



Resolving the Medical Malpractice Crisis: Fairness Considerations

Maxwell J. Mehlman

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Printed in the United States of America.

ISBN 0-9741239-0-0

Table of Contents

Acknowledgments	iii
Executive Summary	1
Table I: Characteristics of a Fair Malpractice System	7
Table II: Is the Current System Fair?	8
Table III: Fairness of Reform	9
Introduction	11
Why Fairness Matters	13
Substantive Fairness	15
Appropriate Objectives	16
Appropriate Achievement of Objectives	21
Compensating Victims	23
Preventing Injury	32
Punishing Wrongdoers	35
Procedural Fairness	39
The Fairness of the Current System	47
Setting Objectives	47
Achieving Objectives	48
Procedural Fairness	55
The Fairness of Reforms	59
Reforms Within the Tort System	61
Systemic Changes	71
The Fairness of the Reform Process Itself	81
Conclusion: Fairness Trade-Offs	87
References	89
The Author	97
About the Project	Inside Back Cover

Acknowledgments

The author wishes to thank William Sage and David Studdert for their helpful comments and suggestions. The opinions stated in the paper are the author's and not necessarily those of The Pew Charitable Trusts.

Executive Summary

For the first time in twenty years, much of the nation finds itself in a medical malpractice crisis. Physicians and hospitals in many states are experiencing sharply higher malpractice insurance premiums. This has raised concerns that patients may have difficulty accessing medical services, particularly in high-risk specialties such as obstetrics.

As in previous decades, the current crisis has stimulated calls for changes to the legal rules that govern medical malpractice. Most proposals attempt primarily to reduce malpractice insurance premiums. Some, however, see an opportunity to improve the overall performance of malpractice law, including far-reaching changes such as replacing the tort system with a no-fault or administrative approach to compensation.

Why Fairness Matters

It is generally accepted that **fairness** is an important attribute of a properly functioning system of medical liability. Fairness is both a legitimate objective in itself and a means of achieving important social goals, such as preserving patient-provider relationships and maintaining confidence in courts and legislatures. If changes to the malpractice system are viewed as fair, they are more likely to be enacted and retained.

WHAT FAIRNESS MEANS

Fairness is an elusive concept. In malpractice, what matters most is fairness to patients and potential patients. However, the relational aspect of health care implies that the system must also be fair to physicians. Fairness has two core components, substantive fairness and procedural fairness (see **Table I**).

Substantive fairness includes **setting appropriate goals** for the malpractice system. Goals may be in tension with each other. How the malpractice system is financed is an indication of its goals. Appropriate goals are:

- Compensation of injured patients
- Deterrence of poor quality medical care

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- Corrective justice (punishing providers who commit malpractice), but this may be in tension with other goals
 - Affordability of malpractice insurance
 - Availability of medical services

Substantive fairness also includes **achieving these goals appropriately**:

- Validity: The system properly identifies the conduct it purports to target.
- Consistency: The system treats similar cases alike.
- Proportionality: The system distinguishes among cases rationally.
- Predictability: Providers understand in advance the consequences of particular conduct.

Procedural fairness means that the malpractice system is fair in operation:

- It produces substantively fair outcomes.
- It employs rules that are acceptable to all parties.
- Parties have a meaningful opportunity to be heard.
- Parties are adequately represented.
- Decisions are reasoned, based on evidence that is openly gathered and recorded.
- Decision-makers are neutral and impartial.
- The parties are treated with dignity and respect.
- Decision-makers are accountable

FAIRNESS OF THE EXISTING SYSTEM

The traditional medical malpractice system **performs poorly** on many benchmarks of substantive and procedural fairness (see **Table II**).

In terms of **objectives**:

- The “negligence” standard for malpractice is too narrow. A fairer system would compensate all those who suffered harm as the result of avoidable

medical error.

- The system does not articulate and address conflicts among compensation, deterrence, and corrective justice. The main emphasis in a fairer system would be on preventing future errors rather than punishing individual malfeasance.
- The financing of the system is unsteady, and there is anecdotal evidence that it threatens access to care for some patients.

In terms of **achieving objectives**, the system:

- Lacks validity
- Is inconsistent
- Is only somewhat proportional
- Imposes its costs disproportionately on providers of high-risk care and their patients
- Sends erratic deterrence signals
- Punishes erratically

In terms of **procedural fairness**, the system:

- Produces outcomes that are not substantively fair
- Uses rules that are not acceptable to all parties
- Produces most results without written decisions on the merits
- Does not always treat the parties with dignity and respect

FAIRNESS OF REFORMS

Changes to the traditional malpractice system can be evaluated on fairness grounds (see **Table III**). **Fair reforms within the tort system** include:

- Periodic payment
- Tightening the regulation of insurers

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- Deterring the assertion of frivolous claims, properly defined
 - Limiting attorney contingent fees, as long as patients can still obtain representation

Reforms within the tort system that **might be fair if properly implemented include:**

- Repealing the collateral source rule
- Enterprise liability
- Scheduling damages, as long as victims would receive on average as much as under the current system
- Practice guidelines, so long as they are adopted by unbiased decision-making and can be relied upon by all parties

Unfair reforms within the tort system include:

- Expert screening of claims, because decision-makers are unlikely to be neutral and impartial
- Abolishing joint and several liability, which makes it harder for patients to recover full compensation
- Abolishing *res ipsa loquitur*
- Reducing the statute of limitations
- Flat caps on non-economic damages, which arbitrarily deny compensation to the most seriously injured patients and therefore violate the cardinal rule of distributive justice

Among **reforms that alter one or more core features** of the tort system, some seem **unfair:**

- Medical courts, because decision-makers are not neutral and impartial
- Contracting, because patients are at a bargaining disadvantage

Systemic changes **might be fair if properly implemented:** Many of these proposals attempt to improve fairness, but **may come up against unfair budget constraints.**

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- Alternate dispute resolution, if voluntary or non-binding
 - Scheduling compensable events
 - Early-offer approaches, if voluntary
 - Workers compensation-type or no-fault systems, as long as they do not substantially reduce the amount of compensation victims would receive on average
 - The Institute of Medicine demonstration proposal

A FAIR REFORM PROCESS

Procedural fairness is important to the **process of changing the malpractice system** as well as to keeping the system up and running. The fairness of the political process cannot be assumed because some stakeholders have greater influence than others. Experimenting with different types of reform may be advisable.

- Views of patients and potential patients should be elicited directly.
- If reforms are adopted as “social experiments,” fairness requires:
 - Clearly identified measures of success or failure
 - Informed consent of patients subject to experimental reform
 - Automatic termination unless explicitly made permanent after public evaluation and discussion.

FAIRNESS TRADE-OFFS

There are tensions between fair compensation and fewer medical errors, on one hand, and patient access to health care, an economically viable health care sector, and a sustainable malpractice insurance financing system on the other. **At some point, even severely injured patients would lose more by being denied access to health care than by not being fairly compensated.** Policy-makers and the public must work to assign values to these effects and to weigh them against each other.

Tables

Table I. *Characteristics of a Fair Malpractice System*

Substantive Fairness Factors		Procedural Fairness Factors
<i>Appropriate Objectives</i>	<i>Appropriate Achievement of Objectives</i>	
a) Compensation b) Deterrence c) Punishment d) Affordability e) Access to care	a) Compensating Injured Patients (i) validity (ii) consistency (iii) proportionality (iv) predictability (v) adequacy b) Preventing Injury (i) adequate information on causes of patient injury (ii) correct deterrent signals to providers c) Punishing Wrongdoers (i) distinguish individual from system failure	a) Produces substantively fair outcomes b) Rules acceptable to all parties c) Meaningful opportunity to be heard d) Adequate representation e) Decision-making on record, reasoned, written f) Neutral and impartial decision-makers g) Parties treated with dignity and respect h) Accountable decision-makers
Note: These characteristics are not listed in order of importance		

Table II. *Is the Current System Fair?*

Substantive Fairness Factors	
<i>Appropriate Objectives</i>	
Compensation	SOME
Deterrence	SOME
Punishment	SOME
Affordability	N
Access to care	N
Appropriate Achievement of Objectives	
<i>Compensating injured patients</i>	
(i) validity	N
(ii) consistency	N
(iii) proportionality	SOME
(iv) predictability	N
(v) adequacy	SOME
<i>Deterrence</i>	
(i) adequate information on causes of patient injury	N
(ii) correct deterrent signals to providers	N
<i>Punishment</i>	
(i) distinguish individual from system failure	N
Procedural Fairness	
Produces substantively fair outcomes	N
Rules acceptable to all parties	N
Meaningful opportunity to be heard	SOME
Adequate representation	SOME
Decision-making on record, reasoned, written	SOME
Neutral and impartial decision-makers	?
Parties treated with dignity and respect	N
Accountable decision-makers	SOME

N = Current system does not aim to achieve objective or achieves its objectives unfairly

SOME = Current system only partially aims to achieve objective or only partially achieves its objectives fairly

? = It is unclear whether current system achieves the objective

Table III. *Fairness of Reform*

Malpractice Reforms	Substantive Fairness Factors										Procedural Fairness						
	Appropriate Achievement of Objectives										Appropriate Achievement of Objectives						
	Compensating Injured Patients					Deterrence					Deterrence			Punishment			
Appropriate Objectives	Access to care	Validity	Consistency	Proportionality	Predictability	Adequacy	Adequate information on causes of patient injury	Correct deterrent signals to providers	Distinguish individual from system failure	Produces substantively fair outcomes	Rules acceptable to all parties	Meaningful opportunity to be heard	Adequate representation	Decision-making on record, reasoned, written	Neutral and impartial decision-makers	Parties treated with dignity and respect	Accountable decision-makers
Systemic Reforms	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Reform within the Tort System	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Repeal collateral source rule	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Enterprise liability	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Periodic payment	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Tighten regulation of insurers	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Defer frivolous claims	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Expert screening	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Schedule damages	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Practice guidelines	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Abolish joint-and several liability	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	?	?	?	?	?	?	?
Abolish res ipsa loquitur	N	N	N	N	N	?	Y	N	N	N	?	?	?	?	?	?	?
Reduce statute of limitations	N	N	N	N	N	?	Y	N	N	N	?	?	?	?	?	?	?
Caps on damages	N	N	N	N	N	?	Y	N	N	N	?	?	?	?	?	?	?
Limit attorneys' fees	N	Y	Y	Y	Y	?	Y	Y	Y	N	?	?	?	?	?	?	?
Medical courts	Y	Y	Y	Y	Y	?	Y	Y	Y	N	?	?	?	?	?	?	?
ADR	Y	Y	Y	Y	Y	?	Y	Y	Y	N	?	?	?	?	?	?	?
Contracting	Y	Y	Y	Y	Y	?	Y	Y	Y	N	?	?	?	?	?	?	?
Schedule compensable events	Y	Y	Y	Y	Y	?	Y	Y	Y	N	?	?	?	?	?	?	?
Early-offer	Y	Y	Y	Y	Y	?	Y	Y	Y	N	?	?	?	?	?	?	?
Worker-compensation-type system	Y	Y	Y	Y	Y	?	Y	Y	Y	N	?	?	?	?	?	?	?
No-fault	Y	Y	Y	Y	Y	?	Y	Y	Y	N	?	?	?	?	?	?	?
IOM	Y	Y	Y	Y	Y	?	Y	Y	Y	N	?	?	?	?	?	?	?

Y = Reform either attempts to achieve the objective or does so in a fair way

N = Reform aims to interfere with the achievement of the objective or achieves its objectives unfairly

? = Reform does not affect this variable

? = Reform may or may not attempt to achieve the objective or do so fairly depending on how it is implemented

Introduction

Much of the nation currently finds itself in a medical malpractice crisis. According to the American Medical Association, eighteen states (Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia) are experiencing sharply higher malpractice insurance premiums (AMA 2003). This has raised concerns that physicians in these states will stop practicing high-risk specialties such as obstetrics, relocate to other states, or abandon the practice of medicine altogether, all of which could create access problems for patients.

As in the previous malpractice crises in 1975 and 1985, the current crisis has stimulated calls for changes in the legal rules that apply to medical malpractice. Many policy-makers focus primarily on ways to reduce malpractice insurance premiums. Others view the current crisis as an opportunity to improve the overall performance of malpractice law. Still others advocate more far-reaching changes, such as replacing the tort system with a no-fault or administrative compensation approach, which, in their opinion, would make the system less expensive, prevent patient injury, and compensate more injured patients.

Aside from reducing premiums and injuries, or compensating victims more efficiently, an important objective in reforming the malpractice system is promoting fairness. Proponents of reform often complain that the current system is unfair. In a recent speech, President Bush stated: "If you get hurt, you ought to be able to go to your court, the courthouse and be treated; you ought to get fair compensation for your economic damages. But we cannot have unlimited, non-economic damages and punitive damages (White House 2002)." At the same time, opponents of reform object to limitations on recoveries on the ground that they are unfair. Leo V. Boyle, President, Association of Trial Lawyers of America, writes: "Caps on damages set absolute, arbitrary limits on what medical mal-

practice victims may receive for injuries suffered. They make no distinction between a patient whose facelift left unexpected scarring and one left brain dead because of an overdose of anesthesia” (Boyle 2002).

As this exchange suggests, there is no consensus as to what fairness means in malpractice reform. In a recent report, the Institute of Medicine (IOM) declares fairness to be one of its liability reform goals, but does not explain what the term means (Institute of Medicine 2002). In its major study of medical malpractice in 1987, the U.S. Department of Health and Human Services lists “Prompt Resolution and Fair Compensation” as one of 8 policy objectives, but its only amplification of what constitutes “fair compensation” is that it should be “in amounts proportional to the injury (Department of Health and Human Services 1987).” The best work to date refers to “fairness to individual participants, that is, to claimants and implicated medical providers” (Bovbjerg and Sloan 1998), and notes the importance of two kinds of “equity,” “horizontal” and “vertical” (Bovbjerg, Sloan, and Blumstein 1989).

This paper begins by explaining why fairness is an important consideration in responding to the current malpractice crisis. It then defines fairness in the context of a medical malpractice system and describes the characteristics of an optimally fair approach. After comparing this model with the current malpractice system, the paper considers whether any of the reforms that are being proposed would produce a fairer result, and also addresses the fairness of the reform process itself. It concludes by discussing the appropriateness of sacrificing fairness for other societal objectives.

