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A MOVE IN THE WRONG DIRECTION

Alternative compensation schemes: A radical move in the wrong direction

Administrative compensation schemes offer a radical alternative to our civil justice system by abolishing the right to access the courts in medical malpractice cases. The law requires that there be a fair trade-off before Constitutional rights may be satisfied by a substitute system. None of the proposals on the table approach a fair trade-off, but instead move in the wrong direction – extinguishing rights, shifting costs to taxpayers, and doing nothing to genuinely advance patient safety.

Not a fair trade-off for innocent patients and their families

Patients would bear the burden of proving fault. None of the proposals on the table are "no-fault." Patients harmed by medical error would not be guaranteed compensation. Instead, patients and their families would be required to prove an injury or death was caused by an "avoidable" medical error[1] to qualify for any compensation,[2] which is no easier than having to prove the error was caused by negligence in a court and has no advantage for patients.[3]

The process would be biased against patients. Hospitals or insurance adjusters[4] would get to decide if a patient would be compensated and in what amount,[5] rather than an impartial court or jury. Normal safeguards would not be guaranteed; patients would not be free to hire experts to prove fault, and legal precedent would be discarded. In such a setting, patients would not be able to identify the evidence that matters for their claim.

The process would intimidate patients and encourage acceptance of an early offer. Because of its sheer complexity, the "health courts" alternative envisioned[6] would intimidate patients from challenging the denial or amount of compensation. Indeed, cost savings could be achieved only if most patients take an early offer – otherwise, the elaborate process would not achieve speed or cost efficiency – two of the primary goals desired by proponents.[7]

Compensation would be rationed to reduce costs. To reduce costs for medical providers and their liability insurers – a critical goal[8] – not all injuries would be compensated, but only those caused by "avoidable" medical errors. That alone would diminish greatly the number of eligible patients. Any economic compensation would cover only out-of-pocket (net) losses for certain expenses, like lost wages and medical care,[9] and would be paid out periodically.[10] Compensation for pain and suffering arbitrarily would be fixed based on severity and age through a rigid "schedule" (*e.g.*, a set amount for a lost limb of an elderly patient) and *capped* so that it would not exceed that amount regardless of individual need or circumstances. A schedule calibrated to save costs and dispense one-size-fits-all compensation is offensive because it *discriminates most*

against severely injured and elderly patients – those who stand to lose the most. Indeed, many state courts have held that a cap on non-economic damages violates state constitutions.[11]

Patients may not be given a choice to participate. Proposals for "health courts" are vague. Yet virtually all states guarantee victims of negligence a right to access the courts. Before patients relinquish that right, they must be guaranteed a meaningful choice.[12] No system should compel patients to participate *before* an error occurs.[13]

Not a fair trade-off for taxpayers

Taxpayers would be paying for the negligence of medical providers. The costs of compensating medical errors would be shifted from negligent medical providers and their liability insurers to taxpayers and patients, their families and communities. State taxpayers would be burdened with paying for a multi-layered administrative process *in addition* to paying for their own state court system.[14] Costs would be shifted onto the backs of patients through caps on damages for the few who would qualify for compensation and by preventing the vast majority, who would not qualify under the restrictive new rules, from seeking any redress whatsoever. Some even advocate shifting more costs to taxpayers by denying Medicare and Medicaid their right to reimbursement for medical expenses when the patient receives payment on a liability claim.[15]

Not a fair trade-off for patient safety

Medical providers, like hospitals, would not be required to correct errors or make improvements to patient safety. Currently, malpractice cases provide a strong incentive to reduce medical errors. Under a "health courts" model, or similar administrative alternatives,[16] medical providers merely would be "encouraged" to correct errors or make systemic improvements, but would not be held accountable if they do not do so.[17] Similarly, negligent physicians would be shielded from discipline by state medical boards, even for repeated acts of negligence.[18] Without an enforceable commitment to put patient safety first, the rationale for replacing our civil justice system evaporates.[19] Given the disturbingly high incidence of medical errors that cause serious injury or death *each* year – estimated between 48,000 to 98,000 year – we cannot afford the luxury of just trusting medical providers to reduce errors as they see fit.[20] Medical providers must be held accountable for fixing serious errors that give rise to patient injury.

Not a fair trade-off for our constitutional rights

A *quid quo pro* is required before the right to a jury trial may be extinguished. As Chief Justice Rehnquist stated:

> *"the right of trial by jury in civil cases at common law is fundamental to out history and jurisprudence" and "was not guaranteed in order to facilitate prompt and accurate decisions of lawsuits."*[21]

Virtually every state constitution guarantees a right to a civil jury trial or access to the courts. Courts, therefore, have held that there must be a fair trade-off before an administrative forum can be substituted for it.[22] A fair trade-off may only exist if an individual no longer has to prove fault ("no-fault") to receive reasonable compensation – the *quid quo pro*. No proposals on the table come close to providing a "no-fault" substitute.[23] A constitutional guarantee may

not be extinguished merely for the sake of speed, predictability or cost controls.[24]

Principles for alternative dispute resolution

Alternatives to the civil justice system must follow fundamental principles:

Preserve Right to Jury Trial; Court Access. The right to a civil jury trial or access to the civil courts must be protected. Only if a "no-fault" alternative is created – *the quid pro quo* – may the right be abrogated. Otherwise, any waiver of rights may only be effective if patients make a knowing waiver, as described below.

