

**MEDICAL PROFESSIONAL LIABILITY
REFORM FOR THE 21st CENTURY:
A REVIEW OF POLICY OPTIONS**

**Report of the Advisory Committee on
Medical Professional Liability**

MARCH 2005



General Assembly of the Commonwealth of Pennsylvania
JOINT STATE GOVERNMENT COMMISSION
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The release of this report should not be interpreted as an endorsement by the members of the Executive Committee of the Joint State Government Commission of all the findings, recommendations and conclusions contained in this report.

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TO THE MEMBERS OF THE GENERAL ASSEMBLY:

The Joint State Government Commission is pleased to present this report of the Advisory Committee on Medical Professional Liability, entitled Medical Professional Liability Reform for the 21st Century: A Review of Policy Options. The report is presented pursuant to 2003 Senate Resolution No. 160.

The report provides background information for consideration of medical malpractice reform, including the current crisis in the medical malpractice insurance market, criticisms of the tort liability system, reform measures enacted to date, and research on improving patient safety. The advantages and disadvantages of key policy options are then discussed, namely a no-fault administrative compensation system, screening panels, specialized courts, and measures to encourage arbitration and mediation.

The Commission acknowledges with gratitude the work of the advisory committee and the other persons and agencies who gave invaluable assistance to the preparation of this report, who are listed in the introduction.

Respectfully submitted,

A large, stylized handwritten signature in black ink, appearing to read "Roger A. Madigan".

Roger A. Madigan
Chair

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EXECUTIVE SUMMARY

This report is presented pursuant to 2003 Senate Resolution No. 160, which directed the Joint State Government Commission to “study the feasibility of establishing an alternative to the existing liability system with regard to medical professional liability actions.” To guide the study, the Commission assembled an advisory committee of representatives of relevant private interests and public agencies. The advisory committee met five times to discuss the policy issues included in this report. Participation on the advisory committee does not necessarily imply endorsement by its members of all the findings and conclusions in this report.

As background, chapters 1, 2, 3, and 4 comprise material prepared by Commission staff on the recurring medical liability crises that have faced Pennsylvania, criticisms of the present system for compensating medical malpractice, the recent measures that the General Assembly and the Pennsylvania Supreme Court have taken to respond to medical malpractice issues, and recent studies and initiatives to address patient safety.

The remainder of the report consists of policy analyses of the reform strategies discussed by the advisory committee.

No-Fault. Many participants in the medical liability debate advocate substitution of the tort system with a “no-fault” or strict liability system similar to workers’ compensation. A key component of this system is the use of an “avoidability” test under which the patient would be compensated for an adverse outcome, whether or not any provider was demonstrably at fault. Different tests for compensability may apply, the most prevalent of which is the “avoidability” test, under which the event is compensable if it would have been avoided if the best medical practice had been followed, even where the treatment was not negligent under prevailing practices. The determination of liability would be made by an administrative body rather than a court, with the right of review by an appellate court. Some proponents of this system envision a move toward “enterprise liability,” so that the costs of the awards would be shifted from individual practitioners toward hospitals and health systems, including health systems jointly managed by hospitals and physicians. Also contemplated is a

substantial reliance on scheduled compensation formulas, under which the amount awarded for particular injuries would be determined by a predetermined table for the more common injuries.

The main benefits argued for this system are that it would speed up and broaden eligibility for compensation and lower litigation costs. No-fault is the only alternative designed to systematically provide consistency of compensation and link the compensation system with medical practice, thus potentially improving patient safety. Critics predict the more lenient standard of liability would cause the costs of the program to spiral out of control. They also argue that the standard of liability is unfair to providers because it holds them liable for hazards of medical practice that are beyond their control.

No state presently uses a no-fault system for the broad run of medical patients. Florida and Virginia have instituted a no-fault system for patients with neonatal brain injury. New Zealand and Sweden have long-standing programs in conjunction with broad public health insurance coverage. Studies have indicated that a broad no-fault program could be instituted within a reasonable cost, but compensation would have to be limited in various ways, such as a four- or eight-week disability threshold or a bar to recovery of non-economic damages.

The no-fault medical liability system offers the theoretical prospect of compensating injured patients with a substantial savings of time and money. By giving a broad scope to expert determination of medical avoidability, no-fault may be the alternative that would best foster continuous improvement in medical practice. At the same time, institution of such a system for the broad run of medical patients would represent a radical departure without a track record of success in any other state. Such a system could change nearly every aspect of injury finding and resolution—the standard of care and coverage, the rules of damages, the forum and process of decision making, and the bearer of financial risk.

If the no-fault approach is considered promising, it would be prudent to prepare the way to adoption by careful empirical study. Discussions aimed at formulating a demonstration project have been convened under the auspices of the Hospital & Healthsystem Association of Pennsylvania (HAP), and a complete proposal is expected to be presented this spring. The plan will likely require funding and other support from the Commonwealth. The representatives of the hospitals and the physicians strongly support further exploration of a no-fault compensation system through a demonstration project.

Screening Panels. Under this alternative, medical malpractice suits are reviewed by a nonjudicial panel before they can proceed to trial. This alternative has been implemented at one time or another in Pennsylvania and 30 other states and is currently used in 20 states in a variety of configurations.

In Pennsylvania, a screening system called the Arbitration Panels for Health Care was instituted as part of the Health Care Services Malpractice Act of 1975 (HCSMA), but the Pennsylvania Supreme Court invalidated it in 1980 because it found that the delay in the processing of cases through the arbitration system effectively denied plaintiffs the right to a jury trial. Screening panel legislation can avoid such a challenge by including reasonable time limits, but the program must then be staffed and funded robustly enough to meet those deadlines. Other challenges to the validity of screening panel legislation have been mostly unsuccessful.

The screening panel strategy suffers from a lack of clarity about its underlying aim which has been variously identified as screening claims, improving expertise, and expediting settlement. As these goals somewhat conflict with each other, critics charge that this system has not demonstrably done any of them well. The few academic studies of screening panels do not support their efficacy in significantly improving the handling of malpractice cases or lowering malpractice premiums, except for some success with ob/gyn physicians. The advisory committee did not recommend that the General Assembly place a high priority on consideration of screening panels in preference to other policy options, at least until it is shown that the current certificate of merit procedure has failed to adequately discourage weak claims.

Specialized Tribunals. This alternative would retain the present negligence standards of medical professional liability, but transfer responsibility for deciding the cases to a specialized court or administrative tribunal. Specialized courts could improve the expertise of the decision makers, but it runs the risk of increasing the politicization of the system, especially combined with Pennsylvania's tradition of an elective judiciary. Because statewide specialized malpractice courts permit fewer venues for trying malpractice cases, this measure is likely to increase travel expenses, which would fall especially hard on plaintiffs. Judicial expertise may also be concentrated by a medical malpractice division within the county trial court, but such a division can be established only in the few counties that see enough medical malpractice cases to make it feasible.

Specialized courts for highly technical classes of litigation have been established at the federal level, and some of these courts have been successful. Their success depends, among other factors, on whether their area of jurisdiction is clearly demarcated, whether there is a broad consensus on the overall goals to be served by the area of law in question, and whether that area seems to be in

need of greater cohesion and coherence of decisions. The effect of the specialized court on the litigants, the bar in that specialty, and the ability of such a court to attract judicial talent must also be considered. Implementation of a specialized court must include consideration of the manner of selecting the judges and whether the specialization is to be at the trial level, the appellate level, or both.

The advisory committee considered this alternative worthy of consideration, but did not reach a strong consensus to recommend specialized tribunals over other policy options.

Arbitration and Mediation. Current law provides avenues for disposing of cases through alternative dispute resolution (ADR). The most common of these are arbitration and mediation. Neither has been used much in medical malpractice cases, although mediation is becoming more common.

Arbitration has much in common with the trial system in that it usually renders a final decision based on the application of traditional negligence law. By agreement, the parties submit the dispute to a panel of arbitrators, who may be selected on the basis of expertise in either medicine or malpractice law. The parties can vary the procedural rules in their agreement to a much greater extent than is possible in conventional litigation. Arbitration can be speedier and less expensive than conventional litigation, but the genuineness of the patient's consent can become an issue, and the loss of judicial control over proceedings can be seen as a disadvantage. Federal and Pennsylvania law provide for arbitration, and the advisory committee had no recommendation on how it can be effectively encouraged.

Mediation is growing in popularity in Pennsylvania, partly because of the initial success of the Drexel University Hospital program and the Rush-Presbyterian Hospital program in Chicago. In mediation, the parties attempt to settle the case with the help of a trained mediator. Because settlement occurs only if the parties agree to it, the parties have greater control than under binding arbitration. Settlement may include terms other than money damages, such as a formal apology or the promise by the provider to change its treatment procedure. In Pennsylvania the Supreme Court has encouraged mediation by promulgating rules requiring its consideration. The Medical Care Availability and Reduction of Error (Mcare) Fund has been supportive of mediation and active in resolving cases through that method. The advisory committee applauds these initiatives, as well as the Drexel University Hospital program. Although some suggestions are discussed in this report, the committee did not arrive at any recommendation for a change in statutory law to encourage mediation. It cautioned that measures mandating participation in mediation are likely to be counterproductive because mediation is useful only if the parties' participation is genuinely voluntary.

INTRODUCTION

This report is presented in response to 2003 Senate Resolution No. 160, adopted by the Senate on March 10, 2004. The resolution mandated the Joint State Government Commission to “study the feasibility of alternatives to the existing liability system with respect to medical professional liability actions.”¹ Citing studies by the United States General Accounting Office (GAO), Americans for Insurance Reform, and the Project on Medical Liability in Pennsylvania of the Pew Charitable Trusts, the enabling resolution observes that despite the many measures adopted in response to the recent issues relating to medical malpractice, “it continues to be urged that more health care liability reforms are necessary to lower the cost of liability insurance and that more actions need to be taken to reduce medical errors and ensure that meritorious claims continue to receive fair and adequate compensation.” The resolution then asserts that various strategies are available to “control costs, improve predictability, and attract insurers to the Pennsylvania market, including . . . systematic changes to the way injuries caused by medical care are identified, compensated, and prevented.” The core operative clauses of the resolution state the nature of the study:

RESOLVED, That there is a need for a comprehensive study of the value of making long-term systemic change that would replace the current medical tort liability scheme with a more reliable and predictable system of medical justice that protects patients against bad practices, protects providers who act reasonably, collects adequate data, and interprets standards of care so that all participants know where they stand and where they must improve; and be it further

RESOLVED, That the Senate direct the Joint State Government Commission to conduct a study to consider the feasibility of creating a new system, such as a new no-fault administrative system, a peer review system, or specialized medical malpractice courts, which will promote better health care practice, regulate costs and rates, and fairly compensate patients.

The enabling resolution further directed the Commission to create an advisory committee to direct the study and to report its findings and recommendations.

¹ The resolution appears as appendix A.

The Commission proceeded to assemble the advisory committee. The committee included representatives from HAP, the Insurance Federation of Pennsylvania (IFP), the Pennsylvania Bar Association (PBA), the Pennsylvania Medical Society, and the Pennsylvania Trial Lawyers Association (PaTLA). Input from the executive branch of Pennsylvania government was provided by representatives of the Department of Health, the Governor's Office of General Counsel, the Governor's Office of Health Care Reform, the Pennsylvania Health Care Cost Containment Council (PHC4), the Insurance Department, the Office of Mcare of the Insurance Department, and the Patient Safety Authority (PSA). Two members of the Pennsylvania Conference of State Trial Judges participated on behalf of the judicial branch. A complete list of the participants on the advisory committee is included in the front matter of this report.

The first meeting of the advisory committee was held on May 17, 2004. The meeting included a round table discussion of the issues raised by the enabling resolution. At the conclusion of that discussion, the committee decided to take up the no-fault system as its initial focus.

The committee devoted two meetings to consideration of no-fault. The first of these was held on June 28, 2004. After consideration of the issues relating to such a system, which are discussed in chapter 5, the committee called for expert guidance on a research design of a detailed empirical study of the costs and operational consequences of establishing a no-fault system as a voluntary alternative to the tort system. On August 31, the committee heard presentations on that topic from two of the leading experts on medical malpractice policy: Dr. William M. Sage of Columbia Law School, who is principal investigator for the Project on Medical Liability in Pennsylvania; and Dr. David M. Studdert, associate professor of law and public health in the Department of Health Policy and Management of the Harvard University School of Public Health. There was an extensive discussion of the no-fault alternative among the committee members and Drs. Sage and Studdert. Representing HAP, James Redmond undertook to contact its members to determine if there was interest in establishing a demonstration project to gather data on the feasibility of instituting a voluntary no-fault system.

On October 1, 2004, the committee met to consider screening panels and specialized medical courts. The committee heard presentations from Professor Catherine T. Struve of the University of Pennsylvania Law School and Ms. Franklin Stone of the public advocacy organization Common Good. The committee directed staff to include a discussion of the advantages and disadvantages of both of these alternatives in the report. It was the sense of the committee that the General Assembly should not consider the screening panel alternative a high priority at this time.

On November 5, 2004, the committee discussed alternative dispute resolution of medical malpractice cases, specifically arbitration and mediation. The committee directed that the report include a discussion of these topics. The committee found the favorable experience with mediation in the Drexel University Hospital program encouraging. However, the committee found no consensus on a change to existing law that it could recommend.

Drafts of the report were circulated for comment to the advisory committee twice for their comments.

Chapters 1, 2, 3, and 4 consist of background material assembled by Commission staff to place the policy discussions in context. Chapters 5, 6, 7, and 8 comprise a policy discussion of the alternatives discussed by the advisory committee, and reflect its views as well as the cited sources.

The Commission staff acknowledges the assistance of the advisory committee members. Others who provided advice that was of great value in the preparation of the report included: Dr. William M. Sage, Dr. David M. Studdert, Professor Catherine T. Struve, Ms. Franklin Stone, Professor Donald A. Tortorice, Professor Frank A. Sloan, Carl (Tobey) Oxholm III, and Ms. Jane Ruddell. The staff also acknowledges the assistance of the staff of the Insurance Department and the Bureau of Workers' Compensation of the Department of Labor and Industry.

CHAPTER 1

THE MEDICAL MALPRACTICE CRISIS

In order to understand why there has been a call for consideration of alternatives or basic reforms to the tort litigation system, some background discussion is included in this report. This chapter, chapter 2 (Deficiencies of the Tort System) and chapter 4 (Patient Safety, especially the policy discussion in the first half of the chapter) are based on data collected and commentary advanced by some reputable and highly qualified observers on the issues they address, as compiled by Commission staff. They should not be read as a comprehensive statement of the facts or as reflecting the opinions of all such observers on those issues. Some equally qualified commentators have presented views at variance with those presented in those chapters and elsewhere in this report.

Observers look at the current medical malpractice crisis as the third in a series of waves, the first breaking in the mid-1970s and the second in the mid-1980s. The present crisis has largely resulted from, or at least manifested itself as, an increase in malpractice insurance rates charged to health care providers.

Medical Malpractice Insurance Market

Mandatory Liability Coverage

Pennsylvania law requires physicians, with limited exceptions, to maintain primary professional liability coverage and to pay an assessment to the Mcare Fund, a patient compensation fund previously known as the Medical Professional Liability Catastrophe Loss (CAT) Fund.²

Physicians in compliance with the mandatory requirements have coverage of \$1 million per incident/\$3 million per annual aggregate. Currently, the mandated primary coverage is \$500,000/\$1.5 million, and the Mcare Fund

² Section 711 of the act of March 20, 2002 (P.L.154, No.13) (Mcare Act) (40 P.S. § 1303.101 et seq.) (hereafter cited in text). The Mcare Act is commonly referred to as “Act 13.” Additional detail on mandatory coverage and the Mcare coverage phase-out appears in the Medical Malpractice Insurance section of chapter 3.

provides additional coverage of \$500,000/\$1.5 million. The Mcare Fund also provides first dollar “tail” coverage on claims filed more than four years after the alleged incident of malpractice.

Under the Mcare Act, the Mcare Fund coverage will be phased out in two phases. Phase I (tentatively scheduled to be implemented in 2006) would raise the primary coverage to \$750,000/\$2,250,000 and decrease the Mcare coverage to \$250,000/\$750,000. The Mcare tail coverage also ends in 2006. Phase II (tentatively scheduled for 2009) would raise the primary coverage to \$1 million/\$3 million and completely eliminate the Mcare coverage. Implementation of the phase-out depends on the Insurance Department’s determination of whether there is sufficient capacity in the primary market to absorb the phased-out coverage. (§§ 711(d)(4), 712(c), and 745(b)) Because the Mcare Fund is operated on a pay-as-you-go basis, participating health care providers, as the law now stands, will be required to pay an Mcare assessment in 2009 and for a number of years thereafter to cover the Mcare Fund’s unfunded liability, estimated to be \$2.40 billion dollars.³ (See § 712(d)).

Availability of Insurance

Since the mid-1990s, many malpractice insurance carriers have exited the market, either involuntarily (after becoming insolvent and liquidated by state insurance regulators) or voluntarily (by withdrawing their business from Pennsylvania or discontinuing malpractice insurance as a line of business). For example, in 1998 PHICO Insurance Company was the largest malpractice insurance carrier in Pennsylvania, collecting approximately \$73.1 million in premiums and controlling 26.3% of the market share in the state. PHICO then became insolvent, and in February 2002 it was ordered into liquidation. The Medical Inter-Insurance Exchange of New Jersey, Princeton Insurance Company, PIC Insurance Group, and PIE Mutual Insurance Group also withdrew from the Pennsylvania medical malpractice insurance market. Still other carriers have remained in the market but have underwritten health care providers more selectively. Table 1 shows how changes in market share among carriers have shifted from 1998 through 2003. Because of these supply constraints, many health care providers have found it increasingly difficult to obtain medical professional liability insurance. Pennsylvania also appears to have one of the worst insurance availability problems in the nation for hospitals. (Bovbjerg and Bartow 2003, 7-9; see also GAO 2003, 64)

³ The estimate of unfunded liability is from PricewaterhouseCoopers, Pennsylvania Medical Care Availability and Reduction of Error Fund: Estimation of 12/31/2003 Unfunded Liability (Philadelphia, March 2004), 7.

Table 1

Medical Malpractice Insurance Carriers in Pennsylvania

Rank	Company	Premiums (\$ millions)	Market share
<u>1998</u>			
1	PHICO Ins. Co.	\$73.1	26.3%
2	Pennsylvania Med. Soc. Liab. Ins. Co.	46.0	16.6
3	Medical Inter-Insurance Exch. of N.J.	38.5	13.9
4	Medical Protective Co.	16.4	5.9
5	Princeton Ins. Co.	13.3	4.8
6	Steadfast Ins. Co.	11.9	4.3
7	Tri Century Ins. Co.	7.5	2.7
8	VHA Risk Retention Group Inc.	6.6	2.4
9	Preferred Professional Ins. Co.	6.0	2.2
10	American Continental Ins. Co.	6.0	2.2
<u>2001</u>			
1	Pennsylvania Med. Soc. Liab. Ins. Co.	68.8	18.5
2	Medical Inter-Insurance Exch. of N.J.	52.0	14.0
3	Medical Protective Co.	30.0	8.1
4	Tri Century Ins. Co.	23.8	6.4
5	Lexington Ins. Co.	19.3	5.2
6	VHA Risk Retention Group Inc.	18.8	5.1
7	Princeton Ins. Co.	18.3	4.9
8	Franklin Casualty Ins. Co. RRG	17.5	4.7
9	First Professionals Ins. Co.	13.6	3.7
10	St. Paul Fire & Marine Ins. Co.	11.2	3.0
<u>2003</u>			
1	Medical Protective Co.	74.9	12.6
2	Pennsylvania Med. Soc. Liab. Ins. Co.	65.2	11.0
3	Lexington Ins. Co.	55.1	9.3
4	Mountain Laurel RRG Inc.	43.2	7.3
5	Tri Century Ins. Co.	37.0	6.2
6	Pennsylvania Prof. Liab. JUA	36.0	6.1
7	Cassatt RRG Inc.	31.6	5.3
8	Community Hospital RRG	24.1	4.1
9	Preferred Professional Ins. Co.	22.4	3.8
10	Franklin Casualty Ins. Co. RRG	19.8	3.3

SOURCE: Bovbjerg and Bartow 2003, 8; Pennsylvania Insurance Department, Annual Statistical Report of the Insurance Department of the Commonwealth of Pennsylvania for the Period July 1, 2003 to June 30, 2004 (Harrisburg: Insurance Department), 276.

Relying on a recent survey HAP conducted of its membership, HAP believes there is virtually no commercial market remaining for hospital medical liability coverage.

- 84% of the hospitals in Pennsylvania use risk retention groups or are self-insured to meet mandatory insurance coverage requirements.
- 91% of Pennsylvania's hospitals cover some portion of their medical staff under their facility's medical liability policy.
- 28% of all physicians on hospital medical staffs are now covered under the hospital's medical liability insurance policy.⁴

Another manifestation of pressure on the supply of malpractice insurance is the growth of the market share of the Pennsylvania Professional Liability Joint Underwriting Association (JUA), the Commonwealth's "insurer of last resort" for practitioners and institutions unable to obtain coverage elsewhere at affordable rates. By February 2003, total JUA enrollment stood at approximately 1,800. During some periods in 2002, as many as ten hospitals at a time had JUA coverage, an unusually high number.⁵

Increasing Premiums

In view of these factors, it is not surprising that the period 1999-2002 saw sharp increases in medical malpractice premiums. Table 2 shows the percentage increases in the premium base rates for the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) in the Philadelphia, Pittsburgh, and Harrisburg areas from 1999 to 2002, for selected specialties.⁶

Table 3 shows the amount of medical malpractice premium base rates for PMSLIC in the Philadelphia and Pittsburgh areas for 2002, for the same three specialties as in table 2.⁷

⁴ HAP Statewide Membership Survey on Medical Liability, April 2004 and September 2004.

⁵ The number of JUA insureds fluctuates greatly within the course of a year as policyholders find more favorable terms elsewhere. By early 2003, all but two hospitals had found coverage outside JUA, mainly through risk retention groups, a self-insurance-like mechanism for pooling risk across similar insureds. (Bovbjerg and Bartow 2003, 10)

⁶ The figures in table 1 are based on an analysis of annual surveys by the *Medical Liability Monitor*.

⁷ The figures in table 2 are based on an analysis of annual surveys by the *Medical Liability Monitor*. Premium rates are the annual base rates for coverage under a claims-made policy with a cap of \$1 million per incident and \$3 million per year.

Table 2

Percentage Increase in Premium Base Rates, 1999-2002

Insurer	General surgery	Internal medicine	Obstetrics/ gynecology
PMSLIC – Philadelphia	73%	73%	99%
PMSLIC – Pittsburgh	82	82	110
PMSLIC – Harrisburg	130	130	165

SOURCE: GAO 2003, 12.

Table 3

Premium Base Rates, 2002

Insurer	General surgery	Internal medicine	Obstetrics/ gynecology
PMSLIC – Philadelphia	\$50,000	\$11,000	\$64,000
PMSLIC – Pittsburgh	28,000	6,000	35,000

SOURCE: GAO 2003, 14.

PMSLIC implemented further base rate increases of 38.9% in 2003 (54% overall), 13% in 2004 (15.1% overall), and 8% in 2005 (10.8% overall).⁸

⁸ Pennsylvania Insurance Department. The “overall” rate appears to be a weighted average after adjustment for risk premiums, which are based on medical specialty and rating territory.

Until recently, physicians in Pennsylvania paid liability premiums roughly typical of the nation as a whole. In 2000, however, Pennsylvania ranked ninth highest in the nation in terms of premiums, approximately 50% above the national average.⁹

A 2002 study of malpractice insurance premiums charged to orthopedic specialists found that Pennsylvania is one of the most expensive states for that specialty, and premium rates are rising much more rapidly than the national average. Premiums increased almost 30% a year over the prior two years, and the average premium went from 60% to 90% above the national norm. Table 4 summarizes this information.¹⁰

Table 4

Average Premiums and Rates of Change
for Orthopedic Surgeons, 2000-02

State	2000	2001	2002	Average change
Maryland	\$23,500	\$18,600	\$24,300	1.6%
New Jersey	28,200	29,600	30,600	4.1
New York	54,000	54,800	60,000	5.4
Ohio	29,500	34,200	49,500	29.6
Pennsylvania	43,700	54,300	73,300	29.5
United States	28,100	31,400	38,200	16.6

SOURCE: Bovbjerg and Bartow 2003, 15.

The increases in individual premiums are reflected in sharp increases in aggregate malpractice premiums. Since 1982, a substantial proportion of the malpractice premiums have been collected by the CAT Fund. Under HCSMA, the CAT Fund was established as a secondary insurer in medical malpractice cases. When HCSMA was repealed by the Mcare Act, the CAT Fund was liable

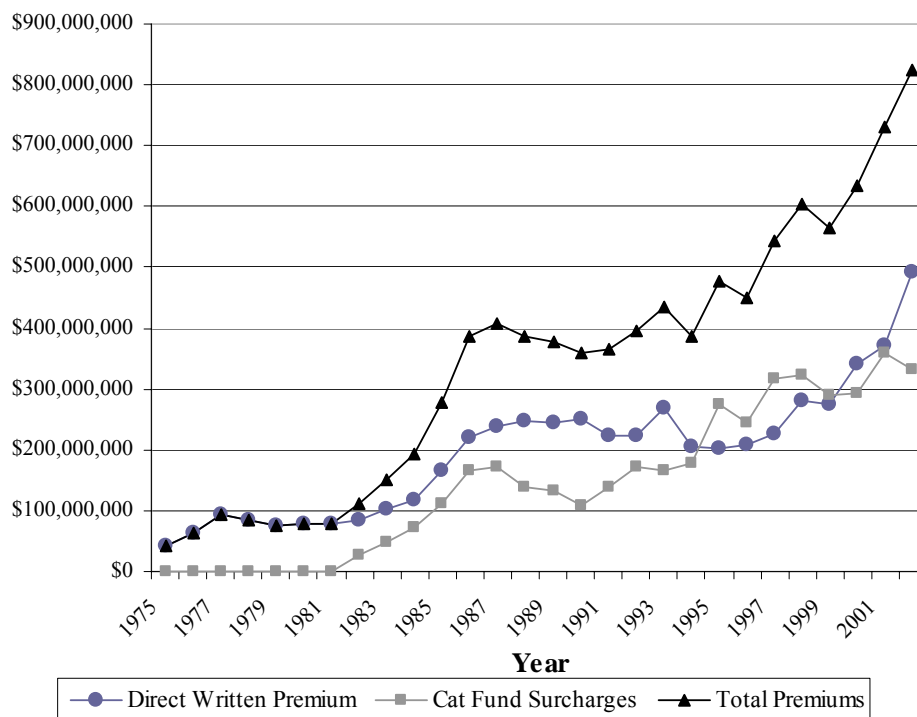
⁹ Bovbjerg and Bartow 2003, 11, 12. In the United States in 2000, the estimated premiums per practicing physician were \$18,487, compared to Pennsylvania's figure of \$27,494. However, Pennsylvania's neighboring states also ranked well above average: Delaware - \$26,345 (11), Maryland - \$18,470 (20), New Jersey - \$35,301 (2), New York - \$27,854 (8), Ohio - \$23,122 (13), and West Virginia - \$39,050 (1). (Bovbjerg and Bartow 2003, 13)

¹⁰ The figures are derived from a national physician survey. Delaware and West Virginia are omitted because of small sample sizes.

for the excess over the provider’s basic coverage, up to \$700,000 per occurrence and \$2.1 million annual aggregate. Under the Mcare Act, the Mcare Fund replaced the CAT Fund. The liability limits for the Mcare Fund are currently \$500,000 per occurrence and \$1.5 million annual aggregate. (Mcare Act, § 712(c)) The aggregate premiums and CAT Fund surcharges are shown in figure 1, and the specific amounts are set forth in appendix B.

Figure 1

Total Pennsylvania Medical Malpractice Premiums



SOURCE: Pennsylvania Insurance Department, May 20, 2003.

HAP’s Statewide Medical Survey of April 2004, based on reports from its members, concluded that the total cost of medical liability coverage for Pennsylvania hospitals increased 106% from 2000 to 2003.

Losses by Insurers

From 1998 to 2001, paid losses by insurers in Pennsylvania increased by approximately 70.9%, while incurred losses increased by 97.2% (GAO 2003, 18, 20). Rates of litigation with respect to malpractice filings have varied

substantially by geographic location. Historically, rates in Philadelphia and Allegheny Counties have been quite high per population, and Pennsylvania's urban counties had about four times the rate of malpractice trials as the national median in 1996. (Bovbjerg and Bartow 2003, 27-28) The National Practitioner Data Bank (NPDB) reported that in 2001, Pennsylvania had 8.5 payments per 100,000 population, representing a rate over 23% higher than the 1995 rate. Table 5 shows the frequency of paid physician claims reported by the NPDB by year.

Table 5

Number and Rate of Paid Physician Claims

State	Total payments 1990-2001	Rate per 100,000 population (1995)	Payments 2001	Rate per 100,000 population (2001)
Delaware	382	4.43	52	6.53
Maryland	2,554	4.24	283	5.25
New Jersey	6,496	6.80	940	11.04
New York	21,437	9.84	2,085	10.93
Ohio	7,526	5.62	677	5.94
Pennsylvania	9,993	6.91	1,049	8.53
West Virginia	1,640	7.51	206	4.22
United States	157,720	5.00	15,771	5.53

SOURCE: Bovbjerg and Bartow 2003, 29.