Why Fairness Matters

Fairness is important both as an end in itself and for its instrumental value. As an end in itself, fairness incorporates notions of appropriateness, reciprocity, proportionality, and impartiality that are central to conceptions of moral behavior and that are so closely entwined with principles of justice that the terms “fairness” and “justice” are often used

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interchangeably. As philosopher D. D. Raphael points out, “[f]airness is a notion that is acquired at an early stage of life: young children are quick to complain that action which discriminates in favor of one child or one group is unfair, and they do not confine this complaint to thought of their own advantage but are ready to speak up for the claim of others” (Raphael 2001: 208).

From an instrumental standpoint, fairness is an essential attribute of social relationships that rely on voluntary adherence to systems of rules to achieve mutual gain. The focus of this paper is on the relationship between patients and health care providers. A medical malpractice system that is perceived as unfair, for example, is leading some physicians publicly to “go on strike” (New York Times 2003). Complaining of unfairness, health care professionals may refuse to treat high risk populations, abandon certain specialty practices or geographic areas, or act in other ways that are not in patients’ best interests, such as by being wary of patients or practicing medicine defensively. On the other hand, changes to the malpractice system that are perceived as unfair to malpractice victims could make patients distrustful of providers and cynical about the political process that adopted and implemented the so-called reforms.

Fairness also is an important factor in making beneficial change possible. The per-

The perception that a modification of the law is fair to stakeholders acts as a civic lubricant, reducing the social and political costs of enactment, and increasing the chances that the change will be retained long enough to achieve its desired effect.

ception that a modification of the law is fair to stakeholders acts as a civic lubricant, reducing the social and political costs of enactment, and increasing the chances that the change will be retained long enough to have an opportunity to achieve its desired effect. To the extent that the current malpractice system is in serious need of improvement, the fairer the changes, the more likely that they will be both significant and sustainable. Finally, fair reforms are less likely to be successfully challenged on constitutional grounds. Several state

supreme courts have struck down caps on malpractice awards in part on the basis that they were unfair (WI: *Martin by Scoptur v. Richards* 1995; TX: *Lucas v. U.S.* 1988; NH: *Carson v. Maurer* 1980).

Substantive Fairness

As Supreme Court Justice Potter Stewart famously remarked about “obscenity,” fairness is an intuitive but elusive concept: You know it when you see it but have trouble defining it. One thing that is clear is that what counts as fairness varies according to the context. A fair presidential election, for example, is not the same as a fair distribution of partnership assets. In short, the concept of fairness must be considered in the specific context of medical malpractice. Moreover, two types of fairness must be distinguished: “*substantive fairness*,” or the fairness of the results or outcomes of the malpractice system, and “*procedural fairness*,” which encompasses both the fairness of the processes that the malpractice system employs to achieve its results and the processes that are used to make changes in the malpractice system.

One source of insight into the meaning of substantive fairness might be constitutional principles of due process. But “substantive due process” has had a limited and controversial role in American jurisprudence. Unless government action runs afoul of a more specific constitutional prohibition, such as by abridging free speech or religion or constituting cruel and unusual punishment, judges who declare it to be a violation of substantive due process seem merely to be substituting their own notions of fairness for that of the legislative or executive branch. Accordingly, substantive due process violations of the Constitution tend to be limited to a narrow set of egregious cases where the government acts in ways that are arbitrary (*Wolff v. McDonnell* 1974), “oppressive,” (*Palko v. Connecticut* 1937), or that “shock the conscience” (*Rochin v. California* 1952).

To articulate a concept of substantive fairness that can be used to evaluate malpractice reform, we need to go beyond the Constitution. Philosophers and legal scholars who have sought to define substantive fairness have come up with “horizontally and vertically equitable,” “balanced,” “proportional,” “avoiding surprise,” “treating equals the same,” “accurate,” “objective,” “based on true facts,” “adhering to established rules,”

“neutral,” and “selected from behind a veil of ignorance.” From these starting points, these formulations suggest that a substantively fair medical malpractice system must set appropriate objectives and must achieve those objectives appropriately.

Appropriate Objectives

In order to be substantively fair, the malpractice system has to aim to achieve appropriate objectives. To borrow a phrase from constitutional law, the system has to serve a “legitimate state purpose.” It would be unfair, for example, for the malpractice system to have as its goal to make it more difficult for one group of citizens to obtain health care, or to harass doctors. The medical malpractice system has developed as a part of a general system of tort law, and therefore shares its objectives: *compensation*, *deterrence*, and *corrective justice*. In the context of medical malpractice, these goals can be stated as:

- Compensate patients who are injured by malpractice; that is, negligent* behavior by health care providers
- Deter malpractice
- Punish those who commit malpractice.

There seems to be general agreement among those engaged in the medical malpractice debate that the goals of compensating injured patients and deterring patient injury constitute appropriate objectives. See Table I. But there is controversy over whether the focus should be limited to “negligent” medical care; that is, care that falls below a legal standard of reasonableness. Many commentators argue that the malpractice system ought to compensate *all* patients who have suffered net harm as a result of medical care, or at least all patients whose injuries are caused by medical care and could have been avoided.

* Patients also may be injured by intentional wrongdoing, such as when a physician knowingly operates on a patient without permission. Since these incidents thankfully appear to be rare, and since courts increasingly are treating these torts as negligent rather than intentional anyway, this paper will focus on negligence as the chief type of malpractice.

As Weiler states in urging adoption of a “no-fault” approach, “victims of all medical accidents would be eligible for compensation solely because of the nature of the losses they have suffered, not because their injuries were fortuitously produced by the carelessness of a doctor or nurse ...” (Weiler 1991: 134).

In terms of need, a strong argument can be made that someone who is seriously injured through no one’s fault requires just as much economic assistance as someone who is injured through wrongdoing. Indeed, it can be argued that, since avoiding severe economic dislocation is a prime motive for compensating malpractice victims, even persons whose injuries are *unavoidable* should receive compensation, as is the case to some extent in New Zealand (Henderson 1981). Even if a medical malpractice system did not go as far as New Zealand, confining compensation to injuries caused by wrongdoing seems unfair.

This unfairness is inherent in one of the underlying principles of the fault-based tort system: economic efficiency. According to this principle, an injury is caused by negligence if the cost to society of preventing the injury is less than the cost of the injury (its probability of occurrence multiplied by its severity). If a fall that causes \$10,000 in injury and that occurs on one in a hundred flights of unlighted stairs can be prevented by installing a \$10 light bulb, it is negligent not to light each flight because the cost of injury (\$10,000 times $1/100 = \$100$) exceeds the cost of prevention (\$10), and whoever is responsible for failing to do so must compensate victims. On the other hand, if the cost of preventing the injury exceeds the cost of the injury, the tort system leaves victims to bear their own losses, despite the fact that the victims are innocent and the injuries have been caused by the action or inaction of others. Thus, if the only way to prevent \$100 worth of falls is to install a new lighting system at a cost of \$500, in theory the stair owner is not negligent for leaving the stairs in darkness. But people are still falling and being injured. In effect, the innocent victims are made to bear the cost of efficiency for society, which

wants to avoid paying \$500 to prevent only \$100 worth of injury.* Weiler's no-fault approach would correct this unfairness by compensating innocent victims regardless of whether their injuries were caused by fault – that is, regardless of whether or not society gained by their loss.

There is less consensus about the appropriateness of the third goal of the malpractice system — punishing mal-practitioners — than about compensation or deterrence.

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Under the fault theory of tort, one reason why negligent providers deserve to be punished is that, in some sense, they have benefited at patients' expense — for example, surgeons who injure a patient by operating too quickly in order to squeeze another elective surgery into the same day, or hospitals that try to get by with outmoded equipment instead of spending the money to obtain state-of-the-art technology. Another purpose of corrective justice is to prevent the patient or the patient's family from obtaining revenge by taking matters into their own hands. Critics of the punishment goal, on the other hand, assert that it interferes too much with the other goals of the malpractice system. It undermines the compensation goal, they say, because it discourages providers from revealing that they have made compensable errors and encourages them to contest claims

* Note that instead of bearing this cost out-of-pocket, the victim may be able to purchase first-party insurance, such as health or disability coverage. First-party insurance is generally thought to be a cheaper way of compensating injured persons than shifting losses to third-parties, such as physicians or their malpractice insurers. This raises the question of why the compensation function of the malpractice system should not be eliminated altogether and replaced with a system of first-party insurance, subsidized as necessary for those who are

vigorously, making compensation more expensive. It undermines the deterrence goal, the critics continue, by focusing too much attention on detecting “bad apples” – an approach that has been described as “the seductive (but erroneous) notion that significant advances in quality are achievable by discovering aberrant behavior and punishing individuals who are ‘guilty’ of it” (Studdert and Brennan 2001). The critics argue that “most human errors are induced by system failures” (Institute of Medicine 1999), not by individual laxity or incompetence. According to this position, greater reductions in patient injury can be accomplished by using a “systems approach” to identify and prevent future problems than by punishing past transgressions. De-linking the malpractice system from punishment is also promoted as a way to encourage individuals to report errors so that the root causes can be uncovered. In the view of these critics, if some providers must be punished, regulatory mechanisms like professional and state disciplinary bodies and hospital privileging decisions are better ways to do it than the malpractice system.

Even if the foregoing set of goals is appropriate, is it complete? In particular, it omits two other critical goals: *affordability*, or maintaining adequate resources with which to compensate victims, and *access*, or ensuring that adequate medical services are available to meet the medical needs of the population. If we continue to rely upon the system of private malpractice insurance to serve as a chief source of victim compensation, then one of the goals of the malpractice system has to be to make sure that private malpractice insurance continues to be available and affordable. If private insurance proves to be inadequate, then alternative, public funding must be put in place. But it is unreasonable, and

unable to afford it. One malpractice reform discussed below – the abolition of the collateral source rule – does this to some degree by denying malpractice victims the ability to recover from defendants damages that are reimbursed by the victim’s own insurer or employer. However, virtually no one during the current malpractice reform debate is suggesting that the tort system be replaced entirely with a system of first-party insurance, perhaps because of concerns that this would interfere with the deterrence goal of the malpractice system.

therefore unfair, to saddle a compensation system with costs that it cannot bear.

A second necessary objective is to make sure that the malpractice system does not inadvertently prevent individuals from receiving adequate medical care. It would be no good to have a system that generously compensated patients who were victims of malpractice, if this made health care unavailable to people in the first place. The quality of most medical care in the U.S. is good for those who have access to it. Avoidable errors occur only in 3 to 4 percent of hospitalizations (Institute of Medicine 1999). While this figure – and the companion estimate that between 9 and 14 percent of these errors result in patient deaths – arguably is far too large to be socially acceptable, it represents only a small proportion of the total care that Americans receive. In its zeal to accomplish other goals, the malpractice system must take care not to compromise access to health care.

This is important to remember in trying to identify the key stakeholders in the malpractice system; that is, the principal persons or institutions whose interests must be

Two other critical goals are *affordability*, or *maintaining adequate resources with which to compensate victims*, and *access*, or *ensuring that adequate medical services are available to meet the medical needs of the population*.

fairly met in order for the malpractice system to be fair. Doctors and trial lawyers are most visible in the press and at legislative hearings. But doctors purport to speak not so much for themselves as for patients; the current medical malpractice system, doctors maintain, threatens access to health care by driving doctors out of practice or out of high-risk specialties or geographic areas, and by increasing costs to patients. Similarly, lawyers claim not to represent their own interests but the interests of

patients, warning that changing the malpractice system will have deleterious effects on overall quality of care, and that patients who have been seriously injured by malpractice will be unable to obtain proper compensation. In short, the primary stakeholders in the medical malpractice system are the consumers of health care: patients and potential patients. At the same time, patient welfare depends on physicians and other health care providers. A malpractice system that seemed fair to patients but that frustrated doctors' ability to practice would be of little value to those patients. It therefore matters if caregivers perceive the system to be unfair to them. Remember what was stated at the outset:

A malpractice system that seemed fair to patients but that frustrated doctors' ability to practice would be of little value to those patients.

Fairness is an essential attribute of social relationships that rely on voluntary adherence to systems of rules to achieve mutual gain. Reciprocal relationships like those between patients and their caregivers must be fair to all parties.

To summarize, then, the traditional objectives of the malpractice system are to compensate victims of medical negligence,

deter error, and punish wrongdoers. These are legitimate objectives, but a fairer system would compensate all those who suffered harm as the result of medical error rather than just those who were victims of negligence. Moreover, the main emphasis would be on preventing future errors rather than punishing individual malfeasance, and in order to carry out its objectives, the malpractice system would maintain an adequate source of compensation funding. Finally, a fair malpractice system would preserve access to care.

Appropriate Achievement of Objectives

In order to be fair, the malpractice system not only has to have fair objectives, but

it has to fulfill them in a fair manner. This requires that its actions generally be *valid, consistent, proportional, and predictable*.

The term “validity” is a scientific term that simply means that the system does what it claims to do – in this case, identifying and compensating events having certain characteristics. A malpractice system that targeted medical malpractice but did not correctly define “malpractice,” for example, would not produce valid results. Since there is no necessarily true definition of a concept like “malpractice,” validity is a matter of stakeholder acceptance; the greater the degree of stakeholder acceptance, the more valid the definition.

“Consistency” means that similar cases are repeatedly treated alike. Other terms for this are “horizontal equity” (Bovbjerg, Sloan, and Blumstein 1989) and the scientific concept of “reliability.” The concept also is reflected in the philosophy of equal protection. Even if the malpractice system employed a valid definition of “malpractice,” for example,

In order to be fair, the malpractice system not only has to have fair objectives, but it has to fulfill them in a fair manner. This requires that its actions generally be *valid, consistent, proportional, and predictable*.

its actions would be unfair if it consistently failed to identify true instances of malpractice. This could happen because the system for detecting malpractice lacked “sensitivity” – meaning that too often it missed true cases (the problem of “false negatives”) – or because the system lacked “specificity” – meaning that too often it erroneously considered cases in which there was no malpractice to be true cases (the problem of “false positives”). An inconsistent system could make either or both types of errors.

A fair malpractice system not only must treat like cases alike but different cases differently, and it must have a rational basis for the differential treatment. In other words, it must act “proportionally.” Another term for this is “vertical equity” (Bovbjerg, Sloan, and Blumstein 1989). Even if it usually could identify true cases of malpractice, the system would be unfair if it reacted to a minor deviation from the standard of care that produced trivial patient injury in the same way that it reacted to a case of gross negligence that resulted in patient death.

