, and drug side effects could lead to a dramatic increase in claims for which

resolution would be difficult.\textsuperscript{159} For this reason, the Patient’s Compensation proposal below will focus on a discrete set of injuries.

**Scheduling Remedies for Medical Injury.**

The use of scheduling in cases of medical injury has been proposed for decades, although initially as a way to constrain the discretion of legal decision makers in assigning damage awards.\textsuperscript{160} To be fundamentally fair, similarly situated parties should be treated similarly; although tort valuations in the aggregate may be reasonable, awards in individual cases vary greatly.\textsuperscript{161} Scheduling of damages for medical injury, by improving accuracy and predictability of costs allows both the injured and those under whose watch medical injury happens.\textsuperscript{162} Other types of tort reforms are generally perceived as a ‘zero sum game’ in which plaintiffs lose while defendants gain.\textsuperscript{163} Three alternative types of scheduling reforms were advanced: matrices, scenarios, and ranges.\textsuperscript{164} Of the three options, systematizing standard awards by developing a matrix of dollar value remedies based on type of injury and injury severity appears the best option;

\textsuperscript{159} One Size Does Not Fit All: The Promise of Pharmacogenomics, http://www.ncbi.nlm.nih.gov/About/primer/pharm.html (Last accessed Aug. 28th, 2011)(Adverse drug reactions accounted for more than 2.2 million serious cases and over 100,000 deaths in the United States. The science of pharmacogenomics is beginning to determine whether people will respond well, badly, or not at all to a medication. Pharmaceutical companies are limited to developing drugs using a “one size fits all” approach, where both adverse reactions and lack of effect impact patients. For instance, adverse drug reactions are now known to be due in part to individual genetic variation.)


\textsuperscript{161} Bovbjerg, et al., *supra* note 160 at 909.

\textsuperscript{162} Bovbjerg, et al., *supra* note 160 at 975.

\textsuperscript{163} *Id.*

\textsuperscript{164} Bovbjerg, et al., *supra* note 160 at 940.
minimizing variability and predictability while maintaining a degree of flexibility.\textsuperscript{165} Setting remedies for medical injury requires careful consideration of the spectrum of conduct to be covered. To cover all injuries – physical or otherwise – would extend the range of variation in individual cases to an unworkable system. There are several approaches to announcing remedies for medical injury, one includes those euphemistically called Medicare ‘never events’.\textsuperscript{166} Such events were initially termed Hospital Acquired Conditions.\textsuperscript{167} The concept was expanded by the Affordable Care Act to include Medicaid.\textsuperscript{168} Further tailoring of the remedy can be made by stratifying the severity of injury based on one of several standardized scales of severity. Announcing remedies make sense in such cases, where the array of claims is narrow, and the phenomena associated with each claim is precise.\textsuperscript{169} Scheduling of medical injuries requires consideration of a number of factors, including a mandate for disclosure, types

\textsuperscript{165} Bovbjerg, et al., \textit{supra} note 160 at 975 (1988).
\textsuperscript{166} Deficit Reduction Act of 2005 \textsection 5001(c), 42 U.S.C. \textsection 1395ww(d)(4) (adding subparagraph (D)(iv), in which Congress directed the Secretary of Health and Human Services to select diagnosis codes for conditions which have a high cost or high volume, or both; codes which result in the assignment of a case to a diagnosis-related group that has a higher payment when the code is present as a secondary diagnosis; and, codes which describe such conditions that could reasonably have been prevented through the application of evidence based guidelines.)
\textsuperscript{167} Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System Changes and FY2011 Rates, 75 FR 50084-85 (Aug. 16, 2010)(The codes chosen represent what were termed Hospital Acquired Conditions (HAC) for which higher payments related to the HAC were prohibited and which were limited in scope to hospitals participating in the Inpatient Prospective Payment System. Hospital-acquired conditions for which higher payment is disallowed include foreign objects retained after surgery, air embolism, blood incompatibility, Stage III and IV pressure ulcers, falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock), manifestations of poor blood sugar control, catheter-associated urinary tract infection, vascular catheter-associated infection, certain surgical site infections, deep vein thrombosis and pulmonary embolism).
\textsuperscript{168} Prohibition on Payment for Provider-Preventable Conditions, 42 C.F.R \textsection 447.26 see also 76 Fed. Reg. 32816, 32837 June 6, 2011.(Section 2702(a) of the Affordable Care Act requires that as of July 1, 2011, the Secretary of Health and Human Services must also prohibit Medicaid payments to States for health care-acquired conditions (HCACs) as defined supra in section 1886(d)(4)(D)(iv)).
\textsuperscript{169} Bray, \textit{supra} note 11 at 45 (making the case that the legitimate range of variation for some wrongs, such as all defamation cases, breaches of contract, or intangible injury is too large.)
of claims to be scheduled, the standard for compensating, what elements should be included in a compensation package, and the threshold at which injury is deemed compensable.

*Mandate for Disclosure*

Patients need to know when injuries sustained as a result of medical care have happened so they can receive compensation. As patient safety initiatives have grown in importance, so have reporting obligations to state and national entities. Pennsylvania has a progressive statutory provision in this regard in the “M-CARE” Act. A number of other states have also enacted patient safety statutes which also require analysis and reporting of error. Resolution of most scheduled injuries should operationally resemble health or disability insurance, not liability. Several Massachusetts healthcare organizations received a health planning grant from the Agency for Health Care Research and Quality (AHRQ) to examine the potential for a disclosure, apology and offer (DA&O) program. Massachusetts, in a recent law also aimed at imposing cost growth

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170 40 PA. CONS. STAT. ANN. § 1303.308 (West 2006) Reporting and notification.
171 see for example CAL. HEALTH & SAFETY § 1279.3 (West 2007) Information regarding reports of substantiated adverse events and outcome of inspections and investigations; FLA. STAT. ANN. § 429.23 (West 2009) Internal risk management and quality assurance program; adverse incidents and reporting requirements.
173 Massachusetts Medical Society, A Roadmap for Removing Barriers to Disclosure, Apology and Offer in Massachusetts http://www.massmed.org/AM/Template.cfm?Section=MMS_News_Releases&CONTENTID=70930&TEMPLATE=/CM/ContentDisplay.cfm (last visited August 7, 2012) (The executive summary cited strong support for the DA&O approach among respondents to a survey; that such disclosure is the “right thing to do” ethically; and that patient safety is enhanced by encouraging open discussion of error, with improved reporting and understanding of safety risks.)
controls on health care entities, also requires health care providers to fully inform patients
about mistakes leading to unanticipated outcomes and medical complications.\textsuperscript{174}