Pennsylvania also ranks high in payments per paid case, averaging approximately \$400,000 in 2001, up from an average of just over \$300,000 for the entire period 1990-2001.¹¹ Its payouts were higher than any neighboring state and almost a third above the national average. Pennsylvania takes a mean of 5.7 years to deliver payments to claimants, over a year slower than in the nation at large. (Bovbjerg and Bartow 2003, 30-31)

¹¹ The Pennsylvania Medical Society notes that this average claim payment data is based on NPDB data and observes that this data understates the payment amount for Pennsylvania: When the liability is split between the primary carrier and the Mcare Fund, the NPDB treats each payment as a separate claims payment, rather than aggregating the two payments to reflect the full payment made on the claim.

Causes of Premium Increase

High jury verdicts contribute to higher professional liability insurance premiums for doctors, especially those practicing within certain specialties.

The number of mega-verdicts is increasing rapidly. The average award rose 76% from 1996-1999. The median award in 1999 was \$800,000, a 6.7% increase over the 1998 figure of \$750,000; and between 1999 and 2000, median malpractice awards increased nearly 43%. Specific physician specialties have seen disproportionate increases, especially those who deliver babies. In the small proportion of cases where damages were awarded, the median award in cases involving obstetricians and gynecologists jumped 43% in one year, from \$700,000 in 1999 to \$1,000,000 in 2000. (USHHS 2002, 9)

It should be noted, however, that jury awards may be larger than payouts, due to such factors as remittitur, reductions on appeal, and post-verdict settlements in lieu of such proceedings.

Many other factors have contributed to the increases in medical professional liability premium rates: insurers' losses, declines in investment income, a less competitive climate as insurers have left the market, and increases in reinsurance rates for some medical malpractice insurers.

While predicting the length, size, and turning points of a medical malpractice insurance market cycle may be impossible, the relatively long period of time required to resolve claims makes the market cycles more extreme than in other insurance markets. Higher medical malpractice rates primarily result from increased losses on claims, not increases in the number of claims. Like premium increases, annual paid losses and incurred losses for the national medical malpractice insurance market began to rise more rapidly beginning in 1998. (GAO 2003, 15)

Higher paid losses on claims reported in current or previous years increase insurers' estimates of expected payouts on future claims. Large losses, particularly paid losses, on even one or a few individual claims may make it more difficult for insurers to predict how much they may have to pay on future claims. When losses on claims are difficult to predict, insurers tend to assume that losses will be toward the high end of the predicted range of losses. Large losses on individual claims may raise plaintiffs' expectations for damages on similar claims, resulting in higher losses on claims both settled and proceeding to trial.

Finally, an increase in the percentage of claims requiring payouts increases the average amount insurers expect to pay per policy, again resulting in higher premium rates. (GAO 2003, 22)

Premium rates are also affected by insurers' investment income. State laws restrict medical malpractice insurers to conservative investments, primarily bonds.¹² In 2001, the 15 largest writers of medical malpractice insurance, including commercial companies and physician-owned nonprofit insurers, invested approximately 79 percent of their investment assets in some combination of U.S. Treasury, municipal, and corporate bonds. Since 2000, annual yields on bonds have steadily declined. To compensate, medical malpractice premium rates have increased. (GAO 2003, 24, 26)

Industry competitiveness also impacts premium rates. When a large insurer leaves a state insurance market, the supply of medical malpractice insurance decreases, and the remaining insurers may not need to compete as hard on the basis of price. Because state insurance statutes limit the amount of insurance that carriers can write relative to surplus, which is difficult to expand quickly, the remaining insurers are limited in the amount of insurance that they can supply to fill the gap. (GAO 2003, 31)

Medical malpractice insurers purchase reinsurance, or excess loss coverage, to protect themselves against large unpredictable losses. Because of reinsurers' losses resulting from the September 11, 2001, terrorist attacks and increased risk associated with providing reinsurance to the medical malpractice market, reinsurance premium rates have increased, putting even more upward pressure on medical malpractice premium rates. (GAO 2003, 32)

The market for medical malpractice insurance has evinced a cycle between "hard" and "soft" markets. (AIR 2002, 2, 3) The period since 1999 has seen a hard market, characterized by rapidly rising premium rates, tightened underwriting standards, narrowed coverage, and withdrawal of carriers. Previous hard markets occurred in the mid-1970s and mid-1980s, coinciding with periods of crisis. A soft market, like that from 1990-98, is characterized by slowly rising premiums, less stringent underwriting standards, expanded coverage, and strong competition among insurers. The broader property-casualty insurance market follows a similar cyclic pattern, but the swings have been more extreme for medical malpractice; the long period required to dispose of medical liability claims and the great variation in the size of those claims may account for this difference. (GAO 2003, 33-34) It has been observed that one way the current malpractice crisis differs from the previous two is that the medical establishment

¹² In Pennsylvania, the restrictions on investments are provided by §§ 518-C and 602.1 of the Insurance Company Law of 1921 (40 P.S. §§ 653c and 722.1).

is more brittle to financial shocks than it was previously, due to enhanced cost containment pressures in the 1990s. (Bovbjerg and Bartow 2003, 45; Sage 2003b, 20-26)

Ironically, advances in medical treatment may contribute to increases in tort recoveries and therefore indirectly to malpractice premium rates. For instance, fragile premature infants who would earlier have been stillborn may remain alive and generate claims for negligent care. Not only can the claims in such cases result in liability for a high dollar amount, but they also have a long “tail”—in other words, the claim may be filed as much as 20 years after the care took place. The latter factor contributes to uncertainty in rating the claim, resulting in higher premiums. (Sage 2003b, 11-12; Mcare Act, § 513(c)) In most cases, however, malpractice claims are filed within the statute of limitations for negligence, which expires two years from the date of the injury. See 42 Pa.C.S. § 5524. In the case of an infant injured by malpractice, the claims of the parent relating to the injury are barred unless suit is commenced within that two-year period.

The relative significance of the causes for the increase in malpractice rates is highly controversial, particularly the causal relationship between premium increases and insurers’ investment yields and the underlying cost of medical care.¹³ Also much contested is how malpractice premiums affect retention of physicians, and their choices of location, specialty, and scope of practice, and whether or how much these factors may affect access to and quality of care. This report will not attempt to resolve those issues, as they are beyond the scope of the enabling resolution.

Malpractice Litigation

Based on Pennsylvania court statistics, the number of medical malpractice filings generally fell for the period 2000-03. Table 6 summarizes the information from the 20 largest Pennsylvania counties.¹⁴ The report of filings for all counties is included as appendix C, and the aggregate number for the state is shown by figure 2. Medical malpractice case filings declined by 28.6% from 2000 to 2003.

¹³ For instance, Nathanson 2004 argues that premiums are largely driven by interest rates and can best be reduced by measures that reduce litigation defense costs. AIR 2002 argues that premiums are driven by the general state of the economy.

¹⁴ At the time the survey was initiated, many judicial districts did not have a docket identifier to distinguish medical malpractice cases from other civil actions. As a result, various methods were used to compile the data, including case-by-case review of the files in the office of the Prothonotary. To facilitate accurate data collection in future surveys, Chief Justice Ralph J. Cappy directed that each district institute a procedure for prospectively tracking medical professional liability cases, effective January 2004.

It is unclear whether this drop is the result of the reform measures described in chapter 3. It is also unclear whether the apparent drop in case filings shown by this preliminary data indicates a definite trend.¹⁵

Table 6

Medical Malpractice Case Filings, 2000-03

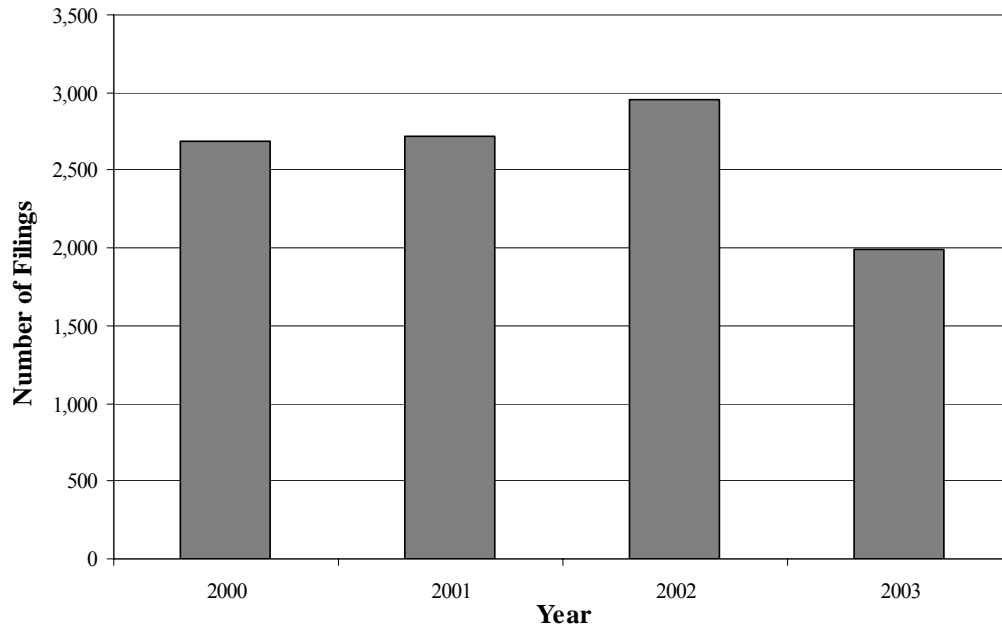
County	2000	2001	2002	2003	Percentage change in 2003 from 2000-02 average
Philadelphia	1,085	1,162	1,365	577	-52.1%
Allegheny	392	372	427	272	-31.5
Montgomery	24	40	32	151	+371.9
Bucks	78	42	52	45	-21.5
Delaware	69	86	77	82	+6.0
Lancaster	11	3	11	9	+8.0
Chester	46	37	41	69	+66.9
York	58	40	48	34	-30.1
Berks	44	37	31	19	-49.1
Westmoreland	59	63	65	49	-21.4
Luzerne	43	32	29	39	+12.5
Lehigh	82	79	59	105	+43.2
Erie	46	56	59	44	-18.0
Northampton	64	65	89	47	-35.3
Dauphin	72	86	84	46	-43.0
Cumberland	22	21	24	27	+20.9
Lackawanna	99	88	70	35	-59.1
Washington	8	11	3	4	-45.5
Beaver	29	18	23	17	-27.1
Butler	22	29	26	16	-37.7
Pennsylvania	2,686	2,714	2,957	1,989	-28.6

SOURCE: AOPC Press Release, March 18, 2004.

¹⁵ Administrative Office of Pennsylvania Courts (AOPC) Press Release, March 18, 2004.

Figure 2

Pennsylvania Medical Malpractice Case Filings



SOURCE: AOPC Press Release, March 18, 2004.

Table 7 summarizes the numbers of medical malpractice jury verdicts, for the period January 2000 to July 2003.¹⁶ The AOPC chart of jury verdicts is included as appendix D. There were also 20 non-jury verdicts, four of which were \$500,000 or more.¹⁷

¹⁶ As mentioned, verdict amounts are mostly for compensatory damages, but in some instances they may include punitive and delay damages and judicial offsets and adjustments. They do not reflect post-trial settlements or actions of an appellate court and therefore do not report actual payouts.

¹⁷ AOPC Press Release, March 18, 2004.

Table 7

Medical Malpractice Jury Verdicts, January 2000 - July 2003

County	Total cases	Defense verdicts	Less than \$500,000	\$500,000 to \$1 million	\$1 million to \$5 million	Over \$5 million
Philadelphia	407	241	54	29	58	25
Allegheny	147	119	14	8	5	1
Montgomery	79	58	13	3	5	--
Bucks	36	33	1	2	--	--
Delaware	73	62	3	3	5	--
Lancaster	17	17	--	--	--	--
Chester	35	26	7	1	--	1
York	9	7	--	2	--	--
Berks	10	6	2	--	2	--
Westmoreland	19	15	4	--	--	--
Luzerne	16	14	1	--	1	--
Lehigh	60	54	2	1	1	2
Erie	18	15	2	--	1	--
Northampton	23	17	1	2	3	--
Dauphin	35	26	5	2	2	--
Cumberland ¹	--	--	--	--	--	--
Lackawanna	27	24	2	1	--	--
Washington	9	6	2	--	--	1
Beaver	7	4	1	1	1	--
Butler	4	4	--	--	--	--
Pennsylvania	1,143	834	130	60	87	32

1. Data not available.

SOURCE: AOPC Press Release, March 18, 2004.

CHAPTER 2

DEFICIENCIES OF THE TORT SYSTEM

One of the most common causes cited for the current medical malpractice crisis is an overall deficiency in the United States' tort system; the system of civil redress for injury to persons or property.¹⁸ Although some statutorily created administrative systems provide compensation to the injured (workers' compensation, for instance), the tort system is undoubtedly the most common means employed for an injured party to seek compensation. In state constitutions, such as Pennsylvania's, this right is jealously guarded by a provision guaranteeing access to the courts.¹⁹

The goals of the United States' tort litigation system, which includes medical malpractice law, are "compensation, deterrence, and justice" (Struve 2003, 19). This society values the right to seek redress for wrongs committed and trusts that, as a result of the process, injuries will be reduced. While the tort system protects our right to seek redress and pursue justice, its many shortcomings are widely recognized.

This chapter will examine some of the specific criticisms of the tort system as it pertains to medical malpractice, where some of the deficiencies seem to be particularly serious. It is a system which has been criticized as being too costly, too slow, and ineffective in achieving its goals, often resulting in an improper distribution of the funds available for compensating injured victims. It is commonly asserted that the most seriously injured fail to receive proportionate compensation and that too much of the compensation for successful plaintiffs goes into the coffers of their lawyers.

¹⁸ See first paragraph of chapter 1. Many studies by qualified observers present a more favorable account of the tort system than that presented here, including Vasanthakamur N. Bhat, *Medical Malpractice: A Comprehensive Analysis* (Westport, Conn.: Auburn House, 2001); Carl T. Bogus, *Why Lawsuits Are Good for America: Disciplined Democracy, Big Business, and the Common Law* (New York, N.Y.: New York University Press, 2001); and Thomas H. Koenig and Michael L. Rustad, *In Defense of Tort Law* (New York, N.Y.: New York University Press, 2003).

¹⁹ Pa. Const. art. I, § 11.

Excessive Cost

The tort system is costly for both claimants and providers. There are fees for court filings, attorney fees, expert witness fees, and costs for compilation of records, in addition to lost work time for plaintiffs and defendants during depositions and the trial itself. For defendants in medical malpractice cases, there is the potential that the jury will award a large verdict, costing the insurance company a substantial sum in economic damages, non-economic damages, and attorney fees. All of this is compounded further if the verdict is appealed.

Although it costs a plaintiff's attorney a considerable sum of "upfront" money to pursue a medical malpractice action, typically, the plaintiff is represented under a contingent fee arrangement, under which he or she pays no attorney fees unless there is a favorable verdict or a settlement. If the claim prevails, the plaintiff's attorney recovers expenses and fees from the plaintiff's award, and attorney fees alone often represent 30%-40% of the award or more. (USHHS 2002, 10)

The cost to the defense if the plaintiff prevails primarily include the verdict or the settlement and attorney fees. In most cases, these costs are borne by the defendant's insurer. On average it costs \$24,669 to defend a claim (USHHS 2002, 8). As cases often include claims against multiple defendants, the defense cost can be several times that number.

Both parties will likely be required to hire medical experts to review their case, issue a report, and, if necessary, testify in court. Sometimes more than one expert will be required by each side, depending on the nature of the case and whether more than one medical specialty is involved. Medical malpractice cases generally require many depositions, each one costing attorney time and expenses for court reporters and transcripts.

From the cost of bringing suit to the cost of paying a verdict, it is no surprise that the high cost of the tort system is one of the leading complaints against it. As shown in chapter 1, the high cost of litigation may constitute a major factor in driving up malpractice premiums. Adding all the transactions costs mentioned in this section, only 40%-45% of the resources put into the tort system through malpractice premiums actually compensates victims of medical injury (Weiler 1991, 52).

Undue Delay

The legal system in the United States has long been criticized for moving too slowly. From the filing of a case with the court to the ultimate airing of the claim at trial, many years may elapse. In a complex medical malpractice case, it may take years just to prepare a case for trial. Many medical professionals may be involved, and an intensive effort is required to gather all of the relevant medical records and conduct the necessary discovery. Physicians tend to resist settlement of claims unless there is very clear evidence of fault, a tendency reinforced by the federal mandate to report settlements to the NPDB (Metzloff 1996, 205).

For Pennsylvania medical malpractice cases, the average period from filing to recovery in a successful case was 5.7 years in 2001, a year longer than the national average (Bovbjerg and Bartow 2003, 30-31). A GAO survey of claims closed in 1984 found a time lag from medical injury to compensation of 36 months. By contrast, disability insurance pays compensation almost immediately, and workers' compensation pays claims within three weeks for an uncontested claim and four months for a contested claim (Weiler 1991, 52-53).

Of course, the most notable side effect of these delays is that the plaintiff remains uncompensated for his or her injuries, but the cloud of uncertainty and the stress of a claim disturbs both plaintiffs and defendants.

The Pennsylvania Medical Society maintains that physicians and other defendants are disadvantaged by delays inherent in the current system. For example, they are penalized by the requirement that they pay delay damages because they have elected in good faith to exercise their constitutional right to defend the allegations against them. Also, even pending claims can significantly increase their premiums and jeopardize their ability to obtain coverage in the commercial market.

PaTLA maintains that almost all delay in malpractice cases is caused by defendants. PaTLA argues that plaintiffs' lawyers are primarily paid on a contingent fee basis, and therefore are strongly motivated to resolve the case quickly. In its view, delay damages under Pa.R.C.P. No. 238, which have been upheld against a constitutional challenge,²⁰ are not unfair to medical providers, who can avoid them by making an adequate offer.

Thus, the slow pace of the process is another common criticism of the tort system, especially in medical malpractice cases (USHHS 2002, 8-11).

²⁰ *Costa v. Lauderdale Beach Hotel*, 626 A.2d 566 (Pa. 1993).

Disproportionate Compensation

Another drawback of the current tort system in medical malpractice cases is that only a small number of truly injured patients receive any compensation. Often less seriously injured plaintiffs recover a larger share of their losses than plaintiffs with graver injuries.

The cost and time commitment involved in filing a malpractice claim deter many injured patients from doing so. Furthermore, an attorney evaluating a potential plaintiff's claim must evaluate as a business decision whether it is worth pursuing the claim on the prospective client's behalf.

Most victims of medical error do not file a claim—one comprehensive study found that only 1.53% of those who were injured by medical negligence even filed a claim. Most claims—57%-70%—result in no payment to the patient. When a patient does decide to go into the litigation system, only a very small number recover anything. One study found that only 8%-13% of cases filed went to trial; and only 1.2%-1.9% resulted in a decision for the plaintiff. (USHHS 2002, 8)

The high initial costs of the tort system thus contribute to a wide disparity in the amounts recovered through it.

The Harvard Medical Practice Study found that only one in eight cases of medical malpractice generated a tort claim and only one in three instances of serious malpractice generated a claim. At the same time, most of the claims that were filed arose from cases where there was no malpractice—and often where there was no injury. The mismatch between claims and actual negligence reflects the difficulty patients have in determining whether their condition results from negligent treatment or the disease process itself. (Weiler 1991, 73-74; Weiler 1993, 912-13)

The tort system is further plagued by the unpredictability and wide disparity of jury verdicts, especially with regard to non-economic damages. While economic damages are rather easily quantified, non-economic damages (i.e., “pain and suffering”) are less quantifiable and predictable.

Non-economic damages are an effort to compensate a plaintiff with money for what are in reality non-monetary considerations. The theories on which these awards are made, however, are entirely subjective and without any standards.

Unless a state has adopted limitations on non-economic damages, the system gives juries a blank check to award huge damages based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status (educated, attractive patients recover more than others). (USHHS 2002, 8, 9; see also Metzloff 1996, 206)

The lack of standards for non-economic damages can result in less severely injured plaintiffs receiving greater compensation than some who are more severely injured.

Unqualified Juries

Doctors have long argued that judges and lay juries lack the qualifications to accurately determine medical malpractice liability (Struve 2004a, 955-64).²¹ The tort system relies largely on lay juries who lack the necessary knowledge to render a well-informed verdict. In complex litigation such as medical malpractice, the technical nature of the issues may often be beyond the grasp of the juror. When the jury does not understand the evidence, the danger increases that the jury will act on personal bias, deciding the case by factors irrelevant to the merits. Some have argued that this happens too often.

With respect to liability, critics argue that juries are predisposed toward compensating sympathetic plaintiffs, are subject to cognitive biases that lead them to blame bad outcomes on negligence, and lack the capacity to understand expert testimony, especially if that testimony concerns probabilistic evidence. (Struve 2003, 34-35)

This negative view of the jury's performance is itself controversial; indeed, Struve herself concludes that "the available data suggest that, overall, juries perform fairly well in malpractice cases, though aspects of their work could be improved" (Struve 2003, 35). Among the measures that may improve jury performance are permission to take notes, structuring the trial to permit a more logical sequence of evidence and argument, and giving the jurors written copies of crucial exhibits and the legal instructions (Struve 2003, 86-87).

²¹ For a comprehensive analysis of the performance of the jury in medical malpractice cases, see Neil Vidmar, *Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets and Outrageous Damage Awards* (Ann Arbor, Mich.: University of Michigan Press 1995).

One criticism of the jury that seems unfounded is the claim that juries are predisposed to find for the patient. The studies evaluating jury performance disagree regarding whether juries tend to favor the physician (see Struve 2003, 39-40) or are about equally inaccurate in favor of each side (see Weiler 1991, 25-26 and note 26), but they fail to find systemic bias in favor of the patient.

Biased and Unqualified Expert Witnesses

Expert witnesses are almost always employed by both sides to evaluate the case and explain the scientific basis for the claims and defenses. However necessary, expert witnesses are expensive, and the cost they add to the case directly reduces the compensation the plaintiff receives.

From the 1890s to the present, physicians have complained that the trial courts permit medical expert testimony from people whose qualifications are insufficient to render a sound opinion or whose opinion can be bought for a sufficient price. The evidence suggests that judges assess the educational and professional qualifications of expert witnesses; once the judge is satisfied on that score, further consideration of the validity of the opinion is left to the jury, because the courts have trouble performing the additional screening for such factors as methodological error as mandated by controlling case law. (Struve 2004a, 980-82)

Emotional Stress

The adversarial nature of the tort liability system leads many claimants and physicians to view it as highly unpleasant at best. Neither claimants nor individual medical providers are routine litigants. On the patient's side, the lawsuit can bring back memories of an unexpected injury or the death of a loved one, along with anger at the health care provider's real or imagined fault in bringing the injury about. Although the doctor or other health care professional usually relies on insurance coverage to defray the amount of a judgment, he or she may see the case as a quasi-prosecutorial inquest into professional competence, giving rise to anger when the charge is untrue and to guilt when the facts are

ambiguous. Malpractice cases are particularly likely to be the kind Judge Learned Hand had in mind when he remarked that “as a litigant I should dread a lawsuit beyond almost anything else short of sickness and death.”²²

Some litigants on both sides may see the trial process as personally demeaning:

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. (Mehlman 2003, 56)

In medical malpractice litigation, the obstruction of lines of communication due to fear of damage to each party’s legal position may heighten anxiety and anger even before the filing of the complaint. Indeed, it appears that many cases are filed partly because the patient feels a lawsuit is the only way to discover what went wrong (Struve 2003, 23). The fact that medical malpractice litigation tends to be prolonged also contributes to emotional distress.

Impediments to Patient Safety

The need to establish negligence is at the heart of the tort system as it relates to medical malpractice, but some observers believe the establishment of fault does little to make the health care system safer for patients. While the case is pending, communication between the patient and the health care provider often ceases altogether, making it difficult for the provider to assess what went wrong and what can be done to prevent recurrence of the problem. In cases that settle, there are often non-disclosure agreements, further hindering the flow of information in the effort to improve patient safety. One observer finds the litigation process incompatible with patient safety initiatives.

²² Quoted in *Nixon v. Fitzgerald*, 457 U.S. 731, 763 n. 6 (1982).

Almost all of what ought to happen in error reduction is inconsistent with almost all of what happens in traditional litigation. For example, error reduction requires that errors be addressed as outputs of systems. Litigation, by contrast, focuses on the isolated activities of individuals. Error reduction requires full information about the instances and causes of errors. The risks of creating adverse evidence for litigation, however, tend to push information further underground. Error reduction requires a non-punitive environment, within which accidents can be approached as learning opportunities. Medical liability litigation is nothing if it is not punitive. (Dauer 2000, 7-8)

This emphasis on fault may obscure the fundamental reality that many medical errors result less from personal fault than from failure of the treatment system. The effort to attribute fault may be better directed toward improving patient safety. Furthermore, the obsession with proving fault likely contributes to the inequitable distribution of compensation to victims and inappropriate branding of certain doctors as incompetent or dangerous.

According to a recent report by the Kaiser Permanente Institute for Health Policy, relatively few medical errors result from incompetence, carelessness, or intentional misconduct by caregivers. Most errors result from human shortcomings and lapses made under time pressure within complex systems of care that have not been designed to prevent errors. (OHCR 2003, 11)

The focus on establishing and defending against malpractice claims may divert time and money from the potentially more fruitful efforts to improve medical safety for all and to compensate the medically injured quickly and equitably.

Conclusion

This chapter has focused on the criticisms of the present tort litigation system of compensation for medical malpractice, which is by far the predominant system at present. Numerous sources agree that the malpractice system is too costly, too slow, emotionally distressing, and too scattershot in matching compensation to injury and damages. The criticisms leveled at the tort system partly explain why some observers have advocated an alternative system or a more radical reform of the tort system than has yet been implemented.

CHAPTER 3

CURRENT REFORMS

This chapter details the recent changes in the statutory law and court rules that have been implemented to respond to the medical malpractice crisis, starting with the adoption of the Mcare Act.

Medical Care Availability and Reduction of Error (Mcare) Act

Policy

The Mcare Act²³ is intended to ensure access to a comprehensive and high-quality health care system, affordable medical professional liability insurance throughout Pennsylvania, prompt determination and fair compensation for injuries resulting from medical negligence, and a comprehensive effort to reduce medical errors and promote patient safety. (§§ 102 and 502)

Patient Safety

Patient Safety Authority (PSA). The act establishes the PSA,²⁴ which is directed to collect, analyze, and evaluate data regarding reports of serious

²³ Section references in this subchapter are to the Mcare Act, unless otherwise noted. This subchapter summarizes the provisions of the Mcare Act, omitting details that may be significant in individual cases. The following provisions in the Mcare Act substantially reenacted provisions of the Health Care Services Malpractice Act (October 15, 1975 (P.L.390, No.111)) (HCSMA) and are therefore not summarized here: informed consent (Mcare Act § 504; HCSMA § 811-A); punitive damages (Mcare Act § 505; HCSMA § 812-A); dismissal of uninvolved providers from liability (Mcare Act § 506; HCSMA § 827-A); and advance payments by providers to claimants (Mcare Act § 507; HCSMA § 831-A).

²⁴ The composition of the authority is set forth in § 303(b).

events and incidents,²⁵ including the identification of performance indicators and patterns in frequency or severity at certain medical facilities or in certain regions of Pennsylvania; recommend changes in practices to reduce the number and severity of serious events and incidents; advise medical facilities of changes that can be instituted to reduce serious events and incidents; and report annually on its activities, findings, and recommendations (§ 304).²⁶ The Department of Health assesses the medical facilities a proportionate share of the authority's budget, paid as a surcharge on its licensing fees (§ 305).

Patient Safety Plan. In order to improve patient health and safety, a medical facility must develop and comply with an internal patient safety plan. The plan must designate a patient safety officer and establish a patient safety committee under statutory guidelines,²⁷ a round-the-clock system for reporting serious events and incidents, and safeguards against retaliatory action against a worker for reporting. Compliance with the patient safety plan is required as a condition of employment or credentialing at the medical facility. (§ 307)

Notice of Serious Events. A health care worker who reasonably believes that a serious event or incident has occurred must report it within 24 hours after its occurrence or discovery. A medical facility must provide written notification of a serious event to the patient or the family within seven days of occurrence or discovery. Notification does not constitute an acknowledgment or admission of liability. (§ 308) The act also provides a comprehensive framework regarding confidentiality and use of relevant information (§ 311).

Patient Safety Discounts. A medical facility may apply to the Insurance Department for a patient safety discount regarding any certified program that results in the reduction of serious events at the facility, pursuant to certification criteria developed by the Department of Health in consultation with the Insurance Department (§ 312).

