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The Clinton-Obama Approach to Medical Malpractice Reform: Reviving the Most Meaningful Features of Alternative Dispute Resolution

Grant Wood Geckeler¹

I. INTRODUCTION

“Most medical malpractice lawsuits are frivolous.” “High insurance premiums are driving obstetricians into early retirement.” “Jury verdicts usually result in huge awards to plaintiffs.” “More tort reforms will solve these problems.” These sound bytes encapsulate many of the conventional justifications for the recent surges in medical malpractice liability insurance premiums—what has been called the first medical malpractice crisis of the twenty-first century.²

An introduction to medical malpractice reform would be incomplete without mentioning the Institute of Medicine’s (IOM) 1999 report, *To Err is Human: Building a Safer Health System*, which lists medical errors as the eighth leading cause of death in the United States.³ While much attention

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2. William M. Sage, *Medical Liability and Patient Safety*, 22 HEALTH AFF. 26, 27, n.4 (2003).

3. THE INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM* 1-2 (Nat’l Academy Press 2000). The report, published in 1999, estimated that 98,000 medical error-related deaths occurred every year in the United States. *Id.* The IOM report is one of the most cited sources for introducing the epidemic of medical malpractice and error in the United States. See generally TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* (Univ. of Chicago 2005)

has been paid to the prevalence of medical error and increases in liability premiums, the media's recent interest in the application of alternative dispute resolution (ADR) tactics in medical malpractice cases has increased.⁴ The quest for a one-size-fits-all fix to rising health care costs has turned to ADR for guidance in the past, with hopes that binding arbitration and voluntary mediation would resolve the crisis.⁵ Recently, the search has unearthed a new and somewhat counterintuitive champion: the early settlement of potential malpractice claims through the combination of medical error disclosure and apology.⁶

The IOM's report recommends a strategy for improvement based on health care organizations' ability to learn "from errors by developing a nationwide . . . reporting system" and encouraging healthcare providers "to develop and participate in voluntary reporting systems."⁷ Introduced six years after the publication of IOM's recommendations, Senate Bill 1784, "The National Medical Error and Compensation (MEDiC) Act of 2005"⁸ stood the best chance of realizing the report's normative advice. The MEDiC Act, introduced by Senators Hillary Rodham Clinton and Barack Obama, is modeled after several successful state programs that have effectively reduced the occurrence of medical errors while simultaneously reducing legal costs.⁹ The bill contains incentives for physicians to disclose medical errors to patients and participate in a national medical error

(citing the IOM report as a common source for nationwide statistics relating to medical malpractice and error).

4. See BAKER, *supra* note 3, at 22-24.

5. See Carol B. Liebman & Chris S. Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients: A quicker, less alienating route to closure than malpractice litigation*, 23 HEALTH AFF. 22, 22 (2004) (discussing the extensive research that has been conducted on the use of mediation to manage communications with patients); Nicholas Terry, *The Technical and Conceptual Flaws of Medical Malpractice Arbitration*, 30 ST. LOUIS U. L.J. 571, 629 (1986) (discussing the debate over the application of arbitration to medical malpractice cases).

6. Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205, 2205 (2006). In 1987, the Veterans Affairs (VA) Hospital in Lexington, Kentucky pioneered a policy that combined the full disclosure of medical errors with appropriate expressions of empathy and some early offers of compensation to its injured patients. *Id.* at 2207. Several other institutions, the most notable of which include the University of Michigan Healthcare System (UMHS) and Children's Hospitals and Clinics of Minnesota, have successfully adopted similar programs. *Id.* at 2207-08; 109 CONG. REC. S10599 (daily ed. Sep. 28, 2005) (statement of Sen. Clinton).

7. THE INSTITUTE OF MEDICINE, *supra* note 3, at 3.

8. The National Medical Disclosure and Compensation (MEDiC) Act of 2005, S. 1784, 109th Cong. (1st Sess. 2005).

9. S. 1784, § 1. The UMHS, VA, and Children's Hospitals have reduced their legal administrative costs by a statistically significant amount since adopting their respective policies. Clinton & Obama, *supra* note 6, at 2207; 109 CONG. REC. S10599 (daily ed. Sep. 28, 2005) (statement of Sen. Clinton).

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reporting system.¹⁰ The remainder of this article will analyze the recurring problems inherent in the medical malpractice environment, explore a portion of ADR's impact on the reformation of this environment, and offer the MEDiC Act as ADR's contemporary solution for a more equitable and sustainable medical malpractice environment.

II. THE PROBLEMS

The current medical malpractice environment must be examined in light of the amalgamated changes adopted since the last malpractice crisis of the 1980's.¹¹

A. *The Volatility of Insurance Markets*

Most Americans think malpractice lawsuits are the number one cause of soaring insurance premium rates.¹² The American Medical Association (AMA) contends that "the litigation system is . . . raising the costs of health care for all Americans."¹³ However, a recent academic study by Dartmouth College researchers asserts the contrary is true.¹⁴ The Dartmouth study determined that increases in physician malpractice payments between 1991 and 2003 were consistent with general increases in health care costs.¹⁵ The researchers' findings directly rebutted the AMA's contentions by demonstrating that large jury awards were not responsible for the significant

10. S. 1784, §§ 3-935.

11. Sage, *supra* note 2, at 27-31.

12. BAKER, *supra* note 3, at 45. According to the American Medical Association, "82% of Americans believe that physicians are being forced to leave their practices because excessive litigation puts the cost of liability insurance out of reach." AMERICAN MEDICAL ASSOCIATION, *MEDICAL LIABILITY REFORM - NOW!* 4 (July 19, 2006) <http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlmow.pdf>.

13. AMERICAN MEDICAL ASSOCIATION, *supra* note 12, at 6.

14. See Liz Kowalczyk, *Rising Doctors' Premiums Not Due to Lawsuit Awards*, BOSTON GLOBE, June 1, 2005, at D1 (describing the findings of the Dartmouth researchers).

15. See Amitabh Chandra et al., *The Growth of Physician Medical Malpractice Payments: Evidence From the National Practitioner Data Bank*, 24 HEALTH AFF. 240, 240 (2005). The researchers examined data from the National Practitioner Data Bank and found that the overwhelming majority (ninety-six percent) of physician malpractice payments come from settlements. *Id.* Judgments at trial accounted "for less than 4 percent of all payments and 5 percent of all medical malpractice dollars." *Id.* at 242.

magnitude of recent malpractice payment growth.¹⁶ Moreover, the study demonstrates that “the current increase in premiums is not attributable to the increase in [physician malpractice] payments.”¹⁷

Professor Tom Baker tenders an explanation for the lack of causal relationship between rising insurance premiums and malpractice payments: the boom-and-bust cycle of the liability insurance market.¹⁸ In short, Baker’s research suggests that the insurance underwriting cycle creates medical malpractice insurance crises when insurance companies rapidly increase rates to make up for losses incurred from the mismanagement of soft markets.¹⁹ Data shows that the insurance industry as a whole underpriced actual losses between 1987 and 2001.²⁰ That underpricing of liability insurance explains the sudden increase in premium rates beginning in 1996 as well as the continuation of premium rate increases well into the foreseeable future.²¹ The above average rise in premium rates beginning in 1999—what many refer to as the prelude to the present medical malpractice crisis—was exacerbated by widespread declines in insurers’ investment income.²² Insurers’ lower-than-expected return on investment incomes

16. *Id.* at 242. The Dartmouth study found “that growth of the top 10 percent of payments [was] smaller than that of the average payment.” *Id.* at 247.

17. *Id.* at 246-47. A new report suggests medical liability costs have risen an average of 11.7% per year since 1975. TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS AND CROSS-BORDER PERSPECTIVES: 2005 UPDATE 10 (2006), available at http://www.towersperrin.com/tillinghast/publications/reports/2005_Tort_Cost/2005_Tort.pdf. However, these cost increases have been quite erratic as opposed to the relatively constant increases in physician malpractice payments. See Chandra, *supra* note 15, at 243.

18. See generally BAKER, *supra* note 3, at 45-67. A simplistic description of this cycle begins with the over-reserving of payments in proportion to the relatively low levels of future losses predicted by insurers—the “boom” of the cycle. *Id.* at 51. This under-allocation of risk results in prices that do not fully cover the insurer’s actual risk level. *Id.* Unlike other liability insurance schemes, the long time lag between medical malpractice litigation filing and award payment result in late detections of under-reserving. *Id.* at 52. Insurers are not able to determine a fiscal year’s actual losses until approximately 9 years after the event corresponding to the loss payment. *Id.* at 53. When insurers realize they have both under-reserved and underestimated payment rates, they metaphorically “bust.” *Id.* at 66. Insurers then simultaneously increase the level of predicted losses and enlarge their payment reserves. *Id.* This translates into higher prices that over-emphasize the insurer’s actual level of risk. *Id.* at 66-67.

