No Fault in Lieu of Medical Malpractice[1]

The tort system has been widely criticized as an inefficient, unfair, and costly method for addressing personal injury claims generally, and especially in the medical malpractice arena. In particular, critics charge that the tort system "falls short of achieving its two main goals: compensation and deterrence" in medical cases.[2] Empirical evidence suggests that in medical malpractice cases, the tort system "gets it wrong" about 25% of the time, either by compensating for non-meritorious claims or by not compensating for meritorious claims.[3] Others note that relative to the rate of medical error, more problematic deficiencies of the tort compensation system are that too many medical errors go unreported, uncompensated, and undeterred.[4]

A further criticism of the tort system is that it is an expensive method to resolve claims. Indisputably, litigation is financially costly, but that is not all. As one commentator observed:

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[1] H. Ramsey Ross & Hazel G. Beh (2009).

[2] Gil Siegal, Michelle M. Mello, & David M. Studdert, Adjudicating Severe Birth Claims in Florida and Virginia: The Experience of a Landmark Experiment in Personal Injury Compensation, 34 AM. J. L. & MED. 493 (2008).

[3] See David M. Studdert & Michelle M. Mello, when Tort Resolutions Are "Wrong": Predictors of Discordant Outcomes in Medical Malpractice Litigation, 36 J. LEGAL STUD. S47 (2007) (examining 1452 closed malpractice cases and concluding that discordant outcomes occur in 25% of cases.)

[4] See, e.g., Institute of Medicine, To Err Is Human: Building a Safer Health System (Linda T. Kohn, et al. eds., 1999) (examining rate of medical errors). Of the Harvard Medical Practice Study, Tom Baker has commented:

> Over fifteen years after first reporting to the State of New York, the Harvard Medical Practice Study (HMPS) continues to have a significant impact in medical malpractice policy debates. In those debates the HMPS has come to stand for four main propositions. First, "medical injury ... accounts for more deaths than all other kinds of accidents combined" and "more than a quarter of those were caused by substandard care." Second, the vast majority of people who are injured as result of substandard care do not file a claim. Third, "a substantial majority of malpractice claims filed are not based on provider carelessness or even iatrogenic injury." Fourth, "whether negligence or a medical injury had occurred ... bore little relation to the outcome of the claims."

Tom Baker, Reconsidering the Harvard Medical Practice Study Conclusions About the Validity of Medical Malpractice Claims, 33 J.L. MED. & ETHICS 501 (2005).

> The cost of resolving a medical malpractice dispute, which may be measured in terms of transaction costs, parties' overall satisfaction with the resolution process, the effect on the doctor-patient relationship, and the finality of the resolution, is very high in litigation. Transaction costs include attorneys' fees, time lost, and emotions spent. Both doctors and patients suffer high transaction costs in medical malpractice litigation.[5]

All of these costs undermine confidence in the justice system.

Perhaps the greatest flaw of the tort system is that it is ineffective at stimulating systemic improvements in health care safety. Most medical errors are causally complex, and involve both individual and system factors. Mello and Studdert summarized empirical findings in a study of 1452 closed malpractice cases and concluded:

> Health care systems, hospitals and other large entities through which care is delivered are directly implicated in the majority of harmful medical errors. Measures designed and implemented at the institutional level represent our best shot at reducing the frequency of those errors. Such measures are probably also our best shot at curbing the residual burden of harmful errors --- those to which institutions are peripheral or non-contributors. However, neither plaintiffs nor the tort system see this easily. Information problems, tort doctrine, and litigation dynamics make them quite insensitive to the nuances of the injury causality. The result is a mis-targeting of the deterrent signal and a lost opportunity to use the legal system to improve patient safety.[6]

Amid these and other criticisms of the tort system,[7] policymakers have long searched for reforms that can better achieve just results in individual cases with fewer associated costs, while also achieving societal aims, including improving patient safety.

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[5] Scott Forehand, Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice, 14 OHIO ST. J. ON DISP. RESOL. 907 (1999).

[6] Michelle M. Mello & David M. Studdert, Deconstructing Negligence: The Role of Individual and System Factors in Causing Medical Injuries, 96 GEO. L.J. 599, 620 (2008).

