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ARTICLE: A Medical Complication Compensation Law: Improving Quality Healthcare Delivery While Providing For Injury Compensation

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LEXISNEXIS SUMMARY:
... Workers' compensation laws are fundamentally different from tort liability concepts in that tort liability is grounded in fault, while workers' compensation payments, are based on a test of work-connectedness between the employee and her injury. ... State legislatures in all states except for Florida have protected the content of these discussions from suit in tort, thereby implying that they recognize physicians' consideration of complications does not belong in the provenance of ordinary medical malpractice negligence theory. ... Similarly, many physicians declare today, through their choice of specialty or through their direct statements, that unless tort reform occurs, many will refrain from high-risk practices. ... Elements of a Medical Complication Compensation Law New York has already taken the first steps towards creating a direct compensation fund for patients' injuries in the field of obstetrics, but why not take it further? ... To receive funding for the Medical Liability Reform and Patient Demonstration Projects, an eligible state must demonstrate how its project: (A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes; (B) encourages the efficient resolution of disputes; (C) encourages the disclosure of health care errors; (D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; (E) improves access to liability insurance; (F) fully informs patients about the differences in the alternative and current tort litigation; (G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative; (H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and (I) would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim. ... MCCL as Hybrid Adjudication This paper does not propose that the Health Courts become mere administrative bodies

that provide compensation without any kind of judicial evaluation of claims.

TEXT:
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I. Introduction and Rationale

The provision of medical care in the United States has undergone a radical transformation over the past three decades. n1 What was once a common practice - a primary care physician hanging out a shingle and practicing medicine on his own - has now largely been replaced by a complex system involving myriad layers of regulation. n2 From the moment a patient walks through the door into her doctor's office, her visit is regulated. n3 Multiple government and non-government agencies, medical societies, third-party payers, and quality review boards require her physician to provide medical care to her under an extraordinary set of rules, which in and of themselves do not affect her physician's actual practice of medicine, but instead increase the amount of paperwork and regulatory work the physician must perform surrounding her visit. n4

[*56] In addition to the increased mandatory regulatory work, the physician must also balance an increasingly voluminous and complex amount of patient care due to an aging population. n5 These two components, increased regulatory work, and increasingly voluminous and complex patient care, combined with the technological innovations and stricter requirements of documentation, place the twenty-first century physician in a position of overwhelming scrutiny while providing care to his patients. n6

This paper does not question the importance of increased scrutiny for the purpose of increasing healthcare quality. Instead, this paper questions whether continuing to rely on current traditional tort law as the method to scrutinize physician provided care is in patients' and their families' best interests. For public policy reasons, in many areas of law the common law jury trial system has changed to better meet the needs of the populace. n7 The current medical malpractice system, namely one of punitive, adversarial, negligence theory, is outdated and does not recognize true issues of errors in delivering health care, nor does it serve the public good. n8 But most importantly, the current system unfairly detracts from the true purposes behind imposing liability on those who have committed malpractice: increasing patient care and safety and providing compensation to those who are injured. n9

[*57] In particular, New York State provides a good example of how the current medical malpractice systems in most states have lost their way. n10 The litigation process for those who are injured during medical treatment presents inequities for injured patients, physicians, and health care consumers alike. n11 In New York, annual losses incurred by insured physicians, which include damage awards and attorneys' fees for prior claims, reflect a steady increase. n12 For example, in 1971, physicians lost $ 7.1 million, while in 1980, physicians lost $ 81.9 million, and in 2011, physicians lost $ 677 million. n13 Despite that many patients recover disproportionately large awards, others, unable to prove negligence, receive no compensation whatsoever. n14 However, the inability of injured patients to even enter the adversarial system at all is by far more [*58] concerning and frustrating for these patients. n15 Although fear of lawsuits has led to some changes in physicians' behavior, physicians have largely become insulated from the deterrent value of tort awards through malpractice insurance. n16 Specifically, physicians engaged with malpractice carriers already pay high fees to a system that functions largely on its own for its survival, while the dual goals of the system, namely providing equitable compensation for injured parties, and increasing the quality of medicine physicians provide, are not met. n17

This paper explores the legal and public policy risks and benefits of creating a new system to compensate patients for medical injuries. This new system will be a hybrid of the current tort-negligence system, expanding upon successful programs in New York State such as Judge-Directed Negotiation and the current Obstetrical Fund. n18 [*59] Based on prior success of New York's Workers' Compensation program before the United States Supreme Court, the hybrid system we are proposing preserves individual Constitutional rights and brings the successful parts of our current tort

system into what this paper calls a "Health Court." n19 The social problems that led to the creation of the [*60] Worker's Compensation system exist today when we consider medical care complications and the ability of patients to receive compensation for medical injury. n20 This is particularly true considering the disparity between the likelihood that an injured plaintiff can afford to pursue litigation compared with a hospital's ability to pay to defend one of its physicians in malpractice litigation. n21

This piece argues that since the practice of medicine is inherently dangerous a patient should be compensated for her injuries despite her informed consent, assumption of risk, and contribution to her injury from any preexisting physical conditions. n22 However, changing how injured patients are compensated will also require a shift in how we understand medical complications, from fault attributed to the physician to no-fault attributed to the event. n23 The goals of this proposed hybrid systems are: (1) to fairly compensate patients who suffer from complications, not as victims but as individuals undergoing potentially hazardous care, and (2) to increase physician accountability - financially and professionally - in order to increase the quality [*61] of care provided. n24

While the scheme to create a Medical Complication Compensation Law (hereinafter "MCCL") would serve as a wide departure from common law standards and understanding respecting the responsibility of the physician to the patient, such a law would be wise from a public policy standpoint. n25 Although there would undoubtedly be serious lawyer and physician political discourse and consequences for such a law, a MCCL would help the population most in need of compensation and protection, the patient. n26 The enactment of a MCCL would declare a physician's liability in negligence law inapplicable to the modern realities of patient care. n27

This paper first addresses the social, economic, and legal issues that exist today and compare these issues to the impetus behind the New York State Workers' Compensation Law. n28 In order to divorce current malpractice common law from patient care, this paper argues that medical error is not correctly understood in terms of negligence theory. n29 Based on these foundations, as well as other areas of accepted law, this piece describes and examines the fundamental aspects of a MCCL. n30 This article also addresses the practical aspects of a MCCL, including the need for an administrative structure capable of maintaining physician responsibility, improvements in quality care, and the development of a Health Court. n31 Lastly, this paper also addresses the Constitutional hurdles and opposing arguments that such a law is likely to encounter. n32

II. The Rise of Worker's Compensation: A Comparative Historical Perspective

Workers' compensation is a mechanism for providing cash wage benefits and medical care to persons who are injured on the job, and for placing the cost of these injuries ultimately on the consumers of the employer's product through the medium of insurance. n33 With this definition of workers' compensation in mind, one might be [*62] inclined to accept modern day workers' compensation laws simply as a historical inevitability. Indeed, in light of the fact that most of our nation's compensation laws were passed by individual state legislatures between 1911 and 1920, relatively few Americans can speak of a time when workers' compensation laws were not the norm. n34

The necessity of workers' compensation laws arose from the sharp increase in industrial accidents attending the rise of the factory system and a simultaneous decrease in individual employees' common law remedies for their injuries. n35 Workers' compensation is not an outgrowth of common law or of employers' liability legislation; rather, it is the expression of an entirely new social principle originating in nineteenth century Germany. n36 Furthermore, although Anglo-Saxon common law would seem to suggest that workers' compensation laws were developed by judicial decree, that is not the case. n37 Quite the contrary, the seeds of modern day workers' compensation laws were the product of sociopolitical thought in nineteenth-century Prussia, subsequently expanding to England and then to the United States. n38

In the United States, the markedly increased number of injuries, which resulted from the industrial revolution and the larger desire for corporate profit, led to an expansion of the tort system. n39 Considering the number of large and powerful firms hired to represent employers in these actions, the legislatures, in an attempt to protect the population,

created employer liability statutes. n40 Specifically, these statutes tried to [*63] expand employer liability, however, inherent deficiencies persisted. n41 These deficiencies were the direct result of the statutes' reliance on the tort doctrine of respondeat superior, which allows for numerous defenses, including assumption of risk, and contributory negligence. n42 This heavy reliance on actions in tort eventually led to the enactment of employer liability statutes across the country. n43 The tribulations of injured workers during the turn of the twentieth century are remarkably similar to those of injured patients in our current medical malpractice tort system. n44

Recognizing that tort theory at best only played a limited role in restoring "[an] injured employee to a position no worse than that of a stranger injured by the negligence of the employer[,]" it became obvious that a new legal principle was needed to address the needs of injured employees. n45 Beginning in Wisconsin in 1911, and quickly spreading to other states including New York, state legislatures enacted Workers' Compensation Acts, which were challenged but ultimately upheld. n46 The fundamental [*64] social philosophy behind compensating injured employees was the belief that an enlightened community should provide financial and medical benefits for injured workers in the most efficient, dignified, and certain form, by allocating the burden of the payments to the consumer of the product the employer produced. n47 In other words, workers' compensation acts were founded upon the desire to provide efficient and effective financial and medical benefits for victims of work-related injuries, and the appropriate source of these benefit payments came from the consumer of the product. n48

As a fundamental, intrinsic premise, it must be reemphasized that doctrines of tort generally, and in particular "of fault," cannot affect resolutions under New York State's Workers' Compensation Law, as "the test is not the relation of an individual's personal quality (fault) to an event, but the relationship of an event to an employment." n49 Simply put, there are essentially two key issues to be decided in a workers' compensation proceeding; first, did the employee suffer a work-connected injury; and second, did the employee receive compensation. n50 Workers' compensation laws are fundamentally different from tort liability concepts in that tort liability is grounded in fault, while workers' compensation payments, are based on a test of work-connectedness between the employee and her injury. n51 Principles of tort focus on the [*65] individual and his or her righting of an individual wrong, whereas workers' compensation is concerned with the benefits derived from collective social involvement and protection of our workers. n52

III. Redefining Medical Complications: The End of Malpractice As We Know It

The question we must ask is whether medical malpractice is appropriately framed and housed in tort law. In other words, when a patient sues a physician for malpractice, is it proper to look at the suit as one that is grounded in negligence, wherein the physician has deviated from a standard of care? Several modern definitions of medical malpractice derive from the standard enunciated in Pike v. Honsinger: n53

> The law relating to malpractice is simple and well settled, although not always easy of application ... . Upon consenting to treat a patient, it becomes [a physician's or surgeon's] duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgment in exercising his skill and applying his knowledge. The law holds him liable for an injury to his patient resulting from want of the requisite knowledge and skill, or the omission to exercise reasonable care, or the failure to use his best judgment. n54

The essence of Pike, its progeny, and the common law to-date has been that the complication a patient suffers is based on the physician's negligence. n55 But in practice, injuries incurred by patients based on the actions of physicians do not necessarily result from "want of the requisite knowledge and skill." n56

[*66] Modern medical care is highly organized and complex, with the goal of providing the best possible quality of care to patients. n57 However, it is profoundly limited, by the unavoidable and inherent medical complications that

can occur with certain patients. n58 Our current adversarial system, with its expense and delay, high volume of settlement without oversight, in which only "[forty-six] percent of the total direct costs of the tort system go to victims in the form of economic and noneconomic damages; [fifty-four] percent go to transaction costs," is widely regarded as a defeat of justice and does too little to rectify patients who suffer from the inevitable. n59 Too often the injured patient and his family are left to bear the greater burden of the medical [*67] accident. n60 The current system in place encourages "tainted relationships" between patients and physicians, nurses, and other health care providers. n61

IV. A No-Fault Scheme

Workers' compensation is a "no-fault scheme." n62 Courts have upheld this arrangement in order to balance an injured party's rights with those of his employer, by awarding payment for the party's injuries while removing liability from the employer. n63 Physicians and patients could benefit from a similar scheme. Though, like workers, patients should be compensated for their injuries, a report of a physician's fault to the National Practitioner Data Bank (hereinafter "NPDB") causes anxiety, fear and denial, in the mind of the physician in question. n64 The physician, who largely believes the care [*68] she delivered to her patient, has been the product of great education, thought and sincere application often refuses to acknowledge fault. n65

A physician sued for malpractice, unlike a railroad company or a car driver sued for negligence, is highly trained, often overworked, but most importantly, deeply engaged in, often unpredictable, patient care. Responses to surgery and to medications vary. Poor outcomes and complications occur even when-based on experience, research, and common medical knowledge-they are unexpected. n66

If we now modify our discussion above and place instances of medical malpractice in the context of a workers' compensation no-fault liability scheme, "the test [would not be] the relation of a [physician's] (fault) to an event, but the relationship of an event to [patient care]." n67 As in a no-fault workers' compensation scheme, there would be only two relevant issues to be decided in the proposed MCCL: (1) did the patient suffer a patient care-related injury; and (2) did the patient receive compensation? n68

Take for example a colonoscopy procedure: a gastroenterologist can perform thousands of successful colonoscopies, but might accidentally perforate one patient. n69 Toward that injured patient, the gastroenterologist feels natural guilt and empathy, but most likely, the gastroenterologist herself is not at "fault" for perforating the patient. "Perforation" is a known risk during colonoscopies, and study after study demonstrates that most perforations are not only largely unavoidable, but are also part and parcel of the procedure. n70 In an adjudicative proceeding, the physician's attorney could [*69] conceivably argue multiple defenses to alleviate the physician's liability, but unfortunately this only confuses the issue. n71 Without a doubt, the practice of medicine carries with it inherent risks and benefits. n72 For this reason, the physician only performs a procedure after her patient gives "consent" and "assumes the risk" of the procedure. n73

Providers have a sincere desire to improve care, and strive to do so. n74 While the practice of medicine includes a constant focus on "what the physician could have done better," this should not be the basis of fault in tort. Going back to our example, when a gastroenterologist perforates a patient's colon, she is not necessarily at fault, and has not necessarily breached the applicable standard of care to her patient. n75 In fact, in order to further medical education, all fifty states have passed laws protecting morbidity and mortality conferences, in which the complication, medical and/or nursing staff error, and ideas for improvement are seriously discussed. n76 State legislatures in all states except for Florida have protected the content of these discussions from suit in tort, thereby implying that they recognize physicians' consideration of complications does not belong in the provenance of ordinary medical malpractice negligence theory. n77

Surprisingly, the majority of patient care injuries are not related to "malpractice" [*70] as most would think of it - e.g. negligence from a deviation in the standard of care. n78 For example, if a physician administers a vaccine designed to prevent a common infectious disease, such as Pertussis, and the pediatric patient develops a certain complication

within a certain amount of time after receiving the vaccine, the physician is not culpable. n79 Importantly, this lack of blameworthiness extends from the physician to the vaccine manufacturer unless gross negligence can be shown in the preparation of the vaccine. n80 The severe complication, in this scenario, would have occurred regardless of who the administering physician was, and despite the unblemished final manufactured vaccine.

