One very clear conclusion emerges from the research on medical malpractice and medical malpractice lawsuits: The real medical malpractice problem is medical malpractice. It is not pretty to say, but doctors and nurses make preventable mistakes that kill more people in the United States every year than workplace and automobile accidents combined. Any research-driven approach to medical liability reform must start with this fact firmly in mind.

The evidence shows that the fundamental problem with medical malpractice lawsuits is almost exactly the opposite of what the medical malpractice myth would have us believe. The problem is not that there are too many claims; the problem is that there are too few. And, because our health-care system does such a poor job of giving injured patients the information they need to tell whether their injuries were due to malpractice, too many patients have to file lawsuits to find out.

If we were to base proposals for liability reform upon the available evidence, we would make it easier to bring a claim. Such evidence-based reform also would provide a way for injured patients to find out what caused their injuries without having to bring a lawsuit, so that they could make better informed decisions about whether to bring one. In addition, evidence-based liability reform would encourage doctors and other health-care professionals to take responsibility for, and learn from, their mistakes. It would also address the real malpractice insurance problems discussed at the end of chapter 3.

This chapter offers an evidence-based alternative to the myth-based reforms that have dominated the medical malpractice policy debate. In the first part of the chapter I provide a conceptual blueprint for a state statute to be called the Patient Protection and Healthcare Responsibility Act. The
The tone of the description is more technical than most of the rest of the book. Readers who do not need to understand the details should be able to get by with the text boxes that set out the main points. I find that it is helpful to have an overall sense of the statute before delving too deeply into any one part.

In the second part of the chapter I go back through the four parts of the proposal more slowly. I explain the research behind each part, and I address some of the complications and potential objections.

For most readers, the most important things to take from this chapter are, first, a general understanding of the goals of the reforms and, second, an appreciation for the fact that both the reforms and the goals grew out of the research. I don’t have an ideological commitment to these particular reforms, and I don’t think anyone else should, either. But we should have a commitment to the goals: reducing patient injuries, improving the accuracy of medical malpractice claiming, improving patient compensation, and reducing the disruption that the insurance cycle imposes on doctors. These reforms represent my best shot at achieving these goals. Whatever their other strengths and weaknesses might be, these reforms are much more likely to meet the goals than anything that grows out of the medical malpractice myth.

I harbor no illusions that a statute like this will be enacted overnight, or ever in this precise form. But I do hold out the hope that we can learn from studying these evidence-based reforms and from comparing them with the tort reform ideas that have emerged from the medical malpractice myth.

There are four parts to the act. The first part sets up a medical-injury disclosure and enforcement process. Disclosure should help reduce injuries and improve patients’ ability to evaluate whether their injuries were preventable. The second part contains an apology and early-offer procedure for medical malpractice lawsuits. The third part contains a supplemental no-fault patient-compensation insurance program with modest benefits. The fourth part creates a new insurance requirement that should protect doctors from the worst effects of the insurance cycle.

I will discuss potential objections and complications after I describe the main ideas. As will be obvious, there are many important details to be worked out. Nevertheless, we can evaluate the basic concepts before getting to the details.

The PPHRA Disclosure Requirement

PPHRA would require health-care providers to inform any patient (or the person responsible for the patient) whenever they realize the patient has suffered an adverse health-care event, or an event that possibly was an adverse health-care event. Providers would have to tell the patient (a) what happened, (b) what the preferred outcome would have been, (c) how what happened differed from the preferred outcome, and (d) what they or others could have done differently to increase the chance of getting the preferred outcome. This disclosure must be oral and in writing. When health-care providers tell patients that they suffered a possible adverse event, they would have to tell the patients again if they decided that the event was actually an adverse event.

It is important to note that this disclosure requirement is only a more...
PPhRA Disclosure Provisions

- Must disclose—oral and in writing—any adverse and possible adverse events to patient, Department of Public Health, and patient's health insurer.
- Obligation is on all health professionals providing care.
- DPH has strong enforcement powers, including audit.
- Nondisclosure means that the adverse event will be treated as negligent in any medical malpractice claim.

detailed version of what doctors are already supposed to do under the AMA's code of medical ethics, as I will explain shortly. A health-care provider could satisfy this disclosure obligation merely by telling the patient or responsible person directly or by receiving a copy of a written disclosure from another provider, together with proof that the patient or responsible person received and understood it. The obligation would fall on every professional involved in the care, not just the physician in charge. In most cases the right person to make the disclosure to the patient would be the physician in charge, but everyone involved would have an obligation to make sure that happens. The consequence for not disclosing would potentially be severe: if the patient brings a civil action, the adverse health-care event will be regarded as resulting from the negligence of any health-care provider who had an obligation to disclose it but did not do so.

The act would also require health-care providers to provide information regarding adverse or possible adverse health-care events to the Department of Public Health and to the health insurance company or other entity paying for the affected patient's health care, in a form that the department would develop for this purpose. The Department of Public Health (DPH) would be responsible for collecting and analyzing the event reports. After taking appropriate measures to protect the privacy of patients, the DPH would make the information from the reports available to the public in a form that would promote patient-safety research and awareness. I am not wedded to giving this responsibility to state departments of public health. That agency would be a logical choice in Connecticut, but other states may have another more appropriate agency.