Reporting by Medical Facilities. A medical facility must report the occurrence of (1) a serious event to the Department of Health and the PSA within 24 hours of the medical facility's confirmation of the occurrence, (2) an incident

²⁵ A "serious event" is defined as an event or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient. An "incident" is an event or situation involving the clinical care of a patient in a medical facility that could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health services. (§ 302)

²⁶ The authority may conduct reviews of anonymous reports from health care workers regarding a serious event. After providing notice to the affected medical facility, the authority must conduct its own review unless the medical facility has already begun an investigation. (§ 304(b))

²⁷ The guidelines governing this committee are set forth in § 310.

to the authority as prescribed by the statute, and (3) an infrastructure failure (as defined in § 302) to the Department of Health within 24 hours of the medical facility's confirmation of its occurrence or discovery (§ 313). Failure to report a serious event or infrastructure failure, develop and comply with the patient safety plan, or properly notify a patient violates the Health Care Facilities Act (35 P.S. §§ 448.101 et seq.) and may result in administrative penalties of up to \$1,000 per day of violation. (§ 313(f))

Medical Professional Liability

Collateral Sources. A claimant may not recover damages for past medical expenses and past lost earnings incurred to the time of trial to the extent that they are covered by a private or public benefit or gratuity that the claimant has received before trial. Although the claimant may show the amount of medical expenses incurred, the claimant may not recover them if insurance is responsible for their payment. There is no right of subrogation or reimbursement from a claimant's tort recovery with respect to a covered public or private benefit. Exceptions to these provisions include life insurance, pension or profit-sharing plans, other deferred compensation plans, Social Security benefits, and certain state and federal public benefits. (§ 508)

Determination of Damages. In actions governed by Mcare, the trier of fact must make separate findings for each claimant specifying the amount of past and future damages for medical and other related expenses, loss of earnings or earning capacity, and noneconomic losses. Future damages must generally be paid periodically unless they amount to less than \$100,000. (§ 509) Future damages for loss of earnings or earning capacity must be reduced to present value based on the return that the claimant can earn on a reasonably secure fixed income investment. Damages must be presented through competent evidence concerning productivity, inflation, and the applicable discount rate. (§ 510)

Expert Qualifications. A person is competent to provide an expert medical opinion against a physician only if the person possesses sufficient education, knowledge, and experience to provide credible and competent testimony. In order to testify on a medical issue, the expert must possess an unrestricted license to practice medicine in the United States and be engaged in active clinical practice or teaching, or retired from those pursuits within the previous five years. An expert testifying as to a physician's standard of care must be familiar with the applicable standard of care for the care at issue, practice in the same subspecialty as the physician or in a subspecialty that has a similar standard of care, and be board certified by the same or a similar board as the defendant physician. The act provides limited exceptions to these rules. (§ 512)

Time Limitations. With limited exceptions, a medical malpractice claim may not be commenced after seven years from the date of the alleged tort or breach of contract. If the claim is brought under 42 Pa.C.S. §§ 8301 and 8302 (relating to death actions and survival actions), the action must be commenced within two years after the death unless there was misrepresentation or fraudulent concealment of the cause of death. An alleged victim who was less than 18 years old at the time of the injury may sue within seven years or until he or she turns 20, whichever is later. (§ 513)

Remittitur. If a health care provider challenges a verdict on grounds of excessiveness, the trial court in deciding whether to reduce the verdict must consider the impact on availability or access to health care in the community if the defendant must satisfy the verdict.²⁸ If the trial court denies the motion, it must set forth the factors and evidence considered. (§ 515)

Vicarious Liability. A hospital may be held vicariously liable through ostensible agency only if either (1) a patient would be reasonably justified in believing that the care was rendered by the hospital or its agents or (2) the care was represented to the patient as rendered by the hospital or its agents. Evidence that a physician holds staff privileges at a hospital is not by itself sufficient to establish such agency. (§ 516)

Medical Malpractice Insurance

Mandatory Coverages.²⁹ The Mcare Act mandates that each health care provider who renders 50% or more of his or her professional medical services within the Commonwealth must obtain basic (primary) professional liability insurance with an insurance carrier licensed or approved by the Insurance Department or with an approved self-insurance plan (primary coverage). In addition, each participating health care provider must also obtain excess professional liability coverage by paying a certain percentage of the prevailing primary premium charged by JUA to Mcare. The appropriate percentage (assessment) varies each year based upon payments made by Mcare in the previous year. All assessment funds received by the Mcare Fund are used either to pay claims against participating health care providers for losses or damages awarded in medical professional liability actions in excess of the required basic insurance coverage, up to the limits of the fund, or to pay for the administration of the Mcare Fund.

²⁸ The Supreme Court has promulgated a rule requiring remittitur where the award deviates from a reasonable amount. See page 44.

²⁹ This section is based on material supplied by the Office of Mcare of the Insurance Department. See Mcare Act, §§ 711, 712, and 745.

Participation in Mcare is mandatory for hospitals, nursing homes, birth centers, primary health centers, physicians, osteopathic physicians, podiatrists, and nurse midwives licensed or approved by the Commonwealth who conduct 50% or more their health care business within the Commonwealth. Professional corporations, associations, or partnerships owned entirely by health care providers may elect to insure their basic liability. If they so choose, then their participation in Mcare is mandatory.

Historically, the necessary coverage limits required to be maintained by participating health care providers has varied from \$200,000 to \$400,000, with a required mandatory coverage of \$1.2 million per occurrence. However, for 2003 and beyond, under the Mcare Act, the total required limit of medical professional liability coverage, excluding hospitals, is \$1 million per occurrence, and \$3 million per annual policy year aggregate. For hospitals, the required total limits are \$1 million per occurrence, and \$5 million per annual aggregate. This breaks down as follows:

Primary Limits. For 2003-05, the Mcare Act requires primary coverage in the amount of \$500,000 with a total annual aggregate of \$1.5 million. Hospitals must obtain primary coverage in the amount of \$500,000, with a total annual aggregate of \$2.5 million.

Mcare Limits. For 2003-05, Mcare provides participating health care providers, other than hospitals, coverage of \$500,000 per occurrence, and \$1.5 million per annual aggregate in excess of the primary coverage. Hospitals are provided coverage of \$500,000 per occurrence and \$1.5 million per annual aggregate in excess of primary coverage.

As of 2006, the primary limits are scheduled to increase to \$750,000 per claim, and the Mcare Fund's layer of coverage is scheduled to decrease to \$250,000 per claim, unless the Insurance Department determines that there is insufficient capacity in the primary market. As of 2009, Mcare coverage is scheduled to be phased out completely, again unless the Department determines that there is insufficient capacity in the primary market. Any balance remaining in the fund as of termination is to be returned pro rata to participating health care providers.

Mcare Fund. The purpose of the Mcare Fund is to pay claims, up to specified liability limits, against participating health care providers for damages awarded in excess of required basic insurance coverage. (§ 712)

The act provides a formula for discounts on surcharges and assessments. JUA must annually file updated rates for all health care providers with the Insurance Department. The department may adjust the prevailing primary premium in line with any changes approved by it.³⁰ The premium of a participating non-hospital provider may be increased by as much as 20%, based on the frequency and severity of claims paid by the fund on behalf of the provider. The premium of a participating health care provider not engaged in direct clinical practice on a full-time basis may be decreased up to 10% based on lower risk. The premium of a hospital may be increased or decreased up to 20% based on the frequency and severity of claims paid by the fund compared other similar hospitals. The act also addresses self-insured health care providers, changes in basic insurance coverage, and payment of claims.

The fund is supported primarily by the annual assessment on participating health care providers. The surcharges for the vehicle violations listed in 75 Pa.C.S. § 6506(a) are to be added to the Mcare Fund to reduce Mcare premium surcharges and assessments.³¹ Other funding sources are the funds remaining in the CAT Fund under the former HCSMA, investment income, and contributions from nongovernmental sources. The aggregate assessments must produce an amount sufficient to reimburse the fund for the payment of reported claims that became final during the preceding claims period, plus administrative expenses, principal and interest on moneys transferred into the fund,³² and a reserve of 10% of its obligations.

Claims. The Insurance Department may defend, litigate, or settle claims payable by the fund. A party may request mediation where multiple carriers disagree on the disposition of a case, and upon the consent of all parties, the mediation is binding. (§ 714)

Joint Underwriting Association. The act provides a statutory framework for JUA, which offers medical malpractice insurance to health care providers who cannot conveniently obtain such insurance at reasonably affordable rates (§§ 731—733).

Claims Made Policies. Malpractice policies written on a “claims made” basis are illegal unless the insurer guarantees to the Insurance Department the continued availability of adequate “tail” coverage (§ 742).

³⁰ The “prevailing primary premium” is the schedule of occurrence rates approved by the insurance commissioner for the JUA (§ 702).

³¹ This provision expires at the end of 2013. Thereafter, the vehicle violation surcharges are to be deposited into the General Fund.

³² The Governor may transfer amounts to the fund from other sources, such as the Catastrophic Loss Benefits Continuation Fund, as necessary to pay the fund’s liabilities until the fund realizes sufficient revenues (§ 713(c)).

Reports. The Insurance Department must prepare an annual comprehensive report of data related to the Mcare Act under detailed guidelines. To assist the department, insurers and self-insured providers are required to report claims paid, expenses incurred, and loss reserves to the department. (§ 743)

Licensure Regulation

Reporting. A physician must report to the State Board of Medicine or the State Board of Osteopathic Medicine (licensure boards) within 60 days of occurrence a medical malpractice action, disciplinary action by the licensing authority of another state, sentencing for specified offenses listed in the professional licensure statutes, or arrest for criminal homicide, aggravated assault, a sexual offense, or a drug violation (§ 903).

Disciplinary Investigations and Actions. The licensure boards are directed to develop standards for review based on the frequency and severity of complaints filed against physicians. An investigation based on a complaint must be started within four years from the complaint. Unless an investigation has already been initiated, the licensure board must commence an action against a physician no later than four years from the time it receives notice of a malpractice action, a payment reported to the NPDB, a payment in a medical malpractice action reported to the licensure board by an insurer or a report made under section 903, whichever occurs first. (§ 904) If the licensure board determines that the physician has practiced negligently, it may impose disciplinary sanctions or corrective measures (§ 905).

Confidentiality. A confidentiality agreement in a medical malpractice action or a court order sealing the settlement records may not prevent the licensure board from obtaining the medical records of the patient. The licensure board must obtain the consent of the patient or his or her legal representative. (§ 906)

Information used solely for the state board's investigation, including the complaint, is confidential, and no one may testify about it in a judicial or administrative proceeding without the licensure board's written consent. However, the contents of an investigative file or related witness testimony may be introduced in a hearing or proceeding before the licensure board. Disclosure is permitted regarding the status of a professional license, permit, or certificate, or a public disciplinary proceeding. (§ 907)

Penalties. In addition to any other applicable penalties, the licensure boards may levy a civil penalty of up to \$10,000 on a licensee who violates the Mcare Act or the medical or osteopathic licensure acts, or on a person who practices medicine or osteopathic medicine without being properly licensed. (§ 908)

Reports. Each licensure board must submit an annual report to the Legislature that includes the numbers of complaints, disciplinary sanctions, and other specified licensure actions over the preceding five years. (§ 909)

Continuing Medical Education (CME). Each licensure board must promulgate and enforce regulations regarding CME requirements. Licensees must complete at least 100 hours of mandatory during each two-year licensure period. The licensure board is to establish a minimum number of CME hours required in patient safety and risk management. Qualifications for exemptions and waivers are provided. (§ 910)

Other Legislation

Joint and Several Liability

Act 57 of 2002³³ replaced joint and several liability with proportional liability.³⁴ The section now provides that where liability is determined against more than one defendant, each defendant is liable for that proportion of the total dollar amount awarded as damages in the ratio of the amount of that defendant's liability to the amount of liability attributed to all defendants and other persons. A defendant's liability is several and not joint, and the court must enter a separate judgment against each defendant for the apportioned amount of that defendant's liability. There are exceptions where a defendant's liability remains joint and several, including where the defendant is liable for 60% or more of the total liability apportioned to all parties.³⁵

³³ Act of June 19, 2002 (P.L.394, No.57), amending 42 Pa.C.S. §7102.

³⁴ Under joint and several liability, a defendant with very minimal negligence could be held responsible for the entire damage award, with a right to contribution from the other co-defendants for the amount that defendant's payments exceeded the proportionate part of the total award.

³⁵ Whether joint and several or proportional liability applies, a defendant may recover from any other person damages assessed the defendant under the terms of a contract (42 Pa.C.S. § 7102(b.1)(4)).

The constitutionality of Act 57 was challenged almost immediately after its enactment on the grounds of violations of the Original Purpose³⁶ and the Single Subject³⁷ Clauses of the Pennsylvania Constitution. *DeWeese v. Weaver*, 824 A.2d 364 (Pa. Commw. 2003). Senate Bill 1089 of 2001, the legislation that became Act 57, originally consisted of amendments to the DNA Detection of Sexual and Violent Offenders Act, and the proportional liability measure was amended into the bill after the DNA Act amendments had been passed by both Houses in different versions. The Commonwealth Court overruled the objection based on the Original Purpose Clause, but permitted suit to proceed on the Single Subject issue without finally invalidating Act 57. The court held that the DNA Act amendments and the amendment instituting proportional liability were not sufficiently germane to one another to satisfy the Single Subject Clause. As of this writing, the case is pending before the Pennsylvania Supreme Court.³⁸

Venue

Act 127 of 2002³⁹ specified that a medical professional liability action may be brought against a health care provider only in the county in which the cause of action arose. The intent of § 5101.1 was to prevent the costly practice of “venue shopping,” the practice where plaintiffs moved their cases to counties where they could expect more favorable judgments.⁴⁰

Mcare Premium Abatement

Act 44 of 2003⁴¹ provides a statutory framework to waive or significantly reduce Mcare premiums relative to the physician’s specialty for 2003 and 2004. The legislation establishes the Health Care Provider Retention Program within the Insurance Department. The program includes eligibility standards for health care providers; procedures for application, review and refund; reports concerning the

³⁶ “No law shall be passed except by bill, and no bill shall be so altered or amended, on its passage through either House, as to change its original purpose.” Article III, § 1.

³⁷ “No bill shall be passed containing more than one subject, which shall be clearly expressed in its title, except a general appropriation bill or a bill codifying or compiling the law or a part thereof.” Article III, § 3.

³⁸ In *Estate of Louise Hicks v. Dana Corp.* (Case Number 3509, Philadelphia Court of Common Pleas, December 2002) the court also held that Act 57 violates the Single Subject Clause.

³⁹ Act of October 17, 2002 (P.L.880, No. 127), adding 42 Pa.C.S. § 5101.1.

⁴⁰ The statutory provisions were incorporated into Pa.R.C.P. No. 1006. See page 42.

⁴¹ Act of December 23, 2003 (P.L.237, No.44), adding § 443.7 and article XIII-A (§§ 1301-A—1310-A) to the Public Welfare Code; 62 P.S. §§ 443.7 and 1301-A—1310-A. A recent amendment extended the program through 2006 and made podiatrists eligible. Act of November 29, 2004 (P.L.1272, No.154).

number of health care providers who apply for abatement, who are granted abatement, and who leave Pennsylvania after receiving abatement; the number of and reason for any unapproved applications; and violations for submitting false or fraudulent information and for willfully divulging confidential information.

Physicians assessed as members of one of the four highest rate classes of the prevailing primary premium, emergency physicians, physicians routinely providing obstetrical services in rural areas, and certified nurse midwives are entitled to have all of their Mcare premium paid through the program. Other physicians may receive a 50% abatement. With limited exceptions, a health care provider seeking an abatement must continue to provide health care services in Pennsylvania for at least one full calendar year following the year for which the abatement was received, or the provider must repay all the abatement plus administrative and legal costs. The program will expire December 31, 2006.

The program is in part funded by a 35-cent increase in the cigarette tax, 25 cents of which is earmarked for this program, yielding \$181 million.⁴² Supplemental funding as needed is mandated from the Mcare Fund. As of May 12, 2004, the department had reviewed 36,091 abatement applications from 33,239 health care providers for the 2003 abatement program. Of the health care providers who submitted 2003 abatement applications, 4,928 certified themselves as eligible for 100 percent abatement, and 25,360 certified themselves as eligible for 50 percent abatement. The 2003 abatement program has provided over \$207 million of financial relief to Pennsylvania Mcare participants.⁴³

Supreme Court Rules

Since enactment of the Mcare Act, the Pennsylvania Supreme Court has promulgated a substantial set of procedural rules that either cover medical malpractice litigation or seem directed at issues associated with such litigation.

⁴² The cigarette tax increase is provided by § 1206 of the Tax Reform Code of 1971, added by the act of December 23, 2003 (P.L.250, No.46). The partial allocation of the cigarette tax increase to the program is made by § 1211 of the Tax Reform Code, also added by Act 46. The estimated yield of the allocation to the program is supplied by the Fiscal Note to 2003 House Bill 200, the bill enacted as Act 46.

⁴³ Insurance Department, Mcare Fund, Health Care Provider Retention Program (Harrisburg: Insurance Department, May 15, 2004), 2, 3, 5.

Frivolous Lawsuits

Rules of Civil Procedure have been promulgated to discourage frivolous lawsuits in general. A pleading, motion, or other formal written submission to the court must be signed by an attorney of record or by the party if there is no attorney. Signatories certify that they have read the document and to the best of their knowledge, after reasonable inquiry, it has not been presented for an improper purpose; the legal contentions are warranted by existing law or by a nonfrivolous argument for its modification or reversal; and the factual allegations or denials are supported by evidence or are likely to have evidentiary support after further investigation. The sanction for a violation is limited to what is sufficient to deter repetition of similar conduct, and may include the dismissal of all or part of the submission, monetary penalties, or reasonable attorney fees and expenses. (Pa.R.C.P. Nos. 1023.1—1023.4)

Certificate of Merit

In actions for professional malpractice (including medical malpractice), plaintiff's attorney, or the plaintiff if he or she is not represented, must sign and file a certificate of merit with the complaint or within 60 days after filing it. The certificate must state that either (1) an appropriate licensed professional has supplied a written statement that there is a reasonable probability that the care, skill, or knowledge exhibited in the work that is the subject of the complaint fell outside acceptable professional standards and that such conduct was a cause of the harm;⁴⁴ (2) the claim that the defendant deviated from an acceptable professional standard is based on allegations that other licensed professionals for whom this defendant is responsible deviated from an acceptable professional standard;⁴⁵ or (3) expert testimony of an appropriate licensed professional is unnecessary for prosecution of the claim.⁴⁶ A separate certificate must be filed for each professional defendant. A defendant who files a counterclaim asserting a claim for professional liability must also file the certificate. However, any defendant who has joined a licensed professional as an additional defendant need not file the certificate unless the joinder is based on negligent acts unrelated to those alleged by the plaintiff. (Pa.R.C.P. No. 1042.3)

⁴⁴ The professional who supplies the statement in support of the certificate need not be the same person who will actually testify at trial, but must have sufficient qualifications to give credible, competent testimony.

⁴⁵ In such a case, certificates of merit must be filed as to the other licensed professionals whether or not they are named as defendants in the action.

⁴⁶ Absent exceptional circumstances, the attorney filing under this alternative is bound by the certification, and the trial court must preclude the plaintiff from presenting expert testimony on standard of care and causation.

If plaintiff fails to timely file a certificate of merit or move for an extension, the defendant may have the claim dismissed (Pa.R.C.P. No. 1042.6). If a plaintiff files a certificate of merit as to a particular defendant and that defendant is dismissed from the case, the plaintiff must provide the written statement of the licensed professional, upon which the certificate of merit as to that defendant was based, within 30 days of the defendant's written request. The court may impose appropriate sanctions upon the attorney if the certification was not supported by the required professional statement. (Pa.R.C.P. No. 1042.7)

Designation

In actions in which there is a claim of medical professional liability, all legal papers filed in the action must contain the designation "Civil Action-Medical Professional Liability Action" (Pa.R.C.P. No. 1042.18). This will assist the Court in collecting data concerning such litigation.

Venue

In accordance with 42 Pa.C.S. § 5101.1(b), as amended by the Act 127 of 2002, Pa.R.C.P. No. 1006 is amended to lay venue in medical malpractice actions only in a county where the malpractice cause of action arose. This rule applies even if the medical malpractice claim is joined with other claims against the defendant. If an action claiming joint or joint and several liability against two or more defendants includes a medical malpractice claim, the action must be brought where venue for the malpractice claim may be laid against any defendant.⁴⁷

Pre-Trial Procedures

Settlement Conference or Mediation. Prior to the exchange of expert reports in a medical malpractice action, a health care provider may move for a settlement conference or court-ordered mediation. If some of the parties do not consent to the motion, the moving party must certify that it believes a realistic possibility of settlement exists. A motion requesting mediation must describe the mediation sought, and the moving party must pay for the mediation. The court must consider any objections before entering an order. (Pa.R.C.P. No. 1042.21)

⁴⁷ This rule is applicable to defendants who are business entities as well as individuals (Pa.R.C.P. Nos. 2130, 2156, and 2179).

Expert Reports. Rules 1042.26 through 1042.38 regulate the preparation and exchange among parties of expert reports in medical malpractice actions. These rules apply only in judicial districts where the court of common pleas has not established case management deadlines.

A party may request the production of expert reports summarizing the testimony pertaining to all liability issues, including professional negligence and causation, for which the requested party will offer expert testimony at trial in support of claims or defenses against the requesting party. An expert report must reflect the best information available to the party producing the report at the time it is produced. (Pa.R.C.P. No. 1042.27) Time requirements are provided for the exchange among the respective parties of the reports. (Pa.R.C.P. No. 1042.28, 1042.29, and 1042.30)

A party may serve additional and supplemental expert reports without leave of court, unless the court's deadline for the production of expert reports has passed or the court has precluded such production. The reports may introduce new theories of liability or causation or new defenses. (Pa.R.C.P. No. 1042.32)

A party who has not received an expert report required to be produced may move for a court order compelling production. The court must consider the complexity of the case and the diligence of the parties in making and responding to the motion. A party who has proceeded with reasonable diligence must be given a reasonable time to complete necessary discovery and produce the report. The court may impose sanctions, including barring expert testimony on behalf of a party, for non-compliance with an order to compel production of the report. (Pa.R.C.P. No. 1042.31)

Mediation Privilege. In accordance with 42 Pa.C.S. § 5949, mediation communications and documents may not be obtained through discovery (Pa.R.C.P. No. 4011).

Scheduling Order. If there is no court-established schedule for the completion of discovery and production of expert reports and if more than one year has elapsed since the first answer was filed, a party to a medical malpractice action may move the court to issue a scheduling order (Pa.R.C.P. No. 1042.41).

Pre-Trial Conference and Elective Mediation. After the parties have produced or exchanged expert reports as to liability and before the court has set a trial date, any party to a medical malpractice action may move to schedule a pre-trial conference. At the conference, the court must schedule either the trial or another pre-trial conference and must ask the parties whether they are willing to

participate in mediation. On February 1 and September 1 of each year, the judicial districts must file with AOPC a list of all medical malpractice cases that have not been tried within nine months of the pre-trial conference. (Pa.R.C.P. No. 1042.51)

Standards for Noneconomic Damages

The Court has specified the jury instructions that must be given in an action for bodily injury or death in which a plaintiff has claimed noneconomic loss. The jury instructions explain that the plaintiff is entitled to fair and adequate compensation for the following noneconomic losses resulting from the injuries sustained: pain and suffering, including physical pain, mental anguish, discomfort, inconvenience, and distress; embarrassment and humiliation; loss of the ability to enjoy the pleasures of life; and disfigurement. In determining damages for noneconomic loss, the jury must consider the following eight factors: the plaintiff's age, the severity of the injuries, whether the injuries are temporary or permanent, how much the injuries affect the plaintiff's ability to perform basic activities in which he or she previously engaged, the duration and nature of medical treatment, the duration and extent of the physical pain and mental anguish, the plaintiff's pre-injury physical condition, and the nature of any disfigurement and its consequences. (Pa.R.C.P. No. 223.3)

Findings of Damages

At the request of any party to a medical malpractice action, the trier of fact must determine specific amounts of past and future damages by category for each plaintiff as required by Mcare Act § 509 (Pa.R.C.P. No. 1042.71).

Remittitur

In medical malpractice actions, a defendant may file a post-trial motion claiming that the damage award for noneconomic loss is excessive and asking that it be reduced. An award is excessive if it deviates substantially from what is reasonable, after consideration of the evidence supporting the plaintiff's claim; the factors that are required to be taken into account in making the award;⁴⁸ and whether the award assessed in light of the evidence strongly suggests that the trier of fact was influenced by passion or prejudice. The defendant bears the burden of convincing the court that the award deviates from reasonable compensation. If

⁴⁸ These are set forth in Pa.R.C.P. No. 223.3.

the court finds that the award for noneconomic damages is excessive, it must grant remittitur. If the plaintiff declines to accept the award as remitted, the court is to grant a new trial limited to the amount of noneconomic damages. The court must decide the motion within 120 days of filing. (Pa.R.C.P. Nos. 1042.72 (added)⁴⁹ and 227.4 (amended))

⁴⁹ Pa.R.C.P. No. 1042.72 expires on September 17, 2009, unless continued by Supreme Court order.

CHAPTER 4

PATIENT SAFETY

A growing body of research focuses on patient safety enhancement as a promising means for improving the medical delivery system.⁵⁰ Effective patient safety measures will lead to fewer medical errors and fewer malpractice claims, thereby alleviating some of the problems with the liability compensation system as well. According to law and health policy researchers, patient safety can be realized best in the context of institutional reform and must be tied to strong reporting requirements that nevertheless deemphasize personal blame. Systematic study of errors that occur despite increased vigilance of patient safety can guide future improvements. The intensive study of patient safety issues has largely developed since the malpractice crisis of the 1980s and represents a significant change in the health policy landscape.

A major impetus for the recent emphasis on patient safety has been a multi-year study conducted by the Institute of Medicine (IOM), the public health research agency of the National Academy of Sciences. Its series of comprehensive reports, comprising *To Err Is Human* (2000), *Crossing the Quality Chasm* (2001), and *Patient Safety* (2004), included a large number of patient safety recommendations.

State of Patient Safety

It has been estimated that medical errors lead to 44,000 to 98,000 deaths out of 33.6 million annual hospitalizations; death by error amounts to the eighth leading cause of death overall. Of these, approximately 7,000 deaths are from errors in medication. More deaths result from medical errors than from motor vehicle accidents, breast cancer, or AIDS. (IOM 2003, 1, 26)

⁵⁰ See first paragraph of chapter 1.

The problem of medical errors is exacerbated by the loose and fragmented system of care. Patients are seen by a number of rigidly defined specialists, who often fail to share information. Information glitches reduce the effectiveness of coordinated care. “Unsafe care is one of the prices we pay for not having organized systems of care with clear lines of accountability.” (IOM 2003, 3)

Improving patient safety has been as important a goal of state legislatures as has medical malpractice litigation reform. Various states have implemented procedures for hospitals to evaluate the performance of new doctors and report on adverse events. Health care organizations have been prodded to develop guidelines and protocols for risky procedures, and state health departments have become more vigilant in observing medical conduct by monitoring hospital incident reporting mechanisms, reports from malpractice insurers, and patient complaints. (Weiler, et al. 1993, 10)

Kieran Walshe and Stephen M. Shortell studied instances where deficiencies in a health care organization have led to a series of incidents that affected many patients over a short time period. These include persistent unsafe practices, selection of clearly incompetent practitioners, and even serial murders by hospital personnel. They find a “culture of secrecy, professional protectionism, defensiveness, and deference to authority” at the core of such events. Improved patient safety requires cultural as well as structural change in health care systems. In many ways, these improvements are similar to safety and reliability standards that have long been applied to industrial and commercial settings. (Walshe and Shortell 2004, 103)

In outlining the nature of major failures several common themes appear. They often result from longstanding problems that are known to health care organizations before these problems are made known to outsiders. In some organizations, some doctors have performed very poorly, even causing intentional harm, for years before their malpractice is publicized. In some instances problems are well-known to health authorities, but no action is taken to resolve them. Failures in patient safety can cause widespread harm that lead not only to malpractice suits but also to damage to the reputation of the health care organization. Many patient safety failures result from a lack of clinical leadership and fundamental management systems for ensuring patient safety. Finally, some patient safety failures recur, suggesting that “lessons are not being learned.” (Walshe and Shortell 2004, 105-06)

Barriers to disclosure and investigation favor the development of major failures. Such failures are not usually exposed by the quality assurance system implemented to improve patient safety, despite accreditations and licensures. The culture of secrecy entices doctors to place self-interest above patient safety and some organization leaders to thwart accountability. Fragmentation of services

and personnel in the clinical setting inhibits discovery of the problems, as does duplication of investigative agencies and authorities. When failures occur, there are often many stakeholders who may know of the failure, but their disparate knowledge impedes post-event analysis. Self-deception can lead individuals and organizations to discount findings of failure and assignment of fault. Formal resolution is often replaced with informal actions, such as shuffling problem-prone doctors away to other regions of the health care system. Most importantly in the context of the liability system, nondisclosure agreements that often result from malpractice settlements impede patient safety improvements. Such settlements are a “Faustian bargain,” benefiting the injured patient at the expense of overall patient safety. (Walshe and Shortell 2004, 106-08)

Patient Safety and the Tort System

In chapter 4 of *Medical Malpractice on Trial*, Paul C. Weiler sets forth an influential analysis of the relationship that currently prevails between the tort law system and patient safety. The analysis begins by asking why patient injuries are compensated through medical malpractice insurance rather than first-party loss insurance, which compensates in proportion to need and avoids a costly and inefficient adversarial process. The tentative answer is that the tort system deters malpractice better. Loss insurance removes the financial burden from the party responsible. Tort liability, by contrast, assigns the cost to the party who was in a position to prevent harm, but failed to do so. “The prospect of legal intervention gives actors a financial incentive to do what is reasonable to protect others from the risk of injuries arising from the actor’s conduct.” (Weiler 1991, 70)

There is some doubt, however, whether the malpractice insurance and tort law system deters malpractice efficiently. Empirical research on whether or how much tort law deters malpractice is difficult. No comparison can be made between tort and non-tort jurisdictions in the United States because all jurisdictions use the tort system. (Some such research has been done concerning motor vehicle liability, but the analogy between that field and medical liability is obviously problematical.)

One reason why tort law may not effectively deter malpractice is that it is directed toward enforcing a customary standard of care, rather than an optimal standard. Furthermore, as this report has mentioned, the fit between tort recovery and cases of actual negligent medical injury is very poor. However, deterrence is provided to some extent because doctors cannot know which of the relatively small number of torts will end up in court, and research shows that doctors considerably overestimate the true risk of suit.

The growth in malpractice as a public issue is actually a consequence of the ever more exacting nature of medical practice. Technological and scientific advances make the operating room “a dangerous and unforgiving environment” where cases that formerly could not be treated at all now give rise to malpractice claims for injuries arising from “occasional and inadvertent slip-ups” (Weiler 1991, 75). Human error and frailty, including doctors’ mistakes, cannot be fully eradicated.

