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Toward Healing and Restoration for All: Reframing Medical Malpractice Reform

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The medical malpractice liability system is blamed for everything from the high cost of health care to quality assurance issues. This Article suggests that one of the problems with the current approach to medical malpractice is that legal remedies for medical error are not viewed as part of the continuum of care, and that answers to the recurrent medical malpractice crises may lie in health care's core values. Thus, a new model—driven by the principle of care and the goal of healing—is needed to address medical errors more effectively. Building from these core principles of care and healing, this Article develops a new healing-centered framework which provides a better assessment of the strengths and weaknesses of the current medical malpractice liability system and existing alternative schemes. Evaluating existing options using this new framework, the Article finds that each of the current models falls short in important ways. The Article then turns to restorative justice for guidance in fashioning an alternative system for addressing medical error that meets the objectives of the healing-centered framework. Building on restorative justice principles, this Article proposes a restorative medical error resolution scheme aimed at providing healing for patients, healthcare providers and the community.

ARTICLE CONTENTS

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JONATHAN TODRES*

I. INTRODUCTION

The U.S. health care system is considered so burdened with problems that it has been deemed "a $1.3 trillion per year fiasco."[1] In fact, many experts suggest that the practice of medicine in the United States has been in "crisis" since at least the early 1960s.[2] The finger pointing is often directed at the medical malpractice liability system, which bears the blame for everything from the high cost of health care to quality assurance issues. Over the years, Congress and many state legislatures have deliberated over, and in some cases adopted, measures to reform medical malpractice litigation in an effort to reduce the number of claims brought against doctors, limit the size of awards to patient-plaintiffs, and control the rising costs of medical malpractice insurance premiums.[3] Questions persist whether these efforts are ultimately the best way of achieving a top quality health care delivery system with a safety net for those injured during the course of treatment.

This Article suggests that current medical malpractice reform efforts are deficient because they consider remedies for medical errors as being separate from the health care system. Thus, the core principle—care—and

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[1] J.D. KLEINKE, OXYMORONS: THE MYTH OF A U.S. HEALTH CARE SYSTEM 2 (2001). *See also* Andrea Gerlin, *Health Care's Deadly Secret: Accidents Routinely Happen*, PHILA. INQUIRER, Sept. 12, 1999, at A1 (reporting that health care deaths compare unfavorably to airplane crash deaths). In fact, an American NGO—Health Care Problems—catalogs problems identified by patients, health care professionals, insurance companies, attorneys, and others. *See* The Health Care Problems Archive, www.healthcareproblems.org (last visited Oct. 29, 2006).

[2] *See generally* THE CRISIS IN AMERICAN MEDICINE (Marion K. Sanders ed., 1961). For more recent reports on the medical malpractice "crisis," see Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515, 515 (2005) ("The United States is in its fifth year of what is now widely referred to as 'the new medical malpractice crisis.'"); Ralph Peeples & Catherine T. Harris, *Learning to Crawl: The Use of Voluntary Caps on Damages in Medical Malpractice Litigation*, 54 CATH. U. L. REV. 703, 704 (2005) ("Again we find ourselves in a medical malpractice crisis."); Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, W4 HEALTH AFF. 20 (Jan. 21, 2004), http://www.healthaffairs.org/WebExclusives.php (follow "Web index pages" hyperlink; then follow Web Exclusives "2004" hyperlink) (reporting that the United States is in the midst of its third medical malpractice crisis).

[3] *See* William P. Gunnar, *Is There an Acceptable Answer to Rising Medical Malpractice Premiums?*, 13 ANNALS HEALTH L. 465, 484–92 (2004).

the primary goal—healing—of health care are not properly taken into account when devising a system to address medical errors.[4] Consequently, the medico-legal community needs a new framework for reform that is care-based and serves the goal of providing healing and restoration for patients, healthcare providers, and the community.

Today, legal remedies for medical errors are not considered part of the continuum of care. If something goes wrong during patient treatment, the typical response is to call in the attorneys. Lawyers take over, and the patient's problem is no longer seen as situated in the health care system; rather, it is under the auspices of the legal system. The focus then shifts to limiting information flow, stating one's case, making the better argument, and proving the other party wrong. Very little in this endeavor fosters an environment of care, and no part of it readily leads to healing.

Yet, the essence of health care is a *care* relationship aimed at providing healing for the patient. The fact that a patient is injured as a result of medical intervention should not mean that these core values are abandoned. Redress for medical malpractice should be part of the continuum of care in the health care delivery system, incorporating into its processes medicine's goals of alleviating suffering and providing healing. By adopting a healing-centered approach to medical malpractice, the legal system can provide healing to patients, healthcare providers, and the broader community.

To date, political debates over medical malpractice reform have narrowly—and at times incorrectly—construed the issues (e.g., excessive jury awards) and, as a result, developed limited stopgap measures (e.g., caps on non-economic damages), instead of addressing the underlying problems entrenched in the current medical malpractice litigation system. Scholarly debates over the medical malpractice liability system have

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[4] The medical profession has used various terms, often inconsistently, to describe the events that result in bad outcomes, leading to confusion. *Compare* INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 36 (Linda T. Kohn et al. eds., 2000) (using "medical error" to include any technical error, misdiagnosis, failure to prevent injury, or medication error) [hereinafter IOM REPORT], *with* LOUIS HARRIS ET AL., NAT'L PATIENT SAFETY FOUND. AT THE AMA, PUBLIC OPINION OF PATIENT SAFETY ISSUES RESEARCH FINDINGS 30 (1997), *available at* http://www.npsf.org/download/1997survey.pdf (viewing "medical mistakes" as covering the following: misdiagnosis, medication error, medical procedure error, administrative error, communication error, incorrect laboratory results, equipment malfunction, and other errors).

In this Article, I use the term "medical error" to refer to any individual or systems error. As such, this Article focuses on "preventable adverse events" that result from any such medical error—an "adverse event" being "an injury that was caused by medical management rather than the patient's underlying disease." These definitions track that of the American Society of Healthcare Risk Management used by the Harvard Hospitals. *See* MASSACHUSETTS COALITION FOR THE PREVENTION OF MEDICAL ERRORS, WHEN THINGS GO WRONG: RESPONDING TO ADVERSE EVENTS: A CONSENSUS STATEMENT OF THE HARVARD HOSPITALS 4–5 (2006) [hereinafter HARVARD HOSPITALS STATEMENT]. "Bad outcome" cases, in which no medical error occurred but a suboptimal outcome resulted, are not the focus of this Article, though I believe that the R-MER system described herein has value even for patients who experience a bad outcome that is not the result of any error. For more on definitional issues, see JOHN D. BANJA, MEDICAL ERRORS AND MEDICAL NARCISSISM 1, 4–7 (2005).

questioned whether tort law is the best mechanism for addressing medical error, or whether contract-based or administrative (e.g., no-fault) models would produce better results.[5] This Article suggests a different starting point, arguing for refocusing on medicine's core values, with a view to utilizing them as the basis for a new framework to better serve the needs of all parties affected by medical error. In other words, the medico-legal community must first rethink the objectives of the medical malpractice liability system before moving to consider various reform proposals. With a clearer understanding of our objectives, we can better determine the most effective approach to achieving our stated goals, whether that is tort law or another legal model.

By using health care's core values as the foundation for a new framework, the medico-legal community will position itself to develop a system that effectively addresses not only medical errors, but also quality of care, patient compensation, and a host of other issues that plague the current system. Thus, in Part II, this Article begins by returning the focus to the fundamental principles and goals of medicine. These core values can inform our approach to remedying medical error, and I draw upon these values to develop a "healing-centered framework" for evaluating medical malpractice reform measures. I posit that the healing-centered framework produces a set of objectives for medical malpractice liability systems that, if fulfilled, would benefit patients, healthcare providers, and the broader community. These goals, though similar to the goals of traditional torts models, demand a focus that differs in a number of important respects from some of the traditional aims of the tort system.[6] Specifically, the healing-centered framework establishes five objectives for a medical malpractice liability system: (1) patient compensation; (2) safety promotion (or error reduction); (3) harm reduction; (4) information exchange; and (5) restorative opportunities for all parties. These objectives

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[5] *See* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 17–18 (1991) (describing four models: tort liability, contractual agreement, administrative no-fault compensation, and social insurance); Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1932 (2003) (supporting a tort-based model because "contracts and market forces are not sufficient to ensure optimal care"); Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87, 91, 93–94 (1976) (articulating a contract-based approach).

[6] Medical malpractice law is typically described as having two aims: compensation of patients injured by medical errors and deterrence of negligent behavior by health care providers. *See, e.g.*, SYLVIA LAW & STEVEN POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE 1 (1978); Allen Kachalia et al., *Physician Responses to the Malpractice Crisis: From Defense to Offense*, 33 J.L. MED. & ETHICS 416, 417 (2005); Douglas W. Taylor, *Assessment and Plan for Medical Malpractice: Quality Improvement Through Mediation*, 6 DEPAUL J. HEALTH CARE L. 343, 345 (2003). As a tort law model, medical malpractice law theoretically should achieve other traditional torts goals, including punishing wrongdoing, determining appropriate standards of conduct, and internalizing costs of accidents to those responsible.

go beyond the traditional objectives of medical malpractice law, which primarily emphasizes just compensation and deterrence. Employing the healing-centered framework will help reorient the medical malpractice reform debate toward a set of results that addresses the needs of all parties.

After establishing a new framework, this Article evaluates the merits of current available means of dealing with medical errors. Using the healing-centered framework as the basis for this analysis, in Part III we see that the traditional medical malpractice liability system fails to provide sufficient healing opportunities for all participants. Part IV then evaluates proposed reforms and existing alternative models through the lens of the healing-centered framework, finding deficiencies in each of these approaches. The healing-centered framework not only provides a systematic approach for evaluating models that attempt to address medical error, but can also help in guiding the development of a better alternative model.

Finding that no current option fulfills all goals of the healing-centered framework, I turn in Part V to the task of determining *how* to reform the current system to achieve the goals of the healing-centered framework. In doing so, I draw upon the principles of restorative justice for guidance in developing a new approach to medical malpractice. A healing-centered approach to medical malpractice would parallel, in many respects, restorative justice's response to retributive justice systems. Restorative justice rejects retributive justice's focus on punishment, striving instead for resolutions that provide healing for the victim, offender, and community.[7]

Restorative justice presents a model for addressing medical errors that attends to the needs of patients, physicians, and the community. Concentrating primarily on patients, physicians and the community is not a suggestion that the other key players in health care—including nurses and other healthcare providers, hospitals, nursing homes, and insurance companies—are not important; rather, viewing medical malpractice through the healing-centered framework requires giving priority to the physician-patient care relationship.[8] Other key players, such as hospitals and managed care organizations, are not ignored. To do so would be foolhardy. Yet these entities, while important, are not the reason for health care, but rather are entities created to help optimize the performance of the health care delivery system. Accordingly, the healing-centered framework focuses primarily on patients, doctors (as well as other healthcare providers) and the community.[9]

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[7] *See infra* note 179 and accompanying text.

[8] While discussions herein of healthcare providers focus primarily on physicians, many of the experiences and implications discussed apply similarly to nurses and other providers, and any R-MER model should consider their needs and roles as well.

[9] Much of the literature on medical malpractice reform focuses on doctors, hospitals, and insurance companies, but gives little attention to the impact of reform on patients and the community. In contrast, restorative approaches to medicine require primacy of the patient and community, in

In exploring restorative justice, this Article examines the experiences of truth commissions in addressing human rights violations. While truth commissions address a starkly different set of problems, they offer important lessons for creating systems that facilitate healing for all. In fact, truth and reconciliation commissions, such as the one in South Africa, have fostered healing in the context of some of the most horrific crimes known to humanity. Their capacity to enable healing in the context of torture and other grave human rights abuses suggests that healing is also possible in the context of a physician-patient care relationship that has been damaged by medical error. Building on restorative justice principles, in Part VI, I propose a restorative medical error resolution (R-MER, pronounced "armor") system that meets the objectives of the healing-centered framework. I then propose a model for an R-MER system. This model—a Truth-in-Medicine (TIM) Commission—suggests one way in which an R-MER scheme can play out in practice to ensure healing and restoration for patients, healthcare providers, and communities.[10]

II. THE CORE GOALS AND PRINCIPLES OF MEDICAL CARE

A. *Health Care's Foundational Values*

Each time health care finds itself in a medical malpractice crisis, legislators push for reforms that address only certain symptoms of an ailing medical malpractice litigation system. This cycle is likely to repeat unless the medico-legal community charts a different course. To avoid further crises, I believe we must return to the core values of medicine and use them as the basis for building a better system.

The history of the medical profession reveals a continued emphasis on care and healing. "The obligation of physicians to relieve human suffering stretches back into antiquity."[11] In taking the Hippocratic Oath, physicians throughout the centuries have sworn to apply their skills for the "benefit of the sick."[12] Such a noble obligation led Erasmus, almost 500 years ago, to

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addition to healthcare providers. For more on the role of insurance companies, see *infra* notes 305–06 and accompanying text.

[10] In outlining the TIM Commission, I do not intend to present a detailed plan that explains every procedural and substantive aspect of this model. Doing that would require much more space than is available in this Article. Rather, I offer the TIM Commission to provide a sense of what R-MER models might look like in practice. *See infra* Part VI.B.

[11] ERIC J. CASSELL, THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE 29 (2d ed. 2004). *See also* JOSEPH H. KING, JR., THE LAW OF MEDICAL MALPRACTICE IN A NUTSHELL 1 (2d ed. 1986) ("Medicine is the science of preventing, palliating and healing illness. The practice . . . can be traced back to the origins of Middle Eastern and Oriental civilizations.").

[12] *Hippocratic Oath*, *in* LUDWIG EDELSTEIN, THE HIPPOCRATIC OATH: TEXT, TRANSLATION AND INTERPRETATION 2–3 (1943) (translated from Greek). The Hippocratic Oath is also available online at http://www.pbs.org/wgbh/nova/doctors/oath_classical.html.

author the essay *In Praise of the Healing Arts*, in which he marveled at the power of the physician:

> The special glory of the healing arts is self-sufficient and recommends itself to mankind by its value and utility. . . . Its true and inborn greatness, its elevation which exceeds human comprehension cannot fully be expressed in mortal words . . . . Many sicknesses have such a power that death is the sure fate of a patient if the doctor does not interfere immediately.[13]

Subsequently, societies maintained their high regard for the physician's powers of healing. In 18th century Germany, doctors ranked above knights.[14] In the early 19th century, Thomas Carlyle wrote that "[t]he physician can abolish pain, relieve his fellow mortals from sickness. He is indisputably usefullest of all men."[15] How the mighty have fallen, some might say. Despite the remarkable developments in medical care, the power to heal is no longer treated with such reverence, and doctors are no longer seen as all powerful.[16] Yet today, physicians can cure patients of so many more diseases than just a few decades ago, let alone centuries ago. Despite this progress, patients today frequently question the expertise of doctors, and skepticism abounds over the motives of health care professionals.[17] That is not to say that the changes in perceptions of doctors are altogether bad. Some of the traditional paternalistic approaches of doctors negatively affected the patient experience, especially for women,[18] and having patients take more responsibility in their care can contribute positively to their treatment.

While health care delivery has changed dramatically since the days of Erasmus, the core values have not; today physicians (and hospitals) still espouse as their primary goal "the best possible patient care" or "first-class

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[13] *See* JOHN GORDON FREYMANN, THE AMERICAN HEALTH CARE SYSTEM: ITS GENESIS AND TRAJECTORY 11 (1977) (quoting Desiderius Erasmus, *In Praise of the Healing Arts*, *reprinted in* 210 J. AM. MED. ASS'N 1587, 1587–88 (1969)).

[14] *Id.*

[15] *Id.*

[16] *See* CASSELL, *supra* note 11, at 23 (noting, particularly, the significant changes that occurred during the 1960s).

[17] *See id.* (stating that the doctor-knows-best view has "virtually disappeared" and that patients now "frequently believe themselves to be active partners in their care"); *see also* Timothy Hall, *Bargaining with Hippocrates: Managed Care and the Doctor-Patient Relationship*, 54 S.C. L. REV. 689, 695 (2003) ("Payment structures, such as capitation, bonuses and withholds, and provider selection and retention based on economic criteria, all tend to cause physicians to consider economic factors in their medical decisionmaking to an extent they would not under a pure fee-for-service regime."); Arnold S. Relman, *The Impact of Market Forces on the Physician-Patient Relationship*, 87 J. ROYAL SOC'Y OF MED. 22, 22 (1994) ("[P]rofessionalism in medicine seems to be giving way to entrepreneurialism.").

[18] *See, e.g.*, FEMINISM & BIOETHICS: BEYOND REPRODUCTION 11 (Susan M. Wolf ed., 1996); Leslie Bender, *Teaching Feminist Perspectives on Health Care Ethics and Law: A Review Essay*, 61 U. CIN. L. REV. 1251, 1260–61 (1993).

patient care."[19] These noble ideals have been joined by other goals in the modern practice of medicine, foremost among them the education of doctors and nurses and research. These other goals, however, are pursued in furtherance of the ultimate aim of medicine—optimizing care and healing of patients.[20]

Even with the increasing commercialization and commoditization of health care, medicine remains "fundamentally a moral enterprise because it is devoted to the welfare of the persons it treats. Medicine is also primarily therapeutic, a matter of helping those who cannot help themselves and who are thereby critically vulnerable."[21] The goal of medicine remains "a right and good healing action" for patients.[22] Thus, while money and prestige may play a larger role in modern medicine, writings on medicine consistently return to the central idea of care being the foundational principle and healing being the primary objective.

These attributes make health care different from other enterprises in modern society, and make the physician-patient relationship unique as well. The relationship is one that relies on trust and caring, with a view to alleviating suffering and meeting the physical and mental health needs of the patient. Professor Mark Hall explains that "[d]octor-patient relationships are characterized by levels of intimacy, dependency, and vulnerability that are matched or exceeded only by family relationships."[23] Professor Cassell emphasizes that it is "a healing relationship."[24] Despite the profession's long-standing commitment to relieve suffering, "little attention is explicitly given to the problem of suffering in medical education, research, or practice."[25] While healthcare providers treat physical symptoms, they often pay comparatively little attention to patients' emotional suffering.

Similarly, the current medical malpractice litigation system pays little attention to suffering. The highly contentious nature of medical malpractice lawsuits frequently does nothing to address patient suffering. In addition, as cases can languish in the courts for years, the suffering can be prolonged. Too often in a medical malpractice action, all parties—the injured patient, doctors and other health care professionals who provided

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[19] FREYMANN, *supra* note 13, at 226.

[20] *Id.* at 228.

[21] CASSELL, *supra* note 11, at 26–27.

[22] EDMUND D. PELLEGRINO & DAVID C. THOMASMA, FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE 10 (1988) (explaining that "healing involves more than a cure" and includes not just physical, but also "psychological, social, [and] even spiritual dimensions).

[23] Mark A. Hall, *Can You Trust a Doctor You Can't Sue?*, 54 DEPAUL L. REV. 303, 303 (2005). *See also* CASSELL, *supra* note 11, at 62.

[24] CASSELL, *supra* note 11, at 65.

[25] *Id.* at 29.

care, and the community—suffer much more than they ought to. Care and healing, therefore, must be center stage in any system that seeks to remedy medical errors.

B. *Developing a Healing-Centered Framework for Medical Malpractice*

The preceding historical review reveals care to be the guiding principle for medical treatment and healing its most important objective. These core concepts, which form the foundation of the practice of medicine, should guide the development of our system of responding to medical errors. Building from these foundational principles with a view to identifying the conditions necessary for successful medical practice that effectively minimizes and addresses medical error, several important objectives emerge. Therefore, I submit that a care-based, healing-centered approach to medical error requires a medical error resolution system that: (1) provides compensation to injured patients; (2) promotes safety; (3) reduces harm (minimizes suffering); (4) fosters information exchange; and (5) offers restorative opportunities for all parties (facilitates healing). These five objectives form what I refer to as the "healing-centered framework." A system that fulfills these five objectives will achieve more successful outcomes for patients, healthcare providers, and communities, while also satisfying other traditional aims of tort law, including efficient allocation of costs.[26]

Patient compensation remains an integral component under the healing-centered framework. Patients injured as a result of substandard care typically face significant costs in the form of hospital bills, lost wages, and other economic hardships. They require monetary compensation to help them through this difficult period of their lives. Effective compensation includes (1) covering all individuals injured as a result of medical error, and (2) ensuring appropriate compensation for each such individual.

Second, safety promotion (or error reduction) addresses three traditional tort law concerns—punishment of wrongdoing, deterrence, and determination of standards of conduct—but does so with a different focus. Traditional tort law models of punishment and deterrence effectively consist of the stick without the carrot.[27] As healing for all parties is important, utilizing the threat of punishment as the primary means of improving care seems fraught with risk.[28] Too often, the traditional tort

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[26] *See, e.g.*, LAW & POLAN, *supra* note 6, at 1 ("In the most general terms, the tort law allocates the costs of losses resulting from human activity.").

[27] *See, e.g.*, Arlen & MacLeod, *supra* note 5, at 2005 (noting that the current system's incentive structure provides doctors with little benefit from good outcomes, and thus does not properly incentivize investment in improving expertise).

[28] Similar concerns have been raised about traditional criminal justice models by proponents of restorative justice. *See* RUTH ANN STRICKLAND, RESTORATIVE JUSTICE 137 (2004) ("[T]he punishment structure utilized in the traditional criminal justice system, with its focus on doling out just

law approach to medical error results in doctors, hospitals, and HMOs trying to avoid punishment, and thus engaging in practices aimed at reducing risk rather than error.[29] This approach, in turn, fails to foster the conditions necessary for optimal development of standards of care and compliance with best practices. The healing-centered framework emphasizes safety promotion, which relies on requiring affirmative steps by doctors and hospitals to improve care, rather than the threat of punishment, which encourages providers to manage risk (and exposure to liability). In other words, the objective is error reduction, not just risk reduction.

