I. EXECUTIVE SUMMARY

This report evaluates a proposal to replace the current civil justice system for compensating patients who have been injured by medical malpractice with a system called "health courts," in which claims that were not settled in response to an apology and offer of settlement on behalf of providers would be adjudicated by medically-trained decision-makers employing pre-established guidelines and schedules.

The report concludes that the health court proposal is ill-conceived, that it would be unfair to patients, that it would be unlikely to achieve its objectives, and that such of its goals as are reasonable can be achieved more fairly and with greater efficiency under the existing civil justice system.

Specifically, the report makes the following findings:

1. **The "health court" concept is the latest in a series of proposals over the years to eliminate or drastically reduce the rights of injured patients in order to accomplish various goals.** The health court concept is still emerging, and its details are vague and sometimes inconsistent. (See Sections III & IV.) But the following appear to be its basic components:
   a. To create a new bureaucracy to adjudicate claims, staffed by medically-trained decision-makers and employing decision-aids created and maintained by the medical establishment.
   b. To deprive injured patients of their right to a jury trial and thus to eliminate problems thought to be associated with the use of juries.
   c. To provide an environment that would, it is thought, encourage providers to admit errors and encourage liability insurers to offer limited compensation to a limited class of injured patients.
   d. To discourage injured patients from obtaining legal representation and thus reduce recoveries by injured patients and, ostensibly, the administrative costs of the system.
   e. To deprive many patients injured by malpractice of the right to obtain legal redress by creating a tort immunity for smaller claims so that the costs of the new health court system will not explode.
   f. To compensate a larger number of injured patients but with smaller amounts of compensation than successful claimants would receive under the traditional system.
   g. To collect information for use in improving patient safety and providing greater guidance to practitioners about appropriate medical practices.
   h. To finance the new system with higher malpractice insurance premiums and funds diverted from health insurance (mostly paid by employers and employees) and public benefit systems (paid by taxpayers).

2. **The ostensible rationale for health courts—that the existing civil justice system does a poor job—is not supported by the data.** An extensive amount of empirical data is now available about the functioning of the medical malpractice system and has been carefully analyzed by independent scholars. These analyses show that:

   a. **The civil justice system does a good job of sorting valid from invalid medical malpractice claims.** Numerous studies have revealed a fairly consistent picture. As a mechanism for adjudicating claims, the malpractice system does remarkably well. With surprisingly small rates of error, it separates claims without merit from those with merit and compensates the latter. (See Section V.A.)

   b. **Frivolous lawsuits are not a serious problem.** The available empirical evidence shows that the great majority of malpractice claims are filed against doctors who made medical errors. In addition, the incentive structure for plaintiffs' attorneys assures careful screening of the merit of potential claims before filing. (See Section V.B.)

   c. **Plaintiffs attorneys do not refuse to settle cases.** The data show that an overwhelming majority of medical malpractice lawsuits are settled without trial. Moreover, in most medical malpractice cases that go to trial, the defendants make no settlement offers whatsoever. (See Section V.C.)

   d. **Juries are competent to decide medical malpractice cases.** There is no evidence that juries are incompetent to evaluate the kinds of evidence presented in malpractice cases, including the testimony of expert witnesses. Indeed, jury verdicts on liability are correlated with the judgment of neutral physicians asked to assess the same cases, and damage awards by juries are correlated with the severity of injury. Studies show that jurors, if anything, are predisposed to favor defendant physicians. (See Section V.D.)

   e. **The tort system is not causing serious problems of "defensive medicine" or lack of patient access to care.** Not only is the concept of defensive medicine ill-defined, but there are no reliable data showing that it occurs. Moreover, claims that the malpractice system is causing patients problems of access to care are unsupported. Shortages of doctors do occur but are explained by factors such as rapid population growth in particular parts of the country, a lack of health insurance, and long-standing efforts to restrict the supply of doctors. (See Section V.E.)

   f. **The malpractice system does not prevent the disclosure of errors.** There are no data showing that fear of litigation is driving error reporting underground. In fact, the evidence shows that error reporting does not increase when the risk of litigation is low. (See Section V.F.)

   g. **Weakening the tort system risks reducing, rather than improving, the quality of care.** The available data show that the civil justice system makes a positive contribution to patient safety. (See Section V.G.)

h. **The somewhat higher administrative costs of the malpractice system, as compared to other tort litigation, are largely due to uncertainy about what constitutes proper medical care.** Measures of the administrative efficiency of the malpractice system cited by health court proponents are misleading. The costs of the civil justice system are unfortunately high, but unsurprisingly so. This is due largely to the uncertainty among physicians about what constitutes proper medical care. (See Section V.H.)

i. **The cost of the medical malpractice system has little impact on the overall cost of health care, physician income, or fluctuations in malpractice premiums.** The costs of the malpractice system comprise less than half of one percent of total health care spending. Even the sharp increases in malpractice insurance premiums during the so-called malpractice insurance crises had only a small effect on overall physician income, and these crises were not caused by the malpractice system. (See Section V.I.)