\textit{Types of Claims}

Scheduling injuries for which claims are allowed is one of the most important
decisions. Too wide a definition of injury, and uncertainty enters regarding whether a
claim fits jurisdiction under the schedule.\textsuperscript{175} Defining a narrower subset of injuries makes
claiming predictable, but compensation is limited to a smaller number of injured.\textsuperscript{176} An
alternative approach is to use a defined list of injuries all of which are highly likely to
arise as a result of treatment, not underlying disease. Medical adversity insurance, a form
of no-fault compensation for medical injuries, was proposed as an alternative to
malpractice during the malpractice insurance crisis of the 1970’s.\textsuperscript{177} Building on the
medical adversity insurance concept, a system of designated compensable events was
championed as a form of limited no-fault by Danzon in her analysis of medical
malpractice.\textsuperscript{178} Neither commentator tried to further define such events.

\textsuperscript{174} Bill S.2400 “An Act improving the quality of health care and reducing costs through increased
transparency, efficiency and innovation” Section 10(b)
http://www.malegislature.gov/Bills/187/Senate/S02400 (last accessed Aug. 12, 2012.)(Adding to the
General Laws; Part I: Administration of the Government; Title II: Executive and Administrative Officers of
the Commonwealth; Chapter 6A: Executive Offices).
\textsuperscript{175} Michelle M. Mello & Allen Kachalia, Evaluation of Options for Medical Malpractice System Reform: A
Report to the Medicare Payment Advisory Commission (MedPAC) January 29, 2010 30
http://www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf (last visited Sept. 30,
2012)(on file with author)
\textsuperscript{176} Id.
\textsuperscript{177} Clark C. Havighurst & Laurence R. Tancredi, \textit{Medical Adversity Insurance” — A No-Fault Approach to
Medical Malpractice and Quality Assurance}, 51 \textit{THE MILBANK MEMORIAL FUND QUARTERLY. HEALTH
AND SOCIETY} 125, 133-34 (Spring, 1973) (suggesting, as a start, events arising generally from surgical
treatment and post-operative patient management; post-operative infections, thrombophlebitis and
embolism, catheter infections, allergic and toxic reactions to antibiotics and other drugs, blood transfusion
reactions, foreign bodies, hospital accidents, adverse consequences during experimental treatment,
secondary injuries from surgery).
\textsuperscript{178} DANZON, \textit{supra} note 145 at 217-18.
Decades ago, Bovbjerg and Tancredi first suggested the National Quality Forum (NQF)’s list of serious reportable events as the basis for ‘Avoidable Classes of Events’ 179. The NQF threshold criteria appear to hold the promise of the best starting point for a schedule of medical injuries, and balance predictability with compensation for many injured by healthcare (Appendix 1). The NQF serious reportable events have been updated, and require that such events be unambiguous, largely or entirely preventable, and serious. 180 Twenty nine events have been recommended for endorsement as voluntary consensus standards. 181 Additional specialty specific and diagnostic injuries (failure to diagnose) including those caused by independently practicing physicians with admitting privileges to the hospital, and those caused by diagnostic or treatment decisions made in the physicians’ offices could also be added once the original compensation plan is up and running. 182

A second consideration is when to update the scheduled remedies. Two options are, first, to update at frequent intervals increasing information costs, hence emphasizing precision over communication. 183 Alternatively, updates could be infrequent but in larger increments improving communication at the expense of precision. 184 Lastly, a concern more theoretical is the crowding out of a social norm, that of preventing medical injury.

179 Bovbjerg & Tancredi, supra note 172 at 487.
182 WEILER, ET AL. supra note 145 at 151.
183 Bray, supra note 7 at 46.
184 Id. (noting the future-proofing problem by analogy with VII Amendment’s right to a civil jury when the amount in controversy exceeds a mere $20).
If the remedies for injury are not set high enough, health care institutions may view compensation for injuries as a cost of doing business rather than as an imperative for improving patient safety.

Compensation Standard

Defining a schedule of injuries creates a broader standard that does not require proof of fault or negligence. The NQF’s list of 29 injuries that should not happen in a quality healthcare organization are clear, easily decided, and encompass most of the unexpected outcomes likely to award patients compensation. Further, none of these injuries - with the exception of suicide - is easily accomplished by a patient who might wish to profit by creating an injury. Lastly, the negative effect on a healthcare organization that injures patients aligns safety principles with compensation; there is an institutional incentive to prevent such injuries.\(^{185}\)

Other alternatives to negligence as a standard are found in foreign systems that have moved to a ‘no-fault’ form of compensation for medical injury. Avoidability is the standard applied in Sweden and Denmark; injuries are compensable if they would not have occurred in the hands of a highly skilled and experienced physician in the relevant specialty.\(^{186}\) In New Zealand, currently the standard is treatment by a registered health professional causing a physical injury that is not a necessary or usual outcome of the treatment.\(^{187}\) Such avoidability or treatment injury standards rather than negligence — as the standard for compensation of medical injuries would likely increase — not decrease — the direct expenditure of resources of a scheduled compensation Patient’s

\(^{185}\) Mello & Kachalia, supra note 175 at 31.

\(^{186}\) Mello et al. supra note 185 at 4.

\(^{187}\) Id.
Compensation. Rightly so; the intent is to compensate more not fewer injured patients, and scheduling injuries may also improve ease of adjudication.

Financing

From where will the money come? Congress authorized appropriation of, $50,000,000 for the five year period beginning fiscal year 2011 to carry out authorized State Demonstration Projects. Under the Affordable Care Act, each state desiring a tort reform grant must identify the sources from and methods by which compensation is paid for claims under the proposed alternative to current tort litigation, which may include public private funding sources, or a combination of such sources. The Affordable Care Act also requires that funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

The Patient’s Compensation program should be funded through a combination of state funds, assessments on physicians and hospitals, and participation fees. The Florida Birth Injury Compensation Program (Florida Program) is a good model. When the Florida Program was created in 1988, the Florida Legislature made a one-time appropriation of $20 million. These funds were appropriated as a transfer from the

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189 Mello & Kachalia, supra note 175 at 31.
192 Id.
Insurance Commissioner’s Regulatory Trust Fund. A second $20 million installment that could have been transferred was not necessary to maintain the program on an actuarially sound basis. In addition to these funds, the Florida Program receives annual assessments from participating and non-participating physicians, participating midwives, and hospitals. Appropriate adjustments could be made in the revenues received for services, for example direct agreements between a given hospital and attending staff physicians regarding risky procedures, or based on specialty with higher claims experience specialties paying higher premiums into the Compensation Program.