Malpractice insurance cushions the risk of liability by pooling it among individual doctors, thereby diluting liability’s deterrence effect. “Because it is the malpractice carrier for an entire pool of doctors that actually pays the award and the legal bill when a doctor is found negligent, the prospect of having to face such damages cannot be a meaningful spur to the individual doctor to be more careful and attentive” (Weiler 1991, 75-76). The liability insurance system thus creates a separation between the goals of patient compensation and error prevention.

Experience rating formulas could conceivably be used to resolve these goals. However, no effective system of deductibles and surcharges exists for medical malpractice liability, as it does in other forms of insurance (such as product liability and auto insurance). Instead, doctors are pooled geographically and by specialty, and malpractice premiums are determined from past results and future expectations for the entire pool. Tort awards drive up premiums for all physicians within a geographical area and specialty, while the doctor responsible for a tort sees no increase in premium as an individual. Consequently, the doctor has only an attenuated financial incentive to improve his or her practice of medicine. In order for an experience-rating mechanism to effectively prevent malpractice, the rating formula must produce actuarially credible indications of the true relative risk posed by individual doctors, the premium surcharge must be great enough to give doctors a significant financial incentive to improve their quality of care, and physician behavior must respond to such economic motivation. No experience rating system satisfies any of those criteria for individual doctors, although such systems have been effective for hospitals. (Weiler 1991, 77)

The bulk of the penalties imposed on a doctor by a malpractice claim occurs whether he or she wins or loses the tort case: psychological stresses, threat to professional reputation, and time and money lost from the practice of medicine to defend the case. Surcharges are unlikely to add a substantial incentive to these uninsurable costs.⁵¹ (Weiler 1991, 80-81)

According to Weiler, there is “elusive” evidence that malpractice cases have an effect on doctors’ behavior, but that effect is mainly to reinforce adherence to existing medical “custom,” not necessarily to institute practices that enhance patient safety (Weiler 1991, 84). There is evidence that malpractice litigation does prevent unsafe practices, but the effect appears to be “fairly modest” (Weiler 1991, 90).

Because insurance carriers (not physicians) pay malpractice settlements and judgments, and premium levels bear little relation to experience, incentives to ensure patient safety are not tightly connected to the actions of hospitals and doctors. Under the current litigation system, providers collect \$7 billion annually from patients to defray malpractice premiums, of which \$3 billion is paid to “a selection of injured patients” (Weiler 1991, 91). In the end, there is room for disagreement as to whether the current tort system provides sufficient incentives for doctors and hospitals to promote patient safety, and whether it does so at a reasonable cost.

Dr. William M. Sage sums up the deficiencies of the tort system as it related to patient safety:

In practice . . . the malpractice system fails to send clear signals for quality improvement. Few iatrogenic [physician-caused] injuries generate claims, courts do not always demand persuasive evidence of negligence, and juries may not award damages consistent with loss. Liability insurers do not experience-rate physician premiums and engage in risk-based underwriting only in troughs of the “insurance cycle,” which further attenuates the connection between liability and quality. Consequently, physicians consider malpractice law intrusive, expensive, and arbitrary and may react by covering up errors or practicing defensively. (Sage 2003, 28)

⁵¹ Weiler notes that average malpractice premiums are \$15,000, and he assumes a 100% surcharge for bad experience. To the extent premiums now are higher relative to physician income than they were in 1991, the deterrent effect of such a surcharge would presumably be greater.

The Pennsylvania Medical Society and the IFP vigorously dispute the claim that medical liability insurance insulates physicians from the consequences of medical malpractice and substandard care. Although it is difficult, if not impossible, to implement a fair and equitable experience rating system for physicians at present, virtually all carriers do employ experience rating plans that levy substantial surcharges on physicians with paid or even pending claims. Carriers terminate coverage on physicians with many claims or incidents, in which case they must face higher premiums either from alternative carriers or on the residual market. For physicians who are retained by a carrier, there are substantial variations in malpractice premiums based on their claims experience.

Harvard medical malpractice researchers David M. Studdert and Troyen A. Brennan suggest that shifting the onus of liability squarely onto institutions will encourage them to make changes in their practices. Such reforms must be grounded on reporting systems that define the degree of obligation placed on prospective reporters and the availability of data to third parties. A sound structure for the reporting and analysis of claims data through state clearinghouses is critical to effective institutional and governmental patient safety reform. (Studdert and Brennan 2001, 228)

Studdert and Brennan argue that a no-fault enterprise liability system would most effectively promote patient safety. They see the tort system as fundamentally opposed to a more efficient and effective systems-oriented approach. In fact, the malpractice system deters open reporting by medical institutions and professionals and thereby stands as a formidable obstacle to patient safety initiatives. In light of the consequences of the tort system, hospitals support confidential, voluntary reporting systems (which is the approach to patient safety endorsed by the IOM).

Initiatives to Improve Patient Safety

The following programs and other initiatives illustrate the substantial efforts that governmental entities and the medical community have made recently to improve patient safety.

Institute of Medicine (IOM)

The IOM made the following recommendations in its report *To Err Is Human: Building a Safer Health System*.

- Congress should create a Center for Patient Safety within the Agency for Healthcare Research and Quality.
- A nationwide mandatory reporting system should be established that provides for the collection of standardized information by state governments about adverse events that result in death or serious harm. Reporting should initially be required of hospitals and eventually be required of other institutional and ambulatory care delivery settings.
- The development of voluntary reporting efforts should be encouraged.
- Congress should pass legislation to extend peer review protections to data related to patient safety and quality improvement that are collected and analyzed by health care organizations for internal use or shared with others solely for purposes of improving safety and quality.
- Performance standards and expectations for health care organizations and health professionals should focus greater attention on patient safety.
- The Food and Drug Administration should increase attention to the safe use of drugs in both pre- and post-marketing processes.
- Health care organizations and the professionals associated with them should make continually improved patient safety a declared and serious aim by establishing patient safety programs with defined executive responsibility. (IOM 2000, 5-14)

Recommendations to Prevent Patterns of Malpractice

In their article on major failures, Walshe and Shortell make recommendations to overcome the obstacles to improving patient safety. They suggest that incentives be put in place for reporting medical errors, and disincentives removed. Reporting should begin at the clinical level. Feedback to clinical staff through regular meetings and safety reports is necessary for frontline reporting to succeed in improving patient safety. Existing quality management systems should be strengthened through regular testing. Rigorous testing, through the use of simulations, for example, will show where improvements are needed in reporting and responding to major medical errors. Investigations of major patient safety failures must be prioritized and coordinated among the various responsible agencies, so that information can be thoroughly analyzed and expertise effectively applied. The lessons learned from each event must be identified and explicitly incorporated into reforms. (Walshe and Shortell 2004, 108-09)

State Legislation

There have been two kinds of legislative responses to the IOM reports, those that seek to sanction at-fault providers and those that seek to improve patient safety without assigning blame. Some states are attempting to improve reporting of preventable “adverse events” (injuries caused by medical management) by developing programs that focus on analyses to change processes and reduce hazards. The National Conference of State Legislatures (NCSL) lists 17 states, including Pennsylvania, with programs that require hospitals to report adverse events. An additional five states have voluntary reporting programs.

Some states are going further by offering incentives or imposing mandates for hospitals to acquire technologies that reduce mistakes. An example of such a technology is Computerized Physician Order Entry (CPOE), which is an electronic prescription ordering system. CPOE operates through a hospital-wide network that automatically checks the prescription order against patient records and drug information to insure compatibility.

Leapfrog Group for Patient Safety

The Leapfrog Group is a consortium of 160 companies and purchasers of health care services, organized in 1998, that reward providers for making “leaps” in improved patient safety.⁵² The stated goals of the Leapfrog Group are to:

- Reduce preventable medical mistakes and improve the quality and affordability of health care
- Reward doctors and hospitals for improving the quality, safety, and affordability of health care
- Encourage public reporting of health care quality and outcomes, so that consumers and purchasing organizations can make more informed health care choices
- Help consumers reap the benefits of making wise health care decisions.

⁵² The Leapfrog Group, The Leapfrog Group for Patient Safety: Rewarding Higher Standards <http://www.leapfroggroup.org/home> (December 1, 2004).

The organization is supported by the Business Round Table and the Robert Wood Johnson Foundation (RWJF) as well as its members. Leapfrog has funded an \$8.8 million initiative to develop incentives for high-quality health care and plans to begin offering the incentives in 2005.

Leapfrog bases its provider performance comparisons on the following safety and quality practices:

- CPOE. The use of CPOE has been shown to reduce medical prescription errors by more than 50 percent
- Evidence-Based Hospital Referral. Referring patients needing certain complex procedures to hospitals offering the best survival odds can reduce a patient's risk of dying by 40 percent
- ICU Physician Staffing. Staffing ICUs with "intensivists," doctors who are specially trained in critical care medicine, can reduce a patient's risk of dying by 40 percent
- Leapfrog Quality Index. The National Quality Forum endorsed 30 safe practices that cover a range of medical treatments that can reduce a patient's risk of harm.⁵³

Leapfrog has chosen these criteria because they are based on evidence that they may reduce preventable medical mistakes; their implementation is feasible in the near term; patients readily appreciate their value; and health plans, purchasers, and consumers can easily ascertain their presence when selecting a health care provider. Research commissioned by Leapfrog has shown that if the first three criteria were implemented in all non-rural hospitals in the United States, over 65,000 deaths and over 900,000 medical errors could be avoided annually, and up to \$51.4 billion annually in health care costs could be saved.⁵⁴

⁵³ The Leapfrog Group, Leapfrog Fact Sheet, Leaps in Hospital Quality and Safety http://www.leapfroggroup.org/about_us/leapfrog-factsheet?tid=105941 (December 3, 2004).

⁵⁴ The Leapfrog Group, What Does Leapfrog Ask Hospitals About? http://www.leapfroggroup.org/for_consumers/hospitals_asked_what (December 3, 2004).

Pittsburgh Regional Healthcare Initiative (PRHI)

PRHI, founded in 1997, is an organization working to improve various aspects of the health care industry in western Pennsylvania.⁵⁵ PRHI is comprised of clinicians, hospitals, insurers, health care purchasers, and corporate, civic, and elected officials. The core belief of PRHI is that faulty systems, not faulty people, underlie most medical errors. At the center of this effort is a reliance on leadership to facilitate improvements at different levels of the health care delivery system.

One of the challenges being addressed by PRHI is in the area of medical malpractice. PRHI is targeting a number of patient safety issues, not only to improve the quality of health care for patients, but also to alleviate the pressures brought on by the medical malpractice crisis. PRHI states in its goals that it strives to eliminate medication errors and healthcare-acquired infections and to attain perfect clinical outcomes, as measured by complications, readmissions, and other patient outcomes.

Through its Perfecting Patient Care (PPC) system, PRHI encourages its participating health care providers to design work systems that allow everyone involved to learn from errors and problems and to experiment with ways to improve health care delivery processes quickly and frequently. Other examples of PRHI's efforts include the development of working groups to address specific medical conditions, such as diabetes and heart disease, and the establishment of information registries.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

JCAHO is an independent, not-for-profit organization established in 1951 for the purpose of setting standards of quality and safety in the health care industry. JCAHO evaluates and accredits approximately 16,000 health care organizations and programs in the United States. The many organizations that are accredited by JCAHO include all types of licensed health care providers, from general hospitals to behavioral health care organizations to clinical laboratories. JCAHO's primary mission is the continuous improvement of patient safety and the quality of care provided to the public.⁵⁶

⁵⁵ PRHI, Perfecting Patient Care, <http://www.prhi.org/ppc.cfm>.

⁵⁶ JCAHO, Facts about the Joint Commission on Accreditation of Healthcare Organizations <http://www.jcaho.org/about+us/index.htm> (July 2004).

To meet the objectives of its mission, JCAHO annually revises the standards by which it evaluates participating health care organizations, in consultation with health care experts, providers, measurements experts, purchasers, and consumers. The standards address key functional areas, such as patient rights, patient treatment, and infection control.

Patient Safety Authority (PSA)

Established by section 303 of the Mcare Act, PSA is charged with reducing or eliminating medical errors by identifying problems and recommending solutions that promote patient safety in hospitals, ambulatory surgical facilities, and birthing centers. Under the Mcare Act, all such providers must report defined “serious events” and “incidents” to PSA, which analyzes the data and makes recommendations for improvements in health care practices and procedures. PSA's role is non-regulatory and non-punitive.

PSA has developed the Pennsylvania Patient Safety Reporting System (PA-PSRS), a confidential web-based system that receives and analyzes the reports of serious events and incidents. Ambulatory surgical facilities, birth centers, and hospitals are required to report such events and incidents to PA-PSRS (Mcare Act, §§ 302, 308). As of June 28, 2004, more than 400 health care facilities were subject to PA-PSRS reporting requirements.⁵⁷ An important component of PA-PSRS is the ability of individual health care workers to submit anonymous reports. Facilities subject to the Mcare Act must make anonymous report forms available to health care workers, who may submit those reports to the PSA according to the protocols established through the PA-PSRS system.

Complaint Reporting Systems

In addition to PA-PSRS, which is specifically designed for reporting by facilities, other complaint and error reporting systems are available to Pennsylvania consumers. Through these systems, Pennsylvania citizens can file complaints against individual health care providers and facilities.⁵⁸

⁵⁷ Patient Safety Authority (PSA), PA-PSRS. <http://www.psa.state.pa.us/psa/cwp/view.asp?a=1165&q=441808&psaNav=1> (June 13, 2004).

⁵⁸ Individuals can make complaints related to hospitals and ambulatory surgical facilities by calling 800-254-5164 and complaints related to birthing centers by calling 717-783-1379. Complaints against licensed medical professionals can be filed with the Department of State's Bureau of Occupational and Professional Affairs at 800-822-2113.

Health care providers who are not required to report to PSA must report serious events to the Department of Health,⁵⁹ which can issue sanctions and penalties, including fines and forfeiture of license, to facilities as appropriate.

Pennsylvania Health Care Cost Containment Council (PHC4)

PHC4 is an independent state agency that collects, analyzes, and reports comparative health care data that can help to improve quality and restrain costs.⁶⁰ PHC4 has two major ongoing patient safety initiatives, in addition to its regular public reports on quality of care issues.

The first initiative mandates that PHC4 “provide each hospital with individualized data on patient safety indicators.”⁶¹ The data is intended to provide the patient safety committee of each hospital with information necessary to assist in conducting patient safety analysis. PHC4 issued the first of these patient safety reports to hospitals in October 2003 and has continued to provide this information to hospitals each quarter. These reports provide detailed information for the individual hospital, as well as peer-group and statewide comparisons.

PHC4’s newest patient safety initiative began in early 2004 when PHC4 started to collect information on nosocomial infections (those contracted in the hospital). The first quarter of data collection focused on four types of hospital-acquired infections: surgical site infections (for orthopedic surgery, neurosurgery, and surgeries related to the circulatory system), central line associated blood stream infections, ventilator associated pneumonia, and catheter associated urinary tract infections.⁶² An implementation schedule has been developed for phasing in the collection of the remaining types of nosocomial infections by January 1, 2006.

⁵⁹ 28 Pa. Code Ch. 51, esp. § 51.3.

⁶⁰ This section is based on information supplied by PHC4.

⁶¹ Act of July 17, 2003 (P.L.31, No.14) (Health Care Cost Containment Act), § 5(4.1) (35 P.S. § 449.5(4.1)).

⁶² Nationally, it is estimated that nosocomial infections affect two million Americans each year at an estimated cost of \$4.5 to \$5.7 billion.

CHAPTER 5

NO-FAULT MEDICAL COMPENSATION

As 2003 Senate Resolution No. 160 indicates, some of those who have engaged in the public debate over medical liability policy have advocated a systemic change that might create a more permanent and satisfactory solution to the problems evident in the present tort liability system. The alternative that has received the most commentary is “no-fault” largely because it is the only strategy that promises to tie together patient compensation with patient safety.

Goals and Features

Two prominent participants in the medical professional liability debate have described the broad aims of the alternative as follows:

The key requirements of an alternative compensation model have been exhaustively reviewed by other commentators. It must be able to channel compensation to eligible patients in a manner that is predictable, timely, affordable, and fair. In order to target safety improvement activities, the system must generate or at least be compatible with the generation of detailed information about errors without fear of reprisal against those who report that information. At the same time, the system must find ways to [motivate] health professionals and organizations to work to improve quality of care. In addition, the compensation system must emphasize what the IOM Report concluded: most of the preventable injuries in our hospitals are not due to bad medical professionals, but rather to the imperfect systems in which these professionals work. Although the system must have mechanisms for identifying and protecting patients from those few truly incompetent practitioners, it must avoid adhering to . . . “The Theory of Bad Apples”—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 2001b, 228)

Several leading commentators advance a no-fault compensation system as the leading or most intriguing means of accomplishing those goals. Interest in this type of system has been spurred by the 1993 Harvard Medical Practice Study headed by Professor Paul C. Weiler of Harvard Law School. Based on data from patients in New York, that study concluded that the tort system fails as a compensation system and recommended substitution of a no-fault system, further finding that a properly crafted no-fault system would be economically feasible. (Richards 1996, 111-12; Weiler 1993, 925) (While the terms “administrative compensation” or “strict liability” may more accurately describe this approach, it is almost always referred to as “no-fault” in the literature.)

Under such a system, all medical injuries would be compensated under the direction of an administrative panel, without a determination of negligence on the part of the medical provider. Instead, the test for compensation would be that the medical injury be avoidable or preventable. The administrator’s determinations could be appealed to the court, but the court’s scope of review would be limited. Like the present system, no-fault would be financed predominantly although commercial insurance companies.

The appeal of this approach arises from the prospect that a larger number of medically injured claimants can receive compensation and that claims can be paid more promptly with lower administrative costs. Compensation would apply to more patients because the patient would not have to prove negligence to collect. Because fewer claims would need to go to trial, administrative costs should be greatly reduced, especially if the compensation amount is scheduled by injury. For the same reasons, compensation could be paid much faster than under the current system. (Bovbjerg and Sloan 1998, 70-71) Administrative costs, which now consume 50 to 60% of the costs of the system, could be cut to 30% or less, thus allowing no-fault to largely pay for itself (Weiler 1993, 926; see Bovbjerg and Sloan 1998, 77).

Proponents assert that the no-fault approach has the best potential of any alternative to improve patient safety by better internalizing costs of medical injury into insurance premiums, improving the collection of medical data, enhancing the medical credibility of liability determinations, creating greater incentives for medical providers to improve care, and allowing earlier remedial intervention. At the same time no-fault may curb defensive medicine, partly because awards under no-fault will be more consistent and determined by patient outcome. The less adversarial and stigmatizing nature of the no-fault system may permit a more open discussion of the causes and remedies for medical error, and thereby encourage medical providers to change their procedures so as to reduce the frequency of iatrogenic injuries, whether arising from negligence or not. The

greater consistency and speed of the awards under no-fault will make this system more just than the current tort system. (Bovbjerg and Sloan 1998, 71-72; Studdert and Brennan 2001b, 229; Weiler 1993, 937-43)

No state presently uses no-fault to deal with the broad range of medical injuries. Finland, Sweden, and New Zealand do have broad-based no-fault medical compensation systems. These nations, Sweden especially, also have broad public medical insurance systems that may lower the additional costs of medical no-fault in those countries. Florida and Virginia have instituted systems that cover medically-caused neonatal brain injuries. (Studdert, Thomas, et al. 1997, 1-2) The federal government's National Vaccine Injury Compensation Program operates on a no-fault basis. These three limited programs are the only no-fault medical compensation systems presently operating in the United States. Two no-fault injury compensation systems are widely prevalent in the United States for other types of injuries, viz., workers' compensation and automobile liability. Major feasibility studies of a broadly applicable no-fault system were conducted for Colorado and Utah under the sponsorship of the RWJF, but the reform was not adopted by either state.⁶³

Perhaps the leading objection to a no-fault system is the fear that the cost of such a system will be unworkable because a larger number of claims will be filed. Sweden and New Zealand have both had to amend their statutes to put in restrictions in order to control costs (Studdert, Thomas, et al. 1997, 10-15). The demonstrated feasibility of workers' compensation and automobile no-fault may not apply because it is more difficult to separate damages from medical treatment for people who suffer from a pre-existing disease than to determine damages from a traumatic injury (Bovbjerg and Sloan 1998, 73-74). Cost estimates of a hypothetical no-fault system for Colorado and Utah predicted an increase in medical injury compensation costs of about 45 to 64% with compensation packages similar to the present tort system; this cost increase is equivalent to 0.33% of total medical costs in each state (Studdert, Thomas, et al. 1997, 25). Proponents argue, however, that with reasonable limitations a no-fault program could compensate at least two to three times as many claimants as the tort system at comparable or significantly reduced cost, and would compensate three to over six times as many claimants with the cost increases determined by the Colorado-Utah study (Studdert, Thomas, et al. 1997, 25, 31-32). In states that currently experience high malpractice costs, the cost of no-fault may be comparable to the present system (Weiler 1993, 925). Opponents of no-fault believe the plan will either cost considerably more in practice than these projections estimate or that awards will have to be drastically reduced from those under the tort system (Foster 1994, 747, 755; Mehlman 2003, 77, 79). One

⁶³ Robert Wood Johnson Foundation (RWJF), National Program Project Report <http://www.rwjf.org/reports/grr/032865.htm> (September 2002).

observer argues that workers' compensation is a poor model for any reform, citing its "drastically rising costs, a broadening idea of what is compensable, low benefits, widespread abuse, and fraud" (Richards 1996, 119).

Critics of no-fault raise a number of other objections. No-fault could not apply to medical injuries arising from failure to diagnose or recommend treatment, which cases could be compensated only under a system that required a determination of fault (Foster 1994, 754; Richards 1996, 116). Doctors and hospitals would be unfairly required to be "guarantors against any number of unfortunate happenstances that can occur in the non-negligent treatment of patients" (Foster 1994, 755-56). Critically ill patients with a high risk of bad results may find it more difficult to get treatment. Patient consent to no-fault cannot be truly informed or voluntary. (Foster 1994, 756) The assumed federal waivers required to make no-fault feasible may not in fact be granted. No-fault also faces the peril of constitutional invalidation under federal and state jury trial provisions or state open courts provisions (Richards 1996, 125-30).

Current No-Fault Programs

As the only medical no-fault systems presently in operation in the United States covering complex care, the Florida Neurological Injury Compensation Association (NICA) and the Virginia Birth Injury Fund (BIF) have been extensively studied. (See Bovbjerg, Sloan, and Rankin 1997; Bovbjerg and Sloan 1998, 82-123; Horwitz and Brennan 1995 (NICA only); Sloan, Whetten-Goldstein, et al. 1997) Both programs combined had processed a total of 226 claims as of 1996; Florida had received an average of 26 claims per year, Virginia four per year at the time of these studies. (Bovbjerg, Sloan, and Rankin 1997, 87, 98; Bovbjerg and Sloan 1998, 106)

The Florida and Virginia programs were established to cover claims arising from newborns with severe neurological injuries (so-called "bad baby" cases). Neonatal neurological claims, while relatively few in number, often lead to very high and unpredictable damage awards that may include compensation for the lifetime of the patient. Largely because of such cases, malpractice premiums for obstetricians are among the highest in the medical profession. (Bovbjerg and Sloan 1998, 80-81)

The analyses have concluded that no-fault claims have been settled more rapidly and at a lower cost than comparable tort claims. The number of claims has been lower than expected, partly because court rulings in Florida have made no-fault largely an elective rather than exclusive remedy. (Bovbjerg, Sloan, and

Rankin 1997, 104-05 (NICA); Bovbjerg and Sloan 1998, 84, 106-08; Sloan, Whetten-Goldstein, et al. 1997, 63-64) The Florida program has not solved the problem of high malpractice insurance rates for ob/gyn specialists (Sloan 2004, 63). Although in its early stages the Virginia program was considered actuarially sound, later analysis has shown an actuarial deficit (Mercer 2003).

Even its proponents agree that in order for an across-the-board no-fault system to be economically feasible, eligibility limits must be defined. Weiler, for instance, advocates a two-month waiting period, based on the assumption that the compensation system should concentrate benefits on the patients who are most seriously injured. (Weiler 1993, 923) Other proposed cost limitation measures include restricted compensation for pain and suffering and other non-economic damages, restricted compensation for wage loss and lost household production, restricted recovery of attorney fees, and scheduled compensation based on designated compensable events (DCEs). (Foster 1994, 744; Studdert and Brennan 2001, 232-33; Studdert, Thomas, et al. 1997, 30-31; Weiler 1993, 933-35) A crucial cost control measure is making the no-fault coverage secondary to any other compensation, including Medicare and Medicaid, and insulating the no-fault fund from subrogation claims by other insurers, which may require amendment or waiver of the Employee Retirement Income Security Act (ERISA). (Studdert and Brennan 2001, 233, 245-51; Weiler 1993, 925) Such federal waivers are justified on the grounds that they will reduce total insurance costs (Weiler 1993, 925-26).

Common Good Proposal

The public advocacy organization Common Good has proposed a Health Court that includes several features similar to a no-fault system:

- Expert judges who make rulings on standards of care as a matter of law
- Expedited proceedings, with experts hired by the court
- A liberalized standard for patient recovery: a mistake or medical treatment falling outside a range of good practice, without need to show personal fault or negligence
- Scheduled limits on non-economic damages, set by an independent body

- Protection for open, non-identified disclosure of mistakes, with a penalty for non-disclosure.⁶⁴

Policy Considerations

This subchapter discusses the policy considerations that have been identified by one or more of the sources that have described no-fault.

Exclusivity

This issue involves whether no-fault is exclusive within the range of cases covered by it, or is elective. When the no-fault system covers a class of patients (as the neonatal birth injury programs do), there will be cases where the applicability of the no-fault system will be in issue. In Florida, despite the legislature's intent to make the no-fault system exclusive for the injuries it applies to, in practice the NICA program has been treated as an elective remedy, to be pursued only where it promised a higher recovery than tort litigation (Sloan, Whetten-Goldstein, et al. 1997, 63-64).

Under both the Florida and Virginia statutes, the findings of the administrative agency hearing the case are conclusive and binding on questions of fact, and both provide for appeal to the court of appeals (Fla. Stat. §766.311(1); Va. Code § 38.2-5011A). Florida has several provisions that qualify the exclusivity of the remedy. If the patient's claim is denied, a tort suit may be instituted. The statute of limitations is tolled during the pendency of the claim. The administrative findings are not admissible in the tort proceedings, but exhibits and testimony from the administrative hearing may be used to discredit trial testimony. However, if the administrative law judge (ALJ) approves the claim or the claimant accepts an award before the hearing, the claimant may not sue in tort. (Fla. Stat. §§ 766.303, 766.304, and 766.306)

Leading proponents of no-fault consider exclusivity to be a requisite for an effective no-fault system, because otherwise the tort system will continue, as well as litigation over the respective applicability of no-fault and tort. "Simply grafting no-fault on to the tort system would inevitably raise the overall costs of

⁶⁴ Common Good, Possible Structure for a Reliable System of Medical Justice, paper furnished to Commission staff by Franklin Stone, executive director of Common Good. The website of Common Good is www.cgood.org.

compensating medical injuries. It would also be likely to put the purported benefits of no-fault out of reach” (Studdert and Brennan 2001b, 234; see also Bovbjerg and Sloan 1998, 67, 84-85).

Applicability to Patient and Doctor

A number of choices must be made as to what persons are compensable under the no-fault system. The first of these is whether the system is to be mandatory or voluntary for the patient. Only a mandatory system can operate as a complete replacement to the tort system. At the same time, a voluntary system will be better accepted by the public, and may obviate constitutional issues—especially the right to jury trial—by means of waiver.⁶⁵ The neonatal programs only apply if the providers agree to participate. (Bovbjerg and Sloan 1998, 89-90)

Notice and Consent

The use of a voluntary system raises a number of subsidiary issues. The first is whether the patient’s consent can be inferred from the insurance contract between the provider and the patient’s employer. Studdert and Brennan envision a system where no-fault is instituted through the employer’s health insurance plan, and the consent of the employer binds the patient (Studdert and Brennan 2001, 235, 238-39); however, it may be asked whether that arrangement would shift the point of the patient’s adhesion from the health provider to the employer, leaving the patient equally stuck with the bargain in either case, unless the patient-employee is offered a tort alternative. If the patient’s personal consent is needed, at what point in the treatment process is it valid? This seems to depend in part on how close the patient is to a major procedure. An issue that has caused a considerable problem in both Florida and Virginia is the adequacy of the notice to the patient. (Bovbjerg and Sloan 1998, 85)

Eligibility of Event

Once no-fault is determined to be applicable to the persons involved in the medical liability claim, a key issue is the test of whether the event is such as to make the patient eligible for compensation. The broadest test would compensate the patient for any adverse event, so that the patient would be compensated

⁶⁵ In “carve-out” systems like BIF and NICA, the type of injury may in part determine whether the program applies.

whenever a treatment failed for any reason. This is considered overbroad, both because it would be too expensive to fund and because it would fail to adequately differentiate rates based on quality of care. (Weiler 1991, 143; Weiler 1993, 937)

Considered more feasible is the test under which compensation would be limited to an “unintended or unexpected adverse consequence of medical care.” Such consequences can occur without any fault on the part of the physician. Weiler gives the following three examples of non-negligent medical injury that would be compensable under this test:

In the first case, a patient has a breast lump that a biopsy indicates is malignant. On the recommendation of her doctor, the patient agrees to a mastectomy. Once a more complete examination of the tissue becomes possible after surgery, however, the earlier diagnosis is revised: the lump is benign. In the second case, a patient is diagnosed with a condition that is best treated with a particular drug. When the patient uses the prescribed drug, however, it becomes evident for the first time that he is susceptible to a reaction to the drug that is even worse than the original illness, which might instead have been addressed with a different, although less effective, treatment. In the third case, a coronary catheterization required by the patient’s condition unfortunately precipitates a blood clot that travels to the patient’s foot and cuts off the flow of blood. This rare, but not unheard-of, event requires amputation. (Weiler 1993, 930)

While under the negligence standard, treatment decisions are considered based on the knowledge available to the physician at the time of treatment, the unanticipated adverse event standard also includes injuries known only through hindsight. (Weiler 1993, 930) The determination of which adverse outcomes are anticipated and which are unanticipated is largely based on the statistical rarity of the outcome.

