

MEDICAL ERROR REDUCTION AND TORT REFORM THROUGH PRIVATE, CONTRACTUALLY- BASED QUALITY MEDICINE SOCIETIES

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ABSTRACT

The current medical malpractice system is broken. Many patients injured by malpractice are not compensated, whereas some patients who recover in tort have not suffered medical negligence; furthermore, the system's failures demoralize patients and physicians. But most importantly, the system perpetuates medical error because the adversarial nature of litigation induces a so-called "Culture of Silence" in physicians eager to shield themselves from liability. This silence leads to the pointless repetition of error, as the open discussion and analysis of the root causes of medical mistakes does not take place as fully as it should. In 1993, President Clinton's Task Force on National Health Care Reform considered a solution characterized by Enterprise Medical Liability (EML), Alternative Dispute Resolution (ADR), some limits on recovery for

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non-pecuniary damages (Caps), and offsets for collateral source recovery. Yet this list of ingredients did not include a strategy to surmount the difficulties associated with each element. Specifically, EML might be efficient, but none of the enterprises contemplated to assume responsibility, i.e., hospitals and payers, control physician behavior enough so that it would be fair to foist liability on them. Likewise, although ADR might be efficient, it will be resisted by individual litigants who perceive themselves as harmed by it. Finally, while limitations on collateral source recovery and damages might effectively reduce costs, patients and trial lawyers likely would not accept them without recompense. The task force also did not place error reduction at the center of malpractice tort reform—a logical and strategic error, in our view.

In response, we propose a new system that employs the ingredients suggested by the task force but also addresses the problems with each. We also explicitly consider steps to rebuff the Culture of Silence and promote error reduction. We assert that patients would be better off with a system where physicians cede their implicit “right to remain silent,” even if some injured patients will receive less than they do today. Likewise, physicians will be happier with a system that avoids blame—even if this system placed strict requirements for high quality care and disclosure of error. We therefore conceive of de facto trade between patients and physicians, a Pareto improvement, taking form via the establishment of “Societies of Quality Medicine.” Physicians working within these societies would consent to onerous processes for disclosing, rectifying and preventing medical error. Patients would in turn contractually agree to assert their claims in arbitration and with limits on recovery. The role of plaintiffs’ lawyers would be unchanged, but due to increased disclosure, discovery costs would diminish and the likelihood of prevailing will more than triple.

This article examines the legal and policy issues surrounding the establishment of Societies of Quality Medicine, particularly the issues of contracting over liability, and outlines a means of overcoming the theoretical and practical difficulties with enterprise liability, alternative dispute resolution and the imposition of limits on recovery for non-pecuniary damages. We aim to build a welfare enhancing system that rebuffs the culture of silence and promotes error reduction, a system that is at the same time legally sound, fiscally prudent and politically possible.

I. INTRODUCTION

For centuries, physicians have been held liable for medical error.¹ However, it is particularly in the last thirty years, beginning with the malpractice

¹ PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 2 (1985) [hereinafter *MEDICAL MALPRACTICE*]. Even as far back as the Babylonian Code of Hammurabi, *circa* 1780 B.C., medical error is mentioned and remedies to deter it are sought: “If a physician make a large incision with an operating knife and cure it . . . he shall receive ten shekels in money . . . If a physician make a large incision with the operating knife, and kill him . . . his hands shall be cut off.” Ancient History Source Book, Code of Hammurabi, <http://www.fordham.edu/halsall/ancient/hamcode.html#text> (L.W. King trans.), (last visited Oct. 26, 2009). The Code is the oldest written legislation pertaining to the practice of medicine and “set out for the

crises in the 1970's and continuing with subsequent crises in the 1980's and 2000's,² that many observers began devoting considerable intellectual energy to the structural and conceptual deficiencies in tort's management of medical negligence.³ As a result, scholars now generally agree—although often for different reasons—that when addressing malpractice the current American tort system is broken.⁴ Some of this failure has to do with an inefficient mechanism for compensation. First, injured patients determined to proceed with litigation often face structural obstacles to having their claims proceed through the tort system.⁵ Equally problematic the system is neither sensitive nor specific. Ideally, the set of negligently caused injuries and the set of compensated victims would be identical,⁶ but the tort system neither identifies nor compensates most medical injuries that are the result of negligence.⁷ Similarly, studies indicate the tort system is also nonspecific, as some compensated injuries are actually the result of the normal risk of treatment or expected course of disease, or are accidents for which no one is at fault.⁸ In fact, re-

first time the concept of civil and criminal liability for improper and negligent medical care. Penalties ranged from monetary compensation to cutting off the surgeon's hand." Cyril H. Wecht, *The History of Legal Medicine*, 33 J. AM. ACAD. PSYCHIATRY & L. 245, 245 (2005). In England, physicians have been liable for medical malpractice since the fourteenth century; in the United States, since the late eighteenth century. MEDICAL MALPRACTICE, *supra* at 59.

² In the early 1970's, increasing claims and inadequate malpractice insurance rates caused some insurers to leave the market, causing a crisis of availability and price for physicians and hospitals. In the 1980's, a second crisis of affordability occurred as premiums rose quickly in response to increased claim frequency and severity, leading many physicians in high risks specialties, such as obstetrics and gynecology, to reduce risks by limiting care. Finally, in the 2000's continued affordability and liability concerns led to closure of practices and decisions by trainee physicians not to enter high-risk fields. See AM. MED. ASS'N, MEDICAL LIABILITY REFORM - NOW! 2 (2008), available at <http://www.ama-assn.org/go/mlrnow>.

³ E.g., Joseph Bernstein et al., *Topics in Medical Economics: Medical Malpractice*, 90 J. BONE & JOINT SURGERY 1777 (2008); Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS. 5 (1986); PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (1991). For a good overview of approaches to tort reform in general, see Jay M. Feinman, *Unmaking and Remaking Tort Law*, 5 J. HIGH TECH. L. 61 (2005) (critical of recent tort reform proposals) and Stephen D. Sugarman, *Tort Reform Through Damages Law Reform: An American Perspective*, 27 SYDNEY L. REV. 507 (2005) (describing American tort system). See also FRANK A. SLOAN ET AL., INSURING MEDICAL MALPRACTICE 4-7 (1991) (discussing medical malpractice debate).

⁴ E.g., Bernstein et al., *supra* note 3, at 1777; Note, *Fixing Medical Malpractice Through Health Insurer Enterprise Liability*, 121 HARV. L. REV. 1192, 1192 (2008). See also MEDICAL MALPRACTICE, *supra* note 1, at 85-87 (discussing issues in medical malpractice insurance).

⁵ See, e.g., U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION 23 (1987) [HEREINAFTER FRAMEWORK FOR ACTION] (noting that most plaintiffs' attorneys refuse a case that promises a recovery under \$50,000). See also STEPHEN DIETZ, ET AL., *The Medical Malpractice Legal System*, in REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, APPENDIX 97-106 (1973) (noting that out of every eight potential malpractice suits offered to patients' attorneys, only one is accepted, and that a substantial portion of recoveries goes to lawyers).

⁶ OFFICE OF TECHNOLOGY ASSESSMENT, IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS 14 (1993) [hereinafter IMPACT OF LEGAL REFORMS].

⁷ See, e.g., Bernstein et al., *supra* note 3, at 1777-78.

⁸ See Bernstein et al., *supra* note 3, at 1779. See also Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1963 (1996) (noting the severity of physical disability but not the presence of medical negligence as dispositive factor predicting payment to the patient.)

search suggests that severe injuries, regardless of physician fault, will likely be compensated at a rate disproportionate to the victims' actual losses.⁹ One study, for example, indicates non-meritorious claims approximate over forty percent of all malpractice claims.¹⁰ And even among those deserving injured who prevail in their claims, frictional costs eventually prevent up to half of the monies paid out from reaching plaintiffs.¹¹ Direct costs to physicians not borne by insurance are also significant.¹² Finally the time from an injury and even commencement of a malpractice action to a final verdict can take years, creating a disincentive for injured patients to initiate claims, and a situation that subjects both patients and physicians to extreme emotional distress for protracted periods of time.¹³ As a result, the best available data suggests that the current medical malpractice regime fails to compensate seriously injured patients adequately and fails to serve as an efficient conduit to channel medical malpractice premiums into the hands of deserving, injured patients.¹⁴

⁹ See Brennan, *supra* note 8, at 1963. See also Richard A. Epstein, *Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice*, 54 DEPAUL L. REV. 503, 512 (2005) [hereinafter *Contractual Principle*] (arguing that much compensation may be occurring *without* negligence); WALTER K. OLSON, *THE LITIGATION EXPLOSION: WHAT HAPPENED WHEN AMERICA UNLEASHED THE LAWSUIT* 267-68 (1991) (arguing that malpractice case results not wholly explained by merits of claims).

¹⁰ Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429, 431 (1992) (citing Frederick W. Cheney et al., *Standard of Care and Anesthesia Liability*, 261 JAMA 1599 (1989) (finding 46% of more than 1,000 cases of medical malpractice claims were non-meritorious)).

¹¹ While estimates vary, the plaintiff receives at best only about fifty cents out of every dollar spent by insurers on handling a malpractice claim; at worst, about a fifth. See, e.g., IMPACT OF LEGAL REFORMS, *supra* note 6, at 38; PAUL C. WEILER ET AL., *A MEASURE OF MALPRACTICE* 77, 109 (1993); Sage et al., *Defense Costs and Insurer Reserves in Medical Malpractice and Other Personal Injury Cases: Evidence from Texas, 1988-2004* 41 (Univ. Ill., Law & Econ. Research Paper No. LE07-012, 2007; Univ. Tex. Law Sch., Law & Econ. Research Paper No. 99, 2008), available at <http://lawweb.usc.edu/academics/assets/docs/black.pdf> ("[T]he per-case efficiency of the system is a bit under 50%. Stated differently, it costs about a bit over a dollar in legal fees and expenses for the plaintiff to end up with \$1 in his pocket."); F. Calvin Bigler, *Medical Professional Liability in the United States, in MEDICAL MALPRACTICE SOLUTIONS: SYSTEMS AND PROPOSALS FOR INJURY COMPENSATION* 33, 41 (M. Martin Halley et al. eds., 1990) [hereinafter *MEDICAL MALPRACTICE SOLUTIONS*].

This loss is frictional and directly related to the costs of litigation. See generally Sage, *supra* (examining increasing rate of defense costs). And it should be remembered that even claims that are settled with no payment to the plaintiff consume significant amounts of resources. See Bigler, *supra*.

¹² Such as time away from practice spent defending suits, lost opportunity costs, choice of career, etc. See, e.g., AM. MED. ASS'N, *supra* note 2, at 2-4 (detailing various stresses malpractice litigation imposes on physicians). It has been reported that the average time from injury to filing of an action is 16.4 months, with another 25 months until resolution of the claim. See Bigler, *supra* note 11, at 41.

¹³ See WEILER, *supra* note 3, at 52.

¹⁴ See, e.g., IMPACT OF LEGAL REFORMS, *supra* note 6, at 38. See also MEDICAL MALPRACTICE *supra* note 1, at 24-25 (reporting that less than 10% of injuries resulted in claims filed, and only 40% of those resulted in eventual payment, for an average of one payment for every twenty five injuries); A. Russell Localio et al., *Relationship Between Malpractice Claims and Adverse Events Due to Negligence: Results from the Harvard Medical Practice Study III*, 325 NEW ENGL. J. MED. 245, 245-51 (1991) (reporting that although nearly 4% of patients in the Harvard Medical Malpractice Study suffered iatrogenic injury, only one claim was filed for every 7.5 of those negligent medical injuries).

Perhaps most egregious, however, is tort's inability to induce physicians to take steps to reduce or eliminate medical mistakes, i.e., the failure of the tort system's deterrent effect.¹⁵ Simply put, the rationale for having a system of deterrence based on individual fault, wherein individual actors—i.e., physicians, nurses and other allied health professionals—are theoretically deterred from committing error by the threat of malpractice litigation,¹⁶ is not working because it is based on faulty premises and subject to deforming incentives, as we shall explain below.¹⁷

With a system arguably failing in so many aspects, no single causative factor predominates. Accordingly, over the past several decades varied efforts at tort reform have included legislative provisions limiting attorney fees, awarding attorneys' costs for frivolous suits, and modifying joint and several liability, as well as adopting clinical practice guidelines as evidence of the standard of care.¹⁸ Other programs have involved voluntary binding arbitration, limiting malpractice awards through caps on damages, and collateral source offsets whereby patients who receive disability insurance payments, for example, have their awards reduced accordingly.¹⁹ Still others have explored shifting from individual liability to enterprise liability, in which hospitals and/or managed care organizations rather than physicians are held responsible for negligent injury.²⁰ Others have emphasized no-fault liability or combined entity-

¹⁵ One of the principal justifications for tort is that the threat of financial sanctions induces physicians to take optimal precautions to avoid injuries by investing in training, equipment, time, care, and continuing education, as well as self-monitoring for best and safe practices. Jennifer Arlen, *Private Contractual Alternatives to Malpractice Liability* 6 (New York Univ., Law & Econ. Research Paper No. 05-07, 2005) [hereinafter *Private Contractual Alternatives*], available at <http://ssrn.com/abstract=726503>. Professor Patricia Danzon argues that since the other central goal of tort law, compensation, can be achieved more efficiently through existing first-party insurance systems, such as life and disability, the only convincing economic rationale is that of deterrence. MEDICAL MALPRACTICE, *supra* note 1, at 3. In effect the theory of deterrence presumes that physicians cannot be trusted fully to act optimally to reduce error based on ethical or professional considerations alone, in that physician self-interest will interfere with the goal of error reduction. Jennifer Arlen, *Contracting Over Malpractice Liability* 9-12 (Am. Law & Econ. Ass'n., Annual Meetings Paper 42, 2008) [hereinafter *Contracting Over Liability*], available at <http://law.bepress.com/cgi/viewcontent.cgi?article=2627&context=alea>. In response to this assumption, by imposing the threat of financial sanction, the tort system "transforms physician's motivations to protect their own welfare into a desire to protect others by holding them liable for the harms they cause to others." See *Private Contractual Alternatives*, *supra* at 6. In effect, tort liability functions not only as a system of compensation and hence corrective justice but also as one of "quality control." MEDICAL MALPRACTICE, *supra* note 1, at 10.

¹⁶ See, e.g., MEDICAL MALPRACTICE, *supra* note 1, at 9-15.

¹⁷ See *infra* text accompanying notes 233-67; Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 406, 407 (1994) (discussing use of tort litigation to control error as a "somewhat speculative venture").

¹⁸ See generally Bernstein et al., *supra* note 3 (reviewing different tort reform proposals); see also FRAMEWORK FOR ACTION, *supra* note 5, 19-30 (discussing proposals for reform); Robinson, *supra* note 3, 23-26.

¹⁹ IMPACT OF LEGAL REFORMS, *supra* note 6, at 23-55.

²⁰ See, e.g., Abraham & Weiler, *supra* note 17 (promoting enterprise liability for hospitals); William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROB. 159 (1997) [hereinafter *Enterprise Liability*] (advocating for liability for managed care organizations (MCOs)); Paul C. Weiler, *Reforming Medical Malprac-*

level liability with no-fault compensation schemes.²¹ Much of the scholarship in law and economics, for example, articulates competing proposals centered on private, contractually-based solutions in order to determine optimum solutions maximizing welfare, either by allowing unlimited contractual freedom or allowing state laws to serve as default rules in the absence of contract.²² But none of these specific, narrowly focused reforms has been demonstrated to reduce substantially the costs associated with malpractice litigation, with the exception of caps on damages.²³

More widespread tort reforms have not fared well, either.²⁴ The favored solution of the Harvard Medical Malpractice Study Group has been a no-fault system similar to worker's compensation.²⁵ No state has adopted this scheme, although Florida and Virginia do have extremely limited no-fault regimes for catastrophic birth injuries resulting in neurological damage—programs that have shown limited success in removing a small subset of medical injury from the tort system.²⁶ The American Medical Association, in contrast, proposed over twenty years ago an administrative system in which medical malpractice claims would be heard by a panel of experts,²⁷ and which promised in theory swift, efficient resolution of claims across a broader spectrum of injured patients.²⁸ No state has ever implemented it, and it has effectively died on the

tice in a Radically Moderate—and Ethical--Fashion, 54 DEPAUL L. REV. 205, 225-26 (advocating enterprise liability to be allowed by state regulation).

²¹ See, e.g., Michelle M. Mello & Troyen Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595 (2002) (advocating hospital liability combined with no-fault regime); Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908 (1993) (Making the case for no-fault as an ethical proposition).

²² E.g., *Contractual Principle*, *supra* note 9 (allowing patients and physicians complete freedom to contract); Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491 (1997) (discussing imposition of MCO limited liability by contract); Richard Epstein, *Medical Malpractice: The Case for Contract*, 1 AM. B. FOUND. RES. J. 119 (1976) (discussing contractual liability for physicians).

²³ *Contractual Principle*, *supra* note 9, at 504 (citing RAND INSTITUTE FOR CIVIL JUSTICE, RESEARCH BRIEF: CHANGING THE MEDICAL MALPRACTICE DISPUTE PROCESS: WHAT HAVE WE LEARNED FROM CALIFORNIA'S MICRA? (2004) [hereinafter RAND STUDY], available at http://www.rand.org/pubs/research_briefs/RB9071/RB9071.pdf) (discussing the experience of California's Medical Injury Compensation Reform Act (MICRA), which capped non-economic damages). In California, the RAND Study sample demonstrated that a reduction in defendants' liabilities by 30 percent and attorneys fees by 60 percent, both due to MICRA. RAND STUDY, *supra*.

²⁴ While the reasons for such failures are numerous and generally beyond the scope of this article, they include: effective and principled opposition by trial lawyers, the cumbersome nature of the complicated administrative proposals combined with the significant frictional costs associated with various plans for reform, and the complex legislative measures needed to address errors while simultaneously protecting physicians from increased rates of malpractice claims.

²⁵ See Paul C. Weiler et al., *Proposal for Medical Liability Reform*, 267 JAMA 2355, 2355-59 (1999).

²⁶ See IMPACT OF LEGAL REFORMS, *supra* note 6, at 43-45.

²⁷ James S. Todd et al., *The Model Medical Liability and Patient Protection Act: A Fault-Based Administrative System for Resolving Medical Liability Claims*, in MEDICAL MALPRACTICE SOLUTIONS: SYSTEMS AND PROPOSALS FOR INJURY COMPENSATION 129, 129-39 (M. Martin Halley et al. eds., 1990).

²⁸ See IMPACT OF LEGAL REFORMS, *supra* note 6, at 41-42.

vine.²⁹ Furthermore, many remedial measures have been passed by state legislatures, only to be declared unconstitutional by state supreme courts.³⁰

Finally, in 1993, during the Clinton administration, the Presidential Task Force on National Health Care Reform considered a general solution involving many of these features, characterized by enterprise liability, alternative dispute resolution, and limits on both collateral source recovery and recovery for non-pecuniary damages.³¹ While we believe the task force contemplated the correct ingredients for effective reform, we note that its proposal did not include a specific strategy to surmount the difficulties associated with each element, and it did not place error reduction at the center of malpractice tort reform.³² In this article, we will use the 1993 health care task force considerations—which we believe continue to have great merit despite the eventual failure of the Clinton health plan—as a springboard to offer such a strategy, focusing on the need for error reduction. In doing so, however, we will eschew a public, legislatively-driven public solution as in the Clinton plan and instead explore a private, contractually-based solution to the current failure of the American tort system to deter medical malpractice.

How the medical profession, the health care industry, and the American tort system handle medical error of all types—ranging from medication errors to misdiagnoses and surgical blunders—is contradictory, secretive, and counter-productive.³³ Moreover, the three systems not only fail to eliminate peculiar incentives to ignore medical error, but also they *create* incentives to err.³⁴ Based on both our observations of medical care as practicing physicians in university academic facilities, state hospitals and private hospitals, and our review of the relevant literature, we contend that these perverse incentives induce a culture of silence when medical errors occur.³⁵ One might even assert that some physicians perceive a perverse right to remain silent in order to avoid legal sanctions.³⁶ In addition, we maintain that what we call a “mal-

²⁹ *Id.* at 43-45. We also recognize that in the absence of universal coverage, the expense of a complete, unfettered no-fault regime would be prohibitively expensive to implement. One study of such costs examined proposed no-fault regimens in Utah and Colorado and found costs substantially exceeding the amount spent on malpractice premiums in the two states; however, costs were lower and affordable for a “preferred” model of no-fault that limited compensation based on “avoidability criteria” and mandated a disability period of several weeks, and which covered health care costs, pain and suffering, and partial to full wage replacement. ROBERT WOOD JOHNSON FOUNDATION, RESEARCHERS EVALUATE THE FEASIBILITY OF A NO FAULT SYSTEM FOR MEDICALLY INJURED PATIENTS IN UTAH AND COLORADO, GRANT RESULTS (Sept. 2006), <http://www.rwjf.org/reports/gr/032865.htm#RESULTS>.

³⁰ IMPACT OF LEGAL REFORMS, *supra* note 6, at 100-03.

³¹ Robert Pear, *Clinton May Seek Lid on Doctor Fees and Liability Suits*, N. Y. TIMES, Mar. 9, 1993, at A1.

³² *See id.*

³³ *See infra* text accompanying notes 298-328; ROSEMARY GIBSON & JANARDAN PRASAD SINGH, WALL OF SILENCE: THE UNTOLD STORY OF THE MEDICAL MISTAKES THAT KILL AND INJURE MILLIONS OF AMERICANS 11, 16, 39, 135-49, 155-68 (2003) (examining concealment of medical error by healthcare professionals).

³⁴ *Id.* at 137, 148, 166-67.