This logic comes from The Vaccine Injury Compensation Program (hereinafter "VICP"). n81 Much like workers' compensation schemes, the VICP creates a no-fault compensation system. n82 For instance, if a patient receives a covered vaccine and presents with a covered injury from the vaccine; the patient is entitled to compensation. n83 Thus, neither the administering physician nor the manufacturer is at fault for an injury that falls under the jurisdiction of the VICP. n84 A table, created and modified by the Secretary of Health and Human Services, sets the covered vaccines, the covered injuries, and the amount of compensation. n85

The VICP was created partly in response to increased litigation surrounding complications from many widely approved, required, and effective vaccines. n86 Vaccine manufacturers warned they would stop producing the vaccines if the environment remained heavily litigious, and many companies began to stop production. n87 Similarly, [*71] many physicians declare today, through their choice of specialty or through their direct statements, that unless tort reform occurs, many will refrain from high-risk practices. n88 Although critics of the VICP contend that the process is heavily weighted against injured parties, because it takes too long and/or the Secretary of Health and Human Services has removed too many injuries from the table, from a logical public health and utilitarian standpoint, the VICP has been successful in allowing our nation to continue to receive available vaccines and prevent the spread of disease. n89

In order to address critics' concerns regarding the VICP, it is prudent to address whether the problem is the theory behind the VICP or the poor application of justifiable compensation for injured patients. In terms of the theory behind the VICP, it is not difficult to recognize the need to vaccinate the entire population and fairly compensate patients injured by a public health decision. n90 Bad reactions are rare while the societal benefits are enormous. Society has a duty to compensate the injured for such benefit. n91 Once the absence of fault is recognized, the importance of limiting liability and protecting the manufacturer who is following the needs of society become apparent. Thus, concerns regarding the VICP need only be addressed towards imperfect implementation rather than the theory behind the compensation scheme.

V. A Demonstrative Case

Going back to this paper's MCCL proposal, we must outline an illustrative case where the res ipsa loquitur doctrine could apply in theory, if not in practice. n92 In this case, [*72] malpractice is so obvious that it would seem that an expert witness is often not required:

Res ipsa loquitur is frequently used in medical malpractice cases when: (1) an injury occurred outside the site of an operation; (2) a foreign object is left within the body of a patient after surgery; or (3) an injury occurred while the patient was under anesthesia. When, however, the occurrence is within the normal and anticipated sequelae of a procedure or when there may be several other non-malpractice causes for the condition complained of, then a res ipsa loquitur charge will not be given. n93

A classic case of medical malpractice, Kambat v. St. Francis Hospital, n94 is illustrative of our point. In Kambat, plaintiffs (the decedent's husband and children) brought a malpractice claim after an 18-by-18 inch laparotomy pad was discovered in decedent's abdomen following a hysterectomy performed by a physician at the defendant hospital. n95 The New York Court of Appeals held that the jury should have been instructed on the principle of res ipsa loquitur. n96

[*73] Following the operation, the decedent's condition was unremarkable, however, in November 1986 decedent reported to the hospital with abdominal pain and x-rays revealed the foreign object. n97 On December 5, 1986, a

laparotomy pad measuring 18-by-18 inches - similar to those used during the hysterectomy - was discovered in the patient's bowel and surgically removed. n98 Following the second operation, the patient's condition deteriorated, and she died on December 29, 1986 from infection-related illnesses. n99

Despite the obvious fault in Kambat, the case was heavily litigated. n100 Under our current system, the family of the deceased would receive compensation, if at all, by settlement or by trial. n101 The compensation to the family might include loss of consortium (for the deceased's spouse) and loss of income to the family members. n102 Nevertheless, litigation, however punitive and deterrent, does not necessarily get to the crux of the problem. What happened in the operating room is evident: the surgical team left a laparotomy pad behind. n103 To determine negligence, the hospital would have to investigate at multiple levels whether the surgical team followed protocol, whether the surgeon paid close attention during the count, and whether the surgeon lead the count with the scrub nurse. n104 The investigation would likely include the particular state's health department and various accrediting organizations. n105

[*74] With this in mind, one must ask, what was the real role of the trial court? To judge fair compensation at such great cost to a deceased woman who will never benefit? This question of pain and suffering and loss of income to family members is embedded in the complicated tort system, which addresses fault, but in a costly manner. n106

Fault would not be excused in this case based on defenses of consent, assumption of risk, and/or comparative fault. n107 In Kambat, the decedent underwent a potentially hazardous medical procedure performed by a dedicated team of well-trained personnel in an accredited hospital. n108 Research has shown that in surgical procedures, 1 in 10,000 will result in a foreign object, such as a pad being left inside the patient. n109 An estimated 1,500-2,000 retained surgical item cases are brought each year in the United States. n110 There is no data, other than individual case reports, on the frequency of retention in hospitals around the world, but every year more than 45 million inpatient procedures are performed in the United States and 234 million operations are performed globally, so it is likely the frequency of retention is probably higher than most would expect. n111

The prevention of retained surgical items requires practice change, knowledge, and shared information between all perioperative personnel. The current tort system does nothing to address these issues. However, perhaps based partially on a fear of litigation, physicians, hospitals, accrediting bodies, and state and federal agencies have developed programs to prevent these unfortunate outcomes. n112 For example, "NoThing Left Behind" a voluntary surgical patient safety initiative started in 2004, aims to [*75] discover why retained surgical items are such a persistent problem and to further develop practices to ensure deadly complications like those in Kambat become "never happen events." n113

VI. Transforming the Concept of Physician Liability - From Fault to Inherently Dangerous Care

The focus of our understanding as to why patients are injured should shift from a concept of fault to a concept of an inherently dangerous activity requiring the highest degree of care. To put it candidly, medical care is inherently dangerous. n114 We now know roughly the complication rates for different areas of medicine and surgery, ranging from retained items in surgical procedures to life-threatening medication-related and allergic reactions, such as Steven Johnson Syndrome and anaphylaxis. The medical community works diligently to prevent these complications and intrinsically studies the risks and benefits to determine when a medical intervention should occur. n115 The law has established certain activities as inherently dangerous and, in many cases, has modified tort law to preclude suit when injuries result from such activities. n116 Section 520 of the Restatement Second of Torts lists six factors that are to be considered in determining whether an activity is inherently dangerous. n117 The factors are as follows:

(a) existence of a high degree of risk of some harm to the person, land, or chattels of others;

(b) likelihood that the harm that results from it will be great;

(c) inability to eliminate the risk by the exercise of reasonable care;

(d) extent to which the activity is not a matter of common usage;

(e) inappropriateness of the activity to the place where it is carried on; and

[*76]

(f) extent to which its value to the community is outweighed by its dangerous attributes. n118

Although the discussion regarding "inherently dangerous activities" largely focuses on strict liability for ultra-hazardous activities, such as lighting fireworks, the question when applied to medicine must consider a patient's need, consent, assumption of risk, and contribution to his injury. n119 The essential question that must be asked in terms of medical and surgical procedures is whether the risk created is so unusual, either because of its magnitude or because of the circumstances surrounding it, as to justify the imposition of strict liability for the harm that results from the procedure, even if the procedure is performed with all reasonable care. n120

For example, when addressing the inherent dangerousness of fireworks displays, the factors as laid out by the Restatement (Second) of Torts § 520 are easily met. n121 "Any time a person ignites aerial shells or rockets with the intention of sending them aloft to explode in the presence of large crowds of people, a high risk of serious personal injury" ensues. n122 That high risk arises given the possibility that a shell or rocket will malfunction or misdirect into the crowd. n123 Furthermore, no matter how much care pyro-technicians exercise, they cannot entirely eliminate the risk inherent in setting off powerful explosives. n124 Therefore, parties detonating fireworks are deemed strictly liable for damages caused by such activities. n125

Policy considerations support imposing strict liability on pyro-technicians for damages caused by their firework displays, although such considerations alone do not justify that conclusion. n126 The question is whether the same is true for medicine. Although the practices of medicine and surgery are inherently dangerous, patients often present with life-threatening need for medical care. At issue is who should bear the cost [*77] when an innocent patient suffers injury through the non-culpable, but inherently dangerous activities of the physician. Conceptually, strict liability exists not only to rectify a wrong and put the burden where it belongs as a matter of abstract justice (that is, upon one whose acts instigated the harm), but also to help resolve problems of proof. n127 From a public policy perspective, liability and compensation should fall upon those best suited to afford the compensation.

A. New York's Obstetrical Fund

Medical malpractice settlements in New York are the costliest in the nation. n128 This is not due to bad doctors or poor provision of health care. n129 In 2010, five New York hospitals (or hospital systems) were each paying in excess of $ 100 million per year in medical malpractice costs. n130 At that time, annual malpractice premiums for obstetricians practicing in Suffolk and Nassau County, Bronx County, and Kings County, New York averaged $ 186,772, $ 176,573, and $ 171,430 respectively. n131

Recognizing the excess costs to the Medicaid program, malpractice premiums, and the profound limitations in

quantifying and providing for future medical costs for infants injured during obstetrical care, New York established the New York State Medical Indemnity Fund (hereinafter "the Fund"). n132 The history of the Fund reform is [*78] overwhelmingly based on public policy considerations. n133 Although obstetrics has not been not articulated as an inherently dangerous activity, the rationale behind the Fund lies in principles that recognize that childbirth can be problematic. n134

The Fund is supported by a state appropriation and pays the:

Qualifying health care costs [of a] qualified plaintiff [who] (i) has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice, or (ii) has sustained a birth-related neurological injury as the result of alleged medical malpractice, and has settled his or her lawsuit or claim therefor. n135

[*79] The Superintendent of the Department of Financial Services administers the Fund. n136 Its purpose, as stated in the statute, is to "provide a funding source for future health care costs associated with birth related neurological injuries, in order to reduce premium costs for medical malpractice insurance coverage." n137 In establishing the Fund, New York State intervened, creating a hybrid system that combines a no-fault worker's compensation-like scheme with an adjudicative scheme that - in obstetrics - reduces medical malpractice insurance costs by indemnifying carriers, shifting the burden to the public in general, while allowing the courts to determine who is considered "qualified plaintiff." n138

In light of the foregoing, a court must exercise care in determining whether a claimant is "qualified" to seek relief from the Fund. The plaintiffs to a malpractice action involving an infant will generally have a significant incentive to place the case to the Fund, so long as there is any argument that the plaintiff and his or her injury meet the statutory terms. n139 New York's Fund does not restrict a litigant's right to sue; instead it requires that plaintiffs be reimbursed. n140 Thus, the Fund represents a hybrid of a general compensation system and tort law. n141

VII. Elements of a Medical Complication Compensation Law

New York has already taken the first steps towards creating a direct compensation fund for patients' injuries in the field of obstetrics, but why not take it further? Modeling the public policy, legal, and theoretical frameworks on already-established reforms in tort, such as the Workers' Compensation Program, it is possible to envision a solution to litigation crises in medical malpractice. The goals of such [*80] reform must be based on the twin goals of compensating patient injuries and enhancing patient safety. These were the goals espoused by the American Association for Justice when it defined the benefits of the current tort system in addressing medical malpractice. n142

This paper does not argue for the total elimination of our current adversarial system. However, in recognizing the limitations of our current system, the complexity of medical care, the desire to limit the concept of fault, and the dual goals of providing speedy compensation for the injured patient and enhancing patient care, we should implement a more effective and efficient system to address these objectives.

To achieve such a system, this paper proposes the following:

1. Creation of Administrative-Judicial Health Courts;

2. Establishment of expert groups to define hazardous medical treatments and procedures.

3. Definition of a "patient" as one undergoing a hazardous medical procedure/intervention.

4. Definition of "extent of injury" based on the medical procedure/intervention.

5. Requirement that all physicians and/or employers of physicians provide payment to a compensation fund for patients (thus replacing the current insurance system).

6. Compensation that is no longer based on negligence, but based on "an event" leading to a patient's loss of earning power, pain and suffering. In other words, compensation that is no longer based on proving a physician's breach of the standard of care, but rather based on the injury in and of itself.

[*81]

7. Compensation correspondingly tied partially to quality: physicians with fewer instances/events pay into the fund less (70%, for example), than those with average instances/events who pay into the fund (100%, for example), and those with numerous awards who pay into the fund (130%, for example).

8. Establish a program that coordinates with existing programs (i.e. the Joint Commission) to increase the quality of provided care with the ultimate goal of future injury prevention.