DPH would be responsible for ensuring compliance with the disclosure requirements and would administer an auditing program with unannounced audits of patient records and verification from patients that disclosures were received and understood. DPH would be authorized to develop and require health-care providers to adopt reasonable procedures to ensure compliance with the disclosure obligations. DPH also would be authorized to assess fines on noncompliant providers. Persistent noncompliance would be grounds for withdrawal of the license to practice.

As part of the enforcement effort, DPH would be authorized to work with health-care payment organizations to develop electronic and other procedures for matching disclosures to events and for audit planning. In connection with this effort, DPH would be authorized to require the payment organizations to provide patient treatment data to DPH.

Obviously, the definitions of "adverse health-care event" and "possible adverse health-care event" would be very important. I suggest starting with the definitions used in the hospital record-based research, such as the Harvard Medical Practice Study discussed in chapter 2. The Harvard researchers defined an adverse event as "an unintended injury caused by medical management rather than by the disease process."

As reflected by the disagreements among reviewers in the research effort and by the Tony Sabia case discussed in chapter 4, it is not always easy to make judgments about cause. For example, causation can be hard to judge when there is a delayed diagnosis of a condition that might well have resulted in death or disability anyway. Requiring providers to disclose possible adverse events relieves them from having to resolve difficult causation issues when deciding whether and what to disclose, and it also means that patients will be informed more often. If there is a reasonable possibility that medical management made the patient's condition worse, the provider must disclose that fact. The patient would then be able to consider whether to consult another doctor or take other steps to obtain additional information.

In addition to providing a broad general definition of adverse health-care events and possible adverse health-care events, the act would direct DPH to develop lists of adverse and possible adverse events, based on the analysis of the reports and the patient-safety literature. For example, a postoperative infection is at least a possible adverse event, and a sponge left in the body would certainly be an adverse event. The definitions of adverse
The PPHRA Apology and Restitution Incentive

The act would create a new apology and restitution procedure that would give providers and patients an incentive to settle cases early. The procedure would work as follows. A health-care provider who apologizes and acknowledges fault for a medical injury would be able to offer restitution for that injury within a reasonable time after it becomes possible to know the extent of the patient's injuries and future losses. Significantly, the apology would be an admission of liability. The patient would then have a reasonable time to consider whether to accept the offer. If the patient rejects the offer, the case would proceed to trial, but the only question at trial would be the amount of the patient's damages.

The incentive comes from a rule about what happens if the patient does not accept the offer. If the patient rejects the offer, the patient will become responsible for the defendant's litigation expenses, including attorney fees, from the time of the offer until the end of the trial, unless the verdict is at least 20 percent more than the offer. In addition, the plaintiff can recover more than the amount of the offer only if the verdict at trial is at least 20 percent more than the offer. If the verdict is less than 20 percent above the offer, the plaintiff gets the lower verdict amount.

The incentive would be most effective in speeding up claims in which the defense team knows that liability is relatively clear. As the closed-claim research we reviewed in chapter 4 revealed, a large percentage of the paid claims involve cases that insurance company experts regarded as “indefeasible.” Speeding up the resolution of those claims offers obvious savings of time and expense. In addition, as ethicist Lee Taft explains in a thoughtful recent essay introducing this incentive idea, apology and restitution offer therapeutic benefits to both health-care providers and patients.

The PPHRA Supplemental No-Fault Compensation Provision

PPHRA would create a new no-fault patient-compensation program with modest benefits principally intended to provide compensation for, and an incentive to avoid, moderate injuries. Any patient injured by an adverse health-care event would be entitled to compensation for that injury from insurance purchased by the responsible health-care provider(s) according to a schedule to be established by the Department of Public Health. (Once again, I am not wedded to that agency being given this responsibility. In many states, there may be another, more appropriate, agency.) The schedule would compensate patients for reasonable health-care and rehabilitation expenses not covered by other insurance or benefit plans, as well as for lost wages or services not recoverable from other sources, up to a maximum amount for an adverse event (or series of related events).

PPHRA Patient Compensation Program

• Designated health-care providers must obtain insurance (or make acceptable self-insurance arrangements).
• Insurance benefits are paid to any patient injured by an adverse event caused by the provider.
• Benefits cover uninsured medical expenses and wage losses, after a deductible and up to a maximum per injury according to a schedule to be established by DPH.
• Maximum benefit per injury will not exceed $50,000.
• DPH will create an administrative enforcement process modeled on workers' compensation and Social Security disability.
EVIDENCE-BASED MEDICAL LIABILITY REFORM

The size of the maximum amount would be set by the legislature. My suggestion would be to set a relatively low amount, for example $50,000 or $80,000, and to minimize interference with the current tort approach. In addition, there should be a period of disability or an amount of health and rehabilitation expenses that would be uncompensated and that would function like an insurance deductible to discourage very small claims. The goal here would be to avoid the problem of our automobile accident compensation system, in which the research tells us too much money is spent on minor injury claims.2

The act would direct the Department of Public Health to set up an administrative procedure for determining eligibility and compensation under the new no-fault liability. The administrative procedure would be modeled on workers' compensation and Social Security benefit procedures. Patients would be allowed to have the assistance of an attorney or patient advocate at any hearing, at their own expense. The legislature might consider having state-paid advocates available for patients with earnings below a certain amount.