³⁵ *Id.* at 135-68 (detailing a “culture of coverup” by physicians hiding medical error).

³⁶ *See* Bernstein et al., *supra* note 3, at 1778. Nor is this concern unfounded. At time of this writing, the Massachusetts Supreme Court is scheduled to hear oral arguments that the state licensing board may have access to peer review documents without any administrative

practice nihilism” occurs among practicing physicians as a result of the malpractice tort regimen viewed as erratic and unpredictable.³⁷ While there do exist numerous studies of physician practices and responses to errors and to the malpractice system, society has not fully appreciated that a negative feedback loop has developed, in which efforts by the tort system to deter medical error actually impede its resolution.³⁸

To this end, we offer an original proposal employing tort reform to minimize medical error, one that will draw on many different proposed, existing, and successful programs for both reducing tort costs and achieving error reduction. Such programs are to be synthesized into an overarching proposal to create private physician groups dedicated to the fearless examination and reduction of error, unhindered by fear of malpractice litigation. We call these groups “Societies for Quality Medicine” (“SQM”) that will have as their primary goal the realignment of medicine to circumvent the seemingly innocent but often pernicious incentives for ignoring error. We conceive of SQMs as operating outside of the tort system. They will serve as part of health plans in which patients privately contract out of tort liability and into a regimen of alternative dispute resolution consisting of mediation and arbitration, a regimen focused on holding liable only the enterprise of the SQM and not the individual physician. In addition, awards of noneconomic damages (i.e., pain and suffering damages) will be capped. Patients in turn will be cared for by a group of physicians—the SQM—who agree to prompt identification of error, notification to patients and families when error occurs, and acceptance of responsibility through apology, remediation, and compensation.

As a result of this strategy, we conceive not of a medical practice system devoid of error (as that is incompatible with human involvement) but one borrowing from a Platonic notion of justice, “striving toward the good,”³⁹ a system that is both more sensitive and specific than the present one. This system will compensate more injured patients equitably and allow medicine to advance more rapidly as a practical discipline. At the same time, we acknowledge the historic role of the plaintiff’s lawyer as an advocate for the injured in the time of their greatest need.⁴⁰ The SQM preserves that role by creating a system in which net collections are anticipated to be higher than the current

proceeding having commenced against a physician. See Brief of Appellant Board of Registration, Medicine, Bd. of Registration in Med. v. Hallmark Health Corp., 910 N.E.2d 898 (Mass. 2009), available at http://www.ma-appellatecourts.org/display_docket.php?dno=SJC-10297.

³⁷ We use the term “malpractice nihilism” to mean an environment in which moral actions to prevent injury are deemed by the relevant actors (e.g., physicians) *not to matter* due to a perception of a “lottery-like” aspect to medical malpractice. See *infra* text accompanying notes 329-38.

³⁸ See Abraham & Weiler, *supra* note 17, at 408 (“The individualistic quality of malpractice litigation . . . is more of an obstacle to, than a vehicle for, effective injury prevention.”).

³⁹ Andrew Feenberg, *Can Technology Incorporate Values? Marcuse’s Answer to the Question of the Age*, (Conference on The Legacy of Herbert Marcuse at the Univ. of Cal., Berkeley, 1998), available at <http://www-rohan.sdsu.edu/faculty/feenberg/marcuse.htm>.

⁴⁰ See Robert J. Condlin, “What’s Love Got To Do With It?” - “It’s Not Like They’re Your Friends for Christ’s Sake”: *The Complicated Relationship Between Lawyer and Client*, 82 N.E. L. REV. 211 *passim* (2003) (examining history of and arguing against the “lawyer-as-friend” view).

system because many more injuries will be identified and many more patients will be compensated, albeit at lower individual rates.⁴¹

While we do not pretend to offer the definitive solution to the problem of medical error, we hope this proposal may provide a crystallizing seed eventually yielding systems in which hospitals, physicians, and indeed, society at large, can rectify these problems through apt incentives rather than harsh—and ultimately futile—coercion. In our proposal, we acknowledge the simple fact that doctors need to be constrained, for despite their best intentions, human nature with all its frailties will resist the strong ethical and professional imperatives for quality medicine.⁴² Therefore we recognize the importance of incentives; however, we want the incentives to be mutually beneficial. If the doctor is worse off, but the harmed patient is not appreciably better off, a negative-sum result is achieved. We would argue that today's tort system, where many patients cannot even bring claims, and where those compensated may not in the end be much better off, and where physicians are motivated to hide medical errors and even close practices—approaches in the aggregate such a negative-sum result.⁴³ In contrast, by our proposal, we are trying to channel losses into gains for the maximum number of actors, including physicians, injured patients, and future patients (all the while being neutral or better for the plaintiff's bar). We believe that as a result, a "culture of safety" will replace the current tort culture of blame, inefficiency and blatant unfairness to the injured.

Part II of this article introduces the problem of medical error, reviews various studies on error rates, and arrives at a conservatively estimated baseline rate on which we base our analysis. Part III presents an ideal, general form of our proposed solution, one derived from the original 1993 Clinton health care task force considerations, including enterprise medical liability, alternative dispute resolution, caps on non-pecuniary damages, and limitations on collateral source recovery. Part III also discusses the omission of no-fault insurance from the ideal, general form. Building on the general form presented in Part III, Part IV presents our conception of an independent physician group—the SQM—that would contract with individual patients outside the bounds of traditional tort and refocus responses to medical error in a more efficient manner. Next, Part V presents a detailed economic analysis of the SQM proposal, and presents calculated figures in the Appendix. Part VI addresses the use of contract and why the SQM proposal may satisfy some of the most cogent and principled criticisms of contracting out of tort liability from legal scholars. Part VI also specifically addresses the criticisms of Professor Jennifer Arlen, who argues against private contracting out of the tort system.⁴⁴ Finally Part VII explores how the SQM will mitigate deforming incentives in the current tort system, including the responses by physicians to the prospect of medical malpractice litigation.

⁴¹ See *infra* text accompanying notes 182-223.

⁴² See, e.g., MEDICAL MALPRACTICE, *supra* note 1, at 9-17.

⁴³ See Epstein, *supra* note 9, at 512.

⁴⁴ See *infra* text accompanying notes 269-97. See also *Contracting Over Liability*, *supra* note 15 (arguing against such contracting).

II. THE PROBLEM OF MEDICAL ERROR

Despite the significant resources devoted by multiple healthcare systems to medical error reduction in the United States alone,⁴⁵ and the billions of dollars consumed administratively by the tort system,⁴⁶ preventable iatrogenic injuries continue to affect almost one million hospitalized patients annually.⁴⁷ Many more patients also suffer injuries occurring in nursing homes, rehabilitation facilities, outpatient practices, day surgery enterprises and other venues where medical care is provided.⁴⁸ Even though some of these errors are insignificant and cause no harm, others lead to increased rates of both morbidity and mortality.⁴⁹ While it is not the purpose of this article to review the many studies of medical error occurring over the past thirty years, these studies indicate iatrogenic injury rates ranging from above 40% down to as low as approximately 3%.⁵⁰ The California Medical Association's Medical Insurance Feasibility Study—which in 1974 retrospectively examined hospital records from 23 short stay hospitals in California—indicated an approximately 5%

⁴⁵ See GIBSON & SINGH, *supra* note 33, at 171-81 (discussing different error reduction strategies in American hospitals).

⁴⁶ In 2005 the American tort system was estimated to have cost \$260.8 billion for all claims (roughly \$880 per person) and \$29.4 billion due to medical malpractice, costs being defined as all of the various outcomes of a claim. This total cost represented an increase of 0.5% compared to 2004, when totals costs increased 5.7%, and was the lowest increase since 1997. TILLINGHAST-TOWERS PERRIN, 2006 UPDATE ON U.S. TORT COST TRENDS, 3, 15 (2006), available at http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2006/200611/Tort_2006_FINAL.pdf.

⁴⁷ See INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 29-33 (Linda T. Kohn et al. eds., 2000) [hereinafter IOM REPORT].

⁴⁸ See MEDICAL MALPRACTICE, *supra* note 1, at 20 (discussing problem of undercounting error). See also GIBSON & SINGH, *supra* note 33, at 42 (noting the IOM figures represent undercounting of error rates).

⁴⁹ See *Contracting Over Liability*, *supra* note 15, at 8 (discussing error rates in medicine). See also Fred Rosner et al., *Disclosure and Prevention of Medical Errors*, 160 ARCHIVES INTERNAL MED. 2089, 2089 (2000). The Institute of Medicine has concluded that between 44,000 and 98,000 deaths occur yearly due to medical mistakes, making medical error the eighth leading cause of death. See IOM REPORT, *supra* note 47, at 1. See also GIBSON & SINGH, *supra* note 33, at 42 (discussing IOM report and impact of error).

⁵⁰ See Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 370 (2005) (observational study over 15 years reporting 45.8% of patients experience medical error during treatment); Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients -- Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370, 370 (1991) [hereinafter *Incidence of Adverse Events*] (discussing results of the Harvard Medical Practice Study demonstrating nearly a 4% rate of injury in New York State in 1984); Troyen A. Brennan, *The Institute of Medicine Report on Medical Errors - Could It Do Harm?* 342 NEW ENG. J. MED. 1123, 1123 (2000) [hereinafter *Could It Do Harm?*] (discussing 1992 study of Utah and Colorado hospitals revealing a 2.9% rate); Robert W. Dubois & Robert H. Brook, *Preventable Deaths: Who, How Often, and Why?* 109 ANNALS INTERNAL MED. 582, 585 (1988) (retrospective study of 377 patients admitted to hospitals for heart attack, strokes, or pneumonia revealed that errors in diagnosis or management probably caused the deaths of 14%); Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377, 397 (1994) (citing Lori B. Andrews, *Medical Error and Patient Claiming in a Hospital Setting* (Am.B.F., Working Paper No. 9316, 1993) (revealing that in a study of more than one thousand patients at one hospital, medical errors occurred during the care of approximately 44% of those patients and serious injury to approximately 14%)).

overall injury rate (roughly 1 in 20 admissions) and implied an average risk of negligent injury of four-fifths of 1% (or 1 in 126 hospital admissions).⁵¹ If applied nationwide, this California Medical Association (CMA) figure indicates approximately 1,500,000 injuries annually, out of which four fifths of 1% (or 1 out of 126 hospital admissions) are caused by negligence.⁵² Similarly the Harvard Medical Practice Study estimated that despite the various risk reduction strategies promoted in American hospitals, negligent injury occurs in approximately one percent of hospital admissions.⁵³

While we believe an exact error rate is probably not precisely discernable, we will rely on the extremely conservative CMA study to estimate an overall risk of iatrogenic injury at 5% (1 in 20 encounters).⁵⁴ We infer from that figure that 80 percent of those injuries will be the result of disease progression or non-negligent treatment, leaving a risk of negligent injury of 1% (1 in 100 encounters).⁵⁵ We count as a negligent event outpatient treatment that results in hospitalization but will not count errors occurring in nursing homes, etc. Since the CMA study identified errors retrospectively and employed broad exclusionary criteria, it provides for a reasonable and conservative analysis of medical error that cannot be accused of exaggerating the problem.⁵⁶ Further-

⁵¹ See MEDICAL MALPRACTICE, *supra* note 1, at 20 (citing Cal. Med. Ass'n., MEDICAL INSURANCE FEASIBILITY STUDY (1977)).

⁵² However, given that this study only counted those mistakes apparent from the record as negligent (not accounting for mistakes not reported in the record), and did not include errors occurring outside the hospital, or in nursing homes or long-term rehabilitation facilities, it certainly underestimates the problem. MEDICAL MALPRACTICE, *supra* note 1, at 20.

⁵³ Sage, *supra* note 20, at 161 n.5 and accompanying text (citing HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS AND LAWYERS: STUDIES OF MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION IN NEW YORK (1990)).

⁵⁴ See MEDICAL MALPRACTICE, *supra* note 1, at 20 (explaining that the CMA study “implies an average injury rate of 4.65 injuries per 100 hospital admissions, or roughly 1 in 20” and that the study “understates the total universe of iatrogenic injuries.”).

⁵⁵ *Id.*

⁵⁶ The National Academy of Sciences has recently estimated that medication errors alone throughout the United States injure approximately 1.5 million people. National Academy of Science, *Medication Errors Injure 1.5 Million People and Cost Billions of Dollars Annually; Report Offers Comprehensive Strategies for Reducing Drug-Related Mistakes*, NEWS FROM THE NATIONAL ACADEMIES, July 20, 2006, <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=11623>. Rates of mortality are equally alarming. A 2008 HealthGrades Corporation study restricted to Medicare patients indicated that between 2004 and 2006, 238,337 preventable deaths occurred in that cohort alone as the result of 1.1 million medical errors. HEALTHGRADES, THE FIFTH ANNUAL HEALTHGRADES PATIENT SAFETY IN AMERICAN HOSPITALS STUDY 2-3 (2008) [HEREINAFTER HEALTHGRADES STUDY], <http://www.healthgrades.com/media/DMS/pdf/PatientSafetyInAmericanHospitalsStudy2008.pdf>. Even if preventable deaths due to medical error are held to an estimate of 100,000 patients annually—a figure roughly equal to other recent research on this topic, see Weiler, *supra* note 20, at 214-215 (estimating 115,000 deaths)—this is approximately twice the annual death rate on American highways. See GIBSON & SINGH, *supra* note 33, at 42. Similarly, the Institute of Medicine (IOM) Report on Medical Error states that in American hospitals medical errors cause between 44,000 and 98,000 deaths each year. IOM REPORT, *supra* note 47, at 1. Moreover, the IOM statistics reflect medical error in hospitals only. Errors occurring in ambulatory settings, other institutional settings such as nursing homes and pharmacies around the country—that is, errors in diagnosis, treatment, and execution of physician orders—most probably represent the majority of cases of medical error, dwarfing those occurring in hospitals. See GIBSON & SINGH, *supra* note 33, at 42.

more, this error rate tracks approximately the estimate of the Harvard Medical Practice Study.⁵⁷

While some baseline error rate is accepted as “the cost of doing business” in some manufacturing contexts, when considering the human cost in suffering attached to a 1% rate of medical error,⁵⁸ it is far less acceptable to acquiesce to the status quo.⁵⁹ Furthermore we recognize that despite the fact that various studies reported different rates of medical error, the associated costs of medical error are huge, ranging in some estimates from 17 to 38 billion dollars a year.⁶⁰ Therefore, based on both the human and financial costs of a high error rate, it is our beginning contention that the tort system is at least partially failing its deterrence function by not operating efficiently to reduce error—i.e., to improve the quality of medical practice.⁶¹ More specifically, and as we shall explain below, the system is failing to induce physicians to invest optimally in preventing injury due to a flawed incentive structure.⁶² Given these rates of error, indicating systemic failure, we therefore turn to offering an alternative to traditional tort, outlining the background and then the specifics of the Society for Quality Medicine, a theoretical construct designed to better regulate and deter medical error than the present day tort system.

III. THE GENERAL FORM OF THE SOLUTION

In 1993, the Clinton Task Force on National Health Care Reform seriously considered the key ingredients for malpractice reform: enterprise medical liability, alternative dispute resolution, caps on non-pecuniary damages, and reduction of damages when the patient recovers monies from insurance or worker’s compensation.⁶³ Of course, the significant difference between a list of ingredients and a recipe is that a large gap exists between identifying the elements of reform and delineating how these elements come together, and it

⁵⁷ See Sage, *supra* note 20, at 161.

⁵⁸ Such as increased morbidity, the psychological effects of illness, stresses on the family, etc.

⁵⁹ See Sage, *supra* note 20, at 203 n.218 (citation omitted) (discussing how in low tolerance, high reliability industries such as air transport, mail transportation, and banking, even a 0.01% error rate “would mean that 84 unsafe airplane landings occurred each day in the United States, that 16,000 letters were lost each hour by mail carriers, and that banks made 32,000 check processing errors each hour”).

⁶⁰ See IOM REPORT, *supra* note 47, at 40-41 (estimating the “national costs of adverse events to be \$37.6 billion and of preventable adverse events to be \$17 billion”). See also HEALTHGRADES STUDY, *supra* note 56, at 2 (finding that “safety incidents” in Medicare-related hospitalizations from 2004 through 2006 resulted in \$8.8 billion in preventable costs, or an average of 4.4 billion dollars annually); William G. Johnson et al., *The Economic Consequences of Medical Injuries*, 267 JAMA 2487, 2487-92 (1992) (discussing a study of costs in New York); National Academy of Science, *supra* note 56 (finding that “extra medical costs of treating drug-related injuries occurring in hospitals alone conservatively amount to \$3.5 billion a year”).

⁶¹ Although we discuss the compensatory justification for tort, we follow Professor Danzon’s premise that the primary economic rationale for tort liability is deterrence. See MEDICAL MALPRACTICE, *supra* note 1, at 9 and accompanying text.

⁶² See MEDICAL MALPRACTICE, *supra* note 1, at 9.

⁶³ See Pear, *supra* note 31, at A1; Sage, *supra* note 20, at 165.

is noteworthy that none of these reforms found their way into the final Health Security Act proposed by the Clinton administration. In its general form, the SQM proposal embraces enterprise liability, alternative dispute resolution, and some limits on recovery, which include primarily caps on non-pecuniary damages, but also elimination of collateral source recovery and calibration of awards to their net present value. We consider each of these elements in turn.

A. ENTERPRISE MEDICAL LIABILITY

Under enterprise medical liability (EML), health care enterprises such as large hospital systems and HMO's, and not individual physicians, are the named defendants of malpractice claims.⁶⁴ The rationale for this method is that many medical errors are systems failures and therefore the enterprise is the entity that can best prevent them.⁶⁵ By transferring the legal responsibility for error onto the enterprise rather than the individual physician, the tort system will impose more effective and appropriate incentives on an entity that can efficiently exercise its authority to prevent errors by instituting system-wide quality control measures. Various options for identifying the enterprise have been offered, but most have focused on holding either hospitals or managed care systems liable.⁶⁶ The 1993 Clinton Task Force on National Health Care Reform floated trial balloons for a legislatively created system of health plan based enterprise liability, one composed of integrated organizations combining financing with delivery of care, the so-called "health plans."⁶⁷ The Clinton plan died, however, in part due to effective opposition from organized medicine and the insurance industry, particularly around issues of enterprise liability.⁶⁸

Enterprise liability is more than a mere theoretical construct, however. The Department of Veterans Affairs (VA),⁶⁹ the Public Health Service⁷⁰ (including the Indian Health Service),⁷¹ and the Department of Defense⁷² health systems all operate under a system of enterprise liability.⁷³ For example, if a patient of a VA hospital asserts a malpractice claim, the Federal Government assumes responsibility for the negligence of its employed physicians.⁷⁴ Removed from the threat of malpractice liability, physicians working for the Veterans Administration are said to be proactive about error detection and dis-

⁶⁴ See Abraham & Weiler, *supra* note 17, at 383; Sage, *supra* note 20, at 159.

⁶⁵ See Abraham & Weiler, *supra* note 17, at 400.

⁶⁶ See *id.* at 384-85 (discussing hospital-based enterprise liability); Sage, *supra* note 20, at 162 (discussing enterprise liability based on managed care organizations).

⁶⁷ See Sage, *supra* note 20, at 164.

⁶⁸ See *id.* at 170-71.

⁶⁹ See 38 C.F.R. § 14.514 (2005) (permitting the Department of Veterans Affairs to indemnify an employee named as defendant in any civil suit).

⁷⁰ 42 U.S.C. § 233(a) (2003).

⁷¹ See 28 U.S.C. § 2672 (1988 & Supp. IV 1992) (Federal Tort Claims Act allowing heads of federal agencies to settle claims against employees).

⁷² See 32 C.F.R. § 61 (2005) (permitting malpractice claims against armed forces personnel).

⁷³ William M. Sage & James M. Jorling, *A World that Won't Stand Still: Enterprise Liability by Private Contract*, 43 DEPAUL L. REV. 1007, 1026-27 (1994).

⁷⁴ See Sage, *supra* note 20, at 173-74.

closure, apology, and rapid remedy.⁷⁵ This mode cannot be extrapolated to the general population, however, as healthcare in the Veterans Administration is highly integrated, with virtual “one stop shopping” at many facilities.⁷⁶ With the possible exception of non-governmental entities such as Kaiser Permanente and Sharp Health Care in California,⁷⁷ this highly integrated and stable delivery method is rare in the United States.⁷⁸ As such, the major impediment blocking the broad application of enterprise liability nationally is a dearth of large-scale enterprises that are integrated enough to be charged fairly with the responsibility of enterprise liability. Additionally, integration is a necessary but not sufficient step, for control of care must be achieved after integration. That is, although many entities (university health systems and third party payers, among others) are large enough to qualify as “enterprises,” they do not control the delivery of care to the extent that the Veterans Administration or Kaiser controls their providers.⁷⁹ Recall that it is not a matter of finding a defendant to designate. If the goal is to reduce error, that designee must have the power to change the behaviors and the cultures that lead to error.⁸⁰ Unless and until the enterprises have the right to articulate standards of physician behavior and the power to enforce them, the promise of enterprise liability won’t be reached.

To fill this gap, effective malpractice reform must promote the formation of entities that can serve as the enterprise, ones that can effectively examine the root causes of error and correct them. Various scholars have promoted different enterprises to assume liability, but the choice historically has come down to either hospitals⁸¹ or managed care organizations.⁸² Neither of these organizations is ideal.

⁷⁵ See Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 *FORDHAM URB. L.J.* 1447, 1465 (2000) (describing the proactive approach to address error disclosure and systemic error used by VA hospital in Lexington, Kentucky).