19. See *id.* at 45-67.

20. See *id.* at 51-58.

21. *Id.*

22. See Chandra, *supra* note 15, at 246-47. The Dartmouth researchers found evidence that recent premium increases were partially correlated to lower-than-predicted returns from insurers’ investment activities. *Id.* Malpractice liability insurers experienced substantial declines in income from major bond holdings between 1998 and 2001. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 20 (2003).

coincided with the beginning of their “bust” cycle.²³ By the end of 2002, volatile insurance premium increases confirmed what many industry experts were predicting—the start of our nation’s third medical malpractice crisis.²⁴

B. High Rates of Medical Error

Since late in the twentieth century, several notable researchers and policymakers have obviated the traditional “blame the lawyers” approach to analyzing rising medical malpractice insurance costs in the face of several notable studies that have negated such a position.²⁵ The 1999 IOM report found evidence that medical errors are responsible for the deaths of 98,000 patients annually in the United States.²⁶ Even more startling is the proposition that the majority of the deaths measured by the study were causally linked to a single, or small series of human or system errors capable of prevention by simple and inexpensive safeguards.²⁷ In over ninety percent of these deaths, there was no verifiable physician negligence.²⁸ Instead, failed hospital systems and procedures were causal factors in more than nine out of every ten deaths measured by the IOM report.²⁹

The sad reality is that despite extensive research, the general public is mostly unaware that the occurrence of preventable medical errors is so widespread. As early as 1974, studies began to unveil that a startling

23. See BAKER, *supra* note 3, at 51-58. Insurers had generally postponed raising premiums to cover their marginal losses from predicted income streams coming from bonds. *Id.* However, by 2001, it became apparent that an upward premium adjustment was needed to cover these marginal losses. See Kenneth Thorpe, *The Medical Malpractice ‘Crisis’: Recent Trends and the Impact of State Tort Reforms*, HEALTH AFF., Jan. 21, 2004, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1/DC1#10>. In early 2002, the three largest national medical malpractice insurers raised rates in reflection of higher than expected loss payments during the course of the early 1990’s and increasing current/future risk projections. See BAKER, *supra* note 3, at 2.

24. See BAKER, *supra* note 3, at 2.

25. THE INSTITUTE OF MEDICINE, *supra* note 3, at 1-2. The report, published by the Institute of Medicine, sparked great debate upon its publication and has been scrutinized in a number of follow-up studies. See BAKER, *supra* note 3, at 2; see also Bryan A. Liang, *The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal Systems*, 29 J.L. MED. & ETHICS 346 (2001) for a discussion of how the reality of human error has been widely ignored in the U.S. healthcare system.

26. See THE INSTITUTE OF MEDICINE, *supra* note 3, at 1.

27. See Clinton & Obama, *supra* note 6, at 2205.

28. *Id.*

29. *Id.*

percentage of patients experienced injury from medical errors.³⁰ The 1974 Medical Insurance Feasibility Study found that one out of every twenty discharged patients suffered injury as a result of a medical error.³¹ The subsequent Harvard Medical Practice Study (HMPS) found a high incidence of adverse medical events which caused 27,000 injuries in New York hospitals during 1984.³² The HMPS researchers defined “adverse events” as “situations in which an inappropriate decision was made when, at the time, an appropriate alternative could have been chosen.”³³ The researchers established that there was an adverse event in nearly half of the hospitalizations³⁴ and that the adverse event was deemed to be serious in eighteen percent of the hospitalizations.³⁵ Indeed, a later hospital observation study in Chicago calculated that some form of mistake was made on almost half of the study’s patients and that these mistakes “seriously injured nearly 20 percent of those patients, causing anything from temporary disability to death.”³⁶

C. Low Levels of Compensation

Of the large pool of patients suffering some form of injury as a result of medical errors, a miniscule portion is offered early or informal compensation. Data from studies conducted in New York, Utah, Colorado, and Chicago show that only between two and four percent of patients who suffer a serious injury caused by medical malpractice actually initiate litigation.³⁷ However, in those studies, insurance companies and hospitals generally offered compensation *only* to a fraction of patients who pursued

30. See CAL. MED. ASS’N & CAL. HOSP. ASS’N, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY (Donald Harper Mills ed., 1977); see also Donald Harper Mills, *Medical Insurance Feasibility Study: A Technical Summary*, 128 W. J. MED. 360 (1978). Sadly, of the injured patients sampled, roughly ten percent died from their sustained injuries. See BAKER, *supra* note 3, at 26. Extrapolating this data, the researchers determined that 140,000 patients were injured by a medical error in the state of California during 1974. CAL. MED. ASS’N & CAL. HOSP. ASS’N at 47-53. Similarly, they determined 14,000 patients were killed by a medical error in the state of California during 1974. *Id.*

31. BAKER, *supra* note 3, at 25-26.

32. Tom Baker, *Reconsidering the Harvard Medical Practice Study Conclusions About the Validity of Medical Malpractice Claims*, 33 J.L. MED. & ETH. 501, 502 (2005).

33. S. I. Chaudry, K. A. Olofinboba & H. M. Krumholz, *Detection of Errors by Attending Physicians on a General Medical Service*, 18 J. GEN. INTERNAL MED. 594, 594-600 (2003); Baker, *supra* note 32, at 505.

34. Baker, *supra* note 32, at 505. Not every adverse event measured resulted in a quantifiable injury. *Id.*

35. *Id.* A “serious” event is an event that produced at least a temporary physical disability. *Id.*

36. BAKER, *supra* note 3, at 35.

37. *Id.* at 69; see also Baker, *supra* note 32, at 501-05.

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legal recourse.³⁸ The overwhelming majority of patients who experienced quantifiable injury from medical malpractice, but did not sue, were never offered monetary compensation for the injuries and inconveniences they sustained.³⁹ Of the patients who did sue, the HMPS “found that the tort system fails to compensate the majority of patients injured by their medical care.”⁴⁰

D. Low Levels of Litigation

The initiation of litigation has traditionally been the primary means by which injured patients obtain monetary compensation.⁴¹ The level of compensation among the pool of patients injured by medical error is very small, which leads one to speculate that few injured patients actually sue.⁴² Research confirms this supposition. For example, contrary to news headlines, most patients who suffer a medical error or malpractice-related injury do not sue.⁴³ Data from empirical evidence and observational studies suggests the there are almost ten incidences of medical malpractice for every one malpractice claim.⁴⁴ Since medical errors do not always amount to the legal definition of medical malpractice, one can assume that the rate of medical errors to malpractice claims is even higher.⁴⁵

E. A Culture of Silence

Numerous studies have listed “a general lack of communication” or “suspicion of a cover-up” as primary factors in plaintiffs’ decisions to file

38. BAKER, *supra* note 3, at 69.

39. *See id.* at 69-73.

40. Liebman & Hyman, *supra* note 5, at 22.

41. *See* Terry, *supra* note 5, at 571-80.

42. BAKER, *supra* note 3, at 91.

43. *See id.* at 22-25, 69-73.

44. *See* BAKER, *supra* note 3, at 69. Dr. Patricia Danzon suggests that because hospital record reviews miss many instances of malpractice, the actual rate of malpractice may be even higher. *See* PATRICIA DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 21-25 (Harvard Univ. Press 1985). Harvard researchers determined there were seven occurrences of malpractice for every litigation filing in their sampling. Russell Localio et al., *Relation Between Medical Malpractice Claims and Adverse Events Due to Negligence, Results of the Harvard Medical Practice Study III*, 325 *NEW ENG. J. MED.* 245-51 (1991). In a Utah study, a five-to-one ratio was found. Studdert, David, et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 *MED. CARE* 250 (2000).