The test used in Sweden, which has a generous public health insurance and universal health care system, compensates injuries that are caused by treatment where the outcome is determined to be “avoidable.” This approach is more restrictive than the adverse event test advocated by Weiler, but less restrictive than the negligence test. (Studdert, Thomas, et al. 1997, 7-9). The avoidability standard would compensate patients where the injury would most likely have been present had the provider used the “best practices” applicable, even if the treatment was not negligent under the prevailing practices actually in use by most physicians. The best clinical practices against which the care actually given is judged would include system-based patient safety improvements. The

system would permit providers the option of compensating unavoidable outcomes on the same basis as avoidable ones, which may be useful in especially tragic cases, such as infants with cerebral palsy.

Under either approach, many of the determinations may be streamlined by using a DCE system to pre-define compensable injuries. In this system, a panel of medical providers and attorneys defines recurring medically caused injuries that are automatically compensable if they meet other requirements of the plan. In such cases, no specific determination of causality need be made. Tentative lists of DCEs have already been devised for general surgery, orthopedic surgery, and obstetrics, and these lists cover many of the potentially litigable cases. (Weiler 1993, 933-34)

In order to keep costs in line, differentiate unexpectedly severe medical injuries from expectable injuries, and channel the benefits to the most seriously injured claimants, the no-fault system may include a deductible period, such that injuries which fall below that threshold are not compensated. For instance, in Sweden the injury must have required ten days in a hospital or the use of 30 sick days. In New Zealand, the injury must usually result in hospitalization for more than 14 days or significant disability lasting more than 28 days (Studdert and Brennan 2001b, 232). Studdert's cost analysis of no-fault for Colorado and Utah alternatively assumed four- and eight-week disability thresholds (Studdert, Thomas, et al. 1997, 27-29); Weiler advocates a two-month disability period (Weiler 1993, 923).

Damages Covered

If a given injury is determined to be compensable, it must next be determined what elements of damages should be compensated. Economic losses include unreimbursed medical expenses, lost wages, and lost household production; as these are easily determinable, they are presumably compensable in principle, as they are under the tort system. As with workers' compensation, only a proportion of lost wages can be recovered, in order to discourage claimants from malingering, and the amount recoverable as lost wages must be capped at 150% to 200% of the statewide average wage or at two-thirds of the claimant's previous wage, or both, on the assumption that wealthier claimants can be expected to purchase disability insurance for wage loss above that level. (Weiler 1993, 924-25; see Studdert, Thomas, et al. 1997, 31)

The no-fault system entails more restrictive rules for compensating non-economic damages ("pain and suffering"). Damages for pain and suffering, which account for about 50% of damages awarded under the tort system, are highly variable and difficult to quantify. No-fault proponents therefore advocate

compensation for pain and suffering through a DCE-type schedule based on the nature of the injury and the age of the claimant, or based on a given proportion of the economic damages. Since non-economic damages are not really compensable by money, damages for pain and suffering should apply only to those who suffer significant long-term disabilities and should be moderate in amount. (Studdert and Brennan 2001b, 233; Weiler 1991, 55-61; Weiler 1993, 923)

Under current tort practice, pain and suffering damages often actually offset the attorney fees. Instead, Weiler recommends establishing reasonable attorney fees based on the time put in on the case and including the fee as part of the economic damages. (Weiler 1991, 66; Weiler 1993, 923) In any event, one of the major anticipated benefits of no-fault is that it is expected to greatly reduce attorney fees by prompt and non-adversarial procedures.

Benefit Determination and Structure

As has been mentioned above, the compensation scheme must address the manner of determining damages. For noneconomic damages the lowest cost alternative is to have the benefits determined by a pre-determined scale based on the claimant's age and the nature of the injury, or a schedule that provided for a fixed amount for a given injury. (Weiler 1991, 58-61) Economic damages may be more efficiently determined by replacing the traditional lump sum damages based on estimated losses with periodic payments based on losses documented at intervals and ceasing upon full recovery, at least in those cases of long-term disability where the success of treatment is difficult to determine in advance. (Studdert and Brennan 2001b, 233) Because periodic payments permit closer cost controls while allowing some protection against unanticipated changes in needs, some proponents consider them an essential part of the no-fault scheme (Bovbjerg and Sloan 1998, 68).

Coordination of Benefits

A premise of the no-fault system is that as much as possible of the recovery for medically injured individuals should be borne by first-party loss insurance because loss insurance is more accessible and efficient than collecting from third-party insurance upon proof of eligibility. Consequently, proponents of no-fault envision it as paying only the costs not otherwise covered by public or private insurance. (Studdert and Brennan 2001b, 245; Weiler 1993, 924) If the no-fault system is the primary payer of medical losses, the cost of the program may be 20%-33% larger than it otherwise would be. This creates a potentially serious difficulty because Medicare and Medicaid are secondary payers by federal law. Preemption under ERISA may also exempt self-insured private employee

health plans from state regulation, which would enable the plan to deny subrogation claims for reimbursement from the no-fault plan. The financial viability of a no-fault plan may therefore depend on waiver of Medicare and Medicaid second-payer status. By careful drafting, it may be possible to circumvent ERISA preemption, or a waiver may be obtainable from the Secretary of Labor. (Studdert and Brennan 2001b, 245-51)⁶⁶

Funding

The funding method for the administration of a no-fault program may be open-ended or fixed and be geared to provide an ample or minimum level of funding. If, as most proposals envision, the major source of funding is premiums on providers, they may be determined on a community or experience rating basis. In case the generally used funding method proves insufficient, a mechanism should be in place to ensure the plan's solvency. This may take the form of a guaranty fund or private reinsurance. (Bovbjerg, Sloan, and Rankin 1997, 69) An agency may be directed to adjust premiums from time to time. It would seem prudent to provide for continuous review of the actuarial soundness of the system.

As an illustration of how the funding system may work, the Florida and Virginia neonatal brain injury funds may be instructive. In Florida, NICA is funded by assessments on hospitals, physicians, and casualty insurers. The assessment on hospitals is \$50 per live birth, but publicly owned hospitals, state university hospitals, and teaching hospitals are exempt, nor is the assessment paid for births to charity or Medicaid-reimbursed patients. The assessment on physicians varies depending on whether the doctor participates in the NICA program. Those who participate pay \$5,000 per year. Certified nurse midwives who are supervised by participating physicians are charged \$2,500 per year. Nonparticipating physicians are charged \$250 per year, with exceptions for resident and retired physicians. NICA may collect delinquent assessments by suit, and failure to pay the assessments may be punished by loss of licensure. Additional funding is provided by a charge on licensed casualty insurers of up to 0.25% of net direct premiums as determined by the Office of Insurance Regulation. OIR is also charged with conducting actuarial investigations of the system at least biennially. If funding is insufficient, up to \$20 million is appropriated to NICA from the Insurance Regulatory Trust Fund. Standards are also provided for suspending intake of claims due to insufficient revenue. (Fla. Stat. § 766.314)

⁶⁶ See Chirba-Martin and Brennan, 1994 for a general discussion of ERISA preemption of state health insurance regulation.

Virginia's assessment structure is very similar to Florida's. Recent legislation has raised BIF assessments on physicians. For participating physicians the assessment will rise from \$5,000 by \$100 per year up to \$5,500, and for non-participating physicians the assessment will rise from \$250 by \$10 per year up to \$300. (Va. Code § 38.2-5020) According to the 2003 actuarial analysis conducted for the Virginia State Corporation Commission's Bureau of Insurance, BIF faces a projected actuarial deficit of \$80.4 million as of December 31, 2003, and this deficit is projected to rise to \$148.3 million by the end of 2005. However, the fund is able to pay its claims as presented and will continue to have that ability until about the end of 2016. The deterioration in the fund's financial status from 2003 to 2005 is due largely to the uncertain impact of amendments effective July 1, 2003, to BIF's enabling statute, which are expected to encourage more claims. (Mercer 2003, 5-15)

Loss Prevention and Enterprise Liability

In order to control costs, the no-fault system will need to have a loss prevention strategy, either explicitly within the enabling statute or delegated to the program administration to develop and implement by regulation (Bovbjerg and Sloan 1998, 69). The strategy may incorporate procedures to enhance patient safety.

Proponents of no-fault emphasize enterprise liability as a major loss prevention feature of this system, although enterprise liability is theoretically compatible with the tort system as well.⁶⁷ Under enterprise liability, a hospital or other health care organization will be liable for all claims against individual providers associated with it. This system would transfer the responsibility for the premiums for high-risk specialties from individual physicians and spread it as a cost of business for the hospital. Another advantage to enterprise liability is that a claimant will more likely have only one medical entity to sue, thereby eliminating the expensive apportioning of relative liability among various defendants. Enterprise liability can reduce the incentive for unnecessary defensive medicine by removing the physician's personal liability for the injury, although the hospital may take its own action in response to the event. No-fault may further reduce defensive medicine by its focus on patient outcomes rather than the failure to follow established procedures. Finally, enterprise liability promises to direct energy from blame toward changing professional procedures to improve patient safety because the insurance and liability costs will better match the hospital's patient safety record. (Studdert and Brennan 2001a, 221-22, Weiler 1991, 124-27; Weiler 1993, 937-44) However, enterprise liability may imply that

⁶⁷ For example, rising insurance costs are forcing independent physicians to seek coverage through the hospitals they are affiliated with (Sage 2003b, 19).

physicians who practice outside a hospital will be subject to greater control by that hospital, resulting in loss of professional independence. Conversely, hospitals may take on new oversight responsibilities over physician practice in both hospital and outpatient clinic settings. (Richards 1996, 118-19) A sound data collection system will be required to support the patient safety aspect of the no-fault plan.

Representatives of the physicians, who sympathize with the no-fault concept, point out that no-fault does not necessarily require the adoption of enterprise liability. Even under an enterprise liability system, the hospital need not be the entity that assumes the liability for all the other participants in a health care system. For example, the liability for a health system could be assumed by an entity jointly controlled by the physicians, hospitals, and other health care providers in the system. In their view, patient safety will be best improved by a collaborative effort by physicians and hospitals.

Critics of no-fault warn that enterprise liability may introduce a host of problems, including hospital supervision of physicians in outpatient settings, adjustments in charges for services between physicians and hospitals, and insurance underwriting difficulties (Richards 1996, 118-21).

Procedure

Legislation providing for a no-fault plan will need to provide guidelines for the procedure for making and disposing of claims. A pervasive consideration is the degree of formality of proceedings (Bovbjerg and Sloan 1998, 68). Proceedings that require sworn documentation and apply formal rules of evidence implicitly require claimants to retain professional counsel and may therefore be reserved for claims that raise nonroutine issues.

The legislation must provide a claim intake procedure, including the required information to initially support the claim. This issue may be delegated, in whole or in part, to the body established to administer the program.

The legislation must also provide the administrative process to determine whether or not the claim is compensable under the law. A crucial issue here is the composition of the board that initially reviews the claim. It would seem necessary to provide for administrative review of claims where a party is aggrieved by the board's decision. Availability of judicial review of the decision after exhaustion of administrative appeals is required by the federal and state constitutions. (Pa. Const. art V, § 9)

The birth-related neurological injury programs of Florida and Virginia are similar but not identical in their procedural provisions, and may be a useful model for the General Assembly to consider. Both prescribe by statute the information that must be submitted in the claim petition. Supporting medical and financial documentation that must be submitted with the claim petition in Virginia may be submitted within ten days of filing in Florida. (Fla. Stat. § 766.305; Va. Code § 38.2-5004) The adjudicator in Florida is an ALJ under the division of administrative hearings of the department of management services (Fla. Stat. §§ 766.302, 766.304); in Virginia the cases are decided by the workers compensation commission (Va. Code § 38.2-5003). (Florida originally assigned the adjudications to the workers' compensation commission, but reassigned it after three years due to dissatisfaction with its performance (Bovbjerg and Sloan 1998, 87).) In both states the respondent to the petition is the administrative agency for birth-related neurological injuries. (Bovbjerg and Sloan 1998, 88) The hearing must be held within 120 days of the filing of the petition (Fla. Stat. § 766.307; Va. Code § 38.2-5006). In both states, the initial adjudicator must determine the applicability of the program to the injury, eligibility for compensation, and amount (Fla. Stat. §766.309(1); Va. Code § 38.2-5008A). In Virginia, claims are screened by panels appointed by three medical schools in the state. The medical panels are directed to submit reports within 60 days of the filing of the claim, and at least one member of the panel must be available to testify at the hearing. (Va. Code § 38.2-5008B, C) There is no administrative appeal, but the decision may be appealed to the district court of appeal. (Fla. Stat. §§ 766.309, 766.311) In Virginia, the administrative determination on these issues is made by a panel of members of the workers' compensation commission, and an appeal may be taken to the full commission, excluding any members who participated in the determination; the redetermination may be appealed to the court of appeals. (Va. Code §§ 38.2-5008, 38.2-5010, 38.2-5011)

Other Operational Issues

Coverage Structure. In terms of the structure of the insurance coverage, there is the issue of whether the no-fault coverage should be first party (insuring the patient) or third party (insuring the physician or hospital) (Bovbjerg and Sloan 1998, 69).

Public and Private Responsibilities. The no-fault plan must address which features of administration and governance are to be within the Commonwealth government and which may be contracted out to private providers (Bovbjerg and Sloan 1998, 69).

Legal Issues

Constitutional Validity

A no-fault system may raise issues under several provisions of the federal and Pennsylvania Constitutions, including the Due Process Clause (U.S. Const. amend. XIV); right to jury trial (U.S. Const. amend. VII; Pa. Const. art. I, § 6); the Open Courts Clause (Pa. Const. art. I, § 11); infringement on the judicial power (Pa. Const. art. V, §§ 1 and 10); and the prohibition on tort compensation limits (Pa. Const. art. III, § 18). (See Richards 1996, 125-29) The validity of the no-fault statute will depend on the details of the legislation, but some guidance may be found from cases on the automobile no-fault statute and the arbitration panels for health care under HCSMA.

Due Process. A carefully drafted no-fault statute will most likely be upheld under the Due Process clause. “[T]he essential elements of procedural due process are notice and opportunity to be heard and to defend in an orderly proceeding adapted to the nature of the case before a tribunal having jurisdiction of the cause. . . . [T]he proceedings need not be attended by the full panoply of trial type formalities.” *Parker v. Children’s Hospital of Philadelphia*, 394 A.2d 932, 945 (Pa. 1978) (internal quotations omitted). In *Parker*, the Court rejected challenges based on possible conflict of interest of the medical members of the panel; objections to the panel administrator’s power to choose panel members and the attorney who would serve as chair; and the panel chair’s duty to both instruct on the law and participate in the decision of the case. The due process challenge to compulsory arbitration was summarily rejected in *Mattos v. Thompson*, 421 A.2d 190, 191-92 (Pa. 1980).

Jury Trial. *Mattos* shows that a more serious issue facing a no-fault statute will be the impingement on the right to jury trial. As it had in *Parker*, the Court considered the constitutionality of the compulsory arbitration panels under HCSMA, but the Court invalidated the procedures it had earlier upheld.

The right to jury trial does not require unfettered access to jury trial, but only that a jury trial must be available before the rights in question are finally determined. Thus, compulsory arbitration of civil claims under a statutorily prescribed amount has been upheld. “All that is required is that the right to appeal for the purpose of presenting the issue to a jury must not be burdened by the imposition of onerous conditions, restrictions, or regulations which would make the right practically unavailable.” *Mattos*, 421 A.2d at 190, 192 (quoting *Parker*). In *Mattos*, the Court held that because of delays in processing malpractice claims, the arbitration provisions rendered a jury trial “practically unavailable.” (194-95)

Under no-fault, the liability and damages would be determined by an administrative panel without a jury trial. A comprehensive no-fault procedure might nevertheless be upheld under the legislative power to abolish common law causes of action, which was applied in *Singer v. Sheppard*, 346 A.2d 897 (Pa. 1975) to validate no-fault automobile liability. The effect of the legislation was to bar damages for pain and suffering if the medical damages amounted to less than \$750. If the Legislature can abolish a common law tort action, and it does so for medical malpractice, there is arguably no cause of action to which the right to a jury trial attaches. Reliance on *Singer* is problematic, however, for at least two reasons. The decision dealt with challenges under the prohibition against compensation limits, the Open Courts Clause, and the Equal Protection Clause; the case did not deal directly with the right to jury trial. Second, the no-fault legislation considered in *Singer* applied to non-economic damages and left the right to sue for economic damages intact.

One commentator argues that no-fault would violate the right to jury trial in civil cases under the Seventh Amendment of the federal Constitution as well (Richards 1996, 125-26). However, it is settled law that there is no federal constitutional right to a jury trial in civil trials in state courts. *Minneapolis St. Louis R.R. Co. v. Bombolis, Adm'r*, 241 U.S. 211, 217 (1916); *Younis Bros. & Co., Inc. v. Cigna Worldwide Ins. Co.*, 882 F. Supp. 1468, 1473 (E.D. Pa. 1994). For claims based on federal statutes, the existence of a right to jury trial depends on whether the cause of action is sufficiently analogous to one that would have been triable to a jury in 1791. *City of Monterey v. Del Monte Dunes at Monterey Ltd.*, 526 U.S. 687 (1999).

Compensation Limit. Article III, § 18 precludes legislation that “limit[s] the amount to be recovered for injuries resulting in death, or for injuries to persons or property . . .” with the exception of workers’ compensation cases, where the General Assembly is authorized to provide for “reasonable compensation” and “fix[] the basis for ascertainment of such compensation and the maximum and minimum limits thereof.” As those familiar with Pennsylvania medical malpractice law know, this section prohibits the imposition of dollar “caps” on malpractice recoveries. The provision does not prohibit limitations upon the kind of damages available for a given cause of action. It did not preclude legislation making automobile accident victims with medical costs under \$750 ineligible for non-economic damages because those victims were nevertheless able to collect economic damages in any amount. *Singer*, 346 A.2d 897, 900-902 (Pa. 1975). The Pennsylvania Medical Society argues that a plan imposing compensation limits would be valid under this provision if the patient voluntarily consented to it. See *Anderson v. Carnegie Steel Co.*, 255 Pa. 33 (Pa. 1916). PaTLA cautions that such a consent could in many cases be invalid, either because the contract between parties of such unequal bargaining power may

be deemed by the courts a contract of adhesion, or because the consent may not be knowing and voluntary, as where the term waiving the right to jury trial is not conspicuous.

Open Courts and the Right to a Remedy. Article I, § 11 states in pertinent part: “All courts shall be open; and every man for an injury done him in his lands, goods, person or reputation shall have remedy by due course of law, and right and justice administered without sale, denial or delay.” Challengers to constitutionality have attempted to read this provision to argue that the General Assembly may not cut back on legal rights previously granted, but without success. The Supreme Court has held that this section permits the Legislature to alter or abolish causes of action. *Singer*, 346 A.2d at 897, 902-04.

Causation

Concerns have been raised about proof of causation in medical malpractice actions. In workers’ compensation, it is rarely a problem to determine whether an injury occurred in the course of employment, and it is also relatively easy to differentiate the injury caused by an automobile accident from other medical conditions a claimant may have. By contrast, in medical no-fault, a distinction must be made between the injury caused by the event in question and the damage to the patient’s health resulting from the underlying condition that required the medical treatment; even where the injury is caused by the treatment, there must be a judgment about whether the adverse outcome is compensable or an unavoidable hazard of competent treatment. (Richards 1996, 123) Compensation must be limited to unexpected adverse results or avoidable results of the treatment, depending on the standard adopted. Proponents claim that this is not a major difficulty, as only about 5% of claims in the Harvard Practice Study appeared to seriously raise a causation problem, and the issue has been successfully addressed in Sweden and New Zealand (Weiler 1993, 932-33). Opponents claim that proof of causation will be very costly under a no-fault system, as it is under tort (Richards 1996, 124).

Empirical Studies

To assess the feasibility of no-fault as an alternative for Pennsylvania, the General Assembly may wish to consider conducting one or more detailed empirical studies, either of the broad cross-section of patients or limited to obstetric cases preparatory to consideration of a neonatal brain injury program like that in Florida or Virginia.

A feasibility study of a hypothetical comprehensive no-fault liability system was conducted for Colorado and Utah under the partial sponsorship of the RWJF (RJWF 2002; Studdert, Thomas, et al. 2001, 18-34). The investigators examined a randomly selected sample of 15,000 patient records and compared the cost of awards under the tort system against compensation using the criteria used in Sweden, using both four- and eight-week disability thresholds. Awards included wage and fringe benefits; loss of household production; health care expenses, assuming second-payor status for the program; non-economic damages capped at \$250,000; and a \$5,000 funeral expense award for death cases. Duration of injury estimates were made by physician investigators and insurance claims adjusters. Birth injury estimates were made by adjustments to data from the Florida NICA program because the number of such cases from Colorado and Utah was considered too small to be reliable. (Studdert, Thomas, et al. 2001, 19-23)

Based on these data, a cost estimate was made for each state based on somewhat differing criteria:

The estimated annual cost of the preferred no-fault model for Utah was \$54.9 million (in 1992 dollars) and for Colorado \$82.0 million. The preferred models for the two states differed. Utah's was based on the Swedish criteria and a four-week disability prerequisite, and compensated health care costs, pain and suffering up to \$100,000, and a 66% wage replacement. Colorado's was based on the Swedish criteria and an eight-week disability prerequisite, and covered health care costs, pain and suffering, and full wage replacement. Neither paid for lost household production. (RJWF 2002)

The comparable costs in each state of compensation under the tort system were \$25-30 million for Utah and \$45-50 million for Colorado. The total compensation cost figure calculated by the Studdert and Thomas study for a "moderately generous compensation package" was approximately \$40 million for Utah and \$78 million for Colorado. (Studdert, Thomas, et al. 2001, 25)

The cost of instituting a limited neonatal injury program modeled after Florida's NICA or Virginia's BIF could probably be estimated fairly well based on extrapolations from the data collected by those two states.

Demonstration Program

At the August 31, 2004, meeting of the advisory committee for this study, Dr. William M. Sage of Columbia School of Law and David M. Studdert of the Harvard School of Public Health, proposed a pilot program based on an administrative system using “avoidability of error” instead of “negligence” as a basis for determining compensation to a patient and a schedule of damages to limit excessive payments. Both believe such a pilot program can best be tested in self-insured hospitals and health systems with most of all of the physicians covered by the same entity. HAP offered to contact its members about developing and participating in a demonstration program.

On October 25, 2004, 15 hospital executives and medical staff leaders, representing eleven health systems, met and developed the following preliminary outline of the program proposal:

Purposes. It is proposed that a demonstration program be established to examine an administrative medical liability system in Pennsylvania. This demonstration program is intended to help determine whether the institution of such a system would be likely to confer the following benefits:

1. Reducing the time necessary to make payments to injured patients
2. Expanding the number of patients that may receive compensation for a medical injury
3. Establishing fair, more predictable, and more uniform payments for patients with similar medical injuries
4. Encouraging better exchange between health care providers and patients regarding preventable medical errors, consistent with the goals of patient safety
5. Reducing legal fees and administrative costs associated with the current system
6. Promoting patient safety by identifying preventable errors and developing changes to reduce their incidence in the future.

Features. This program shall have the following features:

1. *Compensation to Patients.* All patients who suffer temporary or permanent injury as a result of an “avoidable medical error” shall be compensated for economic and non-economic damages.
2. *Determination of Compensable Events.* Every participating health care provider and patient shall agree to submit medical injury cases to an independent panel of medical and legal experts to determine if an “avoidable medical error” resulted in the patient’s injury or death.
3. *Determination of Compensation.* Every participating health care provider and patient shall agree to a uniform schedule of compensation for injuries based on type of injury, severity of the injury, age, life expectancy, past and future medical costs not covered under other programs, and lost past and future wages.
4. *Early Offers.* Health care providers may compensate any patient for any injury within a set period of time following knowledge of the injury or death without having a panel rule if the injury was “avoidable.”

Evaluation. The Commonwealth shall contract with an appropriate expert to monitor and evaluate the effectiveness of the program on criteria, including the following:

1. Cost of the program to compensate patients to the same extent as under present law
2. Changes in patient compensation limits necessary to compensate patients at a cost comparable to the present system
3. Comparative cost of alternative patient compensation limits
4. Time needed from filing of claim to payment of compensation to patients
5. Satisfaction level of patients and health care providers with the administrative compensation system
6. Effect of administrative compensation system on patient safety
7. Effect of administrative compensation system on consistency and predictability of claim amounts.

The study would need to be authorized by legislation that would assign responsibility for overseeing the study and provide at least part of the funding; other funding may be available from federal sources or foundation grants.⁶⁸ To help meet any constitutional challenge, the legislation must declare a public purpose and provide such guidelines for patient consent as are determined to be necessary. The legislation may include incentives for hospitals and health systems to participate in the program.

Details of the proposed demonstration program are being developed, and a final proposal is expected to be formulated in the spring of 2005. Representatives of the medical providers strongly support proceeding with a no-fault liability demonstration program, which should be given as much support by the Commonwealth as is feasible.

Conclusion

The no-fault medical liability system offers the theoretical prospect of compensating injured patients with a substantial savings of time and money. By giving a broad scope to expert determination of medical avoidability, no-fault may be the alternative that would best foster continuous improvement in medical practice. At the same time, institution of such a system for the broad run of medical patients would represent a radical departure without a track record of success in any other state. A no-fault system “could change nearly every aspect of injury finding and resolution—the standard of care and coverage, the rules of damages, the forum and process of decision making, and the bearer of financial risk” (Bovbjerg and Sloan 1998, 64). If the no-fault approach is considered promising, it would be prudent to prepare the way to adoption by careful empirical study.

⁶⁸ S. 1518 (proposed Reliable Medical Justice Act) was introduced in the 108th Congress by Sen. Michael R. Enzi of Wyoming to provide federal funding for state demonstration programs aimed at improving the medical litigation system. This legislation is expected to be reintroduced in the current 109th Congress.

CHAPTER 6

SCREENING PANELS

Starting in the 1970s, state governments attempted to resolve the malpractice insurance crisis by reducing the number of malpractice claims. States employed several different reforms to eliminate frivolous lawsuits, including screening panels, which will be described in this chapter. “The basic concept [of screening panels] is that a body composed at least partly of physicians will review evidence concerning a malpractice claim and provide an opinion regarding its merit” (Struve 2003, 58-59).

Theoretical Evaluation

Aims and Advantages

Researchers have mentioned a number of benefits that may be afforded the medical professional liability system through the use of screening panels.

Increase Expertise for Malpractice Judgments. Many doctors distrust the malpractice litigation system, believing that jurors are biased toward awarding damages to sympathetic claimants whose claims lack actual legal merit and that judges fail to protect defendants against unjustified verdicts. Many doctors hold the opinion that most judges are not sufficiently skilled in handling these suits because they lack medical expertise or even expertise in handling malpractice suits, which is especially evident, in this view, in the failure to protect the process from unqualified or biased expert witnesses (Struve 2003, 18). Defendants might have more confidence in the legal system if it incorporated input and opinions from the defendant’s professional peers (Struve 2003, 55). PaTLA views the fears of the medical community in this regard as unwarranted, since in its view procedures are in place to ensure that only qualified experts are permitted to opine in malpractice cases and that the testimony they present meets reasonable standards of validity. The inquiry into the admissibility of expert opinion often involves time-consuming and expensive hearings to test the soundness of the expert’s methodology against the established legal criteria.

Screen Cases for Validity. Screening panels might be able to identify weak claims and discourage complainants from proceeding, while encouraging valid claims that are often uncompensated under the present system (Struve 2003, 55).

Encourage Early Resolution of Claims. By providing a mechanism for evaluating claims early in the litigation process, it is hoped that screening panels can encourage an earlier and hence less costly and stressful settlement of the claim (Struve 2003, 56).

Provide Low-Cost Information. Panels are a less costly alternative to formal discovery to allow claimants to find out what went wrong in their treatment. Plaintiffs who are unable to afford expert witnesses can use the panel system to gather information about their cases. Panels might also provide expert witnesses in states where panelists can be called as witnesses in malpractice trials. (Struve 2003, 55-56, 59-60)

Disadvantages

Increased Claims. Some data suggest that panels may increase the number of claims filed. (Nathanson 2004, 1099-1101) The National Center for State Courts (NCSC) found that states with mandatory panels experienced an increased rate of litigation in 1992. The NCSC study did not, however, demonstrate a causal link between mandatory panels and increased frequency. It could have been the case that states with higher than average rates of filing might have implemented panels to curtail them (Struve 2003, 60). If panels encourage an increase in claims, if a portion of the additional claims are weak, and if the panel findings then discourage the pursuit of those weak claims, it would seem that the panels afford little benefit with respect to the disposition of weak claims (Struve 2004a, 994).

Other research shows no systematic effect on the frequency of claims (Struve 2003, 61). Some claimants may be discouraged because panel proceedings increase the cost and length of litigation, especially in jurisdictions where panel findings are admissible at trial (Struve 2004b, 35).