The PPHRA Insurance Requirement

PPHRA's medical liability insurance provisions adopt the "enterprise insurance" approach I described at the end of chapter 3. The act would require hospitals and comparable organizations (such as nursing homes, rehabilitation centers, and surgery centers) to obtain liability insurance (or comparable protection) for all the medical professionals who provide services using the organization’s facilities. The insurance would cover the professionals for all claims relating to services provided, or to be provided, in the organization’s facilities. For example, an obstetrician would be covered for claims relating to a particular pregnancy by the insurance provided by the hospital in which the doctor delivered, or planned to deliver, the baby. The insurance would cover traditional tort claims and it would also provide the patient-compensation benefits just described.

Doctors with both office and hospital practices would still need to purchase their own medical liability insurance policies to cover their office practice. Most serious medical malpractice suits, especially for obstetricians, involve services that are provided in a hospital. This means that the premiums for the personal medical liability insurance of a doctor with a

substantial hospital practice would be much less than it is now, even with the new patient-compensation benefits.

Of course there would be important details to be worked out (such as the amount of protection for each doctor, whether a hospital can purchase a single policy for all its doctors, and whether a hospital may fulfill the insurance obligation through alternatives to traditional liability insurance). And undoubtedly there would be some initial difficulties in figuring out which claims are covered by which insurance policies. But these are technical problems that would be easy to resolve. In the long run, organization-based medical liability insurance makes more sense from both a tort and insurance perspective, as I will explain shortly.

CONSIDERING THE PATIENT PROTECTION AND HEALTHCARE RESPONSIBILITY ACT

The basic framework of PPHRA should now be clear. The act would create a new disclosure obligation with a strong enforcement system. The act would create a procedure to encourage apologies and early settlements in cases involving clear liability, and it would create a new no-fault compensation program that would be especially important for moderate injuries, which are almost completely ignored at present. And the act would shift more of the responsibility for medical liability insurance to hospitals and comparable health-care organizations, which are better able to manage the volatility of the insurance underwriting cycle.

This is a completely different approach to medical liability reform than

PPHRA Insurance Provisions

- Hospitals and other designated organizations must purchase insurance covering claims made against a health professional arising out of care provided or to be provided in a facility of the organization.
- Insurance will provide $2 million per occurrence per professional, in addition to defense costs, and will be primary for covered claims.
- If patient compensation program is adopted, this insurance will cover those benefits as well.
EVIDENCE-BASED MEDICAL LIABILITY REFORM

the damage caps and other tort reforms offered by the White House and the AMA. This approach would do a much better job than those tort reforms at meeting the stated objectives of compensating more patients who are injured by medical injuries and encouraging fewer "invalid" claims.

Of course, it seems likely to make medical liability insurance more expensive, particularly for hospitals and comparable health-care facilities. But more expensive is not always bad. Medical liability insurance may cost more after PPHRA, but we would have safer health care, better compensation for patient injuries, and a fairer distribution of insurance premiums.

In addition, it is vitally important to remember that PPHRA only "costs" more from the perspective of medical providers, who would like us to ignore the lion's share of the injury costs, which injured patients presently bear. Taking a broader, more public-minded perspective, we can easily see that PPHRA would not increase the costs of medical injuries. Instead it would shift more of those costs to organizations that are in a good position to prevent injuries in the first place. That should cut costs, not increase them.

The Disclosure Requirement

It is hard to argue with the proposition that patients are entitled to know what happened to them, particularly when the result is not what their doctors intended. In fact, the American Medical Association medical ethics code requires doctors to tell their patients about both good and bad outcomes. The general principal is "a physician should at all times deal honestly and openly with patients." More specifically, "Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from a physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred." As the ethics code emphasizes, "Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient."

In light of the Institute of Medicine report, To Err Is Human, and the research reviewed in chapter 2, it became obvious by the late 1990s, if not earlier, that doctors in fact were not fully disclosing medical injuries, particularly preventable injuries. In response, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO—"Jayco"), a private organization that accredits hospitals, began in 2001 requiring hospitals to adopt policies to ensure that the lead doctor on a case discloses any "unanticipated outcomes" to the patient. But JCAHO almost immediately backed off from a literal reading of the new disclosure requirement by suggesting that it would be checking to see only that hospitals were disclosing "sentinel events," JCAHO's term for the most serious injuries or death.

PPHRA improves on the JCAHO rule in many ways, all of which are designed to ensure that patients actually receive the information doctors have long been obligated to provide them. First, the scope of the disclosure is much broader, and PPHRA creates a procedure that will provide increasingly specific guidance about what must be disclosed. Significantly, PPHRA puts a publicly accountable government agency in charge, not an unaccountable private association or professional society.