45. *See* DANZON, *supra* note 44; *see also* Localio, *supra* note 44, at 247-50.

malpractice litigation.⁴⁶ One study indicated that seventy-six percent of physicians polled said they had failed to disclose a serious medical error to one or more of their patients.⁴⁷ In a controlled series of focus groups, researchers determined that [m]any physicians said that fear of litigation limited what they tell patients about errors."⁴⁸ This fear of litigation creates a culture of silence in modern physician-patient communications, but such trepidation is largely misplaced.⁴⁹ A HMPS follow-up study confirmed that physicians' perceived risk of being sued was greater than three times the actual risk.⁵⁰ Other key studies have demonstrated that sharing medical errors can actually decrease physicians' likelihood of being sued, yet the concept of the "sue-happy" patient remains widely intact across most disciplines in the medical profession.⁵¹ Such skepticism not only reinforces

46. See J. Avery, *Lawyers Tell What Turns Some Patients Litigious*, 2 MED. MALPRACTICE REV. 35, 35-37 (1985); see also Thomas May & Mark Aulisio, *Medical Malpractice, Mistake Prevention, and Compensation*, 11 KENNEDY INST. ETH. J. 135, 135-46 (2001). Avery estimates that 70 to 80% of medical malpractice litigation involves failed physician-patient communication. *Id.* at 135. Another study interviewed plaintiffs of 127 closed Florida malpractice claims between 1986 and August 1989. G. B. Hickson, et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1359-63 (1992). Interviewees provided many unexpected reasons for filing. *Id.* at 1359. Twenty-four percent of plaintiffs responded that they "recognized a cover-up." *Id.* Twenty percent said they felt it was the only way to obtain the "information they needed." *Id.* Nineteen percent wanted to seek revenge or protect others from harm. *Id.* "Families expressed [a general] dissatisfaction with physician-patient communication." *Id.* Thirty-two percent of plaintiffs believed that physicians were afraid to, or were not able to talk openly. *Id.* An overwhelming 48% thought that their physician(s) had attempted to mislead them. *Id.* "Malpractice suits are often prompted by the desire to obtain explanations for unexpected tragedies or to overcome failures of empathy and communication by physicians." Sage, *supra* note 2, at 31.

47. Albert W. Wu et al., *Do House Officers Learn From Their Mistakes?*, 265 JAMA 2089, 2089-94 (1991).

48. Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001, 1001-07 (2003). One of the forty-six physicians who participated in the focus groups elaborated:

Everything you read and everything that you're told says that you are supposed to tell what errors you make as soon as you can. Let them know what your thinking is, what you are going to do about it. And your chances of having an adverse litigation are less if you take that approach. Now, the question is, how many of us believe that?

Id. at 1004.

49. See May & Aulisio, *supra* note 46, at 137 (for a description of how physicians' fear of litigation "engenders a climate of fear that inhibits open reporting of errors").

50. See Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York: The report of the Harvard Medical Practice Study to the State of New York* (1990), <http://www.nysl.nysed.gov/scandoclinks/OCM21331963.htm>.

51. Amanda Craig, *A Physician's Perspective on the Medical Malpractice Crisis*, 13 ANNALS HEALTH L. 623, 625-26 (2004).

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the culture of silence and fear for new physicians, but also acts as the primary impediment to the implementation of patient safety improvements.⁵²

The open communication of medical errors is just as important as the discussion of medical success to the development of meaningful patient safety improvements.⁵³ Yet physicians seem to be increasingly reluctant to discuss patient safety and quality improvements with their peers and colleagues.⁵⁴ In fact, a 2002 report by the U.S. Department of Health and Human Services (HHS) determined that as many as ninety-five percent of doctors “are reluctant to collect quality-related information and work together to act on it for fear that it will be used against them or their colleagues in a lawsuit.”⁵⁵ But open channels of communication and collaboration among physicians is exactly what is needed to ascertain how to best improve patient safety.⁵⁶

III. ADR’S MOST PREVALENT RESPONSE: VOLUNTARY BINDING ARBITRATION

Of the current alternative dispute resolution vehicles used by healthcare providers today, voluntary binding arbitration⁵⁷ is perhaps the most widely

52. Craig, *supra* note 51, at 625-26. The “climate of fear . . . is exacerbated by psychological feelings of stress and shame associated with malpractice.” May & Aulisio, *supra* note 46, at 137. This climate of fear is responsible for much of the resistance healthcare providers have to openly disclosing errors and negligence. *Id.*

53. *Id.* at 626.

54. *Id.*

55. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 3 (July 2002), available at <http://www.aspe.hhs.gov/daltcp/reports/litrefm.pdf>.

56. See Clinton & Obama, *supra* note 6, at 2205-08; see generally The National Medical Disclosure and Compensation (MEDiC) Act of 2005, S. 1784, *supra* note 8.

Any effort to prevent injury due to medical care is complicated by the dead weight of a litigation system that induces secrecy and silence. No matter how much we might insist that physicians have an ethical duty to report injuries resulting from medical care or to work on their prevention, fear of malpractice litigation drags us back to the status quo.

Troyen A. Brennan, *The Institute of Medicine Report on Medical Errors: Could it do Harm?* 342 NEW ENG. J. MED. 1123, 1125 (2000).

57. Binding arbitration produces a final decision that is binding on all interested parties. Patricia I. Carter, *Binding Arbitration in Malpractice Disputes: The Right Prescription for HMO Patients?*, 18 HAMLINE J. PUB. L. & POL’Y 423, 423 n.2 (1997). On the other hand, non-binding arbitration produces an advisory decision which may be rejected at the discretion of any party. *Id.*

used. Most states have enacted legislation allowing and governing the use of voluntary binding arbitration in medical malpractice cases.⁵⁸

A. Background

Elective arbitration procedures first surfaced in the 1970's as a cost containment mechanism used by hospitals involved in medical malpractice lawsuits.⁵⁹ However, problems inherent with the nonbinding nature of these arbitrations soon surfaced.⁶⁰ Voluntary binding arbitration filled this gap, and soon became the preeminent form of ADR employed by medical professionals.⁶¹ Today, many large Health Maintenance Organizations (HMO) employ some form of voluntary binding arbitration for the resolution of malpractice claims.⁶² A smaller percentage of private physicians and hospitals have also asked their patients to agree to remove malpractice claims from the courtroom by consenting to binding arbitration agreements.⁶³ The physicians who use such binding arbitration schemes claim that they: (1) present a more cost-effective resolution process than litigation and (2) decrease the resolution time when compared to a traditional medical malpractice trial.⁶⁴

58. Albert Yoon, *Mandatory Arbitration and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the West*, 6 AM. L. & ECON. REV. 95, 101 (2004). South Dakota and South Carolina have not. Carter, *supra* note 58, at 430.

59. Yoon, *supra* note 59, at 99.

60. Armand Leone, Jr., *As Health Care Enterprise Liability Expands . . . Is ADR The RX For Malpractice?*, 49-SEP DISP. RESOL. J. 7, 10 (1994).

Unless arbitration is binding, neither party prepares the case for a full presentation with the idea that it is best to keep something in reserve for use at the trial when the claim will really be decided. Furthermore, without binding arbitration, the losing side in arbitration gets two bites of the apple, and the benefits of reduced resolution time are lost.

Id.

61. Elizabeth Rolph et al., *Arbitration Agreements in Health Care: Myths and Reality*, 60 LAW & CONTEMP. PROBS. 153, 158-60 (1997).

62. Karl Polzer, *Emerging Issues in the Use of Binding Arbitration to Resolve Disputes between Individuals and Health Plans*, NAT'L HEALTH POL'Y F. 5 (2000). One RAND study found that eight of the twenty California HMOs reported using binding arbitration agreements with enrollees to resolve both contractual and medical malpractice disputes. *Id.* The RAND study also found that about nine percent of hospitals (roughly twenty percent of annual California hospital admissions) and nine percent of physicians surveyed used binding arbitration agreements to settle medical malpractice claims. *Id.*

63. See Yoon, *supra* note 59. Some states have even experimented with using arbitration screening panels to reduce the number of nonmeritorious suits in their court systems. *Id.*

64. Carter, *supra* note 58, at 451.

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B. The Contemporary Debate

Arbitration has become a synonymous complement to many state-level tort reform initiatives because of its professed advantages of economy and speed.⁶⁵ Statistical data from the American College of Obstetricians and Gynecologists suggest that its California members who used arbitration resolved their medical malpractice claims more quickly and for less money than the national average.⁶⁶ One national HMO has previously reported that “their arbitration cases last an average of nineteen months, compared with thirty-three months for the court system.”⁶⁷ This HMO also claimed its arbitration system compensated a larger percentage of injured patients compared to its prior experiences with malpractice litigation.⁶⁸ Other hospitals using similar arbitration techniques have reduced their legal defense costs by as much as twenty percent.⁶⁹ Despite initial concerns that arbitration may open the floodgates to frivolous litigation, research has shown the contrary.⁷⁰

However, the elusive benefits of medical malpractice arbitrations have generally tended to be one-sided, in favor of physician users.⁷¹ Data has shown that substituting litigation with binding arbitration may enlarge the pool of injured patients who are awarded some form of compensation, but compensation levels in arbitrated cases have proven to be much smaller than