Finally, the malpractice system must be “predictable,” meaning that the relevant stakeholders (primarily, in this context, the providers) must have a good idea in advance of how the system will respond to their behavior. A malpractice system would be unfair, for example, if the rules changed unexpectedly or were applied in an unexpected fashion.

With these requirements in mind, how would a fair malpractice system carry out its objectives?

Compensating Victims

In order to be *valid*, compensation decisions must be based on a definition of what constitutes a compensable event that is acceptable to the stakeholders. As noted in the previous section, there are different notions of what types of events ought to trigger compensation – negligent injury, avoidable injury, or all injury. Whichever type of event is deemed compensable, the stakeholders must agree on the characteristics that describe the event. In order to be *consistent*, the compensation system must not fail too often to identify true compensable events and to distinguish non-compensable events. The severity of the patient’s injury, taking into account both its nature and duration, is generally accepted as the metric of proxy for proportionality for purposes of compensation. In order for a malpractice system to be *proportional*, therefore, the compensation system must provide more compensation to more severely injured patients than to less severely injured patients.

In addition, there must be a rational basis for the progression in the amount of compensation from less to more severe cases. It would seem unfair, for example, for a person who had lost one arm to receive \$100,000, a person who had lost both arms to receive \$200,000, a person who had lost both arms and a leg to get \$300,000, and yet a person who had lost both arms and both legs to receive only \$310,000. Finally, the relevant stakeholders must have a good idea of how much compensation will be awarded for different compensable events. The better their foreknowledge of these consequences, the more *predictable* the compensation system will be.

With respect to compensation as an objective of a fair malpractice system, the requirement of validity also implies that the system provides *adequate* compensation, meaning that the stakeholders must agree on *how much* compensation injured patients should receive for a given injury. Should someone who loses an arm, for example, receive \$1 million, \$100,000, or \$10?

This decision in turn depends on what losses are deemed to be eligible for compensation and how they are measured for purposes of calculating damages. The timeliness of compensation is also important to the fairness analysis of damages even if the overall amount is adequate. This is particularly true for payment of unreimbursed medical expenses and lost wages. Delay can cause severe dislocations, especially for those with severe injuries, inadequate health or disability insurance, or few economic reserves. The award even may come too late to enable them to obtain needed medical care. The only problem with immediate compensation is that the victim's losses may still be uncertain. Greater exactitude can be accomplished in a fairer manner by postponing delivering compensation until the money is actually needed, but this entails additional administrative expense.

Economic damages. There seems to be general agreement among stakeholders that "economic" losses caused by malpractice should be fully compensated. Economic

losses are medical and other out-of-pocket expenses (including such things as arranging transportation if an injury leaves the patient unable to drive); lost income from being unable to work; and lost future income resulting from a reduction in the patient's earning capacity. There also seems to be agreement that these losses must be "reasonable"; for example, patients should not be entitled to recover the cost of extended vacations on the Riviera even though this might help them feel better.

One area in which disputes arise is over how to compensate for future losses. Significant disagreement occurs over how to predict future earnings for someone like a child who has no earnings record, and how to estimate life expectancy. More minor questions include whether and how to discount recoveries to present value, whether and how to take inflation into account, and how to consider the tax treatment of recoveries in calculating their amount.

Another disputed area is whether victims should receive damages for costs of injury that have been paid by "collateral sources" such as health and disability insurers or employers. The traditional rule under the tort system is that the fact that the plaintiff is entitled to recover losses from third parties is not to be taken into account in calculating damages. One rationale is that the defendant should not be relieved of having to pay for injury because the plaintiff had the foresight to arrange for first-party insurance or because the plaintiff's employer generously paid wages even when the plaintiff was laid up. Another theory is that the plaintiff has actually paid for these first-party benefits, in the form of premiums for the insurance and higher productivity or lower wages in return for the employer's largesse, so being compensated by the defendant is not really a wind-fall. In the case of insurance, moreover, the money that the plaintiff recovers from the defendant usually has to be repaid to the insurers under a subrogation agreement. Nevertheless, many states have abolished the so-called "collateral source" rule, allowing

or obligating juries and judges to consider these collateral payments in calculating damages.

Non-economic damages. While there seems to be general agreement that full compensation for economic losses is fair, there is much less agreement on the issue of compensation for pain and suffering. Some commentators conclude that there should be no compensation for pain and suffering at all. They argue that patients themselves do not think that being compensated for pain and suffering is truly important, based on the fact that they do not purchase coverage for it as part of first-party health care or property-casualty insurance (Bovbjerg, Sloan, and Blumstein 1989). Some economists explain this by suggesting that the marginal value of being compensated in a post-injury state is lower than the value of the money that it would take to purchase insurance for pain and suffering in a pre-injury state (Croley and Hanson 1995; Geistfeld 1995). Another argument is that, while economic damages to some extent can restore a person to the financial state they would have been in absent malpractice, money cannot produce freedom from pain or suffering. Victims may be able to purchase a new car or a fur coat, but they will still endure discomfort. In the case of a severely injured patient — for example, a severely brain-damaged infant — it may be questioned whether money for pain and suffering can do them any good at all.

On the other hand, there is no denying that pain and suffering is a real loss. Yale Komisar asks: “Would you be indifferent or even nearly indifferent between an uninjured state and a severely injured state, such as paraplegia, blindness, or severe brain damage, so long as your income and wealth remain constant?” (Komesar 1990). According to this reasoning, the failure of individuals to purchase insurance coverage for it is more likely to be due to their reluctance or inability to pay the necessary high premiums than to a sense that the loss is inconsequential. The same phenomenon presumably explains automobile

drivers who fail to purchase first party insurance.information failures in the insurance market. (Croley and Hanson 1995).

If pain and suffering loss is real, it would seem unfair to deny full compensation for it. The question then is how to calculate the amount. This is more difficult than calculating economic damages, since pain and suffering are intangible and subjective concepts. The rule of tort compensation – to place the victim in the position they would have been in if the injury had not occurred — sometimes leads people to describe full compensation as what it would take to make the victim “indifferent” to the fact that they had suffered a malpractice injury (Posner 1998). But there is no market for malpractice injury, no auction where people can “sell” their vision or their right leg.

An alternative might be to ask victims in hindsight what amount of compensation would have been necessary to induce them to make this choice, but this is no different than asking them how much money they would like to receive, and is bound to lead to unacceptably high figures. Another alternative might be to ask a large number of people hypothetically how much money they would want in return for certain injuries, and use the responses to construct some sort of general price list. But people have trouble placing themselves in hypothetical situations, and there is no assurance that their responses to hypothetical questions would in any way resemble how much they would feel they deserved if they were actually injured.

One author presents an economic defense of allowing juries to estimate how much a reasonable person would have paid *ex ante* to eliminate the risk of enduring the pain and suffering of their injury (Geistfeld 1995). Another approach is to derive a scale of damages for pain and suffering by taking the average of jury awards in similar cases, or by averaging judgments for plaintiffs after judges have had an opportunity to increase or reduce the amount the jurors awarded (Bovbjerg, Sloan, and Blumstein 1989). Deciding

which cases were similar to the victim's would be difficult, since each plaintiff is unique and there are many variables that shape jurors' or judges' awards. Awards in settled as well as decided cases ideally should be considered, since otherwise the averages would reflect only the most contentious claims. But settlement figures are hard to come by, because typically they are not made public.

Another question is whether a malpractice victim has suffered special harm because of the blameworthiness of the health care provider's conduct. This is distinct from the problem of punitive damages, which are not related to the amount of the victim's loss. One interpretation of why torts such as malpractice are wrongs is that they represent an appropriation of the victim's welfare by the tortfeasor for the tortfeasor's benefit, without the victim's permission. This is what happens, for example, when a driver speeds in order to get somewhere quickly; or when a doctor denies a patient a medically necessary service in order to get a bigger bonus at the end of the year from a managed care plan. Malpractice seems particularly blameworthy because health care providers owe patients a "fiduciary" duty of loyalty reflecting disparities of information and unequal bargaining power (Mehlman 1990). Fair compensation for malpractice victims therefore plausibly should include inchoate losses like loss of autonomy or erosion of trust. Also, patients who have been injured by malpractice are less likely to trust health care providers in the future, and can be expected to expend more resources to preserve their autonomy and monitor provider behavior. On the other hand, as discussed more fully in the next section, it may be desirable to divorce deterrence and punishment functions from the compensation system.

Should anyone besides the patient be compensated for non-economic injury, such as grief or emotional suffering? A fair system should compensate dependents for the economic losses that they will sustain as a result of a breadwinner's death. By the same token, it seems fair for close family members to be compensated for their emotional losses. A dif-

difficult question is whether members of the immediate family should automatically be compensated, or whether they should have to prove that they suffered harm, such as by demonstrating that their emotional suffering produced physical manifestations? What about someone who is not a member of the immediate family, such as a favorite aunt or cousin? In the case of well-known people, the circle of people seriously affected by their injury or death could be enormous; recall the outpouring of grief over the death of Princess Diana. To prevent the total amount of compensation from becoming absurd, a line has to be drawn somewhere. Unfortunately, the law has been unable to develop a principled approach, part of the problem known as proximate causation. Because case-by-case determinations would be extremely expensive, courts have ended up drawing lines arbitrarily, such as that non-immediate family members must have witnessed the injury taking place (*Dillon v. Legg* 1968), or that their emotional harm resulted from a realistic fear for their own safety (*Waube v. Warrington* 1935).

Financing compensation. A final subject in connection with the fairness of the malpractice compensation system is how it is financed. In theory, financial responsibility could lie with individual providers who cause patient injury; institutional providers like hospitals or HMOs; all providers, whether or not they caused injury; patients or some subset, such as those with health insurance; employers; employees; or taxpayers. It might seem fairest for those who cause injury to compensate their victims. This does not necessarily mean specific health care professionals; as noted earlier, many commentators believe that the main cause of medical malpractice is system failure, rather than individual misfeasance. If true, then it would be fairer for health care institutions, rather than individuals, to pay the bill. This approach, known as “enterprise liability” (Sage 1997, Abraham and Weiler 1994), briefly was included in the Clinton health reform proposal but was dropped under pressure from trial lawyers and, surprisingly perhaps, organized medicine (which

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objected that it would reduce physician decision-making authority) (Rogers 1993).

Complicating the analysis is the fact that the initially responsible party may pass on the cost of compensation to others. If health care providers add this cost to their fees, it ends up being borne by patients and third-party payers. To the extent that patients, employees, or taxpayers pay the bill for malpractice anyway, it might be fairer for them simply to purchase and collect damages from first-party malpractice insurance. The main argument for retaining

third-party liability insurance is the deterrent effect resulting from the effort required to pass costs on and the residual costs that cannot be shifted, such as injury to providers' reputations.

In either case, a fairness concern would arise if the manner in which costs were borne after being passed on by providers were regressive or oppressive. If compensation costs end up being paid by patients, taxpayers, or employees, these costs should be spread in such a way that they do not fall too hard on any individual, and are not borne disproportionately by the poor or the sick. It is worth noting that it may no longer be possible for providers to pass on increased malpractice costs, at least in the short term. Medicare and private managed care are under severe pressure to hold down health care spending. In addition, providers must bear certain uninsured costs mentioned above.

Is it fair to make providers bear a significant portion of the costs of compensat-

ing injured patients? It would not be fair if the compensation system frequently erred in attempting to identify compensable injuries, particularly if the error were in the form of false positives. High false positives mean that physicians often must defend themselves in cases where they had not caused injury, or, under a fault regime, had not done so negligently.

Unfairness also would occur if blameless providers were made to pay for the mistakes of others. One way of avoiding this would be for malpractice insurance to be “experience rated,” meaning that providers who cause more patient injuries pay higher premiums than providers with fewer injuries. (Darling 1987). In order to be fair, experience rating would need to control for the risk inherent in the provider’s patient population or case mix. Perhaps because of the difficulty of doing this, insurers claim that they cannot experience-rate medical malpractice premiums in an actuarially fair manner (Schwartz 1990).

What about removing providers from financing patient compensation altogether? It might be argued that a certain proportion of patients are at higher risk for malpractice because they have conditions that are difficult to diagnose and treat correctly, and that the health care system must take care of these patients. On this basis, the costs of malpractice might be viewed as part of the overall cost of medical care, in which case it would be fairest for the system to be financed by all patients, or by society as a whole.

There is one other fairness concern that might affect how much compensation injured patients were entitled to receive and how it was paid for. It would arguably be unfair to deny patients access to necessary health care services in order to compensate victims of malpractice. This would be especially objectionable if the patients who did not have access were members of a discrete class, such as the poor, the seriously ill, pregnant women, or people living in rural areas. But neither is it fair to maintain access by reducing the amount of compensation substantially. Patients injured by malpractice arguably are

no better off than those who might lose access, and are worse off than healthy individuals or uninjured patients generally. Therefore, it would seem fairer to maintain access by shifting the cost of compensation to all patients, or to taxpayers.

In sum, a fair malpractice compensation system would make valid, consistent, proportional, and predictable compensation decisions. It would provide an amount of compensation sufficient to offset the past and future economic losses of the patient and the patient's dependents. It would compensate the patient and the patient's immediate family for pain and suffering and emotional loss, and the amount of compensation could be fairly based on an adjusted value of average malpractice recoveries. Compensation could be financed in a number of ways, including first-party insurance, public funding, or experience-rated provider premiums, as long as the financing system was not oppressive or regressive, its costs were commensurate with its benefits, and it was sufficiently well-funded to enable patients to receive fair compensation. Finally, it would be unfair for the compensation system to cause patients to be denied access to needed health care services, but there are fairer ways to handle the access problem than decreasing compensation for injured patients below what is fair.

Preventing Injury

In addition to the goal of compensating injured patients, a second legitimate goal of the malpractice system is preventing patient injury. One way to deter injurious conduct fairly is to make those who injure patients compensate them. In theory, the injurers would then be motivated to expend whatever resources were necessary to prevent an equivalent amount of patient injury. In order to prevent \$1,000 of injury, for example, a rational provider would spend up to \$1,000, with the money going for such things as better education and training, better equipment, taking more time with patients, and so on.