VIII. Administrative-Judicial Health Courts

Considering the differences between ordinary negligence claims and medical malpractice claims, especially in light of the complexity of medical care, this paper argues that claims for medical malpractice should be removed from the civil justice system entirely. The key to the proposed Health Courts would be their ability to provide a faster, more reliable system of resolving medical malpractice claims with more experienced and focused judges. n143 Specifically, the reasoning behind this argument is similar to arguments made in favor of removing family law cases to specialized courts. n144

New York State has already begun the process of creating specialized courts and programs that "marry administration of the law with adequate [sic] response to society's needs." n145 Its' highly successful Judge-Directed Negotiation program, created in conjunction with the Health and Hospitals Corporation, exemplifies this process. n146 Although one would have anticipated more pushback from the New York Trial Lawyers Association, the fact that the program is lead by visionary judges, including New York Chief Judge Jonathan Lippman, has led to much enthusiasm. n147 As described by the Honorable Douglas E. McKeon, the Judge-Directed Negotiation concept is quite simple:

One judge, well versed in medicine, is assigned to a malpractice action from inception to jury selection. Cases are

analyzed early on as to whether they have the [*82] potential to settle. If the facts warrant settlement (or the discontinuance against a blameless medical provider) even before discovery commences, discussions among the parties are initiated. Each case is closely monitored to reduce court appearances and lower defense costs. n148

Further,

the [Judge-Directed Negotiation] model has, at its core, a rather basic philosophy: If you promote discussion about a case; analyze its legal and medical pros and cons; and create an environment where lawyers view the court as credible, fair, and willing to become actively involved in the settlement process, you will settle cases. [Judge-Directed Negotiation]'s aim is to establish a process where meritorious claims are promptly identified and resolved and, just as importantly, where meritless claims against physicians and health providers are just as promptly identified and resolved. n149

In the traditional adversarial system, almost fifty-four percent of the dollars paid to medical malpractice plaintiffs goes to the attorneys, however specialized programs like judge-directed negotiation will likely be profoundly less expensive, and plaintiffs will likely receive more compensation. n150 Additionally, before patients in the current adversarial system can collect any compensation, blame must be assigned to the physician and thus reported to the NPDB. n151

The success of the Judge-Directed Negotiation Program is demonstrated by a decrease in medical malpractice indemnity costs by 50 million dollars over five years and by wide support, including support from the New York Trial Lawyers Association. n152 Though the Judge-Directed Negotiation Program is in its infancy, as Chief Judge [*83] Lippman has stated, "the eyes of the country are focused on our efforts to improve the administration of justice in medical malpractice litigation ... ." n153

When evaluating a physician's act, medically and/or legally, the Health Court judge or panel that this paper proposes, with guidance from experts, would consider a variety of factors too multifaceted for a jury to consider in a reasonable amount of time, including:

The usefulness and desirability of the intervention/medication;

Safety aspects of the intervention/medication - i.e. the likelihood that it will cause injury, and the probability of it causing serious injury;

The availability of an alternative intervention and or medication;

The physician's ability to eliminate the unsafe character of the intervention without impairing its usefulness or making it too expensive to maintain its utility - i.e. the practicality of the physician avoiding danger by the exercise of care;

The patient's and/or the physician's anticipated awareness of the dangers inherent to the procedure in question;

The physician's history of generating complications in previous patients. n154

To illustrate the use of these factors, imagine again that a fifty year old presents to a gastroenterologist for a screening colonoscopy to prevent colon cancer. After an explanation of the risks and benefits, including bleeding, infection and perforation, the risk of missing significant pathology, and a discussion of alternative methods of screening, the patient consents and undergoes the screening colonoscopy. During the procedure, performed by an experienced, board certified gastroenterologist, a [*84] perforation occurs. n155 The physician quickly recognizes the perforation and immediately has the patient transferred to surgery. Although the surgical correction is performed, there are some further complications, including an infection. Due to the unanticipated surgery, the patient files suit for two months lost work, and pain and suffering.

In this proposal, rather than a trial court judge and jury hearing the case, the case would be transferred or referred to a Health Court. The Health Court judge and/or panel would then consider all the issues described above. In particular the Health Court would consider important issues that separate this case from a typical negligence case. The gastroenterologist, for his part, "would become more comfortable in [his] practice and more open to discussing [his] potential faults with the knowledge that [this and all] malpractice proceedings are handled by specialized administrative judges and neutral expert witnesses who are more likely to understand the gravity of [this] difficult medical [crisis]." n156 Referring to the elements described above, the Court will consider (a) the fact that the procedure is considered lifesaving in preventing colon cancer, recommended by all medical societies, including The U.S. Preventive Services Task Force; n157 (b) that although there are alternative methods to screening, colonoscopy is widely considered the most effective method; (c) the physician has expertise, having performed 8,000 similar procedures with only one other such complication, typical for a gastroenterologist. The Court will recognize that the complication is known, and unavoidable in many cases. n158 After careful consideration, the Health Court will not assign fault to the physician.

After recognizing the lack of fault on the part of the physician, the Health Court can focus on the crucial issue of compensation to the patient. While in this example, two months of lost work and pain and suffering may not appear financially important to [*85] a trial lawyer who is working on a contingency fee basis, the Health Court will consider the actual financial impact on the patient. n159 The Health Court would then determine the compensation owed to the patient from the MCCL Fund. During the proceedings, the Health Court could also consider additional findings, like information about the perforated colon that could increase public safety during a colonoscopy, and then refer those findings to the Department of Health. n160 Thus, the twofold goals of (1) compensating patient injuries and (2) increasing patient safety are met, while managing to avoid inappropriately assigning blame to the physician.

IX. A Constitutional Basis for, and Federal Challenges to, Medical Malpractice Reform

The Constitutional basis for modifying tort on both a federal and state level is complex and evolving. n161 The substantial premise of the proposed Health Court system that is most constitutionally troubling is the avoidance of fault coupled with the absence of juries. n162 A constitutional challenge to a MCCL would likely focus on issues of due process, deprivation of property, and the constitutional right to a civil trial as defined by the Fifth and Seventh Amendments. n163 Forcing physicians to pay into a compensation system for patients could be interpreted as a property taking without due process of the law. n164 If New York State were to enact a MCCL, the law might be challenged on Fourteenth Amendment grounds because the physician would be subjected to "liability" for compensation without regard to any neglect or fault on his part. n165 As such, the [*86] MCCL would likely need to limit the amount of compensation a patient could receive. n166 Such a limitation on compensation might in turn interfere with the patient's rights, as the patient would be barred from receiving full compensation. n167

Proponents of judge-directed negotiation, health courts, and initiatives like the MCCL cite workers' compensation laws, vaccine injury compensation funds, tax courts, and even the National Labor Relations Board. n168 Although each of these programs was built on a different authorizing structure, they utilize a similar adjudication function without the aid of a jury. n169 Under each scheme, the injured party is compensated based on a no-fault legislative provision and is

barred from bringing a tort claim for the injury. n170 Statutory liability has mollified the loss of the common law right of tort for almost a century. n171

Following the unsuccessful constitutional challenges to New York State's Workmen's Compensation Act, the Federal Government similarly began restricting tort actions. n172 In 1937 the Supreme Court upheld the National Labor Relations Act, thus confirming Congress's ability to create separate courts under certain conditions. n173 The National Labor Relations Act creates an adjudicative body, which administers ""public [*87] rights' created by statutory law." n174 The Constitution allows Congress to create certain rights and to establish administrative tribunals to interpret, and in some cases limit, those rights. n175

Congress's ability to implement administrative tribunals to handle disputes outside of the judicial system is not, however, without limits. For instance, Congress may not circumvent the Constitutional right to a jury trial in civil cases by transferring tort, contract, or property cases from civil court to administrative or legislative tribunals. n176 Though state constitutional claims arising from pilot health programs [*88] would not implicate the Seventh Amendment, this constitutional doctrine is useful in delineating between administrative and judicial tribunals. n177 Health Courts may face an uphill battle in removing private medical tort actions from the civil courts, thus circumventing the judicial safeguards embodied within the current system. n178

X. Recent Federal Action to Reform the Tort System

Over the last decade, Congress has acted to introduce reforms to the current liability system in medical malpractice actions. n179 For example, in 2005 Senators Mike Enzi (R-WY) and Max Baucus (D-MT) introduced legislation granting federal money to states for the implementation of specialized health courts. n180 This legislation, the "Fair and Reliable Medical Justice Act," outlines four models for states to use as templates in [*89] devising an alternative for medical malpractice tort claims. n181 The first model includes any proposal that fulfills the goal of being an "alternative to current tort litigation" and meets the following criteria: "(A) makes the medical liability system more reliable through prompt and fair resolution of disputes; (B) encourages the early disclosure of health care errors; (C) enhances patient safety; and (D) maintains access to liability insurance." n182

The Patient Protection and Affordable Care Act (hereinafter "PPACA") also sets out an extensive and demanding list of criteria that states must meet in order to receive funding when creating projects to reform the tort system. n183 To receive funding for the Medical Liability Reform and Patient Demonstration Projects, an eligible state must demonstrate how its project:

(A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

(B) encourages the efficient resolution of disputes;

(C) encourages the disclosure of health care errors;

(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;

(E) improves access to liability insurance;

(F) fully informs patients about the differences in the alternative and current tort litigation;

(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, [*90] including litigation, outside the alternative;

(H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and

(I) would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim. n184

Though the requirements of the demonstration project are demanding, New York State has received such an award based on the initiatives described above. n185

The prohibition against any demonstration project conflicting with state law may bar funding of projects involving practices that are unavailable under existing state law. n186 For example, safe harbor protections against liability for physicians who adhere to specific evidence-based practices would be unavailable for testing in a demonstration project if such protections would require a change in existing state liability rules. n187 Similarly, funding under PPACA would be unavailable for administrative compensation systems that attempt to make the medical tort process more like the workers' compensation process. Such a system, which would enhance the predictability and consistency of awards for injured parties, would also inevitably involve substantial changes in patients' rights to bring traditional medical malpractice lawsuits. n188 Beyond the Medical Liability Reform and Patient Demonstration Projects, the PPACA does little to directly address malpractice litigation, and may in fact lead to an increase in the number of malpractice cases and related costs as its provisions go into effect. n189

[*91]

XI. Current State Programs and Challenges

Some states have already implemented compensation programs and tort reforms. Florida's and Virginia's Birth Injury Compensation Funds are the most analogous to this paper's proposed Health Courts. n190 These two states created programs similar to the Vaccine Injury Compensation Program to handle a very small subcategory of birth injury cases. n191 The programs are no-fault models, removing the burden of proof from the plaintiff in exchange for transferring the claims out of the civil court system. n192 In particular, Florida's model has an important procedural safeguard, allowing claimants to opt-out of the administrative scheme and proceed in civil court under normal litigation rules, provided the claimants were not given notice prior to the delivery of medical care of the physician's participation in the alternative compensation plan. n193 Additionally, the Florida statute also provides for civil actions, "where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property, provided that such suit is filed prior to and in lieu of payment of an award under [the alternative compensation plan]." n194

Challenges to state laws limiting compensation have occurred nationwide and can provide some insight into how the courts might proceed against our proposed MCCL. For example, in a challenge to the Texas Medical Malpractice and Tort Reform [*92] Act (hereinafter "Texas Act"), victims of medical malpractice filed suit against medical providers, seeking a declaratory judgment that the Texas Act violated their constitutional right of access to the courts and the Takings Clause of the Fifth Amendment. n195 The plaintiffs contended the limitation on damages left them without an "adequate, effective, and meaningful remedy at law, and thus violated their constitutional right of access to the courts." n196 The State of Texas intervened to defend the constitutionality of the law. n197 Siding with the State, the district court upheld the law, stating "statutes limiting liability are relatively commonplace and have consistently been enforced by the courts." n198 Considering all relevant factors, the court held that the challenged Texas Act did not deprive the plaintiffs of the entire value of their claim nor did in constitute a taking in violation of the Fifth Amendment. n199

[*93] To avoid challenge, any proposed compensation program must recognize a quid pro quo tradeoff. n200 The program must remove the dispute from the jury, relieve the plaintiff of the burden of proving fault and allow guaranteed compensation if certain conditions are met. State constitutional provisions have been important in determining the validity of damage limitations, and some courts have demanded that the statutory scheme provide an adequate substitute for the malpractice victim's rights and remedies. n201 A few states have specifically emphasized that the quid pro quo must benefit the individual, and not just benefit society in general. n202 The quid pro quo analysis would likely be used

to ratchet up the level of scrutiny from a rational basis test to an intermediate level of scrutiny. n203

XII. MCCL as Hybrid Adjudication

This paper does not propose that the Health Courts become mere administrative bodies that provide compensation without any kind of judicial evaluation of claims. Health Courts should not be created until the sponsors provide concrete assurances that such courts will employ procedures ordinarily used in administrative proceedings. n204 These protections should include the opportunity to do meaningful discovery, to present witnesses, including at least one expert on liability, and to cross- [*94] examine all adverse witnesses including court appointed experts/panels. It is impossible to overstate the importance of these provisions. Without these safeguards, the transfer of medical malpractice claims to a streamlined administrative tribunal will undo a century of judicial reforms designed to ensure that cases are decided on their merits. This level of procedural protection may detract from the time and cost savings hoped for by avid Health Court supporters, but the Health Courts must provide a more in-depth investigative evaluation for patient care events to first and foremost improve patient safety. n205

Furthermore, although the MCCL would partially model itself after a workers' compensation program, the system should seek to avoid many of the problems that exist in the much criticized workers' compensation system. n206 A highly critical Consumer Reports investigation in 2000 found

[Workers' compensation laws] have generated profits for insurers and savings for employers mainly at the expense of injured workers. Those laws clamped down on benefits, raised eligibility requirements, and put medical treatment mainly in the hands of insurance companies, which can delay or deny medical care or income payments. n207

Therefore, this article suggests the MCCL separate itself entirely from an insurance scheme and instead rely on the state-run fund. n208

Discovery in the MCCL system would need to be supervised by the judge or a panel in one of the Health Courts with a good understanding of what documents are needed, including specified medical records, and radiologic and laboratory tests. After discovery, the defendant physician and/or healthcare facility could obtain summary judgment unless the plaintiff provided evidence demonstrating the defendant physician [*95] violated a standard of care. Only after surviving summary judgment would a plaintiff be entitled to a MCCL trial before a judge.