65. *See id.*

66. D. Lawrence, *The Market Is Already Doing It*, WALL ST. J., Mar. 16, 1994, at A18, Col. 4. However, this claim must be taken in context. At the time of the study, arbitrators hearing the California malpractice disputes were bound by MICRA, and therefore capped any award of non-economic damages at \$250,000. NICHOLAS M. PACE, LAURA ZAKARAS & DANIELA GOLINELLI, CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS: CALIFORNIA JURY VERDICTS UNDER MICRA, 47-48 (RAND 2004). At the time of the study, fewer than twenty states had enacted any form non-economic caps on medical malpractice awards. *Id.* Comparing California arbitration costs to national average litigation costs where the mean of states had not imposed similar non-economic damage caps is akin to comparing apples and oranges. While arbitration alone may have a marginalizing effect on awards, RAND research has shown that, in medical malpractice suits, the imposition of a \$250,000 non-economic award cap: (1) reduces defendants’ liabilities by thirty percent and (2) reduces attorney fees by sixty percent. *See id.*

67. Carter, *supra* note 58, at 439.

68. *Id.*

69. Leone, Jr., *supra* note 61, at 12.

70. *Id.* The observed frequency of all claims filed against hospitals using voluntary binding arbitration declined by more than sixty percent. *Id.* “Most importantly, the defense costs of resolving frivolous claims were reduced by 59%.” *Id.*

71. Carter, *supra* note 58, at 449.

similar jury awards.⁷² Although patients may pay less attorney fees during the course of an arbitration, any savings will likely be completely offset by a comparatively lower damage award.⁷³ Another study of medical malpractice in Nevada suggests that arbitration's most discernable effect is the substantial reduction of claims resolved by the State's court system.⁷⁴ The Nevada study found that the use of arbitration had no statistically significant effect on the time spent resolving claims, the amount insurers paid to plaintiffs, or the amount insurers paid to process claims.⁷⁵ Recent research into compensation levels of arbitrated medical malpractice cases has produced contradictory sets of data and inconclusive findings.⁷⁶ Such economic comparisons between medical malpractice arbitration awards and jury awards are difficult to derive because most information from binding arbitration awards remains confidential.⁷⁷

However, the chief criticisms of voluntary binding arbitration programs are not driven by economic considerations. Many scholars and practitioners have noted that voluntary binding arbitration policies do not accord with traditional notions of alternative dispute resolution.⁷⁸ In fact, the auspices of binding arbitration are closely aligned with those of traditional litigation, and stand in contrast to nonbinding arbitration and mediation. However, binding arbitration's mechanical departures from litigation favor physician users more than patients. Foremost, arbitration is highly adversarial in nature. Although more conciliatory than litigation, binding arbitration eclipses nonbinding arbitration and mediation in terms of parties' hostilities towards

72. *Id.* at 438-39. Similarly, the GAO has determined that between 1977 and 1990 Michigan's Medical Malpractice Arbitration Program reduced average awards by roughly thirty percent versus litigated cases. U.S. GENERAL ACCOUNTING OFFICE, *MEDICAL MALPRACTICE: ALTERNATIVES TO LITIGATION*, app. III-V at 23-29 (1992). The GAO's report determined that arbitration panels awarded compensation to plaintiffs in only seventy of 272 claims, noting "defense costs to be essentially the same in arbitration as in litigation." Carter, *supra* note 58, at 439.

73. See Polzer, *supra* note 63.

74. Yoon, *supra* note 59, at 131. This study compared trends in medical malpractice litigation prior to and after the establishment of mandatory screening panel arbitration enacted by the Nevada Legislature in 1986. *Id.* at 95-112. The screening panels, although rendering no award calculation, may have functioned as a form of mandatory arbitration. *Id.* at 131. The panels were charged with determining whether there was sufficient evidence to make a finding of liability. *Id.* at 102. If the panel found liability and both parties accepted the panel's recommendation, the case was sent to state court where an unassociated judge determined the monetary amount of damages awarded. *Id.*

75. *Id.* at 131. Plaintiffs' attorney expenditures were not assessed in the data analyzed by the study. See *id.*

76. See *id.*

77. See Polzer, *supra* note 63, at 5.

78. See generally Jean R. Sternlight, *Is Binding Arbitration a Form of ADR?: An Argument that the Term "ADR" Has Begun to Oulive Its Usefulness*, 2000 J. DISP. RESOL. 97 (2000).

one another.⁷⁹ This climate of rivalry is espoused by the finality of the arbitration process.⁸⁰ Disputes over the selection of arbitrators are quite common and, in addition to raising the parties' tension levels, can significantly delay the commencement of proceedings.

In 1986, Congress enacted legislation that formally recognized the need for elevated levels of transparency in the dissemination of information relating to instances of medical malpractice.⁸¹ Congress decreed the establishment of the National Practitioner Data Bank (NPDB) to encourage "[s]tate licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior."⁸² Today, the NPDB is the most commonly used database for storing and retrieving documented instances of an individual physician's previous medical malpractice payments and history of disciplinary actions.⁸³ Unfortunately, public knowledge of alleged or actual negligence by individual physicians is complicated by the application of an enterprise theory of liability in arbitrations of medical malpractice cases where an HMO or medical group is a named plaintiff. This is because the application of an enterprise theory of liability prevents individual physicians from being cataloged in the NPDB if an arbitration award is entered against an HMO or medical group.⁸⁴ Some HMOs have responded that any protection of privacy derived from arbitration proceedings benefits the patient. These proponents claim that arbitration offers an advantage to traditional lawsuits in that it protects the disclosure of patients' private information. In reality, such privacy protections benefit HMOs and their

79. See generally William M. Sage, *Health Law 2000: The Legal System And The Changing Health Care Market*, 15 HEALTH AFF. 9 (1996) (discussing how in touting the benefits of health plan-based arbitration mechanisms, proponents of arbitration too often neglect to mention the offsetting effects of the perceived bias of arbitrators, and duress induced from the modern perceptions of binding arbitration).

80. See generally Rolph et al., *supra* note 62, at 156. There is a relatively high improbability of successfully appealing the arbitrators' award. See *id.*; See also Polzer, *supra* note 63, at 5.

81. See The Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 (2005).

82. National Practitioner Data Bank (NPDB), <http://www.npdb-hipdb.hrsa.gov/npdb.html> (last visited Oct. 20, 2007).

83. *Id.*; Wayne J. Guglielmo, *Are Doctors Evading the Malpractice Data Bank?*, 73 MED. ECON. 52, 53 (1996). According to the former President of the Physician Insurers Association of America, "NPDB officials acknowledge that "the number of malpractice-payment reports may have been affected by the corporate shield effect" but the extent to which this occurs "cannot be conclusively measured by available data." Lawrence E. Smarr, *Medical Malpractice: External Influences and Controls*, 60 LAW & CONTEMP. PROBS. 59, 67 (1997).

84. *Id.* at 52.

physicians more than patients.⁸⁵ Since the monetary amount and basis of any awards remain confidential, the election of arbitration may shield HMOs, physicians, and hospitals from most public acknowledgments of any potentially damaging findings of malpractice or negligence in the event of an adverse award.⁸⁶ In the long run, the more troubling derivation of this inherent secrecy is the general lack of publicly-available, comparative information by which researchers can study arbitration awards in medical malpractice disputes.⁸⁷

IV. CURRENT LEGISLATIVE ENVIRONMENT

The emerging science of patient safety has been largely ignored by recent calls for the expansion of existing tort reforms, most notably the use of non-economic damage caps.⁸⁸ Although some state reforms have proven more effective than others, the IOM's call for a nationwide reporting system still remains unanswered.⁸⁹

A. Non-Economic Damage Caps

As the cost of healthcare increases nationwide, President George W. Bush has called on legislators to pass a nationwide \$250,000 cap on non-economic damages in medical malpractice cases.⁹⁰ The limitation of non-economic damage awards in medical malpractice cases has been touted as a leading tort reform solution to rising medical insurance and health care costs.⁹¹ According to the U.S. General Accounting Office:

85. Carter, *supra* note 58, at 445-46. The private nature of the arbitration between patient(s) and physician(s), coupled with the privileged nature of communications during the arbitration, produces an overall dearth of publicity surrounding the legal proceeding. *Id.* at 446. The cameras, reporters, open transcripts, interviews, and public audience are missing—the environment in which the arbitration occurs is most definitely private. *Id.*

86. Carter, *supra* note 58, at 446-47.

87. *See id.* at 447. Eventually, binding arbitration's shielding of medical errors may remove a layer of the court's discretionary policymaking power and release the medical malpractice reform to the whims of a laissez-faire market control. *Id.* at 630-31.