Third, harm reduction is a core goal of the healing-centered framework. Whereas safety promotion is forward looking and seeks to prevent future errors, harm reduction seeks to remedy harms already incurred by minimizing suffering and addressing emotional injury. In other words, responses to medical errors must address not only patients' physical symptoms, but also their emotional healing. Harm reduction also requires the efficient resolution of claims through a fair process. Resolving cases quickly helps patients (and healthcare providers) to avoid suffering through years of litigation. These delays not only extend the suffering of patients and healthcare providers, but also hinder learning that could promote safety and help avoid harm to other patients in the future. Importantly, however, quick resolution of patients' cases alone is not enough. In order to enhance the parties' satisfaction with the resolution and facilitate healing, the process must be one that is perceived as fair by the parties involved.[30]

Fourth, the healing-centered framework prioritizes improving information exchange. There is significant value in ensuring both physician-patient and physician-physician information flow. Physician-patient information exchange is vital to the successful treatment of the

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deserts, generally does not prevent future crime or allow for effective reintegration of offenders into society.").

[29] Risk reduction does not necessarily lead to error reduction. *See infra* notes 71–73 and accompanying text; *see also* Mark Geistfeld, *Reconciling Cost-Benefit Analysis with the Principle That Safety Matters More Than Money*, 76 N.Y.U. L. REV. 114, 169 (2001) ("The degree of risk reduction that can be attained by a negligence standard depends on the evidence available to plaintiffs and courts concerning the burdens and benefits of various safety precautions. When good evidence concerning required safety precautions is unavailable, a potential injurer who fails to take such precautions will escape liability.").

[30] *See, e.g.*, Rebecca Hollander-Blumoff & Matthew T. Bodie, *The Effects of Jury Ignorance About Damage Caps: The Case of the 1991 Civil Rights Act*, 90 IOWA L. REV. 1361, 1390 (2005) ("[T]he process by which a dispute is resolved has a distinct impact on the parties' satisfaction with the resolution, over and above the distributive—that is, typically, the monetary—outcome. . . . [A] fair process is a powerful factor in determining satisfaction.").

patient.[31] "The relationship between doctor and patient is based on the concept of partnership and collaborative effort. Ideally, decisions are made through frank discussion, in which the doctor's clinical expertise and the patient's individual needs and preferences are shared to select the best treatment option."[32] An open dialogue has become increasingly important as patients have become more knowledgeable, especially in recent years as a result of the wealth of medical information available via the Internet.[33] Improvements in information exchange can help restore trust between patients and physicians. The healing-centered model also prioritizes information exchange among healthcare providers. Any learning resulting from particular errors should reach as many healthcare providers as possible, rather than having healthcare providers repeat the mistakes of their colleagues in order to gain the same knowledge.

Finally, underlying all aspects of the healing-centered framework is the idea that a resolution must include restorative opportunities for all. This entails more than just reducing suffering. It encompasses an inclusive process that enables patients, healthcare professionals and the community to restore relationships both in the specific case and in the broader sense of restoring mutual trust between physicians and patients. This restoration of relationships does not mean that a patient and physician must continue to work together (though they can if both desire to do so). Rather, mutual trust and confidence must be restored to ensure the welfare of both current and future physician-patient relationships.

Having a medical error resolution system that achieves these five objectives will ensure better results in patient treatment, as well as more satisfying outcomes for healthcare providers and communities. The next section uses this healing-centered framework to assess the viability of the current medical malpractice liability system.

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[31] *See* CASSELL, *supra* note 11, at 70 (noting that "maximum possible openness to the patient must be present").

[32] JENNIFER JACKSON, TRUTH, TRUST AND MEDICINE 156 (2001) (quoting ANN SOMMERVILLE, MEDICAL ETHICS TODAY: ITS PRACTICE AND PHILOSOPHY 1 (1993)).

[33] *See* Ken Berger, *Informed Consent: Information or Knowledge?*, 22 MED. & L. 743, 747 (2003) ("[T]he internet and many other improvements in health care information technology are changing the kind of knowledge patients consider material to making decisions about health care."); Nicolas P. Terry, *Prescriptions sans Frontières (or How I Stopped Worrying About Viagra on the Web but Grew Concerned about the Future of Healthcare Delivery)*, 4 YALE J. HEALTH POL'Y L. & ETHICS 183, 255–56 (2004) (suggesting that Internet-sourced medical information must be used by patients "not as a substitute for traditional physician-patient relationships, but as a way of increasing their knowledge and asserting their autonomy within increasingly reticulated relationships"). *But see* Ingrid Dreezen, *Telemedicine and Informed Consent*, 23 MED. & L. 541, 543 (2004) (noting that due to the Internet, "the ability of patients to increase their knowledge grows, though no certainty can be given about the effect of this knowledge on the patient-physician relationship").

III. MEDICAL MALPRACTICE TODAY

Many different players in health care make medical errors,[34] including doctors, nurses, hospital staff, Health Maintenance Organization administration and staff, and others.[35] Medical malpractice law is intended to provide protection against such errors. The prevailing view is that it has two primary purposes—to provide patients with compensation for injuries resulting from substandard care and to deter healthcare providers from negligent behavior.[36] Analyzing the current system's performance based on only these two factors, however, fails to provide a comprehensive assessment with respect to all issues that a medical error resolution system should cover. Thus, this section utilizes the healing-centered framework to provide a more critical appraisal of today's medical malpractice liability system.

A. *Compensation of Victims*

Under the healing-centered framework, medical malpractice liability systems should ensure adequate compensation to patients injured as a result of negligent medical intervention.[37] Nonetheless, the current system fails by leaving most victims of medical error either without any compensation or with compensation only after long delay.

An estimated 4% of hospitalized patients experience an adverse incident caused by medical intervention.[38] Roughly half of these are preventable and 25% of cases are the result of negligence.[39] Therefore, approximately 1% of hospitalized patients are injured as a result of medical malpractice.[40] Professor David Hyman explains the troubling effects of the incidence of medical error, noting that hospitalized patients who are victims of medical malpractice experience consequences ranging from "complete recovery in less than one month (46% of those negligently injured) to death (25% of those negligently injured). If these figures are

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[34] Recall that, as used herein, "medical errors" include both errors by individuals and systems errors. *See supra* note 4.

[35] Taylor, *supra* note 6, at 345.

[36] *Id.*; Kachalia et al., *supra* note 6, at 417.

[37] Negligence in the medical treatment context is traditionally defined as a breach of the standard of care that a reasonable healthcare provider would have delivered in the same or similar circumstances. *See* 70 C.J.S. *Physicians, Surgeons, and Other Health Care Providers* § 83 (2005).

[38] HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 3 (1990). *See also* David A. Hyman, Commentary, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1642 (2002).

[39] HARVARD MEDICAL PRACTICE STUDY, *supra* note 38, at 3; Hyman, *supra* note 38 at 1642–43. For a review of the major studies on patient injuries and malpractice claim frequency, see TOM BAKER, THE MEDICAL MALPRACTICE MYTH 25–36 (2005).

[40] HARVARD MEDICAL PRACTICE STUDY, *supra* note 38, at 3.

extrapolated to the entire nation, adverse events account for more than 200,000 deaths every year, with medical negligence accounting for 120,000 (60%) of the total."[41] These figures demonstrate the urgent need for a system that effectively compensates injured patients (and reduces error rates). But does medical malpractice litigation meet that need?

Tort reform proponents rely on a limited number of cases, in which very large sums of money were awarded, to suggest that almost anyone could obtain compensation for practically any injury.[42] Empirical research offers a very different picture. The seminal Harvard Medical Practice Study, which reviewed hospital and insurance records, determined that approximately "27,000 hospital patients in New York State in 1984 were injured as a result of negligent medical care, but that fewer than 3,800 patients asserted medical malpractice claims."[43] Of those who did sue, many of them did not have valid malpractice claims. This indicates that, of the estimated 27,000 injured patients, the number that proceeded with a malpractice lawsuit was significantly lower than 3,800.[44] A 1992 study in Utah and Colorado also found a significant gap between the number of injuries suffered and the number of claims, as well as a mismatch between the individuals injured by negligent care and those who asserted malpractice claims.[45]

In fact, studies of medical malpractice cases typically find that most victims of substandard care do not file claims or recover any compensation.[46] The Harvard Medical Practice Study revealed that only

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[41] Hyman, *supra* note 38, at 1643 (citations omitted).

[42] *See, e.g.*, Michael J. Saks et al., *A Multiattribute Utility Analysis of Legal System Responses to Medical Injuries*, 54 DEPAUL L. REV. 277, 277 (2005) ("[Q]uite a lot of discussion about medical malpractice and corresponding law proceeds on erroneous assumptions, speculations, and anecdotal impressions about the operations and effects of the existing system."); Kenneth G. Standard, President, N.Y. State Bar Ass'n, Push for So-Called Tort Reform by President and Congress is a Mistake 1 (Jan. 14, 2005), http://www.nysba.org/Content/NavigationMenu/News/Letters_to_the_Editor/socalledtort reform.pdf (stating that tort reform proponents misleadingly suggest that the medical malpractice crisis is due to a "litigation culture" in the United States and "slick trial lawyers" duping juries into awarding outrageous amounts of money); *see also* David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 N. ENG. J. MED. 2024 (2006) (reporting research findings that show most claims lacking evidence of error are denied compensation).

[43] *See* HARVARD MEDICAL PRACTICE STUDY, *supra* note 38; *see also* Catherine T. Struve, *Doctors, the Adversary System, and Procedural Reform in Medical Liability Litigation*, 72 FORDHAM L. REV. 943, 976 (2004) (citing PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 69–70 (1993)).

[44] *See* WEILER ET AL., *supra* note 43, at 71 (discussing the "mismatch" between those who are injured and those who assert malpractice claims).

[45] *See* David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 253–55 (2000).

[46] *See* Deborah L. Rhode, *Frivolous Litigation and Civil Justice Reform: Miscasting the Problem, Recasting the Solution*, 54 DUKE L.J. 447, 467 (2004); *see also* Tom Baker, *Reconsidering the Harvard Medical Practice Study Conclusions about the Validity of Medical Malpractice Claims*, 33 J.L. MED. & ETHICS 501, 502 (2005) ("[T]he finding that most eligible people do not bring medical malpractice claims is well supported and confirmed by other studies using both similar and very different research methods" than the Harvard Medical Practice Study; however, "the finding that most medical malpractice claims are not based on either iatrogenic injury or provider negligence stands on a small and precarious empirical base."). One reason why many meritorious claims are not pursued is the way

1/16 of patients injured due to negligent acts actually received compensation through the medical malpractice litigation system.[47] According to the Physician Insurers Association of America, only 0.9% of malpractice claims result in jury verdicts for the plaintiff (27.4% are settled prior to trial; 67.7% are dropped or dismissed, and 4% result in a verdict for the defendant).[48]

A related concern is that litigation can often drag on for years, with multiple appeals, before any compensation is paid to injured patients. A Philadelphia county judge noted that, in 1993, cases often languished for six years before coming to trial.[49] Changes were instituted and "[s]ince the year 2000, medical malpractice cases have been routinely brought to trial two years from initiation."[50] While these improvements are commendable, the reality is that an injured patient must still wait two years before trial (often while continuing to incur medical expenses) and then still face several more years of waiting while the trial and appeals process works itself out. The financial burden and years of delay in compensation come at a time when the trauma of the injury has created great physical and emotional stress for the patient and his or her family. Moreover, at the end of the lengthy litigation process, there is a significant likelihood that a plaintiff could receive no compensation at all.[51]

An effective compensation system not only assures compensation to those who deserve it, but also provides adequate compensation to such individuals.[52] Here again, public perception does not reflect the full picture.[53] Research findings on the size of jury awards are inconsistent.

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that medical malpractice litigation is funded. An injured patient considering legal action must find a lawyer, and plaintiffs' attorneys are almost always paid on a contingency fee basis. Given the potential expense of litigating any case, plaintiffs' attorneys can take only those cases that make "economic sense." *See* David N. Hoffman, *The Medical Malpractice Insurance Crisis, Again*, 35 HASTINGS CTR. REP. 15, 17 (2005) ("Plaintiff's attorneys are less likely to bring a case worth seventy-five to one hundred thousand dollars, no matter how strong the likelihood of success, than they are to bring a multi-million dollar case with a questionable liability claim.").

[47] *See* Taylor, *supra* note 6, at 348 n.40.

[48] Christopher H. Schmitt, *A Medical Mistake*, U.S. NEWS & WORLD REP., Jun. 30, 2003, at 24–27, available at LEXIS, News Library, USNPUB File. *See also* Taylor, *supra* note 6, at 348 (noting a study finding that almost 50% of patients who proceeded to trial came away with nothing).

[49] Mark I. Bernstein, *The Opportunity for ADR in Medical Malpractice Cases*, 26 PA. LAW. 32, 32 (2004).

[50] *Id.* at 33.

[51] *See* Schmitt, *supra* note 48, at 26 (based on findings of the Physician Insurers Association of America that among cases that reach the jury, a plaintiff has roughly only a one in five chance of a favorable verdict).

[52] Effective compensation also means that doctors and hospitals do not make settlement payments on meritless claims.

[53] Even in cases with large jury verdicts, there is often more to the story than is reported. Perhaps the most famous case—the "McDonald's coffee case"—demonstrates the gap between perception and reality. The media reported that a woman spilled coffee while driving through a McDonald's drive-thru, sued, and was awarded $2.7 million in punitive damages. Troy L. Cady, *Disadvantaging the Disadvantaged: The Discriminatory Effects of Punitive Damage Caps*, 25 HOFSTRA L. REV. 1005,

Some have suggested that the median award doubled between 1995 and 2000 from $500,000 to $1 million.[54] Others report that the median award is approximately $295,000, "far below the median jury award of $1 million the [American Medical Association] and others often cite."[55] Whatever the case, the average size of awards does not tell us whether compensation was adequate in particular cases. What we do know, however, is that the majority of patients injured in the course of treatment fail to receive compensation from the medical malpractice litigation system.

The fact that the majority of patients who suffer injury as a result of negligent care receive no remedy from medical malpractice litigation is a strong indictment of the system. Moreover, those who do receive compensation often must wait years to do so, and may or may not receive adequate compensation. When malpractice litigation fails to provide compensation for most of the injured, it not only fails with respect to one of its core tasks, but it also fails under a healing-centered framework analysis.[56]

1032 (1997). This sound-bite-friendly portrayal made for good headlines. Lost in the uproar was that McDonald's coffee was considerably hotter than that at other fast-food restaurants; McDonalds had faced hundreds of prior claims from individuals burned by its coffee; and the eighty-one-year-old woman suffered third-degree burns on 6% of her body, was hospitalized for eight days, and initially offered to settle her claim for only $20,000, but was rejected. *Id.* at 1033. Further, the trial court reduced the amount of punitive damages to $480,000, and the case ultimately settled for an undisclosed amount. *Id. See also* Joseph T. Hallinan, *In Malpractice Trials, Juries Rarely Have the Last Word*, WALL ST. J., Nov. 30, 2004, at A1, *available at* LEXIS, News Library, WSJNL File (reporting on a case in which a New York state jury awarded a couple $112 million in a medical-malpractice case filed on behalf of their brain-damaged daughter, but ultimately only received $6 million). In addition, "[i]n 2000, Pennsylvania reported three of the largest medical-malpractice verdicts in its history, all of them rendered in Philadelphia: one for $100 million, another for $55 million and a third for $49.6 million." *Id.* These cases ultimately settled for dramatically less: the $55 million case settled for $7.5 million, the $49.6 million case settled for $8.4 million, and the $100 million case settled for an undisclosed sum, which the plaintiff's attorney indicated was "significantly less than $100 million." *Id.* The point here is not to argue the merits of these cases, but rather to suggest that the anecdotal evidence behind the push for tort reform is often misleading. Misleading evidence, in turn, leads to framing the issue incorrectly and developing solutions that do not address most important problems.

[54] Gunnar, *supra* note 3, at 477 (reviewing the impact of malpractice on doctors, lawyers, and the insurance industry, but not the impact on patients). One reason why award sizes may have increased is that plaintiff's attorneys cannot take smaller cases in which expenses could exceed awards. *See* Hoffman, *supra* note 46, at 17 (noting that the economics of contingency fee-based litigation make it likely that plaintiffs' attorneys will pass on small claims and take those cases where damages are potentially very large); *see also* Kathryn Zeiler et al., *Physicians' Insurance Limits and Malpractice Payments: Evidence from Texas Closed Claims 1990–2003*, 36 J. LEGAL STUDIES (forthcoming 2007) (on file with Connecticut Law Review) (finding amounts recovered by plaintiffs often capped by medical malpractice insurance policy limits).

[55] Schmitt, *supra* note 48, at 25.

[56] *See* Edward A. Dauer, *A Therapeutic Jurisprudence Perspective on Legal Responses to Medical Error*, 24 J. LEGAL MED. 37, 40 (2003) ("[W]e know that the tort system as a compensation device is almost unconscionably inefficient."); William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, HEALTH AFF., Jul.–Aug. 2004, at 10, 14 ("If medical errors are widespread, compensating injured patients takes on considerable social importance. Tort litigation is poorly equipped to accomplish this task because third-party liability insurers are preoccupied with deterring claims and contesting fault.").

B. *Safety Promotion*

Safety promotion mandates a focus on error reduction, rather than risk reduction, with a view to improving standards of care and compliance with best practices. This distinction between error reduction and risk reduction illuminates one of the primary drawbacks of the current medical-malpractice liability system.

The high incidence of medical error suggests that the current system is failing to produce an effective response. In a 1999 report, the Institute of Medicine (IOM) estimated that between 44,000 and 98,000 Americans die each year as a result of preventable medical error.[57] Others have suggested that the number may be twice as high.[58] Four percent of hospitalized patients experience an adverse event, and 1% of patients suffer due to a negligent act.[59] Health care's 96% proficiency rate may sound high, but compare the fact that a 99.9% proficiency rate in the airline industry would mean two unsafe airplane landings every day at Chicago's O'Hare airport and, in banking, 32,000 checks would be debited from the wrong account each hour.[60] While we can never completely prevent error from ever occurring, such error rates would be unacceptable in other fields and should not be tolerated in health care.[61]

To successfully reduce medical error, a liability system must help determine standards of conduct that will reduce errors and foster compliance with such standards. The current system fails on both counts. Medical malpractice "standards of fault and causality are vague and inconsistent, experts routinely disagree, results are unpredictable, deterrence signals are confounded by liability insurance, and high rates of

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[57] IOM REPORT, *supra* note 4, at 26. *See also* Baker, *supra* note 46, at 502 ("Over 75,000 people die every year from medical malpractice, more than the total number of deaths from automobile and workplace accidents combined."). For an update on the IOM study, see Maxine M. Harrington, *Revisiting Medical Error: Five Years After the IOM Report, Have Reporting Systems Made a Measurable Difference?*, 15 HEALTH MATRIX 329, 380–81 (2005) (stating that "it is debatable whether any real improvement has been made" in patient safety in the five years since the IOM's findings were published).

[58] *See supra* note 41 and accompanying text; *see also* WEILER, *supra* note 5, at 12 (reporting that the number of deaths or serious injuries due to negligence of physicians and hospitals exceeds 180,000 each year); Lori Andrews, *Studying Medical Error* In Situ*: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 358 (2005) (reporting findings that "[n]early half of all patients had errors in care" and "[n]early one in five patients had errors with a serious harm").

[59] *See supra* notes 38–40 and accompanying text.

[60] Andrea Gerlin, *For a Systemic Problem, No Easy Fix*, PHILA. INQUIRER, Sept. 13, 1999, at A1.

[61] Some might raise questions regarding potential costs of prevention, suggesting that U.S. society may not be willing to pay these costs. I submit that there is evidence that many errors could be avoided without incurring significant costs. Moreover, the costs incurred to reduce errors would serve to save costs caused by errors (as well as lives). *See, e.g.*, Baker, *supra* note 39, at 93 (noting that anesthesiologists have been among the most willing to learn from mistakes and as a result now pay less for malpractice insurance that most other hospital-based doctors).

preventable error and injury persist."[62] Physicians—the primary target population of deterrence—believe liability relates more to the severity of the patient's injury than to whether the injury was a result of actual negligence.[63] Additionally, each year approximately fifteen claims are filed for every one hundred physicians in the United States, and 30% of those claims result in an insurance payment.[64] With rising numbers of claims and increasing payouts,[65] it is no surprise that many doctors worry about malpractice and feel that they are at constant risk of being second-guessed by expert witnesses at trial.

Many physicians feel that they are being singled out and portrayed negatively.[66] The Harvard Medical Practice Study found that doctors' perception of the risk of being sued is three times greater than the actual risk.[67] A study on doctors' views in Pennsylvania found that "[t]hree-fourths of specialists agreed with the statement, 'Because of concerns about malpractice liability, I view every patient as a potential malpractice lawsuit.'"[68] In addition, 91% of specialists surveyed reported that the medical malpractice liability system limits physicians' ability to provide the highest quality care.[69] Concern over the threat of lawsuits and large damages awards likely leads some doctors to practice "defensive medicine."

Defensive medicine involves physicians altering their practice in order to reduce the risk of lawsuits.[70] It results in some doctors ordering unnecessary tests, which drives up the costs of health care and leads to

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[62] Randall R. Bovbjerg & Laurence R. Tancredi, *Liability Reform Should Make Patients Safer: "Avoidable Classes of Events" are a Key Improvement*, 33 J.L. MED. & ETHICS 478, 479 (2005). Not all of these claims have merit. *See supra* notes 43–45 and accompanying text.

[63] Dauer, *supra* note 56, at 39.

[64] CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 4 (2004), *available at* http://www.cbo.gov/showdoc.cfm?index=4968&sequence=0.

[65] *Id.* at 3–4 (reporting that the average payout on malpractice claims rose from $95,000 in 1986 to $320,000 in 2002, reflecting an annual growth rate of almost 8%, which was more than double the general rate of inflation). *But see* Zeiler et al., *supra* note 54 (finding claim rates and average payments in Texas remained relatively stable from 1990–2003).

[66] *See* Gunnar, *supra* note 3, at 476.

[67] *See* HARVARD MEDICAL PRACTICE STUDY, *supra* note 38, at 9; *see also* Bryan Liang, *Medical Malpractice: Do Physicians Have Knowledge of Legal Standards and Assess Cases as Juries Do?*, 3 U. CHI. L. SCH. ROUNDTABLE 59, 90 (1996) (reporting survey data suggesting physicians do not fully understand the legal standards for medical malpractice).