[7] The debate over tort reform involves many stakeholders. Insurers, physicians, patients, politicians, hospitals, and lawyers are only some of the stakeholders. The clamor for reform typical heats up when a perceived “medical malpractice crisis” is identified, usually because insurance premiums rise or insurance becomes less available. See Tom Baker, Medical Malpractice and the Insurance Underwriting Cycle, 54 DEPAUL L. REV. 393 (2005) (observing that stakeholders take political advantage of these crises without understanding the dynamic effect of the underwriting cycle on cost and availability of medical malpractice insurance).

Other Alternatives

Proponents of tort reform have proffered a number of modifications or alternatives to the current system aimed at reducing the amount of litigation or the amount of damages. The most common proposals are limiting noneconomic damages,[8] eliminating joint and several liability,[9] establishing alternative forums for pressing claims such as arbitration,[10] health courts,[11] or administrative fact-finders, and creating procedural hurdles designed to screen, reduce, or channel claims.[12] Hawai'i currently has implemented several tort reform measures in medical malpractice cases, including a cap on pain and suffering (but not other noneconomic damages),[13] a shortened statute of limitations,[14] and the Medical Claims Conciliation Panel (MCCP).[15]

"No Fault" in Lieu of Malpractice

"No fault" is another tort reform measure often proposed as a preferable to the current tort system that imposes liability based on negligence. Comprehensive proposals typically include other tort reform measures that reduce damages and promote efficient claims

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[8] See, Frank A. Sloan, et al., Effects of Tort Reforms On the Value of Closed Medical Malpractice Claims: A Microanalysis, 14 J. HEALTH POL. POL'Y & L. 663, 664 (1989).

[9] See Haw. Rev. Stat. § 663-10.5 (2009).

[10] See, Elizabeth Rolph et al., Arbitration Agreements in Health Care: Myths and Reality, 60 Law & Contemp. Probs. 153, 153-54 (Spring 1997).

[11] Michelle M. Mello et al., "Health Courts" and Accountability for Patient Safety. 84 MILBANK Q. 459, 468-71 (2006).

[12] Hawaii's Medical Claims Conciliation Panel (MCCP) requires litigants to first present their claims in a nonbinding alternative forum that encourages earlier and less costly resolution of claims. See Haw. Rev. Stat. § 671-12 (2007).

[13] Haw. Rev. Stat. § 663-8.7 (2009) (limiting pain and suffering to a maximum $375,000).

[14] Haw. Rev. Stat. § 657-7.3 (2007) limits application of the discovery rule and imposes an absolute statute of repose on medical tort claims.

[15] See Steven K. Idemoto, Medical Malpractice in Hawaii: Tort Crises or Crises of Medical Errors? 30 HAW. L. REV. 167 (2007) (providing a brief critique and analysis of Hawaii's current medical malpractice tort system and existing reforms) .

resolution. "No fault," as applied to medical malpractice claims is a misnomer. A true "no fault" system would remove any determination that a party was blameworthy and compensate based merely on the fact of injury. In the medical malpractice arena, no one suggests that all bad outcomes deserve compensation. Thus, however it is phrased, something iatrogenic must have occurred. The "no fault" system envisioned in medical cases would eliminate plaintiff's burden to prove negligence and instead would apply a legal standard such as avoidability, that sits somewhere between negligence and strict liability.[16] The trade-off for plaintiffs is that while their burden of proof would be lower and easier to establish, the potential awards would be smaller, more predictable, and more reasonable.

In the United States, we have extensive experience with "no fault" systems: workers' compensation,[17] minor automobile accident claims,[18] and childhood vaccination claims,[19] are a few of the notable ones.[20] Within the medical malpractice field, two initiatives are noteworthy. In the late 1980's, Florida and Virginia, established "no fault" systems to shore up and stabilize the availability of obstetrical services.[21] Both programs are limited to a narrow class of birth injuries. The approaches of Virginia and Florida have been termed "carve out" programs because they have removed a small but high cost area of medical malpractice from the tort system. Both of these programs move claims for compensation for birth injuries resulting in

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[16] David M. Studdert, Troyen A. Brennan, Toward a Workable Model of "No-Fault" Compensation For Medical Injury in the United States, 27 AM. J. L. & MED. 225 (2001).