In addition, PPHRA imposes the obligation on all the professionals involved in the care, as well as the organization. Providers can fulfill this obligation only by disclosing the event themselves or by receiving a signed document showing that someone else already adequately informed the patient. This means that no one involved in the adverse event can simply assume that someone else will inform the patient or the patient's family. It also means that a senior professional will be less likely to silence lower-ranking professionals involved in the care.

PPHRA requires the disclosure to be both oral and in writing. The writing requirement will improve the accuracy and precision of the disclosure, and it will provide a greater opportunity for providers to reflect on and learn from the adverse event. It also will provide a record that the patient can use to decide what to do. Patients can easily become confused about a disclosure that is not written down, and doctors can too easily gloss over or rush through uncomfortable details in a spoken explanation. We make banks and credit card companies put their interest rates and fee information in writing. Adverse health-care events can be much more complicated to understand than interest and fees. And they are much more important.

PPHRA requires the information to be given to the Department of Public Health so that DPH can study adverse events and improve patient safety. Quality improvement requires the measurement of adverse out
comes as well as continuous efforts to learn from them. If we do not appoint a central agency to count and analyze adverse events, providers will never know how their safety and outcome records compare to other providers, where there is room for improvement, and whether they are getting any better.

Just as important, PPHRA directs DPH to create a serious auditing system to enforce the disclosure requirement. No auditing system can ensure one hundred percent compliance, but it can ensure that providers set up and generally follow systems for reporting adverse events. In addition, PPHRA treats the failure to disclose as an admission of negligence. This makes it much less likely that providers will withhold information in individual cases with very bad outcomes. No auditing system, alone, can eliminate that possibility, because the odds of any particular case being audited will always be very low. Arguably the rule would not have any effect on someone who wanted to cover up a negligent mistake. But it is rare that everyone involved in a patient's care makes a culpable mistake, so the rule places pressure on the other people involved to disclose the adverse event to the patient.

It is easy to think of any number of potential objections to the PPHRA disclosure requirements. But a moment's reflection should be enough to realize that all or most of these objections will fall into one of two categories: "government is bad" and "doctors know best." Self-regulation has not worked to ensure that health-care professionals disclose adverse events. If we are serious about safety improvement, there is no realistic alternative to a publicly administered and enforced adverse-event reporting system.

Someday we will have such a system. Although I doubt that we will get that system because of a desire to improve the accuracy of medical malpractice claiming, there is no doubt that mandatory, strongly enforced, adverse-event disclosure would do far more to improve the accuracy of claiming than any of the tort reforms currently on the political table. Giving patients reliable, detailed information would allow them to make much better decisions about whether to file a medical malpractice claim.

As we saw in chapter 4, the research shows that even an informal and seemingly ineffective hospital complaint process could significantly improve the ability of patients to judge the merit of potential lawsuits. Why?

Because that process gave patients access to information about what happened to them. Reliable adverse-event reporting, backed up by state auditing, would provide even better information to patients and, thus, improve the accuracy of patient claims even more.

The Apology and Restitution Incentive

I am tempted to defend the apology and restitution incentive simply by referring readers to the essay by ethicist Lee Taft that introduced the idea of linking an apology to an attorneys' fee-shifting incentive. But of course that would defeat the purpose of a book like this, which is supposed to pull together research and ideas, not send people off to the library.

When I first read about Taft's idea, I immediately connected it with the closed-claim research described in chapter 4. The closed-claim research shows that in a substantial percentage, probably a majority, of the paid malpractice claims the insurance companies' own experts believe that the health-care provider was liable. The closed-claim research also shows that insurance companies paid bigger settlements in those clear liability cases than in cases involving uncertain liability. In combination, these two facts mean that a substantial percentage of the medical malpractice claim dollars — certainly much more than half — is paid in clear liability cases. Anything that significantly speeds up the resolution of those kinds of cases offers a real improvement in the efficiency of the medical malpractice claiming process, as it actually exists.

Research that I worked on with Northwestern University law professor Albert Yoon strongly suggests that Taft's idea would work. We studied the effect of a similar settlement incentive that New Jersey put in effect in 1994. We found that it speeded up settlements and reduced litigation expenses.

The New Jersey settlement incentive involved what is known as the "offer of judgment" rule. In federal court and in most state courts, this rule allows defendants to make an offer of judgment to the plaintiff much like the restitution offer Taft proposes, but without the apology. If the plaintiff accepts the offer, that settles the case, as in Taft's proposal. If the plaintiff rejects the offer, there is a potential consequence, as in Taft's proposal. The difference is that the offer-of-judgment consequence usually is negligible. If the jury does not award the plaintiff more than 80 percent of what the
defendant offered, the plaintiff has to pay the defendant's court costs, which include docket fees and printing costs and other trivial expenses that the defendant has to pay to the court during the lawsuit.