[68] Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, HEALTH AFF., Jul.–Aug. 2004, at 42, 48–49, *available at* http://content.healthaffairs.org (search by author name and year).

[69] *Id.* at 49. Mello et al. acknowledge that it is difficult to determine the extent to which doctors may overstate their unhappiness or fear of litigation, but suggest that the data indicate that "physicians' fear of lawsuits may be well-founded." *Id.* at 51.

[70] *See, e.g.*, Kachalia et al., *supra* note 6, at 418; *see also* BAKER, *supra* note 39, at 120–34 (reporting on research on defensive medicine); Liang, *supra* note 67, at 91 ("[Physicians'] tendency to overestimate jury error probability, in addition to misperceptions of negligence and physician-jury divergence in negligence determinations, may represent a significant source of defensive medicine." (footnote omitted)).

cost-cutting measures that adversely affect patient care.[71] Second, it causes certain doctors to take actions that reduce risk of liability rather than risk of error.[72] Some doctors may elect not to treat certain high-risk patients. In addition, physicians may take other preventive actions to avoid the risk of liability. "A physician who puts less information into a chart, for example, in an effort to avoid creating evidence for some imagined future malpractice claim may be reducing liability risks but at the expense of increasing patient safety risks."[73]

In all of these cases, medical judgment is supplanted, at least in part, by a desire to avoid legal risk. The safety promotion component of the healing-centered framework enables us to see these shortcomings more clearly. Thus, by utilizing this new framework for analysis, we can see that in these cases risk reduction trumps error reduction, and the system fails to ensure that medical judgment informs best practices and that healthcare providers follow such standards in all cases.

C. *Harm Reduction*

Another problem with a litigation-based recovery system is that upon learning that a patient has been injured, a doctor is often instructed not to apologize or say anything that could be construed as an admission of fault.[74] Once it appears an injured patient may seek legal assistance, direct communication between the doctor and patient ceases. Communications then take place through the attorneys for each party. Not only does the patient not receive an apology or any other expression of empathy or caring from the doctor (who may have been the patient's physician for years, or even decades),[75] but information flow also ceases.[76] In one study of malpractice litigation, patients in over 70% of cases complained about

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[71] *But see* Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. ECON. 353, 385–386 (1996) (finding that, overall, "defensive medicine" practices have a "limited impact on health care expenditure growth").

[72] *See, e.g.*, 1 INSTITUTE OF MEDICINE, MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 75–76 (1989) (reporting on dramatic increases in rates of cesarean sections and other procedures in response to threats of lawsuits).

[73] Dauer, *supra* note 56, at 39–40.

[74] *See* FED. R. EVID. 801(d). On the value of apology, see AARON LAZARE, ON APOLOGY 173 (2004); Erin Ann O'Hara & Douglas Yarn, *On Apology and Consilience*, 77 WASH. L. REV. 1121, 1169–70 (2002).

[75] The emotional trauma experienced by the patient at this point does not necessarily diminish if the physician-patient relationship is relatively new. In the modern hospital setting, patients are often referred by their regular physician to new providers in the hospital for specialized care. Here, mutual trust is less developed and more susceptible to fracture when information does not flow freely.

[76] Dauer, *supra* note 56, at 42 (noting research that demonstrates "convincingly that money . . . is in fact not the dominant need or drive of those patients and family members who bring claims against their physicians. Money may be a surrogate, but it is not a fully satisfying one").

the doctor "devaluing patients' views, deserting the patient, and delivering information poorly."[77]

The cynical observer may think that an apology has limited value and that patients sue only for money. However, empirical research suggests otherwise. A study published in the *Lancet*, the leading British medical journal, found that as many as 37% of medical malpractice plaintiffs reported that they would not have filed their lawsuits if their doctors had sincerely apologized instead of stonewalling.[78] Similarly, Liebman and Hyman have found that "[a]fter a medical error or adverse event, the proper type of apology can have a powerful impact on the patient or family, making them less angry and suspicious."[79]

An apology facilitates patients' emotional healing.[80] Access to information helps patients regain a sense of control and empowerment, as well as a voice in the process. Patients need doctors and other health care professionals to attend to the emotional and psychological aspects of healing, not just the physical.[81] Providing apologies to, and sharing information with, patients enables them to feel that their emotional needs are being addressed, that they understand and have some control over what is happening to them, and that they have support from their doctors and hospitals during their time of need. The litigation-based system, by contrast, discourages apologies, thus hindering patients' (and physicians') healing.

The other requirement under harm reduction is efficient and fair resolution of cases in order to minimize the suffering of both patients and healthcare providers. Medical malpractice litigation can drag on for years,

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[77] MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 266 (6th ed. 2003) (citing Wendy Levinson, *Physician-Patient Communication: A Key to Malpractice Prevention*, 272 J. AM. MED. ASS'N 1619, 1619 (1994)).

[78] Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1612 (1994). *See also* INSTITUTE OF MEDICINE, *supra* note 72, at 88 (citing "breakdown in communication between the doctor and patient" as a primary reason behind many lawsuits); Dauer, *supra* note 56, at 42; G. B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 J. AM. MED. ASS'N 1359, 1361 (1992) (finding that 24% of families sued because they felt their physician lied or was not being completely honest, while an additional 20% sued because they felt they could not get anyone to tell them what happened).

[79] Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients*, HEALTH AFF., Jul.–Aug. 2004, at 22, 27.

[80] *See generally* THANE ROSENBAUM, THE MYTH OF MORAL JUSTICE: WHY OUR LEGAL SYSTEM FAILS TO DO WHAT'S RIGHT 179–210 (2004) (on apology). Recognizing the value of apologies, twenty-nine states have passed legislation providing immunity for doctors' apologies, including: Arizona, California, Colorado, Connecticut, Delaware, Georgia, Florida, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Missouri, Montana, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wyoming. The Sorry Works! Coalition, States with Apology Laws, http://www.sorryworks.net/media25.phtml (follow "link" hyperlink) (last visited Nov. 17, 2006).

[81] Both elements are important aspects of the healing process. *See* Liebman & Hyman, *supra* note 79, at 27 ("[A] prompt apology coupled with an explanation of the event and a fair offer of compensation are critical steps in rebuilding trust between the physician and the patient.").

extending the physical and emotional suffering experienced by patients whose claims remain unresolved and preventing them (and their care providers) from achieving closure. Moreover, neither patients nor healthcare providers view the current process as fair. As such, the current medical malpractice liability system fails to address this important element of harm reduction.

D. *Fostering Information Exchange*

In order to develop a medical malpractice system that prioritizes care and healing, information exchange—both between healthcare providers and their patients and among healthcare providers—is essential. The current medical malpractice liability system deters open dialogue and information exchange to the detriment of patient care as well as the emotional well-being of both patients and healthcare providers.

In recent years, scholars and practitioners have recognized that the healthcare system has held doctors to an impossibly high standard (read: mistake-free), and that the medical malpractice liability system has encouraged doctors to deny evidence of mistakes and thus miss opportunities to improve their skills, their decision-making and, ultimately, the service they provide.[82] As Professor Lucian Leape explains: "Physicians are socialized in medical school and residency to strive for error-free practice. There is a powerful emphasis on perfection, both in diagnosis and treatment. In everyday hospital practice, the message is equally clear: mistakes are unacceptable."[83] Medical errors are often not discussed even privately among colleagues.[84] Leape summarizes the dilemma facing doctors:

> [A]ll physicians recognize that mistakes are inevitable. Most would like to examine their mistakes and learn from them. From an emotional standpoint, they need the support and understanding of their colleagues and patients when they make mistakes. Yet, they are denied both insight and support by misguided concepts of infallibility and by fear: fear of embarrassment by colleagues, fear of patient reaction, and fear of litigation.[85]

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[82] David Blumenthal, *Making Medical Errors Into 'Medical Treasures,'* 272 J. AM. MED. ASS'N 1867, 1867–68 (1994).

[83] Lucian L. Leape, *Error in Medicine*, 272 J. AM. MED. ASS'N 1851, 1851 (1994). *See also* ATUL GAWANDE, COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE 37 (2002) ("Western medicine is dominated by a single imperative—the quest for machinelike perfection in the delivery of care.").

[84] *See* Leape, *supra* note 83, at 1852.

[85] *Id.*

Medical malpractice litigation discourages doctors from admitting mistakes or questioning their decision-making abilities, at least not until proven wrong in a court of law (or until the statute of limitations has run).[86] Research has demonstrated that "blame and the accompanying threat of punishment and stigmatization activates defensive mechanisms, drives out information about systemic vulnerabilities, stops learning, and undermines the potential for improvement."[87] Because litigation may drag on for years, the learning process and any resulting improvements in practice are frustrated or put on hold until resolution of the lawsuit, meaning that safety promotion is also hindered.[88]

The threat of litigation, coupled with the culture of perfection, discourages the flow of information from physicians to patients and among doctors. In addition, the threat of litigation fosters a culture of mistrust that affects the information sharing by both patients and doctors. All of this hinders the development of care relationships and frustrates doctors' opportunities to learn and improve the care they provide.

E. *Providing Restorative Opportunities for All Parties*

The final goal under the healing-centered framework is to ensure that all parties have an opportunity for restoration and healing. This step takes redress of medical errors beyond harm reduction. It requires fostering an inclusive process that enables patients, healthcare professionals, and the community to restore relationships both in the case at hand and in the broader sense of restoring mutual trust between physicians and patients. Drawing on restorative justice's tripartite approach, I analyze the current system's ability to provide restorative opportunities from the perspective of patients, doctors, and the community.

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[86] *See* GAWANDE, *supra* note 83, at 57 (stating that medical malpractice lawsuits prevent doctors from acknowledging and discussing errors publicly, and that "[w]hen things go wrong, it's almost impossible for a physician to talk to a patient honestly about mistakes"); *see also* Gerlin, *supra* note 60, at A1 ("[S]tudies have found that only 5 percent to 10 percent of all medical errors are reported to hospital administrators; the remaining 90 percent to 95 percent go unreported."); Andrea Gerlin, *Mum is Often the Word When Caregivers Stumble*, PHILA. INQUIRER, Sept. 14, 1999, at A1 [hereinafter Gerlin, *Mum is Often the Word*] (reporting on a study that found "only 54 percent of medical residents discussed their mistakes with their attending doctors, who are legally and ethically responsible for them"). *But see* David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 893 (2005) (arguing that fear of malpractice lawsuits does not discourage error reporting).

[87] David D. Woods, *Conflicts Between Learning and Accountability in Patient Safety*, 54 DEPAUL L. REV. 485, 488 (2005).

[88] While other factors—such as personal pride of physicians and internal hierarchy of hospitals—also influence information exchange, there is general agreement that the threat of litigation is a significant factor. *See supra* notes 66–68 and accompanying text.

1. *Patient Perspective*

Medical malpractice lawsuits do not restore trust or relationships.[89] In recent decades, the level of trust and confidence in the medical profession has eroded. In 1966, Americans had a 73% confidence level in medicine (higher than the 40% average for other fields at that time), but that confidence has steadily declined, with 1993 producing a record low of 22%.[90] A 1993 American Medical Association survey sheds light on some of the possible reasons for the decline, noting that "69% of the respondents felt that doctors were 'too interested in making money' and 70% believed that 'people are beginning to lose faith in doctors.'"[91] Philip Peters explains: "Money appears to play a role in the rise of cynicism. In a 1996 national poll, 82% of respondents believed that medical care had become a big business and that the industry put profits ahead of patients."[92] Doctors spend less time with patients, refer them to specialists with whom the patients have little or no prior relationship, and generally offer little to address the emotional side of the patient experience.[93] When medical errors occur, the problem is only exacerbated.

After a patient is injured as a result of medical care, doctors' reluctance to apologize and share information makes them appear incapable of or unwilling to empathize with patients who are suffering. A dehumanized response by doctors undermines the care relationship and destroys the trust that patients have in their doctors. It leaves patients in an anxiety-provoking position, needing medical care but feeling they cannot trust their doctors and unsure of where else to turn.

2. *Physician Perspective*

For many physicians, the current medical malpractice liability system fosters dissatisfaction by increasing financial stress, heightening anxiety associated with the practice of medicine (by the potential threat of being second guessed in hindsight at trial), and creating a frustrating dynamic whereby the patients that doctors are trying to help may be the very same individuals who might sue them. Physician satisfaction and emotional well-being matter, not only for producing happy doctors but also for ensuring quality of care. Professor Michelle Mello explains the effect:

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[89] *See* Hall, *supra* note 23, at 306.

[90] Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 196 (2000).

[91] *Id.* (citation omitted).

[92] *Id.* at 197.

[93] *See id.* at 198; *see also* LAW & POLAN, *supra* note 6, at 208 (citing overspecialization as a significant factor in the deterioration of the physician-patient relationship).

> Satisfied physicians tend to be more attentive to patients and to have higher levels of satisfaction among their patients. Physician dissatisfaction, on the other hand, has been linked to riskier prescribing practices. Dissatisfied physicians are also more likely to leave clinical practice or relocate, disrupting continuity of care and jeopardizing access to services in underserved regions.[94]

Malpractice proceedings and the constant threat of malpractice take an emotional toll on doctors, the effects of which are felt by the health care system.[95]

One of the most commonly cited adverse effects of the current system on doctors is the soaring cost of insurance premiums for doctors. Some doctors have received renewal notices from their insurers informing them of 100% to 200% increases in their premiums over the prior year.[96] Others have simply been informed that their insurer will no longer provide coverage for their high-risk specialty, forcing these physicians to search for new coverage.[97] Overall, government reports have found that medical malpractice insurance premiums for physicians nationwide rose by 15% between 2000 and 2002.[98] Certain specialties were disproportionately affected, such as obstetricians/gynecologists (22% increase) and internists and general surgeons (33% increase).[99]

Rising insurance premiums can affect the financial situation of physicians and their families. They also have an adverse effect on morale, as well-meaning doctors who aim to provide for and serve their community become discouraged by having to spend such a substantial portion of their salary on protecting themselves from the very same individuals that they are trying to help. This dynamic can inhibit the development of trust between physician and patient, which in turn may adversely affect

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[94] Mello et al., *supra* note 68, at 43 (citations omitted).

[95] *Id.* at 44. The current liability system, in theory, should operate such that non-negligent doctors should not have to worry about being sued. There is evidence that it works in a number of cases, see, for example, David Studdert et al., *supra* note 42 (finding most claims involving no error receive no compensation), but as discussed in this section, the current system affects physicians in ways that do not foster optimal care arrangements.

[96] MARTIN D. WEISS ET AL., MEDICAL MALPRACTICE CAPS: THE IMPACT OF NON-ECONOMIC DAMAGE CAPS ON PHYSICIAN PREMIUMS, CLAIMS PAYOUT LEVELS, AND AVAILABILITY OF COVERAGE 4 (2003). *See also* Michelle M. Mello et al., *Hospitals' Behavior in a Tort Crisis: Observations from Pennsylvania*, HEALTH AFF., Nov.–Dec. 2003, at 225, 225 (reporting insurance premium increases of "25–100 percent or more"). The actual amounts of malpractice premiums for some doctors can be as high as $200,000 per year or more. Paul C. Weiler, *Reforming Medical Malpractice in a Radically Moderate—and Ethical—Fashion*, 54 DEPAUL L. REV. 205, 208–09 (2005).

[97] WEISS ET AL., *supra* note 96, at 4.

[98] CONG. BUDGET OFFICE, *supra* note 64, at 14. *See also* Rhode, *supra* note 46, at 458 (reporting that in 2002 alone, malpractice premiums in some areas and specialties increased between 40% and 112%).

[99] CONG. BUDGET OFFICE, *supra* note 64, at 14.

information exchange between the two and, ultimately, the quality of care provided.[100]

The expectation of perfection and the threat of litigation lead to a reluctance among doctors to admit and talk openly about mistakes, and promote a culture of protecting one's colleagues.[101] Just as a doctor would not want to be second-guessed by others, so too will he or she reserve judgment when viewing other doctors' actions. This circling-the-wagons approach fosters an "us vs. them" environment that pits doctors against patients and the community. This is the opposite of what is needed in the context of the doctor-patient relationship—an intimate relationship based on care and trust. When patients cease to trust doctors, information flow is hindered, making the doctor's job more difficult and less enjoyable. All of the above factors weigh heavily on doctors today and increase the risk of medical error.[102]

3. *Community Perspective*

As discussed above, the current system permits mistakes to continue and operates to foster mistrust of doctors and other health care professionals.[103] A lack of trust in the health care system makes individuals more reluctant to see a physician.[104] Consequently, individuals present at health care facilities later in time, when their conditions have worsened, making it more difficult to treat them.[105] Patients suffer

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[100] Lorraine E. Ferris, *Using Therapeutic Jurisprudence And Preventive Law To Examine Disputants' Best Interests In Mediating Cases About Physicians' Practices: A Guide For Medical Regulators*, 23 MED. & L. 183, 183 (2004) ("The patient-doctor relationship relies on mutual respect, on trust in the physician's technical and psychosocial competence, and on the patient's confidence that appropriate care is being given."). *See also* CASSELL, *supra* note 11, at 71 (explaining the importance of trust in a doctor-patient relationship).

[101] *See, e.g.*, Struve, *supra* note 43, at 995 ("[P]hysicians may be reluctant to hold their colleagues liable for errors in judgment that do not rise to the level of gross neglect.").

[102] While this section focused on doctors, nurses and other healthcare providers also experience many of these burdens.

[103] *See* Gerlin, *Mum is Often the Word*, supra note 86, at A1 (reporting that "hundreds of patients suffer medical errors at hospitals across the country every day. One reason the problems persist is that medical professionals routinely do not tell patients or their families about the errors."); Sage, *supra* note 56, at 16 ("The principal method used to contain costs—managed care—also reduces patients' and jurors' trust in medical providers and taints bad outcomes with commercial motivation, potentially increasing the rate and magnitude of claims, settlements, and verdicts and raising the specter of punitive damages.").

[104] *See* Stefanie Mollborn et al., *Delayed Care and Unmet Needs Among Health Care System Users: When Does Fiduciary Trust in a Physician Matter?*, 40 HEALTH SERVS. RES. 1898, 1898 (2005) ("Patients' fiduciary trust in a physician is negatively associated with the likelihood of reporting delayed care and unmet health care needs among most patients."); *see also* Janice Blanchard & Nicole Lurie, *R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care*, 53 J. FAM. PRAC. 721, 721 (2004) (finding individuals who felt a lack of respect from doctor based on race were more likely to put off seeking care).

[105] In some instances, patients' mistrust of doctors leads them to wait so long that it is too late to treat them, further undermining the community's faith in the system.

accordingly. Moreover, presenting at a health care facility when one's condition has worsened increases the overall cost of health care. Absorbing these additional costs puts further strain on an already financially burdened system. In turn, a portion of these costs are ultimately passed on to the consumer in the form of higher costs for various treatments or increases in the cost of health care insurance.

As health care costs increase, fewer people are able to afford needed care. In 2003, forty-five million individuals were without insurance for the entire year (representing over 15% of the civilian, non-institutionalized population of the United States).[106] A study of six industrialized nations' health care systems found that the "United States is an outlier for financial burdens on patients and patients foregoing care because of costs. Half of sicker adults in the United States said that they did not see a doctor when sick, did not get recommended treatment, or did not fill a prescription because of cost."[107]

Kaiser Family Foundation research reveals the troubling consequences of the high cost of health care. Approximately four out of every ten individuals with chronic conditions report that "they or a family member has avoided filling a prescription, has skipped recommended medical tests or treatment, or has cut pills or skipped doses of medicine because of the cost."[108] Twenty-three percent of adults report having problems paying medical bills within the previous year, even though 61% of these individuals have health insurance, and 70% of uninsured individuals report cost as the primary reason for being without health insurance.[109] In short, the increasing cost of health care is leaving a growing number of individuals without the means to afford treatment, and in some instances the consequences are fatal.[110]

Finally, skyrocketing health care costs burden the entire economy.[111] Based on health care expenditure per capita and total expenditure as a percentage of gross domestic product (GDP), the United States spends

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[106] Cathi M. Callahan & James W. Mays, *Estimating the Number of Individuals in the United States Without Health Insurance* 1 (U.S. Dep't of Health & Hum. Serv., Working Paper, Mar. 31, 2005), *available at* http://aspe.hhs.gov/health/reports/05/est-uninsured/report.pdf.

[107] Cathy Schoen et al., *Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries*, W5 HEALTH AFF. 509, 519 (2005), *available at* http://content.healthaffairs.org/webexclusives/index.dtl?year=2005 (follow "PDF" hyperlink).

[108] KAISER FAMILY FOUNDATION, KAISER PUBLIC OPINION SPOTLIGHT, THE PUBLIC ON HEALTH CARE COSTS 1 (Dec. 2005), *available at* http://www.kff.org/spotlight/healthcosts/index.cfm.

[109] *Id.* at 1–2.

[110] *See* Weiler, *supra* note 96, at 214 ("[A]n estimated 18,000 unnecessary American deaths occur every year because of lack of access to health care.").

[111] Many factors contribute to the high cost of health care. *See id.* at 208 ("[M]alpractice insurance and litigation costs have long represented just around 1% of our total health care costs."). While this is true, the economic impact of medical malpractice is much more than just the cost of insurance and litigation. The current system's failure to reduce error results in substantial additional expenditure on health care to treat those injured by error, to name just one additional cost.

more on health care than any other country in the world.[112] Using 1998 figures, the United States spent $4178 per capita on health care, easily outdistancing the second biggest spender, Switzerland ($2794) and more than doubling average per capita spending for OECD countries ($1783).[113] In 2004, the United States spent an estimated $1.9 trillion on health care, equivalent to roughly 16% of its GDP.[114] The high cost affects not only quality of care and access to care but also the overall economy.[115] This dramatic ripple effect reinforces the need for a system that offers restorative opportunities, so that mutual trust can be rebuilt and healing can come to all parties.