88. *See generally* Bryan A. Liang, *The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal Systems*, 29 J.L. MED. & ETHICS 346 (2001).

89. *See id.*; *See also* THE INSTITUTE OF MEDICINE, *supra* note 3.

90. Fact Sheet: President Calls for Medical Liability Reform, <http://www.whitehouse.gov/news/releases/2003/01/20030116.html> (last visited Oct. 20, 2007). President Bush's non-economic damage cap is closely modeled after California's 1975 Medical Injury Compensation Reform Act (MICRA). *Id.*; CAL. CIV. CODE § 3333.2 (West 2006).

91. PACE ET AL., *supra* note 67, at 47-48. Since California's enactment of the first state-level non-economic damages cap in 1975, eleven other states have enacted similar non-economic damage

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After 2000, premium rates began to rise across most states on average, but more slowly among the states with certain non-economic damage caps. In particular, from 2001 to 2002, the average rates of increase in the states with non-economic damage caps of \$250,000 and \$500,000 or less were 10 and 9 percent, respectively, compared to 29 percent in the states with limited reforms.⁹²

However, it has been difficult to substantiate whether California's Medical Injury Compensation Reform Act (MICRA) has in fact reduced the price of premiums paid by California physicians.⁹³ As is the case with most tort reforms, MICRA has been criticized as a metaphorical "double edged sword." Several caveats of MICRA have been identified as having a propensity for significant inequity. First, in cases of catastrophic medical error, the application of non-economic damages caps may isolate the effect of the jury award at the policymaking level.⁹⁴ In these instances of substantial error, there is a need for "carve-out" provisions. Second, the capping of non-economic damages has shifted the perception of risks and rewards for medical malpractice plaintiffs' attorneys by reallocating the costs for compensating medical malpractice from defendants to plaintiffs and their counsel.⁹⁵ This reallocation of cost has increased plaintiffs' attorneys' selectivity of cases, and has likely prevented a subset of injured plaintiffs from finding effective counsel on a contingency basis.⁹⁶

B. Mandatory Reporting Systems

Twenty-one states have enacted legislation requiring the mandatory reporting of medical errors to state agencies.⁹⁷ However, these mandatory reporting systems contain certain concessionary provisions which reinforce the contention that physicians fear that the open reporting of medical

tort reforms. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE REFORM: PERSPECTIVES ON RECENT FINDINGS BY THE GAO 1 (2003), <http://www.house.gov/jec/tort/12-04-03.pdf>. A significant difference between these states' reforms is the amount by which non-economic damages are limited. *Id.* Four states limit non-economic damage awards to \$250,000, while eight states limit non-economic damage awards to an amount between \$250,000 and \$500,000. *Id.*

92. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 31 (2003).

93. PACE ET AL., *supra* note 67, at 47.

94. *Id.* at 58.

95. *Id.*

96. *Id.*

97. MIMI MARCHEV, NAT'L ACAD. STATE HEALTH POL'Y, MEDICAL MALPRACTICE AND MEDICAL DISCLOSURE: BALANCING FACTS AND FEARS 2 (2003); BAKER, *supra* note 3, at 166-67.

mistakes will cause an increased level of litigation.⁹⁸ For instance, a recent National Academy for State Health Policy (NASHP) survey found that most state reporting systems exempted certain reports of medical error from public disclosure laws, and allowed some medical errors to be reported without associating the individual(s) involved.⁹⁹ Available evidence and research do not indicate that these reporting systems have increased the occurrence of medical malpractice filings in any of the respective states.¹⁰⁰ Nevertheless, the United States still lacks a nationwide reporting system to supplement the NPDB.¹⁰¹

V. THE NATIONAL MEDICAL ERROR AND COMPENSATION (MEDIC) ACT OF 2005

Senators Hillary Rodham Clinton and Barack Obama introduced Senate Bill 1784, "The National Medical Error and Compensation (MEDiC) Act of 2005," on September 28, 2005.¹⁰² The bill extends the scope of the Patient Safety and Quality Improvement Act of 2005, in order to further "promote a culture of safety within hospitals, health systems, clinics, and other sites of health care."¹⁰³ The MEDiC Act's goals are fourfold: (1) to improve the quality of health care and open communications between patients and healthcare providers by encouraging the robust disclosure of medical errors and patient safety events; (2) to ensure patients are offered reasonable financial settlements for injuries caused by medical error, negligence, or malpractice; (3) to reduce the occurrence of preventable medical errors; and (4) to reduce the cost of medical malpractice liability insurance for healthcare providers.¹⁰⁴

98. See May & Aulisio, *supra* note 49, at 135-36.

99. MARCHEV, *supra* note 98, at 2.

100. *Id.* at 2-5; May & Aulisio, *supra* note 49, at 143.

101. See generally THE INSTITUTE OF MEDICINE, *supra* note 3.

102. See Clinton & Obama, *supra* note 6.

103. The National Medical Disclosure and Compensation (MEDiC) Act of 2005, *supra* note 8, at § 3. Technically, Senate Bill 1784 sought to expand certain proviso of Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by the Patient Safety and Quality Improvement Act of 2005 (Public Law 109-41). *Id.* Senator Clinton contended the bill "build[s] on the patient safety bill that was signed into law earlier this summer by creating a voluntary program to encourage disclosure of errors, an opportunity to enter negotiations and early settlement, while, at the same time, protecting patients' rights and providing liability protection for healthcare providers who participate in the program." 109 CONG. REC. S10599 (2005).

104. The National Medical Disclosure and Compensation (MEDiC) Act of 2005, S. 1784, *supra* note 8, at § 932. The oft-cited 1999 IOM report supports the goals of the MEDiC Act. See generally THE INSTITUTE OF MEDICINE, *supra* note 3, at 1-2.

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The namesake section of the Act establishes the Medical Error Disclosure and Compensation (MEDiC) Program. The MEDiC Program seeks to foster an environment more conducive to the communication and disclosure of medical errors. The crux of the program, causing considerable debate among health care professionals and policymakers, calls for the timely disclosure of medical errors to the patient, accompanied by an offer to the patient to enter into negotiations for fair compensation.¹⁰⁵ This reporting and disclosure system would commence when a MEDiC program participant becomes aware of any medical error,¹⁰⁶ patient safety event,¹⁰⁷ or notice of legal action related to the medical liability of that participant health care provider.¹⁰⁸ Once aware of the notification event, the participant would be contractually required to fully disclose the suspected medical error, patient safety event, or pending legal action to the participant's designated patient safety officer.¹⁰⁹ The designated patient safety officer must then complete a root cause analysis of the report.¹¹⁰ If the patient safety officer concludes that a patient was injured or harmed as a result of medical error or any breach of the relevant standard of care, the participant would be required to swiftly disclose the matter to the patient verbally, and submit a full, written disclosure to the patient.¹¹¹

105. S. 1784, § 935. Senators Clinton and Obama tailored the program's disclosure and negotiation sections around similar successful programs implemented by the University of Michigan Health System and the Veterans Affairs (VA) Hospital in Lexington, Kentucky. See Clinton & Obama, *supra* note 6. Both programs have resulted in the a significant reduction of the amount of money spent on medical malpractice lawsuits when physicians disclosed that a medical error had in fact occurred, and patients were offered fair monetary compensations for their injuries. *Id.* According to Senator Obama, the MEDiC Program "builds on these hopeful results and incorporates them into a national program." 109 CONG. REC. S10600 (daily ed. Sept. 28, 2005) (statement of Sen. Obama).

106. The term 'medical error' means an unexpected occurrence involving death or serious physical or psychological injury, or the risk of such injury, including any process variation of which recurrence may carry significant chance of a serious adverse outcome. S. 1784, § 931(4).

107. The term 'patient safety event' means an occurrence, incident, or process that either contributes to, or has the potential to contribute to, a patient injury or degrades the ability of healthcare providers to provide the appropriate standard of care. *Id.* § 931(8).

108. *Id.* § 935(c)(4)(B).

109. *Id.* § 935(b)(2).

110. *Id.* § 935. The root cause analysis of each report must be completed within ninety days of the report's receipt, and must be electronically submitted to the National Patient Safety Database. *Id.* § 935(c)(10).