This approach works only insofar as the compensation system functions well. A

compensation system that does not compensate patients fairly – that is, that does not make valid, consistent, proportional, and predictable compensation decisions and that is not financed in a fair manner – will not produce good deterrence. As Bovbjerg has pointed out, such a malpractice system would send erratic signals to providers (Bovbjerg 1989). The result could be under- or over-deterrence – in the foregoing illustration, providers spending far less or far more than \$1,000 to prevent \$1,000 worth of injury. If providers are able to pass the costs of patient injury on to others, or if the financing of the compensation system is not experience-rated, the deterrent effect will be muddled or lost. The converse possibility of wasteful over-deterrence is what many commentators call “defensive medicine.” The term “defensive medicine” is often used to describe services — like diagnostic tests for rare conditions – that offer some clinical benefit to the patient but would be deemed not worth the cost absent the possibility of a malpractice claim. This use of the term is misleading, since it assumes that one can calculate the value of a service objectively. A better definition of defensive medicine is a practice that offers no benefit to the patient at all, or one in which the risk, rather than the cost, exceeds the benefit. A handy test for true defensive medicine is “the Bill Gates test”: A practice constitutes defensive medicine if it would not be provided regardless of the patient’s willingness and ability to pay.

Predictability is a major prerequisite for a fair deterrence system. Providers need to know what behavior causes compensable injury and what behavior prevents it. Unfortunately, this information is sorely lacking. In large part because of its cost, there has been little systematic effort to study the link betweenis still not enough information linking the process of care andto medical outcomes, which is known as “evidence-based medicine” (Evidence-Based Medicine Working Group 1992). Instead, providers tend to employ the same techniques that they have in the past, an attitude that is encouraged by

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the fault-based medical malpractice system because negligence is defined as a deviation from the prevailing “standard of care.”

Some commentators urge that the malpractice system should concentrate on generating the missing information as a prerequisite to effective deterrence. In their view, instead of linking patient injury directly to compensating victims, the system ought to encourage providers to identify

instances in which they injured patients, and to aid in an investigation of why the injury occurred and how it could have been prevented. One such approach would limit the liability of providers who admit error (Institute of Medicine 2002). Part of the rationale is that any loss of deterrence from not having to fully compensate the patient is more than made up for by gaining knowledge about what caused the mishap and how it can be avoided in the future (another part is that more patients might receive compensation if errors were identified promptly). But it seems unfair to obtain this information by reducing compensation to specific victims, at least without their consent (which some might well give, if receiving a prompt explanation or knowing an error would not happen again were important to them). Absent consent, a fairer approach would be to compensate the victim fully, but relieve the provider of some or all of the burden of the compensation, such as by having it borne by a fund financed by all providers, all patients, or all taxpayers.

Another approach to deterring patient injury is to rely more heavily on mechanisms other than the malpractice compensation system. These include sanctions imposed by professional groups, provider institutions such as hospitals, and the government.

Providers who injure patients could be reprimanded, could have their licenses and hospital privileges limited, suspended, or revoked, or could be disqualified from receiving Medicare and Medicaid reimbursement. The fairness of these sanctions depends on the same factors that underlie the fairness of a compensation system: validity, consistency, proportionality, and predictability. An important qualification is that achieving fairness in these systems may be more costly than in the malpractice system, which would limit their effectiveness as a substitute for tort litigation. However, there is a widespread belief that a disproportionate number of patient injuries are attributable to a small number of providers (Ryzen 1992). If true, it may be possible to identify these individuals and institutions and take action to prevent further injuries, even though the deterrence system is not accurate enough to identify less egregious cases in a fair fashion.

A different deterrent technique involves collecting and publishing information that allows consumers to seek services from providers with lower rates of patient injury and avoid those with higher rates. The idea is to create an additional incentive for providers to avoid injuring patients (Health Research Group 2003). In order for this technique to be fair, the information would have to be accurate. For one thing, it would have to be properly adjusted for severity of illness, so that consumers did not mistakenly attribute a high rate of patient injury to misfeasance rather than the inherent risk of the provider's practice. Even armed with good information, however, patients often are in no position to choose their providers – for example, when they are in great pain or in an emergency.

Punishing Wrongdoers

Assuming that punishment is a legitimate objective of the malpractice system, how can it be done fairly? In order to be fair, punishment decisions also must be valid, consistent, proportional, and predictable, and – as was true for compensation and deterrence — this will be difficult absent good information about how providers should behave

in order to avoid patient injury. A related issue, familiar from the deterrence discussion, is whether punishing individual providers would interfere unduly with obtaining information about why injuries occur. Furthermore, when patient injury is caused by system failure rather than by individual wrongdoing, it is unfair to punish providers. Instead, the malpractice system should focus on identifying and correcting the systemic deficiencies.

At the same time, the desire for vindication and retribution may be compelling for some injured patients, and it would be a mistake for the law to ignore this. Providers some-

When patient injury is caused by system failure rather than by individual wrongdoing, it is unfair to punish providers. Instead, the malpractice system should focus on identifying and correcting the systemic deficiencies.

times deserve to be punished, and indeed some are prosecuted criminally for injuring patients (Van Grunsven 1997). It does not seem unfair to punish these individuals even though, due to lack of information or evidence of system failure, it would be unfair to punish every provider who could be causally linked with patient injury. As was true for deterrence, though, the malpractice compensation system may not be the best punitive instrument. Sanctions imposed by professional groups, provider institutions

such as hospitals, and the government may be preferable.

To summarize, a substantively fair malpractice system not only would fairly compensate injured patients, but would employ fair methods for reducing future injury and punishing providers who wrongfully caused injury. Achieving fair deterrence and punishment is hampered by the lack of information linking processes of care with patient outcomes, and using the compensation system to punish individual providers may be unfair if

The desire for vindication and retribution may be compelling for some injured patients, and it would be a mistake for the law to ignore this.

the primarily cause of provider error is systemic failures rather than individual shortcomings. Nevertheless, it seems fair to try to identify those providers who are associated with a disproportionate share of patient injuries and to make them take steps to protect patients, which could include remedial training, enhanced supervision, limitations on the scope of practice, and, if necessary,

forfeiting their privilege to deliver health care services.

Procedural Fairness

Procedural fairness forms the second main component of general fairness. Procedural fairness even might be thought of as the paramount component, since what counts as substantive fairness is often so difficult to identify that we are frequently content to regard a result as fair as long as it is produced by a fair process. As noted at the beginning of this paper, the procedural fairness of the malpractice system is a concern in two contexts: the decision-making processes that the system employs to achieve its objectives, and the processes that are used to make changes to the system. The discussion that follows is concerned with the first set of issues. The procedural fairness of the reform process is discussed later in the paper.

Procedural fairness even might be thought of as the paramount component, since what counts as substantive fairness is often so difficult to identify that we are frequently content to regard a result as fair as long as it is produced by a fair process.

What makes a decision-making process fair? Again, one place to start looking for the answer is constitutional jurisprudence, specifically the principle of procedural due process. But constitutional due process does not provide a ready list of characteristics for fair decision-making in the malpractice system. For one thing, federal constitutional requirements only apply to government actions that deprive someone of life, liberty, or property (U.S. Constitution, amendment V; amend. VI, section 1), and it is unclear which

types of malpractice compensation systems, if any, would trigger these constitutional constraints. More importantly, as the Supreme Court stated in *Morrissey v. Brewer*, “due process is flexible and calls for such procedural protections as the particular situation demands” (408 U.S. 471, 1972). In *Mathews v. Eldridge*, the Court explained that deter-

mining what process is due depends on balancing several factors: the significance of the private and government interests at stake; the risk of an erroneous decision and the reduction in that risk that would result from the use of different decision-making procedures; and the administrative and fiscal burdens that different procedural approaches would impose on the government (424 U.S. 319, 1976).

Outside of the constitutional realm, what counts as procedural fairness is even less definite. Little direct attention has been paid to the dimensions of a procedurally fair malpractice system. However, more has been written about procedural fairness in general (Mashaw 1981, 1976, 1974; Thibaut and Walker 1978; Tyler 1988, 1987) and how to make fair health care decisions (Kinney 1996; Kinney 2002; Fondacaro 1995). From these judicial and scholarly resources, the following emerge as the major characteristics of a procedurally fair malpractice system (see Table 1).

First, a fair decision-making process is one that *produces substantively fair outcomes*, that is, outcomes that are valid, consistent, proportional, and predictable. A fair process is a good predictor of a fair outcome. The reverse is also true: To the extent that what counts as a fair outcome can be identified, a consistent pattern of them is strong evidence that the decision-making process is fair. On the other hand, a consistent failure to achieve fair outcomes is a sure sign of procedural unfairness.

Second, a fair decision-making process must employ *rules that are acceptable to all parties*. This is important because of the voluntary, reciprocal relationship between patients and providers that forms the basis of the health care system. In order for patients to obtain the best health care, both they and their providers must feel that the rules that govern their relationship are mutually satisfactory and beneficial. In other words, the rules not only must be fair, but the parties must perceive them to be fair. This is sometimes referred to as “subjective” procedural fairness (Lind and Tyler 1988).

Third, the parties must have a *meaningful opportunity to be heard* (Goldberg v. Kelley 1970), or as Fondacaro puts it, an opportunity “to state one’s case and to be heard” (Fondacaro 1995). This is vital for fair decision-making because it supplies critical information to the decision-maker. It also enables the parties to feel that the procedures are fair by giving them a “voice” (Leventhal 1980).

Fourth, the parties must be *adequately represented* if necessary to ensure that they have a meaningful opportunity to be heard. Typically this means that they should have access to lawyers. However, the decision-making process does not have to be intensely adversarial. As discussed below, alternate dispute resolution techniques may be fair under certain circumstances, and patients may be able to obtain adequate representation from non-lawyers acting as “medical advocates” (Mehlman 1995). The important thing is that the parties will not regard a process as fair if they feel unable to navigate it. Moreover, if a party on one side of a dispute has access to representation, so must the parties on the other side.

Fifth, evidence must be *on the record and not based on ex parte communications* (information provided privately to the judge or jury), and *decisions should be reasoned and in writing*. These are all hallmarks of American jurisprudence, intended to promote accurate fact-finding and accountable decision-making.

Sixth, *decision-makers must be neutral and impartial* (Schweiker v. McClure, 1982). “Neutral” means that they should not be dominated by members of one side or another (such as physicians or injured patients). “Impartial” means that the decision-makers should not have a direct stake in the outcome or any other reason to favor one party over another. For example, the need for accuracy in medical malpractice decision-making has prompted the suggestion that decision-makers should be medical experts – generally physicians. But injured patients are unlikely to view physicians as neutral and impartial,

It is highly unlikely that people will regard a process as fair if it demeans or intimidates them.

implying that a degree of technical expertise may have to be sacrificed in the interests of fairness. This leaves the task of ensuring accuracy to expert witnesses, although these could be appointed by the court (Federal Rules of Evidence §706) rather than employed by one side or the other.

Seventh, *the parties must be treated with dignity and respect* (Mashaw 1981; Fondacaro 1995). It is highly unlikely that people will regard a process as fair if it demeans or intimidates them. This can be a problem with extremely adversarial procedures, such as harsh cross-examination of physicians or patients. There is a difference between probing questioning and harassment. If the decision-making process is adversarial, the decision-makers must restrain the parties and their representatives, and remain respectful themselves. Preserving dignity and respect also entails protecting privacy. While open proceedings and public access to evidence are means of safeguarding fairness, the process should not unduly publicize the parties' private affairs, nor those of other patients. This is especially important in the case of medical malpractice disputes, where intimate details of a person's health and lifestyle may be relevant.

Eighth and finally, *the decision-makers must be accountable*. One method is to provide a meaningful opportunity for review by other neutral and impartial decision-makers, such as an appellate court. This is the method used in federal courts. Another way to hold decision-makers accountable is to dismiss or replace them if they do not act in a fair manner. This is part of the rationale for electing state court judges. However, judicial elections have been criticized as unrepresentative (Croley 1995), and even the will of a true

majority may trample on minority interests and therefore not be fair. Yet another means of promoting accountability is transparency: Make the decision-making process public. But this may unduly compromise privacy. At the least, the decisions themselves could be publicized, even if some of the underlying evidence is not disclosed for privacy reasons.

While these principles establish the basic foundation for a procedurally fair malpractice system, there are still a number of outstanding questions. One is whether the malpractice system has to be adversarial. Stemming from the English common law tradition, the American system of justice relies on an adversarial approach to produce information and enable decision-makers to ascertain the truth, but the continental civil law tradition employs an “inquisitorial” approach, where the decision-makers elicit the information they deem necessary to arrive at the truth (Thibaut and Walker 1975). One of the problems with an adversarial approach is that it may embitter the parties, making it difficult for patients and providers to admit error and to reconcile. Indeed, one of the rules of evidence in adversarial trial proceedings is that an apology by a provider to an injured patient is admissible as proof of fault (*Senesac v. Associates in Obstetrics and Gynecology* 1982).

Alternative dispute resolution (ADR) systems exist, including arbitration, a technique that is still adversarial but less formal than litigation, as well as non-adversarial approaches like mediation. However, there is some concern that ADR is not fair to patients (Kinney 1996). As Kinney states in regard to the mandatory arbitration proceedings required by some health plans, “[p]rivate ADR procedures are not always designed in ways that enhance the patient’s power ...” This is not the place to reproduce the lengthy debate between advocates of ADR and defenders of traditional litigation techniques. However, it is noteworthy that while there is no evidence that injured patients are pressing for ADR to replace the traditional tort system, there have been a number of lawsuits brought by patients seeking to avoid ADR (Cerminara 2002). In these cases, patients often complain

that they were not made sufficiently aware when they entered into a relationship with a plan or provider that they were agreeing to ADR. If their main objection is not to ADR itself but that they were forced into it, it would be fairer to permit the parties to choose it as an alternative after a dispute has arisen.

This raises the question whether one should simply let the parties design fair procedures for themselves, leaving judicial processes as “default rules” if the parties fail to reach agreement. Since it is so important for the parties to feel that the decision-making process is fair, it has been suggested that the best way to encourage this attitude is to let the parties determine that process through negotiation and private contracting (Havighurst 1986). The parties might even agree to forgo some of the features of a fair system described above.

There are two main problems with the contract model. The first is that the parties are unlikely to have sufficiently equal bargaining power for the bargain to be fair.

It is fair to permit the parties some degree of choice among decision-making processes. However, from the standpoint of the weaker party – the patient – the choice must be framed more as a matter of giving informed consent to treatment than signing a business contract.