⁷⁶ See Robert Cook, *Manchester Veterans Want Their Hospital Back*, *FOSTER’S DAILY DEMOCRAT*, Mar. 13, 2007.

⁷⁷ California’s Kaiser also has a form of modified, voluntary enterprise liability, in which negligent actions by staff physicians are defended by the Kaiser Foundation Health Plan; in practice this arrangement means that plaintiffs’ attorneys usually but not invariably agree to remove the physician as a defendant. See Sage & Jorling, *supra* note 73, at 1032.

⁷⁸ See James C. Robinson & Lawrence P. Casalino, *Vertical Integration and Organizational Networks in Healthcare*, *HEALTH AFFAIRS*, Spring 1996, at 7. While many health care systems are becoming more integrated, one major problem is their stability, as systems frequently acquire and shed practices, clinics, and other hospitals at a fast rate, leading one to observe that the only thing stable about the managed care system in America is its instability. See Sage, *supra* note 20 (discussing organization of MCOs).

⁷⁹ Cf. Cohen, *supra* note 75, at 1452-53 (detailing the organizational framework unique to a particular VA that allowed it to impose a regime of institutional apology).

⁸⁰ Implied in most discussions of medical error, and explicit in many, is the necessity for empowered, relevant decision makers to be able to effect systemic change. See, e.g., GIBSON & SINGH, *supra* note 33, at 172-73 (discussing situation of Boston’s Brigham and Women’s Hospital, which, when management decided to change medication ordering to an electronic system, saw a significant decrease in medication error rates).

⁸¹ See Abraham & Weiler, *supra* note 17, at 384.

⁸² See, e.g., Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 *N.Y.U. L. REV.* 1929, 1933 (2003) (advocating liability for MCOs).

In their present form, most managed care organizations afford little control at all, particularly loosely-integrated “network model” HMOs which contract with, but do not employ, affiliated physicians.⁸³ Additionally, HMOs might not want to institute best practice standards, as their profit comes from limiting medical care; and this profit-centered approach might not hew to best practices standards (i.e., the cheapest care might not be the best care at all).⁸⁴ Employer-sponsored HMOs might be unwilling to assume enterprise liability, as that would mean ceding their treasured ERISA preemption;⁸⁵ they prefer placing the burden for malpractice on the affiliated physician’s shoulders. At present, some HMO-affiliated physicians are required to be responsible not only for holding down costs, but also for adverse outcomes occurring as a result of missed diagnoses, failure to order tests, or even the normal progression of disease.⁸⁶ While physicians might not like this, many HMOs do; accordingly, HMOs would be reluctant participants in EML.

In contrast, Abraham and Weiler have identified hospitals as being better able to monitor, control, and correct risk than managed care organizations.⁸⁷ As an example, they point to hospitals’ ability to control medical teams and promote better communication with regard to such potential pitfalls as discovering a patient’s previous adverse drug reaction.⁸⁸ We agree that hospitals themselves are in a position to control the types of physician performance errors that are the result of a simple “snafu,” such as operating on the wrong leg, or dispensing the wrong medication due to illegible handwriting, or not knowing about a previous adverse reaction to a medication because of poor communication or record keeping. For example, with regard to medication errors stemming from illegible or misread physician handwriting, some hospitals have recently demonstrated notable success by instituting computer medication ordering systems to eliminate the root cause of misread handwriting.⁸⁹

⁸³ Sage & Jorling, *supra* note 73, at 1028. In contrast, more tightly controlled HMOs, such as staff model HMOs, would be able to exercise more control over their physicians but may also transfer liability for highly specialized care for which the HMO contracts with outside entities, such as academic hospitals. *Id.*

⁸⁴ See, e.g., Rebecca H. Sunenshine and L. Clifford McDonald, *Clostridium difficile-associated disease: New challenges from an established pathogen*, 73 CLEVELAND CLINIC J. MED. 187 (2006) (describing a case where the more expensive approach is clearly superior).

⁸⁵ Malpractice litigation against employer-sponsored HMO health plans often runs into thorny issues of pre-emption under the provisions of the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA pre-emption of state law malpractice claims, a topic beyond the scope of this article, hinges on courts differentiating between the determination of covered benefits and the provision of medical care, pre-empting lawsuits dealing the former but not the latter. However, this distinction is conceptually difficult and increasingly hard to make, since the denial of benefits—a coverage determination—often means that care is not provided—a provision of care determination. See Sage, *supra* note 20, at 182-83. Also, MCOs which provide utilization review for insurance purposes will also be very reluctant to assume liability, due to the difficulties of directing care second-hand.

⁸⁶ See Sage, *supra* note 20, at 174-75. We recognize as well that physicians directly employed by HMO’s may also experience similar conflicts but in those instances it is more likely the enterprise itself will be liable. See *id.* at 174.

⁸⁷ See Abraham & Weiler, *supra* note 17, at 385 (arguing that the developments in the law over the last fifty years has left hospitals uniquely well-positioned to adopt enterprise liability).

⁸⁸ See *id.* at 385-97.

⁸⁹ GIBSON & SINGH, *supra* note 33, at 172.

However, hospitals' mechanisms are not necessarily as robust in correcting more subtle—and perhaps more pervasive—errors.⁹⁰ Errors occurring when faulty plans motivate a wrong course of action are more difficult to identify, analyze, and correct as they are often the result of lagging technologies, disputes about best medical practice, and inadequately disseminated data.⁹¹ Certainly, to attack these other more entrenched, complex forms of error, hospitals' continued use of peer review, M&M conferences, etc., has not been convincingly effective, judging by continued high iatrogenic injury rates, as noted above.⁹²

The characteristics of an ideal organization to assume enterprise liability also include an ability to enforce meaningful incentives to reduce error.⁹³ One incentive is controlling access, which has been mostly applied to the context of access to a hospital, i.e., granting admitting privileges to physicians.⁹⁴ Adoption of a broad-based EML, it is argued, would make hospitals solely responsible for the liability of medical care of admitted patients, regardless of where the negligent act occurred (e.g., hospital, clinic, private office).⁹⁵ Such a regime would theoretically promote a credible and effective deterrence effect, as hospitals could threaten withdrawal or limitation of a physician's individual admitting privileges; therefore a net increase in the quality of care, and with it a reduction in patient injuries resulting from malpractice.⁹⁶ In addition, the enterprise accepting liability must be responsible for the malpractice of all affiliated physicians, including patients admitted to multiple hospitals over the course of care and those not admitted to any hospital.⁹⁷ Abraham and

⁹⁰ See CHARLES L. BOSK, *FORGIVE AND REMEMBER: MANAGING MEDICAL FAILURE* (2003) (noting lack of meaningful and extensive social control over physician behavior, even in cases of serious errors leading to significant morbidity and/or mortality).

⁹¹ An error related to a faulty plan motivating a wrong course of action is a form of an error of omission: what's missing is the correct plan. Yet because error reduction analysis focuses most easily on erroneous actions, errors of omission are especially difficult to assess. In the case of a faulty plan motivating wrong steps, the problem is compounded by the cognitive bias that makes it difficult to even recognize that the plan was faulty. Moreover, the bad plan may have been chosen at a point in time greatly removed from the injurious event. As an example, take the case of a patient with a history of gout who presents to an emergency room complaining of an inflamed knee, yet the history of gout is forgotten by or not known to his emergency room treaters. An aspiration of his knees shows 121,000 white cells and the presumptive diagnosis is an infection, the wrong presumptive diagnosis if gout were recalled. The patient is taken to the operating room for irrigation of the knee. In the operating room the patient has reaction to the anesthesia and goes into cardiac arrest. This plan would be an error, for if it's gout, you don't operate but medicate. The key error here was a wrong diagnosis, yet that error would not be the focus of any *post hoc* analysis, as the focus of a morbidity and mortality conference would be the reaction to the anesthesia. It is certainly easy to further imagine scenarios where the error is even more remote, for instance, where the diagnosis of gout is not made previously, though it should have been. See, e.g., GIBSON & SINGH, *supra* note 33, 3-14 (exploring multiple case histories of medical error due to such practices).

⁹² See BOSK, *supra* note 90. See also *supra* note 50, and accompanying text (detailing high rates of error).

⁹³ Abraham & Weiler, *supra* note 17, at 407.

⁹⁴ *Id.* at 414.

⁹⁵ *Id.* at 415.

⁹⁶ *Cf. id.* at 421-22 (hospital assuming liability for physicians who admit principally to that institution despite where malpractice occurred).

⁹⁷ *Id.* at 421.

Weiler postulate that this approach would eliminate the need for physicians to purchase additional malpractice insurance against litigation by patients who are only covered by for injuries occurring in a facility such as a hospital.⁹⁸ They contend that there is no problem with this approach, because hospitals can control physicians outside the hospital, much like airlines control pilots flying in the sky and law firms their lawyers in the courtroom.⁹⁹ While we admit that this is an appealing notion, we are not sure it is practical or reflective of reality.

In our experience most hospitals have little direct control over affiliated physicians, with the exceptions of salaried physicians in large groups such as Kaiser who are more closely managed, or physicians who are direct employees of a particular hospital.¹⁰⁰ One simple phenomenon driving the impracticality of having hospitals assume responsibility for outpatient events—and one not apt to change much in the near future—is that many physicians admit to more than one hospital.¹⁰¹ Pilots, by comparison, typically do not fly for more than one airline. Should an outpatient adverse event occur in a doctor's office or private clinic outside of the institution, each of the (fractionally) affiliated hospitals would be justified in disavowing responsibility, and we believe that much litigation will ensue to find loopholes in the contracts Weiler and Abraham envisage for individual hospitals to assume responsibility in this situation.¹⁰² We envision, in contrast, that the SQM will be able to exert such control on independent physicians in all settings, as we will explain below.¹⁰³

B. ALTERNATIVE DISPUTE RESOLUTION

Mandatory alternative dispute resolution of medical malpractice claims has traditionally been viewed suspiciously by courts, often being invalidated as an unconstitutional infringement on the rights to due process and trial by jury or as the result of an adhesive contract.¹⁰⁴ As courts and legislatures have

⁹⁸ *Id.* at 422.

⁹⁹ *Id.*

¹⁰⁰ Kaiser contracts with its physicians as a group, the Permanente group, but effectively controls them as this group has no other affiliation and exists solely to service the Kaiser plan. See Sage, *supra* note 20, at 175 (describing the relationship between Kaiser and the Permanente group). In addition, hospitals now employ "hospitalists" to manage many inpatients, in lieu of having the patient's own internist follow the patient during hospitalization. See Mark A. Kelley, *The Hospitalist: A New Medical Specialty?*, 130 ANNALS INTERNAL MED. 373, 375 (1999) (discussing increasing role of hospitalists).

¹⁰¹ See Lawton R. Burns & Douglas R. Wholey, *Factors Affecting Physician Loyalty and Exit: A Longitudinal Analysis of Physician-Hospital Relationships*, 27 HEALTH SERVICES RES. 1, 14 (1992) (describing study in which more than half of surveyed physicians admitted patients to more than one hospital).

¹⁰² See Abraham & Weiler, *supra* note 96 and accompanying text; MEDICAL MALPRACTICE, *supra* note 1, at 217-19 (noting probability of increased litigation should "designated compensable events" be adopted as part of limited no-fault tort reform package).

¹⁰³ See *infra* text accompanying notes 172-81.

¹⁰⁴ See Sage *supra* note 20, at 189. See also Clark C. Havighurst, *Private Reform of Tort-law Dogma: Market Opportunities and Legal Obstacles*, 49 LAW & CONTEMP. PROBS. 143, 167 (1986) (noting that arbitration clauses affect substantive outcomes); *Tunkl v. Regents of the Univ. of Cal.*, 383 P.2d 442, 443 (Cal. 1993).

over the past few decades relaxed objections to ADR,¹⁰⁵ however, many commentators now view it as preferable to traditional tort litigation for several reasons:

1. Efficiency and Reduction in Cost.¹⁰⁶

ADR is more efficient, as it requires less discovery, and what discovery occurs is less formal and extensive.¹⁰⁷ If the conflict is resolved through mediation, then the costs of formal hearing time are saved, and disputes that fail mediation and enter arbitration also require less formal hearing time.¹⁰⁸ A resolution is therefore achieved more quickly than traditional litigation and will cost less to pursue.¹⁰⁹

2. Objective, Consistent Decision making.

Arbitration can employ a sophisticated decision-maker, an expert in medical malpractice who is knowledgeable about medicine and yet objective. Thus, the problem of uninformed juries and judges making decisions based on misunderstandings of complex, factual, scientific data is lessened.¹¹⁰ Judgments regarding negligence are therefore more consistent and accord with scientific knowledge.¹¹¹ Moreover, arbitration is not an inherently pro-physician process, as studies show that arbitration actually may tend to favor plaintiffs on such issues as the number of patients compensated, amount of compensation for some injuries, and timeliness of compensation.¹¹² In addi-

¹⁰⁵ Courts “now generally uphold agreements to undergo binding arbitrations as long they comply with state statutory requirements.” Sage, *supra* note 20, at 190 (citing *Morris v. Metriyakool*, 344 N.W. 2d 736, 753 (Mich. 1984)). See also *Madden v. Kaiser Found. Hosps.*, 552 P.2d 1178, 1179 (1976) (upholding contractually-imposed mandatory and binding arbitration of medical malpractice claim).

¹⁰⁶ Metzloff, *supra* note 10, at 435.

¹⁰⁷ See MARGARET C. JASPER, *THE LAW OF ALTERNATIVE DISPUTE RESOLUTION I* (2000) (discussing differences in discovery between ADR and traditional litigation).

¹⁰⁸ See *id.* (citing “more expedient resolution of a conflict” as benefit to ADR).

¹⁰⁹ Elizabeth Rolph et al., *Arbitration Agreements in Health Care: Myths and Reality*, 60 *LAW & CONTEMP. PROBS.* 153, 155 (1997).

¹¹⁰ *Id.* See also JASPER, *supra* note 107, at 4-5, 17 (detailing American Arbitration Association roster of 17,000 impartial experts, “recognized for the standing and expertise in their fields” and requirements for educational degrees and licenses appropriate to field of expertise); Ellwood F. Oakley, *The Next Generation of Medical Malpractice Dispute Resolution: Alternatives to Litigation*, 21 *GA. ST. U. L. REV.* 993, 1006 (2005) (stating how medical expertise can be beneficial in assisting ADR and noting that “it is unrealistic to expect most judges to have the background and training to evaluate claims involving statistical nuance and the scientific methods”).

¹¹¹ There is certainly a debate over whether judges and or juries “in medical malpractice and other tort cases are rational when assessing science and/or awarding damages.” Eleanor D. Kinney, *Administrative Law Approaches to Medical Malpractice Reform*, 49 *ST. LOUIS U. L.J.* 45, 51 (2005). Use of medical experts, it is argued, can lessen the problems of irrational decision making. See Oakley, *supra* note 110, at 1006.

¹¹² ADR seems to more efficiently distribute compensation to patients. One study reported that claims of patients who were permanently disabled tended to be upheld more frequently under arbitration than litigation. But malpractice claims in which fatal injury or no physical, minor or temporary injury had occurred were upheld less frequently. Also the damages for injury awarded by arbitrators were higher for permanent disabilities but lower for temporary injuries. See Irving Ladimer et al., *Experience in Medical Malpractice Arbitration*, 2 *J. LEGAL MED.* 433, 464 (1981). See also *MEDICAL MALPRACTICE*, *supra* note 1, at 202, 203 (reviewing study results suggesting that formal arbitration may increase the frequency of suc-

tion, plaintiffs prevail slightly more often and more quickly when electing arbitration than in the traditional medical malpractice litigation system.¹¹³ In short, arbitration can credibly be described as a pro-plaintiff process, especially for patients seriously injured by medical mistakes, who are those most in need of adequate and timely compensation.¹¹⁴

3. Lessening of Trauma and the Maintenance of Relationship.

Both mediation and arbitration allow the parties to maintain a less adversarial relationship, and therefore, reduce the trauma of malpractice litigation.¹¹⁵ Traditional medical malpractice litigation exacts a significant emotional toll on the parties that ADR lessens by its more private, streamlined process.¹¹⁶ This attribute “is a particularly important feature in the case of health care disputes where a claimant’s well-being may depend on continuity of care.”¹¹⁷

4. Patient Satisfaction.

Similarly to mediation, arbitration allows patients to have their claims heard and so better offers the psychological satisfaction of having one’s “day in court.”¹¹⁸ Related to this advantage is the ability of arbitration to handle the small case. Traditional malpractice litigation makes it very difficult for modestly injured patients to assert a malpractice claim, since the prospects of a small recovery operate as a disincentive for plaintiffs’ attorneys to accept cases on a contingency fee basis.¹¹⁹

5. Confidentiality.

Use of mediation and arbitration allows allegations of negligence to remain in a private, as opposed to public forum.¹²⁰

cessful malpractice claims while decreasing significantly the amount of payment to patients per claim).

¹¹³ Metzloff, *supra* note 10, at 439.

¹¹⁴ One group who demonstrably seems to do worse are those patients with more minor, temporary injuries who under a traditional tort litigation system might be the beneficiaries of huge “windfall” awards. See Ladimer, *supra* note 112, at 464. Thus the use of arbitration promises to eliminate this “lottery-like” aspect of malpractice litigation.

¹¹⁵ See Metzloff, *supra* note 10, at 435.

¹¹⁶ *Id.* at 435-36. See also FRESNO COUNTY SUPERIOR COURT, ALTERNATIVE DISPUTE RESOLUTION (ADR) INFORMATION PACKET 3 (2009), http://www.fresnosuperiorcourt.org/_pdfs/adr_Information%20Pack.pdf (describing benefits to ADR in terms of lessened psychological stress).

¹¹⁷ Rolph et al., *supra* note 109, at 155.

¹¹⁸ *Id.*

¹¹⁹ Metzloff, *supra* note 10, at 436.

¹²⁰ Rolph et al., *supra* note 109, at 155. The question can legitimately be raised whether or not such a private forum would be a good idea, as it arguably would lessen the public impact of disclosure and hence deterrence. However, the public disclosure of error in the SQM proposal should mitigate this concern as, by its very definition, the SQM is dedicated to open discussion of error. See *infra* text accompanying notes 298-338. Moreover, the confidentiality of ADR is an advantage to plaintiffs who may not want publicity about private medical conditions or concerns. See JASPER, *supra* note 107, at 2 (detailing advantage of confidentiality in general). It may be, however, that SQMs, after reporting error to the patient, would also regularly, e.g., quarterly, issue “error reports” detailing errors while preserving patient confidentiality.

6. Finality.

Mandatory, binding arbitration imposed by contract allows for a resolution to be achieved. Since appeals are not allowed, both patient and physician can focus on the future of their relationship instead of focusing on protracted litigation.¹²¹

Given that list of factors, all parties to suits—defendants, plaintiffs, and their respective attorneys—therefore might agree that, in the abstract, ADR in general and arbitration specifically is a fairer, better system than using the courts: the costs are lower, the outcomes are more just, and the resolution reached more quickly. Nevertheless, very few pairs of litigants agree to submit their disputes to arbitration; moreover, it must be recognized that without an agreement for *binding* arbitration the process may be only a first step toward litigation, thus prolonging the process.¹²²

The paradox between the consensus regarding the advantages of arbitration and the reluctance of litigants to elect it can be resolved by noting that the consensus is offered by the *class* of litigants, whereas the routing of a particular case to ADR is agreed to by *pairs of (particular) litigants*.¹²³ Each of the two parties to litigation essentially has veto power over the decision to opt for ADR.¹²⁴ And while ADR might be fairer overall, there are many instances where a particular litigant might be favored by a standard trial.¹²⁵ In such a case, the favored party, quite rationally, has no particular appetite for ADR. For example, a plaintiff with an amputation might anticipate sympathy points from a jury, and would not want a dispassionate finder of fact. Likewise, a deep-pocketed defendant might want to “run out the clock” against a dying plaintiff with depositions, motions, and every other diversion the court system, but not ADR, would allow.¹²⁶

Thus, even if we can stipulate that *on average* ADR does not favor plaintiffs or defendants disproportionately, if the decision to elect ADR is made only after the facts of the particular case are known, we can expect that in a large fraction of cases ADR will not be chosen. In such a situation, one party will have an incentive to litigate the case, calculating that this case will be successful based on a pattern of favorable facts. In effect, this is precisely what is seen today in tort litigation, wherein a minority of cases are settled in ADR.¹²⁷ ADR works not only when it is mandatory and binding, but when mandatory and binding ADR is imposed before litigants have the chance to calculate their particular advantages or disadvantages; therefore, we believe such ADR is seen as more attractive by all parties before they enter into the contract.

¹²¹ See Rolph et al., *supra* note 109, at 155 (discussing continuity of care, i.e., the continuation of the doctor-patient relationship).

¹²² See MEDICAL MALPRACTICE, *supra* note 1, at 202-03 (discussing how lack of finality may impede resolution and how binding arbitration may increase economic efficiency).

¹²³ See JASPER, *supra* note 107, at 9 (discussing roles of individual parties in electing arbitration).

¹²⁴ See *id.*

¹²⁵ See *id.* at 10 (discussing in general some disadvantages of arbitration).

¹²⁶ *Id.* at 10-11 (discussing the curtailed use of extensive discovery in ADR).

¹²⁷ See *id.* at 1 (detailing dramatic growth of arbitration services with 140,000 filed in 1999). Nevertheless, the number of cases settled by arbitration is small compared to cases litigated.

To fill this gap, an effective mode of malpractice reform must include the (contractual) agreement for binding ADR before plaintiffs or defendants can assess their relative advantages opting out of ADR.