As physicians continue to become employees, Compensation Program costs could be a point of negotiation for physician compensation. Physicians appear to be seeking stability of employment, while hospitals seek closer integration with physicians in response to the Affordable Care Act, which is promoting the use of integrated health-care models such as Accountable Care Organizations, bundled payments, and medical homes.

Compensation Package
Another question is what should be compensated for the scheduled medical injuries? The medical liability reform provisions of the Affordable Care Act look remarkably like a bill that died in committee in 2003; the Reliable Medical Justice Act.\textsuperscript{201} The unenacted Reliable Medical Justice Act also describes models for alternative liability regimes in some detail.\textsuperscript{202} The Reliable Medical Justice Act defined Net Economic Loss; elements of which a Patient’s Compensation program could encompass as a compensation package for patients who sustain a medical injury.\textsuperscript{203} Net economic loss, as

\begin{quotation}
\textsuperscript{201} 108th Congress 1st Session S.1518 (July 31 (legislative day, July 21), 2003 Mr. Enzi introduced the bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions, where it presumably never emerged. Much of the text of S.1518 is quite similar to the Affordable Care Act, but there are differences. Section (2) of S.1518 notes that the proposed alternative to current malpractice regime:
(A) makes the medical liability system more reliable;
(B) enhances patient safety; and
(C) maintains access to liability insurance.

In comparison, the Affordable Care Act, Section 10607, the enacted legislation:
(A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;
(B) encourages the efficient resolution of disputes;
(C) encourages the disclosure of health care errors;
(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;
(E) improves access to liability insurance;
(F) fully informs patients about the differences in the alternative and current tort litigation;
(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;
(H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and
(I) would not limit or curtail a patient’s existing legal rights, ability to file a claim in or access a State’s legal system, or otherwise abrogate a patient’s ability to file a medical malpractice claim.).

\textsuperscript{202} 108th Congress 1st Session S. 1518 (JULY 31 (legislative day, JULY 21), 2003. (describing the Early Disclosure and Compensation Model, the Administrative determination of Compensation Model, and the Special Health Care Court Model.)
\textsuperscript{203} 108th Congress 1st Session S. 1518 (JULY 31 (legislative day, JULY 21), 2003.
\end{quotation}

\textbf{(j) DEFINITIONS.—In this section:}

\textbf{(4) NET ECONOMIC LOSS.—The term ‘net economic loss’ means—}

(A) reasonable expenses incurred for products, services, and accommodations needed for health care, training, and other remedial treatment and care of an injured individual;

(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and
defined in the Reliable Medical Justice Act includes four components: reasonable expenses needed for health care and other remedial care of an injured individual; expenses for rehabilitation and occupational training; 100 percent of the loss of income from work that an injured individual would have performed if not injured; and reasonable expenses incurred in obtaining ordinary and necessary replacement of services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.\textsuperscript{204}

A similar approach has been used by the Virginia Birth Injury Compensation Program.\textsuperscript{205} The Virginia program identifies three broad categories of benefits. First, compensation is provided for all “medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel,” except those for which the claimant has already received reimbursement either under the laws of another government entity or the policy of another private insurance program.\textsuperscript{206} Second, it provides payment (in regular installments) for loss of earnings from the age of 18 until 65.\textsuperscript{207} Lastly, the program, allows reimbursement for “reasonable expenses incurred in connection with the filing of a claim . . . including reasonable attorney fees.”\textsuperscript{208} An alternate proposal was put for in a proposal by Weiler and colleagues suggesting legislation require compensation for full

\textsuperscript{204} 108th Congress 1st Session S. 1518 (JULY 31 (legislative day, JULY 21), 2003.
\textsuperscript{205} Code of Virginia Section 38.2-5009.
\textsuperscript{207} Id.
\textsuperscript{208} Id.
out-of-pocket medical expenses (that is, those not covered by direct insurance), 80% of net lost wages up to 200 percent of the state’s average, and specified payments for loss of enjoyment of life associated with certain physical impairments. 209

Establishing an Injury Threshold

The health-care acquired conditions should be further stratified by severity of injury, so appropriate thresholds can be set. 210 Such thresholds direct compensation to those who are more severely injured. 211 There is experience with establishing thresholds. New Zealand provides payment for only for permanent impairment (the loss, or loss of use, of a bodily part, system, or function). 212 Sweden and Denmark pain and disfigurement are compensated even if not disabling. 213 One useful classification system is that of the National Association of Insurance Commissioners (NAIC). 214 Another detailed classification system is that promulgated by the National Coordinating Council for Medication Error Reporting and Prevention (Coordinating Council). 215

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209 Weiler, et al., supra note 145 at 149-52.
210 Mello & Kachalia, supra note 175 at 30.
211 Studdert & Brennan, supra note 59 at 232.
213 Id.
214 M. Patricia Sowka, The Medical Malpractice Closed Claims Study. Conducted by the National Association of Insurance Commissioners: Executive Summary, 45 CONN. MED. 91, 93 (1981)(The nine-point scale includes the following categories (examples):
1. Emotional only (fright, no physical damage).
2. Temporary insignificant (lacerations, contusions, minor scars, rash; no recovery delay).
3. Temporary minor (infections, fracture, fall in hospital; recovery delayed).
4. Temporary major (burns, surgical material left, drug side effect, brain damage; recovery delayed).
5. Permanent minor (loss of fingers, loss or damage to organs; includes nondisabling injuries).
6. Permanent significant (deafness, loss of limb, loss of eye, loss of one kidney or lung).
7. Permanent major (paraplegia, blindness, loss of two limbs, brain damage).
8. Permanent grave (quadriplegia, severe brain damage, lifelong care or fatal prognosis).
Compensation schedule could compensate medical injuries at or above a given Coordinating Council category sustained by patients, including those caused by independently practicing physicians with admitting privileges to the hospital, and those caused by diagnostic or treatment decisions made in the physicians’ offices.