The trial would be segmented, because the court would refer questions about the standard of care to the health panel. This would bring a committee "group think" to the expert stand. Rather than one individual physician and/or other health provider expert, with a financial stake in the process, the health panel committee would be the "expert" responsible for safety and medical care oversight. Panel members would be selected through a nomination process and would include public health officials, judges, and physicians from the community and academic health centers. n209

The goal of this proposed MCCL, namely to provide a speedy resolution and compensation to the injured party, is accomplished in part by recognizing the expertise of the health court judge and/or panel, and by streamlining questions of fact and law. n210 Once the injured party is appropriately compensated, the Health Court could then focus on improving the quality of care and method of delivery provided by the individual physician and health care system in general. n211 Policy considerations suggest that this hybrid scheme provides the best alternative for linking the litigation and regulatory systems. n212

XIII. We Have a Responsibility to Improve the Quality of Care

Our nation's health care providers - physicians, nurses, hospitals, and others - continue to evolve in providing quality life-saving care to millions of Americans. However, the level of quality and efficiency of care provided varies

significantly across [*96] the country. n213 Despite great cost, many physicians do not recognize the importance of quality improvement. n214 In 2008, the United States spent more than seventeen percent of our gross domestic product (hereinafter "GDP") on health care - more than any other industrialized country's per capita spending. n215 By 2017, health expenditures are expected to consume almost 20 percent of GDP, or $ 4.3 trillion annually. n216 While spending is high, our nation ranks low in many areas of quality. n217 Various reports have concluded that our current health care system is not making progress toward improving quality or containing costs for patients or providers. n218 This combination of high spending and lagging quality is unsustainable for patients, businesses, and state and federal governments.

Tens of thousands of Americans - perhaps as many as 98,000 - die each year due to preventable medical errors. n219 The Institute of Medicine has estimated the cost to our economy from preventable errors to approach between 17 and 29 billion dollars. n220 Though the legal system has largely attempted to battle physician error by [*97] introducing a fear of litigation for fault, our tort system is not doing enough heavy lifting in terms of deterrence work. n221 The health courts, judges, and panels in the proposed MCCL must, in the end, also improve patient care and safety. The purpose of such a reform in tort cannot be justified merely because it will provide a more efficient method of compensation to injured patients. The system must also demonstrate an improvement in the quality of care provided. The Health Courts should develop to replace the current adversarial and suspicious relationship between the legal system and health system. The two sides must continuously work together on the common goal: improving patient care.

Driven by initiatives from medical societies, accrediting bodies, government agencies, payers, and trial lawyers, the medical profession has made substantial improvements in patient safety over the last two decades, and the health courts this paper proposes will continue this trend. n222 The health courts should be intimately involved in improving patient care, as the focus shifts from fault-centered to event-centered quality improvement and prevention.

Additionally, the courts will create a protected setting though which information regarding problematic patient care may be collected and analyzed. Information from the health court system, including surveys of facilities and offices, peer review prior to medical events, evaluating for "near misses" and increased communication, will facilitate increased quality of care. n223 As the blame and fault frames recede, physicians and other health care personnel will become more apt to discuss problems, creating an environment of reform throughout the system. Thus, reform of the legal system will translate into a reform in the health care delivery system.

[*98] By removing fault from the equation, perhaps the medical and provider community will have to consider more cases, including these near misses that get pushed under the rug under our current adversarial system. Currently, too few malpractice claims are filed. n224 Only two to three percent of patients injured by medical negligence ever file a claim, and as result, many scholars believe the current legal regime does a poor job of protecting the rights and welfare of injured patients. n225 We thus hope that the health court plan will simplify the claims process by "mandating" disclosure of the plan to patients. We also hope that it will increase the number of claims, thereby improving the system's ability to provide just compensation while also strengthening its deterrent signal.

To touch briefly on deterrence, when a body is developed, such as a health court, to supervise liability, it creates a robust deterrent power. This is best illustrated by the tremendous reduction in anesthesia accidents that occurred at the end of the twentieth century. n226 At the same time, high malpractice premiums and bad publicity prompted the American Society of Anesthesiologists to do a similar intensive study of the causes of anesthesia-related injuries and to develop better protocols. n227 Committees were set up to evaluate the problem, investigate the problem, and determine guidelines to improve patient safety. n228 While not a "health court" in the meaning we ascribe to it, the committees' functions were similar. n229 The improved standards and tools that [*99] resulted from these combined efforts have since become standard across the country. n230 As a result, mortality rates dropped from 1 in 10,000-20,000 to 1 in about 200,000, a ten to twenty-fold improvement. n231 Liability insurance premiums for the specialty of anesthesiology went from being "among the highest in medicine to among the lowest." n232 As demonstrated by the revamping in anesthesiology, an intervention out of the current tort system leading to intense administrative evaluation and implementation, without regard to individual liability, resulted in a broad improvement in patient safety and a decrease

in the need for individual patient compensation.

XIV. Conclusion

This proposed system of medical malpractice is intended to serve two primary objectives: (1) to improve patient safety and (2) to provide compensation to patients injured by substandard care. New York State's two new programs, the Obstetric Indemnity Fund and Judge-Directed Negotiation Program present a successful beginning to a hybrid approach to tort reform. While the programs address economic realities, they adhere to the fundamental right of victims of medical malpractice to be fairly compensated. Recognizing the benefits and limitations to our current health care and legal systems, a transformation is needed in which health care providers and the legal system work in tandem to improve patient-outcomes. When considering the current tort system in light of both patients' and physicians' needs, a system that provides effective remedy without fault would be far more appropriate. Expanding on the ideals and constitutional acceptance of a Workers' Compensation Program, a Medical Care Compensation Law would simultaneously create a fair injury compensation program and a more appropriate forum for the determination of cause. This hybrid system would utilize the best aspects of our current judicial system while assisting physicians, nurses, and other providers by allowing more open discussion of complications and ideas for prevention of injury. In the end, the MCCL would improve patient safety, more readily compensate injured patients, and relieve health care providers' fear of blame, while allowing the judicial system to continue to function as it [*100] currently does. The health care system and legal system would be joined more openly and more effectively, meeting the twin goals of providing injured patients fair and appropriate compensation while improving patient safety and the quality of the delivery of care.

Legal Topics:

For related research and practice materials, see the following legal topics:
Healthcare LawActions Against Healthcare WorkersDoctors & PhysiciansHealthcare LawActions Against Healthcare WorkersSurgeonsTortsMalpractice & Professional LiabilityHealthcare Providers

FOOTNOTES:

n1. See generally Patients or Paperwork? The Regulatory Burden Facing America's Hospitals, The American Hospital Association (Jan. 16, 2014), available at www.aha.org/content/00-10/Final PaperworkReport.pdf?.

n2. See, e.g., id.; 42 U.S.C. § 1320a-7b (1986) (Anti-Kickback Statute). See also 42 U.S.C. § 1395nn (1992) (Stark Law). The Anti-Kickback Statute and the Stark Law both place significant restrictions on compensation arrangements between physicians and other health care providers. 42 U.S.C. § 1320a-7b; § 1395nn.

n3. See The American Hospital Association, supra note 1.

n4. Francis W. Peabody, M.D., The Care of the Patient, 88 JAMA 877 (Mar. 19, 1927) (describing the care of a patient to medical school students). When this paper refers to "actual practice of medicine," we are addressing the time the physician spends interacting with, diagnosing, and treating a patient, rather than, for

instance, transferring paper charts into electronic medical records. See id.

n5. Retirement Policy: The U.S. Population is Aging, Urban Institute Program on Retirement Policy (last visited Apr. 1, 2014), available at http://www.urban.org/retirement_policy/agingpopulation.cfm.

n6. See Bruce Jennings et al., Health Care Quality Improvement: Ethical and Regulatory Issues The Hastings Center 1 (2007), available at http://www.thehastingscenter.org/uploadedFiles/Publications/Special_Reports/Health%20Care%20Quality%20Improvement.pdf. When we refer to increasingly voluminous and complex patient care, we do not mean in the actual practice of medicine but instead in converting paper records to electronic medical records (hereinafter "EMRs"). Id.

n7. U.S. Const. amend. VI. The Sixth Amendment grants the right to a jury trial in criminal prosecutions. In suits where money damages are not claimed (e.g. suits in equity/civil suits), the Seventh Amendment does not ensure a jury trial. U.S. Const. amend. VII. See also Dialogue on the American Jury: We the People in Action, Part 1 The History of Trial by Jury, The American Bar Association 4, available at http://www.americanbar.org/content/dam/aba/migrated/jury/moreinfo/dialoguepart1.authcheckdam.pdf.

n8. Tom Baker, The Medical Malpractice Myth 1-14 (2005).

n9. See Thomas L. Hafemeister and Joshua Hinckley Porter, The Health Care Reform Act of 2010 and Medical Malpractice Liability: Worlds in Collision or Ships Passing in the Night?, 64 SMU L. Rev. 735, 744 (2011) (citing Press Release, U.S. Dep't of Health & Human Servs., HHS Announces Patient Safety and Medical Liability Demonstration Projects (June 11, 2010), available athttp://wayback.archiveit.org/3926/20131018160737/http://www.hhs.gov/news/press/2010pres/06/20100611a.html).

[In fact, t]he Department of Health and Human Services (hereinafter "DHHS") and the Agency for Healthcare Research and Quality (AHRQ) today announced the grants to support efforts by States and health systems to implement and evaluate patient safety approaches and medical liability reforms. The demonstration and planning grants are part of the Patient Safety and Medical Liability Initiative ... . The President directed the Secretary of HHS to help States and health care systems test models that"(1) put patient safety first and work to reduce preventable injuries'; (2) "foster better communication between doctors and their patients'; [and] (3) "ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and (reduce liability premiums).

Id. Thus, it is not only doctors and patients who are ready for a change in how we handle malpractice -it is also our government. Id. This paper acknowledges the implicit necessity for injured patients to file lawsuits in our

current, broken medical malpractice system because they must do so just to find out whether or not their treating physician committed negligence in the course of their treatment. See Baker, supra note 8, at 91 (2005). "Patients and their lawyers often have to file a lawsuit in order to find out whether the treatment was proper." Id. This paper further acknowledges that most medical malpractice lawsuits today are not frivolous. Instead, this paper recommends changing the system so that an injured patient does not need to file a lawsuit in order to discover whether or not his or her physician committed malpractice.

n10. See generally Michael J. Saks, Medical Malpractice: Facing Real Problems and Finding Real Solutions, 35 Wm. & Mary L. Rev. 693 (1994) (reviewing Paul C. Weiler et al Medical Malpractice: Facing Real Problems and Finding Real Solutions (1993)).

n11. Id. at 694.

n12. Douglas E. McKeon, New York's Innovative Approach to Medical Malpractice, 46 New Eng. L. Rev. 475, 483 (2012).

n13. Id.

n14. See Baker supra note 8, at 3, 23.

n15. Id.

Most people [injured by medical malpractice] do not sue, which means that victims - not doctors, hospitals, or liability insurance companies - bear the lion's share of the costs of medical malpractice ... . Depending on how we count, there are between seven and twenty-five serious medical malpractice injuries for every one medical malpractice lawsuit.

Id.

n16. See Jeremy Coylewright, No Fault, No Worries ... Combining a No-Fault Medical Malpractice Act With a National Single-Payer Health Insurance Plan, 4 Ind. Health L. Rev. 31, 38 (2007).

n17. See Dianna Furchtgott-Roth, Reduce the High Cost of Medical Malpractice, Reuters (Aug. 6, 2009), http://blogs.reuters.com/great-debate/2009/08/06/reduce-the-high-cost-of-medical-malpractice/.

An average of 10 cents out of every dollar [a patient] pays goes to the malpractice insurance doctors must have to protect themselves in case a patient sues them. Malpractice premiums cost some doctors many tens of thousands of dollars a year, not because an individual doctor has a history of making mistakes, but because in some states juries make excessively generous awards knowing that insurance companies pay.

Id.

n18. See generally William Glaberson, To Curb Malpractice Costs, Judges Jump in Early, N.Y. Times (June 12, 2011), http://www.nytimes.com/2011/06/13/nyregion/to-curb-malpractice-costs-judges-jump-in-early.html?pagewanted=all&_r=0. "Under the New York program, cases are assigned from their earliest stages to a judge with training in medical issues who holds frequent settlement conferences, often after months, rather than years. A nurse with legal training helps the judge. Lawyers are required to have the authority to settle." Id. The Judge-Directed Negotiation Program:

Is driven by the notion that because medicine is a highly specialized field, medical malpractice cases should be handled by judges who have received special training relevant to medicine-related lawsuits so as to be better able to evaluate the merits of these cases ... Judge-Directed Negotiation has been reported to increase the rate at which medical malpractice cases settle, decrease the average time it takes to resolve cases, and reduce the overall cost of those cases.

Hafemeister & Porter, supra note 9, at 747-48 (citing Gale Scott, Med Mal Cases Get Expert Hearings: Bronx System Uses Judges, Not Juries, Streamlines Costly Process, Crain's N.Y. Business (Aug. 22, 2010), http://www.crainsnewyork.com/article/20100822/SUB/308229981); see also Paul Barringer, Health Courts: A Better Approach to Malpractice Reform, 14 BNA's Health Law Reporter 877 (2005); Michelle P. Mello et al., "Health Courts" and Accountability for Patient Safety, 84 Milbank Quarterly 459, 460 (2006); Glaberson, supra 18, at A1.

Under a $ 3 million federal grant, the city courts are now expanding the [Judge-Directed Negotiation] program beyond [the] Bronx, where it started in cases against city hospitals, to courts in Brooklyn and Manhattan, as well as to cases against private hospitals. It is to begin in Buffalo courts in the fall [of 2011].