Court costs do not ordinarily include attorney fees, and therefore the offer-of-judgment rule does not give a defendant the possibility of recovering attorneys' fees from a plaintiff who turns down a good offer. That is where the New Jersey rule is different, however. In New Jersey the defendant can recover attorney fees from the time of the offer until trial, just like in Taft's proposal. (New Jersey also allows plaintiffs to make offers of judgment, which is not a part of Taft's proposal.) But until September 1994, New Jersey capped the total amount of attorneys' fees that could be shifted at $750 per case, so the rule did not in fact provide a very big incentive.

That situation changed in 1994, however, when New Jersey removed the $750 cap. Albert Yoon and I studied how that change affected New Jersey tort cases. We were able to get access to tort claim records from 1992 to 1997 from a very large company that sold insurance in New Jersey and the surrounding states. When we analyzed those records, we found that New Jersey tort cases settled more quickly after the change—nearly two and a half months quicker on average—and the insurance company on average spent $1,200 less on its own attorneys per claim as a result. Plaintiffs' lawyers presumably also spent less time on each case, but the insurance company records did not contain that information.

There is good reason to believe that Taft's proposal would have a much larger effect on medical malpractice claims than the New Jersey rule had on the claims we studied. The claims we studied were personal auto and homeowners' insurance claims. The average amount paid in cases with a payment was just over $36,000; the average fee paid to the defense lawyer was just over $5,000; and the average duration of the litigation was less than three years. Medical malpractice lawsuits are much bigger and generally take longer to resolve, so there is much more room for savings.

In addition, PPHRA provides a stronger incentive to accept the offer than the New Jersey rule. Under PPHRA, a plaintiff who rejects an offer of restitution has to pay the defendant's attorney fees unless the jury award is at least 20 percent more than the defendant's offer. By contrast, under the New Jersey rule the plaintiff has to pay the defendant's attorney fees only if the verdict is at least 20 percent less than the defendant's offer. The PPHRA approach makes it much more likely that the plaintiff will have to pay the defendant's fees, and therefore increases the incentive to accept the restitution offer.

These are good reasons to support Taft's proposal. But he defends his idea with a very different, and to my mind more profound, reason. Taft argues, convincingly, that apology and restitution offer therapeutic benefits to both doctor and patient. As he observes, "Undisclosed error interrupts the essential ingredient of trust between doctor and patient and disrupts the doctor's sense of integrity. Although the error itself relates to physical harm, the lack of apology disrupts the moral dimension of the doctor's relationship with the patient, the broader medical community, and himself." Apology and restitution help repair the break in the moral order and, thus, promote the corrective justice goal that forms the moral underpinning for medical malpractice law. And, from a practical perspective, the relationship between the doctor and the patient, along with the therapeutic benefits of apology and restitution, makes it much more likely that the offer will be accepted in a medical malpractice case than in the auto and homeowners' cases Albert Yoon and I studied.

Based on his own experience with medical malpractice lawsuits and on research on the effect of apologies in malpractice lawsuits, Taft argues that doctors should be willing to apologize even without an incentive. He cites jury research suggesting that juries award lower damages in cases in which the doctor has apologized and shows genuine remorse. Other research shows that plaintiffs are also willing to accept smaller settlements in that situation. Nevertheless, so much fear and distrust have built up among doctors and their defense lawyers over the years that the incentive probably is necessary.

I am told that some plaintiffs' lawyers do not like Taft's idea and that they find the incentive too one-sided. I imagine they think it would reduce the value of their best cases without offering enough to injured patients in return. I think they are wrong. The apology is an admission of liability, whether the plaintiff accepts the offer of restitution or not. That is a very substantial benefit to the plaintiff. Also, faster settlements benefit injured patients at least as much as doctors. And, perhaps most important, the research shows that plaintiffs are looking for more than money. They want answers to what happened, and they also want the kind of moral closure...
that a sincere apology can help to provide. In addition, widespread acceptance of the apology and restitution framework could reduce the stigma of medical malpractice claiming. That result offers very clear benefits to injured patients and their lawyers.

Lee Taft’s idea is just one among many constructive ideas about how to improve the resolution of medical malpractice claims. I included it in PPHRA because I find the corrective justice implications particularly appealing, and because there is research suggesting that it really will work. But, as with the disclosure concept, my main objective here is to illustrate the difference between evidence-based medical liability reform and the tort reform ideas that emerge from the medical malpractice myth. There are plenty of ways to reform tort law so that medical malpractice lawsuits come closer to achieving their deterrence, compensation, and corrective justice goals, as long as you support the idea that lawsuits have a legitimate role to play in achieving those goals and as long as you are willing to pay attention to the evidence.

Supplemental No-Fault Compensation for Adverse Healthcare Events

No-fault compensation for medical injuries turns out to be an idea that lots of people like in theory but almost no one likes in practice. Health-care providers like no-fault in theory because it feels less adversarial and more consistent with the therapeutic nature of their calling. They do not like it in practice, however, because it threatens to open a floodgate of claims and dramatically increase their insurance premiums. All it takes is one look at what U.S. business pays for workers’ compensation insurance to cool the medical no-fault ardor of almost any health-care administrator. Workplace accidents injure far fewer people than medical malpractice. Yet, as I explained in chapter 1, workers’ compensation premiums in the United States for 2003 were five times as large as medical malpractice insurance premiums.