Both the NAIC and NCC-MERP injury scales allow separation of injuries into lesser and greater degrees; from errors that do not reach the patient – ‘near misses’ – to death. Creating a modest threshold would direct limited resources towards compensation for the injured while expanding coverage beyond those whose serious or catastrophic injuries would allow them to pursue a malpractice lawsuit. At the same time, a threshold would prevent the administrative costs of adjudicating a large number of claims for minor temporary or insignificant injuries.

Announcing Remedies for Patients Suffering Medical Injury

Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom. Monitoring To observe or record relevant physiological or psychological signs. Intervention May include change in therapy or active medical/surgical treatment. Intervention Necessary to Sustain Life Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.). Nine Categories:

Category A: Circumstances or events that have the capacity to cause error.
Category B: An error occurred but the error did not reach the patient (An "error of omission" does reach the patient).
Category C: An error occurred that reached the patient but did not cause patient harm.
Category D: An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.
Category E: An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.
Category F: An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.
Category G: An error occurred that may have contributed to or resulted in permanent patient harm;
Category H: An error occurred that required intervention necessary to sustain life.
Category I: An error occurred that may have contributed to or resulted in the patient’s death.

216 Sowka supra note 214 at 93.
217 Studdert & Brennan, supra note 59 at 232.
218 Id. see also Ryan K. Orozco, Jonathan Talamini, David C. Chang, and Mark A. Talamini, Surgical Malpractice in the United States, 1990-2006, 215 J. AM. COLL. SURGEONS 480, 482 (2005)(noting insignificant injury was associated with a decreased malpractice payment $50,000 less than that of minor temporary injury.)
Announcing Remedies as an Alternative to Medical Malpractice

Samuel Bray has observed that for most violations of legal rules, remedies are tailored to fit a specific wrong.\(^\text{219}\) Announcing remedies for injuries sustained as a result of medical care holds promise of three important patient benefits. First, there is greater equality; an injured patient’s right to compensation is not constrained by what a plaintiff’s attorney would consider to be a ‘valuable’ case or other factors such as race or socioeconomic status.\(^\text{220}\) Second, announcing remedies for medical injury produces greater compliance with rules designed to enhance patient safety, as well as help control positive and negative defensive medicine behaviors.\(^\text{221}\) Lastly, announcing such remedies eliminates the costs of recovery from injury, or hedonic adaptation.\(^\text{222}\) Telling a successful story in a medical malpractice setting impairs hedonic adaptation, an important process for letting patients recover and move on.\(^\text{223}\)

These three benefits of announcing remedies for medical injury - equality for the injured, compliance by providers, and costs of telling - are achieved through one of

\(^{219}\) Bray, supra note 11 at 45.
\(^{220}\) Daryl J. Levinson, Rights Essentialism and Remedial Equilibration, 99 COLUM. L. REV. 857, 886 (1999)(arguing that incorporating a prophylactic remedy into a right may be more efficient; Levinson’s taxonomy would consider announcing remedies for medical injury as remedial incorporation.)
\(^{221}\) Ernst Fehr & Simon Gachter, Cooperation and Punishment in Public Goods Experiments, 90 AM. ECON. REV. 980, 993 (2000)(concluding that cooperators in social dilemma situations will punish ‘free riders’ even if there are no material benefits for punishers) see also Robert Boyd, Herbert Gintis, & Samuel Bowles, Coordinated Punishment of Defectors Sustains Cooperation and Can Proliferate When Rare, 328 SCIENCE 617, 619 (2010)(documenting that costs of punishing free-riders decreases as the number of punishers increases). but see Helen Bernhard, Urs Fischbacher, & Ernst Fehr, Parochial Altruism in Humans, 442 NATURE 912, 913 (2006)(showing that punishment is more likely if the victim and punisher are from the same social ‘ingroup,’ but less if from different social groups.)
\(^{223}\) Bray, supra note 11 at 25 and Samuel R. Bagenstos & Margo Schlanger, Hedonic Damages, Hedonic Adaptation, and Disability, 60 Vand. L. Rev. 745, 748 (2007).
several functions as articulated by Bray.\textsuperscript{224} A first function is that of reducing information costs by announcing remedies for medical injury.\textsuperscript{225} Overhead costs have been estimated at between 40\% and 54\% of the total cost of litigation.\textsuperscript{226} By announcing a remedy for an entire class of injuries, a decision on remedy only needs to be made once.\textsuperscript{227} Patients, often unsophisticated in medical knowledge may underestimate the injury sustained, while health care providers – sophisticated repeat players - know an injury to be caused by the provision of health care.\textsuperscript{228} Announcing a schedule of injuries for which remedy exists would level the playing field with respect to medical injury.

Second, announcing remedies has a precommitment function that reduces information costs for sophisticated repeat players, the health care providers.\textsuperscript{229} By knowing the price of a given medical injury, providers can not only forecast total costs of care, but also generate priorities for further injury reduction strategies.\textsuperscript{230} If obtaining accurate information about external costs is cheaper for health care providers than obtaining accurate information about socially optimal behavior, then they should control the activity by pricing it; if the converse is true, then they should control the activity by sanctioning it.\textsuperscript{231} Both can be difficult for health care providers to determine. External costs have been defined as the change in consumption minus the change in production for

\begin{thebibliography}{231}
\bibitem{224} Bray, \textit{supra} note 11 at 27.
\bibitem{225} Bray, \textit{supra} note 11 at 28.
\bibitem{226} Mello & Kachalia, \textit{supra} note 175 at 34 and Studdert, et al., \textit{supra} note 140 at 2031.
\bibitem{227} Bray, \textit{supra} note 11 at 28.
\bibitem{228} Bray, \textit{supra} note 11 at 37.
\bibitem{229} \textit{Id.}
\bibitem{230} \textit{Id.}
\end{thebibliography}
an individual that receives a health care treatment, where hard data are lacking.\textsuperscript{232} The trend towards evidence-based medicine as defining socially optimal behavior has many proponents, but forging consensus on even basic medical treatments can be difficult.\textsuperscript{233} And yet, precommitting to a schedule of remedies for medical injury takes the ‘yoke of liability’\textsuperscript{234} off the vast majority of physicians who otherwise would be tempted to engage in poorly informed attempts at positive or negative defensive behaviors, and who rarely intend injury to their patients.\textsuperscript{235}