Id.

n19. Glaberson, supra note 18, at A1. Workers' compensation laws generally guarantee that an employee who is injured in the course of his or her employment receives a monetary award, thus avoiding the need for the employee to bring suit against his or her employer. See History of the New York State Workers' Compensation Board, New York State Workers' Compensation Board, http://www.wcb.ny.gov/content/main/TheBoard/history.jsp (last visited Apr. 1, 2014). In New York, Workers' Compensation is guaranteed statutory insurance that benefits those who are injured on the job, but removes the right to sue the employer in tort. See N.Y. Workers' Comp. Law § 67 (McKinney 2013). Employees may not recover for pain and suffering, and may not recover punitive damages against the employer. See id. In fact, it does not matter at all whether the accident was inevitable. See id. If the employee was injured, he or she may collect workers' compensation. See id. The workers' compensation law does not cover teachers or non-manual laborers who work in religious, nonprofit, or educational settings. See id. Domestic employees such as babysitters and housekeepers may not collect either. See id. With a few exclusions most injuries are covered, and the employee may sue in tort a third party whose conduct may have contributed to that employee's injury. See N.Y. Workers' Comp. Law § 67 (McKinney 2013); infra Part IX (discussing the Seventh Amendment); N.Y. Cent. R.R. v. White, 243 U.S. 188 (1917). The Health Courts that this paper proposes would ultimately take away the structure of a jury, which in practice would be the most difficult part of establishing our MCCL system. Often in its Seventh Amendment jurisprudence, the Supreme Court has relied on a public right/private right distinction, stating that the Seventh Amendment does not allow Congress and/or state legislatures to assign adjudication of a private right that is legal in nature to an administrative agency or specialized court without juries. Although Seventh Amendment rights are not wholly applicable to state health court programs (as they currently stand), the distinction between the types of right at issue is informative. So, an alternative to allowing claims to proceed in federal and state courts is to refer certain issues to a Health Court or Panel for resolution. The primary jurisdiction doctrine would require a court to stay (or dismiss) an action so as to defer to agency determination of an issue (or a claim) in appropriate cases. The rationales for deference to the Health Court or Panel may include a need for a uniform determination of an issue, as well as recognition of superior panel expertise, particularly with respect to specialized facts within the medical field. See infra Part IX (discussing the Seventh Amendment and its jurisprudence); U.S. Const. amend. VII.

n20. See History of the New York State Workers' Compensation Board, New York State Workers' Compensation Board, http://www.wcb.ny.gov/content/main/TheBoard/history.jsp (last visited Apr. 1, 2014). One of the main reasons New York developed a Workers' Compensation Board was because when an injured employee sued his employer in the courts, the employer - who likely had better representation - could successfully allege the injury occurred because of the worker's or another worker's negligence. Id.

n21. See, e.g., Sonny Bal, An Introduction to Medical Malpractice in the United States, 467(2) Clinical Orthopaedics and Related Research 339 (2009). "Preparation and prosecution of a medical negligence lawsuit can cost more than $ 100,000; this amount reflects the financial risk assumed by the plaintiff's attorney in return for the probability of settlement or a favorable verdict." Id.

n22. See A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation 16 (Paul C. Weiler, ed., 1993) (noting flaws in malpractice system that leave injured patients without needed compensation if physician faultless). See also Baker, supra note 8, at 15.

n23. See discussion infra Part IV. However, some physicians will be found to truly be at fault in their delivery of patient care. Thus, the term "no-fault" used above can be somewhat misleading. We use "no-fault" as one of our main descriptive terms for our Health Court proposal to avoid the constitutional hurdle associated with removing long-standing common law remedies from the civil justice system without any compromise or quid pro quo.

n24. See discussion infra Part XII.

n25. See Weiler, supra note 22, at 14 (defining well-established common law principles of medical malpractice law). See also 5 Litigating Tort Cases General Theories of Liability § 61.25 (2013) (highlighting variety of areas to find negligence in medical malpractice cases).

n26. See discussion infra Parts III.

n27. See discussion infra Part III.

n28. See discussion infra Part II.

n29. See discussion infra Parts III.

n30. See discussion infra Parts IV through VI.

n31. See discussion infra Parts VII, VIII and XII.

n32. See discussion infra Parts IX through XI.

n33. See Paul Raymond Gurtler, The Workers' Compensation Principle: A Historical Abstract of the Nature of Workers' Compensation, 9 Hamline J. Pub. L. & Pol'y 285, 285 (1989). Workers' Compensation insurance premiums are passed on in the increased cost of the product. Id.

n34. See Price V. Fishback and Shawn Everett Kantor, The Adoption of Workers' Compensation in the United States, 1900 - 1930, 41 J. Law & Econ. 305, 315-320 (1998) (discussing the origins of workers' compensation laws as introduced by various state legislatures).

n35. Arthur Larson & Lex K. Larson, Larson's Workers' Compensation Law § 2.00 (2006).

n36. Gregory P. Guyton, A Brief History of Workers' Compensation, 19 Iowa Orthop. J. 106, 107 (1999), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1888620/

n37. Fishback, supra note 34.

n38. Guyton, supra note 36, at 107. "The state-administered Prussian system also established an important precedent: it was regarded as an "exclusive remedy' to the problem of workers' compensation, employers under the system could not be sued through the civil courts by employees." Id.

n39. See Michael L. Rustad and Thomas H. Koenig, Article: Taming the Tort Monster: The American Civil Justice System as a Battleground of Social Theory, 68 Brook. L. Rev. 1, 25 - 29 (2002) (exploring explosion of torts during the nineteenth century resulting from accidents stemming from rapid industrialization).

n40. See Larson, supra note 35, at § 67.

n41. See generally Emily A. Spieler, Perpetuating Risk? Workers' Compensation and the Persistence of Occupational Injuries, 31 Hous. L. Rev. 119, 168 - 181 (1994) (explaining initial problems with employer liability statutes).

n42. Black's Law Dictionary (9th ed. 2009). Specifically, "respondeat superior' is "the doctrine holding an employer or principal liable for the employee's or agent's wrongful acts committed within the scope of the employment or agency." Id. One of the defenses available, "assumption of risk', is "1. The act or an instance of a prospective plaintiff's taking on the risk of loss, injury, or damage. 2. The principle that one who takes on the risk of loss, injury, or damage cannot maintain an action against a party that causes the loss, injury, or damage." Id. "Contributory negligence doctrine" is "the principle that completely bars a plaintiff's recovery if the damage suffered is partly the plaintiff's own fault." Id.

n43. See Guyton, supra note 36, at 106 (providing history of worker's compensation law). The first comprehensive worker's compensation statute was passed in Wisconsin in 1911. Id. Forty-five states followed suit by the end of the decade. Id. The final state to adopt a worker's compensation law was Mississippi in 1948. Id.; see Gurtler, supra note 33, at 285 (noting most United States compensation laws were passed between 1911 and 1920).

n44. Eleanor D. Kinney, What Does New Theory Contribute to the Evolution of the Tort of Medical Malpractice?, Iowa L. Rev. Bull. 97, 115-121 (2012) (comparing Industrial Revolution's injured workers to current victims of medical malpractice).

n45. See Larson, supra note 35, at § 2.01 (discussing the primitive law of workers' compensation).

n46. See, e.g., N.Y. Cent. R.R. v. White, 243 U.S. 188 (1917) (upholding state constitutional amendment mandating workers compensation benefits permissible under federal law); Pedersen v. Delaware, L. & W. R. Co., 229 U.S. 146 (1913) (defining and upholding Minnesota's Employers' Liability Act); Louisville & N.R. Co. v. Melton, 218 U.S. 36 (1910) (upholding Indiana's Employers' Liability Act and defining work-related injury); Minnesota Iron Co. v. Kline, 199 U.S. 593 (1905) (upholding constitutionality of Minnesota's workers compensation law). See also Alan Pierce, Workers' Compensation in the United States: The First 100 Years, LexisNexis (Feb. 9, 2014), available at http://www.lexisnexis.com/legalnewsroom/workers-compensation/b/workers-compensation-centennial/archive/2011/03/14/worke (discussing the early history of workers' compensation laws in the United States).

n47. See Larson, supra note 35, at § 4 (detailing underlying philosophy of worker's compensation laws).

n48. See Gurtler, supra note 33, at 293-94 (defining worker's compensation as a social benefit). See also

Larson, supra note 35, at § 1.03 [2] (detailing underlying social philosophy of worker's compensation law).

The ultimate social philosophy behind compensation liability is [the] belief in the wisdom of providing, in the most efficient, most dignified, and most certain form, financial and medical benefits for the victims of work-connected injuries which an enlightened community would feel obliged to provide in any case in some less satisfactory form, and of allocating the burden of the payments to the most appropriate source of payment, the consumer of the product.

Id.

n49. Arthur Larson, The Nature and Origins of Workmen's Compensation, 37 Cornell L.Q. 206, 208 (1952).

n50. See Larson, supra note 35, at § 1.03[1] (stating right to compensation depends on whether injury was work-related).

n51. Jules Coleman and Gabriel Mendlow, Theories of Tort Law, The Stanford Encyclopedia of Philosophy (Fall 2010), available at http://plato.stanford.edu/entries/tort-theories/#OveTorLawTorThe (outlining fault liability as basic tenant of tort law). See Guyton, supra note 36, at 109-110 (outlining requirement that injury be work-related and nuances found therein).

n52. See Larson, supra note 35, at § 1.03 (stating contrast between worker's compensation law and tort law).

n53. 155 N.Y. 201 (1898).

n54. Janice Kabel, Medical Malpractice Damage Awards: The Need for a Dual Approach, 11 Fordham Urb. L.J. 973, 973 n.1 (1982) (citing Pike, 155 N.Y. at 209).

n55. See Neal C. Hogan, Unhealed Wounds: Medical Malpractice in the Twentieth Century xii (2002). "[Since] the twentieth century, virtually all malpractice actions have been tortious actions predicated on the legal concept of negligence ... . Under tort law a physician is held responsible for his negligence in performing a procedure if that negligence results in harm to the patient." Id.

n56. See Kandy G. Webb, Comment: Recent Medical Malpractice Legislation - A First Checkup, 50 Tul. L. Rev. 655, 655-56 (1976). Webb asserts:

The first tier and the root cause of the medical malpractice problem as identified by a massive government study commissioned by the Department of Health, Education, and Welfare is that adverse results inevitably occur during the course of medical treatment. These iatrogenic injuries (those induced during treatment) may or may not be caused by the negligence of someone in the health-care hierarchy, but arise regularly because medical technology, though highly sophisticated, has yet to overcome all untoward effects of drugs and surgical procedures. Whether or not due care has been exercised by the health-care provider, a patient injured during treatment often desires recompense.

Id. This paper excludes discussion of truly careless and/or reckless physicians and especially any who intentionally commit malpractice. See id.

n57. See AMA Mission & Guiding Principles, American Medical Association, http://www.ama-assn.org/ama/pub/about-ama/our-mission.page? (last visited Jan. 14, 2014). The mission of the AMA is "to promote the art and science of medicine and the betterment of public health." Id. See also Fed. Trade Comm'n, Improving Health Care: A Dose of Competition 2 (2004) (emphasizing recent innovative improvements in American medical technology, pharmaceuticals and overall health care). "At its best, American health care is the best in the world." Id.

n58. See Jacqueline R. Bau, Medical Malpractice Arbitration: A Patient's Perspective, 61 Wash. U. L. Rev. 123, 126 (1983) (noting increased sophistication in health care technology produces increased risks); Mark A. Healey, MD et al., Complications in Surgical Patients, 137 JAMA 611, 616 (2002), available at http://archsurg.jamanetwork.com/article.aspx?articleid=212419#RESULTS (arguing "patients with ... underlying physiologic derangement or multiple comorbidities may develop complications despite optimal care"). Undergoing medical procedures and treatments pose both unavoidable risks and benefits to patients. See Medical Procedures, Better Health Channel, http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Medical_procedures (last updated Dec. 3, 2012). See also Cass R. Sunstein, Cognition and Cost-Benefit Analysis, 29 J. Legal Stud. 1059, 1059 (2000) (arguing cost-benefit analysis is justified on economic and cognitive grounds). From an economic point of view, cost-benefit analysis prevents inefficiency, and from a cognitive stance, cost-benefit analysis counteracts predictable poor judgments by individuals and society. Id.

n59. See Cong. Budget Office, The Economics of U.S. Tort Liability: A Primer 21 (2003) (asserting current tort system is inefficient).

n60. See supra note 59 and accompanying text. See also Paul C. Weiler, The Case for No-Fault Medical Liability, 52 Md. L. Rev. 908, 912-14 (1993) (highlighting various problems under current medical malpractice regime). There is a litigation gap in medical care cases because although more torts occur than tort claims filed, of those malpractice claims filed, most do not involve negligent medical treatment. Id. at 913. Moreover, though juries tend to award large damages when they are convinced there was negligence, on average patients only win one-third of jury verdicts. Id. at 914.

n61. This article refers to these relationships as "tainted" because there is an adversarial threat to every health care provider-patient relationship.

n62. See, e.g., N.Y. Workers' Comp. Law § 10 (McKinney 2011). "Every employer ... shall ... secure compensation to his employees and pay or provide compensation for their disability or death from injury arising out of and in the course of the employment without regard to fault as a cause of the injury ... ." Id. Thus, generally, "no-fault" is defined as "of or relating to a claim that is adjudicated without any determination that a party is blameworthy." Black's Law Dictionary (9th ed. 2009).

n63. See N.Y. Cent. R.R. v. White, 243 U.S. 188, 201 (1917).

If the [injured] employee is no longer able to recover as much as before in case of being injured through the employer's negligence, he is entitled to moderate compensation in all cases of injury, and has a certain and speedy remedy without the difficulty and expense of establishing negligence or proving the amount of damages.