The healing-centered framework highlights the multiple short-comings of the current system. Today's medical malpractice liability system fails to provide compensation for too many patients, is unsuccessful in promoting safety, does not reduce harm or minimize suffering to the extent needed, provides disincentives for information exchange, and offers little in the way of restorative opportunities for all parties. The next section considers whether other available options offer greater hope.

IV. CURRENT REFORM EFFORTS AND ALTERNATIVES

Various tort reform measures and alternative dispute resolution schemes attempt to deal with medical malpractice. Using the healing-centered framework, we can assess the relative merits of current reforms and alternatives. This section briefly considers commonly-proposed reforms for the current system (caps on damages, statutes of limitations, and attorneys' fees) and the following alternative models: arbitration, mediation, no-fault liability, enterprise liability, screening panels, and medical courts.

A. *"Fixing" the Current System*

Current tort reform measures—most notably caps on non-economic damages, reductions in the statutes of limitations, and limitations on

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[112] BUREAU OF LAB. EDUC., UNIV. OF ME., THE U.S. HEALTH CARE SYSTEM: BEST IN THE WORLD, OR JUST THE MOST EXPENSIVE? 2 (2001), *available at* http://dll.umaine.edu/ble/U.S.%20HCweb.pdf.

[113] *Id. See also* Uwe E. Reinhardt et al., *U.S. Health Care Spending in an International* Context, HEALTH AFF., May–June 2004, at 10, 11–12 (noting, pursuant to 2001 figures, that Switzerland spent only 68% as much on health per capita as the United States, and Canada spent only 57% as much).

[114] *Desperate Measures: The World's Biggest and Most Expensive Health-Care System is Beginning to Fall Apart. Can George Bush Mend It?*, ECONOMIST, Jan. 26, 2006, at 24.

[115] *See, e.g.*, David M. Studdert et al., *What Have We Learned Since the Harvard Medical Practice Study*, *in* MEDICAL ERROR: WHAT DO WE KNOW? WHAT DO WE DO? 3, 19–20 (Marilynn M. Rosenthal & Kathleen M. Sutcliffe eds., 2002) (based on the HMPS and other medical error studies, adverse events in medical practice likely resulted in a total national cost of $38 billion to $50 billion per year).

attorneys' fees—are reforms aimed foremost at addressing compensation issues. However, these reform measures target the much smaller problem of occasional windfall victories for injured plaintiffs while exacerbating the much greater problem of the current system's failure to compensate the thousands of individuals injured by substandard care.

1. *Non-Economic Damages*

Non-economic damages are a favorite target of tort reform proponents who argue that such damages provide a windfall for undeserving plaintiffs and contribute significantly to the astronomical cost of health care today.[116] Non-economic damages, which are often characterized as compensation for "pain and suffering," really represent much more; they include "the cost of restoring the plaintiff as nearly as possible to the quality of life that he [or she] enjoyed before the injury."[117] As David Hoffman explains, "[s]ome of that money surely represents compensation for the physical pain during and following an injury, but a more significant portion represents the actual cost of adapting the plaintiff to pursue whatever profession or avocation gave the plaintiff's life meaning before the injury."[118] Such damage awards offer additional compensation in cases where economic damages may have been undervalued and provide incentive to injured individuals reluctant to come forward to proceed with their claims and help enforce the rule of law.[119]

Conversely, caps on non-economic damages effectively force the most seriously injured patients to take on a disproportionate share of the costs of medical errors.[120] Caps on non-economic damages could result in fewer injured patients with legitimate claims being able to pursue litigation, as the costs of pursuing each claim may be higher than the capped damage awards, leaving such patients unable to find attorneys to take their cases.[121]

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[116] *See* Cady, *supra* note 53, at 1009, 1011; Hoffman, *supra* note 46, at 18 (noting that President Bush has pushed for a hard cap of $250,000 for all non-economic awards).

[117] Hoffman, *supra* note 46, at 18. *See also* Cady, *supra* note 53, at 1009 (noting that punitive damages also serve the necessary functions of deterrence and punishing defendants for truly outrageous conduct).

[118] Hoffman, *supra* note 46, at 18.

[119] Cady, *supra* note 53, at 1010–12. Cady also suggests that educating the public of their legal rights is another function. *Id.* at 1010.

[120] *See* LAW & POLAN, *supra* note 6, at 139 (stating that the medical malpractice crisis "will not be solved by forcing the most seriously injured into dependency on friends, families, or welfare"); *see also* Ferdon v. Wis. Patients Comp. Fund, 701 N.W.2d 440, 465 (Wis. 2005) (striking down Wisconsin's cap on non-economic damages in medical malpractice cases as unconstitutional, in part because "the burden of the cap falls entirely on the most seriously injured victims of medical malpractice").

[121] *See* Kathryn Zeiler, *Turning from Damage Caps to Information Disclosure: An Alternative to Tort Reform*, 5 YALE J. HEALTH POL'Y L. & ETHICS 385, 387 (2005); Rachel Zimmerman & Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases: Limits on Awards for Suffering Create New Impediments*, WALL ST. J., Oct. 8, 2004, at A1, *available at* LEXIS, News Library, WSJNL File.

2. *Statutes of Limitations*

Prior to the 1970s, the statute of limitations in medical malpractice cases was governed by general tort laws.[122] During the medical malpractice crisis of the 1970s, however, a number of reforms were instituted to limit the liability of medical practitioners.[123] Many states shortened statutes of limitations for medical malpractice claims in order to reduce the number of lawsuits and address the "long tail problem that forced insurance companies to impose artificially high present premiums to protect against increased future damage awards."[124] Currently, every state has placed some limitation on the length of time in which medical malpractice claims can be brought—typically about two years.[125] Peter Zablotsky comments on the absence of pure discovery-based statutes of limitations:

> [A]dvocates for medical practitioners prevailed in their efforts to impose restrictive statutes of limitations in the medical malpractice context. No state adopted a pure discovery based statute of limitations to govern medical malpractice. This is so despite the fact that pure discovery based statutes of limitations have become common place for most other negligence based torts.[126]

Again, this measure, while touted as a means of reducing frivolous lawsuits, does nothing to ensure that meritorious cases are discovered and it fails to improve patient compensation. In fact, medical malpractice statutes of limitations have been challenged and, in some cases, struck down as unconstitutional.[127]

3. *Attorneys' Fees*

Another common critique proffered by tort reform proponents is that plaintiffs lawyers retain too much of the claimant's ultimate recovery

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[122] Peter Zablotsky, *From a Whimper to a Bang: The Trend Toward Finding Occurrence Based Statutes of Limitation Governing Negligent Misdiagnosis of Diseases with Long Latency Periods Unconstitutional*, 103 DICK. L. REV. 455, 457 (1999).

[123] *Id.* at 458–59.

[124] *Id.* at 460–61 (citations omitted). *See also* Ann H. Nevers, *Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing?*, 1 PEPP. DISP. RESOL. L.J. 45, 61 (2000) (noting that the "statutes were enacted to fix the problem of the 'long tail' in which claims for injuries are not immediately apparent").

[125] Nevers, *supra* note 124, at 61–62.

[126] Zablotsky, *supra* note 122, at 463.

[127] *See id.* at 457 ("[N]early one-third of the states have either found their statutes of limitations governing medical malpractice to be unconstitutional as applied to victims of medical malpractice who could not have discovered their injuries until well after the statutory period had expired, or have interpreted their statutes to provide for open discovery.").

because of high contingency fee arrangements.[128] This argument is used to advocate for limitations on fees so that "more of actual recovery is channeled back to the victims."[129] Supporters also suggest that limiting contingency fees will reduce the number of frivolous lawsuits.[130]

Like other quick fixes for the malpractice litigation system, limiting contingency fees fails to address patient compensation adequately. "Instead of protecting patients, such laws leave injured patients with no remedy at all" by making it less likely that a plaintiff with a legitimate but relatively small claim will be able to secure representation, because attorneys will not risk taking cases in which damages awarded may not cover their costs.[131]

Equally important, beyond failing to improve the tort system's capacity to compensate victims, current reforms related to non-economic damages, statutes of limitations, and attorneys' fees fail to foster improvements with respect to other components of the healing-centered framework. These measures create incentives for risk management, not safety promotion, potentially leading to questionable treatment decisions. Professor Kathryn Zeiler suggests, for example, that in situations in which providing compliant treatment is particularly costly, caps could have the effect of leading doctors and managed care organizations to provide alternative care and face potential liability, rather than provide the costly treatment that complies with the legal standard of care.[132] Such results will serve to increase the number of injuries and further burden the health care system with additional claims and costs.

Moreover, by failing to address the emotional needs of patients or ensure efficient or fair resolution of claims, these measures fail to facilitate harm reduction. They also leave incentives unchanged for information sharing, as doctors still face the constant threat of litigation, and thus patients have no greater assurances of access to information. Finally, they do nothing to change the structure of the current system to ensure restorative opportunities for all parties. Healthcare providers still are afforded little or no opportunity to discuss and learn from errors (arguably there is more incentive not to discuss errors in the short-term), and patients and the community have no greater reasons for trusting doctors and

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[128] *See, e.g., id.* at 458.

[129] Chandler Gregg, *The Medical Malpractice Crisis: A Problem with No Answer?*, 70 MO. L. REV. 307, 325 (2005).

[130] *Id.*

[131] *Id.* at 326. Alternatively, it may encourage some plaintiffs' attorneys to sue for much more than their client needs in order to ensure legal fees are covered.

[132] Zeiler, *supra* note 121, at 389–90 (also noting evidence that physicians react to other financial incentives in a similar fashion).

hospitals. In short, current "fixes" fail to produce better results with respect to any of the components of the healing-centered framework.[133]

B. *Alternative Processes—Arbitration and Mediation*

Alternative dispute resolution (ADR) has often been proposed, and used, in the medical malpractice context. ADR covers a range of methods which can be thought of as having at least one unifying characteristic—that is, to varying degrees they offer a less restrictive forum than traditional tort litigation, alleviating constraints imposed by precedent and procedural rules. That said, ADR methods differ greatly from each other, as evidenced in this section's examination of two prominent approaches—arbitration and mediation.

For years, healthcare facilities have used arbitration to resolve medical malpractice cases, although the number of claims handled through arbitration remains relatively low.[134] In arbitration, the parties agree to use an arbitrator, instead of a judge or jury, to issue a decision on the merits of their case.[135] The decision is binding on the parties with limited or no right to appeal. In the arbitration context, the parties have significant power to agree on the particulars of the arbitration procedure, including the hearing's length, number of arbitrators, arbitrators' qualifications, and the amount of discovery permitted.[136] Arbitration typically does not alter the basic tort theory of liability, thus the parties must still prove their cases under the applicable substantive law.[137]

Proponents of arbitration maintain that it is a useful alternative for resolving medical malpractice conflicts because of the "parties' ability to control the procedure, the ability to select the arbitrator or expert, reduced cost, shortened time to resolve the dispute, finality of the decision, privacy, reduced emotional trauma of litigation, and self autonomy through the ability to contract and resolve disputes outside of the courts."[138] There is value in many of these "benefits": a 1992 General Accounting Office (GAO) study of medical malpractice litigation found that arbitration resulted in some reductions in the time it took to resolve claims, was more

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[133] In addition, current reform measures reduce the power of individual plaintiffs—particularly those with limited resources—and curtail judicial discretion, which potentially undermines faith in the judicial system.

[134] Nevers, *supra* note 124, at 50. *See also* Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203, 204 (1996).

[135] Metzloff, *supra* note 134, at 204.

[136] *Id.*

[137] *Id.* at 204–05.

[138] Nevers, *supra* note 124, at 49.

effective in compensating a greater number of plaintiffs for their injuries, and produced lower and more consistent awards.[139]

Others have suggested mediation as an appropriate alternative dispute resolution mechanism. "Mediation is based on three core principles: party autonomy, informed decision making, and confidentiality."[140] It involves a negotiation between the concerned parties facilitated by a neutral third party.[141] The mediator does not have independent authority to impose a resolution; rather, he or she is tasked with guiding the parties to a mutually-acceptable resolution.[142] As mediation is voluntary, either party can walk away from or reject the proposed final resolution. If agreement is reached, however, it is typically memorialized in a binding agreement.

Proponents of mediation suggest that it is the best alternative to the current medical malpractice liability system because it results in fewer large jury verdicts and reduces the amount of time, money and emotional capital spent in litigation.[143] Moreover, mediation can be structured to allow more open dialogue between physician and patient about medical decisions and any errors.[144]

Under a healing-centered framework analysis, both arbitration and mediation offer more benefits than current tort reform proposals, yet each method in its current form falls short of providing a comprehensive solution to the medical malpractice crisis. Under current arbitration and mediation programs, patient compensation may improve somewhat (with seemingly greater potential in mediation), but many patients who suffer an adverse event as a result of medical intervention still will receive no compensation. As arbitration relies on the same tort law standards for determining liability and provides limited or no opportunity for a plaintiff to appeal an arbitrator's ruling, it does not appear to reduce doctors' and hospitals' incentive to engage in risk management (rather than error

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[139] *Id.* at 50 (relying on U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: ALTERNATIVES TO LITIGATION 9 (1992), *available at* http://archive.gao.gov/d31t10/145592.pdf).

[140] NANCY NEVELOFF DUBLER & CAROL B. LIEBMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS 9 (2004).

[141] Scott Forehand, *Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation*, 14 OHIO ST. J. ON DISP. RESOL. 907, 919 (1999).

[142] *Id.*

[143] Taylor, *supra* note 6, at 350–51. *See also* Nevers, *supra* note 124, at 87–88 (outlining advantages for both parties in utilizing mediation in medical malpractice cases). There are different mediation styles, including evaluative, facilitative, and transformative. Evaluative mediators identify strengths and weaknesses in each side's case and often predict for the parties the outcome if it went to litigation. In contrast, facilitative mediators see their job as simply helping the parties resolve their dispute without evaluating each side's case. Finally, transformative mediation focuses on empowering the parties and restoring relationships through the mediation process. *See* Zena D. Zumeta, *Styles of Mediation: Facilitative, Evaluative, and Transformative Mediation* (2000), *available at* http://www.mediate.com/articles/zumeta.cfm. The discussion of mediation herein focuses on the latter two methods.

[144] Taylor, *supra* note 6, at 351.

reduction) and admit no wrongdoing.[145] This, in turn, frustrates doctors' and hospitals' learning and fails to optimize safety promotion. Mediation's facilitative or transformative process and its confidential nature allows for greater openness and thus, hopefully, subsequent improvements in standards of care. Given the voluntary nature of mediation, litigation remains a threat, and thus healthcare providers still have some incentive to pick and choose how accommodating they will be in particular cases. Moreover, mediation does not ensure that lessons learned in a particular case reach other healthcare providers.

Both methods offer some potential in terms of harm reduction. Mediation, especially transformative-styled mediation, appears to offer greater hope for creating a forum in which patients can receive information and apologies to help foster emotional healing. In contrast, it is questionable whether arbitration particularly helps minimize suffering. Many question whether patients fully understand provider contracts that make arbitration mandatory, and some have suggested that such agreements are entered into under potentially coercive circumstances.[146] Moreover, many of the so-called benefits of arbitration—including the parties' ability to control the procedure, the ability to select the arbitrator or expert, and greater self autonomy through the ability to contract and resolve disputes outside the courts—mean little to individual plaintiffs injured during the course of medical treatment. These decisions are made by attorneys, giving patients no greater sense of empowerment or control over the process. Both arbitration and mediation may help reduce the time it takes to resolve claims, though the non-binding aspect of mediation leaves open the possibility that lengthy litigation could follow if a resolution is not achieved. Finally, mediation appears to offer greater hope than arbitration that all participants will be satisfied with the outcome.

It is unclear whether arbitration, as it is currently used in medical cases, fosters an environment in which doctors and hospitals feel comfortable sharing information openly with patients. Conversely, "[t]he fact that mediation communications are confidential makes more open, less

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[145] Arbitration also suffers from the "repeat player" problem, which favors large health care providers, giving them less incentive to disclose errors. *See* Elizabeth Hill, *Due Process at Low Cost: An Empirical Study of Employment Arbitration Under the Auspices of the American Arbitration Association*, 18 OHIO ST. J. ON DISP. RESOL. 777, 786 (2003) (the "repeat player" effect occurs when "repeat players repeatedly select favorite arbitrators, who then return the favor with biased decisions in favor of the repeat players").

[146] *See* Carol A. Crocca, Annotation, *Arbitration of Medical Malpractice Claims*, 24 A.L.R.5th 1 (1994); *see also* Broemmer v. Abortion Servs. of Phoenix, 840 P.2d 1013, 1016 (Ariz. 1992) (provider contract held invalid because it was a contract of adhesion which mandated arbitration of malpractice claims and required patient to waive right to jury trial); Forehand, *supra* note 141, at 914 (reporting on Kaiser Permanente's attempt to mandate binding arbitration for all patient malpractice claims, which the California courts struck down because Kaiser's system was "adversarial and biased in favor of Kaiser . . . [and] 'unconscionable'").

strategic communications possible because parties need not fear that what they say then will come back to haunt them in a later proceeding."[147] In mediation, patients, doctors and hospitals can gain access to valuable information.[148] With respect to physician-to-physician information exchange, neither method necessarily results in greater information flow, especially with respect to transfer of learning from one healthcare facility to another.

Finally, restorative opportunities differ under arbitration and mediation. Arbitration, with its use of traditional tort liability standards, limited appeals process, and its repeat player problem and other power imbalance issues, does not appear that well positioned to ensure a positive practice environment in which doctors can discuss errors, learn, and improve their practices. From the patient and community perspective, unless there is clear incentive for truthfulness on the part of doctors and hospitals, arbitration offers little advantage over traditional malpractice litigation for reducing mistakes and ensuring better care and thus little encouragement for greater faith in the health care system. In contrast, mediation offers a better forum for open dialogue that can foster restorative opportunities.

C. *Expanding Coverage—No-Fault and Enterprise Liability*

While ADR focuses on providing alternative processes for resolving cases, other approaches stress the need to increase the number of injured individuals covered by any scheme that addresses medical error. No-fault liability and enterprise liability systems are two models aimed at ensuring compensation for a greater number of individuals.

Some medical malpractice scholars have advanced a no-fault or strict liability system as the answer to the medical malpractice crisis.[149] Under a no-fault regime, injured patients receive compensation without the traditionally required finding of physician negligence.[150] Patients must show only that they have been injured, that the injury is due to their medical care, and that the injury meets the established compensation criteria.[151] The emphasis is placed on compensation whenever there is an "undesirable outcome due to medical intervention" rather than the presence of a negligent act.[152] Proponents of the no-fault system often point to the workers compensation scheme as an example of a successful no-fault

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[147] Liebman & Hyman, *supra* note 79, at 29.

[148] *Id.*

[149] *See, e.g.*, Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1626 (2002).

[150] *See* Gregg, *supra* note 129, at 332.

[151] David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225, 228 (2001).

[152] Ralph Peeples & Catherine T. Harris, *Learning to Crawl: The Use of Voluntary Caps on Damages in Medical Malpractice Litigation*, 54 CATH. U. L. REV. 703, 719 (2005).

scheme.[153] Of existing alternatives, a no-fault liability system offers the greatest potential for meeting the first objective of the healing-centered framework.[154]

With respect to safety promotion, it is unclear whether no-fault provides incentives for improved care, and thus a reduction in medical error. A no-fault system would not provide any deterrence of negligent acts by physicians.[155] On the other hand, doctors have concerns that hospitals and insurance companies would monitor doctors more closely in an effort to reduce adverse events requiring payouts, leaving doctors less freedom in their practice.[156] Still, proponents of a no-fault system argue that doctors benefit by not being stigmatized by malpractice claims and determinations of negligence against them.[157]

By itself, however, no-fault does not address the patient issues of emotional healing, and thus it would not necessarily produce optimal results with regard to harm reduction. However, a no-fault system should produce more efficient resolution of claims, minimizing to some extent suffering endured by patients. It is unclear, though, whether a no-fault system would result in more open discussion of medical errors or foster greater information exchange.[158] Finally, assuming a no-fault system would operate similar to the workers compensation scheme, it may provide little or no forum for restoring the relationships that are so integral to health care.[159]

Like no-fault liability, enterprise liability seeks to ensure greater coverage for individuals deserving of compensation. However, unlike no-

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[153] *See* Studdert & Brennan, *supra* note 151, at 228–29.

[154] Given no-fault's expanded compensation coverage, one major concern is its affordability. Proponents point to cost-savings due to reduced litigation expense as a major benefit, noting that some of those funds could be used to compensate those who would otherwise go without any recovery. *See* Gregg, *supra* note 129, at 332. However, there are concerns regarding a move to a no-fault system, including the potential growth in compensatory payouts because of the sheer number of injuries that occur each year during medical treatment. *See* LAW & POLAN, *supra* note 6, at 152 ("The overwhelming likelihood is that no-fault medical insurance would be astronomically more expensive than malpractice liability insurance."). *But see* Studdert & Brennan, *supra* note 151, at 233 (finding that a no-fault scheme would not cost substantially more than the tort system but would compensate four to six times the number of patients); Weiler, *supra* note 96, at 227 (arguing that it would "add just a tiny fraction to our constantly surging $1.4 trillion health care budget (some part of which is already spent to give the additional care needed by medically injured patients)" (internal citation omitted)).

[155] *See* LAW & POLAN, *supra* note 6, at 155–56 (expressing concern over a lack of deterrence effect under no-fault models); Nevers, *supra* note 124, at 48.

[156] *See* Ken Marcus Gatter, *The Continued Existence and Benefit of Medicine's Autonomous Law in Today's Health Care System*, 24 U. DAYTON L. REV. 215, 254 n.205 (1999).

[157] *See* Gregg, *supra* note 129, at 332.

[158] *See* PA. JOINT STATE GOV'T COMM'N, MEDICAL PROFESSIONAL LIABILITY REFORM FOR THE 21ST CENTURY: A REVIEW OF POLICY OPTIONS, REPORT OF THE ADVISORY COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY 60 (2005).