111. *Id.* § 935. If a patient was harmed or injured as the result of a medical error, or as a result of the relevant standard of care not being followed, the MEDiC program participant must disclose an account of the incident or occurrence to the patient not later than 5 business days after becoming

During the verbal disclosure to the patient, the bill directs the participant to initiate an offer to the affected patient to commence negotiations so that the patient can be presented with fair compensation for the adverse medical event.¹¹² At this point, the patient must consent to an agreement for negotiations after first acknowledging: (1) the confidentiality of such negotiation proceedings; (2) that any “apology or expression of remorse” during the negotiation proceedings is both confidential and inadmissible in any “subsequent legal proceedings as an admission of guilt” if the negotiation proceedings fail to produce a mutually accepted settlement; and (3) that the patient does have a constitutional right to legal counsel.¹¹³ Additionally, both parties may elect to involve a “neutral third party mediator to facilitate” a settlement during the negotiation proceedings.¹¹⁴ The initial duration of the negotiations would be limited to a six-month period.¹¹⁵ As drafted, the bill allows for a onetime extension of three months if the initial negotiation period lapses and all parties to the negotiation request such an extension.¹¹⁶ If the parties do arrive at a mutually acceptable settlement, such an agreement would be deemed a final settlement, barring any further litigation with respect to such matters in federal or state court.¹¹⁷

The MEDiC Act would establish two new entities within the United States Department of Health and Human Services charged with reducing the occurrence of preventable medical errors.¹¹⁸ The proposed Office of Patient Safety and Health Care Quality would collaborate with the proposed Agency for Healthcare Research and Quality to document medical error events and suggest corresponding improvements to increase patient safety.¹¹⁹ The MEDiC Act would establish and maintain a National Patient Safety Database (NPSD) to collect confidential patient safety data from

aware that the injury’s cause. *Id.* § 935(c)(6). The completion status of the root cause analysis does not affect the tolling of 5 day requirement. *Id.* § 935.

112. S. 1784, § 935. At the discretion of the health care provider involved, an apology or expression of remorse may be issued to the patient. *Id.* § 935(c)(9)(B). At this time, the health care provider may also elect to relay to the patient any efforts it plans to undertake in order to prevent a similar reoccurrence. *Id.* § 935(c)(9)(C).

113. S. 1784, § 935(d). If the patient elects to proceed with the negotiations absent counsel, the patient must submit “an affirmative declaration that no coercive or otherwise inappropriate action was taken to dissuade a patient from utilizing counsel for the negotiations.” *Id.* § 935(d)(1)(C).

114. S. 1784, § 935(d)(2).

115. *Id.* § 935(d)(3).

116. *Id.* § 935(d)(3)(B).

117. *Id.* § 935(d)(5).

118. *Id.* §§ 933-35.

119. *See id.* § 933(a).

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participating hospitals.¹²⁰ The NPSD would be electronically accessible to participants and governmental agencies for research purposes.¹²¹ The MEDiC Act would require the regular publication of research studies to analyze the patient safety data in the NPSD to recommend performance and systems standards, best practices for the prevention of medical errors, improvements to patient safety, and changes to increase the general level of accountability within the health care system.¹²²

The MEDiC Act seeks to reduce the cost of medical liability insurance for doctors, hospitals, and healthcare providers by reducing the actual rates of preventable medical errors.¹²³ The primary vehicle to these ends is the Medical Liability Insurance Study commissioned by the Director of the MEDiC Program.¹²⁴ The study's goal is to identify, measure, and track health care changes that have stabilized or reduced the medial liability premiums of healthcare providers.¹²⁵ Program participants would be required to use the savings realized by the reduction of legal defense costs to decrease liability insurance premiums.¹²⁶ Finally, the bill takes a laissez-faire approach to long-term insurance stabilizations in that it relies on the insurance market's favorable response to participants' lower levels of overall risk.¹²⁷

A. *The Record*

In the current legal and regulatory environment, certain derivatives of the medical malpractice lawsuit play indispensable roles in the furtherance

120. S. 1784, §§ 934, 935(a)-(b).

121. *See id.* §§ 934-35.

122. S. 1784, §§ 933-939. The Director of the MEDiC Program will be responsible for the publication of The National Patient Safety and Fair Compensation Accountability Study, The Medical Liability Insurance Study, and The Study to Reduce the Incidence of Lawsuits Not Related to Medical Error. *Id.* § 933(c)(6)-(13).

123. S. 1784, § 932. Senator Obama hopes the MEDiC Act “will help reduce medical error rates and medical malpractice costs by opening the lines of communication between doctors and patients—encouraging honesty and accountability in the process.” 109 CONG. REC. S10596-01 (2005).

124. S. 1784, § 938.

125. *Id.*

126. *See id.* § 935(c)(2).

127. *See generally* BAKER, *supra* note 3, at 68-92. Although the very nature of the insurance market essentially spreads the cost of loss among insured parties, the University of Michigan Health System and Ann Arbor VA Hospitals have both negotiated lower liability insurance premiums based on the success of their programs. *Id.*

of patient safety initiatives. The documentation of negligence and medical error attributable to the modern malpractice lawsuit provides an accessible collective knowledge of past medical errors as well as a quantifiable sampling to measure the effectiveness of patient safety mechanisms.¹²⁸ In order for any medical liability system to function effectively, there must be reliable measures of medical error events by which administrators are able to identify specific areas needing safety reforms.¹²⁹ The same database is equally important in order to ascertain the degree to which implemented safety improvements are effective.¹³⁰ Accordingly, any proposed medical malpractice liability reform or adjudication mechanism must consider the quality of its information management.

In many ways, the networks of information management embedded within the MEDiC Act are superior to those of most states' present legal system.¹³¹ The MEDiC Act would require the recording of suspected medical errors and patient safety events.¹³² After the participant's designated patient safety officer would compile a preliminary root cause analysis of the occurrence,¹³³ the report would be shared with other program participants via the MEDiC Program's national electronic database.¹³⁴ The primary motivation for uncovering and documenting actual medical errors and near misses is the legitimate improvement of patient safety systems.¹³⁵ Through the robust disclosure of medical errors with thorough analysis and

128. *See id.* at 93-117.

129. Litigation filings are not to most effective analytical tools because: (1) most patients who suffer a medical error do not actually sue; (2) many patients who suffer a medical error are never made aware of that error; and (3) the filing of litigation is not necessarily correlated to the severity or frequency of actual medical errors. *See generally* BAKER, *supra* note 3; Guglielmo, *supra* note 84. Nonetheless, the litigation system is able to weed out most frivolous lawsuits. *See* BAKER, *supra* note 3, at 77, 83-87. The remaining record of jury verdicts, coupled with internal insurance records and hospital reports, are usually the primary sources used by administrators in deciding where improvements to patient safety are most necessary. *Id.* at 71-77.

130. This is especially important because many patient safety improvements are instituted on an economic cost-benefit basis. *See generally* BAKER, *supra* note 3; Guglielmo, *supra* note 84. Measuring the designed effectiveness of such improvements is key because doctors and hospitals face a 'double whammy' if plaintiffs prevail in subsequent litigation: the defendants are usually liable for a portion of the attorney costs and the jury award or settlement; the defendants' liability insurance provider will increase premiums accordingly. *Id.*

131. *See* Catherine Becker, *The MEDiC Act of 2005: A New Approach to Safety*, 82 AORN J. 1055, 1055 (2005).

132. The National Medical Disclosure and Compensation (MEDiC) Act of 2005, S. 1784, *supra* note 8, at §§ 934(a)(4), 935(a), 109th Cong. (1st Sess. 2005).

133. *Id.* § 935(e)(2).

134. *Id.* §§ 934(c), 935(a).

135. *Id.* § 932.

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intervention, the Act seeks to document the data necessary to attack recurring occurrences of medical errors.¹³⁶

The MEDiC Act's medical error documentation process is modeled after the successes of predecessor programs, such as the system of full disclosure that has been used by the University of Michigan Health System since 2000.¹³⁷ First started at the Ann Arbor VA Medical Center, the University of Michigan Patient Safety Enhancement Program (PSEP) is primarily focused on increasing the quality of patient care by conducting research to focus on methods of avoiding and preventing adverse patient outcomes and injuries caused by the processes of the health care system.¹³⁸ PSEP's first tier is the collection of reported medical errors and patient safety events.¹³⁹ In practice, this task is facilitated because administrators and doctors agree to work together to quickly analyze and disclose medical errors to patients, in the hope that a swift disclosure and apology would lead to a fair compensation settlement and a drastic reduction in patient litigation filings.¹⁴⁰

The PSEP uses the collected data to: "(1) conduct, synthesize, and disseminate research aimed at reducing hospital-associated patient complications; (2) systematically evaluate errors in processes of care that undermine patient safety; and (3) operationalize these research findings by systematizing methods to improve the safety of hospitalized patients."¹⁴¹ One of the hospital's first patient safety improvement projects was to decrease the relatively high occurrence of infections in patients treated with catheters.¹⁴² The hospital used its cumulative data to diagnose the problem, and postulate a course of corrective action.¹⁴³ The program administrator found that although the hospital was using an appropriate FDA-approved catheter, there existed a possibility of further reducing infections if the

136. *Id.*

137. *See* Clinton & Obama, *supra* note 6, at 2207.