Cost-saving is a third function. Cost-saving as the term is used here does not refer to all costs of remedies for medical injury. In fact, total costs of such a program have been predicted to increase with the increase in paid claims for medical injury.\textsuperscript{236} Instead, the savings are in administrative costs, which in the medical malpractice litigation regime – win or lose - are high.\textsuperscript{237} In case by case remedies, such as those sought in malpractice suits, negligence must be proved under a preponderance of evidence standard, and courts

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\bibitem{232} Magnus Johannesson, \textit{The Willingness To Pay For Health Changes, The Human-Capital Approach And The External Costs}, 36 \textit{HEALTH POLICY} 231, 244 (1996).
\bibitem{234} Clarissa Bonanno, Marilee Clausing, Richard Berkowitz, \textit{VBAC: A Medicolegal Perspective}, 38 \textit{CLINICAL PERINATOLOGY} 217, 223 (2011)
\bibitem{235} Cooter, \textit{supra} note 231 at 1537-38 (defining a simple test for determining whether to impose a sanction or a price: “Sanctions increase with the need for deterrence, as indicated by the actor’s state of mind, whereas prices increase with the amount of external harm caused by the act, which is invariant with respect to the actor's state of mind.”)
\bibitem{236} DANZON, \textit{supra} note 145 at 217-18.
\end{thebibliography}
must decide a remedy in each case.\footnote{Mello & Kachalia, supra note 175 at 34.} Announcing a remedy ex ante for a class of injuries would reduce administrative costs.\footnote{Id. (documenting overhead cost estimates of the U.S. tort system as 40\%, compared to no-fault approaches such as: Sweden and Denmark - 15-20\%, New Zealand - 10\%, Florida/Virginia birth-injury systems - 8-10\%).}

Overhead associated with malpractice claims are a major source of costs that do not directly benefit injured patients. One Harvard study of medical malpractice observed: “In monetary terms, the [malpractice] system’s overhead costs are exorbitant.”\footnote{Studdert, et al., supra note 140 at 2031.} Fifty-six percent of the claims received compensation, at an average of $485,348 (median, $206,400) per paid claim. Fifteen percent of the claims were decided by trial verdict. The awards in verdicts for the plaintiff on average were nearly twice the size of payments made outside of court ($799,365 vs. $462,099). However, plaintiffs rarely won damages at trial, prevailing in only 21 percent of verdicts as compared with 61 percent of claims resolved out of court. Administrative (or overhead) costs associated with defending the claims averaged $52,521 per claim, with the mean administrative costs for claims that were resolved by trial ($112,968) nearly three times those for claims resolved out of court ($42,015).

The combination of defense costs and standard contingency fees charged by plaintiffs’ attorneys (35 percent of the indemnity payment) brought the total costs of claim litigation to 54 percent of the compensation paid to plaintiffs.\footnote{Id.} Nearly 80 percent of these administrative expenses were absorbed in the resolution of claims that involved harmful errors.\footnote{Id.}

The data are remarkably consistent over time. A 1976 study estimated...
that the malpractice system returned at the most only 28 cents of the malpractice premium dollar to injured patients; only 12.5 cents reimbursed the patient for losses not otherwise compensated.\textsuperscript{243} Analysis of over 26,000 malpractice claims closed in the decade ending in 2005 showed a mean defense cost of about $23,000, with non-paid claims payment still at an average cost of about $17,000.\textsuperscript{244}

The Affordable Care Act has made health care insurance a statutory responsibility for all and not a luxury for a select few.\textsuperscript{245} Cost sharing for all covered individuals is capped, so out of pocket expenses – whether for underlying disease or as a result of medical injury – are limited.\textsuperscript{246} Further, there is no good way for such a system to provide prevention of similar future injuries.\textsuperscript{247} Although patient costs for direct care are limited to $5,000, there are still costs borne by the injured and their families in terms of lost wages while healing from such injuries.\textsuperscript{248} In the past, physicians and hospitals could bill for additional services incurred when patients suffered medical injuries.\textsuperscript{249} CMS has adopted a nonpayment strategy that is based on the “never events” approach, recognizing the

\textsuperscript{246} Affordable Care Act § 1302(c)(1)(A) 2014 – The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively for taxable years beginning in 2014.
\textsuperscript{247} Allen Kachalia & Michelle M. Mello, \textit{New Directions in Medical Liability Reform} 364 N. ENGL. J. MED. 1564, 1565 (2011)(noting that evidence suggests that the medical malpractice liability system does not provide a strong incentive to avoid negligent care).
\textsuperscript{248} Current dollar values for coverage according to 223(c )(2)(A)(ii) of the Internal Revenue Code of 1986 are $5,000 for self-only coverage, and twice that dollar amount for family coverage.
added costs to the Medicare program in treating the consequences of such events.\textsuperscript{250} With the inability of health care providers to be paid for care necessary for the treatment of certain injuries, and yet liable for medical injuries under common law torts, health care organizations currently pay twice for injuries; once by absorbing the cost of care-related injuries and second by indemnification against liability claims.

*Uniting Patient Safety Enhancements and Compensation*

**Experience Rating of Physicians and Health-care Organizations**

One concern of eliminating the requirement of negligence is a moral imbalance, that healthcare providers will develop a cavalier attitude towards patient safety if negligence no longer serves as a means for holding doctors responsible for mistakes.\textsuperscript{251} This concern can be overcome by implementing experience rating for healthcare provider contributions, and a strong reporting mechanism. The Patient’s Compensation program should require contributions to the compensation funds for individual physicians and healthcare organizations to be ‘experience-rated;’ where healthcare providers (individual or organizational) with higher than average numbers of announced injuries should have higher contributions.

The mechanics of experience rating could be extremely complex; as an example, the formula for contribution adjustment might vary for particular compensable events or for different levels of payout to reflect perceived needs for greater or lesser incentives or

\textsuperscript{250} Section 2702 of the Patient Protection and Affordable Care Act directs the Secretary of Health and Human Services to issue Medicaid regulations effective as of July 1, 2011 prohibiting Federal payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulation. It will also authorize States to identify other provider-preventable conditions for which Medicaid payment will be prohibited.