Voluntary Choice. Any choice by the patient to forgo the traditional court system must be fully informed, made in writing, and made after the injury has occurred and the consequences of the medical error made known. Merely obtaining the patient's signature on a consent form at the time of visitation when service is rendered, or at the time coverage is elected, is insufficient to preserve the fundamental guarantee to access the courts.

Individualized Compensation for all Damages. The decision-maker must have the ability to consider the full impact of the injury on a patient's life and compensation. Compensation must be commensurate with all damages that patient has suffered – both economic and pain and suffering.

Fair and Impartial Process. Procedural safeguards must be provided for to ensure due process and impartial decisions. Patients should have the ability to hire experts, obtain and present evidence, and be informed beforehand of the evidentiary standards to be applied. Fact-finders and decision-makers must be selected in a manner that prevents any appearance of bias.

Genuine Improvements to Patient Safety. In exchange for an alternative scheme limiting liability, medical providers must be required to improve patient safety by correcting errors and by developing and implementing processes that reduce error rates – or be held accountable if they fail to do so. Negligent medical providers should not be shielded from discipline by state medical boards where serious injury occurs.

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[1] "Avoidable" error is loosely defined as an event that could be avoided if best practices were followed. ; Studdert, David, Thomas, Eric, Zbar, Brett, et al. "Can the United States afford a "no-fault" system of compensation for medical injury?" 60 Law & Contemp. Prob. (Spring 1997). 1-34, at 2. ("Can the U.S. Afford No-Fault"). The concept is taken from the Swedish model of compensating for medical errors, which operates in the context of one of the most generous and comprehensive social insurance systems in the world. Consequently, most of the cost of compensating victims under the program for economic losses is covered by Sweden's extensive social insurance system. Between 1975-1996, approximately 60 percent of the compensation paid was for pain and suffering (average about $6,500), as most of the economic losses were covered by Sweden's social insurance. "Can the U.S. Afford No-Fault" at 3, 10. We note, however, that even the Swedish model permits patients the choice to sue in court. "Can the U.S. Afford No-Fault" at 4, 10.

[2] For certain obvious errors, termed "accelerated compensation events" (ACEs), the harm would be presumed to have been caused by that event, and the patient apparently would not need to show fault. See, e.g., Mello, Michelle M., Studdert, David, Kachalia, Allen B. and Brennan, Troyen A. "Health Courts and Accountability for Patient Safety." *The Milbank Quarterly*. Vol. 84, No.3. November 3, 2006. at 7 ("Nov. 2006 Harvard Proposal"). To date, no list of ACEs has been publicly revealed, and it can be assumed that only glaring errors like wrong-site surgery will be included. For any injury where causation would be in any doubt, the patient would have to prove fault.

[3] "To obtain compensation, claimants must show that the injury would not have occurred if best practices

had been followed or an optimal system had been in place…." "Nov. 2006 Harvard Proposal" at 2. To prove an "avoidable" error (if not an ACE), a patient still would have to show that a standard of care was breached – here best practices or an "optimal" standard of care -- as opposed to a breach of the reasonable standard of care (the existing standard). In either circumstance, expert testimony would be needed. Moreover, there is absolutely no reason to believe that the optimal care/best practices standard would be any clearer, as proponents assert, than the current reasonable care standard, and every reason to believe it likely would be less clear, as it is a new and untested standard in the United States. Id. at 6.

[4] Some plans envision "experts" that would be appointed by a panel heavily weighted with health industry representatives. "Nov. 2006 Harvard Proposal" at 5-6.

[5] "Nov. 2006 Harvard Proposal" at 4.

[6] Id. at 4, Figure 1 ("Health Court Claims Process"). This diagram reveals a multi-step process with four levels of appeal – guaranteed to wear down most persons.

[7] Id. at 8-9. Yet, speed and reliability could only be gained where ACEs are involved.

[8] Id. at 9 ("the size of the award could be controlled").

[9] Economic damages also have eligibility thresholds, e.g., 4 week loss of work or $3,000 - $4,000 in out-of-pocket medical expenses. "Nov. 2006 Harvard Proposal" at 7. However, it is recognized that patients have Constitutional rights in almost all states, thus permitting them to sue in court if their injury fell below the monetary thresholds suggested. Id. One is left to wonder if errors would be revealed to patients in this situation, as doing so could result in tort suits despite the alternative administrative process.

[10] Damages also can be revisited in the future, subjecting patients to repeated hearings to establish continuing eligibility to compensation. "Nov. 2006 Harvard Proposal" at 6.