Id. See also Amy Widman, Why Health Courts Are Unconstitutional, 27 Pace L.Rev. 55, 55 (2006).

n64. National Institutes of Health, Abstract: The National Practitioner Data Bank: An Introduction, PubMed.gov, http://www.ncbi.nlm.nih.gov/pubmed/1620402 (last visited Apr. 1, 2014) (discussing physician anxiety); see Office of Inspector Gen., National Practitioner Database: Usefulness and Impacts of Reports to State Licensing Boards (1993), available at https://oig.hhs.gov/oei/reports/oei-01-90-00523.pdf (discussing fears). See also U.S. Department of Health and Human Services, About Us, The National Practitioner Data Bank, http://www.npdb-hipdb.hrsa.gov/topNavigation/aboutUs.jsp (last visited Apr. 1, 2014). The NPDB is "a confidential information clearinghouse created by Congress with the primary goals of improving health care quality, protecting the public, and reducing health care fraud and abuse in the U.S." Id.

n65. See Charles L. Bosk, Forgive and Remember: Managing Medical Failure 138-39 (Univ. of Chicago Press, 2d ed., 1979).

n66. See supra notes 8-10 (discussing causes of malpractice litigation and need for reform).

n67. See Larson, supra note 35, at § 1.04[2].

n68. See supra note 50 and accompanying text (discussing no-fault workers' compensation scheme).

n69. See Gaurav Arora et al., Risk of Perforation From a Colonoscopy in Adults: A Large Population-Based Study, 69 Gastrointestinal Endoscopy 654, 654 (2009), available at http://www.ncbi.nlm.nih.gov/pubmed/19251006.

n70. Lukejohn W. Day et al., Adverse Events in Older Patients Undergoing Colonoscopy: A Systematic Review and mMeta-Analysis, 74 Gastrointestinal Endoscopy 885, 885 (2011), available at http://www.ncbi.nlm.nih.gov/pubmed/21951478. In many cases, due to a patient's unusual anatomy or idiosyncratic responses, the injuries a patient sustains are the result of what we term "involuntary contributory negligence." See id. For the purposes of this paper, the term "involuntary" refers to the patient's anatomy and/or physiology contributes to his or her injury. Consider, for example, the colonoscopic perforation in the setting of a patient with severe diverticulosis. See Arora, supra note 69 at 660.

n71. Fed. R. Civ. P. 8(d)(2). "A party may set out 2 or more statements of a claim or defense alternatively or hypothetically, either in a single count or defense or in separate ones. If a party makes alternative statements, the pleading is sufficient if any one of them is sufficient." Id.

n72. See supra notes 69-70 and accompanying text (discussing inherent risks in certain procedures).

n73. See Edward L. Raab, The Parameters of Informed Consent, 102 Transactions of the Amer. Ophthalmological Soc'y 225, 226 (2004); see also supra note 42 (defining assumption of risk).

n74. See Raab, supra note 73. The Hippocratic Oath requires primum non nocere ("first, do no harm").

Ludwig Edelstein, The Hippocratic Oath: Text, Translation, and Interpretation, in Cross-Cultural Perfectives in Medical Ethics 49 (Robert M. Veatch ed., 1989).

n75. Baker, supra note 8 at 174. The physicians that we use in all of our examples are properly trained and do not make egregious and/or intentional errors. Thus, this paper agrees with Tom Baker in his argument that we are not "ready to give up on a fault-based system for health-care providers who ... do awful things to hide their mistakes." See id.

n76. Vincent Liu, Error in Medicine: The Role of the Morbidity and Mortality Conference, Virtual Mentor, Ethics J. Amer. Med. Ass'n, Vol. 7, No. 4 (April 2005), available at http://virtualmentor.ama-assn.org/2005/04/pdf/msoc1-0504.pdf (arguing learning from mistakes is more important than assigning blame for patient care).

n77. Nancy Epstein, Morbidity and Mortality Conferences: Their Educational Role and Why We Should Be There, Surgical Neurology Int'l. 3 (Suppl. 5) S377, 20 (2012). Moreover, similar post-accident conferences are not protected or privileged from suit in tort within airline or pharmaceutical companies, for example. Id. at 29. These conferences thus hold a special place in the practice of medicine. Id.

n78. Baker, supra note 8, at 90-91.

n79. 42 U.S.C. § 300aa-11, st seq. (2012). The National Vaccine Injury Compensation Program allows injured vaccine recipients to petition for compensation without demonstrating the administering physician's liability. Id.

n80. Id.

n81. 42 U.S.C. § 300aa-10 et seq.

n82. Id.

n83. Id.

n84. Id.

n85. Vaccine Injury Table, U.S. Dep't of Health and Human Servs.: Health Resources and Servs. Admin., http://www.hrsa.gov/vaccinecompensation/vaccineinjurytable.pdf (last visited Feb, 8, 2014).

n86. See, e.g., National Vaccine Injury Compensation Program, U.S. Dep't of Health and Human Servs.: Health Resources and Servs. Admin., http://www.hrsa.gov/vaccinecompensation/index.html (last visited Apr. 1, 2014).

n87. Stephen D. Sugarman, Cases in Vaccine Court - Legal Battles Over Vaccines and Autism, 357 N. Engl. J. Med. 1275, 1275 (2007). Though many of the claims of injury - such as autism - relied on poor scientific data, and despite the fact that the majority of expert medical opinions felt the vaccines were safe, suits against vaccine manufacturers resulted in large awards. Id.

n88. See Vanessa Lu, Using Medical Liability Tort Reform to Improve Patient Care, 19 Annals Health L. 316, 316 (2010), available at http://www.luc.edu/media/lucedu/law/centers/healthlaw/pdfs/advancedirective/pdfs/issue4/lu.pdf. "Doctors have responded to rising liability insurance rates by giving up high-risk practices, limiting their practice to minimal litigation risk areas, or moving to states that enforce caps on liability." U.S. Dep't of Health & Human Servs., Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System 1, (2002), http://aspe.hhs.gov/daltcp/reports/litrefm.htm (last visited Feb. 8, 2014).

n89. See Elizabeth C. Scott, The National Childhood Vaccine Injury Act Turns Fifteen, 56 Food and Drug L.J. 351, 359 (2001). As of 2001, seventy-five percent of claims against vaccine manufacturers were denied after long and contentious legal battles taking an average of three to five years to resolve. Id. at 358-59.

n90. See Sugarman, supra note 87, at 1276.

n91. Id.

n92. See Restatement (Second) of Torts § 328D (1965). Where the actual or specific cause of an accident is unknown, under the doctrine of res ipsa loquitur, a jury may, in certain circumstances, infer negligence merely from the happening of an event and the defendant's relation to it. Id. Res ipsa loquitur "simply recognizes what we know from our everyday experience: that some accidents by their very nature would ordinarily not happen without negligence." Dermatossian v. N.Y.C. Transit Auth., 492 N.E.2d 1200, 1204, (N.Y. 1986).

Res ipsa loquitur is an evidentiary rule that, in New York, permits an inference of negligence solely because of the happening of an unusual or extraordinary occurrence. Thus, res ipsa loquitur permits a jury to infer negligence based upon circumstantial evidence. Res ipsa loquitur is often used to establish liability in medical malpractice actions when causation is difficult to prove. A plaintiff may show specific acts of negligence and also rely on res ipsa loquitur to establish a prima facie case.

Lee S. Kreindler et al., N.Y. Law of Torts, § 13:24 (2013) (citing Dermatossian, 492 N.E.2d at 1204). See also Kerber v. Sarles, 542 N.Y.S.2d 94, 95 (1989); Abbott v. New Rochelle Hosp. Med. Ctr., 529 N.Y.S.2d 352, 353 (1988); Fogal v. Genesee Hosp., 41 A.D.2d 468 (4th Dep't 1973).

n93. Kreindler, supra note 92.

n94. Kambat v. Saint Francis Hosp., 678 N.E.2d 456 (N.Y. 1997).

n95. Id. at 457.

n96. Id. A "laparotomy pad' is a rectangular pad made from several layers of gauze used as a sponge to control the viscera in operations on the abdomen, and is sometimes referred to as an "abdominal pad." In August 1986 Ralph Sperrazza, a physician, performed an abdominal hysterectomy on a patient, Florence Fenzel, at Saint Francis Hospital. Id. During the surgery, Dr. Sperrazza placed ten laparotomy pads, which were available and marked for the operation, in the decedent's peritoneal cavity. Throughout the procedure, the patient remained unconscious. Id.

n97. Kambat, 678 N.E.2d at 457.

n98. Id. In fact, this finding was so unforeseen that a photographer was called to the hospital to document it. Id.

n99. Id.

n100. Id. at 457-58. An expert for the defendants actually testified that the patient orally consumed the pad in an act of depression. Id. The expert claimed that the pad eroded from the bowel into the peritoneum. Kambat, 678 N.E.2d.at 458. At this time the costs, both monetary and emotional of the litigation, are unknown.

n101. See Holly Piehler Rockwell, What Patient Claims Against Doctor, Hospital, or Similar Health Care Provider Are Not Subject to Statutes Specifically Governing Actions and Damages for Medical Malpractice, 89 A.L.R.4th 887, § 2[b] (1991).

n102. Id. at § 5[c].

n103. Kambat, 678 N.E.2d at 457.

n104. See Rockwell, supra note 101, at § 2[a] (stating that each state has medical malpractice statutes with different requirements). For example, a hospital would have to investigate at the administrative level, at the departmental level in morbidity and mortality conferences, and at the departmental chair level to determine if the surgeon may continue to have surgical privileges.

n105. The Journal's Editorial Staff, A National Survey of Medical Error Reporting Laws, 9 Yale J. Health Pol'y, L. & Ethics 201, 203-05 (2009) (describing trend among states adopting medical error reporting statutes). Today, more than half of states require reporting of medical errors, but chronic underreporting hampers any goal to reduce the total number of errors. John R. Grout et al., Mistake-Proofing Medicine: Legal Considerations and Healthcare Quality Implications, 14 Minn. J.L. Sci. & Tech. 387, 409-10 (2013).

n106. See F. Patrick Hubbard, The Nature and Impact of the "Tort Reform" Movement, 35 Hofstra L. Review 437, 449-50 (2006) (outlining tort law's inherent inefficiencies in spreading losses).

n107. Hubbard, supra note 106, at 464, 468-69 (describing common defenses to medical malpractice claims).

n108. See Kambat, 678 N.E.2d at 456.

n109. Amy Adams, RFID Chips Can Help Surgeons Avoid Leaving Sponges Inside Patients, Study Finds - CHP/PCOR, Stanford University Center for Health Policy/Center for Primary Care and Outcomes Research, July 18, 2006, http://healthpolicy.stanford.edu/news/rfid_chips_can_help_surgeons_avoid_leaving_sponges_inside_patients_study_finds_20060

n110. Verna C. Gibbs, Retained Surgical Items and Minimally Invasive Surgery, 35(7) World J. Surg. 1532, 1533 (2011). This rate may seem high, but every surgeon either knows someone who has had a retained item event or has personally had to address the problem of miscounts in the operating room. Id. In the United States, more than 6,000 hospitals house operating and procedure rooms with an estimated 45-million inpatient procedures performed annually. Id.

n111. Stanislaw P. Stawicki, M.D. et al., Retained Surgical Foreign Bodies: A Comprehensive Review of Risks and Preventive Strategies, 98(1) Scand. J. Surg. 8-17 (2009).

n112. Thomas H. Gallagher, M.D. et al., Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors, 289(8) J.A.M.A 1001 (2003).

n113. See Gibbs, supra note 110, at 1532 (describing No Thing Left Behind initiative).

n114. See generally id. at 1532-39 (describing inherent risk associated with medical care and procedures).

n115. See Catherine Reenaers et al., Impact of Medical Therapies on Inflammatory Bowel Disease Complication Rate, 18(29) World J. Gastroenterology 3823 (2012) (determining best therapy for inflammatory

bowel disease complications).

n116. See Restatement (Second) of Torts § 520 (1977).

n117. Id. The Restatement uses the term, "abnormally dangerous," this article uses "inherently dangerous" for consistency purposes.

n118. Id.

n119. See supra notes 69-70 (providing examples of procedures which provide additional risk to certain patients). When we refer to a patient's "contribution," we do not mean that he has purposefully injured himself, but rather we mean whether his physical state: his age, and/or his proclivity to disease, illness, and/or injury, is such that he effectively "contributes" to his injury.

n120. See, e.g., McKay v. Bankers Life Co., 187 N.W.2d 736, 740 (Iowa 1971).

n121. See Restatement (Second) of Torts § 520 (1977); supra note 118 and accompanying text (identifying the factors).

n122. Miller v. Westcor Ltd. P'ship, 831 P.2d 386, 391 (Ariz. Ct. App. 1991).

n123. Id.

n124. Id.

n125. See id.; see also Klein v. Pyrodyne Corp., 810 P.2d 917 (Wash. 1991).

n126. See Klein, 810 P.2d at 922.

n127. Siegler v. Kuhlman, 502 P.2d 1181, 1185 (Wash. 1972).

n128. Laura Joszt, States with the Largest Medical Malpractice Payouts, Physician's Money Digest (May 15, 2013), http://www.hcplive.com/physicians-money-digest/practice-management/States-with-the-Largest-Medical-Malpractice-Payouts-L

n129. See, e.g., Ben Harder, 5 Cities With Tons of Top Hospitals, U.S. News and World Report (July 16, 2013), available at health.usnews.com/health-news/best-hospitals/articles/2013/07/16/5-cities-with-tons-of-top-hospitals. Harder states, "No metro area can top New York City, with two hospitals on the Best Hospitals Honor Roll and 55 U.S. News-ranked hospitals within its metro area." Id.

n130. See McKeon, supra note 12 at 477-78. Malpractice costs include malpractice insurance premiums, litigation costs (e.g. legal fees, expert witness fees, etc.), and compensatory damages (including lost wages, medical expenses, and damages for physical and psychological harm). Id.