Patient advocates like no-fault compensation in theory because it offers the promise of quick, no-hassle compensation. Patient advocates do not like it in practice, however, once they realize that they still have to prove that medical treatment caused the patients’ injuries and that no-fault damages are not enough to pay for the skilled advocates and experts needed to overcome health-care providers’ causation defenses in serious-injury cases. Also, medical injuries are very different from workplace accidents, so workers’ compensation may be a poor model. Among other differences, workers know what to expect in the workplace, and they generally have a good idea exactly what happened to them in a workplace accident. If they do not know, they usually have ways to find out. Patients do not.

In short, no-fault medical-injury compensation is an old idea whose time has never come. There are two very limited no-fault medical-injury programs in the United States, one in Virginia and one in Florida. Both apply only to a narrow range of birth injuries. Neither is widely regarded as a success.

So why do I include a no-fault compensation concept in PPHRA?

There are two reasons. The first is to provide a contrast with the AMA. The AMA has launched an all-out effort to cut back on tort liability, in part on the grounds that tort lawsuits do not compensate enough injured patients, without offering a serious proposal to increase the number who are compensated.

The second reason is that the approach to no-fault compensation laid out in PPHRA is worth serious examination, notwithstanding the general lack of enthusiasm for no-fault today. The PPHRA concept is different from the Virginia and Florida programs and the massive tort replacement systems suggested in the past.

Unlike the Virginia and Florida birth injury programs, PPHRA’s no-fault compensation would be most important for medical injuries that are ignored by medical malpractice lawyers today. Serious birth injuries are one area where the claiming rate already is reasonably high, and doctors’ fears about liability are real. We do not need a new no-fault compensation system to boost the rate of serious-injury, high-value claims. The PPHRA disclosure program would increase the accuracy of serious-injury claims, and it might help obstetricians and other high-risk specialists emulate the risk management success of the anesthesiologists. That would be improvement enough for the high-value injuries that are the main focus of medical malpractice lawsuits today.

Where we do need streamlined, administrative no-fault compensation is for smaller-value claims. Different lawyers have different cutoffs for different kinds of malpractice claims, but we can tell from the closed-claim research that very few lawyers are taking very many malpractice cases without the potential for a damage award of at least $200,000. Yet the re-
search on medical malpractice reviewed in chapter 2 tells us that medical injuries are like auto and workplace injuries in one crucial respect. The severity of the injuries is like a pyramid—with many more low-value injuries than moderate-value injuries, and many more moderate-value injuries than high-value injuries. With few exceptions, medical malpractice lawsuits completely ignore at least the bottom three quarters of the medical-injury pyramid. That is where we need to focus some new deterrence and compensation energy.

Unlike the massive tort replacement programs proposed but never enacted in the past, PPHRA would be a small, supplemental program that would make no attempt at replacing tort liability. A $50,000 or even an $80,000 maximum award would ensure that the program did not compete with medical malpractice lawsuits, and it would encourage a new kind of patient advocate to build a career around representing people in lower-value claims in which the only question is whether the medical treatment caused the injury.

Currently, giving up tort liability for medical malpractice would be a very bad idea. There is no guarantee that no-fault would work well for high-severity injuries, especially because of the difficulty and expense involved in proving causation in many serious-injury cases. Patients do not have the direct access to evidence and the knowledge that workers can use to help prevent a cover-up in the workers’ compensation context. At least for now, medical malpractice requires the large damages that tort lawsuits sometimes provide in order to motivate advocates to do the hard work needed to prove causation or get to the bottom of a cover-up. Nor are we ready to give up on a fault-based system for health-care providers who make truly awful mistakes, or who do awful things to hide their mistakes.

If you disagree with me about the benefits of tort liability, that is even more reason to get behind PPHRA, so that we develop some real experience with medical no-fault. Until there is a solid track record for medical no-fault, a comprehensive tort replacement program will be dead on arrival in any legislature in any state in the country.

Enterprise Insurance

The enterprise insurance concept in PPHRA is my answer to the medical malpractice insurance crisis. PPHRA would obligate hospitals and similar organizations to provide insurance covering all liabilities arising out of services performed, or to be performed, in their facilities.

I borrowed the name “enterprise insurance” from the concept of “enterprise liability.” Enterprise liability reflects the idea that the best entity to bear the legal liability for medical injury is the “enterprise”—the organization that employs or at least potentially controls the medical professionals who provide patient care. Although individual doctors may make mistakes, those mistakes take place in an organization, and the people who run the organization are in the best position to design medical delivery systems that prevent mistakes or reduce their impact.

True enterprise liability has not caught on. Hospitals and HMOs resisted taking over the liability from doctors, and doctors resisted giving it up. It is not hard to imagine why the organizations did not leap to assume the liability. What might be harder to understand is why doctors refused to give it up. The answer is that doctors were afraid that giving up liability would mean losing control over patient care.