Typically, patients will be at a disadvantage, lacking information that providers possess, being unable to obtain additional information as cheaply, and having few alternatives to accepting the terms that are offered (Mehlman 1990). Even if patients think that what they have agreed to is fair, they may change their minds after they have had to go through the contracted-for process, with consequent damage to their current and future relationships

with providers. The second drawback to the contract model is that it encourages the parties to treat each other as if they are strangers. A contract between patients and providers reflects a fiduciary relationship rather than an arm's length transaction, and for good reason (Rodwin 1993; Mehlman 1990).

Even though the contract model is problematic, it is fair to permit the parties some degree of choice among decision-making processes. However, from the standpoint of the weaker party – the patient – the choice must be framed more as a matter of giving informed consent to treatment than signing a business contract (Studdert and Brennan 2001). The difference is that, in obtaining informed consent, providers must act as fiduciaries for the patient, supplying adequate information and acting in the patient's best interests, rather than feeling free to extract the best deal for themselves as long as they refrain from outright fraud.

The Fairness of the Current System

The preceding sections of this paper have described the requirements of an optimally fair malpractice system, one that aims to achieve fair objectives, that achieves these objectives fairly, and that employs fair procedures to do so. There are only a few instances in which the requirements explicitly balance conflicting goals, such as striking a balance between punishment and producing information that will aid in preventing future patient injuries. However, it would be incorrect to call a system that failed to meet the requirements unfair. Instead, the system would be more or less fair, depending on the number and nature of the requirements that it failed to meet. This section will evaluate whether the current malpractice system is optimally fair, and if not, where it falls down. For a summary of the findings, see Table II.

Setting Objectives

The current malpractice system aims to compensate malpractice victims, deter future injuries, and punish providers who injure patients, all of which are appropriate objectives of a fair malpractice system. However, the system is unfair in that it limits compensation to patients who have suffered “negligent” injuries, rather than having as its objective to compensate all patients who are injured as a result of medical care.

Furthermore, while the current malpractice system strives to reduce future injury and punish wrongdoers, it does so in ways that conflict with each other and that impair its ability to compensate injured patients. The punishment objective weakens the deterrence objective by discouraging disclosures that would aid in the correction of system failures. Together, punishment and deterrence are in tension with the compensation objective because they create a culture of silence, which deprives many injured patients of the information necessary to successfully assert claims.

Funding the current malpractice system by malpractice insurance premiums collected from providers has proved to be an unsatisfactory approach. Periodic dislocations

in the financing system – so-called “malpractice crises” – have been characterized by sudden, sharp increases in premiums and insurers withdrawing from markets or becoming insolvent. Rapid increases in liability costs potentially drive physicians and other health care professionals out of certain specialties or out of practice altogether, or make them relocate to different geographic areas, in some cases compromising access to medical services. Every time a crisis hits, moreover, policy-makers cast about for explanations and carry out repairs. So far, however, the repairs either have been insufficient to prevent subsequent crises or, as the next section demonstrates, markedly unfair.

Achieving Objectives

How fairly does the current system compensate malpractice victims? Even for the subset of patients who have been injured by provider negligence, a consensus exists that the system falls short in numerous respects. In the first place, it is difficult for the system to make valid judgments about what constitutes a compensable event. Typically, this is the

Together, punishment and deterrence are in tension with the compensation objective because they create a culture of silence, which deprives many injured patients of the information necessary to successfully assert claims.

responsibility of lay judges and juries. Based on conflicting testimony from expert witnesses, they have to determine whether the defendant acted negligently and, if so, whether the defendant’s negligence caused the patient’s injury. As discussed below, a number of commentators argue that the system often misses true negligence while incorrectly compensating cases in which no negligence has been demonstrated. One reason for this may be that there is insufficient agreement among the parties on what

should constitute a compensable event – i.e., what is negligence.

The current system also may lack a valid method for measuring the degree of fault, which some feel is one of the considerations that should be taken into account in calculating the amount of damages. Fact-finders may over- or underestimate the extent to which defendants deviate from the standard of care, as well as the blameworthiness of their behavior.

Furthermore, the system has trouble measuring damages accurately. Jurisdictions differ over how to calculate economic damages, taking varying stances on whether to discount future lost income to present value, how to take account of the fact that tort recoveries are not taxable income, and what to do about medical and general inflation. There is also no common approach for valuing pain and suffering, with juries given broad discretion and little or no instruction from the bench (Bovbjerg, Sloan, and Blumstein 1989).

As a result, the consistency of the current system is generally acknowledged to be poor. Some have gone so far as to call it a “lottery” (O’Connell 1979), and to attribute outcomes as much to personal appearance and attorneys’ courtroom skills as to the merits of the case. First, the system lacks sensitivity. One study estimates that only about 1 out of 151.5 percent of actual cases of negligence occurring in hospitals results in a claim (Localio et al. 1991). The most likely reasons are that most patients’ injuries are too minor, making it not worth their effort or the effort of an attorney, and that many are not aware that they have been the victims of malpractice. In addition, some patients simply do not want to sue their providers. Studies have shown, for example, that patients who feel that they have better relationships with their doctors are less likely to sue them, even when the doctors make mistakes (Penchansky and Macnee 1994). Of the small percentage of true malpractice victims who file claims, only about half receive any compensation (Taragin et al. 1992; U.S. General Accounting Office 1987). Again, no one knows for certain why.

Second, the malpractice system exhibits a questionable degree of specificity. There is a widespread impression among providers and others that many claimants who were not injured as a result of negligent medical care nevertheless receive compensation. The data are not clear. Some studies claim a relatively large frequency of this type of error (Brennan et al. 1996). Other studies find far fewer meritless claims (Sloan 1993).

In terms of proportionality, again there are conflicting views. Some believe that the severity of injury (and presumably, the degree of fault) bears little relationship to the amount of compensation received. The President's Council of Economic Advisors recently issued a report implying that tort recoveries in general were "random" (Council of Economic Advisors 2002). The data do not bear this out. On average, malpractice awards increase with the severity and duration of injury (Bovbjerg et al. 1991). Moreover, the economics of the tort system make the idea that recoveries are random highly implausible. To successfully assert a malpractice claim under the present system, a patient almost always needs to hire a lawyer, who takes the case on a contingent fee basis. The lawyer has no interest in representing a client whose recovery will yield the lawyer less than it costs the lawyer to pursue the case. In general, lawyers will take on cases that are likely to be winners, and that promise large recoveries. The main exception to this rule would be "strike suits" – relatively small claims that defendants could defeat in court but settle for small sums because it is cheaper

For those who receive compensation, the amount of compensation is not always fair. Problems include inconsistency and inadequacy. Data show that jury valuations vary widely even for similarly severe injuries (Bovbjerg, Sloan, and Blumstein 1989). There is evidence that patients with minor injuries who recover damages tend to receive more than is necessary to compensate them for their economic losses, while those with severe injuries often do not even recover enough to compensate them for their future medical

costs, let alone for lost future earnings (Sloan and van Wirt 1991; Sloan, Bovbjerg and Githens, 1991; Institute of Medicine 2002).

Because the malpractice system lacks an accepted method for valuing pain and suffering, awards for non-economic damages fall short of optimal fairness. Providers and their liability insurers clearly believe that injured patients receive unfairly generous compensation for pain and suffering. Data confirm the perception of inconsistency, with seemingly similar cases receiving varying awards. Although this may be due to legitimate factors that researchers did not control for, such as the wealth of the victim (or the defendant) and the degree of fault, compensation for pain and suffering is probably unfair in some cases. The same perception would apply to non-economic damages received by family members.

The current system also can be criticized for the time it takes to deliver payment. One closed-claims study found that the average claim against a physician took over a year to be filed and more than an additional 2 years for successful claimants to receive compensation. (U.S. General Accounting Office 1987). Workers compensation systems, which do not require courts to determine fault, pay claims more quickly (Love 1985).

As for how it is financed, the malpractice system hardly seems fair. In most cases, physicians pay premiums based on their geographic location and specialty. There is little fairness in basing premiums on where people live. It might seem fair to charge differentially by specialty if specialization correlated with physician earnings, but specialty-based rates reflect not income but the relative risk of being sued. This means that orthopedic surgeons tend to pay the highest premiums because of how difficult their job is, rather than because of how careless they are or how much money they make. Although the legislatures in both New York and Massachusetts have mandated malpractice experience rating, they do not seem to have been successful. Consequently, physicians who have been held

liable for malpractice are subsidized by other physicians. While this may help spread the costs of compensating patients, it may seem unfair to providers who are more skilled or more careful.

It is unclear how much of the cost of malpractice providers are able to pass on to others. Physician income does not appear to have declined despite rising malpractice insurance premiums. However, there are substantial uninsurable costs, including time, effects on reputation, and emotional impact, that cannot be passed on. These costs can be considered part of the financing mechanism for the malpractice system, and they can be unfair, especially if the lack of validity and consistency requires providers to defend substantial numbers of non-meritorious claims. With regard to those costs that are shifted, there is no clear understanding of where they end up. The less they are spread, and the more that they are borne disproportionately by poorer individuals, the more unfair this would be. This is particularly problematic during “malpractice crises,” when rates rise sharply. In the crises of the 1970s and 1980s, health insurers paid for these increases in providers’ costs of treating patients. However, it is likely that managed care and restrictions on Medicare and Medicaid reimbursement will result in more costs of the current crisis being borne directly by physicians, at least in the short term.

Liability insurers and attorneys account for a significant portion of the cost of the system. Malpractice insurers impose substantial charges for administration and legal defense fees, perhaps as much as 20 cents of each premium dollar. There is a widespread perception that plaintiffs’ lawyers charge too much by way of contingent fees. The trial bar denies this, arguing that fees for successful cases cover the costs of investigating and preparing unsuccessful cases. At the same time, it is hard for patients seeking small or moderate recoveries to find lawyers willing to take their case.

There is little direct public financing of the malpractice system. Even state-spon-

sored reinsurance programs, like Pennsylvania's MCARE fund, tend to be financed by assessments on health care providers. Indirectly, public health care entitlement programs such as Medicare and Medicaid end up paying malpractice costs that are passed on to their beneficiaries as part of providers' fees. The Medicare payment system even employs a complex formula to factor malpractice costs into its prices for physician services (Center for Medicare and Medicaid Services 2003).

Another way in which patients pay the costs of the malpractice system is when they lose access to health care. As noted earlier, the current malpractice crisis has prompted reports that physicians are abandoning practice, shifting specialties, or relocating, and

The most serious flaw in the malpractice financing system is that it is unstable.

that this leaves some patients without ready access to certain types of services, such as obstetric care. It is difficult to pin down the extent of this behavior or whether it is specifically attributable to providers' malpractice woes. Nevertheless, denying patients access to health care in order to sus-

tain the malpractice system would be particularly unfair, since patients are innocent and often ill or in distress.

The most serious flaw in the financing system, however, is that it is unstable. The current malpractice crisis, the third in the past 30 years, has been characterized by sudden, sharp increases in malpractice premiums and the inability of providers to obtain insurance either because insurers are leaving the market or have become insolvent. The effect of crisis is to damage the relationship between providers and patients and between lawyers and doctors, possibly to increase health care costs, and potentially to leave some patients without access to necessary medical services.

In terms of deterrence, there is a general impression that the system does not reduce patient injury very successfully. On one view, the system does not appear to produce enough deterrence. Patients continue to be injured by provider negligence, and as many as 98,000 patients are estimated to die each year as a result of avoidable errors (Institute of Medicine 1999). At the same time, the system may provide too much deterrence, causing wasteful “defensive medicine.”

This peculiar situation can be explained by a malpractice system that is sending out signals that are strong but not specific, so that providers feel that there is a substantial risk of being sued, but do not know what to do to reduce the risk. In other words, along with its lack of validity and consistency, the system lacks predictability. As Bovbjerg explains: “Where liability costs are relatively predictable, they can be avoided (where it is efficient to do so) or ‘built in’ to the costs of goods and services. This is how deterrence is supposed to make the world safer. But errors in valuation may

The malpractice system is sending out signals that are strong but not specific, so that providers feel that there is a substantial risk of being sued, but do not know what to do to reduce the risk.

cause overdeterrence – the taking of too many costly precautions, or withdrawal from the risky activity altogether” (Bovbjerg 1989).

An unpredictable malpractice system also diverts provider interest away from pursuing fails to encourage providers to pursue evidence-based medicine. If they are going to get sued and sometimes be held liable whether or not they practice good medicine, providers have less reason to gather data linking clinical processes to patient outcomes.

This is unfair to patients, because it denies them better quality care.

Finally, how well does the malpractice system punish wrongdoers? Again, if the system sends erratic deterrence signals because of problems with validity, consistency, proportionality, and predictability, it is also likely to be unfair as an instrument of corrective justice.

Procedural Fairness

The other key test of how fairly the current malpractice system operates is the fairness of its procedures. The system falls down on the first part of this test – whether it produces fair outcomes — since, as the foregoing sections show, the fairness of its outcomes leaves much to be desired. Many providers also perceive the rules by which the system operates to be unfair. On the other hand, injured patients who file claims seem satisfied with the process (Sloan et al., 1993).

It is unclear whether the parties are given an adequate opportunity to be heard. The malpractice system relies on representation by attorneys, but attorneys do not always do their jobs correctly. Patients with relatively minor injuries or with cases that do not present clear-cut evidence of negligence may be unable to secure a lawyer at all. Providers have little problem obtaining legal representation, but their attorneys, who typically are appointed by their malpractice insurers, may face a conflict between the desires of the provider and the insurer with respect to contesting or settling a particular case. Providers also complain that their “voice” is muted by jury sympathy for victims, testimony by dubious “experts,” and the sleight-of-hand of plaintiffs’ attorneys.

Malpractice claims that go to trial are heard on the record, and there is no evidence of abuse in the form of ex parte communications with the decision-makers. However, many claims are settled without trial, and while this is laudable for its efficiency and civility, it leaves no record and no written decision on the merits. Moreover, even cases that go

to trial are decided in most instances by general jury verdicts, and are not accompanied by a reasoned statement of the basis of the decision.

There are conflicting views on the neutrality and impartiality of the decision-makers under the current system. Many providers seem to think that jurors on the whole are unfriendly to them and sympathetic to victims. Yet the data suggest that juries in malpractice cases generally favor defendants (Peters 1999).