C. CAPS ON NON-PECUNIARY DAMAGES

Limitations on non-economic damages—i.e., so called “pain and suffering” or “general damages”—are highly controversial and seen by many scholars as retrogressive, punishing those the least likely to be able to withstand the effects of catastrophic injury, such as the poor.¹²⁸ In addition, the plaintiff’s bar depends upon recovery of large awards to offset the large litigation costs malpractice suits often entail, and therefore has a very real economic reason to oppose any limitation on payments.¹²⁹ Therefore, while one may appeal to abstract values such as reason,¹³⁰ economic efficiency,¹³¹ and fairness,¹³² in the end these arguments are not enough to defeat the practical interests (and de facto political veto) of those who would be harmed by a capped regimen.¹³³

¹²⁸ See, e.g., Abraham & Weiler, *supra* note 17, at 384; Lee Harris, *Tort Reform as Carrot- and- Stick*, 46 HARV. J. ON LEGIS. 163, 164-68 (2009); Sugarman, *supra* note 3, at 514 (arguing damages caps tends to harm young more than old as permanent pain and suffering conventionally determined by taking into account the life expectancy of the victim).

¹²⁹ See Christopher S. Kozak, Note, *A Review of Federal Medical Malpractice Tort Reform Alternatives*, 19 SETON HALL LEGIS. J. 599, 601 (1995) (reviewing high procedural costs of malpractice claims and noting that the “potential cost of claims not supported by evidence serves as a barrier to injured, indigent claimants because many attorneys will opt to forego the opportunity to represent that person”).

¹³⁰ According to one line of reasoning, pain and suffering cannot be assuaged with money—anguish simply lies in another realm. For example, if an infant wrongfully dies because of botched medical care and the parents collect \$10 million, no amount of money can repair the loss. Any payment for such a loss, therefore, is an arbitrary token. That is not to say that pain and suffering should go without compensation altogether. It is simply to assert that it would be fairer to avoid potential jury caprice by imposing limits on awards for noneconomic damages. See MEDICAL MALPRACTICE, *supra* note 1, at 153 (arguing that “[f]ull compensation for pain and suffering is unlikely to be optimal because insurance can only transfer money from the healthy to the disabled state, but money cannot replace the nonpecuniary losses of physical injury”).

¹³¹ Limiting a few random large awards, even if it were not to affect the average award very much, could drive down insurance prices by tamping down volatility. See RICHARD E. ANDERSON, MEDICAL MALPRACTICE: A PHYSICIAN’S SOURCEBOOK 223 (2004) (discussing studies showing that, between 2000 and 2001, states with caps of \$250,000 or \$350,000 on noneconomic damages had average premium increases only one third of increases in non-capped states).

¹³² One argument for the imposition of caps is that such a limitation reflects implicit popular preference. The preference for caps is revealed by the behavior of consumers in states such as California that have already imposed these caps. In the states with caps, there has not been a proliferation of secondary insurance sold to patients to make up the difference between what a jury might award and what the caps allow. By contrast, uninsured motorist policies (which also offer “gap coverage”) are very popular. We can infer, consequently, that people do not value limitless awards for pain and suffering—at least not at the price the market says such coverage truly costs. See George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1547 (1987).

¹³³ Nor would we argue the political interests, which are the manifestation of those practical interests. In describing the situation in this way, however, we make no value judgment as to the validity of those interests. Instead, it is the nature of a tort system built on recovery and contingency fees—necessary to fund lawsuits on behalf of the politically and economically disenfranchised—that has structured the behaviors we describe.

Certainly the experience in California, the first state to adopt caps on non-pecuniary damages, indicates that some cases with scant economic damages—for example the negligent death of a retiree, a case which has limited future medical expenses and no wage losses—do not under the current tort system offer enough potential return to plaintiffs' attorneys to justify the expense of litigation.¹³⁴ Under California's Medical Injury Compensation Reform Act (MICRA),¹³⁵ on average defendants' liabilities were reduced by 30 percent and attorneys fees by 60 percent while the net recovery to patient plaintiffs was reduced by 15 percent due to larger proportional absorption of loss by attorneys.¹³⁶ Caps reduce the number of cases brought; however, if they prevent injured patients from having viable claims heard, caps leave these patients without a means of recourse, a situation that we believe to be both untenable and inefficient.¹³⁷ Nonetheless, a majority of states as of this writing have passed some sort of cap, either on punitive damages, non-pecuniary damages, or both.¹³⁸ However, some of these damages caps have been overturned by state courts on various grounds.¹³⁹

To fill this gap, we believe that an effective mode of malpractice reform must therefore acknowledge that, just as plaintiffs' interests (to the detriment of other stakeholders) are served by a regime that imposes no capitation upon awards, a system consisting solely of such limitations provides an unfair boon to the defendants (at the expense of some plaintiffs).¹⁴⁰ Thus, even if caps on

¹³⁴ See Epstein, *supra* note 9, at 504 (discussing MICRA).

¹³⁵ CAL. CIV. CODE § 3333.2 (2009). MICRA places a \$250,000 cap on noneconomic damages, provides for periodic payments (damage awards to be paid over the period of time they cover), places restrictions on contingency fees, and prevents duplicate collections of money for the same damages (i.e., modifies the collateral source rule). *Id.*; ANDERSON, *supra* note 131, at 214 ("These reforms have reduced California malpractice premiums by 40% in constant dollars since 1975, or less than 3% per year uncorrected for inflation.")

¹³⁶ See RAND STUDY, *supra* note 23, at 1-3. See also Epstein, *supra* note 9, at 504 (discussing the California experience and how MICRA and caps in general may increase access ex ante to medical care while reducing costs ex post).

¹³⁷ See Abraham and Weiler, *supra* note 17, at 383 (noting retrogressive nature of caps); Bernstein, *supra* note 3, at 1778; Harris, *supra* note 128, at 179 (citing Lucinda Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263 (2004)) (detailing the argument that caps have been criticized as penalizing marginalized groups more severely than dominant groups).

¹³⁸ Harris, *supra* note 128, at 173-76 (detailing how, at present, twenty-eight states have approved statutory caps on non-pecuniary damages: Alaska, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Vermont, West Virginia, and Wisconsin).

¹³⁹ See, e.g., *Wright v. Cent. Du Page Hosp. Ass'n*, 347 N.E.2d 736, 743 (Ill. 1976) (overturning caps on noneconomic damages as violating Illinois Constitution). However, Illinois preserves caps on punitive damages. 735 ILL. COMP. STAT. 5/2-1706.5 (2009). See also ANDERSON, *supra* note 131, at 215 (noting that Oregon, Alabama, Georgia, Illinois, New Hampshire, North Dakota and Washington state have had tort reforms nullified by state supreme courts). When nullification occurs, malpractice indemnities often rise. See, e.g., *id.* (noting that after Oregon nullified \$500,000 cap on noneconomic damages in 1998, malpractice indemnities increased by 400% in two years).

¹⁴⁰ See MEDICAL MALPRACTICE, *supra* note 1, at 158-63 (discussing advantages versus disadvantages of various capitation systems including how common capitation systems applicable to all claims penalize some plaintiffs disproportionately (e.g., severely injured young claimants)).

damages are “fair” or “logical”, they are not going to be accepted willingly by many parties, despite their success legislatively.¹⁴¹ As a means of getting all to agree to this provision, a simple, reciprocal payment to the other stakeholders will be much better than appeals to subjective notions of logic and fairness. We shall argue below that the SQM provides such a reciprocal trade-off.¹⁴²

D. LIMITATIONS ON COLLATERAL SOURCE RECOVERY AND DECREASING AWARDS TO PRESENT NET VALUE

1. Collateral Source Recovery

Collateral source recovery occurs when a plaintiff is compensated by the insurer or workman’s compensation as well as by damages awarded in a malpractice action.¹⁴³ The collateral source rule bars a defendant from introducing evidence of insurance payments to a plaintiff for the injury at issue.¹⁴⁴ The collateral source rule has been criticized for allowing recovery beyond the extent of loss, and because legal fees are determined as a proportion of the gross tort recovery, unjustly benefiting plaintiffs’ lawyers at the expense of their clients.¹⁴⁵ Accordingly, there has been much scholarly discussion of limiting collateral recovery. The Clinton task force considered doing so, and the rule has also been modified or eliminated in various jurisdictions or for certain types of cases.¹⁴⁶ As described in the legal literature, however, collecting from a collateral source is not, as some critics charge, really a double recovery,¹⁴⁷ because the patient had to buy the insurance that is now providing that collateral source recovery. In the SQM proposal, we limit collateral source recovery because we believe that such a rule will help dramatically improve the social role of tort as applied to medical malpractice, in addition to externalizing costs.

Professor Stephen Sugarman has argued that limiting collateral source recovery will “reserve tort for when it is most needed, that is, to deal with compensation needs not met by the society’s core social insurance arrange-

¹⁴¹ See Harris, *supra* note 128, at 173-76 (detailing success of caps in sense of passing in majority of states).

¹⁴² See *infra* text accompanying notes 172-81. In addition, we note and are impressed with Professor Lee A. Harris’s attempt to legislatively grant noneconomic damages caps to hospitals which perform “best recommended care and avoid error.” Harris, *supra* note 128, at 166. However, we are not satisfied that this would be the best course to follow. Many of the most advanced hospitals in this country, i.e., the major tertiary centers such as Boston’s Harvard-affiliated Massachusetts General and Brigham and Women’s Hospitals, treat the world’s sickest patients with some of the most highly developed surgical and medical therapy, leaving more room for adverse outcomes and more difficulty in determining when “error” actually occurs. A good example of this is the surgical practice of the extrapleural pneumonectomy for mesothelioma at the Brigham and Women’s Hospital, a procedure performed at very few hospitals in the world, and which can have numerous complications and a tortuous recovery, even when successful. In such cases, determining the “best hospitals” would have the patina of a ranking system based on misleading data. See *infra* note 290.

¹⁴³ Sugarman, *supra* note 3, at 509-10.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ See Feinman, *supra* note 3, at 68.

¹⁴⁷ See Sugarman, *supra* note 3, at 510.

ments.”¹⁴⁸ However, we do not advocate eliminating all collateral sources. Those jurisdictions that have limited collateral source recovery have made an exception for privately purchased life insurance, although not for Social Security benefits.¹⁴⁹ The rationale behind this position is that private life insurance is conceived as providing benefits beyond other payments at time of death, is contracted for by the patient, and is culturally considered a supplement to the benefits.¹⁵⁰ In contrast, Social Security income replacement, standard health insurance, and workers’ compensation are viewed as “core safety net protections and not supplements.”¹⁵¹ By offsetting such core safety net protections, abolishing collateral source recovery produces a flexible mechanism whereby costs associated with malpractice litigation can be further reduced should the basic social safety net expand, that is, if public financing increases for these entitlements, more offset occurs.¹⁵² In contrast, if decreased public fiscal reserves mandate reductions in entitlements, there will be less offset as there are fewer collateral resources.¹⁵³

2. Decreasing Awards to Net Present Value.

If the goal of a tort award is to make the plaintiff whole—and no more—discounting the award to its net present value and actuarial risk in our view is mandatory.¹⁵⁴ Without those steps,—unfortunately, steps rarely taken in American jurisprudence—the result is an unvarnished overpayment to plaintiffs, which of course increases associated costs of malpractice litigation.¹⁵⁵ Adjusting awards to their net present value is achieved when a loss which is asserted to accrue over time is paid in a lump sum which reflects the interest that would be earned over the time of the stated loss.¹⁵⁶ For instance, a plaintiff may assert that he will lose \$50,000 a year of wages for 20 years, for a total of \$1 million. The correct lump sum payment for those damages is not \$1

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 511.

¹⁵⁰ *Id.*

¹⁵¹ *Id.* Professor Sugarman argues that treating private life insurance as different from other benefits is justified because it is culturally understood to belong to the patient beyond any tort recovery that is received. *Id.* at 512. He also points out that ignoring private life insurance is consistent with how life insurance was viewed by the compensation program for victims of the September, 11, 2001 terrorist attacks, in which benefits paid to survivors were offset by life insurance payments. In this case, because life insurance varied greatly between survivors, the plan would end up paying those without life insurance more than those with, and “valuing” the lives apparently differently. *Id.*

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ See Bernstein et al., *supra* note 3, at 1780.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* See also Jeffrey O’Connell, et al., *An Economic Model Costing “Early Offers” Medical Malpractice Reform: Trading Noneconomic Damages for Prompt Payment of Economic Damages*, 35 N.M. L. REV. 259, 263 (2005) (defining “net expected present value” as four “adjustments of nominal future jury awards. These four adjustments account for: (1) probability in outcome; (2) timing of outcome, and specifically a positive rate of time preference by individual actors; (3) the claimant’s lawyer’s contingent fee; and (4) other litigation-induced costs. Together, these adjustments return a figure for the value claimants should attach to their claims.”).

million, for it would take less than \$655,000 invested at 5% to generate \$50,000 per year for 20 years.

Actuarial adjustment considers, using the example just given, the possibility that the plaintiff would not have worked for the full 20 years claimed. Many people plan to work until age 65, but some do not;¹⁵⁷ at the minimum, there is a risk of dying from other causes.¹⁵⁸ As such, a fair compensation for the claimed wage loss of \$50,000 over 20 years is not \$1 million; it is not even \$1 million discounted to present value; it is the price of an annuity that pays \$50,000 a year as long as the person remains alive. To be sure, there are justifications offered for not discounting awards to their net present value and actuarial risk—ie, they offset the lawyer's contingency fee, say—but these are arguments based on expediency.¹⁵⁹ The other proposed sources for husbanding funds (i.e., limits on non-pecuniary damages or collateral recovery,) might be debatable; this really is not.

E. NO-FAULT INSURANCE

Curiously, one ingredient not on the task force's list is a regime of comprehensive no-fault insurance. This may be considered an odd omission, especially if one begins with the premise that the system must be reformed precisely because it emphasizes blame and in turn hides (and perpetuates) error.¹⁶⁰ Under a no-fault model, patients who have experienced adverse effects from substandard medical care would be compensated without having to prove negligence.¹⁶¹ Proponents argue that such a regime increases efficiency, reduces litigation costs, expedites the process of compensation, and alleviates the psychological costs for both plaintiffs and defendants.¹⁶² Beyond this, a no-fault model increases the sensitivity of the system by paying claimants who are currently denied compensation.¹⁶³ Equally important, a no-fault system removes blame from the discussion of medical error, because physicians and

¹⁵⁷ See Emily Brandon, *Retirement Often Happens Unexpectedly*, U.S. NEWS AND WORLD REPORT, Mar. 31, 2009, available at <http://www.usnews.com/money/blogs/planning-to-retire/2009/03/31/retirement-often-happens-unexpectedly-.html>; Sandra Block & Stephanie Armour, *Many Americans Retire Years Before They Want To*, USA TODAY, July 9, 2006, http://www.usatoday.com/money/perfi/retirement/2006-07-09-retire-early_x.htm.

¹⁵⁸ Indeed, many patients may find that chronic but previously managed disease can become severe enough to cause mortality well before the retirement years. See DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTER FOR DISEASE CONTROL AND PREVENTION, *DIABETES AND WOMEN'S HEALTH ACROSS THE LIFE STAGES: A PUBLIC HEALTH PERSPECTIVE* 6 (2001), available at <http://www.cdc.gov/diabetes/pubs/pdf/womenshort.pdf> (stating that diabetes "is a leading cause of death among middle-aged American women; rates in 1996 follow: fifth among white women, fourth among black and American Indian women, and third among Hispanic women aged 45-64 years").

¹⁵⁹ While we believe that a cogent justification for keeping such awards not discounted—i.e., one reason that plaintiffs' attorneys take malpractice cases (and provide the injured an ability to recover in tort) is the prospect of an award that is not discounted—we contend that the SQM proposal will redistribute both the amount and number of awards more equitably and not destroy such motivation. See *infra* text accompanying notes 182-213.

¹⁶⁰ See Bernstein et al., *supra* note 3, at 1778-79.

¹⁶¹ *Id.* See also *MEDICAL MALPRACTICE*, *supra* note 1, at 213-19 (discussing general and limited no-fault regimens).

¹⁶² *Id.*

¹⁶³ *Id.*

allied health professionals are no longer targeted to discover who did what wrong. As such, it should foster a climate more conducive to the discussion and reduction of error.¹⁶⁴

No-fault has its champions, and they point to the great success this approach offers for improving the litigation of automobile accidents.¹⁶⁵ However, to our view this is a flawed analogy. For one thing, automobile accidents are encounters of strangers, whereas medicine is transacted, axiomatically, by intimates—i.e., the doctor and the patient who enter into an unique relationship very dissimilar from strangers encountering each other on the highway. Thus, what is an optimal solution for a dispute among strangers (who of course cannot contract *ex-ante*) may be far from optimal for disputes that may arise between those who both would prefer to and can indeed stipulate in advance how to manage any potential dispute.¹⁶⁶

The more important point is that whereas it is obvious when a car accident takes place—*wreck ipsa loquitur*, one might say—it is far from clear when a medical “accident” has occurred. A bad medical outcome could result from bad medical care, of course, but the more typical cause is progression of the underlying disease or simply bad luck.¹⁶⁷ With no method to discern between such causes, a complete or comprehensive no-fault system cannot be applied efficiently. First, the system will be inundated with false-positives, i.e., compensating patients who do not deserve payment. Second, litigation in such a system will focus not on whether the physician is negligent, but on whether or not the injury is a result of the natural progression of disease (and therefore not compensable) or the result of medical care (regardless of whether such care is substandard).¹⁶⁸ Yet by definition, care that causes or contributes to substandard outcomes is substandard care, and so if the real distinction hinges on whether the care was substandard (i.e., the result of error), the notion of “fault” cannot be avoided.¹⁶⁹

Finally, we note that a no-fault system deprives the provider of meaningful feedback on faulty practices and mitigates any deterrence. So while it destroys the culture of silence, it also threatens to kill the deterrence feature of a “fault” system.¹⁷⁰ Further, a comprehensive and true no-fault system poses the risk of increasing the number and frequency of dubious malpractice claims because physicians, no longer at risk for blame, will have scant interest

¹⁶⁴ *Id.*

¹⁶⁵ See Abraham & Weiler, *supra* note 17, at 434-36 (discussing how adopting enterprise medical liability would facilitate eventual adoption of no-fault liability).

¹⁶⁶ See Epstein, *supra* note 9, at 506-11.

¹⁶⁷ For example, despite state of the art care, many spine surgeries fail to resolve back pain. See Jerome Groopman, *A Knife in the Back*, THE NEW YORKER, Apr. 8, 2002, at 66-73.

¹⁶⁸ MEDICAL MALPRACTICE, *supra* note 1, at 214-17.

¹⁶⁹ Also, and not insignificantly, is that under no-fault all examples of missed diagnosis would be eligible for compensation, despite lack of negligence, leading to millions of irrebuttable claims.

¹⁷⁰ See Elizabeth Landes, *Insurance, Liability and Accidents: A Theoretical and Empirical Investigation of the Effect of No-Fault Accidents*, 25 J.L. & ECON. 49, 50 (1982) (showing auto accident fatalities increased in no fault regimes). See also Stephen Sugarman, *Doing Away with Tort Law*, 73 CALIF. L. REV. 558, 589-90 (1985) (arguing Landis' results may only indicate more people encouraged to drive, i.e., engage in behavior that entails some risk).

in resisting claims, however weak these claims may be.¹⁷¹ Therefore, given its limitations, we believe that no-fault should play a minor part, at most, in the SQM proposal.

IV. THE PROPOSAL FOR A SQM

As noted, we deem the current situation economically inefficient (in the classic sense of the term), as both parties to the arrangement can have their situation improved by an exchange that is not currently occurring. The exchange we contemplate is that patients give up their unfettered right to sue in return for efforts (currently impeded by the traditional malpractice system) by doctors to reduce error. While it is hoped that this exchange will result in lower costs to patients and employer groups as a whole, the main trade-off concerns the reduction of error. Furthermore, we will show that error reduction is an inherent feature of the move away from adversarial litigation and not just a welcome side effect.

We propose a scheme whereby physicians in a given location (perhaps organized by specialty) institute a “Society for Quality Medicine” (SQM). The SQM will be open only to those physicians who have obtained an adequate level of training and cognitive competence and, moreover, have demonstrated a high level of quality care as determined by objective criteria such as a maximal rate of adverse events.¹⁷² Maintenance of membership in the SQM would be contingent on adherence to its standards.

The SQM approach to compensating medical error is this: in return for accepting all of the obligations of membership in the SQM, not to mention satisfying the eligibility requirements (themselves not trivial), SQM physicians will have their medical errors addressed not within the tort system but through a sophisticated alternative dispute resolution scheme emphasizing mediation and arbitration. This system will operate with a cap on non-economic damages. Society—i.e., potential patients and thus potential plaintiffs—concede a valuable right, the right to seek (unlimited) damages in court. In return for this concession, society—and, presumably individual patients—

¹⁷¹ Although such criticisms of no fault are applied to a broad regimen, a much more narrowly tailored, limited no-fault regimen might be attractive in order to comprehensively and quickly deal with malpractice that is obvious, grotesque, and that would be settled well before trial in a traditional tort system. See MEDICAL MALPRACTICE, *supra* note 1, at 217-18 (arguing that the “most appealing” approach to no-fault liability may be through elective option in contract). Therefore we note that an extremely limited no-fault regimen may be feasible in the SQM proposal, employing a list of previously designated types of injury or events, or what has been termed “Designated Compensable Events” or DCEs. See *id.* As such, gross mistakes would undoubtedly be settled in a traditional tort system rather quickly. See *id.* Employing DCEs might not reduce frictional costs substantially, but it would still provide some peace of mind for patients who would know that they would not be subject to the psychological and still not inconsiderable costs of pursuing a suit even to the point of settlement well before trial. In addition, the other quality improvement measures of the SQM, see *infra* notes 179, 325-49 and accompanying text, would serve to correct the disincentives to control the error mentioned earlier as a problem of traditional no fault liability.