\textsuperscript{251} , *supra* note 34 at 113-14.
for protection of the provider against costs associated with truly catastrophic outcomes.\textsuperscript{252} Also, the increased contribution might be regarded to a greater or a lesser extent as a repayment to the fund of the compensation paid out, and, if this approach were adopted, the physician's age and remaining years in practice could be a factor.\textsuperscript{253} Such ‘experience rating’ is designed to maintain provider responsibility and is an incentive to minimize medical injuries. Further, announcing the costs for each class of compensable events permits allocation of specific risks in such a way as to focus attention on particular quality questions (for example, hospital acquired infections).

**Medical Reviews of Physicians and Hospitals Should Be Rigorous**

Institutions should be the unit of participation as the best means of announcing remedies for medical injury, and linking the compensation program to patient safety incentives.\textsuperscript{254} The health care facilities’ quality assurance program should include internal oversight measures for assessing accountability for medical injuries identified through the Patient’s Compensation claims process. Immunity from antitrust liability should be extended to cover the physician-members of hospital peer review committees responsible for alteration of the practice privileges of “repeat offender” physicians.\textsuperscript{255} Criteria for

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\textsuperscript{252} Havighurst & Tancredi, supra note 177 at 128.  \\
\textsuperscript{253} Id. at 129.  \\
\textsuperscript{254} Studdert, & Brennan, supra note 59 at 231.  \\
\textsuperscript{255} 42 U.S.C.\textsuperscript{222}§ 11111 Professional Review. (states that a professional review body, any person acting as a member of that body, any person providing services to the body, and any person who participates with or assists the peer review body in the conduct of a professional review action that is taken in the reasonable belief that the action was in the furtherance of quality health care, after a reasonable effort to obtain the facts of the matter, after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts, "shall not be liable in damages under any law of the United States or of any State with respect to the action").
\end{footnotesize}
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deciding upon sanctions and censure should be clear and unambiguous; perhaps a point system similar to that used for vehicle licensing could be considered.

External oversight should also be included in Patient’s Compensation legislation, which should direct the State’s Board of Medicine and Department of Health (DOH) to register and review all submitted medical injury claims.\textsuperscript{256} The Board of Medicine should be required to assess whether the physician(s) involved in the injury claim provided substandard care that would warrant disciplinary action by the Board of Medicine. The DOH would selectively review claims to determine whether the hospital and its staff provided inadequate medical care that should impact the hospital’s license. The State could mandate, by statute, for State’s Board of Medicine and Department of Health to develop a plan for ensuring that all injury claims, are submitted to the State’s Board of Medicine and Department of Health for review. Further, the Board of Medicine and Department of Health could conduct selective investigations of the claimant and other relevant parties of the events surrounding the claims injury and to notify claimants concerning the outcome of the review.

\textit{Filing Method and Adjudication}

Announcing the remedy for medical injury means that the Patient’s Compensation program claims process would be navigable without attorneys. Representation for injured patients would not be barred, and attorneys could still represent the injured for a reasonable, but likely not contingent, fee.\textsuperscript{257} Access to legal counsel would provide

\footnotesize{\textsuperscript{256} Section 38.2-5004 of the Code of Virginia.}
\footnotesize{\textsuperscript{257} Mello \& Kachalia, \textit{supra} note 175 at. 31.}
protection regarding eligibility and payment.\textsuperscript{258} At the time patients are notified of their injury they should be encouraged to file a claim for compensation. Claims should be received at a central organization, preferably at the state level.\textsuperscript{259} This central organization would have responsibility for receipt of claims, adjudication, and dispensing compensation.\textsuperscript{260}

Initial adjudication would fall to an administrative claims manager with a background in law or health care, preferably both.\textsuperscript{261} Claims administrators should have access to experts appointed by the Patient’s Compensation program, and not the parties.\textsuperscript{262} Claims administrators and neutral experts would not necessarily need to be grounded in evidence–based medicine. The list of compensable medical injuries as announced would require little additional knowledge. A database of all claims, kept by the State’s department of health or medical licensure would insure that precedent would be documented improving the accuracy of the claims administrators’ adjudication. The New Zealand and Swedish administrative models both rely on such administrators.\textsuperscript{263}

The claims administration procedure should meet acceptable standards of accessibility, neutrality, and due process. Florida uses two independent experts in the review of birth injury claims, while Virginia uses three.\textsuperscript{264} One argument in favor of Virginia’s consensus-decision approach revolves around the complexities of the

\textsuperscript{258} Bovbjerg, & Tancredi, supra note 172 at 490.  
\textsuperscript{259} Studdert, & Brennan, supra note 59 at 230.  
\textsuperscript{260} Id.  
\textsuperscript{261} Mello & Kachalia, supra note 175 at 31.  
\textsuperscript{262} Mello & Kachalia, supra note 175 at 31-32.  
\textsuperscript{263} Kachalia, et al., supra note 60 at 390-91 and Mello, et al., supra note 212 at 5-6.  
decisions. Deliberations and debate among a group of experts each of whom contributes his or her own perspective and expertise would appear to be a useful way to address complex clinical issues. Unlike the Patient’s Compensation approach, in which a defined set of injuries and severity are clear cut, the use of a panel is also advantageous in ensuring transfer of knowledge and consistency of decision making when individual experts transfer out of and into the program. Overall, one claims administrator should be able to adjudicate most if not all claims.

Informed Consent for Patients Admitted to Hospitals

As required by the Affordable Care Act, participating states must demonstrate how patients are to be notified that they are receiving health care services that fall within the scope of the alternative tort reform program, and the process by which they may opt out of or voluntarily withdraw from participating in the alternative. The Patient’s Compensation should inform, ex ante, all patients about the program, as well as those who are injured ex post. Patients would have to be fully informed in easily comprehensible terms of both the tort rights they were surrendering and the no-fault benefits they would be eligible to receive, before they were asked to decide either to accept medical care under no-fault auspices or to use institutions and doctors still governed by the existing tort regime.