Increased Costs. Perhaps the most frequently raised objection to screening panels is that they force the claimant to “try the case twice.” The claimant must incur attorney and expert fees both at the screening hearing and at any eventual trial. In jurisdictions where panels’ findings are admissible in court, parties may engage in costly and exhaustive discovery for the panel hearing.

(Struve 2004a, 992-93). By making claims more costly, panels may discourage plaintiffs from initiating meritorious claims, or may cause plaintiffs to drop such claims before reaching a settlement.

Failure to Screen Effectively. While physicians on the panel may have greater medical knowledge than lay jury members, their knowledge on the prevailing standard of care may be largely anecdotal, unless they practice in the particular specialty involved in the case (Struve 2003, 66).

Inefficiency. Nine-tenths of all medical malpractice cases settle prior to trial, and some of those that go to trial are straightforward enough that a jury can understand the medical issues. This being the case, it seems unnecessary to require all cases to undergo the screening panel procedure. (Struve 2003, 35, 66; Struve 2004a, 976, 994-5)

Difficulty Recruiting Panelists. In some states, physicians have been reluctant to serve on panels, especially where they may be called to testify in later court proceedings (Struve 2004a, 994).

Constitutional Issues

Screening panel legislation has been considered by the Pennsylvania Supreme Court in three cases that tested the compulsory arbitration provisions of HCSMA.⁶⁹ Because the Court ultimately rejected the arbitration provisions, consideration of this history is clearly crucial to any attempt to reinstate a screening panel system in Pennsylvania.

In *Parker v. Children's Hospital of Philadelphia*, 394 A.2d 932 (Pa. 1978), the Court upheld the validity of these provisions. The right to jury trial under article I, § 6 of the Pennsylvania Constitution was not violated by either the Act's requirement that a plaintiff arbitrate as a condition precedent to trial by jury or that the arbitration panel's decision and findings of fact were admissible at the subsequent trial. The requirement that a plaintiff first exhaust an administrative remedy before seeking redress through the courts did not usurp the powers vested in the courts by article V, § 1 of the Pennsylvania Constitution because the Act provided for a de novo appeal to the trial court. Finally, including two health care providers on the arbitration panel of seven established by the Act did not violate the procedural due process right to an impartial decision maker.

⁶⁹ The screening panels were officially called the Arbitration Panels for Health Care.

Only two years later, *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980) held unconstitutional the section of the Act that gave health care arbitration panels original exclusive jurisdiction over medical malpractice claims because it violated the right to a jury trial. The Court explained that the Pennsylvania Constitution does not require an unfettered right to a jury trial, but does require that access to a jury trial “must not be burdened by the imposition of onerous conditions, restrictions or regulations which would make the right practically unavailable” (192).⁷⁰ The Act failed this test because delays in processing claims under the arbitration procedures were oppressive and impermissibly infringed upon the jury trial right. The court iterated its approval to arbitration in principle as a viable means of dispute resolution, but observed “the inability of [the Act’s] statutory scheme to provide an effective alternative dispute resolution forum in the area of medical malpractice” (196). In *Heller v. Frankston*, 475 A.2d 1291 (Pa. 1984), the Court extended *Mattos* to hold that all the arbitration provisions were unconstitutional, so that the Commonwealth could not establish the arbitration panels even as an elective procedure.

In other states, screening panels have been attacked on the jury trial issue and impedance of access to the courts. In some states, the challenge grounded on delay has been presented under an Open Courts Clause or a Remedy Clause similar to article I, § 11 of the Pennsylvania Constitution.⁷¹ (Maccioroli at nn. 147-200;⁷² Brann, 367-76) The Supreme Court of Missouri reached a similar result to Pennsylvania. (Maccioroli at nn. 156-59, citing *State ex rel. Cardinal Glennon Memorial Hosp. v. Gaertner*, 583 S.W.2d 107 (Mo. 1979)) The Alaska Supreme Court rejected a right to jury trial challenge based on delay, citing statutory provisions assuring that the arbitration procedure could not delay disposition by more than 110 days. (Maccioroli at n. 171, citing *Keyes v. Humana Hosp. Alaska*, 750 P.2d 343 (Alaska 1988)) A time limit on the panel’s hearing and decision may largely insulate a statute from this kind of challenge (Maccioroli at n. 171; Brann, 384, 415-416).

Screening panel statutes have been challenged under a variety of other constitutional provisions on a variety of grounds. Challenges raising denial of access to the courts have focused on requirements that a bond be posted by litigants who lose the panel’s decision and wish to proceed to a court trial nevertheless. To deflect this challenge, bond provisions should include an exception for indigent parties. (Maccioroli at n. 172) Others have argued that the

⁷⁰ In *Mattos* the final word is “available,” misquoting the cited case (*Smith’s Case*, 381 Pa. 223, 231 (1955)), which reads “unavailable,” as the context suggests.

⁷¹ “All courts shall be open; and every man for an injury done him in his lands, goods, person or reputation shall have remedy by due course of law, and right and justice administered without sale, denial or delay.”

⁷² The staff used an e-mail edition of this article that did not include page numbers.

right to jury trial is impeded where the statute provides that the finding and conclusions of the panel are admissible in any subsequent trial, but this argument has met with little success (Maccioroli at nn. 174-200).

The Equal Protection Clause has been invoked based on the discrimination between malpractice and other tort plaintiffs. Except in Rhode Island and Wyoming, these challenges have been unsuccessful. Most courts have correctly applied the “rational basis” test to uphold the statute. (Maccioroli at nn 104-146)

Finally, the statutes have also been challenged on the grounds of interference with the judicial function, because the panels permit persons who are not judges to make quasi-judicial findings. This challenge has succeeded in Illinois, but has failed elsewhere. The other courts have rejected this argument because panel decisions are subject to reversal through a jury trial and appellate review; this was the position the Pennsylvania Supreme Court took in *Parker*, 394 A.2d 932, 942-43. Maryland upheld its screening panel statute against a judicial function challenge, which also raised denial of the right to a jury trial, even though the Maryland statute makes the panel’s findings not only admissible, but presumptively correct. (Maccioroli at nn. 202-241; *Attorney General v. Johnson*, 385 A.2d 57 (Md. 1978))

Any new screening panel legislation in Pennsylvania must be readily distinguishable from the provisions struck down in *Mattos* and *Heller*, or it will almost certainly meet the same fate. Since the ground for invalidation was unacceptable delay, any new statute will have to include a reasonable time limit and deem any case pending with the panel beyond that limit to have satisfied the arbitration requirement. Professor Donald A. Tortorice of the College of William and Mary School of Law, formerly chief counsel of JUA and chief counsel of HAP, advocates establishment of a screening panel mechanism with strict procedural deadlines.⁷³ Alaska’s statute requires a decision within 80 days from its presentation to the panel, with one 30-day extension upon approval of the court (Maccioroli, n. 171). Suggested model legislation requires the panel to hear the case within 60 days after presentation and render a decision within 30 days of the hearing. (Maccioroli, Appendix, Model Medical Malpractice Screening Panel Act, §§ 203(c) and 204(a)) An arbitration system will need to be staffed and funded robustly enough so as to enable it to dispose of all or nearly all of its case load within the required time limit.

⁷³ Personal conversation with Commission staff, July 13, 2004.

Legislative Models

Thirty-one states, including Pennsylvania, have at some point implemented screening panels. Of those, 20 remain in effect. Thirteen panel systems that no longer exist were either repealed by their state legislatures, overturned by courts, or both. Panel legislation has been repealed in nine states and overturned by courts in five. (Illinois has twice repealed panel legislation after having it invalidated by court decision.) See table 8.

Several states adopted screening panel legislation in 1975 or shortly thereafter. While the trend of adopting these statutes has slowed, five states have adopted screening panel systems in the 1990s. At the same time, nine states have repealed screening panel legislation. Nevada repealed its legislation in 2002, but otherwise the most recent state to do so was New York in 1991.

Variations in Other States' Pretrial Screening Systems

Screening panels typically consist of three to seven members. Some panels include only physicians, while on others the physicians are joined by lawyers, judges, and lay members.

Some panels screen claims prior to the filing of the complaint while others screen after the complaint has been filed.

There are variations in the amount of discovery permitted in different states' panels, the type of evidence allowed, the extent of the proceedings, and the scope of the findings (liability only or liability and damages).

The panel reviews submissions and presentations by both plaintiffs and defendants. The screening panel then provides an opinion on whether the claim has a sufficient factual basis to justify a recovery by the plaintiff. (Struve 2003, 58, 59)

Litigants dissatisfied with the findings of the panel may proceed to trial. Some panel systems attempt to discourage the party who loses the panel's judgment from proceeding further by imposing costs or other fees (Struve 2004a, 991).

**Table 8
Screening Panels**

States that adopted panels	Repealed	Invalidated	Currently in effect
Alaska			x
Arizona	1989		
Connecticut			x
Delaware			x
Florida ¹	1983	1980	x
Hawaii			x
Idaho			x
Illinois ²	1979 1990	1976 1986	
Indiana			x
Kansas			x
Louisiana			x
Maine			x
Maryland			x
Massachusetts			x
Michigan			x
Missouri ³		1979	
Montana			x
Nebraska			x
Nevada	2002		
New Hampshire			x
New Jersey	1989		
New Mexico			x
New York	1991		
North Dakota	1981		
Pennsylvania ⁴		1980	
Rhode Island ⁵	1981		
Tennessee	1985		
Utah			x
Virginia			x
Wisconsin			x
Wyoming ⁶		1988	

1. Florida repealed a panel provision in 1983, but the repeal followed the judicial invalidation of that provision in 1980. *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980) (invalidating panel system because, as implemented, it deprived doctors of their right to mediation since proceedings in many cases did not conclude within the statutory deadline, and extending that deadline would deprive malpractice plaintiffs of their right of access to the courts). Subsequent to the 1983 repeal, Florida adopted new provisions permitting procedures that have some aspects of a medical screening panel.

2. Illinois instituted two different panel systems and repealed them both; however, to list Illinois as a repeal state might be viewed as double-counting, since both provisions were judicially invalidated prior to their repeal. *Wright v. Central Du Page Hosp. Assoc.*, 347 N.E.2d 736 (Ill. 1976) (striking down panel provision because it mixed lay and judicial functions in violation of state constitution); *Bernier v. Burris*, 497 N.E.2d 763 (Ill. 1986) (striking down subsequent panel provision on similar grounds).

3. *Cardinal Glennon Mem. Hosp. v. Gaertner*, 583 S.W.2d 107 (Mo. 1979) (holding that panel provision violated state constitutional right of access to the courts).

4. *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980) (invalidating panel system because, as implemented, it resulted in long delays so as to violate state constitutional right to a jury trial).

5. *Boucher v. Sayeed*, 459 A.2d 87 (R.I. 1983), is sometimes described as striking down a panel provision. However, Rhode Island had repealed its medical screening panel provision in 1981. The provision invalidated by the *Boucher* court was not a panel provision, but rather one that provided for a preliminary finding by judge on the merits of the case. *Ibid.*, 89-90.

6. *Hoem v. State*, 756 P.2d 780 (Wy. 1988) (holding that panel provision violated state constitutional guarantee of equal protection).

SOURCE: Struve 2003, 57.

Eleven states with screening panels provide that the panel's findings or reports are admissible in subsequent court proceedings. Some states permit panel members to be called as witnesses to testify in subsequent court proceedings. Fourteen states require the submission of claims to a screening panel; there is no strong correspondence between that requirement and subsequent admissibility of the panel's findings or reports.⁷⁴ See table 9 for a summary of the submission requirements and admissibility provisions for the 20 states where screening panels are currently in effect.

Proposed Legislation in Pennsylvania

House Bill 476 of 2003 (P.N. 554) proposed establishing "preadjudication screening panels" in Pennsylvania. It was not acted upon in the House. The bill directs the Insurance Department to implement a screening panel system in each medical malpractice insurance rating territory. The panels would serve to review each malpractice claim filed before it is brought to trial.

The panels would each consist of three members—a retired judge, a lawyer, and a medical doctor—who would be full-time employees of the Insurance Department. The department would be responsible for determining how many panels are needed in each territory. Regulations necessary to implement the preadjudication screening panels would be promulgated by the department.

The bill mandates that malpractice claims be screened by the panels. Any party that files a claim must submit to its territory's panel a synopsis of the claim along with supporting documentation within 30 days of filing the claim. Non-moving parties are not permitted to respond to a submission or to participate in the screening process.

The panels must return a written determination declaring the claim frivolous or nonfrivolous within 120 days of receiving the claim. No explanation or other comment regarding the claim and its determination is permitted. (This provision eliminates one of the perceived advantages of screening panels: that plaintiffs can use panels as a source of information to find out what went wrong with their treatment.) The determination made by the panel is admissible as evidence at trial, arbitration, or any other proceeding connected to the claim.

⁷⁴ See also Catherine T. Struve, interview by Christopher Guadagnino, Expertise-Enhancing Reform of Medical Malpractice Litigation, *Physician's News Digest*, December 2003, <http://www.physiciansnews.com/spotlight/1203.html>.

**Table 9
Screening Panels Procedures**

State	Type of submission			Findings admissible in court proceedings		State	Type of submission			Findings admissible in court proceedings	
	Mandatory	Voluntary	Other	Yes	No		Mandatory	Voluntary	Other	Yes	No
Alaska ¹	x			x		Massachusetts ¹²	x			x	
Connecticut ²		x		x		Michigan ¹³					x
Delaware ³	x			x		Montana ¹⁴					x
Florida ⁴			x		x	Nebraska ¹⁵	x			x	
Hawaii ⁵	x			x		New Hampshire ¹⁶		x			x
Idaho ⁶	x			x		New Mexico ¹⁷					x
Indiana ⁷	x				x	Utah ¹⁸					x
Kansas ⁸		x		x		Virginia ¹⁹		x		x	
Louisiana ⁹	x			x		Wisconsin ²⁰		x			x
Maine ¹⁰	x			x							
Maryland ¹¹	x			x		No. of states	14	5	1	11	9

1. Submission of claims to an expert advisory panel is mandatory unless the court decides that its opinion is unnecessary. Alaska Stat. § 9.55.536(a) (1976). See Alaska Stat. § 9.55.536(e) (1976) for admissibility provisions.
2. See Conn. Gen. Stat. Ann. § 38a-33 (1977) for voluntary submission provisions. The findings of the screening panel, if unanimous, are admissible in evidence at any subsequent trial of the issues. Conn. Gen. Stat. Ann. § 38a-36 (1977).
3. A party has the right to demand submission to a medical negligence review panel. Del. Code Ann. tit. 18 § 6802(b) (1976). The opinion of the panel is admissible as prima facie evidence on appeal. Del. Code Ann. tit. 18 § 6812 (1976).
4. The court may require that the claim be submitted to non-binding arbitration. Fla. Stat. Ann. § 766.107(1). See also Fla. Stat. Ann. § 766.206. See Fla. Stat. Ann. § 766.107(5) for admissibility provisions.
5. A claimant must submit a statement of the claim to the medical claim conciliation panel before a suit is commenced. Haw. Rev. Stat. Ann. § 671-12(a) (1976). See Haw. Rev. Stat. Ann. §§ 671-16 (1976) and 671-16.6(e) (2003) for admissibility provisions.
6. The state board of medicine must appoint hearing panels to hear medical malpractice cases involving claims of personal injury and wrongful death, the proceedings of which are informal and nonbinding. Idaho Code §§ 6-1001 and 6-1002 (1976). No record of the proceedings is kept, and all evidence and documentation is returned to the parties or witnesses. Idaho Code § 6-1003 (1976).
7. An action against a provider may not be commenced before the claimant's proposed complaint has been presented to a medical review panel and an opinion is given by the panel, unless the parties agree otherwise or the claim does not exceed \$15,000. Ind. Code Ann. §§ 34-18-8-4, 34-18-8-5 and 34-18-8-6 (1998). The medical review panel opinion report is admissible but not conclusive, and a party may call a member of the panel as a witness to testify. Ind. Code Ann. § 34-18-10-23 (1998).
8. See Kan. Stat. Ann. §§ 65-4901 and 65-4904(c) (1976).
9. See La. Rev. Stat. Ann. § 40:1299.47(A)(1)(a) (1975) for mandatory submission provisions. The expert opinion report of the medical review panel is admissible but not conclusive, and a party may call a member of the panel as a witness to testify. La. Rev. Stat. Ann. § 40:1299.47(H) (1975).
10. The mandatory pretrial screening may be bypassed only if all the parties so agree. Me. Rev. Stat. Ann. tit. 24 §§ 2852 and 2853 (1985). The findings and other writings of the panel are generally inadmissible. However, if the panel findings regarding negligence and causation are unanimous and unfavorable to a party, the findings are generally admissible. Me. Rev. Stat. Ann. tit. 24 § 2857 (1985).
11. Claims are filed with the director of the Health Claims Arbitration Office. Md. Code Ann., Cts. & Jud. Proc. § 3-2A-04(a) (1976). The arbitration award is admissible as evidence in a judicial proceeding and is presumed to be correct, with the burden of proving otherwise on the party opposing it. Md. Code Ann., Cts. & Jud. Proc. § 3-2A-06(d) (1976).
12. See Mass. Gen. Laws ch. 231 § 60B (1975).
13. An action must go through the mediation process. Mich. Comp. Laws Ann. § 600.4903(1) (1986). Statements by the attorneys regarding the mediation and the briefs or summaries presented are not admissible in any court or evidentiary proceeding. Mich. Comp. Laws Ann. § 600.4961(4) (1986).
14. See Mont. Code Ann. § 27-6-105 (1977) for provisions regarding mandatory submission to the medical legal panel. The panel's decision is without administrative or judicial authority and is not binding on a party. Mont. Code Ann. § 27-6-606 (1977).
15. Medical review panels must review all claims in advance of filing the action. Neb. Rev. Stat. § 44-2840(1) (1976). A panel report is admissible as evidence in a subsequent court action, but it is not conclusive, and either party may call a member of the panel as a witness to testify. Neb. Rev. Stat. § 44-2844(3) (1976).
16. See N.H. Rev. Stat. Ann. §§ 519-A:2 and 519-A:8 (1971).
17. See N.M. Stat. Ann. §§ 41-5-14(A) and 41-5-20(D) (1976).
18. The Division of Occupational and Professional Licensing establishes procedures for the compulsory consideration by hearing panels as a condition precedent to commencing litigation. Utah Code Ann. § 78-14-12(1) (1985). See Utah Code Ann. § 78-14-15(1) for admissibility provisions.
19. See Va. Code Ann. § 8.01-581.2(A) (1976) for submission provisions. An opinion of the medical review panel is admissible but not conclusive, and either party may call a panel member as a witness to testify. Va. Code Ann. § 8.01-581.8 (1976). However, if the opinion of the panel is not rendered within the specified time, it is generally not admissible as evidence. Va. Code Ann. § 8.01-581.7:1 (1981).
20. See Wis. Stat. Ann. §§ 655.44(1) and 655.445(1) (1985) regarding mediation. There is no stenographic record or transcript. Wis. Stat. Ann. § 655.58(1) (1985).

SOURCE: Staff review of state statutes; see also NCSL State Medical Liability Laws Table 2004.

Empirical Evaluations

Catherine T. Struve of the University of Pennsylvania Law School, a leading expert on medical malpractice procedures, upon whose research this chapter has largely been based, has concluded that available data do not support the use of panels for the medical malpractice litigation system, despite the promise that they appear to hold. Part of the difficulty is that screening panels have been advanced for several different objectives that somewhat conflict with one another. It is not clear whether the panels reduce the frequency or severity of medical malpractice claims being brought to trial. Existing studies are not sufficient to draw firm conclusions on panel performance. The studies bearing on this issue examine data from no later than 1992, so they may not correspond well with present results. The studies also suffer from various methodological difficulties, especially their failure to examine whether the panels increase the accuracy of adjudication in the sense of encouraging strong claims and discouraging weak ones. No statistically significant difference in malpractice premiums has been shown for general practitioners or general surgeons, but obstetricians and gynecologists have experienced a statistically significant reduction where panels have been implemented. (Struve 2003, 55-67; Struve 2004a, 990-96)

An influential⁷⁵ comparative study of screening panels with emphasis on Arizona's experience concluded that the screening panel approach has been an overall failure:

Studies of several states' panel systems . . . reported delays in processing and a trend toward general dissatisfaction with the process by both the plaintiff and defense bar, as well as the insurance industry. These difficulties have been variously attributed to the problems inherent in reconciling the schedules of several physicians, attorneys, and a judge to set a panel hearing, the reluctance of physicians to become involved in judging their peers, inadequate monitoring of the process by the panel chair, the added cost of a second presentation of the case, and strategies developed by plaintiff attorneys to avoid the panel process (e.g., by "appearing" but not presenting evidence). These problems are reflected in the panel systems' rapid decline in popularity.

⁷⁵ This article is cited by other observers to support assertions that screening panels have been a failure (Dauer 2000, 6) and that their ineffectiveness is widely assumed (Metzloff 1996, 217).

The scholarly, medical, social science, and legal literature of the past ten years fails to document a case of a medical panel that “works,” that is, one in which participants are generally satisfied. The “honeymoon” with screening panels seems to be over, with most states now adopting procedural reforms such as requirements for an expert’s certification of the merits of a claim and discovery reforms. . . . (Goldschmidt 1992, 1107-08)

Conclusion

Besides facing apparently weak empirical support, any attempt to revive screening panels in Pennsylvania must take account of their earlier failure to gain approval from our Supreme Court. The constitutional difficulty that felled the 1975 arbitration provisions may be obviated by strict procedural deadlines, but this will work only if the program can operate effectively within them. However, most of the states that adopted this measure have retained it for a considerable period, which may indicate that it is considered at least minimally effective in much of the Nation.

The consensus of the advisory committee to this study is that the General Assembly should not put a high priority on consideration of the reinstatement of screening panels at this time. The most important potential benefit expected from screening panels, namely, enhanced expertise in the disposition of malpractice cases, has been recently addressed by the tightening of the criteria for medical experts⁷⁶ and the certificate of merit requirement.⁷⁷

⁷⁶ Mcare Act, § 12.

⁷⁷ Pa.R.C.P. No. 1042.1-1042.8.

CHAPTER 7

SPECIALIZED TRIBUNALS

This chapter discusses the specialized tribunal proposals, which include various plans to assign medical malpractice cases to a court or administrative agency that would have exclusive jurisdiction over them. Like screening panels, these proposals would fundamentally alter the forums in which malpractice cases can be pursued, while retaining the present negligence standard of liability.

Advantages and Disadvantages

In the context of medical malpractice, institution of specialized courts could improve the decision-making process, chiefly by upgrading the expertise of the decision makers.

The possible advantages of a specialized medical liability court include expertise, speed, and uniformity and coherence of outcomes. Not only might the judges initially be selected for their experience with medical liability cases, but once on the bench, the judges would have the incentive and opportunity to develop additional expertise in relevant areas. Expert judges might be better equipped to evaluate the qualifications of expert witnesses. Moreover, specialized judges reviewing jury calculations of damages would be better acquainted with the amounts that had been awarded in prior, similar cases. Expertise might also help judges to manage cases more actively, with a view to resolving them quickly. In addition, the exclusivity of the court's jurisdiction over medical liability cases would reduce the number of judges hearing those cases, and thus might tend to increase somewhat the uniformity and consistency of decisions. (Struve 2003, 68-69; see also Dreyfuss 1990, 378-80)

Under most specialized tribunal scenarios, except for the one proposed by the American Medical Association, lay juries would continue to be the finders of fact. This factor may dilute the improvement in expertise supplied by specialized tribunals, while arguably maintaining confidence that the liability system is responsive to public perceptions.

A major impetus for court specialization on the federal level has been relief for overcrowded dockets of the regional circuit courts. In the medical malpractice field, the volume of cases seems to be a less important consideration than the complexity of applying the well-settled legal standard to the facts of the particular case. This reform is currently popular with the public: a recent poll by Harris Interactive for the public interest advocacy group Common Good found that 62% of American adults favor the use of special health courts to try medical malpractice lawsuits.⁷⁸

While the advantages of a specialized court are appealing “the disadvantages of specialization are as easy to list as the benefits” (Dreyfuss 1990, 379). A specialized bench may be especially prone to becoming politicized, because interest groups can concentrate their resources to obtain the election or appointment of favorable judges more effectively than they can for a generalist court with a broader docket. Where there is a lack of consensus on the aim of the law, a specialized court may also be overly responsive to trends that favor one side or the other, or there may be forum-shopping between specialized courts that seem to favor a particular side. Tort law has allegedly been prone to ideological divisions between pro-plaintiff and pro-defendant factions. (Dreyfuss 1990, 379-80; Posner 1983, 781-83; Struve 2003, 73-75) The danger of politicization may become greater because of a recent United States Supreme Court ruling striking down rules that formerly prohibited judges from expressing their views on disputed legal and political issues. See *Republican Party of Minnesota v. White*, 536 U.S. 765 (2002).

Another possible drawback is the isolation of the specialized area from related areas of law. “Since specialist judges’ knowledge of their field comes at the expense of familiarity with other doctrinal areas, such judges may fail to draw relevant analogies to other bodies of doctrine, with the result that the specialists’ field may diverge from the larger body of law and may also lose the benefit of experience in other fields” (Struve 2003, 75; see also Dreyfuss 1990, 381).

A third disadvantage is that by limiting the venues available for malpractice actions, specialized trial courts may raise the cost of litigating such actions. This cost increase is likely to be felt more by patients than by health care providers, because the latter usually have greater financial resources than the former. (Struve 2003, 76-77)

⁷⁸ Common Good, press release, New York, July 19, 2004.

Finally, the public could lose confidence in the fairness of a system where the liability determination is made largely or entirely by medical experts because they may be considered biased in favor of the health care providers (Mehlman 2003, 72).

Present Utilization

At present, no state has such a specialized medical malpractice court. However, the federal government has assigned various matters to specialized tribunals, including patents and trademarks (Court of Customs and Patent Appeals), customs and international trade (Court of Customs and Patent Appeals; Court of International Trade), taxes (Tax Court), non-tort claims against the federal government (Court of Claims), energy (Temporary Emergency Court of Appeals), railway cases (Commerce Court), and electronic surveillance to gather foreign intelligence information (Foreign Intelligence Surveillance Courts). The jurisdictions of the Court of Claims and the Court of Customs and Patent Appeals were consolidated in 1982 and assigned to the Court of Appeals for the Federal Circuit, which was established at that time. Specialization at the federal level has met with mixed success: the Commerce Court, for instance, was an abysmal failure and was abolished after three years, while the Tax Court, the Court of Claims, and the Court of International Trade have been respected or at least uncontroversial. (Dreyfuss 1990, 384-406; Jordan 1981, 749; Posner 1983, 782)

Factors Determining Success or Failure

Based on the federal experience, Rochelle Cooper Dreyfuss of the New York University School of Law argues that the success of a specialized court depends on three factors: its field of jurisdiction, the effect of specialization on the parties, and the implementation strategy (Dreyfuss 1990, 407-439).

With respect to the field of specialized jurisdiction, there are five important factors to consider (Dreyfuss 1990, 408-420):

- *Complexity of the facts and law.* Specialization is usually considered only for fields which are perceived to have greater than average complexity; otherwise the generalist court can presumably

handle them adequately. However, it is not necessarily true that the more complex the field, the greater the need for specialization. (Dreyfuss 1990, 409-11)

- *Clear boundaries.* If almost all cases within the specialized court's jurisdiction raise only issues within its scope, there will be little need for bifurcated trials and appeals in different forums, and the specialization of the court will promote efficiency (Dreyfuss 1990, 412-14). In medical malpractice cases, the most common overlap arises in those that combine a malpractice claim with a product liability claim against a drug or equipment manufacturer, and such cases are relatively rare.
- *Consensus on the aims of the law.* Broad agreement on the fundamental aims of the law within the field is critical to public acceptance and the ultimate success of a specialized court (Dreyfuss 1990, 414-18; Jordan 1981, 765). A specialized court must proceed from a pre-existing consensus and cannot be expected to develop such a consensus on its own (Dreyfuss 1990, 416). Consensus lessens the dangers associated with politicization of the appointment process, since if consensus exists, there will be few significant policy differences among judges or prospective judges.
- *Distribution of cases.* The more cases within the field are concentrated in particular courts, the less likely specialization will be needed, because the courts that hear the bulk of the cases will develop the expertise to handle them and the other courts will not have much relief from court congestion by the reassignment of their cases to the specialized court (Dreyfuss 1990, 418).
- *Fragmentation.* This factor refers to the existing level of coherence and consistency in the field. If it is felt that the field is currently plagued with irreconcilable results and unclear rules, a specialized court may help alleviate that difficulty (unless, as mentioned above, the existing disarray reflects underlying legal policy disagreements) (Dreyfuss 1990, 418-420).

The second class of considerations is the effect of specialization on the participants in the field, viz., the litigants, the bar, and the jurists. For the litigants and the bar, the most important concern is whether the balance of power will be upset by assignment to an expert bench. This may be expected to improve the position of the more sophisticated side. Even if the litigants on one side are generally more sophisticated than those on the other, however, this advantage can

be offset if the less sophisticated litigants are represented by a well organized bar. Since a specialized court will have fewer venues, travel costs to litigants will increase, and this burden will likely fall more heavily on patients than health care providers. (Dreyfuss 1990, 422-25)

As for the bench, the view has been expressed that a specialized court will fail to attract the same level of talent as a generalized court, because the best judges will become bored with the lack of challenge and variety of the specialized docket and may also wish to avoid the greater travel burdens that tend to accompany a specialized court. (Dreyfuss 1990, 425; Posner 1983, 779-80) In practice, specialized federal courts seem to have attracted able judges (Dreyfuss 1990, 427), and the boredom factor may be mitigated by rotating generalist judges through the specialized division, as with the family court division.