[11] At least 11 states have found damage caps and other restrictions on medical liability that are much less radical than "health courts" violate the state's constitutional right to jury. Kansas Malpractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988)(damage caps); Smith v. Dep't of Ins., 507 So.2d 1080 (Fl. 1987)(damage caps); Lucas v. U.S., 757 S.W. 2d 687 (Texas 1988)(damage caps); Knowles v. U.S., 544 N.W.2d 183 (S.D. 1995)(damage caps); Lakin v. Senco Products, 987 P.2d 463 (Ore. 1999)(damage caps); Moore v. Mobile Infirmary Assoc., 592 So.2d 156 (Ala. 1992)(damage caps); Sofie v. Fibreboard Corp., 771 P.2d 711 (Wash. 1989)(damage caps); Lloyd Noland Hosp. v. Durham, 2005 WL 32404 (Ala. 2005)(periodic payment schedules); Condemarin v. University Hosp., 775 P.2d 348, 357-60 (Utah 1989) (liability limit for state hospitals); Wright v. Central DuPage Hospital Assoc., 347 N.E. 2d 736 (Ill. 1976)(medical review panels); Boucher v. Sayeed, 459 A.2d 87, (R.I. 1983)(striking down Reform Act under EPC, but opining it likely would not pass muster under jury trial challenge); Duren v. Suburban Comm. Hosp., 495 N.E.2d 51 (Ohio 1985)(damage caps).

[12] Neither the constitution of Colorado or Louisiana guarantee a right to a civil jury trial to redress negligence, but both states have statutory provisions that provide for a right to access the courts.

[13] Under the Harvard proposal, patient notification would occur before any adverse event occurred (at time signed up for health coverage, on first contact, or whenever care sought). "Nov. 2006 Harvard Proposal" at 2.

[14] "Nov. 2006 Harvard Proposal" at 15 ("health courts are likely to be state enterprises').

[15] Studdert, Mello, et al and Common Good draft Health Court Proposal Skeleton, presented Oct. 17, 2005, at 7

[16] None of the pilot programs outlined in a Senate bill introduced in the 109th Congress by Senator Enzi require correction of medical errors by medical providers, but rather only require collection of data to be analyzed by organizations voluntarily. See S. 1337, Fair and Reliable Medical Justice Act (introduced June 29, 2005).

[17] Medical providers are merely "encouraged" to correct errors or to make systemic improvements to patient safety. "Nov. 2006 Harvard Proposal" at 16.

[18] Id.at 16-18 (advocating a firewall between medical disciplinary boards and the alternative health court system). While some argue that physicians will only admit errors if not threatened with discipline, under AMA ethics rules, physicians already are required to admit errors. See American Medical Association Code of Medical Ethics, E-8.12. Hospitals also are required to report errors to receive accreditation by the JCAHO, but reporting is low as there is the enforcement mechanism is weak. See JCAHO, Policies and Procedures, http://www.jointcommission.org/sentinelevents/policies and procedures.

[19] Patients are motivated to sue to hold negligent medical providers accountable and to ensure careless behavior is corrected so future patients won't suffer. See "Nov. 6, 2006 Harvard Proposal" at 9, citing to Hickson, G.B. et al., "Factors that Prompted Families to File Medical Malpractice Claims Following

Perinatal Injuries." Journal of the American Medical Association 1992 267: 1359-1363; see also Christopher, Frank (Executive Producer). (October 2006). "Remaking American Medicine: Silent Killer." Santa Barbara, California and Washington, D.C.: Public Broadcasting Service.

[20] In 1999, the Academy of Sciences, Institute of Medicine (IOM), found that medical errors, such as wrong-site surgery cause as many as 98,000 deaths each year. Kohn, Linda T., Corrigan, Janet, M., and Donaldson, Molla S. To Err is Human: Building a Safer Health System. Washington D.C.: National Academy of Sciences: 2000. A whopping $3.5 billion is spent every year to treat patients injured by medication-related errors alone. See National Academies, "*Medication error injures 1.5 million people and costs billions annually*" at http://wans.nationalacademies.org.

[21] Parklane Hoisery Co., Inc. v. Shore, 439 U.S. 322, 338 (1979) (Rehnquist dissenting).

[22] Courts distinguish between a private right to redress an injury (*e.g.*, common law tort), which cannot be abolished without providing a reasonable alternative to protect that right, and a public right, which can be delegated to an administrative body without doing so (*e.g.*, statutory right like welfare benefits). See Atlas Roofing, 430 U.S. 450, 458 (1977); see also Kluger v. White, 281 So.2d 1 (FL 1973).

[23] Indeed, proponents instead suggest changes to state constitutions or statutes. "Nov. 2006 Harvard Proposal" at 2 ("The state would need to pass authorizing legislation to establish the alternative system as the exclusive legal remedy for all covered patients and providers.").

[24] "Nov. 2006 Harvard Proposal" at 8-9 (claiming "compensation decisions would likely be faster and more reliable" and that costs could be controlled by controlling "the size of the award").