Enterprise insurance offers many of the benefits of enterprise liability, but without asking doctors to give up liability. With enterprise insurance, all the hospital or other enterprise has to do is provide insurance. Liability continues to rest firmly on the doctors’ shoulders (except, of course, for mistakes by hospital personnel). But because the hospital has to pay for the doctors’ insurance, it has a bigger incentive to design systems so that doctors make fewer mistakes, and so the mistakes that do happen have less serious results.

Enterprise insurance also makes more sense than individualized insurance as a strategy for dealing with the insurance underwriting cycle problems discussed in chapter 3. The individualized approach places too much of the burden of rapid premium increases on doctors in high-risk specialties and in high-risk locations. It would be one thing if doctors could simply raise the price of their services when insurance premiums go up, but the reality is that they cannot. Enterprise insurance shifts the burden of rapid and unpredictable insurance price increases to organizations better equipped to manage them.

Hospitals, nursing homes, rehabilitation centers, and other large health-care facilities provide a more diversified range of services than doctors and, thus, face more diversified risks. This greater diversity allows
hospitals to spread the costs of liability insurance across both high- and low-risk services, so that the burden of suddenly increased premiums does not fall on a narrow range of higher-risk services, like obstetrical care.

Many medical schools and some HMOs and hospitals already provide liability insurance for their doctors. As these organizations have found, they are better able to manage the volatility of insurance premiums than doctors are, and they are better able than their doctors to get insurance or to make alternative arrangements in difficult market conditions.

There are many possible objections to enterprise insurance, but they all have good answers. The objection that enterprise insurance would interfere with the health-care market may well be the easiest to answer. The health-care market already is so far from a world of free competition that our individualized approach to medical liability insurance is just as likely to be the result of a market failure. Given the superior ability of hospitals and other health organizations to obtain medical liability insurance, it is surprising that these organizations have not already assumed that responsibility on behalf of all the doctors who use their facilities.

Ironically, one important reason why hospitals are not already providing liability insurance to more doctors turns out to be the unintended consequence of a federal law that was supposed to improve the health-care market. Federal anti-kickback law prevents hospitals from paying doctors to bring patients to the hospital. The idea is that doctors should pick hospitals based on their best medical judgment, not on the share of the hospital bill or other benefits that the hospital is willing to kick back to the doctor. Because of this law, there is real concern that voluntarily providing liability insurance to doctors would be an illegal kickback, unless the doctors are hospital employees.

During the recent insurance crisis some hospitals wanted to provide insurance to private doctors in order to make sure that they could afford to keep practicing in the hospital. Some of those hospitals filed special requests with the U.S. Department of Health and Human Services to make sure that providing the insurance would not get them in trouble under the anti-kickback law. HHS gave the hospitals “advisory opinions” allowing them to provide the insurance, but I have read the letters and they are not encouraging for hospitals that would like to do this on a regular basis.

A state law that required hospitals to provide liability insurance to doctors would completely eliminate the risk of federal prosecution for giving insurance to doctors. Hospitals would not be giving doctors insurance in return for their business; hospitals would be giving doctors insurance to comply with state law. This would not be a subterfuge. If every hospital has to provide the insurance, then the insurance will not affect doctors’ choices about which hospital to use. On the other hand, it might make hospitals choosier about which doctors they allow to use their facilities. That would be a very good thing.

In the short term, enterprise insurance could provide a windfall to private doctors with high-risk, hospital-based practices, such as obstetricians. It also could be a difficult new burden for hospitals. But that windfall and burden would dissipate over time through adjustments in prices and reimbursement rates. In any event, the added burden should not be overstated. The insurance burden already is shifting to hospitals, both through contracting (e.g., hospitals, medical schools, and HMOs providing insurance to their employed doctors) and through plaintiffs’ efforts to hold hospitals responsible for medical malpractice. The comparatively low value of doctors’ insurance policies already encourages plaintiffs to target hospitals; that incentive will only get stronger if more doctors stop carrying insurance.

Enterprise insurance will increase hospitals’ incentive to manage doctors, and that could reduce doctors’ autonomy to some degree. But, the fact that the legal liability remains with the doctor helps the doctor retain moral authority over patient care. This is not to say that there will never be a conflict between doctors and the institutions that provide their insurance, but rather that enterprise insurance gives doctors more autonomy than would enterprise liability. In any event, the large number of doctors who already get their insurance through hospitals, HMOs, and medical schools are not rushing out to buy their own insurance. They seem to be managing fine with this privately arranged form of enterprise insurance.

Of course enterprise insurance will create some new administrative complications, but that should not be a reason to stick with an unsatisfactory situation. Objections about administrative complications almost always are makeweight arguments, hauled in to camouflage less savory interest-based objections, and this situation is no exception. Insurance
companies that sell insurance mainly to doctors surely will oppose enterprise insurance, as will some hospitals, and both groups can be counted on to provide many reasons why it will be very difficult to put enterprise insurance in place. But those reasons will not be their real concern. If anything, putting all the doctors who practice in a hospital under a single insurance program would reduce the expense and complexity of arranging insurance and defending lawsuits. The insurance companies' real concern will be keeping the doctors' insurance business, and the hospitals' real concern will be avoiding the new expense.