[159] Another consideration with respect to feasibility of a no-fault system is patient consent and the validity of the forfeiture of patients' future rights in order to recover within the system. *See* Studdert & Brennan, *supra* note 151, at 235.

fault, enterprise liability utilizes the same liability requirements of the negligence-based medical malpractice litigation system, only it restricts liability to hospitals and other health care facilities.[160] At present, "hospitals can be held liable for physician negligence when physicians are held out as hospital employees."[161] Under enterprise liability schemes, hospitals would be "the exclusive bearers of medical liability for all malpractice claims brought by hospitalized patients—regardless of the provider's status as employee, independent contractor, or holder of admitting privileges, and regardless of the site of the provider's malpractice."[162]

Enterprise liability could help ensure that a greater number of patients receive compensation. Yet, because it draws upon the same tort liability standards, its compensation rates may or may not be significantly better than the current system (it simply may change the defendants in malpractice cases). Proponents of enterprise liability argue that one of its significant benefits is that it removes blame from individual doctors, encouraging candor about mistakes. This might help hospitals in internal reviews of errors and lead to improved practices. However, it is unclear what incentive hospitals have to share information about errors with patients.

Like other tort liability approaches, enterprise liability raises concerns that it will favor risk reduction over error reduction in certain instances, only at the institutional level. Harm reduction may not be achieved either, as enterprise liability does little to address emotional healing and may or may not result in more efficient resolution of claims or patient satisfaction with the resolution process. And with questions surrounding hospitals' willingness to disclose information and the potential lack of reduction in medical errors, enterprise liability may produce limited gains in terms of fostering information exchange or enabling restorative opportunities that heal parties and relationships.

D. *Increasing Expertise—Screening Panels & Medical Courts*

Other proponents of reform suggest that medical malpractice issues may be addressed by increasing the level of expertise of those assessing malpractice claims. Two models have been suggested: screening panels and medical courts.

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[160] *See* HEALTH-CARE LAW AND ETHICS 458 (Mark A. Hall et al. eds., 6th ed. 2003).

[161] Kristie Tappan, Note, *Medical-Malpractice Reform: Is Enterprise Liability or No-Fault a Better Reform*, 46 B.C. L. REV. 1095, 1104 (2005).

[162] Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 393 (1994).

Medical screening panels are used to review the merits of a medical malpractice claim before it is filed.[163] They aim to eliminate frivolous claims and encourage settlement of claims with little merit.[164] Thirty-one states have adopted some form of screening panels, but only twenty states still have such systems; in the other states, provisions creating medical screening panels were repealed or invalidated.[165] Thus, in at least certain forms, screening panels have run afoul of constitutional protections.[166] While screening panels may reduce the number of claims that proceed to trial, they do not do anything to ensure all meritorious claims are discovered and brought.[167]

From the patients' perspective, screening panels are yet another hurdle to overcome before relief can be obtained, further frustrating opportunities for compensation. Screening panels do not offer any greater incentive for healthcare providers to encourage error reduction, nor do they address patients' emotional healing needs. Assuming a patient successfully passes the screening panel stage, he or she must still proceed with litigation in order to obtain compensation. As such, screening panels may extend legal battles and prolong suffering. Moreover, screening panels do not provide much relief to healthcare providers, offering little incentive to share information or to create a better environment for learning from medical errors and improving practice.[168] Finally, from the community perspective, panels may result in some cost savings (precisely how much is unclear). As important, however, screening panels do not do anything to restore the community's trust in doctors and hospitals and instead may suggest to the public that there are additional barriers to truth and compensation.

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[163] *See* Gregg, *supra* note 129, at 327. For an example of such a panel, in the form of a tribunal, see MASS. GEN. LAWS ch. 231, § 60B (2000).

[164] Gregg, *supra* note 129, at 327.

[165] Struve, *supra* note 43, at 990.

[166] Panel provisions have been struck down in Florida, Illinois, Missouri, Pennsylvania, and Wyoming. *See* Aldana v. Holub, 381 So. 2d 231, 238 (Fla. 1980) (invalidating panel system because it violated the due process clauses of the U.S. and Florida Constitutions); Bernier v. Burris, 497 N.E.2d 763, 770–71 (Ill. 1986) (invalidating subsequent panel provision on similar grounds); Wright v. Cent. Du Page Hosp. Ass'n, 347 N.E.2d 736, 739–40 (Ill. 1976) (invalidating panel provision because it mixed lay and judicial functions in violation of state constitution); Cardinal Glennon Mem'l Hosp. v. Gaertner, 583 S.W.2d 107, 110 (Mo. 1979) (holding that panel provision violated state constitutional right of access to courts); Mattos v. Thompson, 421 A.2d 190, 196 (Pa. 1980) (struck down panel system because it resulted in such delays as to violate state constitutional right to a jury trial); Hoem v. State, 756 P.2d 780, 783 (Wyo. 1988) (holding that panel provision violated state constitutional guarantee of equal protection).

[167] *See* Struve, *supra* note 43, at 994–95 (discussing the reluctance of many doctors to label the treatment decisions of other doctors as negligent).

[168] Screening panels may give healthcare providers some comfort that they will face fewer frivolous claims. However, as the vast majority of victims of medical error never bring claims, it seems the overall positive impact of screening panels may be minimal, while their potential negative effects could be significant.

More recently, there have been some calls for specialized courts to handle medical claims. The organization Common Good is one of the leading proponents of medical courts, arguing that judges with special expertise will be better positioned to handle medical cases.[169] Potential benefits of medical courts include "expertise, decision making speed, and uniformity and coherence of doctrine."[170] Medical court judges would have greater incentive to develop expertise in the field, and may be better positioned to evaluate the qualifications of "expert" witnesses.[171] One significant concern however, is that, as such specialized courts would be established at the state level, judges may be elected, rather than appointed, and subject to great pressure from special interest groups.[172]

Similar to other reform measures, the medical courts approach offers hope that frivolous cases can be minimized. However, it remains unclear whether such courts will offer a better, more accessible forum for the many injured patients who do not bring claims under the current system.[173] Consequently, medical courts might fall short of realizing the compensation objective of the healing-centered framework. That said, for those patients who successfully litigate claims in medical courts, the expertise of specialized courts offers hope that compensation will more accurately reflect patients' needs.

Medical courts would operate using the same tort law standards as traditional courts, albeit with a higher level of specialized expertise, and thus healthcare providers would still be subject to the same pressures that exist within the traditional medical malpractice litigation scheme. Consequently, many of the same concerns remain—that risk reduction would trump error reduction, harm reduction would not be fully realized, disincentives for information sharing would persist, and restorative opportunities would be lacking.

V. RESTORATIVE JUSTICE LESSONS

One theme that emerges from a review of the current reform measures and alternatives is that each really targets a narrow set of problems.[174] As a

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[169] *See* COMMON GOOD, AN URGENT CALL FOR SPECIALIZED HEALTH COURTS (2005), *available at* http://cgood.org/brochure-hcare.html.

[170] *See* Struve, *supra* note 43, at 998.

[171] *Id.*

[172] *Id.* at 998–99.

[173] Most patients injured by medial error do not even pursue a claim. *See supra* notes 43–47 and accompanying text.

[174] Other alternatives not discussed in detail here have similar shortcomings. For example, experience-rating doctors—an approach that links the doctor's insurance premium to her risk of being sued based on her track record—is premised on the assumption that the majority of negligent acts are attributable to a few "bad" doctors and driven by the phenomenon of doctors leaving certain "high-risk" specialties due to higher insurance premiums. *See* Gregg, *supra* note 129, at 330–31. Experience rating doctors may enable "good" doctors to obtain some relief from high insurance premiums. However, because doctors may be deemed "bad" merely because a medical mistake occurs on their watch, their incentive not to discuss errors increases. Experience rating's "benefit" to patients—that

result, none of them presents a comprehensive answer to the problem of medical error. Rather than look for additional stopgap measures, the medico-legal community (and patients) would be better served by utilizing the healing-centered framework to guide the development of a comprehensive response to medical error. In working to develop a better system, restorative justice offers valuable lessons.

Therefore, this section draws upon the discourse on restorative justice to fashion a new model to address medical errors that meets the objectives of the healing-centered framework and honors the core values of medicine. Restorative justice provides a useful parallel, because it is an alternative model (developed in the criminal justice setting) that seeks healing of all concerned parties including the community.[175] For that reason, it is a useful starting point for developing a solution to the problem of medical error.

A. *A Preliminary Note*

As restorative justice is a criminal justice mechanism, this discussion necessarily draws upon criminal cases, many of which involve violent acts against innocent victims (especially the human rights examples). It is important to acknowledge this fundamental distinction between restorative justice models and medical malpractice claims, which involve civil lawsuits. In the vast majority of cases, the acts committed by doctors are mistakes—typically either genuine accidents or a result of negligence or, on occasion, reckless behavior—and are not purposeful or criminal.[176] In looking to restorative justice, my purpose is to examine whether elements of that model can help guide the medico-legal community toward a solution for the medical malpractice crisis. In no way should my use of restorative justice suggest that errors by doctors in the ordinary course of their professional lives rise to the level of criminal acts. Equally important, in drawing upon restorative justice examples including the South African

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they will be able to identify good and bad doctors—is also suspect, as most patients have limited choice in doctors due to geographic constraints and limitations imposed by health insurance plans. Moreover, if the system encourages doctors not to admit mistakes, patients will be less likely to receive the apologies or information about their treatment necessary for emotional healing to occur.

[175] Tom Porter, *Circles of Conversations: One Trial Lawyer's Journey into Sacred Spaces*, DISP. RESOL. MAG., Apr. 2004, at 7, 8. While this Article focuses on restorative justice's potential contributions to medical malpractice law, there are other legal approaches that emphasize healing, including therapeutic jurisprudence, collaborative law, holistic law, transformative alternative dispute resolution and others. *See, e.g.*, DAVID B. WEXLER & BRUCE J. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE 17–19 (1991); J. Kim Wright & Dolly M. Garlo, *Law as a Healing Profession*, 63 OR. ST. B. BULL. 9, 9 (2003); Susan Daicoff, *Brief Description of the Vectors of the Comprehensive Law Movement and the Points of Intersection* (2000), http://users.law.capital.edu/sdaicoff/vectors1.htm.

[176] In extreme cases, physicians can be tried by the state for criminal acts related to their practice of medicine. Those cases are the exception, not the rule, and are not the focus of the various tort reform efforts of Congress and the states. Accordingly, they are beyond the scope of this Article.

experience, in no way do I intend to minimize the suffering of victims of gross human rights violations or other crimes.[177]

Despite the differences in the underlying acts, I believe that the principles of restorative justice have application in the medical setting. The physician-patient relationship is founded on care, and thus the gap to be bridged in this context is much smaller than the gulf between the perpetrator of violence and victim.[178] Therefore, if restorative justice can be successful in cases of brutal torture and other human rights abuses where reconciliation would seem impossible, then restorative justice principles should have something to offer in the context of a physician-patient relationship damaged by medical error.

B. *Principles of Restorative Justice*

Restorative justice is a method of resolving criminal justice disputes which aims to "repair the harm that a criminal offense inflicts on victims, offenders, and communities."[179] Restorative justice models have been developed as an alternative to the retributive justice model, which defines crime primarily as "an act against the state."[180] Because the retributive justice model sees crime as only a violation of state law, its response is limited to the state punishing the offender. Victims and the community have no real role in this process, other than perhaps testifying at trial or serving on the jury. Governments that rely on the theory of retributive justice do so in part because of their view that such crime control measures will have a deterrent effect.[181] In similar fashion, many proponents of the medical malpractice litigation system argue that the threat of lawsuits puts pressure on hospitals and medical professionals to reduce the occurrence of

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[177] A second key difference is the influence of political concerns. The new South African government's decision to establish a truth commission, rather than to hold criminal trials, was influenced greatly by the political landscape of the day, as well as the fragility of democracy immediately following the country's first free elections. South Africa's Constitutional Court acknowledged this in ruling on a challenge to the amnesty provision of the Truth and Reconciliation Act, pointing to language in the interim Constitution which stated that the "Constitution provides a historic bridge between the past of a deeply divided society characterized by strife, conflict, untold suffering and injustice, and a future founded on the recognition of human rights, democracy and peaceful coexistence." *Azanian Peoples Org. v. President of the Republic of S. Africa* 1996 (4) SA 671 (CC) at 676–77 (S. Afr.). Ultimately, the Court held that the amnesty provision was "specifically authorised for the purposes of effecting a constructive transition towards a democratic order." *Id.* at 691. While medical malpractice reform is highly politicized, pressures on malpractice decisions do not rise to the level of amnesty decisions in emerging democracies. Theoretically, without such pressure, it should be easier in the medical malpractice setting to address the real problems.

[178] The intimacy of a physician-patient relationship may mean that some injured patients feel particularly betrayed or violated; however, I suggest that such feelings, while important, do not present as significant an obstacle as confronting an individual who tortured one's family members.

[179] STRICKLAND, *supra* note 28, at 1. *See also* Carrie J. Niebur Eisnaugle, *An International "Truth Commission": Utilizing Restorative Justice as an Alternative to Retribution*, 36 VAND. J. TRANSNAT'L L. 209, 213 (2003).

[180] Eisnaugle, *supra* note 179, at 213 (citation omitted).

[181] *See id.*

negligent acts. As discussed above, the medical malpractice litigation system's ability to do this has proven inadequate.

In contrast to retributive justice models, restorative justice requires the involvement of all parties—the victim, the offender and the community. Restorative justice has been defined as follows:

> [A] justice that focuse[s] ... on harm and addressing the harm, first to victims, then to the community as a whole, and finally to the offender as well. This justice involve[s] ... accountability, real accountability, where the person who created the harm [is] ... involved with the victims and the community in determining how to address the harm and make things right.[182]

Restorative justice is different in that it brings together individuals who have been affected by a crime with the goal of having them agree on how to address the harm done by the crime.[183]

Described as "a process whereby all the parties with a stake in a particular offense come together to resolve collectively how to deal with the aftermath of the offense and its implications for the future,"[184] restorative justice asks the following: "Who has been hurt? What do they need? Whose obligations and responsibilities are these? Who has a stake in this situation? What is the process that can involve the stakeholders in finding a solution?"[185]

Restorative justice sees crime as a "violation of people and of interpersonal relationships."[186] It encompasses a range of practices and processes which are aimed at empowering victims, offenders, and communities to "redress the material, psychological and relational harms generated by crimes."[187] In this sense, restorative justice is "less about punishing people and more about achieving a presumed relational

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[182] Porter, *supra* note 175, at 8. *See also* Mary Ellen Reimund, *The Law and Restorative Justice: Friend or Foe? A Systematic Look at the Legal Issues in Restorative Justice*, 53 DRAKE L. REV. 667, 670 (2005) (discussing principles and definitions of restorative justice).

[183] *See* John Braithwaite, *A Future Where Punishment Is Marginalized: Realistic or Utopian?*, 46 UCLA L. REV. 1727, 1743–44 (1999).

[184] Lode Walgrave, *Restoration in Youth Justice*, *in* 31 YOUTH CRIME AND YOUTH JUSTICE: COMPARATIVE AND CROSS NATIONAL PERSPECTIVES 543, 552 (2004) (citations and internal quotation marks omitted).

[185] HOWARD ZEHR, THE LITTLE BOOK OF RESTORATIVE JUSTICE 63 (2002).

[186] *Id.* at 19.

[187] GEORGE PAVLICH, GOVERNING PARADOXES OF RESTORATIVE JUSTICE 2 (2005).

equilibrium."[188] That said, restoring relationships does not necessarily mean complete elimination of punishment for the offender.[189]

Restorative justice models may include programs that provide restorative processes, restorative outcomes, or both.[190] Many different methods fall under the rubric of restorative justice, including victim-offender mediation, victim-offender panels, victim and community impact statements, family or community group counseling, and truth and reconciliation commissions.[191] They offer a range of benefits that are worth exploring in the context of developing medical malpractice reform.

C. *Benefits of a Restorative Model*

The holistic nature of restorative justice offers a number of potential benefits for victims, offenders and the community, as compared to the traditional retributive justice model.[192]

1. *Providing for Victims*

Strang and Sherman identify five elements that victims of crimes want the criminal justice system to provide: information; an opportunity to participate; emotional restoration and apology; material reparation; and fairness and respect.[193] These benefits for victims, and others provided to offenders and the community, parallel much of what the healing-centered framework aims to provide in the health care context.

Information. Victims report that one of the greatest sources of frustration is not being able to get information about what is happening or has happened to their cases.[194] Restorative justice provides an opportunity

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[188] *Id.* at 29.

[189] *See, e.g.*, Stephen P. Garvey, *Restorative Justice, Punishment, and Atonement*, 2003 UTAH L. REV. 303, 303 (2003) ("[R]estorative justice does not, despite what its proponents say, really insist on the total elimination of punishment.").

[190] Examples of programs offering restorative processes include victim offender mediation/reconciliation, family group conferences, victim-offender panels, sentencing circles, and community crime prevention; whereas programs that provide restorative outcomes include restitution, community service, victim support services, victim compensation programs, and rehabilitation programs for offenders. Daniel W. Van Ness & Pat Nolan, *Legislating for Restorative Justice*, 10 REGENT U. L. REV. 53, 54 (1998).

[191] *See* STRICKLAND, *supra* note 28, at 9–12.

[192] Restorative justice models are not free of challenges; they do not always achieve full success. For example, in a minority of cases, victims report feeling upset by something that the offender said in group conferences. JOHN BRAITHWAITE, RESTORATIVE JUSTICE & RESPONSIVE REGULATION 49 (2002). While understanding the reasons behind less successful restorative processes is important, I look to restorative justice to draw upon its principles. As such, in-depth analysis of the shortcomings of each of the myriad of different restorative justice options is beyond the scope of this Article. For more on the limitations of restorative justice, see, for example, DECLAN ROCHE, ACCOUNTABILITY IN RESTORATIVE JUSTICE 12–18, 33–41 (2003); Andrew von Hirsch et al., *Specifying Aims and Limits for Restorative Justice: A 'Making Amends' Model?*, *in* RESTORATIVE JUSTICE AND CRIMINAL JUSTICE: COMPETING OR RECONCILABLE PARADIGMS? 21, 21–24, 31–38 (Andrew Von Hirsh et al. eds., 2003).

[193] Heather Strang & Lawrence W. Sherman, *Repairing the Harm: Victims and Restorative Justice*, 2003 UTAH L. REV. 15, 20–25.

[194] *Id.* at 20.

for dialogue so that the victim has access to the information he/she wants or needs as part of the process of coming to terms with what has occurred.

Similarly, in the medical error context, lack of information is also frequently one of the primary sources of frustration for patients, leading many to instigate legal actions as a means of uncovering information.[195] An approach that maintains an open dialogue—fostering information exchange between physicians and patients—would help ensure that patients receive the information they need without having to resort to litigation.

Participation. Research on victims' views reveals that many victims report frustration at having no voice in criminal law proceedings and no opportunity to participate.[196] Heather Strang explains that "the formality of the justice system, where victims have no opportunity for input beyond their role as prosecution witnesses—and not even that in those cases where the defendant pleads guilty—is a source of frustration and anger for many victims."[197] Lack of a meaningful role, or any role at all, leaves victims feeling powerless and without control over their own cases.[198] As the majority of cases result in plea bargains in the traditional criminal justice model victims may never have an opportunity to confront their offenders at trial, often an important step in understanding and coming to terms with their experience.[199] When victims have a forum to express their views and feel that their desires are not ignored, they express greater satisfaction with the criminal justice system.[200] Restorative justice models create a forum for meaningful participation by victims.[201]

In the medical malpractice context, similar concerns exist for injured patients. "Frequently, in the context of modern medical facilities, the patient's voice is muted, if not lost, and the patient's ability to vindicate his

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[195] *See supra* notes 77–78 and accompanying text. Patients often resort to litigation, in the words of Nancy Berlinger, as an "act of detection" because they cannot obtain information from their doctors. Center for Alternative Dispute Resolution, Honolulu, HI, *Resolving Complex Health Disputes*, ADR TIMES, Spring 2005, at 6, *available at* http://www.courts.state.hi.us/attachment/2E4E92A19A3C8A30EDCB95EB0F/Spring2005.pdf (quoting Nancy Berlinger).

[196] *See, e.g.*, HEATHER STRANG, REPAIR OR REVENGE: VICTIMS AND RESTORATIVE JUSTICE 8–10 (2002).

[197] *Id.* at 10.

[198] STRICKLAND, *supra* note 28, at 38.

[199] *Id.*

[200] STRANG, *supra* note 196, at 10.

[201] *See, e.g.*, Allison Morris & Gabrielle Maxwell, *Restorative Conferencing, in* RESTORATIVE COMMUNITY JUSTICE: REPAIRING HARM AND TRANSFORMING COMMUNITIES 173, 175 (Gordon Bazemore & Maria Schiff eds., 2001) ("Restorative conferencing, then, gives the state a diminished role and locates crime—and responses to it—with these 'communities of care.'"). Morris and Maxwell note restorative conferencing's emphasis not just on bringing victim and offender together, but also on ensuring both participate meaningfully in the meeting. *Id.* at 179 ("The key issue is not simply presence at a meeting, but inclusion in that meeting.").

or her interests is overpowered."[202] Being ill or injured is very disempowering.[203] Patients who have lived independently for decades suddenly must rely on doctors or nurses to assist them with life's most basic tasks. When a course of treatment fails to work as anticipated, patients are even more disillusioned. Providing a process in which patients can regain some sense of personal empowerment can help address these concerns.

Emotional restoration and apology. Research reveals that most victims of crimes do not want to seek vengeance.[204] Some feel anger and initially want vengeance, but most do not.[205] Perhaps even more remarkable is that similar sentiments are expressed in the truth and reconciliation context, following commission of some of the most heinous crimes. Confronting the atrocities committed by the apartheid government in South Africa and brutal regimes in other countries, many victims and family members emphasize foremost the importance of knowing what happened to their loved ones.[206] These findings suggest that victims want the emotional aspects of their suffering addressed, and not merely punishment of the offender.