[17] See 99 C.J.S. Workers' Compensation § 27 (2009). General description of workers' compensation schemes' replacement of tort liability for specific classes of injury cases originating in the workplace.

[18] See 7 Am. Jur. 2d Automobile Insurance § 34 (2009).

[19] The National Childhood Vaccine Injury Act. 42 U.S.C.A. § 300aa-1 (2009).

[20] Federal no-fault compensation programs also include the September 11th Victim Compensation Fund, the National Swine Flu Act, the Price-Anderson Act (to compensate for injuries and damages sustained by the public in the event of a nuclear accident); various federal employment based no-fault compensation programs (workers' compensation) include the Black Lung Benefits Act, and the Agent Orange Fund. See generally See Linda S. Mullenix & Kristen Steward, The September 11th Victim Compensation Fund: Fund Approaches to Resolving Mass Tort Litigation, 9 CONN. INS. L.J. 121-152 (2003).

[21] See Siegel, Mello & Studdert, supra note 1, at 498.

severe neurological impairments from state courts to administrative compensation panels, providing the benefit of immunity to doctors and hospitals from tort litigation.[22] In each system, decision makers are informed by neutral experts and cases are heard by administrative boards. [23]

The programs are similar primarily in that both programs require administrative adjudication of participants' claims, establish strict threshold medical criteria, provide claim review and recommendations by a panel of neutral experts, create a rebuttable presumption of compensability,[24] and provide compensation for meritorious claims more efficiently and expediently than through tort litigation.[25] "Compensation is awarded based on the nature of the nature of the outcome and a finding that the outcome is causally linked to the birth process."[26]

Compensation is paid from the program funds acquired through assessments of medical providers, including hospitals, physicians, midwives, and insurers.[27] In theory, the programs make more payouts because the level of proof is less, but the program costs less to operate and the payouts are smaller. Both programs allow awards for reasonable and necessary medical expenses, lump sum death benefits, and reasonable legal fees.[28]

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[22] Id. at 496-98. See Va. Code Ann, § 38.2-5000 (2008); Fla. Stat. § 766 (2008).

[23] See Siegel, Mello & Studdert, supra note 1, at 500-04.

[24] Id. at 497.

[25] Id. at 496.

[26] Id. at 497. Some commentators also argue that, "combining an avoidability standard with an administrative compensation process holds promise not only for expanding the availability of compensation, reducing overhead costs, and making the overall cost of the medical liability system more predictable, but also for reinforcing the system's deterrence function by incentivizing providers to move towards optimal systems of care."

[27] Id. at 502. The Florida program also assesses non-participating physicians. Id. at 503.

[28] Id at 535.

Allowable damages differ in two significant ways. First, Florida allows a one-time family benefit, up to $100,000, while Virginia awards lost earnings for the age 18 to 65. Second, the Florida program pays a death benefit of $10,000, while Virginia pays up to $100,000.[29]

Florida's program is reportedly financially stable; Virginia's is reportedly unsound. Three possible factors that help Florida are it had an initial $20 million appropriation, it is less generous, and it has a lower rate of accepted cases.[30]

Other Reform Ideas

More global reform ideas have been studied and proposed from time-to-time that principally involve 1) reducing the plaintiff's burden of proof from negligence to avoidability; 2) taking the claims out of the judicial system and locating them in an administrative or health court; and 3) instituting special procedural and substantive reforms to contain costs.[31]

Another proposal that has garnered some attention is called "early offer." Under these proposals, a voluntary program is enabled by statute. After a medical injury a physician would be allowed to promptly make an offer of periodic payments for net wage and medical losses (essentially providing benefits similar to a disability insurance policy), and a small amount of attorney's fees, shortly after the medical misadventure (perhaps 180 days). If the plaintiff declines the offer and proceeds to file a lawsuit, the plaintiff would have a higher burden of proof imposed at trial.[32] These proposals essentially incentivize prompt and informal resolution. They also have the advantage of promoting voluntary acknowledgement of injury and opening the door for the possibility of apology and reconciliation.