n131. See id.; see also Mendez v. N.Y. & Presbyterian Hosp., 934 N.Y.S.2d 662, 665-66 (N.Y. Sup. Ct. 2011). The court stated that "on December 1, 2009 by Lisa Kramer, President and CEO of Hospitals Insurance Company, Inc. (HIC) before the New York State Senate Standing Committee on Insurance, Health and Codes." Mendez, 934 N.Y.S.2d at 665-66; Excellus, The Facts About New York State Medical Malpractice Coverage Premiums 1 (2012-2013), https://www.excellusbcbs.com/wps/wcm/connect/b7cdbf66-dd6b-4fb0-9612-47112e93c9f7/Med+Malpractice+FS+2013-EX+FINAL.pdf?MOD=AJPERES&CACHEID=b7cdbf66-dd6b-4fb0-9612-47112e93c9f7.

n132. N.Y. Pub. Health Law§§2999-g - 2999-j (McKinney 2014). McKeon states, "New York's Fund is mandatory and only available to those qualifying health providers who have resolved a lawsuit, either by settlement or judgment ... . In fact, New York's Fund does not restrict a litigant's right to sue - it requires it." McKeon, supra note 12, at 478. McKeon referenced Daniel S. Ratner's article, "New York State's New Medical Indemnity Fund," which stated that a plaintiff must bring a law suit and either prevail or settle to be eligible for payment from the Medical Indemnity Fund. See Daniel S. Ratner, New York State's New Medical Indemnity Fund, Martindale (Aug. 11, 2011), http://www.martindale.com/medical-malpractice-law/article_Heidell-Pittoni-Murphy-Bach-LLP_1328126.htm.

n133. See Mendez, 934 N.Y.S.2d at 666. The court concluded:

Hence, the creation of an obstetrical fund was an obvious vehicle by which to achieve the Governor's dual objective of reducing both Medicaid costs and medical malpractice premiums while, on a human level, providing a lifetime of guaranteed care, geared to obstetrical mishap victims, as well as the comfort which comes to a parent by the knowledge that help will be provided to a handicapped child when mom and dad are gone.

Id.

n134. See N.Y. Pub. Health Law § 2999-g (stating fund's purpose is to provide resources for health costs related to neurological birth injuries). See also Mendez, 934 N.Y.S.2d at 666 (citing testimony revealing large percentages of birth injury related malpractice suits).

n135. N.Y. Pub. Health Law § 2999-h.

Qualifying health care costs' means the future medical, hospital, surgical, nursing, dental, rehabilitation, custodial, durable medical equipment, home modifications, assistive technology, vehicle modifications, prescription and non-prescription medications, and other health care costs actually incurred for services rendered to and supplies utilized by qualified plaintiffs, which are necessary to meet their health care needs as determined by their treating physicians, physician assistants, or nurse practitioners and as otherwise defined by the commissioner in regulation.

Id.

n136. N.Y. Pub. Health Law § 2999-i(2)(a).

n137. N.Y. Pub. Health Law § 2999-g.

n138. N.Y. Pub. Health Law § 2999-h.

n139. See Joyner-Pack v. State of New York, 38 Misc. 3d 903, 906-07 (N.Y. Ct. Cl. 2012). "The [Fund] is supported by a state appropriation, and pays the "qualifying health care costs' of "qualified plaintiffs.'" Id. A qualified plaintiff is defined as:

Every plaintiff or claimant who (i) has been found by a jury or court to have sustained a birth related neurological injury as the result of medical malpractice, or (ii) has sustained a birth-related neurological injury as the result of alleged medical malpractice, and has settled his or her lawsuit or claim therefore.

N.Y. Pub. Health Law § 2999-h.

n140. See N.Y. Pub. Health Law § 2999-j.

n141. See id.

n142. See generally Debunking The Myths, The American Association for Justice, http://www.justice.org/cps/rde/xchg/justice/hs.xsl/2011.htm (last visited Feb. 4, 2014) (espousing evidence that medical malpractice accounts for very little of overall health care spending). The American Association for Justice is formerly the Association of Trial Lawyers of America. Id.

n143. See generally N.Y. Fam. Ct. (McKinney 2013). New York has moved family law cases to special courts, recognizing that typical trial courts are not the appropriate venue for matters like divorce and child custody hearings. Id.

n144. See id. (examining New York's system, which removes family law cases to special courts).

n145. McKeon, supra note 12, at 480.

n146. Id.

n147. Id.

n148. Id. at 479.

n149. Id. at 481.

n150. See generally Overview of the New York State Medical Indemnity Fund for Neurologically Impaired Newborns, N.Y. Hosp. Ass'n, available at http://www.gnyha.org/10711/File.aspx.

n151. See supra note 64 and accompanying text. Reports to the NPDB are a major impediment to physician acceptance of the current medical malpractice system. Id.

n152. See generally McKeon, supra note 12 at 478-81. The New York Trial Lawyers Association does not oppose the Program's expansion provided that litigants retain their fundamental Seventh Amendment right to adjudicate malpractice claims in court and by a jury. Id. at 480. In fact, "The New York State Trial Lawyers Association ... whose members include some of New York's elite plaintiffs' medical-malpractice trial lawyers, had long been supportive of the [Judge-Directed Negotiation] Program, viewed the model favorably, and did not oppose its expansion..." Id. (citing Interview with Jeff Korek, Esq., former President of N.Y. State Trial Lawyers Ass'n).

n153. State Courts in N.Y. Changing Leadership, Insurance News Net, (Oct. 27, 2011), http://insurancenewsnet.com/print.aspx?id=292284&type=topnews.

n154. Richard Epstein, Intuition, Custom, and Protocol: How to Make Sound Decisions with Limited Knowledge, 2 N.Y.U. J.L. & Liberty 1 (2006). The goals of this final prong are to increase the quality of that physician's performance as well as to add an element of responsibility to the assessment. Id.

n155. See supra notes 69-70 and accompanying text (discussing frequency of perforation during colonoscopies for various patient populations).

n156. Nicholas T. Timm, From Damages Caps to Health Courts: Continuing Progress in Medical Malpractice Reform, 2010 Mich. St. L. Rev. 1209, 1220 (2010) (citing Philip G. Peters, Jr., Health Courts, 88 B.U. L. Rev. 227, 288 (2008)).

n157. See generally U.S. Preventive Services Task Force, Screening for Colorectal Cancer, October 2008, http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm (last updated Oct. 2008). In this particular example, the procedure is even part of the required coverage items in the Patient Protection and Affordable Care Act (hereinafter "PPACA"). See Patient Protection and Affordable Care Act (PPACA) of 2010 § 2713, 42 U.S.C. § 300gg-13 (2011) (outlining requirements for coverage of preventive health services).

n158. Michael T. Draelos, Colonoscopy Perforation Rate Stratified by Age: A Community Based Study, 65(5) Gastrointestinal Endoscopy AB326 (2007). See also supra notes 69-70 and accompanying text (discussing frequency of perforation during colonoscopies for various patient populations).

n159. Timm, supra note 156. In an ideal world, the Health Court might even go so far as, if allowed by statute, considering the financial situation of the patient. We recognize this might be very difficult to implement, however.

n160. See Michael T. Draelos, supra note 158 (noting the New York Department of health already works closely with licensing and accrediting bodies to promote the public health).

n161. See Lu, supra note 7 and accompanying text (discussing Constitutional basis for tort reform).

n162. See Widman, supra note 63, at 61 (stating that some compensation schemes are no fault models while others ignore common law rights).

n163. See U.S. Const. amends. V, VII. See also U.S. Const. amend. XIV (making the Fifth and Seventh Amendments applicable to the States).

n164. Duke Power Co. v. Carolina Envtl. Study Grp., Inc., 438 U.S. 59, 93 (1978). However, in the context of workers' compensation statutes, the United States Supreme Court has said that a "panoply of remedies and

guarantees is at the least a reasonably just substitute for the common-law rights replaced by the [Act in question]. Nothing more is required by the Due Process Clause." Id.

n165. By this the paper means that (1) the money he has paid into the compensation fund will now be given to the harmed patient regardless of whether he was the physician under whose watch the event occurred, and (2) if he was the physician under whose watch the event occurred, he will be subject to having a demerit against his name.

n166. See Lu, supra note 92, at Part IV. Legislation that limits awards is the most effective way to control liability costs. Id.

n167. See Baker, supra note 8, at 14-16. Of course, as medical malpractice law stands imperfectly today in the adversarial system. not all aggrieved patients receive damages in the amount they seek, if at all. Some, granted, receive exorbitant amounts, but some are left with nothing. Id.

n168. See Glaberson, supra note 18; see also supra notes 47, 87 and 152 and accompanying text (discussing workers' compensation laws, vaccine injury compensation funds, and other health courts). See infra notes 180, 184 and accompanying text (discussing National Labor Relations Board and other administrative courts).

n169. See supra notes 47, 87 152 and accompanying text (discussing workers' compensation laws, vaccine injury compensation funds, and other health courts). See infra notes 180, 184 and accompanying text (discussing National Labor Relations Board and other administrative courts).

n170. See John W. Wade, On the Nature of Strict Tort Liability for Products, 44 Miss. L.J. 825, 837 (1973).

n171. See, e.g., N.Y. Cent. R.R. v. White, 243 U.S. 188, 198-202 (1917) (holding common law liability rules may be altered or replaced by reasonably just legislation). In upholding The New York Workmen's Compensation Act, Justice Mahlon Pitney explained that, "negligence is merely the disregard of some duty imposed by law; and the nature and extent of the duty may be modified by legislation." Id. at 198.

n172. See infra notes 173-178 and accompanying text (discussing specific fields where Congress has passed

laws limiting common law tort action).

n173. See National Labor Relations Act, 29 U.S.C.§§151-169 (1935) (creating the National Labor Relations Board and detailing its adjudicatory powers in specified labor disputes); NLRB v. Jones & Laughlin Steel Corp., 301 U.S. 1, 30-32, 49 (1937) (declaring the National Labor Relations Act of 1935 constitutional).

n174. See National Labor Relations Act § 153 (creating the National Labor Relations Board); Widman, supra note 63 at 71 (describing the National Labor Relations Board as adjudicating public rights). "In its Seventh Amendment jurisprudence, the Court has consistently relied on a public right/private right distinction, stating that the Seventh Amendment does not allow Congress to assign adjudication of a private right that is legal in nature to an administrative agency or specialized court without juries." Widman, supra note 63, at n.44 (citing Granfinanciera, S.A. v. Nordberg, 492 U.S. 33, 42 n.4 (1989)). "Private rights are defined as "the liability of one individual to another."' Id. (quoting Crowell v. Benson, 285 U.S. 22, 51 (1932)). Conversely, describing public rights, the Supreme Court has said:

Our prior cases support administrative factfinding in only those situations involving "public rights,' e.g., where the Government is involved in its sovereign capacity under an otherwise valid statute creating enforceable public rights. Wholly private tort, contract, and property cases, as well as a vast range of other cases, are not at all implicated.

Atlas Roofing Co. v. Occupational Safety & Health Review Comm'n, 430 U.S. 442, 458 (1977).

n175. See National Labor Relations Act§§153, 160 (creating the National Labor Relations Board and describing its enumerated powers); Atlas Roofing Co., 430 U.S. at 458. Describing the constitutionality of administrative tribunals, the Supreme Court has stated:

It is apparent from the history of [the] jury trial in civil matters that factfinding, which is the essential function of the jury in civil cases, was never the exclusive province of the jury under either the English or American legal systems at the time of the adoption of the Seventh Amendment.

Id. (citing Colgrove v. Battin, 413 U.S. 149, 157 (1973)).

n176. See Granfinanciera, 492 U.S. at 51. The Supreme Court wrote:

Congress' power to block application of the Seventh Amendment to a cause of action has limits. Congress may

only deny trials by jury in actions at law, we said, in cases where "public rights" are litigated: "Our prior cases support administrative factfinding in only those situations involving "public rights,' e.g., where the Government is involved in its sovereign capacity under an otherwise valid statute creating enforceable public rights. Wholly private tort, contract, and property cases, as well as a vast range of other cases, are not at all implicated."

Id. (quoting Atlas Roofing Co., 430 U.S. at 455, 458).

n177. See, e.g., Kansas Malpractice Victims Coal. v. Bell, 757 P.2d 251 (Kan. 1988). The Bell court held a statute limiting the total amount of damages a plaintiff could collect in a malpractice action from the state did not violate the plaintiff's right to a trial by jury. Id.

n178. Id.

n179. Fair and Reliable Medical Justice Act, S. 1337, 109th Cong., § 2(1)-(3) (2005).

The purposes of this Act are - (1) to restore fairness and reliability to the medical justice system by fostering alternatives to current medical tort litigation that promote early disclosure of health care errors and provide prompt, fair, and reasonable compensation to patients who are injures by health care errors; (2) to promote patient safety through early disclosure of health care errors; and (3) to support and assist States in developing such alternatives.

Id.

n180. Id. at § 3990(d)(4)(A)-(E).

In the special health court model, the State shall - (A) establish a special court for timely adjudication of disputes over injuries allegedly caused by health care providers or health care organizations in the provision of health services; (B) ensure that such court is presided over by judges with health care expertise who meet applicable State standards for judges and who agree to preside over such court voluntarily; (C) provide authority to such judges to make binding rulings on causation, compensation, standards of care, and related issues with reliance on independent expert witnesses commissioned by the court; (D) provide for an appeals process to allow for review of decisions; and (E) at its option, establish an administrative entity similar to the entity described in paragraph (3)(A)(i)(I) to provide advice and guidance to the special court.

Id.

n181. Id.

n182. Id. at § 3990(c)(2)(A)-(D).

n183. Patient Protection and Affordable Care Act, 42 U.S.C. § 280g-15 (c)(1)(A)-(B) (2010).