¹⁷² At first glance, determination of competency could employ board certification in all specialties and subspecialties as a reasonable proxy. It would not be enough, for example, to be a board certified general psychiatrist but one would need to be subspecialty board certified in psychosomatic medicine if one were to offer consults to hospitalized patients.

will be treated by medical doctors who take on explicit and perhaps painful burdens aimed towards reducing error: practitioners of "Quality Medicine."

Under the SQM model, physicians agree to a comprehensive series of wide-ranging quality control and disciplinary measures, including:

Identification of best practices, and adherence to them as an ongoing condition of SQM membership; immediate internal identification of medical error, regardless of subsequent injury and no matter who commits the error (i.e., even so-called "harmless errors" are reported); prompt external notification and full disclosure about the error to the hospital, and, if the mistake has resulted in injury, to the patient and/or the patient's family; immediate acceptance of responsibility and apology for the error on the part of the physician and hospital; arbitration emphasizing fair compensation for the patient; and finally, agreement by the physician to abide by the disciplinary and quality dictates of the society.

Admittedly, none of these measures is original; they all have been implemented individually and successfully at one time or another by particular hospitals.¹⁷³ However, to our knowledge, they have not been implemented simultaneously by one hospital or health system in the form we propose here. The end result, we believe, will be continued physician participation in a culture of safety and responsibility, which we believe will offer the first step toward replacing the culture of silence and denial pervading modern American medicine and impeding error reduction.

Patients who opt for SQM physicians gain in general by receiving care by a physician committed, in concrete terms, to high quality care.¹⁷⁴ Furthermore, we anticipate that the physicians who form and join the SQM will be leaders in their community and already held in high esteem, possessing a signal of quality for any potential patient.¹⁷⁵ In our plan, the SQM centers on groups of physicians, sharing a common specialty and location. Focused on quality, the SQM can identify leaders in the local medical community who will join the SQM and adopt its ideals, and guide others by example. They will already be practicing with the highest standard of professional competence and held in prestige. They are leading practitioners of medicine, the "opinion leaders" whom other practitioners respect, follow, and emulate.¹⁷⁶ In specific terms, patients gain information and the ability to communicate directly with physicians about issues of iatrogenic injury, as the SQM contract will further establish that upon discovery of error (or the occurrence of an adverse event) the patient is to be notified immediately of the error and invited to meet with the physician responsible for the error. The patient will be encouraged to bring his or her attorney and to request that another SQM physician attend as

¹⁷³ See GIBSON & SINGH, *supra* note 33, at 171-181 (detailing efforts to improve patient safety).

¹⁷⁴ While all physicians by virtue of their training should be committed to high quality care, the SQM proposal envisions membership by physicians who agree to relinquish traditional autonomy for imposed quality directives aimed at process and substance, e.g., apology, error notification and correction, and improvement in medical practice.

¹⁷⁵ See *infra* notes 240, 270-73 and accompanying text (discussing the idea of signaling quality).

¹⁷⁶ See David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 ALB. L. REV. 583, 602-03 (1994).

well. At this meeting, the error will be explained to the patient, and the patient will be offered copies of all hospital documentation relating to the error. In parallel, the patient will be offered compensation at some point. This may happen at the meeting or subsequently after the patient has been given an opportunity to describe the type of compensation he or she would like. In addition, the patient will be solicited as to what corrective measures the patient would prefer to see implemented at the hospital in order to avoid repetition of the error. Appropriate expressions of regret will be offered to the patient as well, and the parties will work together to craft a mutually satisfactory solution.¹⁷⁷

However, should the parties fail to agree, the parties will next enter binding arbitration per the contractual terms.¹⁷⁸ Arbitration will be handled by an expert chosen by the parties from a list of recognized, neutral arbitrators competent in malpractice issues. Arbitrators will grant awards based on a published schedule with caps on non-economic damages. Although it is intended that these awards be smaller than “winners” of the malpractice litigation lottery receive today, because of the ease of bringing a successful case and the rapidity with which claims are paid, the average victim of medical error, as we shall show, will fare far better under this model. The arbitrators will have the power to remand a case back to the Society for corrective discipline. In that way, there is no need to add an extra measure to the award for punitive damages as juries do today. The punishment will be separate from the victim’s compensation, and indeed will be inflicted only on the physician who erred. In contrast, were it simply added to the cash award, it is paid by all insured, and thus the cost is passed on to all patients.

In return for this substantial benefit conferred on the physician for being allowed to render care not subject to potential malpractice litigation in the courtroom, physician members of the SQM will be required to adhere strictly to a detailed series of rules and procedures related specifically to medical error. First, the members will agree to notify the SQM office of any error that they participate in or become aware of, no matter who causes that error, and regardless of whether or not the error leads to iatrogenic injury. Physicians will be required to report and detail the error; and to participate fully and forthrightly in any investigation of the error by the SQM office. Errors discovered or suspected by the patient will also be reportable to the Society, which will investigate all complaints. By following these procedures, the SQM will

¹⁷⁷ At this point it is anticipated that SQM will have specially-trained mediators, such as retired judiciary, who will help facilitate an agreement and allow all parties voices to be heard. In addition, we envision that the role of the patient’s attorney, should one be present, will be to protect the patient’s interests such as determining that any error or event falls within the contractual terms, that the proper procedures are being followed, and that the compensation offered is fair, to list a few examples.

¹⁷⁸ We note parenthetically that use of mediators could also take place if the parties are unable to agree, as a step occurring before arbitration, and occurring within a defined period of time agreed by the parties. Such use has been described in the literature as achieving multiple goals of conflict resolution. See Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 *LAW & CONTEMP. PROBS.* 185, 185-218 (1997) (noting mediation as more conducive to apology and rectification of error); Eric Galton, *Mediation of Medical Negligence Claims*, 28 *CAP. U. L. REV.* 321, 321 (2000) (mediation as more therapeutic process than litigation, conducive to medicine’s goals of communication and healing).

seek to identify root causes of error, thereby preventing similar future medical mistakes. The SQM therefore will be constructed not only to react to error but also to preempt it proactively as well.¹⁷⁹

The implementation of our plan for a Society for Quality of Medicine will rest on voluntary contract. Patients who want an SQM physician—with all that it implies—can opt for one; those who do not, will not. By opting for such a physician, of course, the patient will freely accept the costs of such a choice, namely, signing away rights he may currently hold. Patient care will be rendered under a “contract of care” signed by the patient and physician prior to the establishment of a doctor-patient relationship as a condition to treatment. This contract will establish that any potential malpractice claim will be subjected to a program of mediation, binding arbitration and capped awards. The agreement to refer all potential claims to the program will be a prerequisite to receiving care. This choice will be made when the patient selects the type of health insurance he wants from his employer. One option we envision will be the SQM program, which in some cases may become a preferred provider for insurers, particularly if they are to be for a specific specialty in a defined geographic area. This program allows access to SQM physicians, and at the time of selection it requires that patients sign the SQM agreement.

Obviously, there are overhead costs associated with maintaining this society, and we see these borne by local health systems. Health systems will be asked to house chapters of the Society of Quality Medicine and to provide the infrastructure such as record keeping, formal space for meetings of the society, and the needed staff. Although this may seem like a new (and burdensome) requirement; many if not all of the SQM rules apply to health systems currently.¹⁸⁰

We believe that health systems will accept this, not only because it is a good idea, and not only because it overlaps with existing legal requirements, but because the SQM method of taking cases out of court will tend to limit the health system’s liability. This should provide sufficient financial benefits to offset the overhead costs the SQM generates.¹⁸¹ In addition, third party payers (TPPs) will participate in the system as well, and for only one reason: self-interest. We believe that it makes economic sense for these payers to offer a SQM option to employers and to patients. Such an offering will also mitigate a potential criticism against the contractual proposal mentioned above, name-

¹⁷⁹ For example, it can be established that the SQM will hire a “quality systems initiator,” a medical doctor with substantial expertise in systemic reduction of error who will have complete responsibility for, and plenary power over, the institution of strict systems-based quality control measures to be followed by society members. Physicians will be required to adhere to any error-reduction programs or procedures implemented by the quality systems initiator. Failure to adhere to these requirements may result in disciplinary measures, including mandatory retraining, education in error reduction, and even in egregious cases of continued negligence or willful misbehavior expulsion from the Society.

¹⁸⁰ See, e.g., *infra* note 230 (discussing Act 13 in Pennsylvania, which makes error reporting mandatory).

¹⁸¹ We note that a split system in which doctors are outside the legal system and health systems are in it is not tenable: doctors who discuss error (but are immune from suits) will be “spies” against the hospitals who would want to hide error (because they are *not* immune). This would tend to make SQM doctors unwelcome on hospital staffs—a bad thing. So hospitals must be within the umbrella of the system.

ly that the contract would be unconscionable as offered under duress during a time of medical crises, when a patient has imperfect information and no bargaining power. In contrast, a potential patient contemplating entering into a SQM agreement could explore options when contemplating joining a health plan, rationally comparing the risks and benefits of competing plans, and could without duress or compromised information choose the SQM-affiliated plan. To see how this is possible, we present an economic analysis of the SQM approach.

V. ECONOMIC ANALYSIS

An economic analysis of this approach focuses on two issues relevant to implementing a SQM program. First, it must be shown that the SQM system is stable and that all of the relevant stakeholders are made at least no worse off by any change. The second issue is whether this system can be built with the resources at hand and what catalysts are needed to make it form.

A. ECONOMIC STABILITY

Economic stability is defined as the ability to attain all of the goals of the SQM without additional financial input. Specifically, the premiums currently paid to malpractice insurers must be adequate to cover all of the expected liabilities. Additionally, all of the relevant stakeholders must be made no worse off.¹⁸² The concern about stability begins with recognizing that under the SQM approach, there will be an increase in the number of patients receiving compensation for iatrogenic error. The SQM proposal is constructed to inform patients when they have been harmed, and by design fewer obstacles—most especially silence and obfuscation—are placed on their path to financial recovery. We suggest that two sources of savings can be tapped to satisfy the requirements for funding: first, a reduction in the cost of litigation, and second, limits on the magnitude of awards. These limits will be in the form of caps on non-pecuniary damages and the elimination of collateral source recovery.¹⁸³ We also suggest that all awards should be discounted to reflect net present values. With these savings considered, the system will be stable.

By segregating an arbitrary sample of hypothetical patients into categories of “injured,” “litigating,” and “prevailing” according to their current fractional allotment, we can determine the fate of the pot of money paid into the malpractice system in the form of insurance premiums. This distribution can then serve as a basis for comparison for the resultant distribution following parametric alterations in the rates of errors, claims, and victories, as assumed in the SQM model.

As we have noted, in rough terms the following parameters define the current system, in which only a small fraction of injured patients sue for malprac-

¹⁸² Lest they veto the arrangement. We note formally that if the utility of most but not all stakeholders is improved, a veto can be averted by side payments, but ideally the system would inherently improve the lot of all concerned.

¹⁸³ See *supra* notes 128-64 and accompanying text.

tice and only a fraction of that group prevails in court.¹⁸⁴ Approximately 5% of patients are injured by their encounter with the medical system; and 80% of those injured are hurt not by negligence but simply as an adverse effect of their treatment.¹⁸⁵ We further assume that only 10% of those who were injured by negligence will in fact sue.¹⁸⁶ Likewise, because of limited disclosure of error,¹⁸⁷ among other factors, some small percentage—we will hypothesize 5%—of those injured by non-negligent medicine will also sue,¹⁸⁸ as will a very small minority of all patients, estimated at 0.1%, who were not even injured.¹⁸⁹

We further hypothesize that the odds of a claimant winning increase in proportion to the merits of the case, albeit imperfectly so.¹⁹⁰ Accordingly, we estimate that 40% of victims of error who sue will win. This result is contrasted to victory rates of 25% for those injured as a result of normal progression of disease, inherent risk of procedure, etc.—that is, by error-free medicine—for those patients not injured at all who will bring completely non-meritorious claims.¹⁹¹ As a result, in the current system 60% of those plaintiffs who prevail are indeed not victims of negligence. These figures and the conclusion are shown in table I in the appendix.

Under the SQM approach, certain changes can be expected. These include a reduction of the number of patients injured by true negligence,¹⁹² a marked increase in the number of claims brought by victims of error (owing to increased disclosure), a decrease in the rates of suits among those either not injured by negligence or not injured at all (also owing to disclosure, in that

¹⁸⁴ As noted, the system is vexed by imprecision; litigants who were not injured by medical negligence—or maybe not even injured at all—may sue and win. Conversely, those injured may never be able to bring suit for various factors. See *supra* notes 5-30, 33-41, 43-62 and accompanying text.

¹⁸⁵ See *supra* notes 53-7 and accompanying text.

¹⁸⁶ *Id.*

¹⁸⁷ Limited disclosure of error means that at times litigation must be initiated simply to find out if an error took place.

¹⁸⁸ See generally *supra* notes 5-7.

¹⁸⁹ These patients are those who were “victims” of their disease, but either do not realize it or chose to ignore that fact.

¹⁹⁰ See MEDICAL MALPRACTICE, *supra* note 1, at 49-51 (summarizing conclusions that damage awards are influenced by economic loss and the more severe the injury, the more likely verdict in plaintiff's favor).

¹⁹¹ See Frederick W. Cheney et al., *Standard of Care and Anesthesia Liability*, 261 JAMA 1599, 1601 (1989) (finding 46% of more than 1,000 cases of medical malpractice claims were non-meritorious).

¹⁹² This is a fundamental assumption for which there is some empiric support. See Christopher Guadagnino, *Impacts of error reduction initiatives*, PHYSICIAN'S NEWS DIGEST, Feb. 2000, <http://www.physiciansnews.com/cover/200.html> (“Perhaps the greatest success story in medical error reduction is evident in anesthesiology, a specialty which has seen its patient death rate decline from about one in 10,000 in the early 1980s to about one in 200,000 today, according to Ellison C. Pierce, Jr., M.D., executive director of the Anesthesia Patient Safety Foundation. Whereas anesthesiologists paid about \$30,000 for malpractice insurance 15 to 20 years ago, they now pay between \$5,000 and \$10,000, indicating that the specialty has become much safer, says Pierce.”). This drop is directly due to the imposition of numerous, systemic safety measures designed to make the field safer: one example commonly cited is the Harvard anesthesiology department's efforts in spearheading safety reform, leading to a sharp drop in anesthesia-related incidents and a reduction by half in malpractice premiums, reforms which that spread throughout the country. See Abraham & Weiler, *supra* note 17, at 411-12.

there'd be no need to litigate to discover whether an error occurred), and a significantly improved accuracy matching valid claims to legal triumph.

Owing to its higher standard for quality of care, we estimate that the SQM approach can halve the rate of negligent, injurious medical error, from 1 in 100¹⁹³ to 1 in 200.¹⁹⁴ For an upper bounds¹⁹⁵ on the number of claims brought, we can assume (due to the policy of full disclosure) that there will be a 100% rate of claims made among the truly injured by negligence, but likewise the number of erroneous claims will be halved. Both of these changes result from the process of evaluation and admission of error: the increase in valid claims is a direct effect, of course; and the decrease in dubious claims owes to an indirect effect from the greater confidence among potential litigants that the process of evaluation within the SQM would have detected injurious error had it occurred. Finally, because of the fairer processes of assessment brought by the SQM, we expect more of the true victims of medical negligence, and fewer (but not none) of the other claimants, to win their claims. As an upper bound, we will stipulate that 100% of the true victims will win, up from 40% at present; the other victory rates will be halved. This is shown in table I in the appendix.

Certain features of this system should be apparent. To begin with, many more claims based on true negligence will be filed.¹⁹⁶ Also, the overall victory rate is over three times as high, increasing from 25% to 79% for all claims. One can also say that SQM is more just¹⁹⁷ in that with the SQM approach 97% of the winners deserve to win (the true positive rate) and none of those who deserve to win are excluded.¹⁹⁸ In sum, there is more than a doubling of the net number of dollars paid to victims of error; and because the false positive rate is likewise decreased from 60% to 3%, the net payments given to deserving claimants rises from 9.6 per premium dollar to more than 49—a 510% increase.¹⁹⁹

Of course, a source for these payments must be identified. That's because under the SQM approach, there will be more than 5 times the previous num-

¹⁹³ See *supra* notes 53-57 and text accompanying note 185.

¹⁹⁴ See, e.g., *supra* notes 53-57 and accompanying text. A lower rate of error could be expected from quality measures, but the more immediate (if not more significant) factor would be self-selection. Practitioners who simply deem medical error as a cost of doing business, externalized by insurance, are far less likely to join the SQM.

¹⁹⁵ A general reluctance to file a claim no doubt will be felt by some, so this 100% rate is almost certainly not to be seen.

¹⁹⁶ See *supra* text accompanying notes 193-94. Owing to greater disclosure, the rate of claims filed will increase. As an upper bound, this increase will be as high as five fold.

¹⁹⁷ Following the dictum 'justice delayed is justice denied' we note that given the speed with which error is disclosed and claims resolved, injured patients are apt to get paid much sooner. We estimate that this could be up to two year sooner. And although this delay was accounted for in the old, i.e., current, system by the payment of delay damages, the new approach leads to greater justice, as of course delay damages can be collected only by triumphant litigants: if you don't sue and win, you can't get this payment.

¹⁹⁸ The false negative rate under the current system, 96%, is obliterated; that is, whereas at present only 4% of those deserving compensation get it, with the SQM, *every* deserving patient is compensated.

¹⁹⁹ These figures are based on assumption. The net dollars to deserving—i.e., those truly injured by medical negligence—claimants can go up even with a decrease in the average award due to both the increased sensitivity for detecting them and the increased specificity for excluding the non-injured.

ber of winning claims (995 per million patients versus 5,149).²⁰⁰ Limitations on the size of the average award are therefore needed to achieve budgetary neutrality. In particular, under the current system there is 40 cents per premium dollar available for 995 victorious litigants per million patients, whereas under the SQM approach there will be only 70 cents per premium dollar available for 5,149 victorious litigants per million patients.²⁰¹ Simple algebra reveals that the magnitude of the average award must be decreased 66% relative to the current levels in order to maintain balance—a big drop.

We acknowledge that three constraints are therefore needed: caps on non-pecuniary recovery set at \$250,000²⁰²; calibration of awards to their net present value;²⁰³ and elimination of collateral source recovery. These steps are necessary and sufficient to produce the 66% reduction in the magnitude of the average award. A RAND study of the MICRA laws in California, which impose a \$250,000 cap on non-pecuniary damages, concluded “MICRA reduced the overall liabilities of the defendants by 30 percent.”²⁰⁴ The savings²⁰⁵ from eliminating collateral source payments, likewise, have been estimated at ~15%.²⁰⁶ We further note that calibrating awards to their net present value (assuming a hypothetical 5% annual return and 20 year payout period) could save ~35%.²⁰⁷ Taken together, these three criteria—caps on non-pecuniary recovery, calibration of awards to their net present value, and elimination of collateral source recovery—should save enough to fund the enterprise.²⁰⁸ The

²⁰⁰ As shown in the table in the appendix, the rate of total claims inevitably rises (due to increased disclosure).

²⁰¹ With awards held constant and sensitivity for detecting the injured increased, spending goes up unless specificity is also increased by an offsetting amount. That scenario cannot be reasonably expected; accordingly, to make sure that spending does not go up, the average award must be decreased.

²⁰² There is no empirical data regarding caps below \$250,000, though we note that the shape of the distribution is skewed to the left, i.e., there are more awards lower than 250,000 than there are above that threshold, such that a 20% reduction in the cap produces more than 20% additional savings. By the same token, there is also no evidence of support for lower caps. So we leave the analysis with the parameter set at \$250,000, noting that it could of necessity be moved with significant savings accrued.

²⁰³ Part of this calibration should include not only discounting the award to net present value, but also considering actuarial risk. That is, for instance, an anticipated twenty-year wage loss should be discounted for the chance that the claimant dies before retirement.

²⁰⁴ See Epstein, *supra* note 9, at 504 (citing RAND STUDY, *supra* note 23).

²⁰⁵ Mark J. Browne & Robert Puelz, *The Effect of Legal Rules on the Value of Economic and Non-Economic Damages and the Decision to File*, 18 J. RISK & UNCERTAINTY 189, 207 (1999).

²⁰⁶ A perhaps even greater savings could be attained, as some of the collateral source payment may be directed at future health costs; but of course the health systems supporting the SQM could provide that care—at “wholesale prices.”

²⁰⁷ As we calculated elsewhere, “a plaintiff may assert that he will lose \$50,000 a year of wages for 20 years, for a total of \$1 million. Were he to be given that full \$1 million all at once, he would be overpaid: at 5% interest, that \$1 million would generate \$50,000 a year in perpetuity—not only for 20 years. In fact, less than \$655,000 invested at 5% can generate \$50,000 per year for 20 years. Actuarial adjustment considers the possibility that the plaintiff would not have worked for the full 20 years claimed (an obvious reason: dying of other causes). As such, a fair compensation for the claimed wage loss of \$50,000 over 20 years is not \$1 million; it is not even \$1 million discounted to present value; it is the price of an annuity that pays \$50,000 a year as long as the person remains alive.” Bernstein et al., *supra* note 3, at 1780.

²⁰⁸ The terms are not purely additive: the 30% reduction from caps and the 15% from eliminating collateral recovery decrease the average award to 55% of the original; it is this

foregoing analysis answers only half of the question of stability—namely, that if the system were put in place, it could sustain itself with budgetary neutrality. The companion consideration is whether the stakeholders would abide by it. In particular, does the payoff matrix described above yield enough such that patients, trial lawyers, and doctors would choose the system?