Does the malpractice system treat the parties with dignity and respect? Not always. Attorney behavior in depositions and cross-examination can be hostile and insulting. Judges and judicial administrators can be remote and demeaning. Injured patients and in some instances defendants may feel that they have been made to give up too much of their privacy. The highly adversarial nature of the entire procedure may strike some as not being conducive to dignity and respect, although others may feel that dignity and respect are best upheld by allowing the parties to vigorously pursue their claims and defenses.

To what extent are decision-makers accountable? Jurors are accountable only for failing to follow proper procedures, and typically they do not explain their decision (occasionally a special verdict is requested, in which case they must answer questions put to them by the judge). Judges can alter the damages awarded by juries, mostly lowering them, a process called *remittitur*. The outcomes of trials and of some ADR proceedings can be appealed if procedural irregularities are alleged, but there is virtually no formal review for substantive fairness. Other parts of the system are even less accountable. Courts usually do not have to approve malpractice settlements, and nearly always accept them in the few cases where review is authorized (e.g., cases involving minors). Federal judges are appointed for life. State judges are often required to sit for re-election, but there is no evidence that this holds them accountable for their decisions. Trial court and appellate decisions are made public, but typically only appellate decisions are accompanied by written

It might seem obvious that the malpractice system could be changed to make it more fair. But this may not be as easy as it sounds.

explanations. The decisions of arbitrators and mediators, as well as settlements, are not matters of public record.

In summary, the current malpractice system raises numerous fairness objections. Among its most serious shortcomings are that: (1) it only purports to compensate victims of negligence; (2) the punishment

objective conflicts with the deterrence objective; (3) it lacks validity and consistency; (4) compensation is inconsistent and only somewhat proportional; (5) financing mechanisms are unfair and undependable; (6) it may leave some patients without adequate access to necessary health care services; (7) its lack of predictability sends erratic deterrent signals; (8) it operates by rules that providers feel are unfair; (9) some injured patients cannot obtain adequate representation; and (10) parties often are not treated with dignity and respect.

These shortcomings are significant, and it might seem obvious that the malpractice system could be changed to make it more fair. But this may not be as easy as it sounds. As Winston Churchill said, democracy is the worst form of government except all those others that have been tried from time to time. A number of so-called reforms are being adopted or proposed. Although the only definitive way to assess the impact of reform on fairness is by making a change and measuring the results, some changes are better candidates for improving fairness than others. This analysis is the subject of the next section.

The Fairness of Reforms

Since the first malpractice crisis in 1975, many changes to the malpractice system have been enacted or suggested. Some are relatively minor and leave the basic underpinnings of the tort system intact. Others are more ambitious, aiming to replace significant features of the system or, in some cases, abandon it altogether. The issue discussed in this section of the paper is the impact that these reforms are likely to have on fairness. Some may increase fairness. Some may decrease it. Some may have no significant impact on fairness one way or the other.

Before analyzing the reforms in detail, it is necessary to explain the analytic methodology that will be employed. In large part, it tracks the earlier analysis of what a fair malpractice system would look like. One must answer two questions with regard to each reform option. First, which of the objectives of a fair malpractice system is the reform aimed at achieving or improving? Second, does the reform improve this objective fairly?

But this second question differs in an important respect from the earlier analysis of fairness. The earlier analysis was static. It identified the characteristics of a fair malpractice system, and then examined the current system to see whether it exhibited those characteristics. An analysis of proposed change, on the other hand, is a dynamic analysis. It asks whether moving from Point A – the current malpractice system – to Point B – the change – would be an improvement. This requires a further line of inquiry: In the move from Point A to Point B, what is the likely impact on the parties? If only some of them will be better off, or they will all be better off but some will gain much more than others, this raises unfairness flags. Suppose we are distributing units of well-being. If everybody receives some, everybody will be better off and the distribution arguably will be fair.* But

* Units of well-being are a heuristic intended to overcome the conflict between welfare and resource maximization, mentioned in an earlier footnote. It is assumed that the units provide an equivalent amount of well-being to everyone who receives them.

what if only some people receive all or nearly all of the additional units? If the principal gainers are those who started with more well-being than everybody else, then giving them the lion's share of the increase seems unfair. So a malpractice reform that only benefited those who were better off than the rest under the current system would not, in fairness terms, be an improvement.

Now suppose that a reform made some people better off, but at someone else's expense. Someone now has fewer units of well-being than they did at Point A, and those units of well-being have been given to others. What impact a welfare transfer of this sort has on fairness is a difficult question that has been the subject of a long philosophical debate that cannot be more than touched on here. One answer might be: The transfer is fair if the winners deserve to win and the losers deserve to lose. This presumably is what happens when one team wins a game that has been played voluntarily, by the rules, on a level playing field. But it is hard to say who deserves to win or lose in a transfer of welfare produced by a change in the malpractice system. One candidate for a deserving winner is an innocent patient injured by malpractice. But what if some patients win at the expense of others? And it is not clear who deserves to lose; the most obvious candidate is the provider who acts negligently, but according to a system-failure approach, that person may not be the real culprit.

Therefore, the following analysis is in some respects just a starting point. It identifies reforms that raise unfairness flags by transferring welfare, but it may not always be able to say for certain whether a particular reform is fair. Nevertheless, there is one type of welfare transfer that presents an easy case. This is when a welfare transfer violates the cardinal principle of distributive justice: Welfare must not be taken away from those who

One type of welfare transfer presents an easy case: Welfare must not be taken away from those who are worse off and given to those who are better off.

are worse off and given to those who are better off. For example, someone who has 50 units of well-being at Point A should not be forced to give 25 of those units to someone who already had 100 units. There is no way that a “reformed” system that produced such a transfer would be fairer than the prior system that allowed the parties to remain in a 1:2 rather than a 1:5 ratio of well-being.

This follows from two philosophical landmarks for assessing fairness. First, Kant’s categorical imperative states that people must be treated as ends in themselves rather than merely as means to increase the welfare of others. Second, Rawls’ “maximin” principle states that justice requires helping the worst off before helping the better off. (Rawls 1971).

With this in mind, what reforms have been enacted or proposed, which objectives of a fair malpractice system do they aim to achieve or improve, and do they do so fairly? For a summary of the findings, see Table III.

Reforms Within the Tort System

A number of reforms would alter various characteristics of malpractice law but leave the basic framework of the tort system intact. One type of reform changes the party that is initially responsible for paying all or part of a claim. This is the effect of *repealing the collateral source rule* and *enterprise liability*. Both of these are designed to reduce the costs of compensating malpractice victims. Repealing the collateral source rule shifts the burden of paying a certain set of claims from defendants and their malpractice insurers to plaintiffs’ health insurers and employers, in effect creating a partial first-party rather than a third-party insurance system. Enterprise liability allows claims to be asserted only

against institutional providers like hospitals and not against individual physicians or other health care professionals, thus saving defense costs (Abraham and Weiler 1994). Reducing transactions costs is a fair objective, since it can free up more money to compensate victims, and the objective can be accomplished in a fair fashion if the reform does not reduce compensation for victims below what is fair. Still, care must be taken that these reforms do not reduce victims' compensation inadvertently. To this end, for example, some juris-

Reducing transactions costs is a fair objective, since it can free up more money to compensate victims, and the objective can be accomplished in a fair fashion if the reform does not reduce compensation for victims below what is fair.

dictions repealed the collateral source rule but require defendants to pay a portion of the plaintiffs' premiums for their first-party health and disability insurance (N.Y. CPLR §4545(c)).

Periodic payment is a type of reform that changes the manner in which damages are paid. Instead of giving the victim a lump sum, payments are spread over time. The objective is to reduce the financial burden on the payer. This seems to be a fair objective, since it can lower the costs of compensation and help strengthen the

financing of the malpractice system. One objection to periodic payment on fairness grounds is that it denies claimants the opportunity to spend or invest the lump sum as they see fit. But the unfairness can be reduced if the amounts of the periodic payments are properly adjusted for inflation and for the return that the claimant would have received on a lump-sum investment. Rather than calculate a total amount of damages and merely spread payment over time, one variation on periodic payment is to reassess claimants' sta-

tus periodically and calculate payments according to how well they are doing. While this might produce a more accurate assessment of damages, it adds considerable transactions costs, such as the costs of repeated hearings for which claimants might need legal representation and have to pay for medical evidence and expert witnesses. Therefore it is likely to reduce the amount of compensation that victims receive.

Another set of reforms would target malpractice insurers, endeavoring to prevent future dramatic increases in premiums. One approach is to *tighten the regulation of insurers*. This is based on the claim that malpractice crises are caused not by sudden increases in claims frequency or severity (amount) — which tend to rise steadily rather than abruptly — but by the insurers' own practices. This has been termed the “insurance cycle.” The cycle begins when insurers, seeking to attract more business or to enter a new market, charge lower premiums than actuarial projections of claims exposure would indicate. At some point, the insurers find themselves in such a precarious financial situation that they must raise their rates suddenly and significantly in order to pay claims and maintain reserves. Some companies may decide to leave the market altogether.

Crisis periods in the insurance cycle seem to coincide with downturns in the general economy. Insurers invest the premiums they receive from health care providers, and count on the returns from these investments to offset losses from paying claims. Insurers appear predominantly to invest in fixed-income instruments, such as bonds (Physician Insurers Association of America 2002). When the economy sours, the rate of return on these types of instruments often declines, reducing future investment income. Perhaps 15 percent of insurer investments is in equities, which have been battered by recent declines in the stock market. Malpractice insurers purchase reinsurance to protect them against catastrophic losses, but the cost of reinsurance has been rising due to the same market factors, as well as a series of catastrophes unrelated to health care. The idea behind tighter

The objective of preventing frivolous suits is fair, since it promotes accurate compensation decisions and enhances providers' perception that the rules of the system are fair. But how fairly the objective is attained depends on how "frivolous" is defined.

regulation of insurers is to ensure that they do not discount their rates too much or enter overly risky markets. The objective behind this proposal is certainly fair – to strengthen the financing of the compensation system. A concern is that insurers may balk at being subjected to increased regulation and exit the malpractice market altogether.

Another approach to stabilizing the financing system is to provide greater public financial support for insurers. This could take the form of state-sponsored excess insurance funds, insurance guaranty funds,

outright subsidies for insurers to help them pay claims, or various incentives to create more physician-owned insurance companies or joint underwriting associations. These approaches are fair if their costs are paid for by broad progressive taxation, but they could represent an unfair windfall for aggressive insurers who were not restrained by tighter government regulation of their rate-setting and marketing behavior.

Various proposals have been made in an effort to *deter the assertion of frivolous claims*. Rules of civil procedure and ethical rules of the legal profession already provide for sanctioning attorneys who knowingly assert frivolous claims (Federal Rules of Civil Procedure Rule 11). Related reforms specific to malpractice, which have been enacted in a number of states, allow courts to order the plaintiff (and sometimes the plaintiff's attorney) to pay the defendant's legal fees and court costs. The objective of preventing frivolous suits is fair, since it promotes accurate compensation decisions, reduces transactions

costs, and enhances providers' perception that the rules of the system are fair. But how fairly the objective is attained depends on how "frivolous" is defined and on the procedures that are employed to challenge claimants. For example, Ohio recently passed a law that permits any successful malpractice defendant to require the court to hold a hearing to determine if the plaintiff's claim was made "in good faith" (S.B. 281). In making this determination, the court is required to consider whether the plaintiff reasonably relied on a review of the merits by a physician or other qualified health care professional. But there is no penalty for defendants who frivolously demand a hearing, such as making them compensate claimants for the costs of defending a baseless allegation. This could lead defendants to request hearings in nearly all cases.

Proposals have been made to require some sort of *expert screening of malpractice claims* before a suit can be filed. A number of states require a complaint to be accompanied by an affidavit of a physician certifying that the claim is meritorious. This should not be a serious obstacle to fair compensation of victims, since their attorneys ought to have had their claims reviewed by physicians anyway. By the same token, however, it is unlikely to accomplish much unless a physician who certifies a non-meritorious suit can be sanctioned. Other states require a claim to be reviewed by a panel of physicians before it can be filed (Office of Technology Assessment 1993). If the objective truly is to prevent non-meritorious claims, then this approach is fair. But an unfair objective would be to avoid paying claims by having valid cases rejected by decision-makers sympathetic to defendants. Because of this risk, some method satisfactory to claimants must be employed to select neutral and impartial reviewers.

In order to reduce the variability of damage awards, one suggestion is to create a *schedule of damages* by injury, similar to workers compensation (Blumstein, Bovbjerg, and Sloan 1991; Bovbjerg, Sloan, and Blumstein 1989). In its pure form, this proposal has

a fair objective: to increase the consistency, proportionality, and predictability of malpractice recoveries. The fairness issue is how the damage amounts would be calculated. As the discussion above explained, a fair starting point would be the amounts for average recoveries under the present system for the same injuries, if this information were available. A more refined assessment also would consider the relative impact of the injury on victims and their families, and possibly the degree of the defendant's fault. The main fairness objection to this approach is that, since it is not as sensitive as a traditional jury trial to the characteristics of the parties and the case, it may sacrifice a measure of accuracy in order to promote consistency. For this reason, an alternate version of the proposal is to retain the role of the jury in calculating damages, but to use the schedule as a guideline or as a range within which the jury's award must fit (Bovbjerg, Sloan, and Blumstein 1989). However, this is likely to reduce the consistency, predictability, and perhaps compared with eliminating the role of the jury in setting damages, proportionality of this is more likely to produce consistent, predictable, and perhaps even proportional results.

To make it easier to determine when a provider has acted negligently, some have suggested formulating *practice guidelines* that would clarify the standard of care for specific situations. This would enhance the validity, consistency, and predictability of the malpractice system. There is a large literature on the pros and cons of practice guidelines, and it cannot be reviewed here. Although fair in its objectives, this proposal could easily be implemented unfairly. For one thing, there is the problem of bias. Since they are expressions of expert opinion, guidelines must be established by physicians, often acting through medical specialty societies. Yet these experts and the members of the groups they represent are all potential defendants, who have an interest in creating the least stringent guidelines in order to avoid liability by using them as evidence that they behaved reasonably. Another problem is that the use of guidelines could be unfairly restricted. Several years

ago the legislature in Maine approved a demonstration program in which guidelines created by medical specialty groups within the state are given the status of administrative rules, meaning that their substantive validity cannot be challenged after they are promulgated. Moreover, although defendants who follow the guidelines are conclusively presumed to have acted reasonably, plaintiffs may not introduce defendants' failure to follow the guidelines as evidence of negligence (Office of Technology Assessment 1993).