Each state desiring a grant under subsection (a) shall develop an alternative to current tort litigation that - (A) allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and (B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resoled under subparagraph (A) by organizations that engage in efforts to improve patient safety and the quality of health care.

Id.

n184. Id. at § 280g-15(c)(2).

n185. See supra note 18 (discussing the Judge Directed Negotiation Program). See also supra note 134 and accompanying text (discussing the New York Obstetric Indemnity Fund).

n186. See Patient Protection and Affordable Care Act, 42 U.S.C. § 280g-15(c)(2) (outlining requirements for demonstration grants, one of which is compliance with current state law).

n187. See Black's Law Dictionary 631 (3rd pocket ed. 2006). A "safe harbor protection" is "[a] provision (as in a statute or regulation) that affords protection from liability or penalty." Id.

n188. See Hafemeister & Porter, supra note 9.

n189. Mark A. Rothstein, Currents in Contemporary Bioethics: Health Care Reform and Medical Malpractice Claims, 38 J.L. Med. & Ethics 871, 873 (2010).

When fully implemented, PPACA will increase the number of individuals with health care coverage by

approximately 32 million. As a result, there will be many millions of additional patient encounters each year. If the rate of adverse events arguably attributable to medical malpractice remains constant, then it might be assumed that the total number of medical malpractice claims will increase.

Id. at 871. As more patient encounters occur per year as a result of more insured people seeking medical attention, as a matter of course, the total number of adverse events may increase, resulting in a greater number of medical malpractice suits. Id. In addition, because the number of available physicians will remain fairly constant while the number of patients able to obtain medical care will increase, doctors may have to stretch their time and energy to cover more patients, possibly resulting in an increased number of mistakes. Id. Furthermore, patients may have to wait longer to see a physician (a pattern that has already been observed for Medicaid patients), with the result being that when patients are finally able to see a physician, their medical state will have deteriorated making treatment more complicated and resulting in more treatment-related adverse events and malpractice litigation. See generally Carolyn L. Yocom, Letter: States Made Multiple Program Changes, and Beneficiaries Reported Access Comparable to Private Insurance, Congressional Quarterly, Inc., (November 15, 2012) (explaining to Secretary Kathleen Sebelius that Medicaid patients report long wait times for care).

n190. See The Birth Related Neurological Injury Compensation Act, Fla. Stat. Ann.§§766.301 (2013); Virginia Birth-Related Neurological Injury Compensation Program, Va. Code Ann.§§38.2-5002 (2013).

n191. Birth Related Neurological Injury Compensation Act §§766.301; Virginia Birth-Related Neurological Injury Compensation Program§§38.2-5002.

n192. Birth Related Neurological Injury Compensation Act §§766.301; Virginia Birth-Related Neurological Injury Compensation Program§§38.2-5002.

n193. See Birth Related Neurological Injury Compensation Act at § 766.303.

n194. Id.

n195. Watson v. Hortman, 844 F. Supp. 2d 795 (E.D. Tex. 2010). In 2003, The Texas legislature passed the Texas Act, which included caps on non-economic damages. Medical Malpractice and Tort Reform Act, Tex. Civ. Prac. & Rem. Code Ann. § 74.301 (2012). The relevant portion of the Texas Act provides:

In an action on a health care liability claim where final judgment is rendered against a physician or health care

provider other than a health care institution, the limit of civil liability for noneconomic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $ 250,000 for each claimant, regardless of the number of defendant physicians ... .

Id.

n196. Watson, 844 F. Supp. 2d at 799 (referencing Bounds v. Smith, 430 U.S. 817, 822 (1977)). The plaintiffs further argued that a limitation on damages foreclosed their access to courts as a practical matter, because it rendered the pursuit of some health care liability claims uneconomical. Id. Under the plaintiffs' theory, a limitation on awards would result in smaller jury awards and decrease the contingent fees paid to qualified attorneys and experts. Id. at 800.

n197. Id. at 798.

n198. Id. at 800 (citing Duke Power Co. v. Carolina Envtl. Study Grp., Inc., 438 U.S. 59, 88 n. 32 (1978)). Furthermore, a facial challenge to the constitutionality of a state statute required that "the challenger must establish that no set of circumstances exists under which the [Texas] Act would be valid." Id. at 799 (citing Ctr. for Individual Freedom v. Carmouche, 449 F.3d 655, 662 (5th Cir.2006)). See also United States v. Salerno, 481 U.S. 739, 745 (1987).

n199. Watson, 844 F.Supp. 2d at 801; see also U.S. Const. amend. V. Recognizing that not all government regulation reduces the value of a property interest, and thus does not always constitute a compensable taking, the court's analysis concluded that no taking had occurred. Watson, 844 F.Supp. 2d at 803-04. See generally Penn Cent. Transp. Co. v. City of New York, 438 U.S. 104, 124 (1978). The court held that to assess whether a governmental regulation constitutes a compensable taking depends on the economic impact on claimant, the extent of the interference, and the character of the governmental action. Id. Because the damages limitation affected only the plaintiff's ability to recover non-economic damages, plaintiffs were unable to show a taking. Watson, 844 F.Supp. 2d. at 804. In addition, given that the United States Supreme Court has implied a relationship between due process and takings causes of action, the plaintiffs' due process arguments were unsuccessful. Id. (quoting Concrete Pipe & Prods. of Cal., Inc. v. Constr. Laborers Pension Trust for S. Cal., 508 U.S. 602, 641 (1993)). See also Connolly v. Pension Benefit Guar. Corp., 475 U.S. 211, 223 (1986).

n200. See Timm, supra note 156, at 1225. For instance, if the federal government were to establish a form of health court (rather than individual state governments doing so):

Congress may be required to provide a quid pro quo benefit in place of the jury trial ... . Proponents of health courts point to the avoidability standard as a new right for injured claimants, [though] it is unclear whether this standard differs significantly from the traditional negligence standard.

See id. (citing Amy Widman & Francine A. Hochberg, Federal Administrative Health Courts are Unconstitutional: A Reply to Elliot, Narayan, and Nasmith, 33 J. Health Pol. Pol'y & L. 799, 827 (2008)).

n201. Carol A. Crocca, Validity, construction, and application of state statutory provisions limiting amount of recovery in medical malpractice claims, 26 A.L.R. 5th 245 (1995).

n202. Id. Findings of societal benefit usually receive deference in a rationality test. Id.

n203. Amy Wildman, Liability and the Health Care Bill: An "Alternative" Perspective, 1 Calif. L. Rev. Circuit 57, 61 (2010). "The general maxim is that the legislature may not remove a right from the jury without offering a quid pro quo ... ." Id. (citing N.Y. Cent. R.R. v. White, 243 U.S. 188, 201 (1917); see Crowell v. Benson, 285 U.S. 22, 41 (1932)).

n204. See infra note 226 and accompanying text.

n205. Although the purpose of this paper is to promote the concept of Health Courts, we propose Health Courts with adequate precautions. See infra Part XIV (discussing our conclusion about and recommendations for Health Courts). Further, this paper is not the first to contemplate the idea of a "Health Court." See, e.g., Timm, supra note 156 (discussing Common Good's model system in which Common Good "even suggested a health court model as one prospective remedial alternative"). See also Fair and Reliable Medical Justice Act, S. 1337, 109th Cong., § 3(c)(2) (2005). However, the way this paper envisions Health Court(s) is unique. See also Peters, supra note 156.

n206. See Marlys Harris, Workers Comp: Falling Down on the Job, 65 Consumer Reports 28, 29 (Feb. 2000).

n207. Id.

n208. See supra Part VIII (discussing the organization of the MCCL).

n209. When evidentiary issues are in dispute, when the credibility of witnesses may be at issue, and/or when conflicting evidence must be weighed, a full trial would be necessary regardless of whether it is a bench or jury trial. However, when the question concerns drawing inferences from undisputed evidence or interpreting and evaluating evidence to derive legal conclusions, a trial might not add anything to the judge's ability to decide. By contrast, as to questions entrusted to the Health Panel and/or Expert, it might be appropriate for the judge to play even less of a role in screening cases through summary judgment than the judge would ordinarily play in a case where the right to a jury is asserted. In the context of jury trials, the judge plays the role of gatekeeper by determining the admissibility of expert testimony. Judges may be well suited, in comparison to juries, to serve such a function. However, as to questions that the proposed system would relegate to the Health Panel, little purpose would be served by requiring a judge rigorously to screen expert evidence for admissibility prior to sending the issues to the Health Panel.

n210. See supra Part VIII (discussing the organization of the MCCL).

n211. Id.

n212. See generally Timm, supra note 162.

n213. See, e.g., Health System Quality and Efficiency, The Commonwealth Fund, available at http://www.commonwealthfund.org/Program-Areas/Archived-Programs/Delivery-System-Innovation-and-Improvement/Health-S "Significant variability in 30-day readmission rates across U.S. hospitals suggests that some are more successful than others at providing safe, high-quality inpatient care and promoting smooth transitions to follow-up care." Id. (referring to Elizabeth H. Bradley et al., Contemporary Evidence About Hospital Strategies for Reducing 30-Day Readmissions: A National Study, J. Amer. Coll. Cardiology (2012)).

n214. See, e.g., Allison Liebhaber et al., Hospital Strategies to Engage Physicians in Quality Improvement, Center for Studying Health System Change (Oct. 2009), available at http://www.hschange.com/CONTENT/1087/.

n215. See, e.g., Toni Johnson, Healthcare Costs and U.S. Competitiveness, Council on Foreign Relations (Mar. 26, 2012), available at http://www.cfr.org/competitiveness/healthcare-costs-us-competitiveness/p13325.

n216. American Society of Health System Pharmacists, Pay-For-Performance (P4P): Evaluating Current and Future Implications, http://www.ashp.org/DocLibrary/Policy/QII/Pay-For-Performance.aspx (last visited February 9, 2013).

n217. The Commonwealth Fund, U.S. Spends Far More for Health Care Than 12 Industrialized Nations, but Quality Varies (May 3, 2012), available at http://www.commonwealthfund.org/News/News-Releases/2012/May/US-Spends-Far-More-for-Health-Care-Than-12-Industrializ

n218. Chunliu Zhan, MD, PhD and Marlene R. Miller, MD, MSc., Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization, 290 JAMA 1868 (2003).

n219. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, To Err is Human: Building a Safer Healthcare System, Committee on Quality of Health Care in America, Institute of Medicine (2000), available at http://neurosurgery.ucsf.edu/tl_files/NS_Main/QI/IOM_To%20Err%20is%20Human.pdf.

n220. Id. One Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, nineteen percent of medication doses were given in error, seven percent of which were life threatening. KN Barker, et al., Medication Errors observed in 36 health care facilities, 162(16) Arch Intern Med. 1897 (2002). In 1999, operating rooms teams around the country left sponges, clamps and other tools in more than 1500 patients out of 28.4 million inpatient operations. Atul Gawande, et al., Risk Factors for Retained Instruments and Sponges after Surgery, 348 N. Eng. J. Med. 229 (January 16, 2003). "According to a study published in the Annals of Surgery in August of 2008, discrepancies in the count of surgical instruments and sponges occur in 12.5 percent of surgeries." Kate Gamble, No Sponge Left Behind, Healthcare Informatics (Dec. 1, 2008), available at http://www.healthcare-informatics.com/article/no-sponge-left-behind.

n221. See supra note 16 and accompanying text.

n222. See Isaac Montoya et al., Gauging Patient Safety Programs, 42(3) J. Allied Health 182 (2013).

n223. See Daniel R. Levinson, Adverse Events in Hospitals: National Incidence Among Medicare

Beneficiaries, Department of Health and Human Services 7 (2010). A "medical event" is otherwise known as medical injuries that result from a series of failures that are not attributable to one physician's error. See id. at 3.

n224. See generally Timm, supra, note 162 (describing the deficiencies of the medical malpractice system).

n225. A. Russell Localio, et al., Relation Between Malpractice Claims and Adverse Events Due to Negligence - Results of the Harvard Medical Practice Study III, 325 New Eng. J. Med. 245, 251 (1991).

n226. See Lucian L. Leape, Error in Medicine, 272 Jama 1851 (1994); David A. Hyman & Charles Silver, The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?, 90 Cornell L. Rev. 893, 919-20 (2005).

[The reduction in anesthesia accidents] happened because of programs established by physicians in Harvard Medical School's Department of Anesthesia who collaborated with Harvard's own medical malpractice insurance company. Anxious to bring down the payouts being made for injuries occurring in the anesthesia departments of Harvard's nine teaching hospitals, the insurer's risk managers asked the hospital's anesthesiologists to investigate why their collective experience was so poor. The group devised new techniques and equipment to lower the risk of mishap.

Phillip G. Peters, Jr., Health Courts?, 88 B.U.L. Rev. 281 (2008).

n227. See Ellison C. Pierce, Jr., M.D., The 34th Rovenstine Lecture: 40 Years Behind the Mask: Safety Revisited, 84(4) Anesthesiology 965, 971 (1996).

n228. Id.

n229. See, e.g., id. at 971-73.

n230. See Hyman, supra note 226 at 920 (reviewing the standardization done by the American Society of Anesthesiologists). Robert L. Helmreich, Managing Human Error in Aviation, Sci. Am. 62, 67 (May 1997) (describing a program in Basel, Switzerland that uses a computerized dummy to simulate operations); David M.

Gaba et al., Simulation-based Training in Anesthesia Crisis Resource Management (ACRM): A Decade of Experience, 32 (No. 2) Simulation & Gaming 175, 186 (2001). "Today, adverse events and emergencies are so rare that anesthesiologists use simulators to practice responding to adverse, anesthesia-related events." Hyman, supra note 226 at 920.

n231. Hyman & Silver, supra note 226 at 918.

n232. Donna Hammaker, Health Care Management and the Law: Principles and Applications 200 (2011).