The third broad issue is the manner of implementing specialization. Within this category, the most important topics are the method of selection and level of specialization. Because Pennsylvania's judges are elected, the choice of selection methods would seem to be between initial election and appointment subject to retention election. Candidates for election to the court may be rated by the PBA (as appellate judges are now) or by a judicial qualifications commission (as contemplated by 2003 Senate Bill 204 and 2003 House Bill 23).

The second key implementation issue is the level of specialization, whether trial court, appellate court, or both. If the complexity in the specialization area is mostly at the factual level (e.g., patent law), it may be advisable to use a specialized division of the trial court and not use a specialized appeal court; if the complexity is mostly legal (e.g., federal tax law), a general trial court and a specialized appeal court may be indicated. Using both specialized trial and appellate courts may attenuate generalist influence so as to increase the danger of doctrinal isolation and capture by special interests, even though some generalist influence is supplied by the ultimate review of the state and federal Supreme Court. (Dreyfuss 1990, 428-430) If this analysis is accepted, it would appear that specialization of the trial court level would be preferable for medical malpractice, since the complexity of medical malpractice seems to be predominantly at that level. Medical malpractice law would not appear to be more difficult than other fields of legal practice: the negligence standard of medical malpractice is recognizably similar to that first set forth in *Pike v. Honsinger*, 49 N.E. 760 (N.Y. 1898), except for the gradual erosion of the locality rule. (See Hogan 2003, 28-32) The major difficulty in malpractice cases seems to lie in applying the well-settled standard and determining causation in light of the facts in particular cases.

Legislative Proposals

In the 2003-04 session of the Pennsylvania General Assembly, three bills were introduced to establish a specialized medical malpractice court. Senate Bill 204 (P.N.203) and House Bill 23 (P.N.410) are very similar.⁷⁹ They propose a Medical Professional Liability Court consisting of both a trial and appellate division with exclusive jurisdiction over medical professional liability claims against health care providers. There is a right of appeal from the appellate division to the Supreme Court, which would take the appeal if it is accepted for review by two Justices.

The MPLC would consist of 18 judges assigned to one of three geographic districts. The eastern district would have regular sessions in Norristown (SB 204) or Media (HB 23) and Scranton, the middle district in Harrisburg and Williamsport, and the western district in Erie and Pittsburgh. Special sessions are permitted at other places as funding allows. Judges are elected at municipal elections; candidates who wish to do so may have their qualifications rated by a twelve-member qualifications commission. Vacancies are filled by nomination by the Governor from a list developed by the qualifications commission, subject to confirmation by the Senate. Members may run for retention at the expiration of their terms.

Financing for the MPLC would be through a special fund that would include legislative appropriations, a surcharge of 10% on application fees for health care facilities and health care professionals, a surcharge of 25% on civil penalties under the Health Care Facilities Act, and amounts collected on account of MPLC's operations, such as fees and charges. Fees and charges are to be set at a level that will make the court self-sustaining, except for funding from a surcharge on facility application fees that would be reduced from its initial level.

House Bill 1199 of 2003 (P.N.1429) would establish a Medical Claims Court. With respect to membership, division of judicial districts, permanent venues, and funding, this legislation is virtually identical with the MPLC, but there are two significant differences. The MCC would have no appellate division; appeal would be directly to the Supreme Court. There is also no provision for a qualifications commission.

⁷⁹ The differences are that SB 204 divides the Commonwealth into eastern, middle, and western districts for purposes of the MPLC, while HB 23 specifically assigns counties to the same three districts (§ 813(b) in both bills); SB 204 assigns a regular session venue for the eastern district to Norristown, while HB 23 assigns the corresponding venue to Media (§ 813(c)); HB 23 includes a detailed, though largely directive, provision for preparing the master list for jury selection, which does not appear in SB 204 (§ 844).

No legislative action was taken on any of these bills.

Varieties of Specialized Tribunals

Regional Trial Courts

As illustrated by the proposed legislation, the leading proposals would include a limited number of trial venues with provision for special court sessions elsewhere. The state would be divided into three regions, and the jury would be chosen from throughout the region.

One of the reasons given for establishing such a system is to encourage a jury pool that will be less generous to plaintiffs; this is alleged to be the reason why none of the proposed bills includes a permanent venue in Philadelphia. The factual premise for contriving a less metropolitan jury pool may not be accurate. It is true that Philadelphia juries have given awards in higher dollar amounts than elsewhere in the Commonwealth, but it is less clear whether this reflects greater jury sympathy toward plaintiffs in Philadelphia than elsewhere. It may be that health care providers in Philadelphia (and to a lesser extent Allegheny County) receive referred cases that are particularly risky and require particularly advanced treatment techniques, and may therefore be more likely to result in large awards when a mishap occurs. (Struve 2003, 78-80)

Divisions within Common Pleas Courts

Another possible method of implementation is to create a specialized division within each of the courts of common pleas, similar to the present family court division. The number of family law cases, however, is vastly larger than the number of medical malpractice or even professional malpractice cases. In 2002, a total of 407,540 family court cases were filed in the Commonwealth;⁸⁰ in that same year, 2,957 medical malpractice cases were filed;⁸¹ almost 138 family court cases were filed for every medical malpractice case. Therefore, for only the largest judicial districts would it make sense to establish a medical malpractice

⁸⁰ AOPC, 2002 Caseload Statistics of the Unified Judicial System of Pennsylvania (n.p.: n.d.), 54. The cases are listed by type, so cases that raise issues in more than one category may be double-counted.

⁸¹ AOPC, Pennsylvania Medical Malpractice Case Filings: 2000-2003 (March 18, 2004) (reproduced as appendix C).

division.⁸² The remaining judicial districts would then either handle medical malpractice cases as they do other civil trials or combine in a region large enough to justify a division.

Administrative Panels

An alternative to specialized courts is a quasi-judicial administrative agency similar to that already discussed in connection with no-fault, while retaining the current negligence liability standard. This alternative was proposed in the late 1980s by the AMA, in conjunction with medical specialist organizations in a joint undertaking called the AMA/Specialty Society Liability Project. In brief outline, this proposal contemplates an administrative system under which liability would be decided initially by claims reviewers, appealable to an ALJ, and further appealable to a panel of the administrative board. Settlement would be encouraged by imposing sanctions against a party if the final result was not significantly more advantageous to the litigating party than a rejected offer. Appeal of a final board decision would go to the intermediate appellate court, which could review for abuse of discretion, but could not make any determinations regarding the medical standard or the existence of malpractice. The standard of causation would be whether negligence was a contributing factor to the injury, and damages would be apportioned according to a pure comparative responsibility standard, with no recovery for the percentage of injury caused by the underlying medical condition. The administrative board would have substantial powers with respect to education, credentialing, and discipline of physicians, and would have rulemaking powers, including the power to make rules concerning standards of medical practice. (Johnson, et al. 1989, 1379-89)

Common Good has recently proposed an administrative system for determining medical malpractice claims that is similar to no-fault and is described in chapter 5.

⁸² In 2003, a judge assigned exclusively to a medical malpractice division in the Perry/Juniata or the Susquehanna county judicial district would have been idle, as there were no medical malpractice case filings in those districts from at least from 2000 through 2003. Only six judicial districts (Allegheny, Chester, Delaware, Lehigh, Montgomery, and Philadelphia) had more than 50 medical malpractice case filings in 2003. Ibid.

Alternative Methods for Providing Expertise

If the General Assembly wishes to improve the expertise available to the trial court, there may be means of doing so that would change the judicial system less radically than specialized courts or screening panels. The most modest change would encourage or require judges who are assigned these cases to undergo relevant special training. For instance, training in scientific method and the evaluation of probabilistic evidence may help judges determine whether expert testimony should be admitted.⁸³ A recommendation may be made by the General Assembly to the Supreme Court to consider instituting a medical malpractice division within the Court of Common Pleas, at least in the largest counties. Rotation of judges through this division could improve judicial expertise without forcing judges to endure a monotonous docket for too long. (Struve 2003, 80-81)

Conclusion

Specialized judicial or administrative tribunals may hold some promise for bringing greater expertise to bear on the resolution of malpractice cases, thereby improving speed and consistency and, at least in the long run, lowering costs. However, the specialized tribunal approach is unproven in the medical malpractice context. Among other difficulties, policymakers must be satisfied that there will be little chance of a split between pro-doctor and pro-patient venues and that the reduction in the number of regular trial venues will not cause undue hardship to plaintiffs. The advisory committee considered this approach more promising than screening panels, but no consensus was reached to recommend it over other policy alternatives.

⁸³ The Pennsylvania Supreme Court has established medical liability seminars to educate the Commonwealth's trial judges on medical liability procedures and rules. AOPC News Release, September 15, 2004.

CHAPTER 8

ARBITRATION AND MEDIATION

The procedures described in this chapter are ADR procedures that are initiated by the consent of the parties. The issues in contest between the patient and the health care provider are decided under the present negligence standard, but a jury trial is avoided. Under arbitration, a panel of decision-makers is appointed, usually to render a binding decision on the merits, although parties may agree to a merely advisory decision. Under mediation, the parties select a facilitator in order to arrive at a settlement and thereby obviate the need for further litigation. Both of these options, as well as other ADR procedures, are available under present Pennsylvania law for medical malpractice cases if consented to by the parties.⁸⁴

The advisory committee discussed changes to the statutory law or court rules that may make ADR more accessible and attractive to claimants and providers, but did not arrive at a consensus on any recommendations.

Arbitration

Arbitration is commonly used to resolve civil disputes, particularly for commercial contracts and collective bargaining agreements. It is available for use in medical liability cases, although such use has been somewhat rare. The advantages and disadvantages of arbitration in the medical professional liability context are discussed here.

⁸⁴ A consensual procedure that is increasingly popular is “early offer,” whereby a health care provider will evaluate an adverse outcome and offer an amount it considers reasonable as soon as possible after the event. The offer is not a formal recognition of fault. If the patient accepts the offer before any written claim is made, the settlement can obviate a report to the National Practitioner Data Bank. In many cases the patient will accept the settlement and release the provider from liability, thereby avoiding litigation. A program sponsored by COPIC, the largest malpractice insurer in Colorado, encourages providers to make early offers to injured patients without asking them for a release of liability; despite the lack of any formal settlement, patients have not litigated claims compensated under that program.

Advantages

The advantages of arbitration include the possibility of a more prompt and expert and less costly resolution of the malpractice dispute. A major potential advantage of arbitration is flexibility. The disputants can take advantage of the expertise of the organizations such as the American Arbitration Association to structure the arbitration in a way that can be favorable to all parties. Parties can control procedural variables by contract, including the amount of discovery and stipulated maximum and minimum recoveries; such issues can be modified by agreement of the parties upon consideration of suggestions by the arbitrator. Arbitration awards may be appealed to court, but where the award is within the scope of the agreement, the grounds on which the award can be overturned are very narrow: prejudicial partiality, corruption, or misconduct; prejudicial error in the conduct of the hearing; acting beyond the arbitrators' powers (42 Pa.C.S. § 7314(a)); or in the case of common law arbitration, denial of a hearing or "fraud, misconduct, corruption or other irregularity caus[ing] the rendition of an unjust, inequitable or unconscionable award" (42 Pa.C.S. § 7341).

Arbitration can improve the selection and use of medical expert witnesses. Arbitration agreements can limit the number of experts any party is permitted to use and establish more stringent criteria than may be possible by generally applicable statutes or court rules. The agreement can provide for the use of a medical expert in a hearing officer role to judge the validity of a theory of liability. The arbitration rules may also provide for the selection of a neutral expert to evaluate the claim, a procedure that is rarely used in conventional litigation. (Metzloff 1996, 209-10) Most arbitration proceedings are binding, meaning that the parties are legally obligated to comply with the award unless it is overturned by a court. However, the parties may agree to arbitration that is advisory only.

Arbitration hearings are typically shorter and less expensive than a jury trial. Under arbitration programs used by two major California health care providers, proceedings are concluded within 19 months of commencement as compared to 33 months under court litigation. The hearings take two to four days, while a jury trial takes several weeks (GAO 1992, 9). Because of their relative privacy and brevity, arbitration proceedings are less traumatic, especially to the physician (Metzloff 1996, 209).

Disadvantages

Despite these potential advantages, arbitration has been little utilized in comparison with the level of its use in commercial disputes, even where statutes have been drafted to encourage it. In Pennsylvania, arbitration is rarely used to resolve medical malpractice cases. A number of reasons have been identified for why relatively few malpractice litigants have availed themselves of arbitration:

- The arbitrability of the dispute may be subject to preliminary challenge. If this issue must be litigated, the speed and cost advantages of arbitration may disappear. (Metzloff 1996, 211) Challenges to arbitrability are especially likely where the agreement to arbitrate was executed before the adverse outcome occurred because of the inequality in bargaining power between the patient and the provider as well as doubts concerning whether the patient's consent was genuinely informed.
- Lawyers on both sides are comfortable with the present system and are reluctant to experiment with a different procedure (Metzloff 1996, 212-13).
- Counsel must give up judicial oversight over the proceedings, such as control of discovery, sanctions for frivolous claims, and summary judgment (Metzloff 1996, 213).
- The superiority of arbitration over conventional litigation is not empirically demonstrated, in part because little research has been done on the issue (Metzloff 1996, 214).
- Arbitration leaves intact many of the features that are seen as objectionable in conventional litigation, such as contingent attorney fees, large and uncertain awards for pain and suffering, and, of course, the negligence standard of liability. Those who wish to replace negligence with no-fault may view measures encouraging arbitration as inadequate. (Metzloff 1996, 215-16)
- Arbitration has been a low priority for advocates of tort reform. The AMA, for instance, has pushed liability caps much harder than ADR. Even those who support ADR have considered mediation more promising because it is seen as more flexible and more truly voluntary. (Metzloff 1996, 216-19)

- The major policy initiative most similar to arbitration, viz., screening panels, has been evaluated a failure by most observers (Metzloff 1996, 216-17; Dauer 2000, 4-6).
- An effective arbitration system might lead to a flood of claims and higher costs (Metzloff 1996, 219).
- Arbitration carries a reputation of being inclined toward compromise decisions, which is undesirable when either side feels it deserves a clear victory (Metzloff 1996, 220).
- Plaintiffs' advocates feel arbitration favors health care providers, although this concern finds scant support from empirical evidence (Metzloff 1996, 214, 221).
- Because arbitration is a private disposition, it may overly protect health care providers who are at fault (GAO 1992, 3).
- As discussed below, state statutes providing additional requirements for medical malpractice arbitration may diminish the flexibility that is one of arbitration's strengths (Metzloff 1996, 212).
- Concern was voiced within the advisory committee that arbitration has been used by defendants as a delaying tactic.

Arbitration Statutes

Every state has a generally applicable arbitration statute. Pennsylvania is among 31 states that have adopted an arbitration statute (42 Pa.C.S. § 7301 et seq.) modeled after the Uniform Arbitration Act proposed by the National Conference of Commissioners on Uniform State Laws. Fifteen states⁸⁵ have adopted arbitration statutes specifically covering medical malpractice cases. Even in the states that have adopted specially tailored statutes, use of arbitration has been very limited. Michigan enacted a medical malpractice arbitration statute in 1975 but repealed it in 1993. Under that statute, only 882 claims were disposed of by arbitration out of about 20,000 total claims over a 16-year period. (Nevers 2000, 48)

⁸⁵ Alabama, Alaska, California, Colorado, Florida, Georgia, Illinois, Louisiana, Michigan, New York, Ohio, South Dakota, Utah, Vermont, and Virginia (GAO 1992, 5). Alaska, Florida, Michigan, South Dakota, Vermont, and Virginia have enacted both general and medical malpractice arbitration statutes.

The additional provisions in medical malpractice arbitration legislation may have actually discouraged its use. By mandating such requirements as the use of three arbitrators, one of which must be a physician (Michigan) or that the agreement be executed after the alleged negligence and after consultation with an attorney (Georgia), the statutes imposed a rigidity that undermines the effectiveness of arbitration. To genuinely encourage arbitration, the statute should do no more than declare a public policy in favor of arbitration, which would overturn common law judicial decisions hostile to arbitration; all the details should be left up to the parties. (Metzloff 1996, 212)

Restrictive requirements for arbitration may violate the Federal Arbitration Act (FAA).⁸⁶ FAA has been interpreted to preempt any state statute that permits an arbitration agreement to be revoked on grounds other than those that apply to contracts generally. *Doctor's Associates v. Casarotto*, 517 U.S. 681, 116 S.Ct. 1652 (1996). Thus a contract that requires arbitration may be ruled unenforceable as unconscionable only if the same standard of unconscionability applies to the arbitration contract as to any other contract. In *Doctor's Associates*, the Montana statute required the arbitration clause to appear in underlined capital letters on the first page of the contract. "By enacting [FAA] § 2 . . . Congress precluded states from singling out arbitration provisions for suspect status, requiring instead that such provisions be placed on the same footing as other contracts" 116 S. Ct. 1652, 1656. Had the Montana statute provided for revocation under a broader standard, such as a rule requiring unexpected clauses in adhesion contracts to be conspicuous, it might have been upheld (1656, n. 3).

Pennsylvania's Uniform Arbitration Act is consistent with FAA in restricting the grounds for overturning an arbitration clause:

A written agreement to subject any existing controversy to arbitration or a provision in a written agreement to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable, save upon such grounds as exist at law or in equity relating to the validity, enforceability or revocation of any agreement. (42 Pa.C.S. § 7303)

⁸⁶ Nevers 2000, 74, 75. The FAA is at 9 U.S.C.A. §§ 1-14. Section 2 provides as follows:

A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

Contractual Validity Issues

As a defense to the validity of contracts, “unconscionability” refers to a claim that an unfair contract term was foisted on a party with weaker bargaining power by the stronger party.⁸⁷ For instance, a patient on the operating table awaiting anesthesia for coronary bypass surgery has less bargaining power than the surgeon, and the terms of a contract the patient signs with the surgeon in that circumstance are likely to be held unconscionable and therefore unenforceable if the court finds that they unreasonably favor the surgeon.

The beginning of the physician-patient relationship may be a more opportune time to enter into the agreement to arbitrate than after the treatment has failed.

It is unlikely that the provider and patient will agree to arbitration after a dispute arises. At that stage, one party or the other will perceive that litigation offers some advantage, an advantage they will not choose to relinquish by agreeing to arbitration. Moreover, after a dispute arises, the relationship between the parties may already be strained as a result of the dispute itself, making it less likely that they would agree to arbitration.⁸⁸

On the other hand, PaTLA observes that when patients contact a medical provider because they need medical care, they may be vulnerable enough to make agreements that are not in their best interests, and it cautions that agreements signed in such circumstances could be voided as unconscionable.

Buraczynski v. Eyring, 919 S.W.2d 314 (Tenn. 1996) is a leading case on the validity of doctor-patient arbitration agreements (Nevers, 55-56). The Tennessee Supreme Court upheld the validity of a medical malpractice arbitration agreement under its version of the Uniform Arbitration Act. The arbitration provision in the contract was presented as a condition of treatment and was therefore held by the court to be a contract of adhesion. The contract was

⁸⁷ *Lytle v. CitiFinancial Services, Inc.*, 810 A.2d 643 (Pa. Super. Ct. 2002). The case held unconscionable an arbitration clause in a note secured by a mortgage that required the lender and debtor to arbitrate all issues involving more than \$15,000 while the lender could elect to either enforce the debt or commence foreclosure proceedings. The court commented that the case “reveals yet another vignette in the timeless and constant effort by the *haves* to squeeze from the *have nots* even the last drop.”

⁸⁸ National Arbitration Forum, *Medical Justice through Alternative Dispute Resolution: Alternatives to Lawsuits for Healthcare Disputes* (Minneapolis, Minn. 2004), 5 (www.arbitration-forum.com).

nevertheless held enforceable because it provided procedural and substantive protections that assured that the contract was not unconscionable or oppressive and was within the reasonable expectations of the parties. The agreement was on a separate document, and the waiver of the jury trial was conspicuous. Arbitration did not give an unfair advantage to the doctor or limit his liability. Furthermore, the patient could revoke the contract within 30 days. *Buraczynski*, 320.

Where arbitration is made a condition for participation in an HMO or other health insurance arrangement, a serious consent issue arises. In *Madden v. Kaiser Foundation Hospitals*, 552 P.2d 1178 (Cal. 1976), the California Supreme Court upheld a mandatory malpractice arbitration clause in a state employee benefit plan against challenges based on denial of the right to jury trial and unconscionability. The arbitration clause was negotiated by the California Public Employees Retirement Board within the scope of its agency. While the scope of the agent's authority was limited to "proper and usual" measures, the arbitration clause fit that description because it gave the patient an "expeditious and economical method" of resolving the dispute. Arbitration furthered the public policy as recognized by the California Arbitration Act and by court decisions recognizing it as "an accepted and favored method of resolving disputes" *Madden*, 552 P.2d 1178, 1182, including the "increasing volume of medical malpractice claims" (1184). The agreement containing the arbitration clause was not a contract of adhesion because the retirement board and the hospital had equal bargaining power and other plans were offered that did not mandate arbitration (1185-86). Nor was the clause unconscionable, as it applied equally to the hospital and did not limit the hospital's liability (1186). It was not necessary to show that the patient was aware of the arbitration clause, as such a requirement would render plan administration impossible (1184). The contract operated as a valid waiver of the patient's right to trial by jury through the choice of an alternative forum (1187-88).

Legislative Models

Florida Voluntary Arbitration Statute. A detailed model for a voluntary arbitration statute for medical malpractice cases is provided by Fla. Stats. §§ 766.207 through 766.212.⁸⁹ Florida provides for a prelitigation procedure that is largely equivalent to a medical certification of claims and defenses (Fla. Stats. §§ 766.203 through 766.206). If at the conclusion of this stage, the "preliminary reasonable grounds for a medical negligence claim remain intact" the parties may

⁸⁹ A statute providing for compulsory arbitration by the court upon motion by a party was repealed (Fla. Stats. § 766.107 (repealed)).

elect to arbitrate the claim. Two arbitrators are selected by the parties; the third, who serves as chair, is an ALJ selected by the Division of Administrative Hearings. Economic damages under arbitration include past and future medical costs and 80% of wage loss and future earning capacity, offset by any collateral source payments. Damages for future economic losses are awarded in periodic payments. Non-economic damages are limited to \$250,000 per incident, “calculated on a percentage basis with respect to capacity to enjoy life” (e.g., if capacity to enjoy is reduced 50% by the injury, the cap is \$125,000). Arbitrators may not award punitive damages. Defendant must pay reasonable attorney fees up to 15% of the award and must pay the cost of the arbitration. An offer or acceptance of arbitration may be used in evidence in any subsequent proceeding. (Fla. Stats. § 766.207) A separate arbitration is conducted to resolve any dispute among defendants regarding apportionment of damages (Fla. Stats. § 766.208).

An interesting aspect of the Florida law is the inducements it gives for arbitration over jury trial. If a defendant refuses arbitration, exposure for non-economic damages rises to \$750,000 (or \$1.5 million in the case of a persistent vegetative state or death) (Fla. Stats. § 766.118), and attorney fees chargeable to defendant may be up to 25% of the award. If the claimant refuses arbitration, he or she loses the right to collect attorney fees, although the cap on non-economic damages actually increases to \$350,000. (Fla. Stats. § 766.209)

The arbitration provision was upheld against all constitutional challenges asserted by a claimant in *University of Miami v. Echarte*, 618 So.2d 189 (Fla. 1993). The Florida Supreme Court reasoned that to uphold the statute against a claim that it denied access to the courts,⁹⁰ it must be shown that the statute (1) afforded the claimant a reasonable alternative to the procedure prior to the statute or (2) there was an overpowering public necessity for the abolishment of the former right and there was no alternative means of meeting that necessity. In a 4-2 decision, the court held that both alternatives were met. The arbitration procedure had several advantages for the claimant that satisfied the reasonable alternative test: relaxed evidentiary standards, joint and several liability of multiple defendants, prompt payment of damages after the arbitrator’s determination, interest penalties against defendant for failure to pay the award, and limited appellate review requiring a showing of “manifest injustice.” In upholding on the public necessity prong, the court relied heavily on a series of reports by an academic task force on medical liability convened by the legislature, whose findings and recommendations formed the basis for the legislation under review.

⁹⁰ A number of other constitutional attacks, including the denial of the right to jury trial, were made by the patient, but except for the right to access to court, all challenges were summarily dismissed.

Pennsylvania Legislative Proposals. House Bill 1417 of 2003 (P.N.1751), the proposed Medical Arbitration Availability Act, would provide that health care providers and patients may execute an agreement to submit disputes arising from treatment to binding arbitration, subject to safeguards similar to those mentioned in *Buraczynski*. These include requirements for a conspicuous notice that the agreement waives the right to jury trial; the right of the patient, but not the health care provider, to revoke the agreement within three days after execution; and reexecution of the agreement between the patient and a hospital upon each admission to the hospital. The bill goes beyond *Buraczynski* in requiring that the health care provider may not make execution of the binding arbitration agreement a condition for treatment. Contracts complying with the requirements are deemed to be immune from attack as unconscionable. However, the provision that if a health care provider fails to comply with its provisions “the agreement to arbitrate is voidable at the option of the patient” (§ 3(c)) would face a serious preemption issue under the FAA, as non-compliance with the specific requirements of the bill would not render other kinds of contracts voidable. No action was taken on this bill.

House Bill 158 of 2003 (P.N.1973) would amend the Mcare Act to include two arbitration provisions, one (§ 714(g)) applicable to claims under \$250,000, the other (ch. 8) to claims in any amount. The small claims arbitration provision is a detailed procedure for arbitration by agreement of the parties after the claim arises, which is nevertheless subject to an agreement made by the parties concerning arbitration or any other type of ADR (§ 714(g)(5)).⁹¹ The provisions of chapter 8 are similar to HB 1417, except that HB 158 does not require the binding arbitration agreement to be separate or in plain language; more terms are required to be in conspicuous type; its revocation period is more generous to the patient; and procedural requirements are included relating to selection of arbitrators, allocation of expenses for arbitrators, venue, and the binding effect of a split decision. Like HB 1417, chapter 8 of HB 158 includes a voidability provision that may make it vulnerable to pre-emption under FAA. House Bill 158 was passed by the House of Representatives, but no action was taken on it in the Senate.

There may be a positive role for state statutes by providing for a “safe harbor” against unconscionability. The purpose of the statute would be to assure genuinely informed consent by the patient to arbitration without hobbling the consent procedure with unnecessary details that may deter parties from electing arbitration. A statute like HB 1417 without the voidability provision may be useful in shielding arbitration clauses in a doctor-patient setting where they would

⁹¹ HB 158 also includes two additional procedures for resolving small claims: mediation and nonbinding summary jury trial.

otherwise be vulnerable as an adhesion contract. Presumably the court could still invalidate an arbitration contract with a substantively unconscionable clause such as one providing that venue must be in another state or that the doctor may choose all the arbitrators.

A second type of amendment that may aid arbitration would authorize the Mcare Fund to provide an arbitrator, as the fund may do for a mediator under Mcare § 714(g).⁹² The mediation provision provides for confidentiality of the result and exclusion from the Right-to-Know and Sunshine Acts. Similar protections might be suitable for an unappealed arbitration award.

Mediation

The major difference between mediation and arbitration is that the mediator has no power to determine the disposition of the case. The purpose of mediation, rather, is to bring the parties together in a structured setting so that they can discuss the case with the mediator and, if appropriate, with each other,⁹³ and thereby arrive at a mutually agreeable settlement. Like arbitration, mediation can bring expertise to bear on the dispute and lead to a relatively speedy and inexpensive disposition. As a more cooperative structure than arbitration—not to mention court litigation—mediation can be particularly well-suited to dealing constructively with the emotional aftermath of an adverse medical outcome. The legal basis for mediation in the medical professional liability context exists in current law and indeed has been recently expanded. As with arbitration, the issue is whether mediation should be further encouraged and, if so, how it can be done effectively.

A recent article by Carol B. Liebman and Chris Stern Hyman on mediation in the medical setting describes the process in detail:

Mediation is an informal, private, voluntary, and confidential process in which a neutral third party—the mediator—helps the participants negotiate their differences and craft a mutually acceptable resolution to their dispute or decide to

⁹² It should be recalled that the Mcare Act presently contemplates phase-out of the Mcare Fund in 2009 (Mcare Act §§ 711(d)(4) and 712(c)(2)(iii)). If the fund is eliminated under these provisions, an administrative vehicle will have to be designated to enable the Commonwealth to facilitate arbitration or other ADR.

⁹³ During litigation, parties usually cease direct discussion and communicate with each other only through counsel. By contrast, mediation sessions often include a direct meeting between the parties in the presence of counsel for both sides. (Liebman and Hyman 2004, 30)

deal with their problems in some other manner, including litigation. Mediation is based on three core principles: party autonomy; informed decision making; and confidentiality. The participants may end the mediation at any time without adverse consequences. If, however, the resolution is a settlement, it is memorialized in writing, signed by the disputants, and made a binding agreement.

Mediation agreements can be more nuanced than judgments obtained from a court proceeding and can include provisions, such as changes in a policy, that address issues that are important to the parties but that would not constitute a legal cause of action. The fact that mediation communications are confidential makes more open, less strategic conversations possible because parties need not fear that what they say then will come back to haunt them in a later proceeding.

Mediation provides a setting in which physicians, hospital representatives, and patients or family members can offer and request information. In medical cases, plaintiffs may gain information about the complexities and uncertainties of medical care and about exactly what happened to them or their loved one. Hospitals and physicians may learn about missed or ignored information and about insensitive treatment of the patient or family that contributed to the decision to litigate. (Liebman and Hyman 2004, 29)

By encouraging communication between the providers and injured patients, mediation can facilitate improvements in treatment procedures better than more adversarial processes (Liebman and Hyman 2004, 29-30).