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[29] Id.

[30] Id. at 535-37. As of 2008 Florida's case acceptance rate was 36% versus Virginia's 70%. Both programs had paid out approximately $74 million despite Florida having adjudicated 636 cases versus Virginia's 192.

[31] See Paul Barringer, et al., Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again, 33 J. HEALTH POL. POL'Y & L. 725 (2008) (describing various proposals and studies at federal and state levels since the 1980's).

[32] The Synergy of Early Offers and medical Explanations, 103 NW. U. L. REV. 514 (2009).

In order to promote deterrence, another suggestion has been to require hospitals to shoulder liability (enterprise liability) to a greater extent than the physician. The justifications for placing liability on the hospital are that errors are more likely the result of systemic failures that hospitals have the capacity to cure, including policing and weeding out physicians.[33] "Rather than shielding individual physicians from responsibility for errors, an enterprise liability system will strongly motivate hospitals and health systems to find ways to provide incentives for their affiliated physicians to improve the quality of care."[34]

Other reforms that are coupled with these proposals are mandatory injury reporting and other public disclosures. One particular concept that has gained attention is the notion that other aspects of justice can be built into an administrative system, including facilitating apology and reconciliation, aspects of justice that are overlooked in litigation.[35]

Hurdles in implementation

To be sure, legal challenges face any efforts at tort reform. When the state or federal government relegates medical cases to an alternative forum, eliminates the right to a jury trial, and reduces possible damages for particular claims, questions about constitutionality are inevitable.[36] Mello and others, evaluating potential constitutional challenges to administrative compensation systems, conclude that while health courts are constitutionally untested, if the there is a sufficient 'quid pro quo' in the design of these courts, so that what rights claimants lose are offset by benefits such as a lower standard of proof, efficiency, and access, that 'a carefully designed health court pilot could withstand constitutional scrutiny" in most states and

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[33] Barringer, supra note 34, at 747.

[34] Michelle Mello & Troyen Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 TEX. L. REV. 1595 1634-35 (2002).

[35] There has been much written about the value of early apologies and candor about injuries. See generally Jonathan Todres, Toward Healing and Restoration for All: Reframing Medical Malpractice Reform, 39 CONN. L. REV. 667 (2006).

[36] See Michelle Mello, et al., Policy Experimentation with Administrative Compensation for Medical Injury: Issues Under State Constitutional Law, 45 HARV. J. ON LEGIS. 59 (2008).

at the federal level.[37] Notably, voluntary alternative systems that ask patients to "opt in" and seek patient consent prior to participating, such as the Virginia and Florida birth injury programs, are not immune from constitutional challenges as well. However, again, when patients have adequate notice and meaningful choice, Mello believes that consent-based systems are likely constitutional as well.

Commentators weighing the likelihood that a no-fault system would be held constitutional conclude that beginning with a pilot project is prudent, "[C]lear enumeration of the program's anticipated benefits in the enabling legislation, and then rigorous evaluation of program outcomes after several years of operation, will help the legislature exhibit a rational basis to the courts when the inevitable constitutional challenges arise."[38]

In order to make these systems financially viable, most assume that the system would have to be a "secondary payer," in other words, a person's private health insurance (often from an employer-sponsored benefit plan), Medicare, and Medicaid would be primarily responsible for medical payments. Thus, any state legislation will have to carefully navigate a legal minefield, with regard to the subrogation rights of Medicare, and Medicaid[39] and conflicts with employer sponsored plans that are within ERISA's preemption provisions. To avoid these problems, commentators have suggested that, "Although the potential for such activity to interfere with compensation paid under the program may be mitigated by careful statutory construction, designers should pursue ERISA, Medicare, and Medicaid waivers."[40]

Comprehensive "No-Fault" in Other Countries

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[37] Id. E. Donald Elliott makes a similar conclusion under federal law, concluding "that a federal compensation system through administrative health courts should be constitutional provided the statute is appropriately drafted and that appropriate factual findings are made concerning the benefits to patients and the public as well as to doctors and their insurers." E. Donald Elliott et al., Administrative Health courts for medical Injury Claims: The Federal Constitutional Issues, 34 J. HEALTH POL. POL'Y & L. 761 (2008).