3. **Health courts would not perform as well as proponents contend.** Health court advocates claim that health courts would yield substantial benefits to all parties. This is extremely unlikely.

a. **"Avoidability" holds little promise of being a better standard than "negligence."** Health court proponents propose to replace the negligence standard for defining compensable injuries with the standard of "avoidability." In fact, the avoidability standard is imprecise and is defined largely in terms of fault. (See Section VI.A.)

b. **The use of "accelerated compensation events" offers a false hope of scientific objectivity.** Health court proponents propose to create a list of scientifically and statistically valid "accelerated compensation events" (ACEs) to identify compensable claims. In fact, ACEs would be based ultimately on the opinions of a group of physicians, and the statistical standard underlying ACEs turns out to be nothing more than an arbitrary determination of probability by these physicians. (See Section VI.B.)

c. **Practice guidelines are of limited feasibility and usefulness.** Health court proponents' expectation that claims that were not covered by ACEs would be adjudicated with the use of practice guidelines is fanciful. As one of the leading health court proponents admits, "[w]e have yet to resolve basic issues such as which set of guidelines is the authoritative prescription for a particular medical problem, what procedures should be used to create guidelines, what institutions, goals, and values should drive their development, and how we can ensure that guidelines are disseminated and adopted by physicians. It would be foolhardy to make [clinical practice guidelines] the centerpiece of malpractice litigation before the science of creating and implementing them on a wide scale has fully evolved." (See Section VI.C.)

d. **It is unlikely that more patients would discover that they had suffered a compensable injury.** A central feature of health court proposals is that providers would disclose avoidable medical injuries to patients, apologize, and offer compensation. Disclosure is key to the professed goals of compensating more patients and improving patient safety. Yet health court proposals are devoid of effective incentives to induce providers to engage in this behavior. Moreover, a number of features of health courts would discourage disclosure, such as experience-rating malpractice insurance premiums. (See Section VI.D.)

e. **Physicians who committed errors would still have abundant reasons to fear that stigma and punishment would follow voluntary disclosure.** Not only is the avoidability standard essentially a fault standard in disguise, but the financial and regulatory pressures on hospitals and other institutions can be expected to lead them to take adverse personnel actions against professionals who acknowledge mistakes. (See Section VI.E.)

f. **There is no reason to believe that health courts would improve patient safety.** A health court system would reduce the deterrent effect of the civil justice system, for example, by withholding from regulatory bodies the identities of physicians who injured patients. Moreover, health court proponents do not provide any plausible reason why a health court system would be any better at identifying and preventing errors than the current system. (See Section VI.F.)

g. **Health courts would not reduce so-called "defensive medicine."** There is no reason to believe that ACEs, practice guidelines, or a database of health court decisions would provide more meaningful guidance to practitioners about what constitutes appropriate patient care than what could be available from records of jury verdicts, judgments, and settlements. (See Section VI.G.)

h. **Health courts would not prevent malpractice insurance "crises."** Health courts would do nothing to change the insurance industry practices that are responsible for periodic disruptions in the availability or affordability of medical malpractice insurance. In fact, a health court system might exacerbate the volatility of premiums by increasing them significantly in order to finance the new health court bureaucracy and increased compensation costs. (See Section VI.H.)

i. **A health court system would not be affordable without substantial increases in malpractice premiums or some mix of undesirable consequences.** By making it easier for patients to seek redress and liberalizing the standard for recovery, health courts as proposed have the potential dramatically to increase claim volume and total claim amounts. Health court proponents recognize that their proposals to allow offsets for compensation from collateral sources and to reduce administrative overhead, even if successful, would not prevent substantial rises in total direct system costs and malpractice premiums. Hence, their proposals would entail some combination of (1)

dramatic reductions in recoveries to levels well below actual losses, and (2) wholesale tort immunity for a large percentage of claims. (See Section VI.I.)

j. **The experience with other compensation systems does not demonstrate that health courts would work well.** Other compensation systems that proponents point to as evidence of the benefits of health courts, such as workers' compensation and foreign governments' administrative malpractice systems, do not incorporate all of the problematic features of health courts and do not work as well as proponents maintain. (See Section VI.J.)

4. **Not only would health courts not perform as well as proponents contend, but they would be unfair to patients.** The current malpractice system already disfavors claimants. A health court system would be even more unfair.

a. **Liability and compensation decisions would be made by decision-makers biased against patients.** Every aspect of health court adjudication would be controlled by medical or insurance interests, including the selection of judges and expert witnesses and the adoption of standards for liability and damages. At many points there is not even a pretense of even-handedness in the proposals. For example, while the fees for claimants' attorneys would be severely limited, defendants' legal expenditures would remain unconstrained. (See Section VII.A.)

b. **Providers and insurers would take advantage of patients to settle cases for too little.** It is clear from the models cited by health court proponents that disclosures and apologies would function as part of a system intended to discourage patients from obtaining legal advice and adequate compensation for their injuries. (See Section VII.B.)