An attractive aspect of mediation for some providers is its ability in some cases to obviate the need to report the settlement to the NPDB under the federal Health Care Quality Improvement Act (HCQIA).⁹⁴ The obligation to report attaches with a “written claim or demand for payment” by the patient, and therefore does not apply to a mediated settlement concluded before that happens.⁹⁵

⁹⁴ Pub.L. 99-660, §§ 401—432 (42 U.S.C.A. §§ 11101—11152).

⁹⁵ The “written claim or demand for payment” requirement is stated at HCQIA § 431(7) (42 U.S.C.A. § 11151(7)), read together with § 421(a) (42 U.S.C.A. § 11131(a)).

Disadvantages of mediation include the possibility that one or more parties will use it tactically to discover evidence or otherwise explore the opposing party's case without any intention of settling. Because mediation is a private, confidential disposition, it may conflict somewhat with the emerging policy of public disclosure of adverse outcomes.⁹⁶

The advisory committee identified a number of practical factors that enhance the likelihood of success. Discovery should have been completed before the mediation session. All the parties that are needed to consent to a settlement should be present at the session or immediately available for consultation, including the parties and the authorized representatives of all insurance carriers. Parties must be prepared to the same extent as for a trial. The mediator should have knowledge of the intricacies of multiple layers of coverage and expert knowledge of the medical treatment issues as well as mediation skills. A mediation can be successful even if it does not result in an immediate settlement of the case. Particular defendants can be dismissed from the case by a conclusive showing of non-liability, and issues can be resolved that can reduce the scope and expense of the ensuing trial. Lines of communication can be opened that can later lead to settlement, perhaps after one or more further mediation sessions.

Drexel University College of Medicine

Health care providers have increasingly started to adopt mediation as a useful strategy for responding to adverse outcomes. In Pennsylvania, the physicians affiliated with the Drexel University College of Medicine⁹⁷ recently initiated a program to mediate adverse outcomes. The program was initiated with the encouragement of both the Governor and the Supreme Court and advice from the Rush Presbyterian Hospital mentioned below. The physicians contracted with Health Care Resolutions to provide trained mediators for the program. Of an initial group of 15 cases handled under this program, three were settled before the mediation sessions began, four were settled through mediation, four were settled after mediation but before trial, three were litigated, and one is currently awaiting trial.⁹⁸ Other hospitals in the Philadelphia area have participated in 25 to 30 mediations since March 2004 with 90% of those cases resolved without trial.⁹⁹

⁹⁶ This policy is embodied in § 308 of the Mcare Act as well as the NPDB.

⁹⁷ The physicians are based in Hahnemann University Hospital, which is an affiliate of the Drexel University College of Medicine and is managed by Tenet Healthcare Corporation.

⁹⁸ Carl (Tobey) Oxholm (General Counsel, Drexel University College of Medicine) in discussion with Commission staff, October 18, 2004 and January 4, 2005; Oxholm, Memo re Drexel College of Medicine's Medical Malpractice Mediation Program, January 3, 2005.

⁹⁹ Jane Ruddell, Esq. (President, Health Care Resolutions) in discussion with Commission staff, October 19, 2004.

Health Care Resolutions offers neutral professional mediators or experienced malpractice lawyers who have been specially trained to do mediation. The mediation procedure is worked out by the mediators and the parties; the following describes a typical pattern. A mediation session begins with opening statements by all parties that state and support their respective positions in the case. Then the parties caucus with the mediator on a confidential basis. At the mediator's discretion, there may be a meeting between the opposing parties themselves in the presence of their attorneys. If a settlement is reached, a closing meeting is held to outline its basic terms. The settlement is drafted and signed by the parties after the mediation. Mediation sessions average about four to six hours, but may take up to two working days, depending on the complexity of the case. A settlement may include terms beyond a monetary payment, such as a formal apology, establishment of a fund in honor of the patient, or a promise by the provider to review its treatment procedures or make specific changes to them. Mediation is generally most effective in cases where the prospects of the parties are in doubt. A party is much less likely to settle through mediation if he or she is certain of total victory.¹⁰⁰

Rush Hospital Program

The Rush-Presbyterian-St. Luke's Medical Center in Chicago, a major tertiary care center, has pioneered the use of mediation in medical malpractice cases. The mediation program was initiated in 1995. The Rush Hospital program applies to malpractice cases after initial evaluation, which may be years after the litigation commences. The aim is to arrive at a reasonable monetary settlement, although more recently the hospital will include an expression of sympathy for the result without acknowledging responsibility. (Liebman and Hyman, 30)

Rush prefers mediation over arbitration because it "saw arbitration to be potentially as costly and unpredictable as a jury trial;" because it is a compromise between "a binding arrangement, which could be arbitrary, or a non-binding arrangement, which brought no finality;" and because of doubts about the technical adequacy of its compliance with the Illinois Arbitration Act. Cases are selected for mediation based on the desire of the parties for prompt resolution and their genuine agreement to participate; Rush's willingness to offer a monetary settlement; a sufficient informational basis on all sides for meaningful negotiations; completion of all reasonably necessary discovery; unpredictability of the trial result; and lack of success in previous settlement negotiations. (STS 2000, 3).

¹⁰⁰ Ibid.

From September 1995 to April 2000, Rush mediated 33 cases with a total payout of over \$15 million, with settlement amounts ranging from \$21,700 to \$4.7 million. “The vast majority were concluded within a two- or three-hour time frame. The subject matter of mediated claims have included birth traumas, medication errors, treatment errors, and diagnosing errors resulting in deaths or serious injuries.” Results have been settlements at reasonable amounts and a decline in defense costs and the number of suits against Rush. Other hospitals that have adopted similar programs have reported favorable results. (STS, 7) The general counsel for the hospital gives a very favorable evaluation. “We are impressed by the results and intend to continue the program for the foreseeable future. We believe the benefits of the program are clear and have yet to discover a downside.” (STS 2000, 1)

The Pennsylvania Governor’s Office of Health Care Reform (OHCR) supports the Rush model and has undertaken, in cooperation with hospitals and medical associations, to conduct a session for hospital general counsel and CEOs to train them to replicate it (OHCR 2003, 37).

Presently Applicable Law

Some malpractice cases require the participation of the Mcare Fund because they include payment pursuant to section 712 of the Mcare Act out of excess coverage provided by the fund. At least in recent years the Mcare Fund has followed a policy of encouraging and actively participating in mediation, and their participation in such proceedings has been helpful to arriving at a settlement.¹⁰¹ As mentioned above, the Mcare Act permits the Insurance Department to provide for a mediator upon the request of a party where the claim is within Mcare’s coverage limits and the carriers disagree on the disposition or settlement of the case (Mcare Act § 714(g)). Mediations under this provision are confidential and specifically exempted from the Right-to-Know Law and the Sunshine Act.

On March 29, 2004, the Supreme Court promulgated Rule of Civil Procedure No. 1042.1 to facilitate the use of mediation in medical malpractice cases. The rule provides that prior to the exchange of expert reports, a health care provider may move for court ordered mediation. The rule is described further in chapter 3. Rule 1042.51, promulgated concurrently with Rule 1042.21, requires the court at the pre-trial conference to “inquire of the parties whether they are willing to participate in mediation” (Pa.R.C.P. No. 1042.51(b)(2)).

¹⁰¹ Tobey Oxholm, Jane Ruddell.

Legislative Models

Florida Statute. Under Florida law, if the parties do not agree to arbitration, all parties are required to “attend in-person mandatory mediation” within 120 days after suit is filed. (Fla. Stat. § 766.108) The mediation is subject to a provision governing mediations generally (Fla. Stat. § 44.102) and the Florida Rules of Civil Procedure.

Pennsylvania Legislative Proposals. House Bill 158 of 2003, amending Mcare Act § 714(g)(3), provides comprehensive default rules for mediation as one of the three alternatives available for disposition of medical malpractice claims of less than \$250,000. In many respects, these rules parallel those for small claims arbitration in the same bill. The commencement of mediation is done by a statement of claim “with sufficient specificity as required in a formal civil complaint” served with a request for mediation. The provider must agree within 30 days or small claims mediation becomes unavailable. The mediator must be an attorney with at least ten years of experience in medical malpractice litigation. The parties may agree to make the mediator’s recommendation binding, in which case the claimant is entitled to reasonable attorney fees; the mediator’s recommendation is not binding unless so agreed. The mediator may not recommend damages over \$250,000. The mediation provisions may be varied by contrary agreement of the parties.

Other Proposals

The advisory committee expressed skepticism regarding statutes or rules that would require parties to participate in mediation. Mediation sessions may be a waste of time and resources where some or all of the parties are averse to settlement. Tobey Oxholm of Drexel University College of Medicine suggested a provision requiring insurers to participate in mediation if the insured consents, because in his experience the insurance carriers tend to be reluctant to mediate. Their refusal may prevent the physician from participating and making progress toward a settlement, even if no final monetary settlement is possible. Such a provision would be reciprocal to the right insurers have exercised to force doctors to the mediation table as part of the latter’s contractual “duty to cooperate” with the insurer’s defense.

Jane Ruddell of Health Care Resolutions has suggested that adoption of a statute barring the use in evidence of apologies or similar statements by a health care provider may encourage the use of mediation.¹⁰² The advisory committee found this to be an interesting proposal, but did not reach a consensus on it. If the apology statute includes expressions of fault, it can permit a physician to repudiate an admission of fault in later testimony with impunity, thus protecting false testimony. Conversely, an apology statute that does not cover expressions of fault may also be problematical because it could give the provider false comfort where an admission could be implied from the expression and the statement could therefore be used at trial despite the statute. In some individual cases, however, a full apology admitting fault by the provider may be worth the risk because it is more likely to create goodwill that can be powerfully effective in clearing the way for a settlement, while a mere expression of sympathy may impede settlement, depending on the underlying facts (Robbenolt 2003, 505-08).

¹⁰² An example of such a statute is Col. Stats. §13-25-135, which provides as follows:

(1) In any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to such civil action, any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. (Subsection (2), which provides four definitions, is omitted.)

In Pennsylvania, apologies made in the course of mediation are privileged from evidentiary use by 42 Pa.C.S. § 5949.

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GLOSSARY OF ACRONYMS

ADR	Alternative dispute resolution
ALJ	Administrative Law Judge
AOPC	Administrative Office of Pennsylvania Courts
BIF	Birth Injury Fund (Virginia)
CAT	Medical Professional Liability Catastrophe Loss Fund
CME	Continuing Medical Education
CPOE	Computerized Physician Order Entry
DCE	Designated compensable event
ERISA	Employee Retirement Income Security Act (Federal)
FAA	Federal Arbitration Act
GAO	General Accounting Office
HAP	Hospital & Healthsystem Association of Pennsylvania
HCQIA	Health Care Quality Improvement Act (Federal)
HCSMA	Health Care Services Malpractice Act of 1975
IFP	Insurance Federation of Pennsylvania
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JUA	Pennsylvania Professional Liability Joint Underwriting Association

Mcare	Medical Care Availability and Reduction of Error
NCSC	National Center for State Courts
NCSL	National Conference of State Legislatures
NICA	Neurological Injury Compensation Association (Florida)
NPDB	National Practitioner Data Bank
OHCR	Pennsylvania Governor's Office of Health Care Reform
PA-PSRS	Pennsylvania Patient Safety Reporting System
PaTLA	Pennsylvania Trial Lawyers Association
PBA	Pennsylvania Bar Association
PHC4	Pennsylvania Health Care Cost Containment Council
PRHI	Pittsburgh Regional Healthcare Initiative
PSA	Patient Safety Authority
RWJF	Robert Wood Johnson Foundation

APPENDIX A

2003 Senate Resolution No. 160, Printer's No. 1417

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE RESOLUTION

No. 160 Session of
2003

INTRODUCED BY ORIE, KUKOVICH, COSTA, ERICKSON, C. WILLIAMS,
RAFFERTY, LEMMOND AND FERLO, OCTOBER 8, 2003

AS AMENDED, MARCH 10, 2004

A RESOLUTION

1 Directing the Joint State Government Commission to study the
2 feasibility of establishing an alternative to the existing
3 liability system with regard to medical professional
4 liability actions.

5 WHEREAS, Pennsylvania is facing its third medical liability
6 crisis since the 1970s; and

7 WHEREAS, The General Assembly has already enacted numerous
8 reforms to the medical tort system, including the elimination of
9 joint and several liability, limitations on punitive damages and
10 revisions of the expert witness, collateral source and
11 remittitur concepts; and

12 WHEREAS, The General Assembly passed comprehensive
13 legislation, Act 13 of 2002, designed to address the medical
14 malpractice issue systemically; and

15 WHEREAS, The Pennsylvania Supreme Court has approved official
16 rules limiting venue shopping and frivolous lawsuits and
17 requiring certifications of merit in medical professional
18 liability cases; and

1 WHEREAS, In its June 2003 report entitled "Medical
2 Malpractice Insurance: Multiple Factors Have Contributed to
3 Increased Premium Rates," the United States General Accounting
4 Office concluded that falling investment income, rising
5 reinsurance costs and, particularly, losses on medical
6 malpractice claims have all contributed to recent increases in
7 malpractice premium rates; and

8 WHEREAS, In January 2003, Americans for Insurance Reform
9 released a study entitled "Medical Malpractice Insurance: Stable
10 Losses/Unstable Rates in Pennsylvania," which concluded that
11 medical insurance premiums have risen and fallen in relation to
12 the state of the economy while payouts over the last decade have
13 approximately tracked the rate of medical inflation; and

14 WHEREAS, In its June 6, 2003, report entitled "Understanding
15 Pennsylvania's Medical Malpractice Crisis," the Project on
16 Medical Liability in Pennsylvania, funded by the Pew Charitable
17 Trusts, found that this debate is peppered with advocates' own
18 statistics, that judicial data on malpractice litigation and
19 jury verdicts are incomplete and that general economic trends
20 explain part of Pennsylvania's situation, but other State-
21 specific factors affect the affordability of liability coverage
22 in Pennsylvania, including high assessments for the State's
23 catastrophic loss fund, cyclical changes within the insurance
24 industry and the rising cost of legal claims; and

25 WHEREAS, In its June 13, 2003, report entitled "Resolving the
26 Medical Malpractice Crisis: Fairness Considerations," the
27 Project on Medical Liability in Pennsylvania concluded that the
28 traditional medical malpractice system performs poorly on many
29 benchmarks of substantive and procedural fairness because:

30 (1) the "negligence" standard for malpractice is too

1 narrow in that a fairer system would compensate all those who
2 suffered harm as the result of an avoidable medical error;

3 (2) the system is not predictable and consistent in its
4 treatment of cases or providers;

5 (3) a fairer system would emphasize preventing future
6 errors rather than punishing individual malfeasance; and

7 (4) the financing of the system is unsteady, with
8 anecdotal evidence that it threatens access to care for some
9 patients;

10 and

11 WHEREAS, The current system has fostered a culture of blame
12 in which participants must worry about their own legal risk
13 instead of the common good, honesty and candor are hindered,
14 making it difficult to rid the system of bad providers or even
15 determine the proper scope of health care, and some victims are
16 left without compensation while others receive huge rewards; and

17 WHEREAS, Despite the actions already taken by two branches of
18 State government and in light of the foregoing studies it
19 continues to be urged that more health care liability reforms
20 are necessary to lower the cost of liability insurance and that
21 more actions need to be taken to reduce medical errors and
22 ensure that meritorious claims continue to receive fair and
23 adequate compensation; and

24 WHEREAS, There is a wide range of strategies that exist to
25 control costs, improve predictability and attract insurers to
26 the Pennsylvania market, including, in addition to conventional
27 tort and insurance reforms, systematic changes to the way
28 injuries caused by medical care are identified, compensated and
29 prevented; therefore be it

30 RESOLVED, That there is a need for a comprehensive study of
20030S0160R1417

1 the value of making a long-term systemic change that would
2 replace the current medical tort liability scheme with a more
3 reliable and predictable system of medical justice that protects
4 patients against bad practices, protects providers who act
5 reasonably, collects adequate data and interprets standards of
6 care so that all participants know where they stand and where
7 they must improve; and be it further

8 RESOLVED, That the Senate direct the Joint State Government
9 Commission to conduct a study to consider the feasibility of
10 creating a new system, such as a new no fault administrative
11 system, a peer review system or specialized medical malpractice
12 courts, which will promote better health care practices,
13 regulate costs and rates and fairly compensate patients; and be
14 it further

15 RESOLVED, That the Joint State Government Commission create
16 an advisory committee composed of individuals from health care,
17 law and insurance as deemed appropriate by it to assist in
18 exploring alternative mechanisms to resolve health care
19 liability claims; and be it further

20 RESOLVED, That the Joint State Government Commission report
21 its findings and recommendations to the Senate no later than
22 ~~June 1, 2004~~ NOVEMBER 30, 2004. ←

APPENDIX B

Medical Malpractice Aggregate Premiums, Including CAT Fund Surcharges

Medical Malpractice Aggregate Premiums, Including CAT Fund Surcharges

Note: The CAT Fund was abolished by the Mcare Act, and assessments as of January 1, 2003, are payable to the Mcare Fund under § 712 of the Mcare Act.

Prepared by the
PA Ins. Dept.
(Revised May 20, 2003)

Pennsylvania Medical Malpractice Market Share Information

Year	(1)	(2)	(3) = (1) + (2)
	Insurance Market Share Data Direct Written Premium	Cat Fund Collected Surcharges	Total
1975	43,758,000	-	43,758,000
1976	62,775,000	16,049	62,791,049
1977	93,470,000	9,120	93,479,120
1978	85,306,000	7,143	85,313,143
1979	76,795,000	121,382	76,916,382
1980	78,145,000	544,275	78,689,275
1981	78,713,000	839,706	79,552,706
1982	84,522,000	27,012,164	111,534,164
1983	103,474,000	48,551,339	152,025,339
1984	119,245,000	72,872,866	192,117,866
1985	167,606,000	110,676,360	278,282,360
1986	220,432,000	165,618,788	386,050,788
1987	237,593,000	171,622,431	409,215,431
1988	247,164,000	139,011,457	386,175,457
1989	244,712,000	133,177,518	377,889,518
1990	251,566,000	107,292,751	358,858,751
1991	224,509,000	139,822,545	364,331,545
1992	224,111,000	171,818,587	395,929,587
1993	267,732,000	166,719,949	434,451,949
1994	206,781,000	178,605,446	385,386,446
1995	200,841,000	274,855,307	475,696,307
1996	207,331,000	243,748,916	451,079,916
1997	226,482,000	317,365,832	543,847,832
1998	282,109,000	323,095,261	605,204,261
1999	274,508,000	288,855,424	563,363,424
2000	340,006,000	294,224,365	634,230,365
2001	371,152,000	358,834,846	729,986,846
2002	492,661,017	332,374,662	825,035,679

With regard to Mcare surcharges/assessments, this information is valid only as of May 20, 2003. Given the daily receipt of surcharge/assessment monies by the Mcare Fund, the surcharge/assessment collections vary day to day.

Notes:

- 1) Data in Column (1) was adjusted to consistently present insurance industry data without the PA Cat Loss Fund. It represents all data reported by insurance companies on their Annual Statements as "Medical Malpractice" and includes exposures for PA "HCPs" and other classes of business (i.e. dentists, chiropractors and other non-HCPs.) To adjust this data to an HCP-only level, an estimated 5% reduction is suggested.
- 2) Data in Column (2) represents Surcharges Collected in a given Calendar Year and includes surcharges on policies for that year and prior years.

SOURCES:

- 1) Annual Statistical Reports of the Insurance Department of the Commonwealth of Pennsylvania
- 2) NAIC Market Share Reports
- 3) MCARE/Cat Fund Historical data

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- 3) Due to rating concerns, MIXX withdrew from the Pennsylvania marketplace in 2002 and therefore, the 2002 data does not include MIXX's direct written premium.
- 4) The Department notes that Act 13 of 2002 was passed on March 20, 2002 and had varying effective dates. With regard to the discount provision of Section 712(e)(2), the effective date was October 1, 2002, the date the Mcare Fund came under the jurisdiction of the Department of Insurance. Therefore, the discounts provided by Section 712(e)(2) for 2002 were not taken entirely in 2002. Rather, only \$1,600,000.00 in discounts were taken in 2002, and the remaining discounts in the amount of \$16,200,000.00 were taken in subsequent years.

SOURCES:

- 1) Annual Statistical Reports of the Insurance Department of the Commonwealth of Pennsylvania
- 2) NAIC Market Share Reports
- 3) MCARE/Cat Fund Historical data

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APPENDIX C

Case Filing Data from the Administrative Office of Pennsylvania Courts

Table 1: Pennsylvania Medical Malpractice Case Filings: 2000 - 2003

	No. of Filings in 2000	No. of Filings in 2001	No. of Filings in 2002	No. of Filings in 2003	% change in 2003 from 2000 – 2002 average
Adams	6	5	4	8	60.0
Allegheny	392	372	427	272	-31.5
Armstrong	5	3	5	2	-53.8
Beaver	29	18	23	17	-27.1
Bedford	4	0	1	5	200.0
Berks	44	37	31	19	-49.1
Blair	25	32	18	21	-16.0
Bradford	8	4	8	6	-10.0
Bucks	78	42	52	45	-21.5
Butler	22	29	26	16	-37.7
Cambria	28	26	30	32	14.3
Cameron/Elk	5	3	4	2	-50.0
Carbon	2	5	7	12	157.1
Centre	11	17	14	11	-21.4
Chester	46	37	41	69	66.9
Clarion	2	1	7	5	50.0
Clearfield	6	14	6	4	-53.8
Clinton	3	1	3	1	-57.1
Columbia	4	3	7	7	50.0
Crawford	6	1	1	2	-25.0
Cumberland	22	21	24	27	20.9
Dauphin	72	86	84	46	-43.0
Delaware	69	86	77	82	6.0
Erie	46	56	59	44	-18.0
Fayette	22	16	16	13	-27.8
Franklin/Fulton	20	10	8	9	-28.9
Warren / Forest	2	5	4	2	-45.5
Greene	1	1	2	1	-25.0
Huntingdon	6	8	8	5	-31.8
Indiana	1	2	4	4	71.4
Jefferson	6	3	4	4	-7.7
Lackawanna	99	88	70	35	-59.1
Lancaster	11	3	11	9	8.0
Lawrence	2	6	5	4	-7.7
Lebanon	9	11	6	7	-19.2
Lehigh	82	79	59	105	43.2
Luzerne	43	32	29	39	12.5
Lycoming	16	23	16	15	-18.2
McKean	5	1	5	0	-100.0
Mercer	46	42	41	41	-4.7
Mifflin	3	3	3	4	33.3
Monroe	8	14	10	5	-53.1
Montgomery	24	40	32	151	371.9
Montour	11	9	9	23	137.9
Northampton	64	65	89	47	-35.3
Northumberland	12	11	5	4	-57.1
Perry/Juniata	0	0	0	0	0.0
Philadelphia	1,085	1,162	1,365	577	-52.1
Pike	0	0	1	0	-100
Potter	4	1	5	6	80.0

	No. of Filings in 2000	No. of Filings in 2001	No. of Filings in 2002	No. of Filings in 2003	% change from 2000 – 2002 average
Schuylkill	18	35	36	13	-56.2
Snyder/Union	9	4	8	6	-14.3
Somerset	6	6	11	8	4.3
Sullivan/Wyoming	1	8	4	2	-53.8
Susquehanna	0	0	0	0	0.0
Tioga	1	4	3	0	-100.0
Venango	7	6	10	5	-34.8
Washington	8	11	3	4	-45.5
Wayne	2	3	3	3	12.5
Westmoreland	59	63	65	49	-21.4
York	58	40	48	34	-30.1
State Total	2,686	2,714	2,957	1,989	-28.6

Notes:

► In Delaware County, the 2003 year figure (82) refers to January 1 through November 24, 2003. Update pending. Survey updates and corrections will be posted to the website of the Unified Judicial System of Pennsylvania at: www.courts.state.pa.us.

► At the time the survey was initiated, many judicial districts did not have a docket identifier to distinguish medical malpractice cases from other civil actions. As a result, various methods were used to compile the data, including case-by-case review of the files in the office of the Prothonotary. To facilitate complete and accurate data collection in future surveys, the Chief Justice has directed that each district institute a procedure for prospectively tracking med mal cases, effective January 2004.

► A filing refers to the commencement of a civil action by complaint or praecipe for writ of summons. Included in the filing figures are cases transferred from one judicial district to another pursuant to Pa.R.C.P. 1006(a.1).

► "Percent change in 2003 from 2000 - 2002 average" was computed as follows: filing figures for the three-year period 2000 to 2002 were averaged and subtracted from the 2003 filing figure. The difference was then divided by the 2000 - 2002 average. The resulting proportion was multiplied by 100 to convert it to a percentage.

prepared 03/15/2004

APPENDIX D

Jury Verdict Data from the Administrative Office of Pennsylvania Courts

Table 2: Medical Malpractice Jury Verdicts: January 2000 to July 2003

Judicial District	Defense Verdicts		Less than \$500,000		\$500,000 to \$1 Million		\$1 Million to \$5 Million		\$5 Million to \$10 Million		Over \$10 Million		TOTAL
	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	
Adams	2	66.7	0	0.0	1	33.3	0	0.0	0	0.0	0	0.0	3
Allegheny	119	81.0	14	9.5	8	5.4	5	3.4	1	0.7	0	0.0	147
Armstrong	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
Beaver	4	57.1	1	14.3	1	14.3	1	14.3	0	0.0	0	0.0	7
Bedford	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
Berks	6	60.0	2	20.0	0	0.0	2	20.0	0	0.0	0	0.0	10
Blair	4	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4
Bradford	3	60.0	2	40.0	0	0.0	0	0.0	0	0.0	0	0.0	5
Bucks	33	91.7	1	2.8	2	5.6	0	0.0	0	0.0	0	0.0	36
Butler	4	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4
Cambria	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
Cameron/Elk	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1
Carbon	3	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	3
Centre	4	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4
Chester	26	74.3	7	20.0	1	2.9	0	0.0	0	0.0	1	2.9	35
Clarion	0	0.0	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	1
Clearfield	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1
Clinton	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
Columbia	1	50.0	1	50.0	0	0.0	0	0.0	0	0.0	0	0.0	2
Crawford	5	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	5
Cumberland *	.	.	.	.	.	.	.	.	.	.	.	.	.
Dauphin	26	74.3	5	14.3	2	5.7	2	5.7	0	0.0	0	0.0	35
Delaware	62	84.9	3	4.1	3	4.1	5	6.9	0	0.0	0	0.0	73
Erie	15	83.3	2	11.1	0	0.0	1	5.6	0	0.0	0	0.0	18
Fayette	2	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2
Franklin/Fulton	6	75.0	1	12.5	1	12.5	0	0.0	0	0.0	0	0.0	8
Greene	3	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	3
Huntingdon	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1
Indiana	4	66.7	1	16.7	0	0.0	0	0.0	1	16.7	0	0.0	6
Jefferson	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	1
Lackawanna	24	88.9	2	7.4	1	3.7	0	0.0	0	0.0	0	0.0	27
Lancaster	17	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	17

* data pending.

Judicial District	Defense Verdicts		Less than \$500,000		\$500,000 to \$1 Million		\$1 Million to \$5 Million		\$5 Million to \$10 Million		Over \$10 Million		TOTAL
	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	
Lawrence	2	33.3	3	50.0	0	0.0	1	16.7	0	0.0	0	0.0	6
Lebanon	2	66.7	1	33.3	0	0.0	0	0.0	0	0.0	0	0.0	3
Lehigh	54	90.0	2	3.3	1	1.7	1	1.7	0	0.0	2	3.3	60
Luzerne	14	87.5	1	6.3	0	0.0	1	6.3	0	0.0	0	0.0	16
Lycoming	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	9
Mckean	2	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2
Mercer	3	75.0	0	0.0	0	0.0	0	0.0	0	0.0	1	25.0	4
Mifflin	2	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2
Monroe	8	72.7	3	27.3	0	0.0	0	0.0	0	0.0	0	0.0	11
Montgomery	58	73.4	13	16.5	3	3.8	5	6.3	0	0.0	0	0.0	79
Montour	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1
Northampton	17	73.9	1	4.4	2	8.7	3	13.0	0	0.0	0	0.0	23
Northumberland	2	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2
Perry/Juniata	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
Philadelphia	241	59.2	54	13.3	29	7.1	58	14.3	16	3.9	9	2.2	407
Pike	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
Potter	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1
Schuylkill	4	50.0	2	25.0	1	12.5	1	12.5	0	0.0	0	0.0	8
Snyder/Union	2	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2
Somerset	2	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2
Sullivan/Wyoming	1	50.0	0	0.0	0	0.0	1	50.0	0	0.0	0	0.0	2
Susquehanna	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
Tioga	2	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2
Venango	2	66.7	1	33.3	0	0.0	0	0.0	0	0.0	0	0.0	3
Warren/Forest	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1
Washington	6	66.7	2	22.2	0	0.0	0	0.0	0	0.0	1	11.1	9
Wayne	0	0.0	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	1
Westmoreland	15	79.0	4	21.1	0	0.0	0	0.0	0	0.0	0	0.0	19
York	7	77.8	0	0.0	2	22.2	0	0.0	0	0.0	0	0.0	9
State Total	834	73.0	130	11.4	60	5.2	87	7.6	18	1.6	14	1.2	1,143
Annualized State Total**	238	73.0	37	11.4	17	5.2	25	7.6	5	1.6	4	1.2	326

**computed by dividing the state total by 3.5, the number of years covered by the survey. Includes rounding adjustment.

Note: verdict amounts are compensatory damages, but in a few instances may include punitive and delay damages as well as judicial offsets and adjustments. They do not reflect post-trial settlements or actions of an appellate court. They are not a report of actual payouts.