It might be easiest first to tackle the question of whether plaintiffs' attorneys will be able to continue to represent injured patients under a contingency system.²⁰⁹ For them, the SQM is highly beneficial. In both the new and the old system, plaintiffs' lawyers get paid only when they win, and with the SQM their rate of victory more than triples. And since the SQM method requires doctors to provide details of the case—in essence performing “trial discovery” for the attorney—this approach should also lower their evidence-gathering costs too.²¹⁰ This has implications not only for winning the case at hand, but for the overall utility of the trial lawyers in this system as a group: In the current system when a case is lost, it is the attorney, and not the plaintiff, who pays for the costs of litigation. This event—an unsuccessful claim—is the common outcome, taking place approximately 75% of the time.²¹¹ A higher winning percentage, as contemplated in the SQM approach, means fewer instances in which discovery costs have to be absorbed by patients' attorneys.

The physician-provided discovery also makes it easier to determine whether a particular case has merit, again decreasing the work demands on the plaintiffs' bar. We could even further stipulate that pro se litigation would be banned in claims against SQM physicians; i.e., that representation would be required to file a claim (much as corporations cannot appear in court without an attorney). This would further solidify the role of trial attorneys in the system.²¹² Overall, the plaintiffs bar tends to do very well here: more money for less work and less risk. It can be assumed that these stakeholders will go

value, then, that is further discounted 35% yielding an overall award that is 36% the size of the original ($.55 \times .65 = .36$). We acknowledge of course that 36% is not 34% but is certainly a fair approximation.

²⁰⁹ This is correct only if we assume pure rationality. Although the utility of the stakeholders increases, it is not a foregone conclusion that they will go along with the deal—this is a negotiation, and parties are free to hold out for whatever terms they think are in their best interest. Nevertheless, it is reasonable to assume that if every stakeholder is made better off they will be deprived of the political power to scuttle a deal. After all, the trial lawyers, per se, don't formally sign anything here; we speak of their willingness to not try to obstruct politically an arrangement made by the SQM and potential consumers.

²¹⁰ We anticipate that the SQM will hire a quality systems administrator who will monitor physicians and have power to discipline them should they not fulfill their reporting duties. See *supra* note 179.

²¹¹ See Philip Peters, *Doctors and Juries*, 105 MICH. L. REV. 1453, 1459-1460 (2007) (finding juries tended to side with defendant doctors almost 75% of the time, as 27 percent to 30 percent of filed medical malpractice suits end in a verdict for the plaintiff, reportedly the lowest success rate of any type of tort litigation). See also ANDERSON, *supra* note 131, at 223 (“70 to 80% of all malpractice claims today are found to be without merit (i.e., they close with no payment to plaintiff).”).

²¹² We are fully aware that this proposal does short change the defense bar—the frictional costs saved are in no small part monies that would have gone to defense firms. It is our contention that this group lacks the political power and organization to veto reform efforts, unlike the plaintiffs bar, which is not only highly organized but can allude to their clients sympathetic stories for political points.

along with the arrangement.²¹³ The two questions then are, “Will patients sign on?” and “Will physicians join?”

From the perspective of a patient considering only the payout in the event of an injury caused by negligence, the SQM model is an appealing choice. The net number of dollars paid to deserving claimants is more than four-fold higher with SQM.²¹⁴ And that does not even begin to consider the increased utility of better care for the patient,²¹⁵ or the societal benefits to other patients.²¹⁶ So perhaps a better question is: Would some group of patients not be in favor of this?

We believe that two groups of patients would be better off under the current system: risk seeking individuals²¹⁷ and those who anticipate that their damages, should any accrue, would tend to be of the non-pecuniary variety.²¹⁸ About the former, we note that it is precisely to eliminate the “lottery” aspect of the system that many citizens support reform.²¹⁹ For the latter group, we must point out that the likelihood of *any* recovery is higher with the SQM approach; and that non-pecuniary damages are capped, not eliminated.²²⁰

But more to the point, we note that people cannot know if they are among the small minority who are injured when they sign up for the SQM.²²¹ Even if they knew that they are the type of person whose damages would be non-pecuniary,²²² they still would not know if their particular level of damages

²¹³ The significant exception is the rare practitioner whose successful practice depends only on winning cases with catastrophic non-pecuniary damages caused by true negligence – who is a clear loser under this arrangement.

²¹⁴ See *supra* text accompany note 199.

²¹⁵ As discussed elsewhere, see *infra* text accompanying notes 269, 279-97, Professor Jennifer Arlen believes that high volume consumers of health care (i.e., sick people) would be harmed by liability by contract. Her argument addresses the lower price for health insurance overall that would be given to patients willing to sign away their right to sue (as this would be a signal that the patient perceives himself/herself to be a low volume consumer). We note here that the effect on quality brought about by the SQM disproportionately benefits high volume consumers. (We ignore for the moment the question of whether high volume patients would want to free-ride on the benefits created by others).

²¹⁶ Recall that error, and even bad outcomes, is rare: the benefits to a “deserving claimant” are benefits that the average patient will never experience.

²¹⁷ If your marginal utility for money is increasing, i.e. a large payoff is disproportionately valuable, a system with caps is likewise disproportionately unappealing as the chances of winning big is lower.

²¹⁸ As a matter of public policy, it should be made clear that the chronically non-employed (and hence not likely to collect future wage losses) are apt to suffer disproportionately under a system of caps on non-pecuniary losses, as most, if not all, of this group’s losses will be in that category.

²¹⁹ See *Survey Finds Tort Reform Enjoys Broad Bipartisan Support*, AMERICAN TORT REFORM ASSOCIATION, Feb. 27, 2003, <http://www.atra.org/show/7525> (detailing industry-sponsored survey showing 83% of the public believes that there are too many lawsuits). Cf. Feinman, *supra* note 3, at 61-63 (criticizing conservative vision tort reform as promoting business interests to extent of public values).

²²⁰ See RAND STUDY, *supra* note 23 at 1-3 (showing that about 45% of awards reached statutorily-imposed limit and were affected by California’s damages cap).

²²¹ Even those individuals who experience medical error find out about it and are lucky enough to bring a winning claim would still sign up for SQM plan because they could not a priori, know of the outcome of their surgery. Seeking to limit risk, they would operate behind Rawls’ “veil of ignorance” to choose the SQM contract. See JOHN RAWLS, A THEORY OF JUSTICE 136-142 (1971) (discussing the veil of ignorance theory).

²²² And that is knowable, as people with no income are less likely to suffer economic damages.

would exceed the cap.²²³ Thus a rational approach would be to consider the SQM bargain, correctly, from the perspective of one who does not know his or her fate. And because with SQM the overall chance of being injured goes down and the overall chance of collecting at all if you are injured goes up, from behind the veil of ignorance, the SQM is appealing.

Physicians as a group tend to do the least well under the SQM arrangement, solely in financial terms.²²⁴ For one thing, lower malpractice premiums are not contemplated;²²⁵ although the risk will be shifted to the entity, individual physicians will pay the premium to the entity that will aggregate each physician's contribution. In addition, there will be more claims lodged and more of these claims will prevail. At the least, then, this speaks to an initial and perhaps continual investment by physicians and their attorneys in handling greater frictional costs due to the greater number of claims. Not only that, there is an explicit and not insignificant time commitment needed to maintain the Society and follow its guidelines.

Nevertheless, we believe that doctors will be willing to join. The first reason is that the SQM articulates an aspirational standard that not only echoes, but also embodies, the credo of western medicine, and, it has been seen that many doctors are willing to suffer financially for their ideals.²²⁶ We also can predict that some physicians will join out of peer pressure or self-directed forces. Last, there may be a marketing advantage to membership, and indeed third-party payers might find it in their interests to offer a higher fee schedule to physicians within the Society. The significant inducement SQM offers physicians, though, is not economic. It is that as a system of enterprise liability, the "defendant" is not the physician but the SQM itself. This should drastically reduce the psychological costs of lawsuits and therefore remove a major source of stress and dissatisfaction with modern American medical practice.²²⁷

²²³ See RAND STUDY, *supra* note 23 (indicating that less than 1 in 4 awards for non-pecuniary damages were above \$250,000).

²²⁴ That it is proposed here by physician authors, both of whom still maintain clinical practices in addition to their academic careers, may invoke a bit of the "Nixon Goes to China" psychology; that is, it may pass muster with physician groups precisely because it came from within.

²²⁵ Some studies suggest that high premiums are not a problem for doctors in the long run; eventually the costs are integrated into their business model and passed on to patients. The problem is sharp increases in fees, which are a shock to the system. See Mark Pauly et al., *Who Pays? The Incidence of High Malpractice Premiums*, 9 F. HEALTH ECON. & POL'Y 8, 9 (2006), available at <http://www.bepress.com/fhpep/9/1/2>.

²²⁶ We note as an aside that, as of 2003, nearly half of the graduating medical class opted for careers in pediatrics, primary care and psychiatry. See Dale A. Newton et al., *Trends in Career Choice by U.S. Medical School Graduates*, 290 JAMA 1179, 1179-82 (2003). All these specialties offer a maximal anticipated salary one-third or less than what more lucrative fields in medicine produce on average. See Thomas Bodenheimer et al., *The Primary Care-Specialty Income Gap: Why It Matters*, 146 ANNALS INTERNAL MED. 301, 301-306 (2007). Thus, it is safe to say that the utility curves of many graduating medical students are not dominated by financial concerns.

²²⁷ See Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 34-54 (Yale Law Sch. Student Scholarship Series, Paper 30, 2006), available at <http://lsr.nellco.org/yale/student/papers/30> (detailing various stresses upon physicians prompting them to resist disclosure of error).

B. CATALYSTS AND VIABILITY WITH EXISTING RESOURCES²²⁸

We acknowledge that the fixed overhead and start up costs of implementing the SQM are not trivial.²²⁹ Thus, even if in the long run a surplus is generated, the process won't be initiated without a catalyst. We suggest that the resources needed to form SQMs can come from local health systems. Health systems could be asked to house chapters of the Society and to provide the infrastructure such as record keeping, formal space for meetings of the society and the needed staff. Although this may seem like a new and burdensome requirement, many, if not all, of the SQM rules apply to health systems currently.²³⁰ As health systems are already charged with providing these functions in skeletal form, we hypothesize that it would be marginally inexpensive to do so under the rubric of the Society.²³¹ In addition, because the SQM method takes cases out of court, it will tend to limit the health system's own malpractice liability.²³²

Additional and significant activation energy can come from third party payers as well. We believe that third party payers will gain substantially if they offer a "quality option"²³³ to employers and to patients. For one thing, offering a quality option, especially if designated as such, is a marketing tool. Also, quality medicine may save money by offering lower cost care. For example, in states with so-called "defendant friendly" tort laws, the cost of care for certain illnesses is measurably lower.²³⁴ The 3-5% savings seen probably are the result of less defensive medicine.²³⁵ Also, quality medicine is expressly

²²⁸ It is well known in chemistry that not all energetically favorable reactions take place because in addition to considering the net thermodynamic effects—whether energy is taken in or given off—one must also consider the activation energy needed to start the process. *See generally* Activation Energy, <http://chemed.chem.purdue.edu/genchem/topicreview/bp/ch22/activate.html>. Just as a boulder won't roll down hill if a sufficiently large pebble blocks its way, energetically favorable [exothermic] reactions may, like the boulder itself, require a kick to get them started in motion. As such, the formation of an SQM requires not only financial stability (and acquiescence of the stakeholders) but resources and motivation to initiate the process.

²²⁹ At the minimum, a legal challenge can be expected. Thus, any organization without the resources for litigation and the willingness to commit them will shy away from this.

²³⁰ Act 13 in Pennsylvania makes this method of error reporting mandatory. Under Act 13, all Pennsylvania-licensed hospitals, ambulatory surgical facilities, birthing centers, and certain abortion facilities must submit reports of those events to the Authority. In turn, the Authority will analyze the collected data to identify trends and recommend changes in healthcare practices and procedures that may be instituted to reduce the number and severity of future serious events and incidents. Medical Care Availability and Reduction of Error (MCARE) Act, P.L. 154, No. 1340, §746 (2002).

²³¹ *See generally id.* (detailing requirements that health systems in Pennsylvania must follow). We hypothesize that for such health systems, the added costs would be more marginal than for those not currently operating under such statutory standards.

²³² Although we acknowledge the potential for litigation to occur around contract terms when patients elect the SQM. *See infra* text accompanying notes 241-55.

²³³ That is, enrollment in a program all of whose providers are members of the Society and whose explicit rules for joining require signing on to this approach.

²³⁴ *See* Daniel P. Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?* 33 (Nat'l Bureau of Econ. Research, Working Paper No. 5466, 1996).

²³⁵ *See* Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damage Caps*, 80 N.Y.U. L. REV. 391, 411-12 (2005) (citations omitted) (discussing varying calculations

assumed to be better quality: Fewer errors result in less healthcare spending needed to remedy these errors. We estimate that this can save 1-2% of the total health care bill. The third reason that quality medicine can be less expensive medicine is that the SQM will insist that its members follow best practices—even in those instances where agency concerns militate against that.²³⁶ We posit that this type of practice change can save payers an addition 1-2%.

In sum, the SQM method of practicing medicine can lead to a net savings on the order of 5-9% of the total health care bill.²³⁷ This savings can allow third party payers to reimburse SQM physicians a premium on the standard fees, bonuses of as much as 20% over current fee schedules.²³⁸ Further, it may be worthwhile for TPP to pay more to SQM members, even if there were no profits to be had, by paying less to non-member physicians. The pay differential could be exploited as a segregation and sorting strategy.²³⁹ For no cost at all, the TPP discovers which doctors self-identify as “quality” physicians and which do not.²⁴⁰

of costs of defensive medicine, and citing one controversial study showing eliminating defensive medicine resulting in a five to nine percent cost reduction).

²³⁶ A case in point: antibiotics for a sore throat, which is probably virally induced. If everybody were to get antibiotics, society is worse off—not only because antibiotics are not free, but because they induce the formation of resistant bacteria. Douglas E. Drake, *National Antibiotic Timing Measures for Pneumonia and Antibiotic Overuse*, 16 QUALITY MGMT. HEALTHCARE. 113, 113-22 (2007) (discussing overuse of antibiotics in promoting resistance). Therefore, there are now extensive guidelines—best practices—to help physicians only prescribe antibiotics appropriately. Unfortunately, for a given doctor in front of a given patient with a sore throat, the calculus –“it could not hurt, it may help” –tips toward using antibiotics, often inappropriately, due to pressure on the physician from the patient “to do something.” So they are used by many practitioners when not necessarily indicated. *See id.* Yet if the SQM were to issue a Best Practice guideline, and if adherence to that guideline were a requirement of membership in the SQM, as it is, inappropriate antibiotic use may decrease.

²³⁷ Between \$100,000,000,000 and \$200,000,000, approximately, in 2009 expenditures.

²³⁸ Of course, it might not make sense at first glance how a 5% to 9% savings—we’ll call it 7%—allows TPPs to pay a 20% premium to the doctors yet it is the case. The paradox, such as it is, resolves with the awareness that physicians’ fees represent only 1/5th of the entire health care bill. Consider: if a third party payer (TPP) ordinarily spends \$100, a 7% savings puts \$7 back in their till. Meanwhile, out of that \$100, only \$20 is earmarked for physicians’ fees. With a 20% bonus, the total payment is \$24. This still leaves the TPP \$3 ahead. In some specialties, moreover, the physician fee fraction is not 1/5th but perhaps 1/10th or less. (The surgeon’s fee for a total knee replacement is only about 1/20th of the total cost.) For those specialties where the physician fee is small fraction of the total costs—typically surgical fields, themselves very concerned about malpractice—the TPP would be especially induced to offer a “Quality option.”

²³⁹ It might be asked, “What if there is only one pile into which all physicians are sorted?” That is, what if all physicians elected to join? Although there would be a 4% increase in total costs, society has purchased for that sum a stark improvement in the standards of practice. The more pressing problem from the legal perspective is whether the contract would be considered coercive if there were no physician remaining in the standard (non-Quality) pool. We suggest an analogy that perhaps begs the question: “Are contracts with union carpenters valid in areas where there are no non-union carpenters?” Sure they are. The better question is how to handle the free rider problem of a patient who wants the current liability rules but reaps the benefits of the new (proposed) quality standards.

²⁴⁰ Of course it can be argued that this is only a label, but maintaining the SQM standards imposes real demands and joining requires more than lip service. Just as one cannot pretend to be brave—one’s actions are either brave or not brave, regardless of intent—one cannot pretend to be a Quality physician: either one lives up to the standard or one does not. This

VI. THE USE OF CONTRACT

The crux of this SQM approach is that it will be based on the *voluntary* contract that the patient and physician sign prior to treatment, or that the prospective employee elects when joining an SQM-managed plan offered by his or her employer. In this contract, the patient agrees to waive his or her constitutional right to bring a medical malpractice suit against the physician through the civil court system, and the doctor waives his or her prerogatives to remain silent in the face of error. This SQM plan therefore raises several threshold issues, including the mechanics of contracting, the rationale behind it, and the well-known critiques of such contracting.

A. CONTRACTING INTO AN SQM ARBITRATION SYSTEM

This process by which the physician and patient contract to enter a process of high standards of care, unimpeded disclosure of error, and binding arbitration with capped awards to address error offers the greatest chance for increased patient satisfaction with the medical system, fair compensation for patients injured negligently, reduced anxiety about possible future litigation for physicians, and improved error management. This is an approach in which the patient indubitably receives something of value in return for his or her waiver of rights. Still, there will likewise, no doubt, be legal challenges on grounds of adhesion and unconscionability.²⁴¹ Therefore, at the onset of forming relationships with a health plan, all potential patients will be informed that they are choosing physicians who are members of the local SQM and they are agreeing to contract for binding ADR in case of medical error. Contract terms will be delineated clearly to potential patients, who will certainly have time to consider the ramifications of their choices. The health plan contract itself will conform to state and federal law regarding arbitration contracts and will clearly state that the patient is waiving his or her right to trial in favor of arbitration. The patient will not be pressured to sign; in fact the contract would be mailed to the patient for review prior to joining the health plan, and therefore prior to the election date. We envision the contractual language will also provide an escape clause for the patients experiencing "signer's remorse."²⁴² The key is that the patient be given adequate time to rescind the contract before treatment begins, in order to opt in to another non-SQM plan.²⁴³ Moreover, the language of the contract must be clear and

raises the issue of signaling first articulated by Michael Spence and developed by Professor Arlen in the medical malpractice context: How does a product or service signal it is of higher quality reliably without other lower quality products/services mimicking that signaling? See *Contracting Over Liability*, *supra* note 15, at 44 n.128 (citing George Priest, *A Theory of Consumer Product Warranty*, 90 YALE L. J. 1297 (1981) and Michael Spence, *Consumer Misperceptions, Product Failure and Producer Liability*, 44 REV. ECON. STUD. 561 (1977) (discussing problems with signaling)).

²⁴¹ See *Contracting Over Liability*, *supra* note 15, at 21-46 and accompanying text (discussing deforming aspects of contract).

²⁴² In California, for example, the parties must be provided with the option of revoking a medical malpractice arbitration provision by written notice within thirty days of signing the contract. See CAL. CIV. PROC. CODE § 1295(c) (2009). In Ohio, the patient has thirty days to withdraw. See OHIO REV. CODE ANN. § 2711.23(B) (2009).

²⁴³ As a practical matter, this may mean for administrative purposes that the election of an SQM plan will require notification to the employer slightly earlier in the open benefits pe-

explicit, explaining that the patient is giving up any future right to have an issue settled in court, and conform to state law.²⁴⁴

We recognize that such a private contract, as it creates a significant departure from accepted common-law tort principles, will be viewed skeptically by any court. The concerns will focus on two areas. First, the court will want to make certain that the SQM contract is not the result of a process wherein the patient relinquishes important rights due to a lack of information—i.e., that the patient did not understand the value of the rights being signed away.²⁴⁵ In addition, differences in bargaining power between providers and patients may render courts to view any such contract as inherently unfair, the result of a situation whereby a vulnerable patient, injured, in pain and desperate for treatment, feels intimidated into signing the agreement.²⁴⁶ However, we believe that the SQM proposal will survive such scrutiny.

The most dramatic departure from the traditional medical malpractice liability regime are contracts which attempt to immunize the physician from all legal liability for errors related to treatment.²⁴⁷ Such broad exculpatory clauses, however, are uniformly rejected by the courts as examples of overreaching and have become the “paradigm case illustrating the injustice potential of private contracts.”²⁴⁸ Instead of an exculpatory regime, however, the SQM proposal does not deny the patient the ability to recover for negligent injury. Instead, it shifts the forum from the courtroom into alternative dispute resolution and makes the SQM enterprise itself liable. An alternative dispute resolution scheme has been chosen as the centerpiece for the SQM proposal for its numerous advantages, among them being its ability to withstand judicial scrutiny.²⁴⁹

Second, many court decisions invalidating such contracts have to do with the situation of the patient signing a contract at point of service.²⁵⁰ In such cases, courts have found these contracts unenforceable and void as against public policy.²⁵¹ However, the SQM proposal explicitly contemplates pre-

riod, in order to allow for rescission and election of a competing, traditional plan before the open enrollment period ends. To do otherwise would invite litigation around adhesion and duress.

²⁴⁴ In the California medical malpractice arbitration statute, for example, the contract is required to contain not only a detailed explanation of the consequences of the contract in the first article, but also the following paragraph immediately above the signature line in “at least ten-point, bold red type: ‘NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT.’” CAL. CIV. PROC. CODE § 1295(b) (2009).