The criminal justice system has often ignored emotional and psychological aspects of the loss suffered by victims.[207] Victimology literature says little about victims' need or desire for apologies from offenders.[208] Restorative justice aims to incorporate these dimensions into the criminal justice process to provide full healing for victims. Expressions of remorse and sincere apologies can help alleviate the victim's suffering.[209]

Restorative justice models make the apology a key component of the victim-offender dialogue.[210] In Japan, apologies have long been a part of the criminal justice system.[211] Hiroshi Wagatsuma and Arthur Rosett report that the apology can serve three functions: (1) it demonstrates that

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[202] DUBLER & LIEBMAN, *supra* note 140, at 11.

[203] *See id.* ("The physical and emotional stress of serious illness also contributes to an uneven playing field.").

[204] Strang & Sherman, *supra* note 193, at 18.

[205] *Id.*

[206] *See* JEFFREY SARKIN, CARROTS AND STICKS: THE TRC AND THE SOUTH AFRICAN AMNESTY PROCESS 7 (2004) (noting that 76% of black South Africans "strongly or moderately approved of the work of the TRC" which placed a premium on truth and granted amnesty to some perpetrators in return); *see also* BRANDON HAMBER ET AL., CTR. FOR THE STUDY OF VIOLENCE AND RECONCILIATION & KHULUMANI SUPPORT GROUP, SURVIVORS' PERCEPTIONS OF THE TRUTH AND RECONCILIATION COMMISSION AND SUGGESTIONS FOR THE FINAL REPORT (1998), http://www.csvr.org.za/papers/papkhul.htm. *See generally* MARTHA MINOW, BETWEEN VENGEANCE AND FORGIVENESS: FACING HISTORY AFTER GENOCIDE AND MASS VIOLENCE (1998).

[207] Strang & Sherman, *supra* note 193, at 22.

[208] *Id.*

[209] *See* ROCHE, *supra* note 192, at 9.

[210] Elizabeth Latif, *Apologetic Justice: Evaluating Apologies Tailored Toward Legal Solutions*, 81 B.U. L. REV. 289, 291 (2001).

[211] *Id.* at 298.

the offender feels remorse, (2) it shows the intent of the offender to compensate the victim, and (3) if the apology is accepted, it helps restore harmony between the victim and offender.[212] Closer to home, a study of programs in Indiana found that victims appreciated "the expression of remorse on the part of the offender" and offenders valued the opportunity to "mak[e] things right."[213] In other research, victims reported that the mediation process, which included an apology by the perpetrator, offered "a chance for healing; a chance for information sharing; a chance for building relationships instead of destroying them[.]"[214]

Certainly the value of building instead of destroying relationships is at least equally important to individuals in the physician-patient context. At a time when apologies are becoming a growing part of public discourse related to gross human rights violations, there remains significant reluctance simply to say "I'm sorry" in the context of medical mistake.[215] How is it that truth and reconciliation commissions can enable apologies in the context of torture, killings, and other crimes against humanity, but doctors, who are already engaged in a care relationship, remain hesitant to connect on a human level by apologizing to patients?

One reason, as discussed above, is that doctors have been taught that an apology suggests an admission of responsibility, a step which does not make for good results in litigation. A number of states have recognized the value of apologies and amended their rules of evidence to exempt statements or gestures expressing sympathy or a sense of benevolence from being admitted as an admission of guilt by a party in a civil suit.[216] However, in numerous jurisdictions, apologies are still viewed as suggesting an admission of responsibility. Unfortunately, the lack of an apology deprives the injured patient of an important element in the healing process. Failure to apologize is often viewed by patients as an inability to empathize with the patient's plight. It leaves the patient without any

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[212] *See* Hiroshi Wagatsuma & Arthur Rosett, *The Implications of Apology: Law and Culture in Japan and the United States*, 20 LAW & SOC'Y REV. 461, 469, 472, 477 (1986).

[213] MARK S. UMBREIT, VICTIM MEETS OFFENDER: THE IMPACT OF RESTORATIVE JUSTICE AND MEDIATION 17–19 (1994) (reporting the findings of a study in Indiana by Robert Coates and John Gehm).

[214] Latif, *supra* note 210, at 294 (quoting Umbreit, *supra* note 213, at 95).

[215] *See id.* at 289–90 (discussing apologies as being an "international method of restitution"); *see also* LAZARE, *supra* note 74, at 5–8 (finding a rise in public apologies in recent years).

[216] *See, e.g.*, MASS. GEN. LAWS ch. 233, § 23D (2000) (rendering inadmissible "[s]tatements, writings or benevolent gestures expressing sympathy or a general sense of benevolence . . . as evidence of an admission of liability in a civil action"); TEX. CIV. PRAC. & REM. CODE ANN. § 18.061(a)(1) (Vernon Supp. 2005) (rendering inadmissible "a communication that . . . expresses sympathy or a general sense of benevolence relating to the pain, suffering, or death of an individual involved in an accident"); Assembly 2804, 1999 Reg. Sess. (Cal. 2000) (same). *See supra* note 80 for a list of other states that provide exceptions for apologies in the medical error context.

feeling of caring from the one individual who is supposed to care—one's doctor.[217]

Material reparation. Victims of crime suffer bodily injuries as well as economic loss. Compensation remains an important element in ensuring the full healing of victims. Restorative justice utilizes two approaches—compensation funds and restitution.[218] Victim compensation funds typically are established by governments to cover medical expenses incurred by victims due to injuries suffered, as well as losses in earnings for missed work while recuperating.[219] Restitution requires offenders to pay money to victims to cover losses suffered as a result of the crimes and is more common in property crimes.[220] Contrary perhaps to popular belief, material reparation is not necessarily the most important component; victims who participate in restorative processes still report high levels of satisfaction even when compensation is relatively small.[221]

In the medical error context, patients have suffered injuries as a result of substandard care. Medical bills for subsequent care can be very high, and lost wages and other costs can be substantial. As a result, material compensation is, and must continue to be, an important part of any resolution of medical malpractice disputes, but it must not be the only step.

Fairness and respect. Finally, research reveals that the primary factor influencing victims' satisfaction with the justice system is their sense of fairness of the process, rather than the specific outcome.[222] Victims most want a voice in the process and an opportunity to be heard but do not expect that they will have control over the outcome.[223]

In the medical malpractice context, patients typically do not sue doctors when they feel their doctors have been honest, have treated them with respect, and have tried to achieve the best possible outcome for them. Conversely, feeling wronged often leads patients to sue doctors in the hopes of achieving some sense of fairness.

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[217] Having an opportunity to apologize is also important in the healing process of offenders in the criminal context and healthcare providers in medical malpractice cases.

[218] STRICKLAND, *supra* note 28, at 48.

[219] *Id.*

[220] *Id.* at 49.

[221] *See* BRAITHWAITE, *supra* note 192, at 52–53.

[222] Strang & Sherman, *supra* note 193, at 24. *See also* E. ALLEN LIND & TOM R. TYLER, THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE (1988); Hollander-Blumoff & Brodie, *supra* note 30, at 1390; Lawrence B. Solum, *Procedural Justice*, 76–77 (Univ. of San Diego Sch. of Law, Pub. Law & Legal Theory Research Paper Series, No. 2, 2004), *available at* http://law.bepress.com/cgi/view content.cgi?article=1001&context=sandiegolwps.

[223] Strang & Sherman, *supra* note 193, at 24; Tom R. Tyler, *What Is Procedural Justice?: Criteria Used By Citizens To Assess the Fairness of Legal Procedures*, 22 LAW & SOC'Y REV. 103, 125–27 (1988).

2. *Positive Outcomes for Offenders*

The aim of restorative justice is to provide healing for the offender and community, as well as the victim. As a result, restorative justice focuses on "reestablishing the integrated community, rather than exacting retribution for crimes,"[224] and "promoting reconciliation and peace between and among the affected parties is more important than vengeance."[225] In a medical care setting, a process that promotes peace and reconciliation would fit better than one driven by vengeance.

For perpetrators of crimes, the restorative justice model differs from the retributive justice model in one very significant way: "[b]efore any restorative justice process can begin, offenders must take responsibility for their offenses and admit guilt. In an adversarial process, determining guilt is the chief goal."[226] The traditional criminal justice model provides incentives for the defendant not to admit anything, unless a plea bargain is offered. By having offenders accept responsibility at the outset, restorative justice can focus on what offenders can do to make things right with the victim and community.[227]

Restorative justice offers several potential benefits to offenders. In some cases, offenders can avoid a criminal record and its corollary punishments, such as voting and social services benefits restrictions, by completing a restorative justice program. Restorative justice may also enable offenders to make amends to victims, alleviating some of the guilt they feel about the harm they inflicted.[228] Offenders in Germany, for example, reported that they appreciated the opportunity to "explain their own behavior, apologize, ease the conscience and reduce feelings of guilt."[229] One individual stated "that it was important for him to be able to say he was sorry and to agree to do some restitution for the victim."[230]

Many of these issues arise with doctors accused of medical malpractice. In a traditional medical malpractice litigation scheme, the focus is on proving the doctors' liability. By having physicians accept responsibility at the outset for their actions, a restorative model can shift

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[224] STRICKLAND, *supra* note 28, at 19.

[225] *Id.* at 20.

[226] *Id.* at 21. *See also* PAVLICH, *supra* note 187, at 68.

[227] *See* PAVLICH, *supra* note 187, at 68.

[228] Strang & Sherman, *supra* note 193, at 37. *See also* PAVLICH, *supra* note 187, at 70 (noting offenders "often feel profound remorse for their behaviour and so experience a need to be held accountable and to make things right").

[229] Lutz Netzig & Thomas Trenczek, *Restorative Justice as Participation: Theory, Law, Experience and Research*, *in* RESTORATIVE JUSTICE: INTERNATIONAL PERSPECTIVES, *supra* note 180, at 241, 253–56.

[230] Caren L. Flaten, *Victim-Offender Mediation: Application with Serious Offenses Committed by Juveniles*, *in* RESTORATIVE JUSTICE: INTERNATIONAL PERSPECTIVES, *supra* note 180, at 387, 397–98.

the focus to making things right for the patient, doctor, and community.[231] Using a process built on restorative principles, one could envision doctors starting by being open about the choices they made, so that injured patients can better understand what happened and medical professionals can review and determine how the injury occurred and what can be done differently in the future to avoid injuring other patients.[232] This would also provide opportunities for doctors' healing in a way that does not exist under the current medical malpractice litigation system.

3. *Positive Outcomes for Communities*

The third important stakeholder in restorative justice models is the community. The boundaries or definitions of "community" are not always clear and may differ depending on the offender and victim. However, generally speaking, community most frequently refers to a group of people that share a defined geographical place.[233] Frequently, the community is not defined until the crime has been committed and it is possible to determine who is affected by the harm.[234]

In the medical care setting, the community is fairly broad. Foremost, it would include the people living in the geographic area served by the hospital or health care facility where the medical error occurred. However, given that advances in medical care can benefit populations far from the places where they occur, the community which is harmed by failures to address medical errors properly, or could benefit from a restorative approach to medical error, is potentially very large. Once community is defined, restorative justice models seek to ensure that the community plays an important role in the process. Their involvement offers several potential benefits.

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[231] *See* PAVLICH, *supra* note 187, at 68.

[232] In fact, some hospitals have adopted policies whereby they disclose errors to patients and, in some cases, offer some compensation. These "early offer" approaches have been successful in reducing the number of lawsuits filed against those facilities and the average settlement amount per claim. See, for example, the experience of the Veterans Affairs Medical Center, Lexington, Kentucky. Steve S. Kraman et al., *John M. Eisenberg Patient Safety Awards Advocacy: The Lexington Veterans Affairs Medical Center*, 28 JT. COMM. J. QUAL. IMPROV. 646 (2002). *See also* NANCY BERLINGER, AFTER HARM: MEDICAL ERROR AND THE ETHICS OF FORGIVENESS 70 (2005) ("As of 2000, Lexington was averaging $15,000 per settlement, compared with $98,000 for all VA hospitals."); Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1447–63 (2000); HARVARD HOSPITALS STATEMENT, *supra* note 4, at 6 ("Prompt, compassionate and honest communication with the patient and family following an incident is essential."). For another "early offer" model, see Jeffrey O'Connell & Evan Stephenson, *Binding Statutory Early Offers by Defendants, Not Plaintiffs, in Personal Injury Suits*, 54 DEPAUL L. REV. 233, 233 (2005) (proposing model whereby defendants can make "early offer" to pay plaintiffs net economic costs losses as they accrue, and plaintiffs can proceed to trial only by rejecting the offer, after which they would have to prove defendant's conduct grossly negligent beyond a reasonable doubt).

[233] *See* PAVLICH, *supra* note 187, at 86; STRICKLAND, *supra* note 28, at 87 (noting it may also refer to a particular ethnic community).

[234] *See* STRICKLAND, *supra* note 28, at 87.

First, whereas in the traditional criminal justice model the community is represented by the state, in the restorative justice model the community itself plays a more active role.[235] Restorative justice proponents believe that the offender's community has the greatest influence over the offender, and thus must be brought into the process in order to provide the best hope of convincing the offender to try to repair the harm inflicted on the victim and refrain from future criminal acts.[236] In this regard, community in the healthcare context incorporates two important populations—the professional medical community and the general public. Involving the medical community in a way that advances learning, instead of limiting the medical community's role to expert witness testimonials, should create better opportunities for helping doctors repair the harm caused to patients and for avoiding future errors. Involving the general public in efforts to improve care offers the hope of giving the public a greater voice in policies affecting their communities.

Second, restorative justice proponents suggest that when a community is negatively affected by a crime, it needs the opportunity to address the crime and the issues it raises in the community. In a similar fashion, substandard care at a medical facility has an impact on the community in which that hospital is situated, because if it goes unremedied, all members of the community are at risk of being injured in the future. Accordingly, community involvement in redressing medical errors will help to restore the trust between doctors and the communities they serve.

Third, community empowerment is another important potential benefit of restorative justice models.[237] Having greater input in forging remedies for crimes gives the community a stake in the problem-solving process. Finally, for the community, restorative justice means "restoring a sense of peace and harmony or the feeling that justice has been served."[238] Restoring a sense of peace and harmony in communities where members of the community have suffered injuries as a result of substandard medical care is also crucial.

D. *Truth and Reconciliation Commissions—The South African Example*

In the past decade, new governments have turned with increasing frequency to truth commissions as a means to address grave wrongs committed by prior regimes and to facilitate community healing. A truth commission is an official, non-judicial body established by a government with the mandate of investigating and documenting human rights

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[235] *Id.* at 90.
[236] *Id.*
[237] *See id.* at 96.
[238] *Id.* at 104.

violations of prior regimes, and recommending procedures to help prevent future human rights violations.[239] Professor Okechukwu Oko explains "a truth commission seeks to accomplish any or all of the following objectives: to clarify and acknowledge the truth; to respond to specific needs of victims; to contribute to justice and accountability; to outline institutional responsibility and recommend reforms; and to promote reconciliation and reduce conflict over the past."[240]

The most notable recent example, the Truth and Reconciliation Commission of South Africa, offers valuable insight into truth commissions.[241] In the early 1990s, as the world welcomed the end of apartheid and South Africa's achievement of a free society, the country faced the difficult question of how to deal with the apartheid legacy and the terrible crimes committed against innocent civilians during the apartheid era. The new government wanted to provide a full accounting of the atrocities that occurred under the old regime, justice for victims and their family members, and punishment for the apartheid leaders.[242] Many African National Congress leaders maintained that South Africa could not fully heal itself until the perpetrators of apartheid's crimes admitted that, despite what they believed at the time, they had come to realize that they were wrong.[243] Not surprisingly, former leaders, police, and security officials wanted full amnesty.[244]

Establishing respect for human rights and the rule of law is an important task for any new government, and victims and their families deserved some form of justice. South Africa thus could have elected to seek punishment for perpetrators of such crimes in order to send a clear message that these brutal acts cannot be tolerated under any circumstances. However, trials for crimes against humanity threatened to divide rather than unite the country. In addition, given the secretive nature of the apartheid regime, practical concerns existed that the new government might not be able to uncover evidence necessary to convict the perpetrators of these crimes. An adversarial approach would have ensured that members of the apartheid government and its police force would have no incentive to offer evidence. Thus, the new South African government faced the prospect of pursuing, but possibly failing to obtain, criminal

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[239] Okechukwu Oko, *Confronting Transgressions of Prior Military Regimes: Towards a More Pragmatic Approach*, 11 CARDOZO J. INT'L & COMP. L. 89, 138 (2003). *See also* PRISCILLA B. HAYNER, UNSPEAKABLE TRUTHS: CONFRONTING STATE TERROR AND ATROCITY (2001); Ruti Teitel, *Transitional Justice Genealogy*, 16 HARV. HUM. RTS. J. 69, 78 (2003).

[240] Oko, *supra* note 239, at 138.

[241] *See id.* (noting that truth commissions have also been adopted in El Salvador, Guatemala, Somalia, the Former Yugoslavia, and Rwanda).

[242] Gwen K. Young, *All the Truth and as Much Justice as Possible*, 9 U.C. DAVIS. J. INT'L L. & POL'Y 209, 222–23 (2003).

[243] PATTI WALDMEIR, ANATOMY OF A MIRACLE: THE END OF APARTHEID AND THE BIRTH OF THE NEW SOUTH AFRICA 277 (1997).

[244] Young, *supra* note 242, at 223.

convictions of apartheid's worst perpetrators of human rights violations. Would such an approach have been in the interest of the country? Would it have been in the interests of victims' relatives, many of whom had waited years, and even decades, to find out what happened to their loved ones? Ultimately, South Africa answered both questions in the negative. Therefore, rather than create a criminal court to prosecute apartheid's worst offenders, South Africa established the Truth and Reconciliation Commission (TRC).[245]

The TRC had three separate sections, the most widely publicized being the Amnesty Commission, which offered the possibility of amnesty to applicants who disclosed fully and truthfully the details of their crimes, provided that they had been committed in furtherance of a political purpose.[246] The results of the TRC were not without controversy or critics.[247] For example, some argued that "truth" came at the expense of "justice."[248] However, the TRC achieved a number of important objectives relevant to this discussion.

The TRC provided victims the opportunity to confront their abusers, offered offenders the possibility of amnesty if they acknowledged their crimes, and aimed to shed light on apartheid's secrets and establish the truth for all people to know.[249] Perhaps most important, after decades in which the truth about apartheid's ruthless human rights abuses were deliberately kept from the public, the TRC offered victims the opportunity to have "their day in court," to tell the true story about what happened to them or their family members. Victims were able to speak freely without the limitations that would be imposed by court proceedings, and without being subjected to cross-examination.[250] The TRC proceedings also

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[245] *See, e.g.*, Ellen A. Waldman, *Healing Hearts or Righting Wrongs?: A Meditation on the Goals of "Restorative Justice,"* 25 HAMLINE J. PUB. L. & POL'Y 355, 356 (2004).

[246] *See* Penelope E. Andrews, *Reparations for Apartheid's Victims: The Path to Reconciliation?*, 53 DEPAUL L. REV. 1155, 1164–65 (2004). Professor Andrews explains:

> The TRC included, as part of its project, three committees: the Committee on Human Rights Violations, which designated victim status to applicants; and the Amnesty Committee, which granted amnesty to applicants who disclosed fully the details of their acts that must have been committed to further a political purpose. The third committee was the Reparations Committee, which was mandated to explore methods and mechanisms for reparations and to advise the government as to appropriate steps to be taken to compensate victims.

Id. See also Albie Sachs, *Truth and Reconciliation*, 52 SMU L. REV. 1563, 1568–69 (1999).

[247] *See, e.g.*, Eisnaugle, *supra* note 179, at 234–35 (citing lack of direct victim-offender dialogue and minimal resources for reparations as problems); Brandon Hamber & Richard A. Wilson, *Symbolic Closure Through Memory, Reparation and Revenge in Post-Conflict Societies*, 1 J. HUM. RTS. 35, 35 (2002) (suggesting that calls for reconciliation may demand too much, too soon from survivors).

[248] For a critique of truth commissions generally, see, for example, TRUTH V. JUSTICE: THE MORALITY OF TRUTH COMMISSIONS (Robert I. Rotberg & Dennis Thompson eds., 2000).

[249] Waldman, *supra* note 245, at 356–57; Peter Storey, *A Different Kind of Justice: Truth and Reconciliation in South Africa*, 114 CHRISTIAN CENTURY 788, 789–93 (1997).

[250] *See* Andrews, *supra* note 246, at 1162.

eliminated technical legal rules and restrictions, such as hearsay rules in evidence.[251] This forum facilitated long awaited healing for many victims and their family members.

In addition, victims and family members of deceased victims were able to seek compensation with the Reparations Committee. Although the limited funds of the Reparations Committee created concerns, victims' requests were "remarkably modest."[252] As Peter Storey reported: "Most of all, the bereaved want[ed] the return and proper burial of their relatives' remains, or a memorial in their village, or a small scholarship for orphaned children. All agree[d] that the most important thing is to know the truth."[253]

The amnesty component of the TRC, while controversial, did not mean impunity for offenders. Victims and family members, as well as offenders themselves, came to see that "even with amnesty, their tormentors are judged—that there is a difference between impunity, implying escape from accountability, and amnesty, which carries profound inward and social consequences."[254]

The TRC also enabled broader community participation in the proceedings. TRC hearings were held around the country, including in rural community centers.[255] It allowed for a greater sense of participation than a single centrally-located commission would have. The TRC also helped the new South Africa set an example for its own citizens and the world that a healing, restorative approach can repair harms and create a better future.

In opting for a restorative, rather than retributive, model, South Africa demonstrated that healing is possible even under the most difficult circumstances. In setting the example, South Africa challenges others countries to forge new systems that provide healing and restoration in other contexts. Health care, which is built on care relationships, would seem to be a natural place to start.

VI. DEVELOPING A RESTORATIVE MEDICAL ERROR RESOLUTION (R-MER) MODEL

As we have seen, one of the most problematic aspects of using an adversarial approach in health care is that it immediately pits the injured patient against the doctors, nurses and hospital, regardless of whether the injury was preventable, the result of individual or systems errors, or just a bad outcome with no error involved. Overnight, the caregiver becomes the enemy. As with any legal proceeding, the parties are prohibited from

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[251] *Id.*
[252] Storey, *supra* note 249, at 790.
[253] *Id.* at 790–91.
[254] *Id.* at 793.
[255] *Id.* at 788–89.

communicating directly; instead, communication occurs only through counsel. Patients suddenly find themselves searching for a new source of medical care at the precise time when care is needed most. Consequently, they are left struggling to recover from or adapt to injuries while having to establish new care relationships. Patients must face these difficult situations, often without any explanation from their doctors or hospitals, and must brace themselves for a legal battle that could go on for years.