138. Ann Arbor VA Medical Center/University of Michigan Health System Patient Safety Enhancement Program, <http://www.med.umich.edu/psep/> (last visited Oct. 19, 2007).

139. *Id.*

140. Carrie Hagen, *A Prescription for Patient Safety*, U. MICH. HEALTH SYS., Oct. 31, 2002, <http://www.med.umich.edu/opm/newspage/2002/patsafe.htm>. Doctors and administrators told the adversely-affected patients that the data collected by program was being used to improve the hospitals safety systems, so that any the recurrence of errors could be prevented in the near future.

Id.

141. Patient Safety Enhancement Program, *supra* note 139.

142. *A Prescription for Patient Safety*, *supra* note 141.

143. *Id.*

hospital switched to a newly approved antiseptic coated catheter.¹⁴⁴ The hospital instituted the recommendation, and within a few months, the rate of infections was reduced by roughly thirty-six percent.¹⁴⁵

The MEDiC Act is closely modeled on the success of the PSEP and NPDB. In summary, the documentation, tracking, and transparency functions of the MEDiC Act would be far superior to the modern legal system's offering because: (1) medical professionals would be given new incentives to disclose errors that would have previously remained unreported; (2) hospital administrators would be able to comprehensively compare their data on medical errors against other participants' data, and would be able to identify and target internal systems that generate comparatively high occurrences of medical errors; (3) the Office of Patient Safety and Health Care Quality would be able to identify nationwide patient safety deficiencies and recommend improvements to the United States Department of Health and Human Services; and (4) medical malpractice liability insurers would be able to more effectively analyze risk factors.¹⁴⁶

B. The Disclosure

The "culture of silence," promulgated by misconceptions of the litigious patient and runaway juries, directly clashes with the value that modern American society places on the open communication between doctors and their patients.¹⁴⁷ This unintended consequence of the modern tort system has been relatively unaffected by recent tort reforms, and continues to instigate the suppression of the very information necessary to develop more effective patient safety measures.¹⁴⁸ The lasting emotional trauma for injured patients and family members is exacerbated when compounded with perceptions of concealment and less-than-full disclosures from healthcare providers.¹⁴⁹ What patients and family members desire most is an honest and open dialogue regarding the errors that caused the injury, and an explanation of how the healthcare provider plans on preventing future occurrences of similar errors.¹⁵⁰ It is no wonder that when patients and family members perceive they are being told the whole truth, they are much

144. *Id.*

145. *Id.*

146. *See generally* Becker, *supra* note 132.

147. *See* Wu et al., *To Tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients*, 12 J. GEN. INTERNAL MED. 770, 774 (1997).

148. *See id.* at 770-74.

149. *Id.* at 771.

150. Gallagher et al., *supra* note 48, at 1005.

less likely to initiate litigation.¹⁵¹ Unfortunately, the opinions of many healthcare providers have not been swayed by the empirical evidence. These professionals, the majority of which will never face a malpractice trial, remain unwilling to make full disclosures of errors coupled with apologies or commitments to change because they are afraid these statements will be used in court as evidence demonstrating their negligence.¹⁵² This stalemate can be overcome only if healthcare providers receive assurance of legal protection for their medical error disclosures.¹⁵³

The magnitude of undisclosed errors is startling. A recent national survey indicates that only about thirty percent of respondents who suffered a medical error were informed of that error by the responsible medical professional.¹⁵⁴ This is unsurprising, considering some medical professionals fail to disclose mistakes to patients due to a commonly held fear that such a disclosure will be an admission of guilt and will lead to a malpractice suit, damage professional reputation, and have no bearing on the patient's recovery.¹⁵⁵ This startling statistic is even more troubling considering that the American Medical Association instructs doctors that, "[c]oncern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient."¹⁵⁶ Healthcare providers should acknowledge their self-interest in candidly disclosing medical errors to patients. A medical professional's early disclosure of medical mistakes to affected patients may decrease the likelihood of litigation and subsequent findings of legal liability, reduce the likelihood of professional sanctions, and help the medical professional accept their responsibility for the mistake.¹⁵⁷

151. *See id.*

152. *Id.* at 1001.

153. *See id.* at 1006.

154. *Id.* at 1001.

155. *See id.* at 1003-06.

156. *See* AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: ANNOTATED CURRENT OPINIONS (2007). A therapeutic privilege exempts physicians from making detailed disclosures when such a disclosure will have a "high likelihood of causing serious and irreversible harm to the patient." American College of Physicians, *American College of Physicians Ethics Manual*, 117 ANN. INTERNAL MED. 947, 947-60 (3d ed. 1992).

157. *See* Gutheil, Bursztajn & Brodsky, *Malpractice Prevention Through the Sharing of Uncertainty: Informed Consent and the Therapeutic Alliance*, 311 NEW ENG. J. MED. 49, 48-51 (1984).

A recent study published in the Journal of General Internal Medicine found that the nondisclosure of medical errors increased the likelihood of patients seeking legal advice, and was associated with a more negative emotional response.¹⁵⁸ The conservative study concluded that a policy of robust disclosure is likely to have a positive effect on how patients respond to medical errors.¹⁵⁹ Even more persuasive evidence comes from the Patient Safety Enhancement Program. The PSEP encourages proactive risk reduction, and is one of the first U.S. hospital programs to train its staff in making full disclosures of medical errors to patients.¹⁶⁰ The PSEP has “reduced the number of malpractice claims pending against [its] doctors, slashed [its] malpractice expenses, dramatically dropped the amount paid to plaintiffs as a result of judgments or settlements, and cut the time it takes to handle a claim.”¹⁶¹ Since the PSEP was introduced, the hospital system has reduced the number of pending malpractice suits from 260 to less than 100.¹⁶² Other hospital systems have emulated the disclosure policies of PSEP, which are highlighted in a new training film designed to instruct medical staffers how to make effective error disclosures.¹⁶³

C. The Power of Empathy

Malpractice suits often result when a medical error is met with a lack of empathy from physicians and hospital staff.¹⁶⁴ However, when an expression of sympathy or apology is given to patients and their family members in conjunction with the disclosure of medical error, they are less likely to sue.¹⁶⁵ The Pew Demonstration Mediation and ADR Project has substantiated that different categories of apologies have very different effects in a disclosure setting.¹⁶⁶ Apologies of sympathy convey the notion

158. Kathleen Mazor et al., *Disclosure of Medical Errors: What Factors Influence How Patients Respond?*, 21 J. GEN. INT. MED. 704, 707-10 (2006).

159. *See id.* The study concluded that full disclosures most often had a positive effect on how patients responded to medical errors. *Id.* In some instances of disclosure, there was no change between the patient’s reaction when the disclosure was given, compared to when the disclosure was withheld. *Id.* Only in rare circumstances did the patient respond more negatively. *Id.*

160. The University of Michigan Health System (UMHS) Approach to Malpractice Claims, <http://www.med.umich.edu/news/umhsm.htm> (last visited Oct. 20, 2007). UMHS uses a ‘triad’ approach which stresses communication, full disclosure, and learning from experience. *Id.*

161. *Id.*

162. Laura Landro, *The Informed Patient: Doctors Learn to Say ‘I’m Sorry’*, WALL ST. J., Jan. 24, 2007, at D5.

163. *See id.*

164. *See* Clinton & Obama, *supra* note 6.

165. *See* Gallagher et al., *supra* note 48.

166. Liebman & Hyman, *supra* note 5, at 27.

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of objective empathy for a patient's situation.¹⁶⁷ An apology of sympathy may resemble a statement akin to "I'm sorry this happened to you."¹⁶⁸ Apologies of responsibility connote some type of fault, on behalf of the individual making the apology, for the events which injured the patient.¹⁶⁹ An apology of responsibility may be expressed as "I'm sorry we did this to you."¹⁷⁰ Injured patients and their family members are much more likely to respond favorably to apologies of responsibility than apologies of sympathy.¹⁷¹ However, healthcare providers are far less likely to give an apology of responsibility because of the perception of legal liability that may attach to it.¹⁷²

This conundrum of empathy has spurred the Joint Commission on Accreditation of Healthcare Organizations to recommend the extension of legislation to protect disclosure and apology from being used as evidence of liability in the event of ensuing litigation against the apologizer or associated healthcare provider.¹⁷³ Twenty-nine states have enacted laws which, to varying degrees, disallow the introduction of expressions of sympathy after accidents as proof of liability in a state court of law.¹⁷⁴ The MEDiC Act synthesizes these diverse "apology laws" into national legislation applicable to voluntary program participants. Under the bill, any apology offered by a healthcare provider during the negotiations provided for by the Act, shall be

167. *Id.*168. *Id.*169. *Id.*170. *Id.*171. *See id.* at 27-28.172. *See id.* at 28.