²⁴⁵ Clark H. Havighurst, *Malpractice Reform: Getting There by Private Vehicle*, in *MEDICAL MALPRACTICE SOLUTIONS: SYSTEMS AND PROPOSALS FOR INJURY COMPENSATION* 115, 116 (M. Martin Halley *et al.* eds., 1990).

²⁴⁶ See *infra* text accompanying note 251.

²⁴⁷ See Havighurst, *supra* note 245, at 119; *Private Contractual Alternatives*, *supra* note 15, at 12.

²⁴⁸ Havighurst, *supra* note 245, at 119.

²⁴⁹ Although we also note that mediation may also fit in well to this model, as a preliminary step before arbitration. See *supra* text accompanying note 177.

²⁵⁰ See *Private Contractual Alternatives*, *supra* note 15, at 10-12.

²⁵¹ See *id.* An oft-cited case for this proposition is *Tunkl v. Regents*, which held as invalid a clause that released hospital from liability for future negligence due to hospital’s superior bargaining position as well as lack of option for patient to pay higher fee for imposition of liability. *Tunkl v. Regents of the Univ. of Cal.*, 383 P.2d 442, 443 (Cal. 1993).

election of the SQM plan as part of either a benefits package or before needed service, and not at point of service, as noted earlier.²⁵² Furthermore, courts are more likely to approve an arbitration clause embedded in contracts negotiated between enterprises such as an SQM and patients' employers more readily than contracts between individual patients and physicians, because the employer—a presumably sophisticated agent—will represent the patient's rights adequately and will have the financial clout to negotiate a presumptively fair contract.²⁵³ In addition, since it is likely that an SQM option would be only one of several offered, each individual policy holder/employee can make the best rational choice for themselves, based on his or her tolerance of risk.²⁵⁴ This conclusion is consistent with much recent legal scholarship on the role of contract in medical malpractice, finding that while point-of-service contracts between physicians and patients are highly problematic, for the reasons stated above, contracts between patients and enterprises not occurring at point of service eliminate many of these flaws and are favored.²⁵⁵

B. THEORIES FOR AND AGAINST CONTRACT

The proponents of contractual solutions to tort reform have taken several approaches, the most pure form emphasizing the primacy of contract and allowing parties to contract completely out of the tort system into attenuated or different forms of liability, or no liability at all.²⁵⁶ Such a system arguably produces more optimal results for individual parties than—or at least similar results to—the current tort system. Here, both patients and physicians are in the best position to determine how much risk they are willing to accept and afford.²⁵⁷ As long as certain key conditions are met, such as the parties having access to information and a lack of duress or adhesion prior to signing the contract, such a regime is thought to maximize each party's welfare.²⁵⁸

Probably the most eminent and eloquent advocate of this approach is Professor Richard Epstein, who argues that personal injury in malpractice cases is

²⁵² See *supra* text accompanying notes 172-81. We also contemplate that the SQM proposal will not apply to emergency care, for similar reasons of duress, lack of time to investigate alternatives, etc. In these emergency situations courts routinely have rejected contracts limiting malpractice liability. See *infra* notes 245-55 and accompanying text.

²⁵³ See Havighurst, *supra* note 245, at 123.

²⁵⁴ The SQM appeals to the risk averse, not the risk takers who are counting on the lottery aspect of their care. See MEDICAL MALPRACTICE, *supra* note 1, at 13, 119-24 (discussing aversion to risk).

²⁵⁵ However, this is not to elide the still formidable structural problems that are posed for any medical malpractice arbitration scheme. Certainly state legislatures need to examine state statutes that may impede the implementation of arbitration, taking care to eliminate the disincentives inherent to the statutes. Revoking such statutory roadblocks should go a long way towards eliminating the current situation where "few physicians . . . even attempt to enter into arbitration contracts with their patients." Metzloff, *supra* note 10, at 450.

²⁵⁶ See *Contracting Over Liability*, *supra* note 15, at 2-5; *Private Contractual Alternatives*, *supra* note 15, at 10-23 (reviewing and responding to arguments for contracting over tort).

²⁵⁷ See *Contracting Over Liability*, *supra* note 15, at 2-5; *Private Contractual Alternatives*, *supra* note 15, at 10-23.

²⁵⁸ See *Contracting Over Liability*, *supra* note 15, at 2-5; *Private Contractual Alternatives*, *supra* note 15, at 10-23 (reviewing and responding to arguments for contracting over tort).

not a problem of tort law, but rather is a problem of contract that we have been “mistaken” to view otherwise.²⁵⁹ It is important, Professor Epstein acknowledges, to find a system wherein there exists some level of sanctions large enough to influence patient care—i.e., to influence how care is provided by physicians, making sure there are adequate incentives for safe care—but one that is manageable and small enough to prevent extreme deformations that occur as a result of the current system, ranging from the excess care rendered in the name of defensive medicine,²⁶⁰ to the absence of care caused when physicians close their practices due to burdensome malpractice insurance costs.²⁶¹ Therefore, Epstein argues that to maximize welfare society should “both permit and encourage private agreements between physicians, hospitals, and patients to set the terms on which medical services are rendered.”²⁶²

Other scholars have examined the structural and legal problems inherent in such individually-based contracting, and advocate contracting between patients (or their employers) and MCOs, hospitals, or insurance companies, but prohibit contracting between individual patients and individual providers.²⁶³ Doing so would eliminate the problems of adhesion and unconscionability that courts have found with contracts between individual patients and physicians at point of service.²⁶⁴ Proponents include the scholars Kenneth Abraham and Paul Weiler, who have argued that such liability is an improvement over individualistic focus of traditional malpractice law, in that it offers the fairest and most efficient form of insurance to patients injured by malpractice.²⁶⁵ We have followed Professors Abraham and Weiler on this point because we feel that one of the attractions of the SQM is that it not only promotes quality medicine through incentives, but also removes the blame that the traditional tort regimen has historically focused upon individual physicians. It thereby eliminates a deforming incentive while preserving a motivation to strive for error-free medicine.

In response, opponents of contracting out of tort have made several arguments that such contracting is inefficient, no matter if the contracts are between individual providers and patients or between patients and enterprises.²⁶⁶ Primary among these has been Professor Jennifer Arlen, who in numerous articles and forums has raised sophisticated, cogent objections to a contractually-based solution.²⁶⁷ Essentially, Arlen argues that contracting out of tort liability is inherently less efficient than state-imposed tort liability, both in the case of individual contracting and contracting between MCOs and their

²⁵⁹ Richard A. Epstein, *Medical Malpractice: Its Cause and Cure*, in *THE ECONOMICS OF MEDICAL MALPRACTICE* 245, 255 (Simon Rottenberg ed., 1978).

²⁶⁰ The use of the term “defensive medicine” is the authors’ own for this type of practice. See Bernstein et al., *supra*, note 3, at 1777.

²⁶¹ See Epstein, *supra* note 9, at 509.

²⁶² See Epstein, *supra* note 259, at 254.

²⁶³ See, e.g., *Contracting Over Liability*, *supra* note 15, at 4, 53-62 (discussing problems with liability for MCOs).

²⁶⁴ See *id.* at 2-3 (reviewing scholarship on MCO liability).

²⁶⁵ See Abraham & Weiler, *supra* note 17, at 382-85.

²⁶⁶ See, e.g., *Contracting Over Liability*, *supra* note 15. See also Weiler, *supra* note 3, at 96 (discussing arguments for contract but arguing against various permutations of individual contracting out of malpractice liability).

²⁶⁷ See *Contracting Over Liability*, *supra* note 15; *Private Contractual Alternatives*, *supra* note 15.

subscribers.²⁶⁸ As we feel she has developed one of the most multifaceted approaches to this problem, it is to her objections that we now turn.

C. RESPONSE TO PROFESSOR ARLEN

The various objections that Professor Arlen raises include the lack of information about quality—or deficient signaling of quality—in the case of patients contracting with physicians at point of service.²⁶⁹ In her most recent work, she describes what she views as the extreme limitations of a system in which medical malpractice disputes are taken out of the traditional tort system by contract.²⁷⁰ Her concerns are serious and well argued, but we disagree with her conclusion that a private contractual solution is inferior.²⁷¹ Arlen’s critique first notes that tort liability benefits patients by motivating physicians to make quality-enhancing investments before the doctor-patient relationship is formed, and in fact, before the doctor even knows the patient.²⁷² If patients and physicians rely on contract instead of tort, she argues, patients lose this ability because contract by definition is powerless to induce such *ex ante* investments, i.e., pre-contractual investments in care, “By definition, patients cannot use the imposition of contractual liability to alter care investments prior to the contract because those investments are fixed at the moment of contracting.”²⁷³

While Arlen is of course correct that contracts cannot alter the past, contractual promises made for the future can reflect past behavior. In a sense, a warranty is a forward looking contract (to repair future damages) that speaks of an *ex-ante* investment by the guarantor that he or she made “care investments prior to the contract” to limit the likelihood of damages.²⁷⁴ As such, contracts addressing the remedy for a tort, as long as they contain the apt incentives to reward the “care investor” and punish the delinquent, are not in the least limited by their forward looking pose, and in fact signal an investment in quality.²⁷⁵

Accordingly, Arlen’s point must be that medical malpractice is somehow different from the standard case of a manufactured product, and she is appropriately concerned that “low quality providers can mimic the contracts of high quality providers,” and therefore the market won’t discern between them.²⁷⁶ But we wonder if her argument is of the straw man variety. In the usual context of warranties, we don’t concern ourselves that a low quality manufacturer can mimic the warranty of high quality manufacturer. Yes, a generous warranty is a potentially false signal of quality, but the low quality manufacturer will be punished when his or her shoddy goods fail and warranty claims are made—so much so that we need not worry about the potential false signaling.

²⁶⁸ See *Contracting Over Liability*, *supra* note 15; *Private Contractual Alternatives*, *supra* note 15.

²⁶⁹ See *Contracting Over Liability*, *supra* note 15; *Private Contractual Alternatives*, *supra* note 15.

²⁷⁰ See *Contracting Over Liability*, *supra* note 15.

²⁷¹ See *Id.* at 62.

²⁷² *Id.* at 6-7.

²⁷³ *Id.* at 6.

²⁷⁴ *Id.* at 6, 48, 52.

²⁷⁵ *Id.* at 48, 52.

²⁷⁶ *Id.* at 48 (discussing problems of signaling).

We believe that the situation is similar with healthcare. The SQM approach offers a better warranty, so to speak: If you are injured, you are likely to receive more compensation than you would with the present system.²⁷⁷ In turn, a promise to increase the expected compensation for a medical error can be given if and only if “care investments prior to the contract” have been made as well.²⁷⁸

The more nuanced difficulty noted by Arlen is that contracting over liability in the medical domain introduces the problem of adverse selection.²⁷⁹ Arlen asserts that patients who are more likely to use medical services—such as the elderly, chronically ill, and disabled—are more apt to be injured by medical practice and in turn would be benefited more by a traditional tort regime that regulates those services.²⁸⁰ As such, these patients would be less willing to enter a contract with an SQM physician, and thus any given patient’s declining the SQM option is a signal that the patient believes that he or she is going to consume more health care services.²⁸¹ Accordingly, managed care organizations will have to price traditional or non-SQM networks higher because the patients seeking those networks will expect to have higher health care costs.²⁸² In turn, healthy and often younger patients will be forced to choose a plan such as an SQM in order to avoid the higher costs associated with the traditional liability plan whether it appeals to them or not, simply to avoid the higher costs associated with the liability plan (whose price must include not only the actuarial costs of medical care for the general population but also the added cost of adversely selecting patients at risk of higher medical expenses).²⁸³ She goes on to assert that adverse selection will cause many patients to waive liability when they would be better off were liability imposed by common law.²⁸⁴ As an example, Arlen points to the chronically ill, postulating that if members of that group cannot afford to pay the costs of their care in the high priced liability plan, they will, like all other patients, elect to

²⁷⁷ To be clear: although the magnitude of the average individual *award* under SQM is lower than the current mean award, the expected value of compensation *ex ante* for all *errors* is higher, for under SQM more errors receive compensation. In the current system, the expected compensation for a medical error would be higher than under SQM, but only if three criteria are met: a) you know of your tort; b), you elect to sue; and c), you win. Yet in common practice (without SQM) these criteria themselves are far from assured. Accordingly, expected value calculations must subject these criteria to probabilistic winnowing, discounting for the injured being ignorant of their injury, those who know of their injury failing to file a claim, and the valid filers who nonetheless lose at trial. With SQM, the probability of knowing of your tort, making a claim, and prevailing are all higher, hence this system has higher expected value for all patients at the outset.

²⁷⁸ We further note that one can no more pretend to be a high quality physician (as defined here) than a coward can pretend to be brave. We don’t care about your mindset: if the actions taken reflex quality (or bravery) then the label is apt, independent of your state of mind. That is, if you wish to mimic the SQM physician by emulating his or her standards, you are not a simulator but indeed the genuine article.

²⁷⁹ See *Contracting Over Liability*, *supra* note 15, at 57-64.

²⁸⁰ *Id.*

²⁸¹ The relatively greater knowledge about one’s health (compared to what the payer knows) is the prime moral hazard in health insurance. Getting patients to disclose that would be very profitable indeed.

²⁸² See *Contracting Over Liability*, *supra* note 15, at 60-62.

²⁸³ *Id.*

²⁸⁴ *Id.*

waive liability, although she believes “almost all would be better off were liability imposed by fiat.”²⁸⁵

According to Arlen’s reasoning, the decision by a purchaser of health insurance to reject an offer of waived liability—i.e., not to select the SQM option—is a tacit admission by that person that he or she anticipates consuming more than average amounts of health care, for it is the less healthy consumer, she says, that does less well with this method.²⁸⁶ In turn, these patients will be charged more for their health insurance in anticipation of their greater consumption.²⁸⁷ To avoid that higher charge, purchasers of health insurance will accept offers of waived liability, not because it’s in their best interest to do so but because it will allow them to avoid surcharges on their health insurance premiums.²⁸⁸ Owing to this phenomenon, Arlen says, waived liability health insurance can be priced above its fair value and still garner its customers.²⁸⁹ Therefore, those patients who select these waivers are ultimately overcharged, and she maintains, they would be better off if the option for waiver were not permissible.²⁹⁰

There are two basic responses to these objections. For one thing, while it is true that the more healthcare you consume, the more exposure to error you face, we flatly reject the hypothesis that “patients obtain more benefit from the imposition of malpractice liability when they are likely to make significant use of the services that malpractice liability regulates.”²⁹¹ In fact, the expected payment to those who suffer medical negligence is higher under the SQM approach—and that ignores the benefits in *health* which redound to you with this system. Although *some* patients might be better off *ex ante* in the current system (i.e., those who, for some reason, could be sure that if were they to be harmed, they would be able to discover the harm and collect for it), such information is impossible to ascertain. Also, considering the tort implications of medical care is contrary to human nature: Beyond those who might suffer psychiatric disorder, people do not undergo medical care expecting²⁹² to be injured.²⁹³

²⁸⁵ *Id.* at 7.

²⁸⁶ *Id.* at 60-62.

²⁸⁷ *Id.*

²⁸⁸ *Id.*

²⁸⁹ *Id.*

²⁹⁰ *Id.*

²⁹¹ *See id.* at 7.

²⁹² However, there are situations of medical hazard, *see infra* note 293, where high-risk care is undertaken in which the risks of injury due to adverse outcome and not negligence are high.

²⁹³ One class of patients who would arguably be better off under the current system are those who know they are facing an inherently hazardous operation with a high prospect of substantial disability, pain, and disfigurement; for example, extrapleural pneumonectomy. (Extrapleural pneumonectomy is a treatment for advanced mesothelioma that involves removal of one lung, part of the lining of the chest, the diaphragm, and the lining of the sac around the heart. This operation contains substantial risks of disability, pain, and a tortuous recovery. *See* Online Cancer Guide, Mesothelioma Cancer Treatment Guide, <http://www.onlinecancerguide.com/mesothelioma-cancer-treatment.html> (last visited Nov. 3, 2009). *See also supra* note 142 (discussing extrapleural pneumonectomy)). Those facing extrapleural pneumonectomy, for example, might be thought to favor the current system because a poor outcome—independent of negligence—is more likely, and a poor outcome is the best indicator of collecting under the current system. *See supra* note 9 and accompanying text.

Others who might be better off in the current system are those whose damages would likely be in the form of pain and suffering²⁹⁴ (which would be capped under SQM). However, there is no reason to believe that these patients would necessarily be cheaper or more expensive to insure overall, and even if it were relevant, the health insurance company would not need to see those patients' revealed preference for liability, as this could be inferred from demographics.²⁹⁵

The other and equally basic point is that Arlen's concerns are easily circumvented by a law that simply says health insurers shall not be permitted to discriminate on price when offering standard policies versus those with a waived liability, i.e., an SQM option.²⁹⁶ We do not advocate that approach, as it might well be that SQM-leaning patients truly consume less health care (from the omission of defensive medicine, say). We note this only to say that if the first response fails to work, the system can be rescued legislatively.²⁹⁷

VII. DEFORMING INCENTIVES OF TORT

A. HOW PHYSICIANS VIEW AND RESPOND TO ERROR

Recent scholarship postulates that the threat of malpractice litigation impedes investigation and correction of iatrogenic error.²⁹⁸ In somewhat

Still, the class of patients facing this procedure is small; membership in the class is typically unknown at the time insurance is bought; and members of this class are more likely to concentrate on the disease at hand as compared to the problems of recovery in tort. And this previous analysis says nothing about the overall likelihood of recovery, only the relative rate. The overall recovery may still be too low to affect behavior.

²⁹⁴ Again, we note it is not only an absence of economic damages that needs to be assumed, but also that non-economic damages would be above the cap.

²⁹⁵ Tort awards basically comprise wage loss, future medical care, and pain and suffering. If one wished to designate a priori those individuals whose potential tort awards would be weighted toward pain and suffering, it would be a simple matter of identifying those individuals who are less likely to claim wage loss and future medical care losses. And that can be inferred from zip codes (which can inform about average wage), gender (women earn less) and date of birth (as older patients have fewer years to live). That is, all things equal, the malpractice finding favoring a 26 year woman living in a poor neighborhood is apt to contain a greater share of pain and suffering compensation, as compared to an award given to, say, a 59 year old man living in a high-rent district. That is, some information about the relative contribution of pain and suffering in potential awards is inferable already.

²⁹⁶ A similar law, set up to encourage genetic testing, bars discrimination based on those test results, even though the findings have a much more direct effect on health consumption costs than what Arlen contemplates here. See Genetic Information Nondiscrimination Act, Pub. L. 110-233, 122 Stat. 881 (2008).

²⁹⁷ However, given the recent lengthy battles over mental health parity, we have no illusion that such a legislative route would be easy. See Matt Brady, *Insurers, Employers Lose Mental Parity Battle*, NATIONAL UNDERWRITER, July 18, 2007, available at http://www.lifeandhealthinsurancenews.com/News/2007/7/Pages/Insurers--Employers-Lose-Mental-Parity-Battle.aspx?utm_source=15368&utm_medium=redirect&cmpid=redirect (noting opposing views of the Paul Wellstone Mental Health and Addiction Equity Act); Bazelon Center for Mental Health Law, *110th Congress Brings Victories for People with Mental Disabilities*, BAZELON CENTER MENTAL HEALTH POL'Y REP., Oct. 16, 2008, available at <http://www.bazelon.org/newsroom/reporter/2008/10-16-08reporter.htm#1> (discussing Act from viewpoint of disability advocates).

²⁹⁸ Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1851-57 (1994). Similarly, the IOM's report on error laconically notes, "Providers also perceive the medical liability system as

stronger language, the reduction of error in American medicine has been linked to an inefficient malpractice litigation system that not only discourages forthright analysis of error but also “induces secrecy and silence” due to fears of litigation.²⁹⁹ Simply put, physicians are scared that identification and remediation of medical error—whether of their own error or of their colleagues’—will expose them to a lawsuit.³⁰⁰ As a result, a “conspiracy of silence” is both constructed and reinforced by physicians’ perception of malpractice liability, a situation where efforts at error reduction, and hence the advancement of medical knowledge, are retarded due to fears of being dragged into a courtroom and being subjected to the ministrations of the law.³⁰¹

Moreover, physicians’ responses to medical error are also determined by a complex series of factors that reinforce tort’s deforming incentives. One strong influence is the culture of perfection into which physicians are socialized to be error-free,³⁰² and which, we believe, imbues any sort of error with a moral disapprobation. From the beginnings of medical school and on through residency and into practice, physicians are taught to view error as a moral failing,³⁰³ and this emphasis on infallibility “creates a strong pressure to intellectual dishonesty, to cover up mistakes rather than to admit them.”³⁰⁴ We see this pressure, for example, in the “roundsmanship” in which medical students and interns engage on the wards, when young doctors in training try to outshine each other rather than work collaboratively to provide patient care.³⁰⁵ Consequently, apparently nothing less than perfection is required.³⁰⁶ This in and of itself is a cause of personal anguish for individual physicians, as there is a clash between the facade of perfection as presented by the physician to both peers and patients, and his or her own painful awareness of an all-too-human fallibility. As a result, mistakes have been treated as aberrations “requiring no remedy beyond the traditional incident reports and morbidity and mortality conferences,”³⁰⁷ which for all intents and purposes focus on individual blame and do not attempt to root out underlying systemic causes of error.³⁰⁸ As a result of this focus on individual blame—a focus that ironically reproduces the tort system’s focus on individual fault—errors are rarely admitted or discussed

a serious impediment to systematic efforts to uncover and learn from errors.” IOM REPORT, *supra* note 47, at 3.

²⁹⁹ *Could It Do Harm?*, *supra* note 50, at 1125.