Concurrently, doctors lack a forum that fosters optimal conditions for discussing medical errors and learning from mistakes.[256] As a result, they miss opportunities to learn and improve their skills. They are also prevented from expressing empathy toward and continuing to care for their injured patient. Additionally, they must practice under the constant threat of litigation and rising insurance premiums, with little or no opportunity to go through their own healing process after errors are made. Finally, the current environment fails to foster trust and falls short of ensuring the best possible care in the future for the community. I submit that a restorative approach will produce better results, bringing us closer to fulfilling the objectives of the healing-centered framework.

The central component of an R-MER system would be participatory forums in which both patients and healthcare providers would have the opportunity for open dialogue with each other, in order to gain a better understanding of what happened and what each individual wants and/or needs going forward. The process of determining what went wrong would include third-party participation to ensure impartial review of cases and address some of the inherent power imbalances between patients and healthcare providers, but the third-party participants would not sit in judgment. In addition to facilitating healing for the patient and healthcare providers involved in a specific case, the R-MER forum would include in its processes the additional component of developing recommendations for

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[256] Hospitals use morbidity and mortality (M&M) conferences as their primary forum for physicians to discuss poor clinical outcomes, but many question the value of M&M conferences. *See* Laura Lin & Bryan A. Liang, *Reforming Residency: Modernizing Resident Education and Training to Promote Quality and Safety in Healthcare*, 38 J. HEALTH L. 203, 220 (2005) ("The presence of many senior faculty members at these conferences who adhere to the traditional, individually oriented, shame-and-blame approach may discourage open discussion among residents of the possible errors and/or systems issues that could have resulted in the bad outcome. In these environments, medical errors remain hidden by medical residents, and the disincentives and cultural aversion to discussing medical errors are strongly solidified.") (internal citations omitted)); Edgar Pierluissi et al., *Discussion of Medical Errors in Morbidity and Mortality Conferences*, 290 J. AM. MED. ASS'N 2838, 2838 (2003) (reporting research findings raising doubts "whether adverse events and errors are routinely discussed in internal medicine training programs"); Danielle Ofri, *M&M*, 23 MO. REV. 37 (2000). *But see* GAWANDE, *supra* note 83, at 62 ("[T]he M & M is an impressively sophisticated and human institution. Unlike the courts or the media, it recognizes that human error is generally not something that can be deterred by punishment."). Gawande concedes, however, that M&M conferences do not necessarily optimize learning in all cases. *Id.* at 64.

changes in a particular doctor's or hospital's practices or more generally in standards of care, as well as a follow-up monitoring mechanism to ensure that changes have been implemented and practices are improving.[257] These foundational elements must be a part of any R-MER system. Beyond that, just as a range of restorative justice models exist, specific R-MER models could evolve in a variety of ways (one model is offered below).

A. *Advantages of R-MER*

A medical malpractice liability system that has the best hope of providing healing for all parties will: (1) provide compensation; (2) promote safety; (3) reduce harm; (4) foster information exchange; and (5) offer restorative opportunities for all. With respect to these goals, the R-MER approach offers more hope than the current medical malpractice litigation system.

First, the majority of victims receive nothing through the litigation system while others wait years for any compensation.[258] An R-MER model would require a shift away from protracted liability disputes toward collaborative identification of "error" cases and determinations of appropriate compensation.[259] The opportunity for open dialogue in an R-MER system would improve procedures for identifying under-performing medical professionals and facilities, with a view to improving practices and systems rather than apportioning blame and punishment. R-MER models could be funded through insurance, compensation funds, or some combination of means (compensation issues are discussed in more detail below).

Second, the current system provides more incentive for risk reduction than error reduction.[260] The R-MER model would employ restorative processes to ensure a dialogue that leads to identification of errors and development of appropriate measures to prevent recurrence of such errors. The current system leads doctors and hospitals to settle "bad outcome" cases without any admission of fault, thus frustrating learning and opportunities for improving standards of care.[261] The R-MER approach requires a shift away from assigning blame for poor clinical outcomes

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[257] By including patients in this aspect of the process, they may achieve a greater sense of satisfaction knowing that, while they suffered an injury, they helped develop recommendations for protecting patients in the future.

[258] *See supra* notes 43–51 and accompanying text.

[259] Even in "bad outcome" cases, where there was no error and thus no monetary compensation is paid, there is still value for patients and healthcare providers to participate in an R-MER forum, in order to better understand the situation and address issues that can facilitate emotional healing.

[260] *See supra* notes 70–73 and accompanying text. Measures that reduce risk can reduce error in certain instances, but a focus on risk management rather than error reduction will not necessarily lead to improvements in care and, in fact, may increase the risk of error in certain cases.

[261] Learning does occur in some cases under the current system, however an unwillingness to admit mistakes means opportunities for learning are missed and care is not optimized.

toward an acceptance of responsibility on the part of healthcare providers, enabling opportunities for improvements in safety.

Third, medical malpractice lawsuits contribute to doctors' and hospitals' reluctance to apologize, discuss mistakes, or accept responsibility.[262] Moreover, litigation often extends for years, prolonging the suffering of patients (and healthcare providers) and delaying adoption of policies that would avoid future harms to the community.[263] The R-MER approach would allow medical professionals to empathize more openly with patients, provide apologies, and attend to the emotional needs of patients (and facilitate their own healing).[264] In addition, the focus of R-MER proceedings would be on acknowledging the harm, discussing the causes, and developing a plan for remedial action. Done collaboratively, this process could be far more efficient than going through years of discovery, trials, and appeals, and it would provide all parties with a greater sense of procedural fairness.

Fourth, the R-MER model provides an environment in which doctors and hospitals can discuss errors more openly, learn from these mistakes, and improve standards of care.[265] Physician-to-physician dialogue must be truly open to optimize learning. Physician-patient information exchange is vital, especially given that many patients who experience an adverse event during treatment will seek out a new physician and thus will need complete details regarding their conditions and care for their new doctor. Information exchange would also eliminate the many claims that are filed just to compel the hospital or doctors to disclose information about the patient's case, which would reduce costs imposed on the system as well as the incidence of doctors being wrongly "punished" by having meritless lawsuits filed against them. Also, physician-patient information exchange is important to ensure that doctors provide the best care; patients and families hold information vital to care (ranging from medical histories to

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[262] *See, e.g.*, Liz Kowalcyzk, *Hospitals Study When to Apologize to Patients*, BOSTON GLOBE, July 24, 2005, at A1, *available at* LEXIS, News Library, BGLOBE File ("Doctors worry that if they talk to the patient, they're more likely to be sued.").

[263] *See supra* note 49 and accompanying text.

[264] It is important to provide training to medical professionals, so that they are well-equipped to address the emotional needs of patients. *See* Liebman & Hyman, *supra* note 79, at 24 (noting that physicians' experience in delivering bad news and discussing difficult treatment choices may be relevant but that other skills—such as active listening skills—might need further development for effective mediation of patients' cases); *see also id.* at 27–28 (on the importance of apology and potential negative effects of partial apology); Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 485 (2003) (reporting empirical research in non-medical setting finding 73% of plaintiffs likely to settle if full apology offered, as compared to 52% if no apology offered, and only 35% if a partial apology offered).

[265] By prioritizing safety promotion and information exchange, the R-MER approach requires doctors to continue to improve their level of expertise. On the importance of incentives for increasing physician expertise, see Arlen & MacLeod, *supra* note 5, at 1949–53.

responses to current treatment).[266] The R-MER process cultivates collaboration and mutual trust, which encourages information exchange.

Finally, restorative justice models all are designed to ensure that victims, offenders, and the community participate in, and reap the benefits of, healing processes.[267] R-MER forums likewise utilize restorative processes that facilitate physical and emotional healing of patients, as well as that of healthcare providers and the community.

In addition to these macro-level benefits, the R-MER model has the potential to offer specific benefits to patients, medical professionals, and the community.

1. *Benefits for Patients*

The physician-patient relationship is an inherently unbalanced one in which power resides with the physician. Professors Nancy Neveloff Dubler and Carol Liebman write: "The power imbalance in a hospital setting comes from many sources: the difference in level of knowledge and expertise between most patients and the treatment team, the highly technical and unfamiliar physical setting, and the imperfectly allied interests of the patient and the treatment team members."[268] An R-MER system will help correct for some of the inherent power imbalance that exists between the doctor-expert and the patient struggling to understand his or her condition while simultaneously dealing with the physical, psychological and emotional stress of serious illness or injury, by ensuring an open dialogue between the parties and having doctors acknowledge their mistakes.[269] The R-MER approach offers several other potential benefits to patients: (1) an opportunity to receive an apology and further support from physician-caregiver to facilitate emotional healing; (2) an opportunity for continuing communication and the physician-patient relationship, if the patient desires; (3) greater access to information; and (4) greater assurances that his or her medical expenses will be covered in the event of a medical error. Many of these benefits will help restore the human elements of care and treatment.[270]

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[266] *See, e.g.*, Patrice L. Spath, *Safety from the Patient's Point of View*, *in* PARTNERING WITH PATIENTS TO REDUCE MEDICAL ERRORS 19–21 (Patrice L. Spath ed., 2004) (discussing the value of including patients in safety promotion).

[267] *See supra* Part V.B.

[268] Nancy Neveloff Dubler & Carol B. Liebman, *Bioethics: Mediating Conflict in the Hospital Environment*, DISP. RESOL. J., Jul. 2004, at 32, 36. *See also* Ferris, *supra* note 100, at 183 ("The therapeutic relationship is complicated by its inherent imbalance of power that, in part, stems from the one-sidedness of the physical and emotional encounters.").

[269] *See, e.g.*, Dubler & Liebman, *supra* note 268, at 36 ("The physical and emotional stress of serious illness also contribute to an uneven playing field. Patients in hospitals are often very sick; cognition, understanding, and judgment are all affected by illness. Also, families are under moderate to extraordinary stress depending on the health status of the patient and on the trajectory of the illness.").

[270] *See* GAWANDE, *supra* note 83, at 45 ("Modern care already lacks the human touch.... Patients feel like a number too often as it is."); Carole Levine, *Life But No Limb: The Aftermath of*

Whereas under the current system the threat of litigation forms an immediate barrier between the patient and his or her caregiver at the time when injury occurs and the patient most needs care from his or her doctor, in the R-MER system ties between the doctor and patient are not severed. Instead, communication continues in order to uncover what went wrong and to aid the patient's healing. With open lines of communication, a patient can also receive an apology and other forms of support to facilitate emotional healing. If appropriate, the care relationship itself can continue. Similar to some mediation efforts, the R-MER approach will allow the patient, his or her family, and the physician an opportunity "to fully explore what happened, why it happened, and its effects on all concerned."[271] With more open discussion of errors, patients will not have to resort to litigation to determine what went wrong.

In the R-MER model, compensation for injury-related expenses also can be assured to patients injured as a result of medical error.[272] By comparison, under the traditional litigation model, patients face great uncertainty. Their situation is somewhat analogous to playing the lottery; there is a very small chance that the patient could end up with a windfall, but a much greater likelihood that he or she will end up with nothing.[273] Perhaps even more important, litigation may go on for years, delaying compensation and forcing the patient to bear the burden of costs and emotional strain in the intervening years.[274] Under an R-MER system, patients would obtain compensation without having to suffer through years of litigation, physical and emotional stress, and uncertainty.

2. *Benefits for Doctors and Hospitals*

While patients understandably benefit under the R-MER system, what's in it for the doctors and hospitals? Why would doctors or hospitals openly admit mistakes? To answer these questions, consider what doctors (and other healthcare providers) want most: relief from soaring insurance premiums, a supportive practice environment in which they discuss decisions, learn from mistakes and grow professionally, and an opportunity to serve a community without worrying that patients will sue the moment something appears wrong. As we shall see, the R-MER system better addresses doctors' concerns than the current medical malpractice model.

Medical Error, HEALTH AFF., Jul.–Aug. 2002, at 237, 240 (describing the "excruciating" experience that litigation imposes upon injured patients and their family members).

[271] Ferris, *supra* note 100, at 184.

[272] *See supra* note 4 (discussing that "medical error" includes both individual and systems errors). *See also infra* notes 296–300 and accompanying text (discussing compensation).

[273] *See* Schmitt, *supra* note 48, at 24–26.

[274] *See supra* note 49–51 and accompanying text.

First, the R-MER system can reduce large jury awards or settlements, the cost of which, even if it is for only a small percentage of the total number of injured patients, can be dramatic.[275] Offering one example, the General Counsel to Rush-Presbyterian-St. Luke's Medical Center in Chicago highlighted the scenario facing Cook County hospitals:

> In 2002 .... [t]here were 74 medical malpractice cases that settled for a million dollars, and 19 cases settled for more than $5 million. .... The total for medical malpractice settlements [in Cook County] was $334 million. You cannot take $334 million out of a jurisdiction like Cook County year after year and have that system survive. It won't happen. It can't happen.[276]

Moving to an R-MER system should dramatically reduce and possibly eliminate the need for punitive damages, saving hospitals and insurance companies millions of dollars. Accordingly, doctors' insurance premiums should come down as well.[277] Hospitals and insurance companies will realize further savings from reduced litigation costs and reductions in payouts on the non-meritorious cases that are cheaper to pay off than litigate under the current system.[278] The cost savings alone should provide some incentive for doctors, hospitals, and insurance companies to support a restorative model.

In addition, hospitals, doctors, and other health care professionals will benefit from a more open dialogue about medical errors. Improvements in quality depend on obtaining as much information as possible about errors.[279] More open dialogue would foster a better learning environment

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[275] See the research on the impact of apology and information exchange (or lack thereof), *supra* notes 76–80 and accompanying text, and the impact of early offer approaches to medical error, *supra* note 232.

[276] Max Douglas Brown et al., Panel Discussion, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 6 DEPAUL J. HEALTH CARE L. 249, 253 (2003). *See also* Mike McIntire, *Malpractice Claims Rose Against City Last Year*, N.Y. TIMES, Mar. 9, 2005, at B3, *available at* LEXIS, News Library, NYT File (finding in New York City that city-run hospitals paid out $145 million in settlements and judgments in 2005).

[277] *See generally* BAKER, *supra* note 39, at 93 (noting that when anesthesiologists made improvements in standards of care, error rates dropped and so did their medical malpractice insurance premiums). *But see infra* note 305 for the view that insurance cycles have a more significant effect on medical malpractice premiums than the liability system.

[278] See, for example, the University of Michigan Health System program, in which the hospital discloses errors to patients injured by medical intervention and offers compensation immediately. *See* Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 N. ENG. J. MED. 2205, 2207 (2006). Prior to the program's 2002 launch, the organization averaged approximately 260 claims and lawsuits pending at any given time. *Id.* By August 2005, the number was down to 114. *Id.* Claim resolution time was cut by over 50% and annual litigation costs dropped from about $3 million to $1 million. *Id.*

[279] Dauer, *supra* note 56, at 40 ("[Quality improvement] requires as much information about errors and accidents as possible; the risk of tort liability tends to drive information further from the light of investigation.").

in which to practice, as well as to improvements in the quality of care. As one physician notes, "[t]he paradox of modern quality improvement is that only by admitting and forgiving error can its rate be minimized."[280] Some scholars and selected hospitals have already recognized the value of more open dialogue with patients and apologies.[281] Healthcare providers and hospitals share in these benefits, along with patients.

Greater knowledge and improved practice should make the practice of medicine more rewarding and enriching. Not having to practice under the constant threat of malpractice litigation will minimize one of the primary reasons for doctor dissatisfaction. Finally, by utilizing the R-MER approach to improve skills and enhance quality of care, hospitals will be able to present themselves to the public as offering the best care available, providing a competitive advantage over hospitals that still rely on traditional medical malpractice litigation to resolve disputes with patients.

To disclose or not to disclose—a closer look. The R-MER approach depends significantly on doctors' willingness to speak openly about their decision-making. The cost savings for physicians and hospitals (as well as insurance companies) from reductions in compensation payments and transaction costs should provide impetus for disclosure of errors.[282] Resulting improvements in the practice environment should give physicians further incentive to work in an R-MER system. Still, two concerns persist in the R-MER model: (1) will doctors want to discuss mistakes, even with all the attendant benefits, if such mistakes will be made known to others,[283] and (2) will "bad" doctors simply view the R-MER model as an opportunity to admit mistakes and move on without penalty?

At the outset, it bears noting that doctors are already monitored under the current system. There are various websites that provide information about the qualifications and performance of, and disciplinary action

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[280] Blumenthal, *supra* note 82, at 1868.

[281] *See* Bovbjerg & Tancredi, *supra* note 62, at 482–83 (describing how an "early offer" approach "would allow providers who promptly disclose injuries and promise compensation to avoid liability claims for full tort-style damages."); Liz Kowalcyzk, *supra* note 262 (reporting on Harvard Medical School's teaching hospitals consideration of new disclosure policies allowing physicians to openly acknowledge medical errors to patients and to provide training in apologizing). See also the experience of the VA Hospital of Lexington, KY, *supra* note 232, and the University of Michigan Health System, *supra* note 278.

[282] Some may argue that if compensation payments are tied to determinations that mistakes were made, some doctors and hospitals may still have some incentive not to disclose errors. This tension may suggest a move to offering compensation in all bad outcome cases. Alternatively, it may be that R-MER provides significant other incentives for both short- and long-term financial gain, such that the incentive to disclose is sufficient. This tension cannot be resolved here in the abstract but merits continued monitoring to ensure the success of R-MER models.

[283] Arguably, other factors beyond the threat of litigation—such as pride and fear of being shamed in front of colleagues or in the public eye—contribute to doctors' reluctance to admit mistakes.

against, doctors and hospitals.[284] In addition, under the current system, even if doctors settle out of court such that no record of malpractice shows on their record, by law such settlements must be reported to the National Practitioners Data Bank (Data Bank).[285] Although the Data Bank is not available to the general public, it is accessible by hospitals considering the granting or withholding of hospital privileges as well as other entities that monitor doctors' performance.

The question of how much of an R-MER system's records should be made public is an important issue. Certain restorative models, such as truth commissions, suggest that as a general rule more public disclosure is better. In the medical setting, disclosure might provide patients with an increased sense of procedural fairness, provide incentives for doctors and hospitals to take corrective action to reduce errors, and avoid the inherently suspicious nature of confidential proceedings. That said, public, and in particular media, access to R-MER forums is likely to significantly alter healthcare providers' approach to such processes. One of the advantages of mediation, which is confidential, is that dialogue can occur without each party having to worry about strategic considerations.[286] Thus, while there may be potential benefits to public disclosure, on balance, R-MER models are likely to achieve greater success if they are confidential. Confidentiality is likely to foster conditions more conducive to disclosure. In order to mitigate the mistrust that might be caused by confidential proceedings, "independent observers" could attend R-MER sessions, to ensure impartial review of cases and provide limited reports to the public that do not disclose information which the parties want confidential.

The issue of disclosure merits careful consideration, and it is discussed further below in the TIM Commission setting.[287] However, two additional points are worth noting. First, the correct comparison is not zero public disclosure in the traditional litigation context versus disclosure under the R-MER model. As described above, there is limited disclosure already through the Data Bank and various websites. Moreover, newspapers report on doctors and hospitals that are sued for malpractice in certain cases, suggesting that doctors who make errors are often already subjected to some public scrutiny and shaming. Importantly, under the current system, this may occur when the physician has done nothing wrong (but is sued because the patient feels the doctor or hospital is not forthcoming). Under

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[284] *See, e.g.*, New York State Physician Profile, http://www.nydoctorprofile.com (last visited Oct. 29, 2006); American Board of Medical Specialties Home Page, http://www.abms.org/ (last visited Oct. 29, 2006); Federation of State Medical Boards, http://www.docinfo.org (last visited Oct. 29, 2006); HealthGrades: Information on Hospitals, Doctors, and Nursing Homes, http://www.healthgrades.com/ (last visited Oct. 29, 2006).

[285] *See* The Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101, 11131–34 (2000) (establishing that any payment made on behalf of a physician be reported to the Data Bank).

[286] *See supra* notes 140–42 and accompanying text.

[287] *See infra* Part VI.B.

R-MER schemes, disclosure would be limited and would occur only after determinations had been made with respect to error, if any, and steps to be taken to improve practices. This would eliminate the incidence of doctors being improperly "punished" by bad publicity from meritless cases.

Second, the R-MER model provides other benefits for physicians that, I believe, in the aggregate exceed in value the cost of admitting a mistake. These benefits include reduced insurance premiums, reduced threat of protracted litigation and being wrongly "punished" by information-gathering lawsuits, an opportunity to practice in an environment where colleagues can discuss more openly their practices (and errors) and learn from each other, and an opportunity to "make amends" by participating in the patient's healing through an apology, empathy and other emotional support, and continued care (if acceptable to the patient). Further, assuming there is some limited disclosure of errors, it could be designed in a way that protects individual healthcare providers. The R-MER system could also ensure that such disclosure is coupled with positive disclosure regarding steps taken (or to be taken) by doctors and hospitals to improve practices. This positive disclosure would help offset negative press from errors. Follow-up monitoring confirming improvements in practice would further off-set any initial negative publicity.

The other concern, which raises the specter of "bad" doctors using R-MER forums to absolve themselves of responsibility and continue reckless practices, seems unlikely to be an issue for the vast majority of doctors who take pride in their work. Moreover, R-MER forums aim to focus the dialogue on accepting responsibility for what has occurred, not simply conceding errors.[288] In other words, apologies are not sufficient by themselves. They must be accompanied with some form of reparations, which can include both material and non-material components, and agreement on recommendations for future practice. Recommendations might include additional training for the physicians involved in the case. This process will not permit "bad" doctors simply to say "sorry" and move on. In addition, for the small number of doctors who might try to abuse the system, hospitals (and possibly even state licensing boards) might take it upon themselves to police doctors who repeatedly find themselves participating in R-MER proceedings because they repeat the same errors. Finally, if records are made public in a limited way, market pressures might have some effect because patients will be reluctant to visit hospitals with poor records.[289]

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[288] *See* PAVLICH, *supra* note 187, at 68 (describing the goal of a restorative justice system to "focus especially on what offenders can do to 'put things right' with victims and communities").