173. *Innovative Solutions to Medical Liability: Hearing Before the House Committee on Energy and Commerce, Subcommittee on Health*, 109th Cong. 117 (2006) (testimony of Margaret VanAmringe, M.H.S. Vice President, Public Policy and Government Relations Joint Commission on Accreditation of Healthcare Organizations).

174. ARIZ. REV. STAT., § 12-2605 (2005); CAL. EVID. CODE § 1160 (2006); COLO. REV. STAT. § 13-25-135 (2003); 2005 Conn. Pub. Acts 05-275; FLA. STAT. § 90.4026 (2001); GA. CODE ANN. § 24-3-37.1 (2005); HAW. REV. STAT. § 626-1 (2006); LA. REV. STAT. § 3715.5 (2005); MASS. GEN. LAWS ch.233, § 23D (1986); MD. CODE ANN., CTS., & JUD. PROC. § 10-920 (2004); ME. REV. STAT. ANN. tit. 24, § 2908 (2005); N. C. GEN. STAT. § 8C-1 (2007); N. H. REV. STAT. ANN. § 507-E:4 (2005); OHIO REV. CODE ANN. § 2317.43 (2004); OKLA. STAT. tit. 63, § 1-1708.1H (2004); OR. REV. STAT. § 677.082 (2003); S. C. CODE ANN. § 19-1-190 (2006); TENN. EVID. RULE § 409.1 (2003); TEXAS CIV. PRAC. & REM. CODE § 18.061 (1999); VA. CODE ANN. § 8.01-52.1 (2005); VT. STAT. ANN. tit. 12, § 1912 (2006); WASH. REV. CODE § 5.66.010 (2002); WYO. STAT. ANN. § 1-1-130 (2004). These "apology laws" essentially allow doctors to say 'I'm sorry' without the apology being used against them in malpractice suits. *See generally* Clinton & Obama, *supra* note 6.

kept confidential.¹⁷⁵ Any such apology would be shielded to the extent it would be prohibited from introduction in any subsequent legal proceedings as an admission of guilt or culpability in the event those negotiations ended without an offer and acceptance of compensation.¹⁷⁶

The MEDiC Act recognizes that when a healthcare provider decides to disclose a medical error to an effected patient, the outcome of that disclosure is largely determined by how effectively the healthcare provider meets the patient's empathetic needs.¹⁷⁷ Although the MEDiC Act leaves individual health care organizations and providers much discretion as to what form of apology is given, if any, most program participants will likely find it is in the best interest of themselves and their patients to convey some notion of lasting empathy to effected patients.¹⁷⁸ For example, the Children's Hospitals and Clinics of Minnesota adopted a full-disclosure program that incorporated the successes of the Michigan's PSEP and Ann Arbor VA's disclosure program.¹⁷⁹ Children's Hospitals' process of disclosure and truth-

175. The National Medical Disclosure and Compensation (MEDiC) Act of 2005, S. 1784, *supra* note 8, at § 935(d)(1)(b), 109th Cong. (1st Sess. 2005).

An agreement that any apology or expression of remorse by a doctor or other designated health care provider at any time during the negotiations shall be kept confidential and shall not be used in any subsequent legal proceedings as an admission of guilt if such negotiations end without an offer of compensation that is acceptable to both parties.

Id.

176. *Id.*

177. *Id.* Healthcare providers' behavior during a disclosure of medical error influences the patient's perception of the health care organization and can be a pinnacle point in a patient's formulation of how to react to the disclosure. JULIE MORATH & TERRY HART, PARTNERING WITH FAMILIES: DISCLOSURE AND TRUST, 2-5, <http://www.npsf.org/download/Morath.pdf>. Similarly, Senator Obama urges that "[w]hen patients are treated with respect and told the truth, they sue less. More are actually compensated for their injuries . . . and health care professionals actually learn from their mistakes so they're not repeated and lives are saved." 109 CONG. REC. S10600 (daily ed. Sept. 28, 2005) (statement of Sen. Obama). Senator Clinton commented that "[m]alpractice suits often result when an unexpected adverse outcome is met with a lack of empathy from physicians and a perceived or actual withholding of essential information." Clinton & Obama, *supra* note 6, at 2205-07.

178. S. 1784, § 935(c)(9)(c). Patients and physicians both have unmet needs following a medical error event. Gallagher et al., *supra* note 44, at 1005. Patients generally desire the disclosure of all harmful errors and seek elaboration as to what exactly happened, why the error occurred, what remedial efforts can be undertaken to minimize the impact of the error, and how the health care provider plans on preventing future recurrences of similar errors. *Id.* at 1004. Patients have an unmet emotional need during a disclosure and desire genuine, lasting emotional support—more than a passing apology. *Id.* at 1005. Physicians generally want to provide an apology and subsequent emotional support to effected patients, but many fail to do so because they worry that an apology might create legal liability. *Id.* However, when physicians feel shielded from such legal liability, they are more likely to provide these forms of emotional support. *Id.*

179. See MORATH & HART, *supra* note 178.

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telling begins with an apology.¹⁸⁰ Emotional support is subsequently maintained throughout the disclosure process.¹⁸¹ Healthcare providers convey what actions will be taken to treat or ameliorate the consequences of the accident.¹⁸² Patients are provided hospital-appointed counselors, and are offered private counselors at their discretion.¹⁸³ At the completion of the disclosure, healthcare providers tell patients that any charges and expenses related to the accident will be born by the hospital and that the hospital will provide family members with accommodations and will seek to compensate any actual damages related to the error.¹⁸⁴

VI. CONCLUSION

Reforming the legal landscape of medical malpractice is an arduous endeavor. The precarious nature of medical malpractice tort cases presents an interesting dilemma that must be addressed if legislation is to be effective. Malpractice torts are unique because they begin with a situation in which a physician performs a certain plan of care, having some measurable risk, for the benefit of an unhealthy patient. The quandary of tort reform exists in the necessity of reallocating the risks and rewards of the medical malpractice system. Patients' rights advocates must never forget that a physician's primary motivation is the safe and effective treatment of their patients. Most physicians never commit an act of gross negligence. Instead, the majority of medical errors occur because of system-level deficiencies or human errors that do not amount to a legal standard of negligence. When most physicians recognize an error that has harmed a patient, they desire to truthfully, objectively, and professionally disclose these errors. However, the studies cited in this paper emphasize that physicians define these errors more narrowly than patients and choose the verbiage of their disclosures very carefully, fearing the potential for litigation.¹⁸⁵ Although physicians are generally upset by the fact that a patient was harmed by preventable error, many are still concerned that proffering an apology will create a legal liability that outweighs its worth.¹⁸⁶

180. *See id.* at 6-7.

181. *See id.* at 4-8.

182. *See id.* at 7.

183. *See id.*

184. *See id.* at 7-8.

185. Gallagher et al., *supra* note 48, at 1003.

186. *Id.*

Alternatively, physicians and other healthcare providers must approach tort reform without losing perspective of their patients' ultimate needs and motivations. Patients desire the disclosure of all medical errors and most "near misses." Moreover, patients define "medical errors" much more broadly than healthcare providers.¹⁸⁷ Patients value a physician's truthfulness and compassion during a disclosure and generally are more concerned with learning of possible restorative and preventative measures than hearing excuses.¹⁸⁸ Patients desire an apology but note that such an apology should be personal and genuine rather than objective and transitory.¹⁸⁹

The great strength of the MEDiC Act is its ability to provide the incentives necessary to align the attitudes, needs, and motivations of physicians with their patients. By standardizing the liability protection for participating healthcare providers who disclose known medical errors to their patients and the NPSD, the bill may be the first breakthrough medical malpractice tort reform of the twenty-first century. Unlike other tort reforms that supply utility for healthcare providers at the expense of patients, the MEDiC Act focuses on the long-term improvement of patient safety. By reviving the use of alternative dispute resolution tactics to meet the informational and emotional needs of patients, the Clinton-Obama approach to medical malpractice reform presents a meaningful step towards bridging the discord between physicians and patients, while offering effective incentives for change.

187. *Id.*

188. *Id.*

189. *Id.*