³⁰⁰ *See id.*

³⁰¹ *See* GIBSON & SINGH, *supra* note 33, at 135-68 (detailing what the authors call a “culture of coverup” by physicians and hospitals hiding medical mistakes).

³⁰² *See* MARSHALL B. KAPP, OUR HANDS ARE TIED: LEGAL TENSIONS AND MEDICAL ETHICS 21 (1998); Leape, *supra* note 298, at 1851.

³⁰³ *See, e.g.*, David Hilfiker, *Facing Our Mistakes*, 310 NEW ENG. J. MED. 118, 121 (1984) (explaining attitudes from the perspective of a physician).

³⁰⁴ Leape, *supra* note 298, at 1852.

³⁰⁵ *See* Walter S. Davis, Lecture given at University of Virginia Medical School: The Ethics of Being a Medical Student (Spring 2008) (lecture notes available at <http://www.med-ed.virginia.edu/courses/pom1/2007-2008/LectureNotes/Spring/TheEthicsOfBeingaMedicalStudent2007.pdf>).

³⁰⁶ Hilfiker, *supra* note 303, at 121.

³⁰⁷ David Blumenthal, *Making Medical Errors Into ‘Medical Treasures’*, 272 JAMA 1867, 1867 (1994).

³⁰⁸ Leape, *supra* note 298, at 1852.

by physicians, particularly those in private practice.³⁰⁹ And so, whatever remediation does occur happens in secret, away from the knowledge of patients, whom it might comfort, from other physicians, whom it might instruct, and from systemic reformers, who might use the error to highlight systemic problems. Such “privatization” of error means that the doctor who makes a mistake finds no place to process it.³¹⁰ Whatever adjustment eventually takes place, therefore, occurs “in a vacuum.”³¹¹

Yet this attitude toward error is actually contrary to what patients state they want from their physicians. One study revealed that an overwhelming number of patients desire an acknowledgment of even minor errors and suggested that such honesty could actually reduce the risk of punitive actions.³¹² Moreover, patients who were not told about the mistake by their physician but who learned about it by some other manner were significantly more likely to sue.³¹³ Similarly, other studies report finding that poor doctor-patient relationships, negative communications, and poor delivery of information all may increase malpractice risk.³¹⁴

Physicians’ view of error as a personal failing, moreover, ignores the significant scholarship, both in medicine and other industries, which views medical error not as an occurrence requiring the finding of individual fault, but as part of a pattern inherent to any human system and therefore requiring a systemic approach, often emphasizing statistical quality control.³¹⁵ Such an approach sees error not as moral failing, but actually expects error, recognizing it as an inevitable part of a system involving fallible human beings; accordingly, this approach designs ways to manage it.³¹⁶

Physicians, therefore, have fears of error and failure imposed upon them by their socialization into the medical profession as well as by their perceptions of malpractice liability. As a result, they hesitate to admit error and rarely apologize to their patients when iatrogenic injury occurs.³¹⁷ And so the existence and threat of malpractice actions produces in many physicians and hospitals a tendency to treat medical errors “as secrets to be protected from discovery by attorneys.”³¹⁸ One study reports, for example, that house officers admitted discussing medical mistakes with their supervising physician in only

³⁰⁹ Hilfiker, *supra* note 303, at 121.

³¹⁰ *Id.*

³¹¹ Leape, *supra* note 298, at 1852.

³¹² See Amy B. Witman et al., *How Do Patients Want Physicians to Handle Mistakes?*, 156 ARCHIVES INTERNAL MED. 2565, 2565-66 (1996) (showing 98% of respondents desired physicians’ active acknowledgment of medical error).

³¹³ *Id.* at 2565.

³¹⁴ Howard B. Beckman et al., *The Doctor-Patient Relationship and Malpractice*, 54 ARCHIVES INTERNAL MED. 1365, 1365-70 (1994). See also AARON LAZARE, ON APOLOGY (2004), for a discussion of the motivation of injured or aggrieved parties who desire apology and what type of apology may be desired. Professor Lazare makes the interesting distinction between errors that call for immediate apology and those for which such an apology might not serve goals of reparation and healing. *Id.* at 170-79.

³¹⁵ See Blumenthal, *supra* note 307, at 1868.

³¹⁶ *Id.* See also GIBSON & SINGH, *supra* note 33, at 71-73 (examining systemic attempts at error reduction in various medical and nonmedical contexts).

³¹⁷ See GIBSON & SINGH, *supra* note 33, at 135-58 (detailing reluctance of individual physicians and hospital systems to admit error).

³¹⁸ Troyen A. Brennan, *Hospital Peer Review and Clinical Privileges Actions: To Report or Not Report*, 282 JAMA 381, 381 (1999).

54% of cases and with the patient or the patient's family in just 24% of the cases.³¹⁹ And even the confidential sentinel event reporting system, instituted by the Joint Commission on Accreditation of Healthcare Organizations, has not been a success, because hospitals are reluctant to report errors due to fears of a denial of the legal immunity promised to such confidential reports and eventual litigation.³²⁰

Such refusal to accept responsibility for error is promoted by the malpractice defense bar, which sees any admission as leaving a physician vulnerable to liability.³²¹ As one observer notes, a doctor may "correctly" surmise that "[I]f I tell either the patient or my boss about the mistake I made, that admission will just come back to be used against me in court, but if I keep it to myself, I may well get away with it."³²² These fears are real, for in many states an apology can be used as evidence against a physician.³²³ Yet there exists in some states a statutory mechanism for physicians to apologize within a "safe forum" which will protect them from liability.³²⁴ One goal of the SQM proposal is to create the conditions necessary for a physician to admit error and then to work toward its systemic correction in a manner that will not expose him to future legal liability.

The SQM policy of acknowledging error publicly stands in contrast to some proposals for reporting error which have emphasized the necessity of an anonymous confidential reporting mechanism, some of which advocate a system similar to the FAA reporting system for near misses of aircraft.³²⁵ The continued existence of the National Practitioner Data Bank (NPDB), with its public reporting requirements, however, coupled with the failure of an aviation-style system to be adopted despite years of debate, suggests the need for a new approach.³²⁶ Instead of emphasizing confidentiality, which we believe only heightens patients' perceptions that physicians have something to hide, the SQM proposal emphasizes full disclosure in return for mitigating the fear-inducing effects of the malpractice litigation system.

Such disclosure, furthermore, is consistent with physicians' ethical duties. The AMA's Code of Medical Ethics requires physicians to inform the patient of facts pertinent to reaching a full understanding of what has occurred.³²⁷

³¹⁹ Albert W. Wu et al., *Do House Officers Learn from Their Mistakes?*, 265 JAMA 2089, 2092 (1991).

³²⁰ See Brennan, *supra* note 318, at 382.

³²¹ See Cohen, *supra* note 75, at 1465.

³²² *Id.*

³²³ See Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1029-69 (1999).

³²⁴ See, e.g., MASS. GEN. LAWS ch. 233, § 23D (2000). More than twelve states have passed laws protecting apology, typically allowing defendants to prevent plaintiffs from introducing sympathetic statements made regretting outcome of medical treatment. See Wei, *supra* note 227, at 4-6 (citing CAL. EVID. CODE § 1160 (2004); FLA. STAT. ANN. § 90.4026 (2004); TEX. CIV. PRAC. & REM. CODE ANN. § 18061 (2005)) (discussing apology statutes).

³²⁵ See, e.g., Brennan, *supra* note 318; IOM REPORT, *supra* note 47, at 10.

³²⁶ See *id.* (explaining that the NPDB was created by the Health Care Quality Improvement Act of 1986 and required hospitals to report physicians who had had their credentials restricted or terminated, and also required hospitals to query the NPDB when credentialing or recredentialing doctors). See also GIBSON & SINGH, *supra* note 33, at 88-91, 236-38 (comparing medicine with aviation safety systems designed to detect and examine error).

³²⁷ AM. MED. ASS'N, CODE OF MEDICAL ETHICS 125 (1997).

The American College of Physicians' Ethics Manual states that procedural or judgment errors material to a patient's well-being should be disclosed.³²⁸

B. MALPRACTICE NIHILISM AND THE STANDARD OF CARE

There is a growing recognition that to address the problem of iatrogenic injuries the system of malpractice litigation must be reformed to remove the incentives for silence, without removing the incentives for physicians to practice high-quality medicine.³²⁹ Another way to frame the challenge is to reform the litigation system to remove the so-called moral hazard or loss of deterrence effect occurring when a party acts less carefully because it does not bear the full costs of its risky actions.³³⁰ The reasons for this effect are multifactorial but include the "small numbers" problem whereby any physician at any given time is unlikely to be sued, combined with the malpractice insurers being unable to experience-rate physicians accurately.³³¹

However, we maintain there is an overlooked effect. Classic moral hazard theory is framed by examples such as a surgeon being less careful during surgery due to having previously purchased insurance insulating him from economic retribution for error.³³² But we believe that the current system additionally encourages what might be called a "malpractice nihilism" in which moral actions to prevent injury, which are borne by the physician, are seen by the relevant actors *to not matter* due to a perceived "lottery-like" aspect to medical malpractice litigation. This aspect of chance undermines the contention that the tort system can both adequately identify and compensate negligent conduct.³³³ The malpractice system is therefore seen as arbitrarily punishing physicians regardless of whether they followed customary, appropriate standards.³³⁴ Therefore it is easy for physicians to disregard the idea that they will be punished if they make a mistake; instead, physicians view the tort system as acting regardless of their conduct, weakening any argument for deterrence.³³⁵

Moreover, many physicians engage in secrecy because they feel everyone else is doing it, and therefore deviating from this practice risks upsetting the

³²⁸ AM. COLL. OF PHYSICIANS, *ETHICS MANUAL, 4TH ED.*, 128 ANNALS INTERNAL MED. 576, 579 (1998).

³²⁹ See, e.g., GIBSON AND SINGH, *supra* note 33, at 3-14 (examining growing consensus of need to ameliorate error and to continue practicing high quality medicine).

³³⁰ See Priest, *supra* note 132, at 1553.

³³¹ See Sage, *supra* note 20, at 161 n.8.

³³² See Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DE-PAUL L. REV. 393, 412 (2005) (explaining classic moral hazard theory).

³³³ Professor Weiler believes that physicians as a group may be deterred by such concerns about liability, but, as mentioned above, the actual occurrence of malpractice is not an accurate predictor of eventual payment to a malpractice plaintiff. WEILER, *supra* note 3, at 81.

³³⁴ KAPP, *supra* note 302, at 7.

³³⁵ *Id.* Moreover, as Professor Epstein points out, it becomes "no longer possible to argue that the system produces underdeterrence. Rather, the dominant feature is the unreliability of the entire system as a check on medical misconduct. After all, why should anyone take care in medical practice if the likelihood of losing a case depends on the seriousness of the patient's condition and not on the quality of care provided?" *Contractual Principle*, *supra* note 9, at 512.

appreciated and unleashing increased liability and peer opprobrium.³³⁶ They view secrecy as a defensive practice similar to ordering unnecessary tests, a situation which has led one critic to describe this process as “keeping down with the Joneses”—in other words, physicians being awarded peer respect for practicing defensive medicine.³³⁷ Certainly in the SQM regimen, quality medicine will no longer be equated with defensive medicine, and physicians and patients individually and as a group will be encouraged to act proactively, ordering tests and procedures, and scheduling surgeries and therapies as scientifically indicated by best practices and evidence-based data, thereby eliminating waste and maximizing welfare.³³⁸

Finally, one should remember that the legal system allows the medical profession to set its own standard of care: Instead of the courts determining the appropriate standard of care, physicians have been allowed to set the standard through the use of clinical guidelines, national standards for board certification, etc.³³⁹ Physicians are held liable for negligence only if they cause injury as a result of deviating from their self-imposed standard of care.³⁴⁰ One way to raise the standard of care is through medical advancement based on examining and correcting error. But by engaging in a culture of secrecy because they fear litigation and think that tort is unreliable, physicians have implicitly prevented medical advancement and therefore artificially depressed the standard of care—a result that is an extremely deforming incentive of tort. Thus, they keep the standard against which they will be measured low, and keep their perceived risk of liability as minimized as possible.

VIII. CONCLUSION

The SQM proposal is motivated by substantial evidence that due to the deforming incentives of the tort system and the inefficiencies of litigation, the twin goals of medical malpractice—compensation and deterrence—are not met. In addition, recent studies indicate that an ADR system substituted for

³³⁶ See GIBSON AND SINGH, *supra* note 33, at 77-98, 135-68 (detailing reluctance of individual physicians and hospital systems administrators to admit error).

³³⁷ KAPP, *supra* note 302, at 31.

³³⁸ Studies indicate that the malpractice litigation system changes physicians' behavior by indirectly promoting the use of defensive medicine such as ordering more tests and procedures, spending more time in visits, and increasing the number of follow-up visits by patients. See WEILER ET AL., *supra* note 11, at 79-82 (suggesting that rating liability affects standards of care more than peer review). Moreover, there are two types of defensive medicine, positive defensive medicine—such as ordering more tests—and negative defensive medicine, such as closing down practices, moving out of state, retraining in other fields. It also may be that the practice of negative defensive medicine—particularly as it has led to shortages of vital, high-risk specialists such as neurosurgeons and obstetricians—is an equally pernicious and perhaps more damaging aspect. Bernstein et al., *supra* note 3, at 1777. See also *Contractual Principle*, *supra* note 9, at 503-04 (noting the loss of neurosurgical services in Carbondale, Illinois due to high malpractice insurance rates motivating physician relocation); ANDERSON, *supra* note 131, at 220-21 (noting that, due to malpractice pressures, more than 12% of obstetricians/gynecologists nationally have stopped practicing delivering babies and that an area of West Virginia lost all neurosurgeons for approximately two years).

³³⁹ See, e.g., Lee Black, *Virtual Mentor: Effects of Malpractice Law on the Practice of Medicine*, 9 AMERICAN MEDICAL ASSOCIATION JOURNAL OF ETHICS 437-40 (2007), available at <http://virtualmentor.ama-assn.org/2007/06/pdf/hlaw1-0706.pdf>.

³⁴⁰ See, e.g., *id.*

the current legal regime would compensate a greater number of seriously injured patients with more uniform awards and in a more timely fashion. The central tenet of the SQM proposal is that medical errors will be more openly investigated and remedied if physician liability for medical error is limited. As several commentators have acknowledged, the fear of malpractice litigation has induced a “conspiracy of silence” around medical error, a culture of secrecy whereby physicians are hesitant to reveal errors to both patients and hospital administrators for fear of malpractice liability.³⁴¹ While the actual, factual basis of such fear is debatable, with at least one expert postulating that such malpractice fears serve as a pretext for underlying anxieties not related to litigation,³⁴² entry into a contractual arrangement mandating mediation and binding arbitration in return for opting out of the traditional tort system of medical malpractice certainly will reduce the *perception* of physicians that they are being unfairly dragged into court, and should reduce the incentive to minimize, hide, and deny error.

Kenneth Kizer, former Under Secretary of Veterans Affairs during the Clinton Administration, has identified seven principles of what he has called a “culture of safety,” particularly in the context of evolving healthcare systems.³⁴³ Drawing on the Veterans Administration’s experience in implementing safety regulations for its hospitals, Kizer explains that hospitals and physicians need to acknowledge the inherent risk involved in medical practice, rather than indulging in a fiction that physicians are morally responsible for every error.³⁴⁴ The recognition of the potential for danger inherent in medical practice is the first step or principle necessary in any sensible error-reduction strategy. As such, it is directly contrary to the prevalent medical model of viewing mistakes as personal, moral failings and seeking to blame individuals. Second, in this culture of safety, medical mistakes are not hidden, but recognized and valued as opportunities for improvement.³⁴⁵ Third, a non-punitive and safe environment for the establishment of error discussion and examination is developed, an environment where physicians are free from fear.³⁴⁶ Fourth, the system needs open and honest communication and the ability to keep that communication confidential.³⁴⁷ Fifth, hospitals and physician practices need to have specific mechanisms for reporting and learning from human errors that are recognized as inevitable, as explained in the first principle.³⁴⁸ Sixth, a developed and just mechanism for restitution or compensation is necessary to mitigate the injuries caused by error.³⁴⁹ Finally, the seventh requisite is a commitment to—and a mechanism for—organizational accountability to make these other principles work.³⁵⁰

³⁴¹ GIBSON & SINGH, *supra* note 33, at 135-54; *see also* Leape, *supra* note 298, at 1851-52 (discussing generally reactions to mistakes in the medical community).

³⁴² KAPP, *supra* note 302, at 15-23.

³⁴³ Kenneth Kizer, *Large System Change and a Culture of Safety*, in PROCEEDINGS OF ENHANCING PATIENT SAFETY AND REDUCING ERRORS IN HEALTH CARE 31, 31 (1999).

³⁴⁴ *Id.*

³⁴⁵ *Id.*

³⁴⁶ *Id.*

³⁴⁷ *Id.*

³⁴⁸ *Id.*

³⁴⁹ *Id.*

³⁵⁰ *Id.*

We believe that the SQM proposal satisfies these goals while recognizing the sophisticated structural influences that a distorted medical malpractice litigation system imposes on any effort at error reduction. As such, we refer to these principles both explicitly and implicitly throughout the proposal. We hope that the SQM proposal can, if implemented even on a small scale, demonstrate a “win-win” situation can be constructed whereby both parties—physicians and patients—will markedly benefit by improved care, adequate compensation of injury, and effective deterrence of error.

The SQM proposal employs contracting out of the medical practice tort system either by individual patients or by employer groups offering the option to individual employees.³⁵¹ The proposal seeks to eliminate one of the core objections to such contracting, that of informational disequilibrium. Both economic proponents and opponents have recognized that this contracting out of tort threatens to reduce welfare should patients be informed imperfectly about their choices regarding both contract terms and the value of remaining within the tort system.³⁵² The SQM proposal improves communication about error rates and individual medical mistakes, and institutes rigorous quality control within each SQM. It then works to reduce error publicly and compensate victims of malpractice equitably, striving toward providing more perfect information for patients and mitigating the possibility that patients would contract over liability when such contracting would make them worse. Conversely, it will allow those patients who are risk-adverse to contract out of tort and into an SQM-based system.³⁵³

Should this proposal be implemented in a trial basis—a step which may require legislative support in some jurisdictions³⁵⁴—physicians will discuss and examine medical mistakes, and these lapses will be rectified or prevented. Systemic and personal contributions to error will be addressed. The practice of ordinary physicians will no longer be retarded by fears of litigation, and medical science and patient care will advance. In effect, the culture of secrecy will be replaced with a culture of safety. This, in turn, will increase the welfare of all stakeholders, even those who, for the moment at least, are working outside the SQM. Building such a culture of safety will be worth all of the effort the SQM necessarily entails.

³⁵¹ The latter option may be preferred to avoid judicial invalidation. *See supra* text accompanying notes 241-48.

³⁵² Compare, e.g., Richard Epstein & Alan Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, 30 J. LEGAL STUD. 625 (2001) (advocating contracts) with *Private Contractual Alternatives*, *supra* note 15 (advocating maintenance of the medical malpractice tort system without a private contractual alternative).

³⁵³ These undesirable outcomes would occur because the patients would not understand the benefits of tort liability or would experience unacceptably high costs of searching for quality physicians, both problems we feel are mitigated in an SQM system. *See Contracting Over Liability*, *supra* note 15, at 24-25 (discussing problems of information and search costs in the private contracting of malpractice liability). *See also supra* note 139 and accompanying text (discussing state supreme court nullification of tort reforms).

³⁵⁴ Legislature support may be required for caps on damages, limitation of collateral source recovery, and contracting out of tort. *See supra* notes 128-42, 143-53, 241-55 and accompanying text.

APPENDIX

TABLE I

This table summarizes the rates of injury and subsequent malpractice claims for a hypothetical group of 1,000,000 patients under both the current tort system and as envisioned in the SQM, based on Section V., “Economic Analysis,” *supra*.

Distribution of a Population of Patients (n = 1 million)	Current Distribution Under Standard Tort System	Distribution Under SQM System
Injured	50,000	45,000
Victims of negligence	10,000	5,000³⁵⁵
Injured by treatment	40,000	40,000³⁵⁶
Uninjured	950,000	955,000
Posited Rate of suits among injured by negligence	10%	100%³⁵⁷
Posited Rate of suits among injured by treatment	5%	2.50%³⁵⁸
Posited Rate of suits among uninjured	0.10%	0.05%

³⁵⁵ We posit that the rate of injury will be lower in the SQM owing to higher standards and self-selection of better doctors, *see supra* note 194 and accompanying text.

³⁵⁶ This rate would not change, since it reflects the unintended consequences of treatment that is not based on error.

³⁵⁷ This is obviously an upper bound and unlikely to be seen. Some patients may simply refuse to file a claim. However it is aspirational, in the sense the SQM system strives to identify and compensate all those injured by error.

³⁵⁸ The rate will decrease in SQM owing to greater trust in the disclosure process; people will not need to sue simply to “find out what happened.”

Total # of negligence-injured patients who sue	1,000	5,000
Total # of treatment-injured patients who sue	2,000	1,000
Total # of uninjured patients who sue	950	478
Total suits	3,950	6,478
Posited victory rate among injured by negligence	40%	100%
Posited victory rate among injured by treatment	25%	12.50% ³⁵⁹
Posited victory rate among uninjured	10%	5%
Total wins negligence-injured	400	5,000
Total wins treatment-injured	500	125
Total wins uninjured	95	24
Total suits won	995	5,149 ³⁶⁰

³⁵⁹ We posit greater but still imperfect accuracy in judgments. This non-zero rate provides an upper bound on the cost of the system.

³⁶⁰ There are many more successful claims in SQM, but likewise many more of the successful claims will be meritorious.

% of winners NOT victims of negligence	60%	3%
Success rate of all claims	25%	79%