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266 See Joint Legislative Audit & Review Comm’n, Review Of The Virginia Birth-related Neurological Injury Compensation Program 99-101 (2003) (hereinafter “JLARC”), http://jlarc.state.va.us/Reports/Rpt284.pdf. (last visited Sept. 12, 2012, also on file with author) (JLARC found that although the Virginia Birth-Related Neurological Injury Compensation Program supplied patient brochures to physician and health care for distribution, most of the claimant families indicated that the most common source of information about the program was an attorney. Claimants indicated they were not informed about the program through the brochures. Further, the brochure developed by the program inadequately explains the patients’ rights and limitations under the program.)
To encourage announcing, participating physicians and health-care organizations should be mandated by legislation to obtain informed consent regarding program participation from all patients under their care. The Virginia Birth-Related Neurological Injury Compensation Program has used brochures to explain a patient’s rights and limitations under the program, especially the exclusive remedy provisions. Participating physicians and hospitals that fail to obtain informed consent of patients could be made subject to sanctions, such as remedial work plans, monetary penalties, or in the case of recalcitrant physicians, suspension of privileges for a period of time.

**Eliminating the Collateral Source Rule, and Other Insurance Considerations**

The Affordable Care Act, by making health care a responsibility - not a right - has made application of the collateral source rule (the Rule) more complex. Institution of a Patient’s Compensation program would further weaken the rationale for applying the Rule in determination of damages and may render it unnecessary. In general terms, the Rule prohibits reducing a claimant’s medical expense damages by the amount of health insurance coverage. The intent is to prevent the fact-finder, usually a jury, from considering whether the claimant has health insurance in determining fault of the defendant. With the constitutionality of the individual mandate of the Affordable Care Act

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267 Id..
268 Id.
269 Rebecca Levinson, *Allocating the Costs of Harm to Whom They are Due: Modifying the Collateral Source Rule After Health Care Reform*, 160 U. PA. L. REV. 921, 922 (2012).
271 Levinson, *supra* note 269 at 924.
Announcing Remedies for Medical Injury: A Proposal For Medical Liability Reform Based on the Patient Protection and Affordable Care Act

Act affirmed, fact-finders may now assume that claimants have health insurance.272 Continued application of the Rule, therefore, protects only those individuals choosing to willfully forgo health insurance, and rewards such willfully uninsured claimants with full damages despite the decision to forgo coverage.273

Implementation of a Patient’s Compensation program would require that the health care providers cover the medical costs of a health care-related injury. Regardless of insurance status, insurers and their insureds would not bear the costs of paying for such injuries. Further, the scheduled injuries which are announced prior to injury are not expected to occur to anyone, insured or not. Neither would subrogation decrease the remedy to the injured, as these costs are not paid by insurers, who are not entitled to any recovery.274

Health insurers should be involved in setting up a Patient’s Compensation program for two reasons. First, with recent exceptions, insurers currently pay for many of the costs associated with medical injury. If insurers can be persuaded that a Patient’s Compensation approach would lead to improved patient safety through prevention of medical injury, they could be strong advocates for change.275 Second, health insurers should be consulted as any award to the injured patient might otherwise be considered subject to subrogation.276 By compensating injured patients according to an announced, scheduled program of injuries, there is no tortfeasor,

273 Levinson, supra note 271 at 936.
274 Levinson, supra note 271 at 942-47.
275 Studdert & Brennan, supra note 59 at 252.
276 Id. at 245.(defining subrogation as ‘. . . a legal fiction which allows an insurer (the subrogee) to ‘stand in the shoes’ of the insured (the subrogor) and enforce the insured’s legal rights against a third party. . . “).
so insurers could attempt to recover against the insured. Health insurance plans’ benefits will still cover some of the patient's health care related expenses for the interval in which patients are injured. Patient’s Compensation awards should not be reduced to reflect payments from collateral sources as collateral sources should still compensate injury-unrelated medical costs. The cost to the Patient’s Compensation program of the total cost of remedying covered medical injuries would be off-set by decreasing administrative costs (e.g., less court time, lower legal expenses), and ending lengthy discovery about defendants’ negligence, no-fault should provide faster, more efficient compensation. A Patient’s Compensation approach would take on the burden of an amount approaching the total cost of the injuries which occur, health insurers seeking subrogation may have those claims deflected by the requirements that the injured first be made whole.

**Other Administrative Requirements of the Affordable Care Act**

A Patient’s Compensation proposal would also have to account for a number of provisions of the Affordable Care Act. Some are expected of all grantees; such as an application and submission to the HHS Secretary of an annual report evaluating the effectiveness of funded activities, to include the impact of the activities funded on patient

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277 *Id.* at 247. (listing four possible subrogation arguments: attempts to recover payments from the paid compensation to the insured; in the case of an insured attempting to recover medical payments an imposed formal agreement subrogating the insurer to proceeds of any recovery; an attempt to deflect strict liability on the grounds that an insured has received monies from the Patient’s Compensation program; and that with no tortfeasor other subrogation rights may be prejudiced.)

278 Havighurst & Tancredi, *supra* note 177 at 129-30.

279 Studdert, & Brennan, *supra* note 275 at 229.

280 *Id.* at 247.

safety. The specific elements of the proposal would likely be the same as elements upon which the HHS Secretary is required to report. A Patient’s Compensation grant proposal will have to demonstrate how the proposed alternative increases the availability of prompt, fair, efficient resolution of disputes. The program will also have to enhance patient safety by encouraging the disclosure and reduction of medical errors and adverse effects. Further, the grant must provide a mechanism fully informed consent for patients about the differences in the alternative and current tort litigation. There are additional requirements. The Patient’s Compensation program must provide patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation. The Affordable Care Act is careful to make explicit the requirement that any Compensation Project must allow participants to withdraw at any time. One foreseeable problem with the Affordable Care Act’s State Demonstration Project provisions as currently worded is the possibility that an injured patient could file a malpractice claim after settling with the Patient’s

283 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10607(g)(3)(A-H) 124 Stat. 119, 1013-14 (2010)(The elements required by Congress include: the nature and number of disputes over injuries allegedly caused by health care providers or health care organizations; the nature and number of claims in which tort litigation was pursued despite the existence of an alternative; the disposition of disputes and claims, including the length of time and estimated costs to all parties; the medical liability environment; health care quality; patient safety in terms of detecting, analyzing, and helping to reduce medical errors and adverse events; patient and health care provider and organization satisfaction with the alternative and with the medical liability environment; and the impact on utilization of medical services, appropriately adjusted for risk.)
285 Id.
286 Id.
288 Id.
Compensation program.\textsuperscript{289} It is likely the intent of Congress in enacting the Affordable Care Act with regard to a patient’s ability to take advantage of both torts and the alternative would have to be decided by the courts. Other requirements require additional consideration.