The foregoing reform proposals all have fair objectives: reducing the transactions costs of compensating victims; lessening the financial burden of lump sum payments; strengthening the malpractice financing system; discouraging frivolous or non-meritorious claims; and improving the validity, consistency, predictability, and proportionality of compensation decisions. A second set of proposals, like this first set, would retain the basic features of the tort system, but make it harder for injured patients to recover or reduce the compensation that they receive.

The first of these proposals is to *abolish joint and several liability*. Without joint and several liability, plaintiffs who were injured by the combined efforts of a number of

Abolishing joint and several liability makes things fairer for defendants, but at the plaintiffs' expense.

defendants would only be able to recover a part of the overall damages from each defendant. If one or more defendants were unable to pay their portion, the plaintiff's recovery would be reduced. Joint and several liability, on the other hand, increases the chances that plaintiffs will be fully compensated by allowing them to recover all of their losses from a single defendant or to apportion their losses any way they wish among multiple defendants. While this may seem unfair to providers, the law also permits those defendants who are made to pay more than

their fair share of damages to recover the difference from the other defendants. Of course, this may not be any easier for defendants than it is for plaintiffs. Abolishing joint and several liability therefore makes things fairer for defendants, but at the plaintiffs' expense. This makes it hard to say whether the net result is fair or not, although it can be argued that, as between innocent plaintiffs and negligent defendants, and between individual malpractice victims and their families on the one hand and malpractice insurers on the other, it is fairer to ensure that plaintiffs are fully compensated. Nevertheless, a majority of states have abolished joint and several liability (American Tort Reform Association 2003).

A second proposal that would make it more difficult for patients to recover damages is to *abolish the doctrine of res ipsa loquitur* (Latin for “the thing speaks for itself”). This doctrine allows plaintiffs to prevail in certain tort claims when, despite diligent inquiry, they cannot prove in precisely what ways the defendants were negligent. Normally, omitting this evidence would be fatal to the plaintiff's case. If plaintiffs can prove that their injury would not ordinarily have happened without one of the defendants being negligent, however, courts applying the doctrine will compel the defendants to prove that the injury was not due to their carelessness. A good example is *Ybarra v. Spangard*, where the patient woke up after an appendectomy to find that his shoulder had been injured (*Ybarra v. Spangard* 1944). Since he had been unconscious, he had no way of knowing what had caused the injury. Proponents of abolishing the doctrine argue that doing so would help stabilize premiums, encourage providers to feel that the system was fairer, and maintain access to health care (Rustad and Koenig 2002). But if the reform were adopted, injured patients like the deserving plaintiff in the *Ybarra* case would be unable to recover. While the objectives might be fair, the manner in which they would be achieved is not.

Another proposal that would make it harder for victims to obtain compensation

under the tort system is *reducing the statute of limitations*, the time within which they must file a lawsuit. In most states, victims generally have 2 years in which to commence an action, but this period is extended if they could not have discovered their injury within that time or if they were minors when the injury occurred. Proposed reforms would shorten the 2-year period, limit how long a victim had to discover the injury, limit how long a suit could be delayed in the case of a minor, or all three. Proponents of these reforms cite fair objectives: improving the validity of compensation decisions by requiring suits to be brought while memories are fresh and records available, strengthening the financing system by decreasing insurer uncertainty created by the “long tail” of claims for injuries that have occurred in the past, and stabilizing malpractice insurance premiums. But there is no question that this reform would prevent some meritorious claims from being compensated.

A third proposal, *caps on damages*, would make it harder for plaintiffs to receive full compensation. One version is to place a cap on total damages. Another version would only cap damages for pain and suffering. Studies have shown that capping damages (along with shortening the statute of limitations) actually stabilizes premiums (Office of Technology Assessment 1993). Suppose that by doing so and by leading providers to regard the system as fairer, caps keep providers from leaving practice, abandoning high-risk specialties, and relocating geographically. These are fair objectives that seemingly benefit patients by strengthening the malpractice financing system, maintaining access, and possibly even restraining increases in health care costs stimulated by higher premiums.

However, caps achieve their objectives in an unfair manner. To understand why, return to the fairness analysis at the beginning of this section and ask if anyone is worse off at Point B – the malpractice system with caps — than they were at Point A – the system without caps? The answer is obvious. Although the validity, consistency, and proportionality of the current malpractice system is far from ideal, patients who recover large

amounts of compensation under the current system tend to be victims of true negligence who have suffered serious injury. These are the people who stand to lose under caps. In short, caps are regressive and disproportional, transferring welfare from seriously injured malpractice victims to all patients. Unfairness flags go up. Caps violate the cardinal principle of distributive justice.

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Reducing or eliminating recoveries for pain and suffering not only principally affects patients who are seriously injured by malpractice, but it disproportionately impacts several other patient subgroups. One such group is the young. Consider two people both of whom after malpractice reform have a leg amputated by mistake. One of them is 75 years old and the other is 6 years old. Both are limited to the same amount of damages for pain and suffering — \$250,000 in California. Yet the 6 year-old has many more years during which he will suffer from his loss (Rustad 1996).

Women also may be disproportionately disadvantaged by caps on pain and suffering, since for a variety of reasons (e.g., less earned income) they tend to recover less for economic harm than men (Koenig and Rustad 1995). Finally, caps especially target brain-damaged newborns and their families, since they receive among the largest awards for pain and suffering under the present system. Some reformers question whether these awards actually benefit the child, who may be severely incapacitated. But probate courts control expenditure from awards to these children, and

are supposed to ensure that the money is only used for their benefit.

The final proposal that would make it harder for injured patients to recover is to place *limits on attorneys' contingent fees*. Contingent fees can be as high as 40%, even if the case is resolved by early settlement, and if the plaintiff's recovery is large, the attorney ends up with a sizeable amount of money. This has led reformers to argue that limits on contingent fees are necessary in order to preserve awards for victims, correct the rules of the system so providers perceive them as fairer, help stabilize malpractice insurance premiums, and maintain patient access to medical services. These are all fair objectives. Lawyers counter that they need large fees in the most successful cases to offset the costs of investigating claims to determine if they are meritorious, of pursuing meritorious but ultimately unsuccessful suits, and of taking on clients with less severe injuries. On the one hand, fee restrictions may seem fairer than caps, since those who lose from reform are patients with either less severe injuries or less clear-cut cases on the merits. On the other hand, smaller injuries can still significantly disrupt a victim's life, and under a fair malpractice system all victims are entitled to representation if necessary to obtain compensation.

The last three reform proposals – shortening the statute of limitations, caps, and limits on contingent fees – together with repeal of the collateral source rule, form the cornerstone of the reform package adopted in California in 1975, known as MICRA (for “Medical Injury Compensation Reform Act”) (California Civil Code §3333.2). MICRA caps pain and suffering damages at \$250,000, a level that, despite inflation, has remained unchanged since the law was enacted. MICRA is also the blueprint for President Bush's medical malpractice reform initiative (Stolberg 2003).

Systemic Changes

The foregoing reform proposals retain the core elements of the current tort sys-

tem: liability based on causing negligent injury to patients, with causation, negligence, and the severity of injury determined case-by-case through adversarial proceedings in court, and with the facts of the cases usually decided by juries. This section analyzes reforms that alter one or more of these core features.

One of these proposals, sometimes called *medical courts*, is aimed at improving the validity and predictability of compensation decisions by having malpractice cases decided by groups of medically trained experts. A variant of this approach, put forward by the American Medical Association in the 1980's, would have used bodies of expert administrators (AMA 1988). If it reduced the need for expert testimony, this type of reform also could decrease transactions costs. There is said to be precedent for this in the tax, admiralty, and patent courts, but in each of these examples the training of the decision-makers does not align them with one party or another. Injured patients are unlikely to feel that expert medical decision-makers are neutral and impartial, and therefore will tend to regard the process as unfair.

Another proposal is to use *alternative dispute resolution* (ADR) procedures to resolve claims. As discussed above, this approach is unfair if it is forced on patients and either is binding or influences subsequent judicial proceedings (e.g., if the ADR result can be introduced into evidence). But what if patients are given a choice between the current tort system (or some alternative) and ADR, and choose ADR? In other words, should the parties be allowed to select the manner in which they prefer to resolve disputes by *private contracting*. This is still likely to be unfair to patients, who typically lack equal bargaining power with providers, and who cannot expect third parties like employers or health insurers to fully represent them in negotiations.

One reform proposal would eliminate the need to prove the provider's fault on a case-by-case basis, relying instead on a pre-established *schedule of compensable events*.

This would be a list of provider behaviors or patient outcomes which, in the opinion of experts, were sufficiently likely to have been caused by provider negligence that they merited compensation. The list might be thought of as a compendium of *res ipsa loquitur* injuries. The list could be combined with a compensation schedule, or the severity of injury and/or amount of compensation could be decided on a case-by-case basis.

An advantage of scheduling compensable events is that it would save transactions costs, and therefore might stabilize premiums and help maintain access to care. Scheduling also would increase the consistency and predictability of compensation decisions. If the list were constructed carefully enough, it might even improve validity, although some might object that case-by-case determinations can more accurately consider the specific facts of each case. The real question is how much easier this approach would make it for patients to recover. If it became much easier, the total cost of compensation could skyrocket. This might lead to calls to impose caps on damages, or to apply a compensation schedule that deliberately paid less than what successful claimants could expect to receive under the tort system.

How unfair would this be? Severely injured patients who would have recovered large amounts of compensation under the tort system would receive less, but their recovery might be more certain because they would no longer need to prove negligence. Patients with less severe injuries or those with less clear-cut proof of negligence who would have received nothing in litigation would benefit from compensable event schedules. Right at the margin, this seems fair, since patients who recover nothing under the present system may be regarded as even worse off than patients with slightly more severe injuries who do recover. But the farther one traveled from the margin, the less fair the reform would become, since patients with increasingly severe injuries would recover less in order to permit patients with decreasingly severe injuries to recover something.

At the margin, compensable event schedules seem fair, since patients who recover nothing under the present system are worse off than patients with slightly more severe injuries who do recover. But the farther one traveled from the margin, the less fair the reform would become, since patients with increasingly severe injuries would recover less in order to permit patients with decreasingly severe injuries to recover something.

A schedule of compensable events could be combined with the tort system and form the basis of an *early-offer* approach. This proposal would encourage providers to offer to settle meritorious claims quickly by giving them some quid pro quo, such as by penalizing claimants who reject the offers, proceed with litigation, and ultimately are awarded less than the amount of the offer (O’Connell 1982). The early-offer approach also can be implemented without using a schedule of early-offer events, in which case it resembles a formalized settlement scheme with sanctions. Early-offer advocates often urge limiting or denying recovery for pain and suffering if an offer is made, either because they feel that these damages are illegitimate, or because they feel that claimants can be made equally well-off by receiving compensation quickly. The harsher the penalties for rejecting early offers,

and the tighter the association between early offers and damage caps, the more coercive and unfair the proposals become.

So far we have been considering systemic reforms that retain proof of provider fault as one of the prerequisites for compensation. Another set of reform proposals, called

no-fault, would do away with the fault requirement altogether. Instead, they would compensate anyone whose injuries had been caused by medical care, or, to avoid covering injuries like unexpected side effects of treatment, only patients whose injuries were “avoidable.” A number of variations of no-fault have been proposed over the years. One version was put forth in the early 1990’s by a group of experts at Harvard (Johnson et al. 1992; (Weiler 1993; President and Fellows of Harvard 1990). A more recent proposal is by Studdert and Brennan (Studdert and Brennan 2001). The most ambitious variations would employ administrative procedures, including schedules of compensable injuries and damages, which would eliminate the need for fact-finding through the judicial process.

No-fault would correct a major unfairness in the tort system by compensating injured patients even when, from a societal standpoint, the provider behavior that caused their injuries was efficient.... In order to be affordable, however, most no-fault proposals acknowledge that compensation would have to be severely limited.

As discussed earlier, no-fault would correct a major unfairness in the tort system by compensating injured patients even when, from a societal standpoint, the provider behavior that caused their injuries was efficient. Moreover, as with other approaches that employ schedules, if the schedules were prepared carefully enough, no-fault could increase the validity, consistency and predictability of compensation decisions. But no-fault runs into a serious problem. By making it easier for injured patients to recover, and by extending compensation to those who are injured without fault, no-fault risks dramatically increasing the number of paid claims. In terms of fair-

ness, this is commendable. But the cost of the system could be prohibitive. One analysis of the cost of the original Harvard proposal estimated that it could add as much as \$500 million to \$1.5 billion per year to the cost of the current malpractice system, which the Harvard researchers estimated at \$1 billion (Mehlman 1991).

In order to be affordable, most no-fault proposals acknowledge that compensation would have to be severely limited. Studdert and Brennan point to “injury thresholds” as one way of accomplishing this, under which only more serious injuries, such as those that result in minimum hospital stays of between 10 and 14 days, would be compensable (Studdert and Brennan 2001). This was also a feature of the original Harvard proposal. In a 1997 article entitled “Can the United States Afford a No-Fault System of Compensation for Medical Injury,” Studdert and his colleagues answered “yes,” but only with a \$250,000 limit on pain and suffering. Utah, one of two states that was considering implementing a no-fault demonstration project, would only have compensated injuries that resulted in disability lasting 4 weeks or more, would have placed a \$100,000 cap on pain-and-suffering damages, and would have paid only 66 percent of lost wages (Studdert et al. 1997). The good news was that approximately twice as many injured patients would have been compensated. The bad news was that seriously-injured patients would have recovered far less than under the current system.

If a no-fault approach were adopted, the tort system could be replaced with a *workers compensation-type system*, in which claims were resolved by an administrative body that merely had to confirm that the claimant was injured as the result of medical care and determine the severity of the claimant’s injuries. Like scheduling compensable events alone, a workers compensation system most likely would reduce transactions costs, stabilize premiums, help maintain access to care, and increase the consistency and predictability of compensation decisions. As noted, however, so many more patients might become

eligible to recover that the only way to hold costs down to manageable levels would be to severely restrict compensation for each case. Workers compensation, for example, trades lower transactions costs and greater certainty of recovery for far less compensation than workers would receive if they were permitted to sue employers under the tort system. Those who favor this approach often point to its historical acceptance by workers. But the workers compensation program did not replace a system of recovery in which more seriously injured workers generally received larger amounts of compensation. Before workers compensation was adopted, technical rules of tort law made it almost impossible for injured workers to recover anything. In short, workers compensation made all injured workers better off. For medical malpractice injuries, however, a movement from a tort to a capped workers compensation system raises serious fairness concerns.