There will in fact be some complications for doctors who practice inside and outside institutions, or who practice in more than one institution, and who therefore will be covered by more than one liability insurance policy—just like people who are covered by both their companies' auto insurance and their personal auto insurance. It will be necessary to draw lines about which policy pays for which kinds of claims, and there undoubtedly will be some gray areas. But this is no cause for alarm. Whenever insurance arrangements change, there is an initial flurry of disagreements, but then everyone learns how to deal with the new arrangements.

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EVIDENCE-BASED LIABILITY REFORM
VS. MYTH-BASED LIABILITY REFORM

As should by now be clear, each part of PPHRA is evidence-based. The disclosure requirements are based on research that shows that doctors and hospitals do not in fact disclose adverse events and on research that shows that providing patients better information increases the accuracy of medical malpractice claims. Even more important, the disclosure requirements are designed to produce the kind of evidence that we need to reduce patient injuries and improve the quality of health care.

The apology and restitution incentive is based on two kinds of research. First, the closed-claim research shows that most malpractice claim payment dollars are paid in cases in which the insurance company's experts believe that the doctor in fact was negligent, suggesting that these cases are ripe for an apology. Second, the New Jersey research shows that this kind of incentive actually works.

The no-fault concept is based on the research showing that medical malpractice lawsuits almost always involve high-value injuries. Thus, a no-fault program with modest benefits would begin to fill a huge deterrence and compensation hole, without interfering with the current approach.

Finally, the enterprise insurance concept is based on research on the medical malpractice insurance underwriting cycle. That research shows that the malpractice insurance crises result from the boom-and-bust cycle, not short-term changes in medical malpractice lawsuits. That research also shows that the impact of the crisis falls disproportionately on doctors with hospital-based practices. It is also worth noting that the enterprise insurance concept is consistent with the emerging expert view that the best way to prevent medical malpractice is through a system approach.

The tort reform proposals that emerge out of the medical malpractice myth stand in sharp contrast. One good place to see those tort reform proposals is the White House Web site. The White House proposes “curbing lawsuit abuse with needed medical liability reform.” The reform includes imposing a $250,000 cap on noneconomic damages and unspecified limits on punitive damages, eliminating lump-sum damage awards in favor of periodic payments, shortening the period after an injury in which a patient may bring a claim, and eliminating the legal rule that makes each defendant in a case responsible for all of the harm in the event that the other defendants do not have enough insurance or money to pay for their share.11

With one exception, the White House proposals have a clear and well-targeted aim: to reduce the number of high-severity, high-damage malpractice lawsuits, and to reduce the amount of damages that a severely injured patient can collect. The one exception is the punitive-damages proposal. Punitive-damage reform does not have very much to do with true medical malpractice lawsuits, which almost never involve punitive damages. Drug companies and medical device manufacturers are the real constituency for punitive-damages reform, not doctors and hospitals. This is the “hiding behind the doctor’s white coat” side of medical malpractice reform that I mentioned in chapter 5.

These reforms attack tort law rules that English and American judges developed over hundreds of years in a carefully considered effort to balance the interests of plaintiffs and defendants. Plaintiffs’ lawyers did not dream these rules up and impose them on the rest of the world. The rules emerged out of a long, deliberative process in which both sides of every case had full opportunity to be heard. If anyone was at a financial and tactical disadvantage in that process, it was plaintiffs, not defendants.
Not one of the White House proposals would improve the accuracy of malpractice claiming, increase the number of injured patients who will be compensated, or improve patient safety. Not one of the White House proposals will protect doctors from the next medical malpractice insurance crisis or provide real, immediate relief for doctors who deliver babies. What they will do, instead, is increase patients' share of the medical malpractice burden.

Of course the White House proposal does not say that. Instead it says, “Frivolous lawsuits and excessive jury awards are driving many health-care providers out of communities and forcing doctors to practice overly defensive medicine. This reduces access to medically necessary services and raises the costs of health care for all.” For these reasons, “the President has proposed proven reforms, such as common-sense limits on non-economic damages, to make the medical liability system more fair, predictable and timely.”

This is the medical malpractice myth at work. As the research demonstrates, not one of these factual predicates is true. Not frivolous lawsuits. Not excessive jury awards. Not driving many doctors out of communities. Not overly defensive medicine. Not reducing access to medically necessary services. And not raising the costs of health care for all.

This is hardly to say that our current approach to medical liability and insurance is perfect. It is not. There are too few claims to provide an adequate safety incentive. Not enough patients are compensated. Patients get reliable information about what happened to them far too late in the process. And doctors are asked to bear too much of the medical liability insurance burden. If we want to address these real problems, we should start with the evidence, not the myth. Just as we need evidence-based medicine, we also need evidence-based medical liability reform.