c. **Successful health court claimants would be under-compensated.** In all likelihood, compensation for lost wages would be limited, there would be little compensation for pain and suffering, and successful claimants nevertheless would be expected to pay their attorneys on a contingent fee basis. Total compensation costs would be artificially suppressed, eliminating the linkage between harm done and compensation paid, in order to suit the preferences of those who would control the health court system. (See Section VII.C.)

d. **Statutory "deductibles" would unfairly limit access of injured patients to legal redress.** In order to keep costs from escalating, health courts would be limited by statutory tort immunities, misleadingly called "deductibles" by health care proponents, which would bar otherwise legitimate claims just because they were relatively small, without offering any alternative remedy. They also would arbitrarily limit the recoveries of those who could obtain redress within the health court system. (See Section VII.D.)

e. **Health courts would not adequately punish wrongdoers.** Unlike the current system, recoveries under a health court system would not vary according

to the degree of provider wrongdoing. A provider who committed an avoidable error would incur no greater liability if this were accompanied by a breach of fiduciary duty to a patient. Reporting to disciplinary bodies would be severely limited or nonexistent. (See Section VII.E.)

f. **Patients would be forced into a health court system without being given a meaningful choice.** Patients would not be given the choice of being covered under a health court approach or remaining within the civil justice system. In a demonstration project, patients at most would be given the option of switching to a provider that did not participate in the demonstration. As a practical matter, patients may not have the ability to change providers. On a more permanent basis, all providers would be likely to participate, eliminating patient choice completely. (See Section VII.F.)

5. **To the extent that health court proposals seek to achieve appropriate goals, these goals can be achieved more fairly and less expensively under the current system.**

a. **No rule of law prevents providers under the current system from disclosing errors and apologizing to patients.** An increasing number of health care providers are already adopting this approach, in recognition of their ethical obligations to their patients. (See Section VIII.A.)

b. **Nothing but perceived economic self-interest prevents providers and their insurers under the current system from compensating more malpractice victims at lower cost.** By disclosing errors and offering reasonable compensation to injured patients, providers could reduce the costs of paying claims. In place of an expansive new bureaucracy to handle all claims, an optional system could be created to compensate less severe cases. (See Section VIII..B.)

c. **The current system might be modified to give more specific guidance to juries and greater predictability to providers.** If appropriate compensation guidelines could be devised (a very big "if"), there is no reason why they could not be provided to help guide jurors under the current system. Similarly, if appropriate practice guidelines or "accelerated compensation events" (ACEs) could be developed, they could be used by practitioners and given some legal effect. In any event, reporting requirements for the National Practitioner Data Bank could be improved without the need to establish a new database. (See Section VIII.C.)

d. **The current system might be modified by adopting reasonable regulations relating to recoverable damages.** Changes suggested by health court proponents, such as periodic payment of damages, already have been implemented by many states. Although much depends on the details, these and other changes, if appropriate, could be made in the current system as well.

Again, a separate health court system is not necessary to do these things, if they have independent merit. (See Section VIII.D.)

e. **The current system's use of expert witnesses could be improved.** Courts could make greater use of court-appointed experts to supplement experts retained by the parties. This, and other procedural reforms, could ameliorate problems associated with "dueling experts" better than anything presented in health court proposals. (See Section VIII.E.)

f. **Under the current system, nothing prevents the use of information regarding errors to improve patient safety.** A standardized error reporting system could be established. Hospitals already have made significant progress in addressing errors. (See Section VIII.F.)

6. **The constitutionality of health courts is highly questionable.** Health courts violate the right to trial by jury found in the constitutions of 48 states, and, if enacted by Congress, the Seventh Amendment. Health courts deny patients their constitutional rights to open access to courts and to a remedy for their injuries. Health courts do not provide the same quid pro quo that courts have required to uphold the constitutionality of schemes like workers' compensation. Health courts may deny patients equal protection and due process of law. (See Section IX.)

Conclusion. Rather than seriously improving the quality of health care, health courts would create an expensive health court bureaucracy, dominated by the medical and insurance industries, which can be expected to drive down compensation awards to already under-compensated claimants. What we would get from health courts is very modest recoveries, well below full compensation for those who were compensated, including a substantial and unfair reduction in the compensation of those who would recover under the existing tort system; a statutory ban on claims by the vast majority of victims of malpractice; and a shift of significant portions of the burden of malpractice onto taxpayers and those who pay for private health care provision and disability insurance (especially employers and employees). In return for these unequivocally undesirable results, we are promised that there would be an increase in the number of patients who would receive at least some compensation, however minimal, but there are no good reasons to believe this would be so and good reasons to suspect it would not. If there were a substantial increase in the number of patients receiving more than nominal compensation, we could also expect increases in malpractice premiums and efforts to shift even greater portions of the burden of malpractice onto taxpayers, employers, and employees. This "improvement" would be purchased at the cost of blunting the deterrent effect that the tort system now provides. Health court proponents' attack upon the tort system is misguided and their proposal should be abandoned as bad public policy.