No-fault has been instituted in two states for a small subset of medical malpractice cases. These are the *birth-related injury compensation programs* adopted in Virginia and Florida in the late 1980's. Only a narrowly defined group of injuries is compensable under these programs. The Virginia program, for example, only extends to infants whose spinal cords or brains are injured as a result of oxygen deprivation or mechanical injury during labor, delivery, or resuscitation, and who are left permanently and severely disabled (Va. Code Ann. 38.2-5001). Compensation also is strictly limited. Virginia pays for lost future earnings at 50 percent of the average wage level in the state; Florida pays nothing for lost wages. Neither program provides compensation for pain and suffering, although Florida does provide up to \$100,000 to parents for their non-economic losses. Nevertheless, Bovbjerg and his colleagues maintain that compensation is comparable to what claimants would have received through the torts process, (Bovbjerg et al. 1997), largely due to much lower attorneys fees. Participation by providers is voluntary, and both programs are financed by modest surcharges on participating physicians and hospitals.

The enabling statutes require that patients be notified in advance whether the provider is participating or not, but adequate notice may not always be provided, and since virtually all eligible providers have chosen to participate, patients are unlike to have any practical alternative (Bovbjerg and Sloan 1998),

The Florida and Virginia birth-related injury compensation programs are noteworthy for one other reason. They were enacted in response to concerns that patients were in danger of losing access to obstetric care. Rather than adopting reforms that affected the entire malpractice system, Florida and Virginia narrowly targeted the specific threat. This same approach might be employed in the current crisis. If access is primarily a problem for patients in rural areas and those in need of certain types of high-risk specialty care, such as obstetrics or orthopedic surgery, then perhaps reforms that limit compensation should be imposed on those patients alone. It would be fairer, of course, to spread the costs of maintaining access for these patients to all patients or taxpayers. But that is not accom-

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plished by limiting compensation for all severely injured patients.

A final systemic reform is the *Institute of Medicine proposal*, made recently in its report “Fostering Rapid Advances in Health Care” (Institute of Medicine 2002). This proposal, which is called “Provider-Based Early Payments,” combines many of the features of the foregoing alternatives. It is an “early-offer” approach that would allow participating institutional providers and their affiliated

physicians to avoid tort liability by promptly notifying patients that they have suffered an avoidable scheduled injury, apologizing, and offering to pay scheduled amounts of compensation for economic losses not reimbursed by collateral sources, along with capped, scheduled payments for pain and suffering. Patients would be required to accept these offers, but the proposal contemplates that states might give patients the choice to opt out of the program when they enroll in a health insurance plan or are admitted to a participating hospital. All avoidable injuries would be compensable, not just those caused by fault, so this proposal is a form of no-fault. A key objective of the proposal is to encourage providers to alert patients that they have suffered an avoidable injury rather than waiting for the patients to discover the problem themselves. Avoidable injuries would also be reported to state officials, who would implement oversight programs to prevent future systems failure. Another key feature is that this would be a demonstration project, and would be evaluated after a certain amount of time to ascertain if it had accomplished its goals.

The IOM proposal is ambitious. It would expand the class of compensable events to include avoidable injuries that were not caused by fault, thereby permitting more injured patients to receive compensation. It would de-emphasize the punishment objective of the tort system by protecting providers who admitted errors, and would concentrate instead on preventing future injuries at the systems level. The use of scheduled compensable events and compensation amounts would promote the validity, consistency, and predictability of compensation decisions. The proposal also would promote better patient-provider relationships by encourage encouraging providers to apologize to the patients whom they injured. All of these seem like fair, indeed praiseworthy objectives.

Nevertheless, the proposal raises two main fairness concerns. The first is whether, as in the case of other no-fault proposals, the amount of compensation that patients would receive would have to be so limited that it was neither fair nor proportional for more seri-

One of the strengths of the IOM proposal is that it is mindful of the need for fairness.

ous injuries. The IOM publication itself merely speaks in terms of scheduling the amounts and capping damages “at reasonable levels.” Is that the MICRA cap of \$250,000, or a fairer schedule based on average jury awards in states without caps?

The second problem relates to the potentially coercive nature of the proposal. Unless patients were given a meaningful opportunity to remain within the tort system, they might feel that they were being forced into a regime that was governed by unacceptable rules and in which decisions were made by biased decision-makers. While these are serious concerns, it is important to note that they will not necessarily materialize. One of the strengths of the IOM proposal is that, at least in its present preliminary form, it is mindful of the need for fairness and acknowledges that these concerns have to be addressed.

The Fairness of the Reform Process Itself

This brings up the final dimension of fairness: How can malpractice reforms be fairly adopted? Reformers propose to change the malpractice system through legislation, leaving courts – chiefly, state supreme courts — to decide whether or not the legislatures have remained within their constitutional bounds. Given the tenets of representative democracy, the legislative process would seem to be a fair way to accomplish social change. But the legislative process has been criticized from all points of the political spectrum. Judge Frank Easterbrook, for example, argues from public choice theory that, “[a]lthough legislators have individual lists of desires, priorities, and preferences, it turns out to be difficult, sometimes impossible, to aggregate these lists into a coherent collective choice” (Easterbrook 1983). E. E. Schattschneider calls the American political system “the largest, most broadly based, ruling oligarchy in the world” (Schattschneider 1975). As one law professor states: “The representative process tends to degenerate into a bewildering political marketplace dominated by factions about which Madison warned the nation in her crib. Effective political accountability is owed primarily to the diligent, the organized, the historically dominant, and the well-heeled” (Yackle 1989). The same criticisms apply even more strongly to judicial decisions made by appointed state supreme court justices. As for elected justices, in the words of one commentator, “lack of information about judicial candidates has seriously complicated the connection between voter preferences and judicial candidates’ positions” (Croley 1995).

If the fairness of legislative and judicial processes cannot be presumed, then how can it be assessed? These processes certainly do not resemble prevailing philosophical norms of fair society. According to Rawls’ veil-of-ignorance heuristic, fair rules are those that a rational group of self-interested individuals would adopt if they did not know what position they would occupy in society (Rawls 1971). In other words, we should adopt the malpractice reforms that a society would adopt if those making the choices did not know

whether they would be patients, injured patients, physicians, physicians who injured patients, wealthy, poor, and so on. A less altruistic version of this principle is that those who make the rules should be required to live by them. Unfortunately, neither of these formulations necessarily applies to judges and legislatures.

Another approach might be to borrow from the jurisprudence of due process and deem a process to be fair if the relevant stakeholders are given a meaningful opportunity to be heard. Strictly speaking, constitutional requirements of due process do not apply to legislation. As the Supreme Court has stated: “General statutes within the state power are passed that affect the person or property of individuals, sometimes to the point of ruin, without giving them a chance to be heard” (*Bi-Metallic Investment Co. v. State Board of Equalization* 1915). But from the standpoint of fairness, it seems reasonable that a legislative or judicial process should consider the views and the interests of the relevant stakeholders: patients, potential patients, and providers.

Surveying these stakeholder groups is difficult because they are not homogeneous. Malpractice reform must consider the secondary impact on family practitioners as well as on doctors in high-risk specialties (and, for that matter, on doctors who commit malpractice as well as on those who do not). So too there are different types of patients: patients who are injured by malpractice and those who are not, severely injured and less severely injured victims, victims with different ratios of economic to non-economic loss, unemployed patients and patients with high-paying jobs, patients with and without health insurance, etc. These patients may not have the same interests. For example, a malpractice victim who was a homemaker, and therefore in most states entitled to little or no compensation for lost wages, might be less in favor of a reform that limited non-economic damages than a victim who worked outside the home. To be fair, the process of reform should be attentive to all of these perspectives.

The question then becomes whether the views of these stakeholders have been heard in the debate over malpractice reform. There is reason to doubt that this is the case. In the first place, there is no “American Patients’ Organization” to rival the A.M.A., no “Association of Patients of America” to match the Association of Trial Lawyers of America, no umbrella organization of patients to step forward alongside the trade associations of the malpractice insurance industry. The closest things to patients’ organizations are general interest groups like Public Citizen. While these entities have been vocal in the debate over malpractice reform, they are non-profit corporations beholden to their boards of directors and their donors, rather than, in any direct manner, to patients (Health Research Group v. Kennedy 1979; National Nominating Board 2002). Moreover, it is difficult even for a group that purports to represent patient interests in general to give voice to the diverse views of the different types of patients mentioned above. These same limitations apply to professional interest groups that portray themselves as proxies for patient interests, like physicians’ or trial lawyers’ organizations.

One potentially useful method for identifying and articulating the views and interests of patient stakeholders is surveying public opinion directly. While medical organiza-

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tions have conducted numerous surveys of physicians, there has been surprising little effort to obtain the views of patients. One exception is the survey released in October 2002 by the Project on Medical Liability in Pennsylvania of the Pew Charitable Trusts, of which this paper is a product (Pew Project on Medical Liability in Pennsylvania 2002). In addition to survey-

ing owners and managers of small businesses in Pennsylvania, the study interviewed over a thousand individuals about their views toward medical malpractice and the malpractice system. Results were stratified according to a number of variables, including whether someone in the respondent's household had been a victim of malpractice, in order to provide some indication of the views of discrete patient subgroups. If patient views truly are to be considered during the reform process, much more work along these lines is needed.

The reform process is sometimes conducted through deliberate trial-and-error.

Experimentation seems like a good way to identify and test solutions to the malpractice crisis...But in order to be procedurally fair, experimentation has to be properly designed and carried out.

The idea is to experiment with different types of reforms to determine which work best. Beginning in 1994, the Robert Wood Johnson Foundation funded a program called "Improving Malpractice Prevention and Compensation Systems" (IMPACS) to design and implement malpractice reform experiments at the state level (Cantor et al. 1997). Among other things, this effort generated proposals for pilot no-fault programs in Utah and Colorado, although neither pro-

gram ultimately was adopted. Interest in reform experiments has been revived by the recent Institute of Medicine report calling for "state-level demonstrations" that will "offer an opportunity to experiment with alternative models to the current judicial system" (IOM 2002).

Social experimentation of this sort seems like a good way to identify and test solutions to the malpractice crisis. Major changes in federal health policy, such as the prospective payment system for Medicare, have been adopted after successful trial runs in the

states. This is especially important for malpractice reform because many of the reforms enacted during previous malpractice crisis have not been shown to stabilize malpractice premiums, one of the reformers' main goals (Office of Technology Assessment 1993). But in order to be procedurally fair, experimentation has to be properly designed and carried out. For one thing, there need to be appropriate, clearly identified measures of success or failure. In terms of malpractice reform, this must include the impact of the test reforms not only on malpractice premiums, but also on the welfare of the ultimate stakeholders. Furthermore, since they are studies involving human subjects, these experiments should obtain the informed consent of participants, (Rosenbaum 1992), and persons unwilling to participate should be able to opt out and remain covered by the existing malpractice system. Finally, experimentation must not be a subterfuge for more permanent reform, a way of slipping through objectionable changes to the malpractice system on the premise that they are temporary. Reform experiments should include automatic termination dates, with continuation of the programs, either as an extension of an experiment or as final policy, contingent on affirmative action by the legislature.

Conclusion: Fairness Trade-Offs

Fair compensation and fewer medical errors are not the only objectives of the malpractice system, as noted at the outset. It is also vital to maintain patient access to health care, an economically viable health care sector, and a sustainable malpractice financing system. These objectives are in tension. A system that pays optimally fair compensation may be unaffordable, both because of the amount of the compensation itself and the expense of providing the parties with fully fair procedures. Even if the resources somehow could be found, they may be better spent providing the population with necessary medical services. This bears repeating: At some point, even severely injured patients

At some point, even severely injured patients would lose more by being denied access to health care than by not being fairly compensated for their injuries.

would lose more by being denied access to health care than by not being fairly compensated for their injuries.

The chief adversary of fairness might seem to be efficiency. Consistency and proportionality, for example, require consideration of the specific facts of a case, and case-by-case determinations require more time and effort. But efficiency also is an indicator of fairness. For example, a sys-

tem that wasted resources or did not pay compensation in a timely manner would not be fair. In short, the relationship between procedural fairness and efficiency is a balancing act.

It is beyond the scope of this paper to determine how this balance should be achieved. What is important is to acknowledge the characteristics of fairness, identify the mechanisms that enhance or detract from fairness, and recognize the need to place a value on these effects so that they can be weighed against each other. As suggested in the previ-

ous section, one way to do this fairly is to experiment with different approaches and measure their impact on various fairness criteria. Only in this way will we be able to gauge whether objectives achieved at the expense of fairness are worth the price.

A final consideration is the fairness of focusing exclusively on medical malpractice, rather than on the tort system generally. On the one hand, it seems unfair to change the rules for one class of victims – those suffering malpractice-related injuries – while permitting other tort claimants to remain in the established system. Why should someone whose leg is mistakenly amputated, for example, get less than someone who loses a leg being run over by a negligent motorist? On the other hand, health and access to the services that sustain it are such critical needs that they can be said to merit special attention. In paying them this attention, however, we must strive to make the malpractice system as fair as it can be.

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Design and Typography:

Ismael Valentín

Printing:

Columbia University Printing Services

About the Project

The Project on Medical Liability in Pennsylvania (www.medliabilitypa.org) is a two-year program of research, consultation, and communication funded by The Pew Charitable Trusts that seeks to provide decision-makers with objective information about the ways in which medical, legal, and insurance-related issues affect the medical liability system, to broaden participation in the debate to include new constituencies and perspectives, and to focus attention on the relationship between medical liability and the overall health and prosperity of the Commonwealth.

The Pew Charitable Trusts (www.pewtrusts.com) support nonprofit activities in the areas of culture, education, the environment, health and human services, public policy and religion. Based in Philadelphia, with an office in Washington, D.C., the Trusts make strategic investments to help organizations and citizens develop practical solutions to difficult problems. In 2002, with approximately \$3.8 billion in assets, the Trusts committed over \$166 million to 287 nonprofit organizations.

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