[289] It is feasible that an R-MER system, with its open discussion of practices (and errors), could produce a better method of evaluating doctors than malpractice liability determinations offer.

3. Benefits for the Community

Ultimately, the community also benefits from an approach that is less adversarial and more focused on healing and restoration. The more open approach should help to restore the community's trust and faith in the health care system. Professor Mark Hall writes: "Without some minimal level of trust, patients would not seek care, submit to treatment, disclose necessary information, or follow treatment recommendations."[290] When patients are more trusting, they will seek care earlier and be more open with their doctors. This should enable doctors to diagnose problems earlier and help prevent more serious injuries, which will reduce both bad outcomes and health care costs. Reducing insurance premiums will also help to reduce the overall cost of health care, an industry that currently is burdened by overwhelming costs. These cost savings could be used to provide care for those who currently do not have insurance or to improve care offered to the public generally. Finally, improvements in standards of care will mean fewer errors and better outcomes for the community.

B. *A Model—Truth-in-Medicine Commission*

There are a range of possible structures for an R-MER system. Here, I offer one possible variation: a Truth-in-Medicine (TIM) Commission. The purpose of putting forth this model is to provide an example of how restorative justice might play out in a medical setting. A comprehensive discussion of any model would necessarily include detailed economic modeling and other analyses which are beyond the scope of this Article. The TIM Commission, however, can offer a starting point for a dialogue on developing an R-MER system.

A TIM Commission would draw upon principles of mediation and enterprise liability but would supplement them with additional restorative components. As with any R-MER system, the central component of a TIM Commission is a participatory forum for parties affected by a medical error. There are two plausible starting points. A TIM Commission could serve an individual hospital or an existing or newly-created consortium of health care facilities. The former approach builds upon enterprise liability models but, unlike a solely internal-review process contemplated under enterprise liability, a TIM Commission system would be semi-autonomous and include participation by TIM Commission members. The second option, having the TIM Commission serve a consortium of hospitals, would further the independence of panels and facilitate sharing of knowledge regarding errors and best practices among hospitals in a

[290] Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 478 (2002).

consortium, and thus has greater hope of achieving the goals of the healing-centered framework.[291]

In either case, each forum would include the participation of TIM Commission members. Commission members might include medical doctors with specialty expertise, general practitioners, nurses and other allied health professionals, medical malpractice attorneys, insurance experts, and community representatives. TIM Commission members would be trained to manage and facilitate restorative processes (not unlike certain training for mediators).[292] They would facilitate resolutions, not decide cases. The participation of impartial individuals is essential for addressing the inherent power imbalance between healthcare providers and patients, ensuring the integrity of the system, protecting against special interest-dictated outcomes, and restoring trust among patients, doctors, and hospitals. The broad-based representation in the pool of TIM Commission members would ensure that all key constituents, particularly the community as representative of patients, would have a voice in the process.

TIM Commission members would also play a second key role. Not only would they help facilitate a resolution involving the particular patient and healthcare providers, they would also assist in developing recommendations for steps to address individual and/or systems errors. TIM Commissions would also collaborate with facilities on follow-up monitoring of the implementation of agreed-upon recommendations. This recommendation and follow-up monitoring function can help fulfill the safety promotion objective of the healing-centered framework. To the extent there is limited disclosure of TIM Commission proceedings, the prospect of a favorable follow-up report offers positive incentive for doctors to improve their skills and hospitals to improve their systems.

TIM Commission review of a case could be triggered two ways: a patient could request a review following an adverse outcome; and doctors

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[291] If pilot R-MER models are successful, they could be expanded to state-wide approaches, given that medical malpractice historically has been a state law issue, or the federal government could develop a national system. *See* Sage, *supra* note 56, at 20 (suggesting that the federal government can always propose reforms for claims involving Medicare and Medicaid patients, "which could then set the standard for the rest of the health care system").

[292] Training of TIM Commission members is essential, as is working with physicians and hospitals to help ensure that they communicate effectively with patients. *See* CAROL B. LIEBMAN & CHRIS STERN HYMAN, MEDICAL ERROR DISCLOSURE, MEDIATION SKILLS, AND MALPRACTICE LITIGATION: A DEMONSTRATION PROJECT IN PENNSYLVANIA 22 (2005), *available at* http://www.pewtrusts.org/ideas/ (in the drop box, follow "Medical liability" hyperlink; then follow "Grantee Reports" hyperlink; then follow "Medical Error Disclosure" hyperlink; then again follow "Medical Error Disclosure" hyperlink); DUBLER & LIEBMAN, *supra* note 140, at 9; BERLINGER, *supra* note 232, at 92–113 (providing recommendations for physicians and hospital practices that would support an R-MER approach).

would report any medical error.[293] The TIM Commission panel members assigned to that case would review medical reports and facilitate a dialogue between the parties to reach a determination regarding the case.[294] The goal would be to obtain a full and open accounting of the events that caused the injury, agree upon appropriate compensation, if any, for the injured patient, and develop recommendations to improve practices and standards of care. Follow-up assessments of progress and effectiveness of steps undertaken would also constitute an important element of the process.[295]

For patients, the TIM Commission would provide a forum to gain access to information necessary to understand what happened as well as an apology from doctors, thereby reducing harm. It would also offer patients the opportunity to restore their relationship with their doctor, if desired, and their faith in the health care system generally. The TIM Commission's more collaborative process would also be much quicker than pursuing litigation claims that may take years before reaching trial, let alone a final judgment. The TIM Commission might be required to review cases and make determinations within a certain number of days and, if compensation is merited, require it to be paid shortly after final determinations are made in cases.[296] This would help patients avoid prolonged suffering.

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[293] As the research shows that most patients injured as a result of medical error do not file a claim, it is vital that doctors report errors in order to achieve the optimal results in terms of error reduction. It is worth noting that doctors already are required to disclose certain errors to patients by the American Medical Association's Code of Medical Ethics and the U.S. Joint Commission on Accreditation of Healthcare Organizations (JCAHO). AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS § 8.12 (1997); JCAHO, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK (2004). Several states also have mandatory disclosure laws. *See, e.g.*, FLA. STAT. ANN. § 395.1051 (West 2004); NEV. REV. STAT. ANN. § 439.855 (LexisNexis 2004); N.J. STAT. ANN. § 26:2H-12.25 (West Supp. 2006); 40 PA. CONS. STAT. ANN. § 1303.308(b) (2004). The benefits of the TIM Commission for doctors should help incentivize disclosure of errors.

[294] Submitting to a TIM Commission would not require waiving one's right to access the courts. Forcing participants to waive their right to sue might make the TIM Commission process too similar to those mandatory arbitration clauses that have not been upheld by the courts. *See supra* note 146 and accompanying text. That said, building in incentives to accept fair early offers might help ensure the success of the TIM Commission model. *See, e.g.*, Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55, 93–94 (2005) (proposing a model whereby, following an admission of fault and offer of fair compensation by the healthcare provider, the injured party who rejects the offer would receive the lesser of the offer or the verdict and would be responsible for litigation costs incurred by the healthcare provider, if the verdict were within 12% of the early offer).

[295] This follow-up assessment function has parallels in a range of fields, such as corporate and environmental audit practices. For an examination of the ability of various liability schemes to create incentives for enterprises to monitor and improve employee practices in the corporate context, see, for example, Jennifer Arlen & Reinier Kraakman, *Controlling Corporate Misconduct: An Analysis of Corporate Liability Regimes*, 72 N.Y.U. L. REV. 687 (1997). One question regarding the TIM Commission model is whether it would require a large bureaucracy. This is a legitimate concern and not the intention of this model, and thus merits further monitoring. Mediation practice offers some guidance for avoiding big bureaucracy. Thus, although the TIM Commission's recommendation and follow-up component would require greater organization, it can be built on some existing structures and otherwise designed to minimize bureaucracy.

[296] *See supra* note 232.

Moreover, participation in the process should help both doctors and patients feel more satisfied with the outcome.

An R-MER approach is not necessarily a no-fault system; it does not need to guarantee compensation. Ideally it should cover injuries suffered as a result of individual or systems errors, or at least those injuries caused by negligent acts. In the latter scenario, patients who suffer an adverse outcome through no fault of the doctors would not necessarily receive compensation. The other healing and restorative elements of the R-MER forum still would provide benefits to those patients. On the other hand, guaranteeing compensation for all patients regardless of fault would make it easier for patients; however, it would also increase the funding needed to support a TIM Commission.[297] Further research is needed to evaluate the cost and impact of each of these options and determine the optimal approach to the compensation component of a TIM Commission. Overall, a TIM Commission could help achieve the goals of more equitable compensation, safety promotion, harm reduction, information exchange, and restoration.

Assuming the TIM Commission did not operate on a strict liability basis, why would doctors or hospitals want to disclose errors? In the TIM Commission setting, a doctor deemed to have offered a full and open accounting of the case could be "rewarded" in some way, such as protection from individual liability or an opportunity to have the case removed from his or her record subsequently if appropriate improvements are made in practice. This would help provide an incentive for healthcare providers to improve their expertise, furthering safety promotion. Hospitals could also receive some insurance-related benefits by complying with requirements for disclosure of errors and early and adequate compensation offers to patients.

Longer-term, hospitals would realize lower insurance premiums because their error rates and payments to injured patients would go down. Also, any negative effects resulting from a TIM Commission determination that errors were made could be alleviated, at least in part, by publicizing subsequent determinations that commend physicians and hospitals for improvements in practices. Moreover, in determining the cause of the injury, because the doctor and hospital accept responsibility for errors and agree to work to implement recommendations for improving practice and avoiding additional errors, the need for punitive damages would be dramatically reduced, if not eliminated altogether, in most cases. Accordingly, medical professionals, hospitals, and insurance companies would realize significant benefits in reduced compensation paid out, as

[297] Funding needed to support the TIM Commission may increase, but overall costs of health care may not. *See infra* note 309 and accompanying text.

well as significant reductions in costs normally allocated to defending cases for years in the courts. In the short-term, some of this gain admittedly would be offset by payments to a larger pool of patients—including those currently going without compensation under the current system. However, the TIM Commission would achieve improved practices and lower error rates in the long-term, resulting in long-term cost savings.

The question remains: where would the money used to compensate patients come from? In restorative justice models, compensation typically comes from a common fund or from restitution payments. In the TIM Commission context, funding could be hospital-based, with insurance coverage, or could come at least in part from a joint compensation fund if TIM Commissions cover more than one hospital. Doctors (through insurance premiums), hospitals, and insurance companies could contribute to this fund. The savings achieved through avoiding large jury awards (recall, Cook County incurred $334 million in settlement award costs in 2002)[298] and not having to incur high costs in protracted litigation or payoff meritless claims should provide a substantial amount of money for the compensation fund.[299] Also, as mentioned above, long-term savings through error reduction would reduce payments made either out of a fund, or by hospitals and insurance companies. Overall, the cost savings appear significant, especially in the long-run, and thus hospitals and insurance companies should have incentive for supporting an R-MER system.[300] As discussed above, precise details on funding of the compensation component of the R-MER system would require comprehensive economic modeling, which is beyond the scope of this Article but, I submit, is worth pursuing.

In the long run, patients would view hospital systems that have TIM Commission as ones that are more attentive to the needs of patients, are open regarding patient care, and provide the best care available, given that those facilities are continually reviewing and improving practices. Doctors and other healthcare providers would come to see that an R-MER system is a better environment in which to work. Hospitals would achieve a competitive advantage in care offered, as well as reduced costs. TIM Commission hospitals could have the additional benefit of ultimately attracting the top doctors with their better working environments, further improving care and increasing their competitive advantage over hospitals still using the traditional litigation-based model. Finally, the community would benefit from restored trust, improved care, and reductions in health care expenditures.

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[298] *See supra* note 276 and accompanying text.

[299] *See supra* notes 277.

[300] *See supra* notes 275–78 and accompanying text.

C. *Further Considerations*

1. *Implications for Tort Law Generally*

The potential benefits of the R-MER approach to medical malpractice raise questions whether such a model could be applied successfully to other aspects of the health field, or even more broadly to other areas of tort law.

A full exploration of the effectiveness of an R-MER model in other areas of tort law is beyond the scope of this Article, however it is worth noting that there are unique aspects of the physician-patient relationship which suggest that the R-MER approach is perhaps most appropriately suited to addressing medical practice.[301] First, the treatment relationship is ultimately about care and relies on a level of trust and intimacy typically not present in many other interactions governed by tort law. As such, the healing aspects of an R-MER system most readily fit with the care relationship that arises in medical practice. In addition, there are different incentive structures in direct patient care as opposed to the manufacturing of pharmaceuticals or medical devices, let alone with automobile manufacturers, oil companies, and other global businesses. An R-MER system dramatically reduces the need for punitive damages. While hospitals clearly run as businesses today, their direct contact with patients makes them somewhat different from large manufacturers of drugs, medical devices, or other non-medical products.[302] In recent years, we have seen examples of manufacturers making cost-benefit decisions that put profits before people.[303] Reducing the prospect of punitive damages in those cases might eliminate the only deterrent to such actions. Thus, given that revenues in today's world often are calculated in billions, we need to proceed cautiously before removing any counter-balancing protections in place for individuals. Having said that, the goal of healing found in restorative justice efforts is a worthwhile endeavor and as such its potential application to other areas of health care and tort law should not be rejected without further consideration.[304]

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[301] *See, e.g.*, Hall, *supra* note 23, at 306–07 (noting that traditional tort law theories developed in response to accidents between strangers).

[302] For example, pursuant to the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals with emergency departments are required to treat and stabilize patients deemed to have emergency medical conditions, irrespective of patients' ability to pay. 42 U.S.C.A. § 1395dd (West 2006). By contrast, private corporations generally are not required to give away their products and services to those who are unable to pay.

[303] Huge verdicts against General Motors in the 1990s and the infamous Ford Pinto case of the 1970s provide two examples. For more on these cases and cost-benefit analyses, see generally Geistfeld, *supra* note 29.

[304] In the personal injury context, at least one company—Toro Company, a manufacturer of lawn care products—has realized significant benefits from moving from a litigation model toward a

2. *The Insurance Industry's Role Revisited*

Given the prominent role of the insurance industry in U.S. health care, it is fair to ask where insurance fits in an R-MER model centered on the physician-patient relationship. Liability insurance issues have played a key role in the medical malpractice crises of recent decades.[305] Clearly, the insurance industry has to play a role, most notably in developing and supporting the compensation component of R-MER systems. Under the R-MER system, the insurance industry can also contribute to safety promotion and harm reduction.

First, assuming that initially TIM Commissions would be situated within hospitals or consortia of hospitals, insurance companies could help spread learning by requiring other hospitals or consortia to adopt "new" practices to qualify for lower insurance premiums. In addition, by contributing to efficient resolution of cases, the insurance industry can help minimize suffering. In return, an R-MER system should help reduce the incidence of error (number of payouts) and excessive compensation awards (amounts of payouts), providing benefits to the insurance industry. The role of the insurance industry requires additional exploration. Insurance companies will play a key role and that role, if properly designed and managed, can contribute to a healing and restorative model.[306]

3. *R-MER's Affordability*

Any proposal for an alternative approach to remedying injuries suffered as a result of medical error will be met with questions as to affordability of the new system. In addition to the cost benefits associated with an R-MER model identified above, three additional observations are worth mention.

First, I must concede that cries of "it's too expensive" sound a bit like statements that eating healthy is too expensive (or at least much more

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collaborative approach, settling claims more rapidly and for far less cost. *See* Cohen, *supra* note 232, at 1460–61 (Toro responds to claims by offering to mediate, and in mediation provides information, expresses empathy (but does not admit fault), and makes what it believes is a fair settlement offer. The results are that its average claim resolution time has dropped from twenty-four to four months, average payout per claim dropped from $68,368 to $18,594, and average costs and fees per claim dropped from $47,252 to $12,023. Insurance premiums dropped so significantly that ultimately Toro elected to self-insure. Overall, Toro estimates that by 1999 it had saved over $75 million since adopting the new approach in 1991).

[305] Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393 (2005); William Sage, *Medical Malpractice Insurance and The Emperor's Clothes*, 54 DEPAUL L. REV. 463, 469–70 (2005). *See also* Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 PENN ST. L. REV 1077, 1078 (2004) (suggesting that medical malpractice crises are largely a result of cyclical insurance crises due to bond market fluctuations).

[306] Concerns may exist that the insurance industry cares only about the bottom line and thus will support restorative aspects on the doctor/hospital side that reduce costs, but will not support restorative measures that benefit patients. Further development of the insurance industry's role in R-MER system is vital to resolving these issues.

costly than fast food). In fact, it is unclear that eating healthier is more expensive, and substantial evidence supports the position that a healthy diet is affordable (and helps prevent long-term ailments and costs).[307] Similarly, an R-MER scheme can be crafted to provide cost savings that can offset a substantial portion, if not the entire amount, of any increases in expenditures resulting from the new system.[308]

Second, when considering the "cost" of various medical malpractice liability systems, it is important to be clear about the "costs" to which we refer. It is fair to argue that certain alternatives—e.g., no-fault liability—may cost more than the tort liability system. That cost, however, refers to the costs imposed on healthcare providers and facilities. Total payouts by a hospital may increase as a result of switching to a no-fault system. However, under the tort liability system, uncompensated injured individuals still impose costs on the healthcare system (e.g., costs of additional treatment needed as a result of being injured by error), and on society in general (e.g., absenteeism, lost wages, increased reliance on social welfare programs, etc.).[309] In other words, the "lower costs" of one approach may result in savings for certain entities and providers but it does not necessarily mean cost savings for the health care system or for society as a whole. In developing an effective response to medical error, it is important to consider overall costs of health care, not merely compensation payments.

Third, let us assume for the moment that a restorative approach would cost more, but would provide more equitable compensation for injured patients, emotional healing for patients and healthcare providers, opportunities for healthcare providers to improve skills and systems, better care for the community, and a reduction in medical errors. I submit that

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[307] *See, e.g.*, Pat Kendall, Colo. St. Univ., Eating Healthy on a Budget, *available at* http://cetuolumne.ucdavis.edu/newsletterfiles/Home_Advisor_Articles_20057101.doc (last visited Nov. 25, 2006) (finding that the cost of eating healthy for an entire day is "less than the cost of a typical meal at a fast-food restaurant"); Univ. of Pittsburgh Med. Cent., Nutrition Services, Eating Healthy on a Budget, http://nutritionservices.upmc.com/NutritionArticles/Habits/Budget.htm (last visited Nov. 25, 2006) ("It's a common misconception that cutting back on food expenses means sacrificing good nutrition.").

[308] Costs savings could be achieved for doctors, hospitals, and insurance companies in the following areas: reductions in large jury verdicts, reduced pain and suffering awards, fewer payouts in "bad" cases where no wrongdoing occurred but it is cheaper to settle than litigate, reductions in expenses defending lawsuits, and long-term fewer errors and thus fewer injured patients seeking compensation. The economic modeling necessary to determine the total value of such savings is beyond the scope of this Article. Moreover, pure cost comparisons would not recognize the R-MER system's most significant value—providing healing for patients, doctors, and the community.

[309] On the costs of accidents and injury, see, for example, Guido Calabresi, *The Costs of Accidents*, *in* PERSPECTIVES ON TORT LAW 155, 155–76 (Robert L. Rabin ed., 2d ed. 1983); WILLIAM M. LANDES & RICHARD A. POSNER, THE ECONOMIC STRUCTURE OF TORT LAW 314 (1987).

most people would support such a system, even if it costs more than the current, poorly-functioning system. In their daily lives, people frequently make choices to spend more than the minimum because they believe that the better return is worth the incremental investment.[310] Health care is an area in which that choice also makes sense.

VII. CONCLUSION

In recent decades, the medical profession finds itself almost perpetually in a state of crisis. There are deep-seated problems with the current medical malpractice liability system, and current reforms have little hope of breaking us out of this cycle. A genuine solution requires a comprehensive approach to the problem. The healing-centered framework set forth in this Article takes the important first step of reorienting our priorities toward a set of objectives that will achieve optimal results for patients, healthcare providers, and communities. Drawing upon restorative justice principles, the R-MER model offers hope that the law can provide healing, consistent with both the goals of medicine and the healing-centered framework. The R-MER system has the potential to mend physician-patient relationships, restore mutual trust, improve patient compensation, foster a medical culture in which healthcare providers learn from mistakes and improve practices, minimize harm and suffering, facilitate information exchange, provide healing, and improve the overall quality of care provided in this country.

Faced with recurrent medical malpractice crises, we would do well to recall the words of Albert Einstein:

> The formulation of a problem is often more essential than its solution, which may be merely a matter of mathematical or experimental skill. To raise new questions, new possibilities, to regard old problems from a new angle, requires creative imagination and marks real advance.[311]

While it would be obvious hyperbole to suggest that ideas for medical malpractice reform rival the discoveries of Einstein, the critical insight remains the same: the right questions are necessary in order to find the right answers. In the context of medical malpractice, the fundamental

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[310] Post-September 11th, Americans have consistently agreed that they would be willing to pay more for various means of transportation in exchange for greater security. *See, e.g.*, Fabrizio, McLaughlin & Associates, Opinion Poll (Sept. 17–20, 2001) (on file with Connecticut Law Review) (finding 79% of Americans willing to pay higher airline ticket taxes to pay for increased security on flights). *See also* Geistfeld, *supra* note 29, at 118–19 (explaining how the "precautionary principle" in international environmental law creates a dynamic whereby "cost considerations [are] of secondary importance").

[311] ALBERT EINSTEIN & LEOPOLD INFELD, THE EVOLUTION OF PHYSICS: THE GROWTH OF IDEAS FROM EARLY CONCEPTS TO RELATIVITY AND QUANTA 95 (1938).

question is how to create a system for addressing medical errors that is based on the principle of care and provides healing for patients, doctors, and the community. The healing-centered framework and restorative medical error resolution system may be the first steps toward the right answers.

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