[38] Studdert & Brennan, supra note 16, at 252.

[39] Id.

[40] Id. at 252.

There are comprehensive "no fault" systems in existence, notably in New Zealand[41] and in the Scandinavian countries.[42] New Zealand has virtually transformed its entire tort system into a "no fault" system.[43] New Zealand's system has been successful, though it struggled in the area of medical malpractice mainly due to program expenditures outstripping funding.[44] New Zealand instituted a series of reforms in the 1990's, including requiring increased severity of the injury, shortening the time to bring a claim, eliminating lump sum payments for pain and suffering, and ultimately reintroducing an element of fault.[45]

Some have suggested that good model for the United States would be Sweden's where a fund to compensate for medical injury has been established, essentially through a flat per capita tax on medical care.[46] In Sweden, patients who have suffered a medical injury apply to receive compensation. The patient must establish that the injury was avoidable, and not that the physician was negligent. The compensation is coordinated with the patient's socialized health insurance, and so typically compensates for lost wages and pain and suffering not covered by health insurance.

Conclusion

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[41] See, Peter H. Schuck, Comparative Law & Policy Essay: Tort Reform, Kiwi-Style, 27 YALE L. & POL'Y REV. 187 (2008)

[42] David M. Studdert et al., Can the United States Afford a "No-fault" System of Compensation for Medical Injury?, 60 L. & CONTEMP. PROBS. 1, 33 (Spring 1997) ("We conclude that adoption of a Swedish-style approach could lead to a system that is both affordable and positioned to compensate a considerably larger proportion of medically injured patients than the current malpractice system manages or even allows.").

[43] Id.at 187.

[44] Id. at 191.

[45] Id. at 192. Recovery is allowed for "injuries resulting from medical error or mishap," with error approximating negligence, and mishap intended as no-fault for rare (less than 1%) and severe consequences of treatment. Id. Sweden and Denmark employ an avoidability standard in medical injury cases. Id.

[46] Patricia M. Danzon, The Swedish Compensation System, 15 J. LEG. MED. 199 (1994).

Impediments to establishing a compensation system that exists outside the tort arena are many. Factors explaining why health courts and no-fault systems have not gained necessary traction include the lack of political will and the lack of an overarching consensus among stakeholders on what really ails the current system and how it can be cured.[47]

Hawai‘i actually might be the right place to implement change. The MCCP process has been relatively well received by both the plaintiff and defense bar, and it is generally perceived as assisting in resolving cases without resorting to litigation.[48] MCCP facilitates informal conciliation through a nonbinding hearing, and must be attempted before a lawsuit is filed. While not all plaintiffs and defendants take the process seriously, most do and find it useful in learning about and evaluating the merits of the case. Legal practitioners estimate that fifty to sixty percent of cases that enter MCCP never result in a lawsuit, because the cases are either dropped or settled.

Familiarity with MCCP may allow stakeholders to find some common ground and to begin a conversation about administrative health courts generally. If stakeholders are able to identify particular benefits and palatable trade-offs, Hawai‘i could be a pathfinder in this arena.

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[47] Berringer and others explain in reviewing why past efforts failed, 1) health care providers, insurers, and attorneys do not “share a common view of the flaws of the existing liability system” and have “different visions for its future;” 2) “none of the stakeholder groups saw a shift … as offering them a significant advantage relative to the status quo;” 3) there is “no broad agreement” about what an alternative system “for medical injury should look like;” 4) these proposals “gain[] currency during … malpractice insurance crises” and proponents have not been adequately able “to capitalize on the atmosphere crisis “ to mobilize change. Id. at 744-745.

[48] See L. Richard Fried, Jr., A Claimant’s View of the Medical Claim conciliation Panel, 4-Aug. HAW. B.J. 4 (2000); Edmund Burke, Medical Claim Conciliation Panel – a Defense Perspective 11 (2000).