\textit{Scope of Jurisdiction}

A Patient’s Compensation grant will have to determine a scope of jurisdiction sufficient to evaluate the effects of the alternative.\textsuperscript{290} The scope of jurisdiction may be statewide, or based on a geographic region, area of health care practice, or a group of health care providers or health care organizations.\textsuperscript{291} The scope of jurisdiction is not to be based on a health care payer or patient population.\textsuperscript{292}

The Patient’s Compensation proposal must also demonstrate how patients would be notified that they are receiving health care services that fall within such scope, and the process by which they may opt out of or voluntarily withdraw from participating in the alternative.\textsuperscript{293} The Affordable Care Act is explicit that decision of the patient to participate or to continue to participate “shall be made at any time and shall not be limited in any way”.\textsuperscript{294} The scope of the Patient’s Compensation program should not conflict with state law that would prohibit adoption of an alternative and would not limit

\begin{thebibliography}{99}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
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a patient’s existing legal rights, ability to access a state’s legal system, or otherwise abrogate a patient's ability to file a malpractice claim.\textsuperscript{295}

*Preference in Awarding Demonstration Grants.*

Chances for successful funding of a Patient’s Demonstration proposal will be enhanced by noting that the Secretary is required to give preference to proposals developed through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts.\textsuperscript{296}

One good example of ‘substantive consultation with relevant stakeholders’ is the survey of leaders in medical care and health law detailed in a recent roadmap for a disclosure, apology and early offer program developed in Massachusetts.\textsuperscript{297} Interviewees included members of the Massachusetts legislature, hospital systems (academic and community hospitals), practicing physicians, liability insurers, health insurers, medical professional associations, patient advocacy organizations, malpractice attorneys, patient safety experts, major physician practice groups, and a major business association (otherwise unnamed).\textsuperscript{298}

The proposal should also enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events. Here, the Patient’s Compensation proposal, by virtue of the documentation of claims submissions and outcomes will do


\textsuperscript{296} A Roadmap For Removing Barriers To Disclosure, Apology And Offer In Massachusetts 3 April 2012 (Funded By Planning Grant #R21 Hs19537-01 From The Agency For Health Care Research And Quality) http://www.macoalition.org/documents/Roadmap%20FULL%20REPORT%20April2012.pdf (last visited Aug.28, 2012, on file with author).

\textsuperscript{297} Id. at 4.

\textsuperscript{298} Id. at 22.
exactly that. Lastly, The Secretary is to give preference to proposals that are likely to improve access to liability insurance.\textsuperscript{299} For the schedule of announced remedies as proposed in this liability alternative, access to liability insurance is unlikely to be significantly changed. Any claim falling outside of the NQF criteria (Table 1) will still – initially - require litigation. Long-term, however, if successful, the schedule of injuries may be made more inclusive leading to a preference away from litigation, at which point decreased litigation may lead to less expensive – hence more accessible - malpractice insurance.

Conclusions

Patient’s Compensation insurance, or scheduling and announcing remedies for medical injury, is a novel option to current medical malpractice litigation. The proper framework for understanding the rationale of a no-fault based approach to medical injuries is to compensate a higher proportion of patients by eliminating the need to prove negligence. Systems research has shown that few injuries are due solely to the acts of one individual, often making negligence hard to prove. Further, the costs of litigating on a contingent basis severely limits the number of injured patients eligible for compensation. The Affordable Care Act has provided a template for the development of state-based demonstration projects. There is experience both domestically and abroad for how to structure such a program.

A number of the cases that would likely be brought to the Compensation Project are those with a potential payment of less than $200,000 — suggested as a cut-off value

below which plaintiff’s attorneys will rarely take a malpractice case.\textsuperscript{300} Therefore, the lower value injuries are unlikely to be pursued by plaintiff’s attorneys. In tort, the requirement for serious or catastrophic injury limits the number of patients who can hope to receive compensation. This leaves a large number of patients injured by a complex health care system without remedy. For a defined schedule of medical injuries, compensation will be provided as scheduled and announced. The list of injuries for which such a remedy is available has been generally agreed upon as being not related to an underlying medical condition.

The development of a Patient’s Compensation program such as described here is modest in size and intent. Worker’s Compensation also started modestly with an Accident Fund for miners passed by Maryland in 1902, which expired when held unconstitutional in an un-appealed lower court decision.\textsuperscript{301} In 1908 Congress passed a compensation act covering certain federal employees.\textsuperscript{302} The first law held constitutional was passed in New Jersey and it was not until 1949 that all states passed Worker’s Compensation Insurance.\textsuperscript{303}

In summary, from a patient’s point of view, the medical and legal professions can and should do better by those suffering the consequences of medical injury. Just as


\textsuperscript{302} \textit{Id.} at 232.

\textsuperscript{303} \textit{Id.} at 233.
Worker’s Compensation insurance began on a voluntary basis and expanded in scope slowly, state-by-state, a Patient’s Compensation program would begin much the same way. By limiting early claims experience to a scheduled set of injuries all of which are likely to generate little dispute as to whether or not the injury is caused by medical care, the overhead costs of administration on a per case basis are likely to decrease.

Announcing the schedule to physicians and patients alike in a comprehensive but understandable way will be critical to the provision of fair and just compensation for those sustaining medical injury, negligent and non-negligent alike.
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Appendix 1: Serious Reportable Events in Healthcare-2011 Update

1. Surgical or Invasive Procedure Events
   A. Surgery or other invasive procedure performed on the wrong site
   B. Surgery or other invasive procedure performed on the wrong patient
   C. Wrong surgical or other invasive procedure performed on a patient
   D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
   E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient

2. Product or Device Events
   A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
   B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
   C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. Patient Protection Events
   A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
   B. Patient death or serious injury associated with patient elopement (disappearance)
   C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

4. Care Management Events
   A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
   B. Patient death or serious injury associated with unsafe administration of blood products
   C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
   D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
   E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
   F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting

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G. Artificial insemination with the wrong donor sperm or wrong egg

H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen

I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. Environmental Events

A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting

B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances

C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting

D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

6. Radiologic Events

A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

7. Potential Criminal Events

A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider

B. Abduction of a patient/resident of any age

C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting

D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting