ARTICLE

TORT REFORM AS CARROT-AND-STICK

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The most widely accepted tort reforms are limits on damages that a plaintiff can recover in a medical malpractice lawsuit. More than half of the states have passed some type of liability limit under the guise of general tort reform. Hospitals, physicians, and defense lawyers praise these reforms and regard them as a good way to stanch increased costs from medical malpractice lawsuits and limit the exodus of young physicians from high-risk medical practices. On the other side of the debate, trial lawyers and patient advocates argue that these so-called reforms are a scourge that creates a second harm to those who need compensation the most, the injured, and gives a protection to those who deserve it the least, the injurer. Is there a way out of this simple binary in which the players are either for tort reform or against it? Previous reform-minded commentators have failed to offer a solution that both creates better incentives to behave well and recognizes the political appeal of limits on damages. This Article breaks new ground in the tort reform debate by proposing to link the debate about tort reform explicitly to the debate about hospital and physician performance. Specifically, this Article proposes that states consider treating tort reforms as a "carrot" or incentive for positive behavior. That is, state legislatures bent on passing liability-restricting tort reforms should only use these measures to reward healthcare providers, like hospitals and physicians, who routinely follow best practices. For instance, as the Article will show, state legislatures might approve a liability limit only for hospitals that are compliant with the recommended best treatments. These top-performing hospitals, but only these hospitals, would be protected from the specter of virtually unlimited damages in the event of suit. In this way, hospitals will have new incentives to avoid medical error and adhere strictly to best practices. To demonstrate application, the Article draws on a database of twenty-one quality measures of performance for four defined conditions: heart attack, heart failure, adult surgery, and pneumonia. The data is collected by most hospitals in the United States and maintained by the Centers for Medicare and Medicaid Services. The Article proposes tying eligibility for tort reform to healthcare performance based, initially, on these twenty-one measures.

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I. INTRODUCTION

Jésica Santillán, an illegal immigrant to the United States and only seventeen years old when she died at the Duke University Hospital, had a hard-scrabble, hapless childhood.[1] With her family, she snuck into the United States at age fourteen, hoping to realize a long-shot chance at receiving the life-saving heart and lung transplant surgery she needed, which was unavailable in her native country of Mexico.[2] The family crossed the border led by a "coyote," a professional smuggler of desperate immigrant families like Jésica's. If the United States has the finest healthcare in the world, then Durham, North Carolina, the so-called City of Medicine,[3] must have been Jésica's North Star. The family reached Durham but they arrived with virtually no personal effects. Even if Jésica could have been placed on the donor list and given an organ match, the family lacked health insurance or the means of paying for the surgery that Jésica would need.[4] The family panhandled for change in a futile effort to raise the $300,000 the surgery would cost.[5]

After a benefactor learned of her story, he and others gradually raised the money for Jésica to get the heart and lung transplant that few hospitals in the United States perform.[6] Jésica got her transplant but did not survive long. No one—not the team of surgeons, the hospital, the company that manages transplants, technicians, or countless others involved—checked for a blood type match, a basic precaution.[7] The donor's blood was Type A. Jésica's blood type was O. As soon as the mismatched organs were transplanted, Jésica's immune system started fighting what it thought were invaders. Jésica suffered massive trauma and died a couple of weeks later.[8]

Even in Durham's highly regarded hospitals, the best healthcare in the world is managed by human beings who make mistakes. The doctors, the hospital, and the transplant company all admitted they made a terrible er-

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[1] *See* Jeffrey Gettleman & Lawrence K. Altman, *Girl in Donor Mix-up Undergoes 2nd Transplant*, N.Y. TIMES, Feb. 21, 2003, at A1 (stating that at age two Jésica was always tired, and at age twelve she was diagnosed with restrictive cardiomyopathy).

[2] *See* Anne Barnard, *With Her First Transplant Botched, Girl Receives New Heart and Lungs*, BOSTON GLOBE, Feb. 21, 2003, at A16.

[3] *See, e.g.*, John McCann, Group Looking for People Who Make a Difference; Nominations for Neighborhood Heroes Sought, HERALD-SUN (Durham, N.C.), July 28, 2008, at C1.

[4] *See* Alfredo Corchado, *Village Mourns Girl's Transplant Death; Medical Mistake Prompts Tears, Bitterness in Mexico*, SEATTLE TIMES, Feb. 24, 2003, at A2 (reporting that Jésica and her mother were robbed at gunpoint at the Texas-Mexico border).

[5] *See* Gettleman & Altman, *supra* note 1 (upon arrival in the Raleigh-Durham area, the Santilláns joined the Hispanic community and began raising money with a message of "Save Jésica").

[6] *See id.* (finding only twenty-seven similar transplants were conducted in 2001); C.D. Kirkpatrick & Jim Shamp, *Jesica's* [sic] *Ordeal Ends; Teen Dies at Duke After Transplant Efforts Fail*, HERALD-SUN (Durham, N.C.), Feb. 23, 2003, at A1.

[7] *See* Lawrence K. Altman, *Even the Elite Hospitals Aren't Immune to Errors*, N.Y. TIMES, Feb. 23, 2003, at 18 (noting that blood type confirmation is a basic safety protocol).

[8] *See* Kirkpatrick & Shamp, *supra* note 6.

ror—they failed to do a basic check for blood type.[9] However, whether the law will allow Jésica's family to recover anything for their agony or whether those who were negligent are punished for their mistakes depends on the state and whether it has embraced the so-called tort reform movement.[10] In the many states across the nation that have embraced the tort reform movement,[11] Jésica's tragedy would go almost unnoticed by the law, those responsible would be largely unpunished, and Jésica's family would be entitled to scant compensation.

States that have adopted tort reforms have limited damages in medical malpractice cases for pain, suffering, loss of companionship, mental anguish or punitive damages to as little as $250,000.[12] Thus, since Jésica did not have typical so-called economic damages—she had no wage income upon which the family relied, for instance—the vast majority of her family's ability to recover would be cut off under these state limits on recovery.[13] More troub-

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[9] *See* Jeffrey Gettleman & Lawrence Altman, *Grave Diagnosis After 2nd Transplant*, N.Y. TIMES, Feb. 22, 2003, at A11 (reporting that "[t]he critical failure was absence of positive confirmation of ABO compatibility of the donor organs and the identified recipient patient"); Kirkpatrick & Shamp, *supra* note 6 (reporting that Dr. Jaggers took responsibility for not checking the blood type of the first donor); *Transplant Policies Altered*, MILWAUKEE J. SENTINEL, June 28, 2003, at 4A (reporting that correct blood type must now be verified by four different staff members).

[10] *See* Cynthia Tucker, Editorial, *Our Opinion: Girl's Death May Dim View of Tort Reform*, ATLANTA J.-CONST., Mar. 2, 2003, at 8E (reporting that Jésica's story "debunks the stereotypes about gold-digging patients looking to score easy cash"); *see also* Peter Eisler, Julie Appleby & Martin Kasindorf, *Special Report: Hype Outraces Facts in Malpractice Debate*, USA TODAY, Mar. 5, 2003, at 1A (reporting that life-and-death mistakes "may slow the momentum of those who want to limit damage awards").

[11] *See, e.g.*, ALASKA STAT. § 09.17.010 (2006), COLO. REV. STAT. § 13-64-302 (2007), KAN. STAT. ANN. § 60-19a02 (2005), ME. REV. STAT. ANN. tit. 24-A, § 4313(9)(b) (Supp. 2007).

[12] *E.g.*, CAL. CIV. CODE § 3333.2 (Deering 2005).

[13] Under common law, victims of medical malpractice may bring suit to recover their damages against the party who caused the injury. Under traditional case law, victims in a medical malpractice case can recover economic damages (e.g., medical expenses and lost wages), non-economic damages (e.g., pain and suffering) and, in the right circumstance, even punitive damages. Liability limits usually apply to constrain recovery of the last two—non-economic damages or punitive damages—since these are thought to be unpredictable and create the specter of large jury awards. For instance, because pain, suffering, embarrassment, loss of companionship, mental anguish, loss of consortium and other non-economic damages are difficult if not impossible to measure, potential liability could be very unpredictable. Even if the facts are identical, two juries could measure either of these components in different ways and come up with two markedly inconsistent verdicts. *See* Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 404 (1994) (noting that juries are particularly prone to dissimilar and unpredictable verdicts in cases involving permanent injury); Frank A. Sloan et al., *Valuing Life and Limb in Tort*, 83 NW. U. L. REV. 908, 912–14 (1989) ("The law is imprecise even within a single jurisdiction; if one considers cross-jurisdictional variation, the discrepancies are substantially magnified. This imprecision in the substantive law forces the jury to rely on the presentations of the parties when computing losses."). Similarly, punitive damage awards may also be large and unanticipated. The goal of punitive damages is not compensation; instead, damages are intended to punish the wrongdoer for particularly egregious conduct. Such conduct is normally reckless, intentional, or grossly negligent. HENRY COHEN, CONG. RES. SERV., MEDICAL MALPRACTICE LIABILITY REFORM: LEGAL ISSUES AND FIFTY-STATE SURVEY OF CAPS

ling still, on close inspection, statutes governing recovery in medical malpractice cases are more the result of bargains by state politicians, some of whom have been swept up by the momentum of the tort reform movement, rather than a genuine reflection on how to use these rules to help reduce medical errors, like the one that led to Jésica Santillán's death. North Carolina has no limit on recovery for pain and suffering,[14] which likely gave Jésica's family attorney leverage and perhaps partly explains his success in securing a relatively quick, undisclosed settlement with the Duke University Hospital.[15]

Currently, states that have decided to embrace tort reform measures have mainly adopted limits on liability for all health care providers, including hospitals, clinics, and physicians. The statute in California, the first state to adopt limits on non-economic damages, provides that a $250,000 limit applies to all health care providers, including individuals, clinics, and health care facilities.[16] Thus, all physicians—both bad and good—and every hospital—the underperforming and the over-performing ones—get the benefit of liability protection in cases of medical malpractice.

However, as has been noted in other contexts, state regulation of damage awards need not be all-or-nothing.[17] More to the point, in the case of medical error, state legislatures can and should link tort reforms to performance measures. This Article is the first attempt to link state tort reform rules explicitly to provider performance. States should use tort reform as a "carrot," or reward, for delivering the best recommended care and avoiding error. Specifically, this Article proposes that state legislatures bent on passing liability-restricting tort reforms should only use these measures to reward healthcare providers, like hospitals and physicians, who routinely follow best practices. For instance, as the Article will show, state legislatures might approve a liability limit only for hospitals that are compliant with the recommended best practices according to clinical guidelines. These top-performing hospitals, and only these hospitals, would be protected from the specter of virtually unlimited damages in the event of suit.

ON PUNITIVE DAMAGES AND NONECONOMIC DAMAGES 4–5 (2006) (discussing some common law sources of the jury's right to determine punitive damages). As in the case of non-economic damages, a defendant-physician could be liable for a wide range of punitive damages in a medical malpractice case, as juries and judges try to weigh culpability, conduct, and prospects for deterring similar acts.

[14] N.C. GEN. STAT. § 1D-25 (1996).

[15] National Briefing South: North Carolina: Settlement For Transplant Error, N.Y. TIMES, June 26, 2004, at 9.

[16] CAL. CIV. CODE § 3333.2 (Deering 2005).

[17] *See, e.g.*, IAN AYRES & JOHN BRAITHWAITE, RESPONSIVE REGULATION: TRANSCENDING THE DEREGULATION DEBATE 153–57 (Oxford U. Press 1992) (discussing three types of "partial" regulation); Lee Harris, *Taxicab Economics: The Freedom to Contract for a Ride*, 1 GEO. J.L. & PUB. POL'Y 195, 218–19 (2003) (discussing partial regulation as a response to defects in taxicab markets); Lee Harris & Jennifer Longo, *Thoughts on Flexible Tort Reform*, 29 HAMLINE J. PUB. L. & POL'Y 61 (2008).

While tying tort reform to performance has not been previously discussed in detail by reform-minded commentators, adding incentives to healthcare is not unprecedented.[18] For example, private insurance companies have recently begun rewarding doctors who do well.[19] The federal government has also promoted incentive legislation in healthcare. Medicare has instituted bonuses for doctors who agree to track patient care.[20] Even some state legislatures, such as the Massachusetts legislature, have approved bonuses for hospitals that reduce racial disparities in health care.[21] In a similar vein, this Article argues that states should tie tort reforms, like limits on recovery in medical malpractice cases, to measures of provider performance. The benefits of tort reform should only be available to healthcare providers, like hospitals, that routinely follow best practices. To demonstrate an example of an application of performance-based tort reform, the Article draws on an already existing Medicare database of twenty-one measures of hospital performance.[22] The Article proposes tying eligibility for tort reform protection, like limits on damages, to these twenty-one performance-based measures.[23]

Part II discusses the incidence of medical error and several reforms to address medical error. Many legal academics have proposed reforming the tort system by expanding liability for healthcare providers as a way to incentivize such providers to take reasonable precautions. Oddly enough, many of these previous academic proposals have been ignored by politicians. In fact, perhaps because of its political appeal, the predominant medical malpractice reform is actually a limit or cap on liability for healthcare providers. This

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[18] In fact, at the time of this writing, the single mention of tying caps to performance comes in a recent article by Professors David Hyman and Charles Silver, two frequent commentators on medical malpractice and healthcare. In a provocative paragraph, the two suggest using medical liability caps "strategically." Further, the two aptly and neatly sum up the problem: "[C]aps apply whether providers have made great effort or no effort to improve the quality of services they provide. How dumb is that?" David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1131 (2006). *See generally* Harris & Longo, *supra* note 17, for other discussions of how performance can be used to improve healthcare quality in cases of medical malpractice.

[19] *See infra* text accompanying notes 185–186.

[20] *See infra* text accompanying note 184.

[21] *See infra* text accompanying notes 175–177.

[22] Currently, the data measures hospital performance for four conditions: heart attack, heart failure, adult surgery, and pneumonia. This data collection is a requirement of participation in Medicaid and Medicare programs. The data is collected by most hospitals in the United States and maintained by the Centers for Medicare and Medicaid Services, governmental entities. *See* Medicare Prescription Drug, Improvement and Modernization Act, 42 U.S.C. § 1395ww (2003).

[23] Although one measure of performance will probably not work for all states, states can devise an individualized compliance scheme that encourages their state providers to follow best practices. States can use such compliance rates to figure out what level of performance is exemplary in a particular state (e.g., 80%, 90%, 95%, or even 98% compliance with best practices) and tie eligibility to tort reform to the compliance rate. Put another way, states can make eligibility for tort reform protections contingent on meeting a state-relevant threshold compliance rate.

limit on damages is at the frontline of the tort reform movement, as shall be explained.

Part III introduces a proposal for performance-based tort reform—that is, reform responsive to differences in healthcare quality and incidence of medical mistakes. This Article argues that state legislatures considering tort reform should not take up reforms to limit liability for all healthcare providers, regardless of their conduct. Rather, states should consider using tort reform as a carrot to reinforce good performance from providers. In this Part, the Article argues that a proposal for performance-based tort reform probably should be first targeted at hospitals. Part IV shows how performance-based tort reform would affect the conduct of two of the main participants in the delivery of healthcare—physicians and hospitals.

Part V demonstrates how healthcare quality might be measured and a performance-based rule might be applied by state governments. Currently, the Centers for Medicare and Medicaid Services, governmental entities, collect for public view data on compliance with best practices for the vast majority of hospitals throughout the United States.[24] This public information permits a way to measure quality of hospitals in a particular state and apply the proposal for performance-based tort reform. In Part VI, the Article attempts to address some potential criticisms of performance-based tort reform.

Part VII evaluates and ultimately dismisses two alternatives to performance-based tort reform, which appear on the surface to create the same sort of incentives to improve health care. First, the Article considers a plan of direct cash payouts to hospitals that enforce high-quality standards and compares these schemes to this proposal. Second, the Article considers a related plan to tie physician pay to performance measurements, which has lately received significant attention as a result of recent experimental pay-for-performance projects sponsored by Medicare.

II. A Primer on "Tort Reform"

This Part introduces briefly the problem of medical malpractice and some proposals for reducing its incidence.

A. Scope of Medical Error

Several studies have found that a significant share of patients do not receive the best treatment and are injured by medical error. For instance, several accounts suggest that patients routinely receive care at odds with the

[24] Hospital Compare, http://www.hospitalcompare.hhs.gov/ (last visited Nov. 12, 2008). Hospital Compare, initiated in 2002, makes public information on hospital quality in order to help consumers make more informed decisions about what hospitals to use. For information and various updates regarding Hospital Compare, see Ctrs. for Medicare and Medicaid Servs., http://www.cms.hhs.gov/HospitalQualityInits/ (last visited Nov. 12, 2008).

medical literature or clinical guidelines. One report suggests that two out of five chronically ill patients receive care inconsistent with medical literature.[25] Another study shows that close to one in five surgical patients experiences a serious error while receiving care.[26] Indeed the numbers may be even worse for patients generally. One fifteen-year observational study reports that 45.8% of patients experience at least some error while receiving medical treatment.[27] Even worse, researchers have found that many patients suffer serious injury or die from misguided care and medical error. A Harvard University study found that patients had a 4% chance of being injured by their providers.[28] Further, the Institute of Medicine, a nonprofit research organization, has reported that between 44,000 and 98,000 people die annually in hospitals from preventable medical error.[29]

Many of the causes of medical error go uncorrected and unnoticed. In particular, most commentators agree that system-level problems also seem to play a role in medical error and injury, but are too rarely remedied.[30] Some

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[25] *See* Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1938 (2003) (noting that only 60% of patients with chronic diseases received care indicated by the literature and 20% received care contraindicated).

[26] *Id.* at 1939 (citing Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 LANCET MED. J. 309 (1997)) (noting study findings that 18% of patients in surgical units were victims of medical error).

[27] Lori Andrews, *Studying Medical Error* in Situ*: Implications for Malpractice Law and Policy,* 54 DEPAUL L. REV. 357, 370 (2005) (reviewing occurrence reports for 1047 patients).

[28] *See* Arlen & MacLeod, *supra* note 25, at 1938–39 (citing T.A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study*, 324 NEW ENG. J. MED. 370 (1991)).

[29] INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000) (noting that medical error causes more deaths than in cases of motor vehicle accidents, breast cancer, or AIDS). The Institute of Medicine report is based primarily on two studies of hospitalizations that found that 2.9% of patients in New York and 3.7% of patients in Colorado and Utah, combined, had an adverse event or injury caused by medical mismanagement. The studies concluded that the majority of these adverse events could have been prevented. *Id.* (citing T. A. Brennan, *supra* note 28, and David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250 (2000)).

[30] For instance, in an article advocating enterprise liability written more than a decade ago, Abraham and Weiler make the case that hospitals might be better at reducing medical error, improving the lines of communication between doctors, and identifying common and related errors:

> The truth is that the individual physician is typically a member—admittedly a crucial member—of a larger team of medical personnel, all of whom have their own special training and responsibilities for the course of treatment of the same patient. . . . One of the best techniques for protecting patients from . . . medical failings is (when necessary) to redesign both the organization of and the equipment used by the medical team. At the present time, at least, the hospital occupies an ideal strategic position within the health care system from which to accomplish this crucial quality assurance mission.

Abraham & Weiler, *supra* note 13, at 413 (citation omitted); *see also* Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1627–28 (2002) (contrasting systemic problems that produce medical error and individualized negligence). An even more telling example of the consequences of systemic error is an oft-cited study of Harvard Medical School's anesthesia prac-

injuries might be prevented, for example, by simply maintaining sufficient supply of antibiotics, like penicillin, near a patient's bedside. Other errors are caused by faulty equipment, which could be readily replaced.[31] One study of hospitals' responses to error provides that hospitals respond in a way that attempts to correct for future errors in only 1% of error cases.[32] As the Institute of Medicine finds, errors in treatment are caused by things like poor hospital planning: "[E]rrors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them. For example, stocking patient-care units in hospitals with certain full-strength drugs, even though they are toxic unless diluted, has resulted in deadly mistakes."[33]

Systemic errors are particularly disquieting because they are likely to be repeated with future patients so long as the poorly designed system remains intact.[34] Thus, medical error is relatively widespread, suggesting that under the current system hospitals have insufficient incentives to correct such errors.

B. Proposals for Reform

As can be expected given the widespread incidence of medical error, several legal academics have previously proposed reforms to the current medical malpractice system. Many of these proposals for reforming liability for medical malpractice focus on expanding liability. One of the underlying principles here is that if healthcare providers face expanded liability for their conduct, it may create incentives for those same actors to take due precautions.[35] For instance, Kenneth Abraham and Paul Weiler, among others, have advocated entity liability for hospitals on the belief that hospitals will police

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tice, in which Harvard was able to significantly reduce claims and cut its related malpractice premiums by half. John H. Eichhorn, *Prevention of Intraoperative Anesthesia Accidents and Related Severe Injury Through Safety Monitoring*, 70 ANESTHESIOLOGY 572, 575–77 (1989); John H. Eichhorn et al., *Anesthesia Practice Standards at Harvard: A Review*, 1 J. CLINICAL ANESTHESIOLOGY 55, 64–65 (1988). For a full description of the Harvard reforms and citations to relevant studies, see Abraham & Weiler, *supra* note 13, at 411–13.

[31] *See* Andrews, *supra* note 27, at 358 (noting that errors or harm to patients from faulty equipment are rarely corrected because administrators are rarely informed of the problem).

[32] *Id.* at 365 ("In 68.7% of the errors (which had a response) there was a response aimed at correcting the immediate problem, compared to less than 1% with a response aimed at devising specific means for preventing future errors."). In fact, the same study finds that hospitals were about four times as likely to try to calm error victims down than do anything to prevent future harm. *Id.*

[33] INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM 2 (1999), *available at* http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf (summarizing INST. OF MED., *supra* note 29).

[34] *See* Mello & Brennan, *supra* note 30, at 1628 (noting that preventing systemic risk will reduce likelihood that individual negligence will cause medical error).

[35] *See, e.g.*, *id.* at 1603.

misconduct if they could be liable for medical error.[36] Michelle Mello and Troyen Brennan have gone even further and argued for entity liability for hospitals and a no-fault compensation scheme.[37] Under such proposals, a specifically enumerated class of claims would automatically be compensated regardless of proof of fault.[38] Another line of reasoning, articulated recently by New York University professors Jennifer Arlen and W. Bentley MacLeod, argues that third-party insurers, such as managed care organizations ("MCOs"), should have liability for medical malpractice. In this view, managed care organizations increasingly play an active role in the selected treatment of patients. Through utilization review, which MCOs use to rein in medical costs, they make a determination whether a treatment is medically justified.[39] In Arlen and MacLeod's view, MCOs should be liable if their treatment choice leads to injury.[40] Further, MCOs should be liable for the failures in care among their affiliated physicians.[41] Thus, in one form or another, many legal commentators on tort reforms advocate expanding liability.

C. Politics of Reform

Legal academics are not the only group supportive of expanding liability in the case of medical malpractice. For instance, other important constituencies—patient-victims of medical malpractice and trial lawyers—are also in favor of some expansions of liability.[42] However, the politics of tort reform currently cut in exactly the opposite direction.[43] The politics of tort

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[36] *See* Abraham & Weiler, *supra* note 13; Paul C. Weiler, *Reforming Medical Malpractice in a Radically Moderate—and Ethical—Fashion*, 54 DEPAUL L. REV. 205, 225–26 (2005) (discussing briefly why state experiments with enterprise liability are warranted).

[37] *See* Mello & Brennan, *supra* note 30, at 1636 ("A system of no-fault compensation of avoidable adverse events by hospitals and their insurers should be more appealing to both patients and professionals"). Paul Weiler has also argued in favor of no-fault liability. Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 919–20 (1993); Weiler, *supra* note 36, at 227 ("This is an ethical step because it will treat the patient who is injured in the hospital in essentially the same legal fashion as a nurse injured there.").

[38] *See* Mello & Brennan, *supra* note 30, at 1624–28.

[39] *See, e.g.*, Arlen & MacLeod, *supra* note 25, at 1938–39; *see also* Mello & Brennan, *supra* note 30, at 1625 nn.148–49 (noting literature discussing MCO liability). For literature opposing expanded MCO liability, see Arlen & MacLeod, *supra* note 25, at 1945 n.64.

[40] *See* Arlen & MacLeod, *supra* note 25, at 1987 ("In order to induce MCOs to asset optimal authority, negligence liability must ensure that MCOs bear the cost to patients of each decision to substitute expected MCO-selected treatment for expected physician-selected treatment.").

[41] *See id.* at 2005 ("MCOs should be liable for the negligence of all their affiliated physicians; liability should not be limited to those circumstances where an MCO exerts sufficient direct control over the physician to satisfy the requirements of traditional vicarious liability.").

[42] *See, e.g.*, Weiler, *supra* note 36, at 215 (noting that trial lawyers regularly cite to studies supporting their case for legislation expanding malpractice liability).

[43] In fact, some proponents of proposals for expanded liability have noted as much. *See, e.g.*, Mello & Brennan, *supra* note 30, at 1625 ("Full-fledged enterprise liability, involving elimination of individual physician liability, is not politically feasible.") (footnote omitted); *see also* David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and*

reform suggest that legislators, particularly on the state level, are more likely to restrict liability on providers, rather than endorse any of the aforementioned proposals.[44]

Specifically, as malpractice insurance premiums rose in the last quarter century, physicians protested against the tort system and demanded medical malpractice reform in the form of restrictions on liability. At the height of their activism, physicians threatened work stoppages across the country.[45] By some indications, voters, legislators, and some mainstream publications identified with the perceived plight of doctors. At the end of the 1980s, for instance, *Time* ran a cover story which was sympathetic to physicians facing increasingly high malpractice premiums. According to *Time*, rising premiums were a "national crisis" affecting both physicians and patients:

> Given the litigious nature of American society these days, just about any kind of business, profession or government agency is likely to become the target of a suit alleging malpractice or negligence resulting in personal injury. That makes liability insurance, the kind that pays off on such claims, just about as vital as oil in keeping the economy functioning. But in the past two years, liability insurance has become the kind of resource that oil was in the 1970s: prohibitively expensive, when it can be bought at all.[46]

More recently, a Gallup poll suggests that most Americans support limits on the amount a claimant can recover in a medical liability lawsuit.[47] For instance, one commentator aptly encapsulates the political state of reform:

What (If Anything) Should We Do About It?, 80 TEX. L. REV. 1639, 1655 (2002) (noting that Mello and Brennan's no-fault enterprise liability proposal is likely to have little appeal).

[44] The Bush administration and past Republican-led Congresses have advocated for a federal liability cap, though the chances of a national cap appear, to date, to be remote. *See Assessing the Need to Enact Medical Liability Reform: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 108th Cong. (2003) (statement of Donald J. Palmisano, President, American Medical Association), *available at* http://archives.energycommerce.house.gov/reparchives/108/Hearings/02102003hearing780/Palmisano1279.htm (urging Congress to pass the HEALTH Act); *see also* President George W. Bush, Remarks at High Point University in High Point, North Carolina (July 25, 2002), *in* 2 PUB. PAPERS 1292, *available at* http://frwebgate4.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=865690235366+0+2+0&WAISaction=retrieve ("We need a reasonable federal limit on noneconomic damages awarded in medical liability lawsuits, and the reasonable limit in my judgment ought to be $250,000."). For a thorough review of federal efforts at tort reform, see Shirley Chiu, *A Critical Look at the Non-Economic Damage Cap of the HEALTH Act and Its Impact on Consumers*, 18 LOY. CONSUMER L. REV. 85 (2005). *See also* Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?*, 37 AKRON L. REV. 417, 421–28 (2004) (reviewing recent federal efforts at tort reform).

[45] *See, e.g.*, Kevin J. Gfell, Note, *The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions*, 37 IND. L. REV. 773, 778 (2004) (noting well-publicized physician strikes in Florida, West Virginia, and New Jersey in late 2002 and early 2003 to protest increases in medical malpractice insurance premiums).

[46] George J. Church, *Sorry, Your Policy is Canceled*, TIME, Mar. 24, 1986, at 16.

[47] *See, e.g.*, David Rosenbaum, *Debate on Malpractice Looms for Senate*, N.Y. TIMES, Dec. 20, 2004, at A20 (reporting poll results that "found that about three-quarters of those

> The emotional trauma of having to defend against what often turn out to be misguided malpractice claims, together with the financial trauma of occasional jumps in their malpractice premiums, periodically sends doctors to state capitals—and now the nation's capital—for relief. Because both legislators and voters can more readily empathize with the plight of their family doctor than, for example, drug manufacturers or asbestos producers, such statutory relief has regularly been forthcoming.[48]

Healthcare providers continue their political advocacy for tort reform, forming coalitions,[49] lobbying, and writing letters to major media outlets.[50] In Texas, as one commentator recently noted, some agitators for tort reform, in order to boost Republican votes, sent out a mailer that suggested that 86% of lawsuits for medical malpractice were frivolous.[51] In some sense, even liberal advocacy groups have suggested measures aimed at reducing provider exposure, partly perhaps as a result of public opinion. For instance, the Trial Lawyers Association, a typically Democratic group, has proposed medical malpractice reform measures that will likely reduce the number of medical malpractice suits that providers face.[52] Consequently, despite pitches from academics and some other groups for expanding liability, much of the political rhetoric and legislative reform in the area of medical malpractice has focused on reducing liability for health care providers.

In this regard, the reform most widely endorsed by legislators is a limit on damages that a plaintiff or his or her family can recover in a medical malpractice suit. Beginning with California's Medical Injury Compensation Reform Act of 1975,[53] thirty-nine states have replaced the common law rule and passed some form of liability limit under the guise of general tort re-

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surveyed supported 'a limit on the amount patients can be awarded for their emotional pain and suffering.' "); KAISER PUBLIC OPINION SPOTLIGHT, PUBLIC OPINION ON THE MEDICAL MALPRACTICE DEBATE 1–2 (2005), *available at* http://www.kff.org/spotlight/malpractice/upload/Spotlight_Dec05_malpractice-2.pdf (citing Gallup poll and finding that "[a]bout half (49%) of the public says juries award too much money in malpractice lawsuits and three in ten (30%) say jury award amounts are 'about right' . . . . More than six in ten (63%) say they would favor limits on the amount of money patients can be awarded for emotional pain and suffering.").

[48] Weiler, *supra* note 37, at 910.

[49] For instance, the American Medical Association in collaboration with other interest groups recently formed the Health Coalition for Liability and Access to push for caps on medical liability. *See, e.g.*, Health Coalition for Liability and Access, http://www.hcla.org/ (last visited Oct. 9, 2008) (stating that the HCLA has been formed to "urge Congress to protect patients' access to care by passing commonsense federal medical liability reforms.").

[50] For sample letters, see AMA, Letters to the Editor, http://www.ama-assn.org/ama/pub/category/3289.html (last visited Nov. 9, 2008).

[51] Hyman & Silver, *supra* note 18, at 1100–01.

[52] The trial lawyers have suggested that more suits be resolved out of court by arbitration and have suggested limits on the number of frivolous lawsuits. Angela Galloway, *Democrats Weigh in on Medical Malpractice*, SEATTLE POST-INTELLIGENCER, Mar. 15, 2005, at B2.

[53] 1975 CAL. STAT. 3494–4007, codified at CAL. CIV. CODE § 3333.2 (1997). For a legislative history of California's tort reform, see generally Amanda Edwards, Recent Development, *Medical Malpractice Non-Economic Damages Caps*, 43 HARV. J. ON LEGIS. 213, 221–28 (2006).

form, as shown in Tables 1 and 2. Twenty-eight states have capped awards for punitive damages, twenty-eight states have capped awards for non-economic damages, and sixteen states have approved limits on both.[54] Some states have even extended caps on damages beyond medical malpractice to cover all civil tort cases.[55]

State liability limits on recovery in malpractice cases come in many guises with varying caps.[56] For instance, California and Georgia have limits on recovery of non-economic damages and punitive damages set at $250,000.[57] Some states, like Colorado, Idaho, and Arkansas, fix a maximum dollar amount, but set it to increase with inflation.[58] Some limit the ratio of punitive damages to actual damages or relate permissible recovery to the defendant's profit margin or wealth.[59] For instance, in Mississippi, a plaintiff's recovery for punitive damages can be as much as $20 million if the defendant's net worth is over $1 billion, but recovery cannot be more than $5 million if the defendant's net worth is less than $100 million.[60]

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[54] *See infra* Tables 1 and 2.

[55] In addition to liability caps on punitive damages and noneconomic damages, several other tort reform measures have been proposed, including abolishing joint and several liability, abolishing collateral source rule, limiting lawyer contingency fees, requiring periodic payments (as opposed to lump-sum payments), or creating a federal statute of limitations. For a discussion of the pros and cons of each of these proposals, see COHEN, *supra* note 13. For preliminary discussion of ways to improve these other tort reform measures, see Harris & Longo, *supra* note 17. For the most comprehensive and current database on tort reforms in the fifty states, see Ronen Avraham, Dataset of Tort Law Reforms 1980–2005, http://www.law.northwestern.edu/faculty/fulltime/avraham/docs/tortreformshort032707.xls (last visited Nov. 14, 2008).

[56] For a review of the various state approaches to liability caps, see Amelia J. Toy, Comment, *Statutory Punitive Damage Caps and the Profit Motive: An Economic Perspective*, 40 EMORY L.J. 303, 331–39 (1991).

[57] CAL. CIV. CODE § 3333.2 (1997); GA. CODE ANN. § 51-12-5.1 (2000).

[58] *See, e.g.*, ARK. CODE ANN. § 16-55-208(2)(c) (1987) (providing that "as to the punitive damages limitations established in subsection (a) of this section, the fixed sums of two hundred fifty thousand dollars ($250,000) set forth in subdivision (a)(1) of this section and one million dollars ($1,000,000) set forth in subdivision (a)(2) of this section shall be adjusted as of January 1, 2006, and at three-year intervals thereafter, in accordance with the Consumer Price Index rate for the previous year as determined by the Administrative Office of the Courts."); COLO. REV. STAT. § 13-21-102.5(3)(c)(I) (2007) (providing that the calculation of the damages limitations shall be adjusted to account for inflation); IDAHO CODE ANN. § 6-1603(1) (1947) (providing that "the cap on noneconomic damages established in this section shall increase or decrease in accordance with the percentage amount of increase or decrease by which the Idaho Industrial Commission adjusts the average annual wage as computed pursuant to section 72-409(2), Idaho Code.").

[59] *See, e.g.*, KAN. STAT. ANN. § 60-3702(6) (2005) (noting that courts may consider the defendant's wealth in calculating damages); Toy, *supra* note 56, at 333–34.

[60] *See* MISS. CODE ANN. § 11-1-65(3)(a) (1972) (providing a schedule of damages limitations based on the defendant's wealth).

TABLE 1. MEDICAL LIABILITY LAWS BY STATE (ALA. – MONT.)[61]

State	Any Cap	Pain Cap	Punitive Cap	Citation
Ala.	YES	NO	YES	ALA. CODE SEC. 6-11-21
Alaska	YES	YES	YES	ALASKA STAT. § 09.17.010
Ariz.	NO	NO	NO	
Ark.	YES	YES	YES	ARK. CODE ANN. § 16-55-208
Cal.	YES	YES	NO	CAL. CIV. CODE § 3333.2
Colo.	YES	YES	YES	COLO. REV. STAT. § 13-64-302
Conn.	YES	NO	YES	Although there is no statute, punitive damages are limited by judicial decision to a plaintiff's litigation expenses less taxable costs. *Berry v. Loiseau*, 614 A.2d 414, 435–38 (Conn. 1992).
Del.	NO	NO	NO	
D.C.	NO	NO	NO	
Fla.	YES	YES	YES	FLA. STAT. ANN. § 766.118
Ga.	YES	NO	YES	GA. CODE ANN. § 51-13-1
Haw.	YES	YES	NO	HAW. REV. STAT. § 663-8.7
Idaho	YES	YES	YES	IDAHO CODE § 6-1603
Ill.	YES	NO	YES	735 ILCS 5/2-1706.5
Ind.	YES	NO	YES	IND. CODE § 34-18-14-3
Iowa	NO	NO	NO	
Kan.	YES	YES	YES	KAN. STAT. ANN. § 60-19A02
Ky.	NO	NO	NO	
La.	YES	YES	YES	LA. REV. STAT. § 40:1299.42(B)(1)
Me.	YES	YES	YES	24-A M.R.S. § 4313(9)(B)
Md.	YES	YES	NO	MD. CODE ANN., CTS. & JUD. PROC. § 11-108
Mass.	YES	YES	NO	MASS. GEN. LAWS 231, § 60H
Mich.	YES	YES	YES	MICH. COMP. LAWS § 600.1483
Minn.	NO	NO	NO	
Miss.	YES	YES	YES	MISS. CODE. ANN. § 11-1-60
Mo.	YES	YES	YES	MO. REV. STAT. § 538.210
Mont.	YES	YES	NO	MONT. CODE ANN. § 25-9-411

[61] *See generally* Cohen, *supra* note 13; *see also* Avraham, *supra* note 55.

TABLE 2. MEDICAL LIABILITY LAWS BY STATE (NEB. – WYO.)[62]

State	Any Cap	Pain Cap	Punitive Cap	Citation
Neb.	YES	YES	YES	NEB. REV. STAT. § 44-2825
Nev.	YES	NO	YES	NEV. REV. STAT. ANN. § 42.005
N.H.	YES	NO	YES	N.H. REV. STAT. ANN. § 507:16
N.J.	YES	NO	YES	N.J. STAT. ANN. § 2A: 15-5.14
N.M.	YES	YES	NO	N.M. STAT. ANN. § 41-5-6
N.Y.	NO	NO	NO	
N.C.	YES	NO	YES	N.C. GEN. STAT. § 1D-25
N.D.	YES	YES	YES	N.D. CENT. CODE § 32-42-02
Ohio	YES	YES	NO	OHIO REV. CODE ANN. § 2323.43
Okla.	YES	YES	YES	OKLA. STAT. ANN. 63 § 1-1708.1F
Or.	YES	NO	YES	OR. REV. STAT. § 31.740
Pa.	YES	NO	YES	40 PA. STAT. ANN. § 1303.505(D)
R.I.	NO	NO	NO	
S.C.	YES	YES	NO	S.C. CODE ANN. § 15-32-220
S.D.	YES	YES	NO	S.D. CODIFIED LAWS § 21-3-11
Tenn.	NO	NO	NO	
Tex.	YES	YES	YES	CIV. PRAC. & REM. § 41.008
Utah	YES	YES	NO	UTAH CODE ANN. 1953 § 78B-3-410
Vt.	NO	YES	NO	
Va.	YES	NO	YES	VA. CODE ANN. § 8.01-38.1
Wash.	NO	NO	NO	
W. Va.	YES	YES	NO	W. VA. CODE ANN. § 55-7B-8
Wis.	YES	YES	YES	WIS. STAT. ANN. § 655.017
Wyo.	NO	NO	NO	

[62] *Id.*

D. Against Today's Tort Reform

Tort reform, as currently designed, is bad policy for several reasons.[63] Since many of these areas have had sufficient treatment elsewhere in the literature,[64] this Part takes the liberty of moving lightly and briskly.

1. Physician Conduct

Efforts at general tort reform are inadequate because they fail to take seriously the prospect of physician misconduct. The potential of an unlimited or "uncapped" damage award deters misconduct from healthcare providers.[65]

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[63] By "policy" arguments, this Article intends to distinguish but not overshadow the constitutional arguments that might be made against liability caps. Specifically, some of the opponents of caps have argued, frequently successfully, that the caps infringe on important constitutional rights, including most notably, rights to equal protection and trial by jury. *See, e.g.*, Arneson v. Olson, 270 N.W.2d 125, 135–36 (N.D. 1978) (holding that the North Dakota cap of $300,000 violated the state equal protection clause and stating "[c]ertainly the limitation of recovery does not provide adequate compensation to patients with meritorious claims; on the contrary, it does just the opposite for the most seriously injured claimants. . . . Restrictions on recovery may encourage physicians to enter into practice and remain in practice, but do so only at the expense of claimants with meritorious claims."). *Compare* Robert S. Peck, *Violating the Inviolate: Caps on Damages and the Right to Trial by Jury*, 31 U. DAYTON L. REV. 307, 310–11 (2006) (noting that at least eight state courts have struck down damage caps as unconstitutional and that such caps violate the right to trial by jury), *with* James F. Tiu, Comment, *Challenging Medical Malpractice Damage Award Caps on Seventh Amendment Grounds: Attacks in Search of a Rationale*, 59 U. CIN. L. REV. 213 (1990) (making the case that the liability caps do not violate the Seventh Amendment right).

The supreme courts in several states have overturned state damage caps as unconstitutional. For example, in Alabama, the state supreme court found that the cap that limited recoveries to one million dollars in medical malpractice cases violated equal protection and the jury right under the state constitution. Smith v. Schulte, 671 So. 2d 1334, 1342–43 (Ala. 1995) ("The notion that the lives of some of Alabama's citizens are worth less than the lives of others is an idea that carries the gravest of implications. . . . Therefore we hold that § 6-5-547 violates the equal protection guarantee of the Constitution of Alabama." (emphasis omitted)); *id.* at 1343 ("[I]n imposing, regardless of the facts in each [case], an absolute limitation on the amount of damages the jury may assess, [the state damages cap] . . . inhibits the jury in the most fundamental aspect of its function."). In New Hampshire, the plaintiffs challenged the state's damage cap on various grounds under the state's constitution, including equal protection, due process, and the right to a jury. Brannigan v. Usitalo, 587 A.2d 1232 (N.H. 1991). On the basis of a prior state supreme court opinion, the New Hampshire court held that the $875,000 cap violated equal protection and did not reach the other causes of action. *Id.* at 1236. The Oregon Supreme Court held that a damage cap of $500,000 violated the right to jury trial. Lakin v. Senco Prods., Inc., 987 P.2d 463, 473 (Or. 1999) ("We conclude that to permit the legislature to override the effect of the jury's determination of noneconomic damages would 'violate' plaintiffs' right to 'Trial by Jury,' guaranteed in Article I, section 17.").

[64] For a thorough review, see Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501 (2004); Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 PENN ST. L. REV. 1077 (2004).

[65] *See, e.g.*, Arlen & MacLeod, *supra* note 25, at 1939–40 (noting the deterrent effect of liability).

Medical malpractice lawsuits with unlimited recovery are a way of policing misconduct and weeding out bad doctors, which neither insurance companies nor physician organizations track satisfactorily. Unlike other forms of insurance, such as auto insurance, past performance does not affect how much medical liability insurance a private physician pays.[66] Bad doctors are not penalized by insurance companies, which do not normally take into account previous performance when assessing medical malpractice insurance rates. Instead, insurance companies usually charge premiums based on general factors like physician specialty. Thus, insurance companies largely do not account for the competence, skill, and quality of medical services provided by the physician.[67]

At the same time, advocates of unlimited recovery mention that state disciplinary boards may also insufficiently police the conduct of healthcare providers. For instance, according to one report, more than 35,000 doctors had more than one medical malpractice payout between 1990 and 2002.[68] Of those, only 7.6% were disciplined by their respective state disciplinary board.[69] According to this same data, state boards disciplined less than 17% of doctors with five or more medical malpractice payouts.[70] Since these doctors—doctors likely to commit multiple acts of malpractice—do not necessarily face higher insurance premiums or sanction by peer organizations when they demonstrate incompetence, they may be under-deterred.[71]

2. Allocation of Losses

General tort reforms are poorly designed because they tilt the scales, placing undue and unwanted burdens on the injured. Current tort reform limits on provider liability are unfair because they, in effect, transfer losses

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[66] *See* Carrie Lynn Vine, *Addressing the Medical Malpractice Insurance Crisis: Alternatives to Damage Caps*, 26 N. ILL. U. L. REV. 413, 427–28 (2006) (noting that "in most cases prior claim or payout history does not affect premium rates even though such past history has been shown to be extraordinarily useful in setting accurate premium rates").

[67] Catherine Sharkey, *Unintended Consequences of Medical Malpractice Damage Caps*, 80 N.Y.U. L. REV. 391, 410 (2005) (noting that physicians are not experience-rated and, thus, both "negligent and non-negligent physicians pay similar premiums").

[68] PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS: CHALLENGING THE MALPRACTICE CLAIMS OF THE DOCTORS' LOBBY 22 (2003), http://www.citizen.org/documents/FinalBRIEFING%20BOOK—MISDIAGNOSIS.pdf.

[69] *Id.*

[70] *Id.*

[71] For a thorough review of the literature on this point, see Hyman, *supra* note 43, at 1644–45 (noting the consequences of an insurance system not based on experience ratings). *See also* Gary M. Fournier & Melayne M. McInnes, *The Case for Experience Rating in Medical Malpractice Insurance: An Empirical Evaluation*, 68 J. RISK & INS. 255, 274 (2001) ("Proponents of experience rating argue that the tort system is designed to provide incentives for care by allocating costs of negligence to the physician, and that current insurance blunts these incentives because all physicians share the costs.").

from the deserving to the undeserving.[72] The problem with liability caps is that they often operate to prevent full recovery among the parties that are in need of compensation, the recently injured, while permitting the negligent to partially escape liability.[73] Furthermore, according to some commentators, caps on liability, like non-economic damage caps, disproportionately penalize members of vulnerable groups, such as women, children, and minorities, all of whom are more likely to realize comparatively substantial non-economic loss.[74] Lucinda Finley argues that a cap on non-economic damages has a particularly harsh effect on women who experience unique harm from injuries that impair fertility, sexual function, continence and ability to reproduce, but might not necessarily suffer from lost wages or other traditional economic harm.[75] A similar argument is that an overreliance on work-life expectancy to calculate economic damages, and exclusion of non-economic damages under cap legislation, might have an adverse impact on minorities and women who might have, on average, shorter work-life expectancy.[76] Thus, while the losses of cap legislation accrue to the injured, the gains from damage caps accrue to the most negligent physicians. Perversely, doctors who cause the worst injuries are the ones who benefit from a damage cap.[77]

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[72] Weiler, *supra* note 36, at 223 ("[R]eform would apparently make a radical change in our historic 'corrective justice' theory of tort law, making the culpable actor pay for all the damages he has inflicted on the innocent victim.").

[73] Nathanson, *supra* note 64, at 1109 ("As the level of the cap rises, so does the selectivity of the case singled out to bear the brunt (albeit unsuccessfully) of reform. However, as these cases inherently represent the clearest cases of liability and/or the most grievous damages suffered, it is contrary to common sense notions of justice and fairness to place the laboring oar of reform in their hands." (citations omitted)).

[74] Lucinda Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263 (2004) (showing that women tend to be awarded larger sums for non-economic losses).

[75] *See id.* at 1296 (studying twenty-eight cases of gynecological malpractice in California); Edwards, *supra* note 53 at 219; *see also* PAUL RUBIN & JOANNA SHEPHERD, THE DEMOGRAPHICS OF TORT REFORM: WINNERS AND LOSERS, *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=967712 (last visited Nov. 14, 2008) (noting that tort reform has differential impact on death rates for females).

[76] Edwards, *supra* note 53, at 220–21 ("The work-life expectancy of the claimant and the average wage the claimant would have earned absent the malpractice are the factors used to tabulate economic damages. . . . According to the U.S. Bureau of Labor Statistics, the work-life expectancy for a white man injured at age thirty was estimated to be 4.7 years longer than that of a minority man, 8.7 years longer than that of a white woman, and 9.2 years longer than that of a minority woman.").

[77] Nathanson, *supra* note 64, at 1109–10 ("From the perspective of the physician, capping is likewise undesirable in that such a system protects the most clearly negligent doctors at the expense of the non-negligent. Those who commit the most grievous mistakes and cause the most significant injuries are protected through a limitation of their liability, while no protection is offered to those who practice good medicine.").

4. Medical Malpractice Costs

General tort reforms are unlikely to significantly moderate the cost of healthcare, though this claim has been strongly disputed.[78] Opponents of liability caps disbelieve the presupposed relationship between liability caps and medical malpractice insurance premiums.[79] Rather, in their view, insurance premiums are the upshot of investment decisions of insurers.[80] They also point out that this supposed connection between insurance premiums and lawsuits is weak because very few medical malpractice lawsuits actually result in a decision that would implicate a liability cap.[81]

One rebuttal to the assumed relationship between liability caps and medical malpractice insurance premiums attempts to show that healthcare premiums are primarily affected by insurance companies' ability to manage their cash reserves.[82] The consumer group Americans for Insurance Reform

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[78] For instance, one author summarizes the argument that tort reform does in fact result in cost reduction as follows:

> [I]n 1975 California had the highest premiums in the nation, but its premiums currently ran in the lowest one-third; the decrease has been attributed to MICRA [the Medical Injury Compensation Reform Act]. Second, the American Academy of Actuaries, the Physician Insurers Association of America ("PIAA"), and the Medical Liability Monitor ("MLM") have all assessed California data and concluded that, as a result of MICRA, California physicians pay less in insurance premiums and California patients have greater access to healthcare.

Liang & Ren, *supra* note 64, at 505–06 (citations omitted).

[79] Carrie Lynn Vine, *Addressing the Medical Malpractice Insurance Crisis: Alternatives to Damage Caps*, 26 N. ILL. U. L. REV. 413, 424–25 (2006) (arguing that only a small number of cases actually go to verdict for the statutorily capped amount and, thus, have little effect in reducing medical malpractice insurance) ("On average, only 1.3% of medical malpractice claims filed ultimately result in a plaintiff's verdict at trial. . . . In addition, of the 1.3% of cases that do result in a plaintiff's verdict, many are below the established statutory caps. . . . When viewed in light of how few cases damage caps actually affect, it is clear why damage caps do not substantially reduce the combined ratio and therefore do not have a substantial effect on the medical malpractice insurance crises."). Nonetheless, though this area of legal reform only impacts very rare victorious suits with very high damages, these atypical cases are the core of the tort reform debate as to whether such plaintiffs should be able to recover the full extent of their damages. *See infra* text accompanying notes 92–93.

[80] For a good, succinct review of the most recent empirical studies examining a link between liability caps and medical malpractice insurance premiums, see Kathryn Zeiler, *Turning from Damage Caps to Information Disclosure: An Alternative to Tort Reform*, 5 YALE J. HEALTH POL'Y L. & ETHICS 385, 391–94 (2005).

[81] Nathanson, *supra* note 64, at 1102 ("However, as this section shows, because, percentage-wise, so few cases ultimately go to a plaintiff's verdict, such caps and multipliers are, for the most part, directly irrelevant to the problem. Moreover, because the overwhelming majority of cases that settle out of court do so for amounts below the level of most caps, they are of little indirect relevance as well. However, these caps do exact an enormous social cost.").

[82] *See* Lucinda Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263, 1274 (2004) ("[I]nsurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely under-price their policies and insure very poor risks just to get premium dollars to invest. This is known as the 'soft' insurance market." (quoting AMERICANS FOR INS. REFORM, MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES 2–3 (2002), *available at* http://www.insurance-reform.org/StableLosses.pdf)).

argues that in times of rising interest rates insurance companies are able to use their premiums to realize high investment returns.[83] In times of declining interest rates, the opposite is true.[84] Along the same line, opponents of caps would argue that the increases in insurance premiums are a result not just of the economic environment, but also of the investment decisions of insurance companies. They would accuse these companies of too often mismanaging their money and attempting to raise premiums to make up for investment losses.[85]

Critics of caps also argue that the supposed relationship between jury awards and malpractice insurance premiums is a canard, since many medical malpractice cases settle and few go to trial.[86] They argue that few trials for medical malpractice go to verdict, even fewer result in a plaintiff's verdict, and only a tiny minority of those result in a plaintiff's verdict large enough to implicate the cap.[87] Thus, these critics posit, the universe of cases that might actually be subject to a liability cap is microscopic. One study found that from 1985 to 1999, fewer than 7% of medical malpractice claims went to verdict and only 1.3% produced verdicts for the plaintiff.[88] Another study finds that only about one in eight patients injured by negligence files a claim.[89] The study concludes that the problem is "not too many claims, but, if anything, too few claims."[90] Of those plaintiff/claimants who actually recover from a malpractice insurer, most do not recover an amount large enough to be reduced by a liability cap.[91] Consequently, opponents of caps would argue that there is little relationship between medical malpractice liability caps and medical malpractice insurance premiums.

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[83] *See generally* Finley, *supra* note 82, at 1274 (2004) (arguing that the so-called liability insurance crisis is explained by falling interest income, which forces the insurance industry to increase premiums, reduce coverage or both).

[84] *See* Weiler, *supra* note 36, at 210 (noting that insurers left the market when bond interest rates started to decline).

[85] *Id.* at 209–10 (noting that a large part of insurance revenue is generated by investing malpractice premiums in financial markets); *see also* Nathanson, *supra* note 64, at 1081–83 ("In this regard, the first few years of the twenty-first century have been historic for two reasons: both in the depths to which the bond market has plunged as well as the duration of this plunge. . . . The Federal Reserve cut interest rates repeatedly during this time, diminishing the investment returns of commercial insurers with every reduction. This, in turn, has caused premiums to increase repeatedly in order to offset these losses.").

[86] *See generally* Nathanson, *supra* note 64, at 1090–92.

[87] *See id.* at 1102.

[88] Insurance Information Institute, *Hot Topics and Insurance Issues*, http://www.iii.org/media/hottopics/insurance/medicalmal (last visited Nov. 9, 2008) ("Thus, the capping and multiplier statutes have no direct effect on approximately 99% of all medical malpractice cases filed."); *see also* Nathanson, *supra* note 64 at 1107.

[89] COHEN, *supra* note 13, at 1 (discussing some common law sources of the jury's right to determine punitive damages).

[90] *Id.*

[91] THOMAS H. COHEN & KRISTEN A. HUGHES, BUREAU OF JUSTICE STATISTICS, MEDICAL MALPRACTICE INSURANCE CLAIMS IN SEVEN STATES 2000–2004, at 1 (2007), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/mmicss04.pdf (stating that about two-thirds of claimants who received compensation were paid less than $250,000).

Nevertheless, opponents of tort reform are unsuccessfully fighting a two-front war. On one front, they must present the empirical case that major medical malpractice judgments are so few in number as not to make a difference for the insured. Although beyond the scope of this article, the data on this point appears mixed.[92] However, on the other, they must also overcome the belief among many, whether empirically based or not, that medical malpractice awards are bankrupting providers and playing a role in swelling insurance premiums.[93] Even if the opponents of caps are right and the effects of medial malpractice cases on the insured are limited, opponents still must deal with the political appeal of tort reform.

E. Summary

To conclude, although the number of medical errors has been significant, it has not stemmed the demand for tort reform. Most reform efforts to date have aimed to reduce provider liability for medical malpractice, usually in the form of liability limits enacted by state legislatures. Although these efforts contrast noticeably with the types of reform advocated by several notable legal scholars on the subject—many of whom have suggested expanding liability on providers—they remain wildly popular among legislators.[94] As a consequence, it appears that for any reform to have a chance of mobilizing a significant constituency politically, it likely must include some limitation or cap on recovery against healthcare providers.

The idea of creating a tort reform rule based on provider performance has the advantage, therefore, of acknowledging the political reality that liability caps have tremendous appeal and that any proposal that entirely abandon limits on liability would likely be politically unfeasible. This Article proposes instead that state legislatures should continue to embrace liability caps for providers, along with other tort reforms, but also tweak their cap rules to take into account provider performance. In this view, only providers with solid track records of high-quality performance would be eligible for the benefit of a limit on liability. The next Parts explain how states can link tort reform legislation to hospital performance and discuss the most probable effects of such a link.

III. Why Hospitals?

This Article proposes that states should initially tie tort reform legislation to the performance of hospitals, such that only top-performing hospitals would receive the benefits of protections like limits on liability. Under this

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[92] *See, e.g.*, *generally* Tom Baker, The Medical Malpractice Myth (University of Chicago Press 2005).

[93] *See supra* text accompanying notes 42–48.

[94] Most state legislatures have approved damage caps. *See supra* Tables 1 and 2.

structure, performance would be measured based on the frequency with which hospitals comply with the best treatment practices, giving them new incentives to avoid medical error, police misconduct, and adhere strictly to best practices. Before discussing in greater detail the likely positive effects of a performance-based tort reform rule on the behavior of hospitals and physicians generally,[95] it is important to first explain why this Article advocates initially targeting hospitals, as opposed to other types of providers or actors in the healthcare system.

Two principles about healthcare quality and medical malpractice drive the notion that new incentive-oriented tort reform should primarily target the performance of hospitals rather than other healthcare actors, such as physicians. First, a significant share of consequential medical practice and, therefore, medical malpractice occurs at hospitals,[96] so a proposal that targets hospitals would likely have greater effects than one that targets other sites, where fewer cases of medical error actually occur. Second, performance-based reforms only operate as an effective incentive if reliable measures of good conduct exist that can serve as a basis for determining eligibility in the first place, and most modern hospitals generally have more experience policing quality and physician conduct than other actors.[97] Thus, hospitals, motivated by the possibility of a limit on liability, could be positioned to do the work of weeding out bad physicians and rewarding good ones.

A. Site of Medical Error

Performance-based tort reforms should target hospitals because hospitals appear to be the site where most medical errors occur. While no source conclusively measures national levels of medical malpractice by location—that is, whether an alleged incident occurred on or off hospital premises—and some number of medical errors that result in harm certainly occur in settings such as doctors' offices, laboratories, or nursing homes, the currently available data suggests that the vast majority of reported medical malpractice events occur at hospitals.[98]

Ex ante spending on hospital care prior to medical error provides one indication that a significant share of medical events—and, likely, of medical

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[95] *See infra* Part IV ("Performance-Based Tort Reform in Theory").

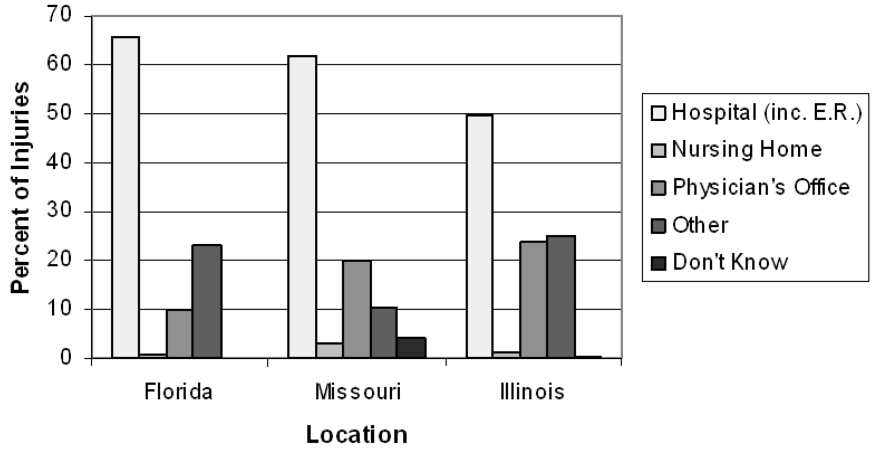
[96] *See infra* text accompanying notes 97–101.

[97] *See infra* text accompanying notes 102–114.

[98] Other authors have concluded the same. *See* Lori Andrews, *Studying Medical Error* in Situ*: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 358–59 (2005) (noting that more than 80% of malpractice claims occur based on actions taken in a hospital). This matches early data on the site of medical malpractice events. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTERS: MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 52–53 (1987) (finding that 80% of claims took place in hospitals); Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 416 (1994) (citing the GAO findings).

malpractice events—occurs at hospitals. The American Hospital Association estimates that hospital care spending represents at least one-third of all healthcare spending, a significant share.[99] A recent Bureau of Justice Statistics study of three states—Florida, Missouri, and Illinois—that have collected records on the site of medical malpractice events over a four-year period found that 50-66% of medical malpractice injuries occurred in hospital facilities, a category that includes inpatient facilities, outpatient facilities, and emergency rooms.[100]

FIGURE 1. MEDICAL MALPRACTICE BY FACILITY IN THREE STATES (2004-05)[101]



Finally, according to national data provided by the National Practitioner Databank, about three-fourths of all allegations of medical malpractice arose out of surgery, treatment, and diagnosis—three areas likely taking place in hospitals.[102] Because these findings suggest that hospitals are the site of most medical malpractice events, states should consider linking tort reforms to hospital conduct.

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[99] AM. HOSP. ASS'N, OVERVIEW OF THE U.S. HEALTH CARE SYSTEM 2 (2005), http://www.aha.org/aha/content/2005/PowerPoint/0502-us-system-overview.ppt (noting that in 2003 about 31% of total healthcare spending—$522 billion out of a total of $1.7 trillion—was spent on hospital care). *See also* David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1648 (2002) (noting that Medicare spending on hospital care was 40–60%, though probably declining over time).

[100] These three states appear to be the only three states in the country that require insurance companies to report on the site of the medical malpractice event. *See* COHEN & HUGHES, *supra* note 91, at 3 (reporting findings and showing that the largest share of injuries occurs in hospital inpatient facilities).

[101] *Id.*

[102] For instance, 70% of surgeries are done in hospitals. *See* National Practitioner Data Bank, http://www.npdb-hipdb.hrsa.gov/ (last visited October 9, 2008).

B. Measures of Medical Error

Performance-based reforms have the best chance of success if they are targeted toward healthcare institutions like hospitals that can reliably measure quality. One reason hospitals may offer a better target for incentive-driven reform is that hospital-level reporting data on measurable indications of quality and error rate offers a greater potential number of observations than physician-level data, providing more raw data to track changes in quality and to work with generally.

More importantly, on the hospital side, data to measure quality is already readily available, making further action by a state legislature interested in this type of reform unnecessary. The federal Centers for Medicare and Medicaid Services currently report hospital-level data, recording whether providers follow clinical guidelines during four targeted conditions: heart attack, heart failure, pneumonia, and surgery.[103] The online data set records how often hospitals throughout the United States provide "some of the recommended care to get the best results for most patients."[104] The data records twenty-one different indications of quality control based on voluntary reporting by hospitals from patient records.[105]

Since about 33% of healthcare spending originates from federal dollars, this data set tends to be fairly comprehensive.[106] More than 4000 hospitals participated in the online database, representing over 70% of all hospitals in the United States.[107] Collectively, these hospitals provided more than 45,000 observations of compliance with clinical guidelines for treatment of the four targeted conditions.[108]

C. Policing of Medical Error

It makes sense to place the incentive on the actor in the best position to police and control treatment choices. Most modern hospitals already have elaborate organizational structures in place, including credentialing, internal

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[103] *See* Hospital Compare, *supra* note 24.

[104] Participating hospitals report whether they have followed clinical guidelines in several areas of treatment. *See id.*

[105] Hospitals that receive payments from Medicare are eligible for incentive payments if they participate. Hospital Compare: How to Use This Information: Information About Hospitals Reporting in Hospital Compare, http://www.hospitalcompare.hhs.gov/Hospital/Static/SupportingInformation_tabset.asp?activeTab=3&language=english&version=default (last visited Nov. 14, 2008).

[106] *See* AM. HOSP. ASS'N, *supra* note 99, at 6 (noting that approximately 33% of healthcare spending originates from Medicare and Medicaid).

[107] *See* AM. HOSP. ASS'N, FAST FACTS ON US HOSPITALS (2006), *available at* http://www.aha.org/aha/content/2007/pdf/fastfacts2007.pdf (noting that there are more than 5747 registered hospitals in the United States); Hospital Compare, Highlights, http://www.cms.hhs.gov/HospitalQualityInits/05_HospitalHighlights.asp (last modified Aug. 28, 2008) (stating that more than 4000 hospitals have voluntarily reported data on quality of care provided from October 2004 through September 2005).

[108] For a list of the clinical guidelines recorded, *see infra* Table 3.

standards, and bylaws, to police and enforce healthcare quality. Hospital governance structure also provides oversight, usually based on the so-called "three-legged stool" model named to reflect the responsibilities of three groups: hospital executives and administrators, the hospital board of directors, and the medical staff.[109] Each of these groups routinely evaluates healthcare quality and clinical ability.[110]

Briefly, credentialing is an appointment process whereby hospitals screen both new and returning physicians to determine whether they should be granted hospital access and staff privileges. As part of the process, hospitals usually appoint new physicians and review and reappoint current physicians every two years.[111] During this ongoing review and appointment process, credentialing committee members conduct background checks;[112] examine past cases performed by the physician; and look for signs of substandard patient care, bad judgment, alcohol or drug abuse, or failure to file or complete medical records.[113]

Hospitals also review quality based on peer review, a process that involves ongoing monitoring of physicians' standards and conduct.[114] Like the credentialing process, peer review gives members of a medical department a chance to monitor levels of care and competence.[115]

Finally, hospitals have also established internal standards of good conduct. The internal standards, for instance, usually dictate the minimum number of cases a physician should have performed.[116]

IV. Performance-Based Tort Reform in Theory

Hospitals are sued frequently for allegations of medical errors.[117] Traditionally, under agency theory, hospitals were able to avoid medical malpractice liability under *respondeat superior* by demonstrating that a medical

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[109] *See, e.g.*, John D. Blum, *Feng Shui and the Restructuring of the Hospital Corporation: A Call for Change in the Face of the Medical Error Epidemic*, 14 Health Matrix 5 (2004) (noting that the "three-legged stool" concept still provides a current description of hospital organizational structure).

[110] John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics, and Conflicting Agendas*, 53 Buff. L. Rev. 459, 467 (2005) [hereinafter Blum, *Beyond the Bylaws*] (explaining credentialing); Ronald G. Spaeth, Kelley C. Pickering, & Shannon M. Webb, *Quality Assurance and Hospital Structure: How the Physician-Hospital Relationship Affects Quality Measures*, 12 Annals Health L. 235, 235–36 (2003).

[111] Spaeth et al., *supra* note 110, at 236.

[112] *See* Blum, *Beyond the Bylaws*, *supra* note 110, at 467. Incidentally, hospitals are also privy to non-public information collected by the National Practitioner Data Bank regarding physician quality. *See, e.g.*, Lee A. Harris, Op-Ed., *Let Patients Know Facts About Doctors*, Com. Appeal (Memphis), Aug. 7, 2005, at V3.

[113] *See* Blum, *Beyond the Bylaws*, *supra* note 110, at 468.

[114] *See* Spaeth et al., *supra* note 110, at 237.

[115] *See id.*

[116] *See id.* at 235–36.

[117] *See* Cohen & Hughes, *supra* note 91, at 3 (citing data from closed claims in three states).

malpractice event was the result of a failure of an independent contractor physician rather than a hospital employee.[118] More recently, however, state courts have increasingly rejected this theory as a means to allow hospitals to escape employer liability.[119] Even if a hospital does manage to avoid liability based on the employee/independent contractor distinction, it still bears the cost of its legal expenses, including hiring lawyers, filing motions or briefs in court, and/or conducting discovery. In addition to employer liability, hospitals also face the prospect of direct liability under theories of corporate liability, based on, for example, allegations that they negligently selected staff physicians or failed to police the conduct of affiliated physicians.[120]

Furthermore, hospitals are more likely to be "repeat players" in medical malpractice suits than other actors, such as physicians, because hospitals are accused of medical malpractice more often, settle more suits, and have more verdicts.[121] The Bureau of Justice Statistics identifies hospitals as the most frequently named institutions in malpractice insurance claims, with claims against hospitals representing 18-27% of all medical malpractice insurance claims.[122] All of these reasons suggest that hospitals, because of their exposure to liability, are likely to respond strongly to well-designed medical malpractice reform.[123]

Accordingly, the proposal for performance-based reform creates several positive incentives for hospitals—not to mention doctors and other providers under the hospital aegis—that neither of the current alternatives, general liability limits or unlimited recovery, provides. Tying eligibility for the protection of tort reforms to performance creates an incentive for underperforming hospitals to improve their overall quality of care. For example,

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[118] *See* Abraham & Weiler, *supra* note 13, at 385 (noting that hospitals historically were "almost totally immune from malpractice liability until the 1940s"); Allen D. Allred & Terry O. Tottenham, *Liability and Indemnity Issues for Delivery Systems*, 40 ST. LOUIS U. L.J. 457, 464 (1996) (explicating the physician's relationship to the hospital and the concept of independent contractor services); Andrews, *supra* note 27, at 380 (discussing traditional protection from liability for independent contractors); Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 299–300 (1995) (discussing history of protection for physicians and nurses as independent contractors of the hospital).

[119] *See* Abraham & Weiler, *supra* note 13, at 385–87 (recounting the history of hospital liability for injuries by employee-physicians, staff or affiliated physicians); Lori Andrews, *Studying Medical Error* in Situ*: Implications for Malpractice Law and Policy,* 54 DEPAUL L. REV. 357, 380–81 (2005) (noting that, in twenty-two states, "agency principles can be used to hold hospitals liable" (citation omitted)).

[120] *See* Andrews*, supra* note 27, at 381–82 (noting that a majority of states permit recovery under corporate liability).

[121] *See* Mello & Brennan, *supra* note 30, at 1623 (noting that hospitals are "repeat players in the tort system").

[122] *See* COHEN & HUGHES, *supra* note 91, at 3 (citing closed claims in Missouri, Texas and Maine, respectively). Furthermore, as the Bureau of Justice Statistics points out, this number is probably under-reported, since many hospitals are self-insured and, thus, not tracked. *Id.* at 9.

[123] *See* Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1625 (2002) (arguing that hospitals are "much more likely than individual physicians to respond to the malpractice deterrent signal").

hospitals would have a greater incentive to act aggressively to punish and expel poorly-performing physicians who could jeopardize their quality standing. Conversely, hospitals would also have a stronger incentive to reward good physicians—for example, through incentive compensation. Reform tied to performance could also be designed to incentivize healthcare cost savings. Finally, a performance-based rule seems to be in line with fundamental notions of fairness. For example, if potential patients were given an opportunity to bargain for who should bear losses in the event of an injury, it seems that the vast majority of patients would favor a rule of performance-based reform over the other two current options, a general liability limit or a rule of unlimited recovery.[124]

A. Underperforming Hospitals

One problem with general liability limits is that they do not create adequate incentives for underperforming healthcare providers to improve their quality. In contrast, since performance-based reform would only be available for top-performing hospitals, it would give underperforming hospitals a new incentive to improve institutional operations such that they might be eligible for a limit on their liability. In an effort to obtain or retain eligibility for a limit on damages, hospitals would have an incentive to attempt to comply with best practices.

For instance, many underperforming hospitals would likely cherish the benefit of the limits on damages, since it would lead to real savings. Underperforming hospitals that buy private market insurance to cover medical malpractice costs would likely invest resources to improve quality along the twenty-one Medicare quality measures previously mentioned because cap eligibility would likely lead to a reduced and renegotiated malpractice insurance contract with insurers.[125]

The operation of the current system suggests that hospitals that buy private insurance could realize significant insurance savings if they were able to avoid large damage awards. For example, the current private insurance market rates hospitals that purchase private insurance based on the claims they pay out.[126] When a hospital experiences an above-average number of claims, the price of its insurance premiums can increase dramatically.[127] It follows that a hospital that can guarantee lower claims because of

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[124] *See infra* text accompanying note 133.

[125] *See* Abraham & Weiler, *supra* note 13, at 403–04 (arguing that hospitals, compared to individuals, are better able to budget outlays for medical malpractice expenses, regardless of whether the hospitals privately- or self-insure).

[126] *See* Mello & Brennan, *supra* note 123, at 1597–98. This is far different from how insurance is priced for physicians. For physicians, their individualized history of claims is not related to the price of medical malpractice insurance charged by insurers. *See id.* at 1598, 1609 (describing empirical results).

[127] *See id.* at 1618 (reporting, in a review of the effectiveness of malpractice reform, that a hospital can see upwards of a twenty-five percent swing in premiums).

eligibility for a liability limit should be able to negotiate a lower insurance bill.

Additionally, rather than buying private insurance, some hospitals self-insure, internally managing the costs associated with medical malpractice allegations.[128] The decision among some hospitals to self-insure arose after several hospitals were unable to buy private insurance following the spike in tort recoveries in the 1970s.[129] Like all hospitals, though, hospitals that self-insure are frequently haled into court to confront allegations of medical malpractice. Because hospitals that self-insure bear the costs of medical malpractice litigation more visibly and in a way that directly affects their bottom line, underperformers that self-insure might have an even greater incentive to make quality improvements, since the savings realized from protection under a limit on liability might seem even more immediate and tangible than a reduction in malpractice insurance premiums.

B. Underperforming Physicians

As recounted above, while general liability limits may serve as a means of reducing the cost of lawsuits and insurance premiums and may expand access to health care, such limits do little to create incentives for health care providers to terminate the employment of underperforming doctors. General liability limits of the kind that states are approving today may arguably actually promote physician misconduct, since they limit the possibility of having to fully compensate every injured patient. As opponents of general liability limits have argued, hospitals and other healthcare providers that operate in states that have adopted limits on liability have less incentive to take precautions.[130] The fact that providers are underexposed to damages because of caps on liability in some states, and consequently do not bear the full negative costs of their actions, means that they have less of a financial incentive to mitigate the chances of these negative events occurring.

In contrast, performance-based tort reform rules might create a positive effect of driving poorly performing doctors out of mainstream practice. In other words, if liability limits are based on performance, hospitals would have a new motivation to do the work of dismissing poorly performing doctors. First, consider the perspective of the top hospitals. Because "over-performing" hospitals will have an incentive to maintain high quality and eligibility for liability limits, they will have a corresponding incentive to punish and expel poorly-performing physicians that could jeopardize their quality standing. Similarly, underperforming hospitals that are improving such that they can gain eligibility for the limit on liability will also have a

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[128] *See* Abraham & Weiler, *supra* note 13, at 403 (citing FRANK A. SLOAN, RANDALL R. BOVBJERG & PENNY B. GITHENS, INSURING MEDICAL MALPRACTICE 70 (1991)).

[129] Mello & Brennan, *supra* note 123, at 1617.

[130] *See, e.g.*, Arlen & MacLeod, *supra* note 25, at 1938 (noting the deterrent effect of liability).

strong incentive to police the quality of physician conduct and get rid of poorly performing doctors. Both the top hospitals and the improving ones will have a greater incentive to increase their screening of doctors before granting credentials and increase monitoring of physicians once they come onboard.

As hospitals weed out poorly performing physicians, these physicians would likely find fewer places to ply their craft. These physicians and other healthcare providers would be at a great disadvantage to other good physicians who have no problem getting credentialed for employment at major hospitals. Because research suggests that a relatively small proportion of physicians account for a disproportionate share of medical malpractice events,[131] the effect on overall healthcare quality could be significant. Also, given that there are relatively few poor physicians compared to the medical community at large, effectively shutting out poorly-performing doctors from performing hospital treatments would likely not significantly reduce the overall volume of treatments in the market.

It is also important to recognize that a physician's quality of performance is not necessarily static, and under a rule of performance-based tort reform, physicians would have a greater incentive to monitor and improve their own performance, since they would face a greater chance of dismissal by hospitals for poor performance. The available evidence suggests that under the current regime, many providers fail to make sufficient investments in human capital. Doctors may fail, for example, to stay abreast of the medical literature, relevant research, or new treatments. One study suggests that the number of physicians who fail to keep up with current medical practice could be close to half.[132] For a physician, the prospect of losing hospital privileges is, no doubt, a devastating professional failure.[133] Under a performance-based tort reform rule, therefore, physicians will have a stronger, more meaningful incentive to improve to avoid sanction by hospitals bent on achieving eligibility for a liability cap. They may, for instance, be more careful to avoid mistakes, more cautiously adhere to hospital and clinical guidelines, or refer tougher cases to their more senior or more skilled colleagues.[134]

C. Top-Performing Physicians

Meanwhile, top-performing physicians might also stand to benefit from making liability limits available only to top-performing hospitals. Physi-

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[131] *See, e.g.*, Frank Sloan, *Experience Rating: Does it Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. (PAPERS & PROC.) 128, 129 (1990).

[132] Arlen & MacLeod, *supra* note 25, at 1950.

[133] *See* Abraham & Weiler, *supra* note 13, at 414 (noting that loss of a hospital affiliation is a "major professional and financial loss against which a physician cannot insure").

[134] *See generally* Arlen & MacLeod, *supra* note 25, at 1950–51 (noting that physician investments in expertise should improve their ability to provide optimal treatment).

cians, like anyone else, respond to financial incentives, like higher pay or lower operating costs,[135] as well as nonfinancial incentives, like better facilities or equipment, by generally moving to environments where they can expect the highest rate of return. As a consequence, top hospitals that are eligible for liability limits might be able to attract good physicians who may be interested in reducing their exposure to liability costs.

Hospitals, for their part, would have a stronger incentive to recruit good physicians under a performance-based tort reform regime because their performance directly determines their eligibility for medical malpractice liability limits. High-performing hospitals would also have greater resources, because of their competitive advantage regarding malpractice insurance premiums, to invest in recruiting good physicians and keeping them performing well.

D. Allocation of Losses

Performance-based reform also offers the potential advantage of greater perceived fairness in allocating patient losses from injury compared with a state liability cap that protects all healthcare providers regardless of relative quality. Recall that opponents of general liability limits argue that the limits place the loss from injury on victim-patients, while providing protection for the injurer. On the surface, performance-based reform appears to create the same problem with respect to top-performing hospitals, since top-performers would be immune from very high awards for noneconomic damages, leaving plaintiffs with large losses unable to seek recompense against them. Thus, if the argument against general liability limits is distributive fairness, it appears, at least on the surface, that a rule calling for performance-based reform might have some of the same problems.

To be sure, under a performance-based rule, some fraction of injured patients will be left uncompensated for the full extent of their losses. However, performance-based reform appears to be more in line with notions of fairness, since it is likely that, given a choice, this is the allocation of losses the patients themselves would have chosen. That is, *ex ante,* it is possible that many potential patients would prefer a rule that provides greater incentives for improving healthcare quality, even if it also meant some small probability that their recovery in the case of medical error might be limited. In fact, prior to injury, it is conceivable that a majority of potential patients would prefer performance-based reform over either of the alternatives: (1) state legislation approving general liability limits or (2) a state legislature's decision against limits.

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[135] *See, e.g.*, David Hemenway et al., *Physicians' Responses to Financial Incentives: Evidence from a For-Profit Ambulatory Care Center*, 322 NEW ENG. J. MED. 1059 (1990) (concluding that monetary incentives may induce physicians to increase their practices).

Potential patients might prefer performance-based reform over a general liability limit because under a performance-based rule, in the vast majority of cases of injury, patients would still be able to sue for full recoveries.[136] Thus, in contrast to a general liability limit rule, in many cases of injury patients would have an opportunity to sue for a full recovery.

Potential patients might prefer performance-based reform over a rule of unlimited damages because they place some value on giving hospitals an incentive for improving care, since it increases the chance that they themselves will receive better care and reduces the chance that they will be victims of malpractice. The cost to potential patients of a rule of performance-based reform compared with a rule of unlimited damages is the likelihood that they may be injured in a top hospital that has achieved significant compliance with Medicare treatment guidelines and, as a result, qualifies for liability limits. However, the cost is likely to be extremely small. Not only would the patient's potential losses be discounted by the likelihood of error, but they would also have to be discounted by the likelihood of being the victim of error causing injury severe enough to exceed the liability limit. Furthermore, the patient's potentially larger recovery under a no-cap system would be discounted by the probability of winning in litigation or settling favorably. Accordingly, potential patients might calculate that the chances that a top-performer would make an error causing serious injury are small enough to make this cost worth it.

E. Medical Malpractice Costs

Another potential advantage of performance-based reform is that it might reduce medical costs. Performance-based tort reform might reduce the incidence of so-called "defensive medicine," whereby providers order unnecessary tests or surgery because of fear of suit. The incidence of defensive medicine is costly.[137]

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[136] Under a performance-based rule, only hospitals that meet the standard of compliance with Medicare quality measures would be eligible for cap protection. The number of hospitals in any particular state ultimately achieving eligibility would, of course, depend on the level of compliance set by the state legislature or regulatory authority. The higher the standard, the fewer the hospitals that would qualify for cap eligibility; the lower the standard, the more hospitals that would qualify. Part V of this Article advocates a high standard of 95% compliance with Medicare quality measures. As it stands now, only a small minority of hospitals achieve compliance with Medicare quality measures 95% of the time. Under this standard, many, if not most, hospitals would likely not qualify for the liability limit. For a fuller discussion of how the level of compliance affects the number of hospitals that are eligible for cap protection, see *infra* text accompanying notes 154–160.

[137] *See* U.S. Dep't of Health and Human Servs., Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System 4–5 (2002), *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.pdf (reporting survey results that link care decisions and fear of litigation); Liang & Ren, *supra* note 64, at 502 ("Medical liability and limited physician and hospital access to malpractice insurance have pushed many providers to leave their states, reduce their services or simply

To the extent such conduct is unwarranted by the patient's condition, such conduct has at least two negative consequences. First, it reduces the amount of time devoted to providing good healthcare.[138] Conceivably, some patients will get more invasive medical care, like surgeries, than a physician would recommend if he or she were not making a calculation based on fear of a medical malpractice lawsuit. Thus, if the tests are unneeded and waste valuable physician resources, these activities likely increase waiting room time, limit access to care for other patients, and perhaps even alienate some patients. Second, defensive medicine may also drive up the costs of medical care to patient-consumers.[139] Since insurance companies bear the lion's share of the costs of extra tests and other forms of defensive medicine, patients arguably end up paying those costs in the form of higher insurance premiums.

By contrast, staff physicians in hospitals with the benefit of limits on damages may have less reason to fear lawsuits and, thus, less reason to contemplate defensive measures. Performance-based reform may also reduce costs flowing from medical malpractice, as the limits incentivize hospitals to correct for systemic error. System-wide errors occur when providers, like hospitals, fail to adopt a protocol that might reduce injury to multiple patients. For instance, a hospital might fail to have a policy of conspicuously labeling certain hazardous drugs. Thus, systemic failures creates almost unlimited opportunity for error and injuries to multiple patients. Since many patients never sue and are not compensated, the losses from injury based on systemic errors are frequently absorbed by the patients.[140] As hospitals remedy systemic error, these patient losses will also be minimized.

V. Performance-Based Tort Reform in Action

As argued throughout, tort reform, like liability limits, should not be available unless the provider has demonstrated a commitment to clinical best practices. This part describes two applications of performance-based tort reform. First, state legislatures might tie eligibility for performance-based reform to a high standard of quality, under which only a small minority of hospitals in the state might be eligible immediately. Second, state legislatures might tweak eligibility to permit more hospitals to gain the benefit of liability limits. As shown below, a state legislature inclined to create more

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retire."); Weiler, *supra* note 37, at 916 (noting that doctors may perform an inordinate amount of Caesarean-sections to avoid possible complications).

[138] *See* Weiler, *supra* note 37, at 942 (arguing that "extra tests, records, and time used by doctors fearful of litigation is unproductive; indeed, some of the additional procedures—for example, Caesarean-section rather than normal deliveries—may actually pose greater medical risks to patients, even if they reduce the legal risks to physicians").

[139] *Id.* at 916–17 (citing research that shows that defensive measures end up costing more than twice the cost of malpractice premiums).

[140] *See generally* Michelle M. Mello et al., *Who Pays for Medical Errors?*, 4 J. Empirical Legal Stud. 835 (2007).

expansive eligibility for limits on liability could simply approve a lower level of compliance to best practices. In either case, current data already under collection by the Centers for Medicare and Medicaid make tying liability limits to performance relatively straightforward.

A. Data Description

The Centers for Medicare and Medicaid have been collecting data on quality from the vast majority of hospitals in the United States. The data were collected by more than 3500 hospitals, all voluntarily participating in Medicare's hospital quality comparison program.[141] The data are comprised of almost 45,000 observed compliance rates with clinical guidelines for the best treatments for patients suffering from heart attack, heart failure, or pneumonia, or undergoing adult surgery.[142] Participating hospitals collected data without regard to whether the care was paid for by Medicaid, Medicare, or private insurance.[143]

Table 3 describes the recommended treatments for each of the four conditions. For instance, according to Medicare, clinical guidelines suggest that a patient suffering from a heart attack should receive aspirin upon arrival, among other recommended treatments. Thus, assume Hospital A always gives aspirin upon arrival for patients suffering a heart attack. For this particular treatment, Hospital A would show a compliance rate of 100%. If Hospital F never gave aspirin upon arrival to patients suffering from a heart attack, Hospital F would show a compliance rate of 0%. If Hospital C only gave aspirin upon arrival to patients suffering from heart attack half of the time, Hospital C would show a 50% compliance rate.[144] The remainder of this Part shows how state legislatures can use the average rate of compliance with

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[141] Hospitals that do not regularly treat the four conditions are not included. Hospital Compare, Information for Consumers, http://www.hospitalcompare.hhs.gov/Hospital/Static/Data-Consumers.asp?dest=NAV—Home—DataDetails—ConsumerInfo (last visited Nov. 12, 2008) (noting that psychiatric, children's rehabilitation, and long-term care hospitals are not among the reporting hospitals).

[142] *Id.* (providing that the data measure compliance with recommended treatments that have been shown to "provide the best results for most adults with those conditions and are an important part of the patients' overall care"). Some observations from the original online database were eliminated and not used in this Article due to very small sample sizes. In particular, scores based on samples of fewer than 25 patients were eliminated. This eliminated 40,161 scores. Thus, the original dataset included well over 80,000 observations from approximately 4000 hospitals.

[143] *Id.*

[144] The observed compliance rates collected and turned over to Medicare are, in turn, derived from varying samples of patients. *See* Hospital Compare, Information for Professionals, http://www.hospitalcompare.hhs.gov/Hospital/Static/Data-Professionals.asp?dest=NAV—Home—DataDetails—ProfessionalInfo (last visited Nov. 12, 2008) (providing that hospital sampling is based on the number of discharges per topic each quarter). The median sample of patients used to calculate compliance rates was 121 patients; the smallest sample of patients was 25. Patients for whom the care is not suitable are excluded from the sample (noting that a patient who was allergic to aspirin would not be included in the measure of whether the hospital treated with aspirin).

Medicare's performance or quality measures to determine eligibility for a limit on liability.[145]

TABLE 3. MEDICARE QUALITY MEASURES[146]

CONDITIONS	Heart Attack	Heart Failure	Pneumonia	Adult Surgery
RECOMMENDED TREATMENTS	Aspirin at arrival	Evaluation of left ventricular systolic ("LVS") function	Oxygenation assessment	Prophylactic antibiotic received within one hour prior to surgical incision
	Aspirin at discharge	ACE inhibitor or ARB for LVS dysfunction	Initial antibiotic timing	Prophylactic antibiotics discontinued within twenty-four hours after surgery end time
	ACE inhibitor or ARB for LVS dysfunction	Discharge instructions	Pneumococcal vaccination	
	Beta blocker at arrival	Smoking cessation advice/ counseling	Influenza vaccination	
	Beta blocker at discharge			Blood culture performed in the emergency department prior to initial antibiotic received in hospital
	Thrombolytic agent received within thirty minutes of hospital arrival	Appropriate initial antibiotic selection		
	Percutaneous coronary intervention received within two hours of hospital arrival			Smoking cessation advice/ counseling
	Smoking cessation advice/ counseling			

Before progressing further, though, it is appropriate to point out at least two potential shortcomings of Medicare's quality measures. First, the data is voluntarily reported and, thus, one might suspect that hospitals can manipulate their treatment guideline numbers with little fear. Somewhat suspi-

[145] The average rate of compliance is a weighted average taking into account the hospital's observed compliance rates for each condition.

[146] Hospital Compare, *supra* note 24.

ciously, for instance, several hospitals reported perfect scores for at least one of the twenty-one recommended treatments of the target conditions.[147]

Still, some evidence suggests that hospitals do not manipulate the truth and that their reporting deserves credibility. In a few cases of treatment, for instance, hospitals reported that they never follow clinical guidelines, an unexpected disclosure from hospitals that may be tempted to manipulate the numbers they report.[148] Further, one might be less suspicious of hospital truthfulness in light of how highly regulated hospital conduct already is. Hospitals operate in a highly regulated environment, where several agencies—local, state, and federal—oversee their conduct. Tax agencies, state healthcare agencies and other entities regularly audit hospitals to ensure compliance. For instance, the conditions of participating in Medicare are complex and touch many areas of hospital structure.[149] Moreover, hospitals must comply with state and federal tax laws, state and local licensure requirements, and private accreditation standards.[150]

A second shortcoming of using this set of measures of quality as a starting point for determining whether a limit on damages will apply is that the measures are arguably incomplete and short-sighted. To be sure, the Centers for Medicare and Medicaid only provide states with good data for best treatments in four routine situations: heart attack, heart failure, adult surgery, and pneumonia. Nevertheless, even if the data paints an incomplete or limited picture in the sense that it only covers four conditions, the data is consistent in that it covers the same four conditions for each reporting hospital. Thus, state legislatures interested in incentive-based reform should have little problem comparing levels of "product" or quality among hospitals. Further, one might suspect that these four conditions may be a proxy for how hospitals perform generally. That is, assuming hospital performance in these four areas is above average, one would expect positive correlation, such that these hospitals would also be likely to be skillful at treating other conditions, particularly those similar to the four mentioned. Finally, if there is some important measure of quality that is left out, state legislatures may easily add it to the reform legislation.[151] For instance, some state agencies, like the Indi-

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[147] The number of hospitals reporting perfect scores for at least one recommended treatment of heart failure is 463, of heart attacks is 1112, of pneumonia is 2772, and of surgery is 26. *Id*.

[148] Twenty-six hospitals reported never following clinical guidelines with respect to heart failure, thirteen reported never following guidelines with respect to pneumonia, and one hospital reported never following surgical guidelines. No hospitals reported a failure to follow treatment with regard to heart attacks. *Id*.

[149] *See, e.g.*, 42 C.F.R. § 482.1 (2005).

[150] *See generally* Blum, *Beyond the Bylaws*, *supra* note 110, at 461–64 (identifying various federal, state and private standards). Moreover, if hospital data-reporting efforts proved suspect under the proposed performance-based reform system, increased government oversight of data collection and truthful disclosure could likely address the problem.

[151] The Centers for Medicare and Medicaid also intend to expand the number of conditions and recommended treatments that are measured. *See* Hospital Compare, Information for Consumers, *supra* note 141. In fact, the Centers for Medicare and Medicaid have been expanding

ana Department of Health, already require that their local hospitals begin the process of making more meaningful quality-measure records on indicia of quality, including non-routine fronts.[152] In that state, hospitals have recently been required to report on twenty-seven different mistakes or offenses, such as the number of surgeries on the wrong body part, abductions, and sexual assaults on patients.[153]

B. An Example of High Quality and Performance-Based Tort Reform

States might tie eligibility for limits on damages to a relatively high measure of compliance with recommended treatments. Figure 2 shows what percentage of hospitals by state would qualify if the level of quality were set at 95% compliance with Medicare's recommended best treatments. Under this standard, states like South Dakota, New Hampshire, and Alaska had the largest percentage of hospitals at or above 95% compliance with Medicare's quality standards. However, at this high rate of compliance fourteen states and the District of Columbia would have no qualifying hospitals.[154] In fact, California, the state with the most hospitals reporting relevant data, would have only one hospital achieving success at the 95% compliance rate.[155]

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the number of conditions and recommended treatments measured since the inception of the program. It published its first ten measures in 2003. *See* Hospital Compare, *supra* note 144 (noting that seven new measures of quality were added in April 2005, three new measures were added in September 2005, and one new measure was added in December 2006).

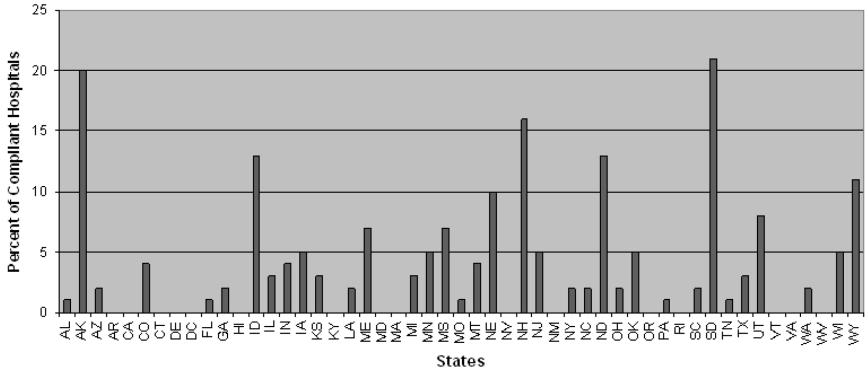
[152] Ice Miller, *Survey of Recent Developments in Health Law*, 39 IND. L. REV. 1051, 1078–79 (2006) (noting that Indiana has adopted mandatory reporting requirements for providers).

[153] Ind. Exec. Order No. 05-10, 410 IN ADC 15-2.4-2.2 (2005). *See generally* Staci Hupp, *Hospital Errors to Go Public in 2007*, INDIANAPOLIS STAR, Sept. 21, 2006, at 1.

[154] The fifteen states with no hospitals demonstrating significant (95%) compliance with Medicare quality standards are Arkansas (home to 71 hospitals), Connecticut (32 hospitals), Delaware (5 hospitals), Hawaii (17 hospitals), Kentucky (93 hospitals), Maryland (46 hospitals), Massachusetts (67 hospitals), Nevada (28 hospitals), New Mexico (41 hospitals), Oregon (55 hospitals), Rhode Island (11 hospitals), Vermont (14 hospitals), Virginia (85 hospitals), West Virginia (52 hospitals), and Washington D.C. (7 hospitals). *See* Hospital Compare, *supra* note 24.

[155] The one hospital is Holderman Memorial Hospital in Yountville, California. *See id.*

FIGURE 2. PERCENTAGE OF HOSPITALS NINETY-FIVE PERCENT COMPLIANT WITH MEDICARE QUALITY MEASURES, BY STATE[156]



C. An Example of Lower Quality and Performance-Based Tort Reform

If the standard is set at a relatively high rate of required compliance, many hospitals may have less incentive to improve their quality. In other words, the low level of current hospitals achieving compliance with a lofty standard suggests that many hospitals will have to undertake unusual investments in quality assurance to meet this high state compliance goal.[157] Some hospitals may be unwilling to undertake such a large investment. As a result, states might devise a lower quality standard, making it more realistic for a hospital to achieve compliance and, in turn, eligibility for liability limits. Figure 3 gives the percentage of qualifying hospitals if the standard of compliance is lowered to 90%. At the lower level almost all states—with only five exceptions—have at least some hospitals that would qualify for protection under a performance-based rule.[158]

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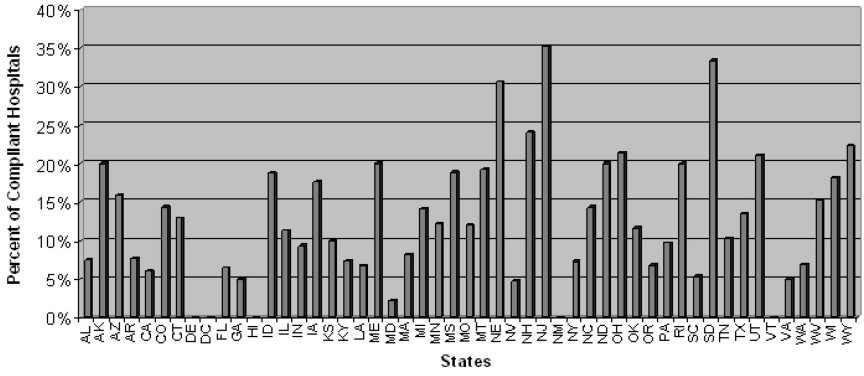
[156] *Id.*

[157] For a description of this problem, *see infra* Part 6.B.2 ("Poor Hospitals").

[158] The five states with no hospitals demonstrating 90% compliance are Delaware (which has 5 hospitals), the District of Columbia (7 hospitals), Hawaii (17 hospitals), New Mexico (41 hospitals), and Vermont (14 hospitals). Hospital Compare, *supra* note 24.

FIGURE 3. PERCENTAGE OF HOSPITALS NINETY PERCENT COMPLIANT WITH MEDICARE QUALITY MEASURES, BY STATE[159]



Even more illustrative of the pronounced effect of lowering the quality standard by 5% is Figure 4. The graph compares the percentage of compliant hospitals across regions at the 95% standard and the 90% standard.[160] In each region there is a dramatic increase in the percentage of qualifying hospitals as the standards are lowered to 90%.

VI. POTENTIAL CRITICISMS

This Article's proposal for performance-based tort reforms may engender some criticisms. Although it might not be possible at this juncture to anticipate all of them, it is prudent to try to short-circuit a few of the most prominent potential critiques.

A. A Superfluous Program?

The driving force of performance-based reform is its ability to incentivize hospitals to improve healthcare quality. However, it could be argued that hospitals already have strong incentives to provide the best care possible. Thus performance-based reform is just another, perhaps superfluous, layer of incentive for a healthcare actor that already has ample reason to provide high-quality care. Hospitals already fear lawsuits, state or federal regulatory enforcement, or being out-of-step with medical norms.

Nevertheless, the unique incentives that a performance-based system might produce should not be overstated. The current incentives, while theoretically powerful, do not appear to be working. As previously stated, a large

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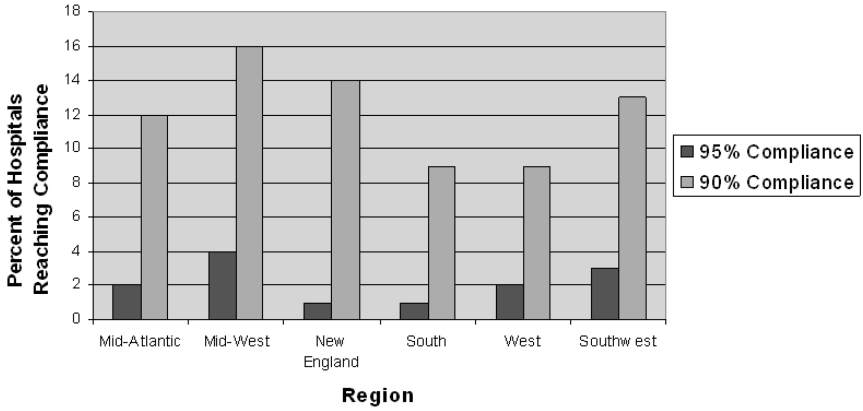
[159] *Id.*

[160] For a list of which states are included within each region, *see* U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES 25, 27 (13th ed. 2001), *available at* http://www.census.gov/prod/www/abs/statab2001_2005.html.

FIGURE 4. COMPLIANCE WITH MEDICARE QUALITY MEASURES, BY REGION



number of deaths and serious injury are from preventable medical errors.[161] Bad doctors with multiple allegations of medical malpractice continue to practice without fear of penalty from their insurers or their peers on state disciplinary boards.[162] The proposal for performance-based reform gives hospitals a new incentive to terminate their relationship with these doctors, lest they put their eligibility for liability limits in jeopardy. Therefore, although there already may be significant incentives for good behavior, performance-based reform adds to them and increases the likelihood of good results. Though some healthcare providers may ignore a new incentive because of the costly investment in quality-assurance required, others will likely respond, since providers seem both to want and to value politically a level of protection against losses in medical malpractice suits.[163]

A slightly more provocative perspective on current incentives focuses on experience rating. This argument is that the experience rating of providers by insurance companies should already create sufficient incentives for high performance by hospitals. Experience rating is a system in which insurers charge malpractice insurance premiums based on the insurer's calculation of hospital-expected losses based on claims history.[164] The calculation of expected losses is a function of the expected frequency of covered loss and the expected severity of the covered loss.[165] Over time, a hospital that is able to

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[161] *See supra* text accompanying notes 25–29.

[162] *See supra* text accompanying notes 30–34.

[163] *See supra* text accompanying notes 43–44.

[164] Gary M. Fournier & Melayne Morgan McInnes, *The Case for Experience Rating in Medical Malpractice Insurance: An Empirical Evaluation*, 68 J. RISK & INSURANCE 255 (2001); Frank Sloan, *Experience Rating: Does it Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. (PAPERS & PROC.) 128, 128 (1990).

[165] *See* Kenneth Abraham, *Efficiency and Fairness in Insurance Risk Classification*, 71 VA. L. REV. 403, 408 (1985) (defining the risk classification calculation used by the insurer as "the predicted probability that an insured [hospital] will suffer a loss multiplied by the predicted severity of the loss").

reduce the number of covered losses can expect a reduction in its insurance premiums and, thus, has a powerful incentive to do so.[166] The problem is that the current method of experience rating of hospitals is not a sufficient incentive for good conduct.

Insurance companies frequently fail to take into accurate account the severity of the loss when pricing insurance premiums on an individualized basis.[167] There are two related reasons for this failure. On the one hand, insurers cannot make an accurate, individualized calculation about size of loss because the information is largely unknowable *ex ante*. The hospital has little control over the size of the award. In part, the award may be subject to the whims of an unpredictable jury. The hospital also has no obvious way to distinguish between injuries that would result in substantial loss from those that would not. For instance, the hospital cannot distinguish low-wage earners who might not generate high damages from high-wage earners who will.[168] Second and related, the insurer may intentionally fail to assess the size of loss for particular hospitals because to do so would create unfairness. Fairness dictates that liability follows discretion. Only in circumstances in which a hospital could have taken measures to avoid the harm should there be a penalty-like response in the form of higher premiums. Recall that an insured hospital can do very little to affect the severity of the harm and accompanying loss, since too many factors outside of its control play a role in affecting claim size. For instance, the amount of loss the hospital will have to cover due to negligence is affected by the make-up of the patient class and disposition of juries, among factors the hospital cannot choose. Because the severity of harm is largely outside of the hospital's control, it is unfair to price premiums on the basis of severity if the hospital has no ability to conduct itself in a way that might minimize large awards. As a result, even if insurance companies have a hospital with a history of relatively large claims, it would not be fair to factor claim size history into premiums.[169]

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[166] Sloan, *supra* note 164, at 129 (noting that the evidence suggests that "experience rating reduces claims frequency and injury rates").

[167] *See generally id.* (noting that automobile insurance companies rely on frequency of loss rather than size of loss, since drivers cannot know in advance whether an accident will cause extraordinary loss).

[168] *Id.* ("Claim frequency is used in experience-rating plans in automobile liability because claim size is thought to be beyond the policyholder's control. A careless driver presumably does not know in advance whether his victim will be a high- or low-wage earner.").

[169] For instance, a doctor may have a long history of committing injuries and an insurance company may charge him a high premium to reflect the increased likelihood of future negligence. But neither the insurer nor the doctor has a good idea about whether the negligence will result in a large damage award or a relatively small one. Too many factors affect this, including juries, location of the injury, and the determination of the injured patient, among others. As a consequence, insurance companies misprice the risk that they bear and everyone suffers higher premiums. Under the new proposal, however, insurance companies would have a better idea about the likely severity of loss. They would know that some providers sued will be liable for the capped amount and no more, regardless of things out of their control, such as juries, location of injuries, or determination of the patient.

Because experience rating fails to take an accurate account of the severity of the risk posed, it also fails to provide adequate incentives to take due precautions. That is, the price for insurance may be too high for some of the hospitals and too low for others, which can distort behavior.[170] If the insurance company prices are too low, some will be able to procure insurance on the cheap given their particular risk. These free-riders have little incentive to take due precautions, which would normally merit a discount in premiums.[171] By contrast, the proposal articulated here would give hospitals the ability to calculate individualized assessments regarding the size of the loss. Well-performing hospitals would get the benefit of a liability cap and be insulated from the prospect of virtually unlimited damages, which insurance companies can use to craft a more accurate rating and price for insurance. This creates the possibility that the hospital could estimate not just the frequency of the claims, but also the severity of the losses, both of which are critical components of insurance pricing. This appeal of being able to partially control size of loss should produce unique incentives for hospitals to pursue good behavior, which would not be achieved under current experience rating scenarios.

B. Unintended Consequences

Until now, this Article has presented the deep and positive incentives to be produced by a rule that bases protection from liability on the performance of the provider. However, this Article would be incomplete without also acknowledging cross-currents. That is, while performance-based tort reform hopes to achieve overall better treatment quality, such a policy change might also create several adverse behaviors among regulated parties. This section examines some of these unwanted effects of performance-based reform.

1. Incidence of Malpractice

One possible unintended consequence is that performance-based reform might actually increase the incidence of medical malpractice. One of the arguments against today's brand of tort reforms is that the reforms do little to prevent physician misconduct and may even encourage reckless conduct.[172] In fact, insofar as physicians are protected from liability through current measures, they may fail to take due precaution. Since the performance-based strategy described herein also acts to insulate those providers that perform

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[170] For a thorough review of this notion, see Abraham, *supra* note 165, at 405 (noting that inaccurate insurance pricing produces a "moral hazard").

[171] *See id.* at 424 (arguing that when insurance is priced too cheaply, the hospital will purchase too much coverage and invest too little in loss prevention).

[172] *See generally* Janet Currie & W. Bentley MacLeod, *First Do No Harm?* (Nat'l Bureau of Econ. Research, Working Paper No. 12478, 2006) (finding that tort reforms may increase the level of poor medical services).

well, it is conceivable that this strategy will similarly reduce incentives to take due care. But this argument probably misunderstands the most likely effect of performance-based reform. On the one hand, it is true that providers might have few incentives to take due precaution because of the limit on liability, depending on how long the period of liability limit lasts from one review period to the next. But under a performance-based rule, hospitals are always policing the performance of their doctors in order to remain eligible. This should serve as an effective check on any proclivity to misbehave.

2. Poor Hospitals

Another possibility is that under a performance-based approach to tort reform some hospitals will effectively opt-out of the system, since these hospitals have little chance of ever being top performers. Becoming a top performing hospital costs money, as underperforming hospitals have to make investments in improvements to meet the quality standard set out by their state legislature. It could be argued that some low quality hospitals will ignore a performance-based rule, rationally electing to avoid making the costly improvements that would be necessary to qualify for a liability limit. For instance, a hospital with currently low compliance rates might have to expend a relatively large amount of resources to improve its care and qualify for a limit on liability. In a few instances, such a hospital might rationally decide to avoid spending if the chances of qualifying for a limit on liability are too remote to warrant the expenditure. Only when expected savings exceed expected costs from making improvements will the hospital change its behavior under a performance-based rule, which may mean that some underperforming hospitals will choose to avoid making improvements.

Certainly some hospitals will have less incentive to improve, since the costs of improvement will vary from hospital to hospital. If state legislatures use a relatively high quality standard to determine eligibility for limits, a few hospitals in some states will ignore the new incentive since it is unlikely that they will ever be top performers. Similarly, under any standards some hospitals will calculate that making improvements along the twenty-one factors would be more costly than the expected benefit of protection from medical malpractice lawsuits. But the important question is, how does the new system compare to the status quo? While, admittedly, bottom-tier hospitals might rationally decide not to take up costly improvements with a performance-based rule, some hospitals will. Thus, the incentive effects of the performance-based rule are uneven. Some hospitals have rather attenuated incentives while those on the cusp of qualification have a marked incentive to meet the performance mandate. Still, as long as at least some hospitals are willing to make an investment in quality in response to performance-based rules, there is justification for performance-based rules over the status quo, which creates no new incentive for good behavior.

3. Risky Patients

Some hospitals may have less incentive to invest in quality-assurance because of the nature of their patient and physician class, which may present unique challenges. These hospitals would be disadvantaged in their attempt to qualify for a limit on liability, not based on their performance, but rather because of the patients they treat, the mix of specialists they employ, and other factors that could affect risk.[173]

However, if state legislatures are worried that some hospitals may be at a disadvantage because of the type of patient the hospital serves or because of the mix of providers on hospital staff, the state may conclude that the simplest solution is to lower the rate of compliance required for eligibility for tort reform protections. For instance, under the lower level of compliance, few states had no hospitals that could not comply. State legislators worried about whether some hospitals are at a disadvantage could easily drop the level of compliance even further, or better yet, calibrate the level of compliance to the availability of financial resources. At a certain low level of average compliance with the recommended treatments, almost all hospitals—regardless of physician or patient mix—should have a realistic and reasonable chance of reaching eligibility for tort reform protection.

VII. Pay-for-Performance vs. Litigation-Based Reform

This paper has advocated for reform of the tort system such that health care providers are partially insulated from liability if, but only if, their performance merits it. Importantly, the reform advocated here continues to rely on the litigation system as the main deterrent to harm-causing activities. However, performance-based reform is not the only way to police misconduct and incentivize healthcare providers to achieve a certain standard of quality. A final question worth asking is whether a cash-based system is a more efficient way of producing similar results. On its face, a system in which providers are given bonuses for good conduct or fined for poor conduct might produce the same sort of incentives for good conduct: "Cash is King."[174] Nevertheless, for reasons to be discussed below, it appears reasonable to suspect that cash will not produce the same positive outcomes as does performance-based reform. This Part thus considers in some detail whether a litigation-based reform is better than an alternative system based on cash transfers.

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[173] *See* Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 Tex. L. Rev. 1595, 1626 (2002) (describing risk-adjustment factors).

[174] This is a favorite saying of the billionaire owner of the San Diego Chargers, Alex Spanos, who professionally advanced in a classic "rags to riches" fashion. *See* Alex Spanos, Sharing the Wealth: My Story 97–107 (2002).

A. Pay-for-Performance and Hospitals

One idea is to transfer cash to well-behaving hospitals. For instance, Massachusetts has offered cash incentives to hospitals and doctors that follow prescribed quality guidelines.[175] The Massachusetts program operates to permit eligible hospitals and physicians to recover hundreds of millions of dollars in Medicaid payments over three years.[176] Under the Massachusetts plan, hospitals must not only be able to demonstrate that they are improving quality, they must also demonstrate that they are reducing racial and ethnic healthcare disparities.[177]

Normally, cash is a more direct mechanism for shifting conduct. Two cash-based systems are possible: a bonus system, in which healthcare providers that meet certain performance standards receive a significant cash transfer, and a fine system, in which providers who fail to meet performance standards are forced to pay a penalty for their lackluster results. However, a cash incentive, as opposed to an incentive rooted in more flexible liability rules, is somewhat unappealing in cases of medical malpractice, because it misses the unique value of litigation in helping to reduce the risk of medical error. Better designed tort reform should focus on preserving litigation as a way to mitigate harm to patients. Steven Shavell argued more than two decades ago that litigation is a more effective way of reducing harm than regulation in cases in which four requirements are met: (1) private parties are in a better position than regulators to identify the risky conduct; (2) private parties are capable of paying for the harm caused; (3) the likelihood of a lawsuit for conduct causing harm is high; and (4) the administrative costs of litigation are less than the costs of regulation.[178] In all these areas, it appears that a reform that centers on litigation is preferable.

First, a reform that focuses on litigation-based rules harnesses the power of private citizens to identify misconduct.[179] A cash-based system would rely on a public regulatory authority as the main monitor of risky conduct. The public authority would have to be able to police misconduct. A necessary consequence is that the public authority would have to police risk *ex ante*, identifying the risks, articulating rules, and monitoring provider conduct prior to any particular mishap. However, for medical treatment the risks of harm are varied and complex. The information regarding harm is generally held by private individuals and not easily obtained by a public authority. Thus, the myriad risks of harm in medical treatments are generally

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[175] MASS. GEN. LAWS chs. 111M, 118E (2006). *See* Liz Kowalczyk, *Health Legislation Puts Emphasis on Pay for Performance*, BOSTON GLOBE, Apr. 5, 2006, at A20.

[176] Kowalczyk, *supra* note 175 (reporting that hospitals and doctors "will get an additional $90 million in the next fiscal year. . . $180 million in fiscal 2008; and $270 million in 2009").

[177] MASS. GEN. LAWS ch. 118E, §13B (2006).

[178] *See* Steven Shavell, *Liability for Harm Versus Regulation of Safety*, 13 J. LEGAL STUD. 357 (1984).

[179] *Id.* at 359–60.

beyond the scope of any public authority to anticipate and police *ex ante*. The public authority will not be able to identify or effectively articulate best standards in all cases of medical treatment. The best way to supervise these novel and complicated risks of harm is to encourage *ex post* policing by private litigants. A policy structure that includes litigation-based controls is perhaps the only way to catch the wide breadth of risky behavior about which public authorities will not readily have knowledge. The reform proposed here, as a consequence, preserves litigation as a way for private citizens to police provider misconduct.

Second, a cash-based system seems to increase administrative costs to police risky behavior. In a cash-based system, administrative costs would revolve around three policing activities: the public regulatory agency would need to (1) keep track of provider performance; (2) certify those achieving performance goals; and (3) be able to perform transfers and/or collections.[180] The issue of collections is critical. Under a cash-based system, the public regulatory authority would have to be able to make either performance transfers—the bonus system—or periodic debits—the penalty system—to all providers. This would be a costly and wide-ranging give-and-take. By contrast, in litigation-based reform, administrative costs likely would be less steep. The universe of providers is smaller, and only actual litigants would receive the benefit of reform measures. Further, although the costs of monitoring performance remain, a litigation-based reform does not require any public regulatory authority to create a collections arm. Litigation-based rules rely on private parties, who would have to show during the course of their litigation whether or not they are eligible for the benefit of the cap. In addition to monitoring performance and certifying providers, a litigation-based rule would avoid requiring public entities to make countless transfers to providers compared with a cash-based system.

Third, litigation-based rules are effective and likely preferable, as Shavell has argued, when private parties have a relatively high likelihood of actually being sued if their conduct causes harm and they have the assets or sufficient insurance to cover losses for the harm caused. If both thresholds are met, Shavell argues that an approach centering on liability is likely to create incentives for good conduct.[181] Private parties who are likely to be sued over their misconduct are likely to take precautions, particularly if their assets are at stake. In the case of medical treatments and medical error, hospitals have sufficient assets to cover the harm caused and are frequently sued. As Shavell argues, a victim might be in a poor position to bring suit if the injury is widely dispersed or takes a long time to manifest itself or if it is difficult to attribute harm to a particular party.[182] However, in the typical case of medical malpractice, the nature of the injury is not dispersed, the

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[180] *See id.* at 363–64.
[181] *See id.* at 360–63.
[182] *See id.* at 363.

tortfeasor is easily identifiable, and the injury likely manifests itself within a reasonable period of time.

In addition to the principles articulated by Shavell, a final problem with a cash-based system, at least one that focuses on bonus transfers, comes from recent research by behavioral economists, which has added a new layer to the basic law and economics analysis. The behavioral research suggests that cash transfers may not produce the same sort of incentives for good behavior as a limit on loss in a litigation setting. Behavioral economists and psychologists have long argued that actors are more motivated by the prospect of losses than the prospect of commensurate gains.[183] In this view, the promise of a cash transfer of one million dollars does not produce the same sort of incentive for good conduct as the promise that one can avoid one million dollars in losses. It is not clear that cash transfers would produce the same level of conduct as being able to avoid liability in a medical malpractice lawsuit.

B. Pay-for-Performance and Physicians

Another suggestion is to give individual providers—individual doctors and nurses, for instance—cash compensation for behaving well. Medicare has recently begun experimenting with bonuses for physicians who follow clinical guidelines in a predetermined percentage of their cases. Congress recently approved a 1.5% bonus in Medicare payments for doctors who report on the quality of the care they provide, such as the drug they provide to patients after a heart attack and its ability to control high blood pressure.[184] At the same time, some private entities, like insurance companies, have experimented with cash incentives for physicians who perform well by controlling patient diabetes.[185] Denver-area physicians and representatives from a major insurer, Anthem Blue Cross Blue Shield, chose ten nationally recognized guidelines for assessing medical care. Doctors receive a bonus for meeting the guidelines and a larger bonus for exceeding them. In Baltimore, CareFirst Blue Cross Blue Shield has awarded physicians fifty dollars per

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[183] *See, e.g.*, Christine Jolls, *Behavioral Law and Economics* (Yale Law Sch. Pub. Law Working Paper No. 130, 2006), *available at* http://ssrn.com/abstract=959177 (describing the endowment effect); Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 ECONOMETRICA 263 (1979); Patricia A. McCoy, *A Behavioral Analysis of Predatory Lending*, 38 AKRON L. REV. 725, 727–28 (2005) (describing how most people are risk-averse when it comes to losses).

[184] *See* Robert Pear, *Medicare to Try 'Pay for Performance'; Doctors Asked to Report Their Quality of Care*, SUN-SENTINEL (Fort Lauderdale, Fla.), Dec. 12, 2006, at 6A (reporting that Medicare officials want to be able to use the statistics to reward doctors who adhere to clinical guidelines and, possibly, punish doctors who do not adhere to guidelines); Hilary Waldman, *Modernizing Medicare; Middlesex Doctors Testing 'Pay for Performance' System*, HARTFORD COURANT, Sept. 25, 2006, at A1 (describing a trial bonus system for doctors in the Medicare program in Connecticut).

[185] Marsha Austin, *Doctors Get a Raise When Patients Get Healthier*, DENV. POST, Oct. 16, 2005, at K-01.

patient if they install an electronic patient-record system.[186] Such proposals might create an important link to performance. However, these reforms are less appealing for the same reasons discussed above.[187]

In addition, it is worth mentioning that cash-based systems focused on physicians do very little to improve medical errors stemming from systemic problems—problems that lead to injuries for more than one patient.[188] For instance, a hospital may fail to have a policy of keeping penicillin in close proximity to patient bedsides, which could create a more generalized risk of injury for multiple patients. Hospitals are in the best position to reduce some of the causes of patient injuries, particularly injuries that may flow from systemic problems.[189] Since hospitals have an incentive under performance-based reform to maintain high quality, these errors are best corrected on the institutional level.

Furthermore, it is not clear that physicians are in a good position to track data on their ability to perform appropriately. Physicians may be reluctant to report their own failures to follow clinical guidelines, since that may expose them to liability.[190] They also may be prone to underreport incidents of error by others, since it may create opprobrium from their colleagues and put in jeopardy their chances of receiving referrals.[191] Other authors have shown that physicians routinely underreport incidents of error.[192] By contrast, since the data at the hospital level is not tracked by physicians, it may provide some level of anonymity and insulation and therefore be more accurate. Second, unlike hospitals, individual physicians have limited staff and resources to dedicate to tracking these data. For instance, the equipment to track patient records electronically, as recommended by CareFirst, can cost about $30,000 per doctor.[193]

A cash-incentive structure in favor of individual physicians is ultimately too simplistic. Some state legislatures may prefer to include a measure of quality not yet under analysis, others may choose to add ten more, and still others may choose to make a more complicated calculation of qual-

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[186] The maximum award per physician is $20,000. M. William Salganik, *Health Record Bonuses Adopted*, BALT. SUN, Mar. 29, 2005, at 1C.

[187] *See supra* Part VII ("Pay-for-Performance vs. Litigation-Based Reform"). A direct cash system would miss many of the positive contributions of a litigation-based system of reducing harm. Also, a cash-transfer system probably does not have the same incentive effects as a system based on loss, one of the core teachings of behavioral economists.

[188] *See supra* text accompanying notes 30 and 34.

[189] *See, e.g.*, Abraham & Weiler, *supra* note 13.

[190] U.S. DEP'T OF HEALTH AND HUM. SERVS., *supra* note 137, at 6 (noting that doctors are reluctant to self-report for fear of litigation). Hospitals, by contrast, appear to be reliable reporters of data. *See supra* text accompanying notes 148–150.

[191] Lori Andrews, *Studying Medical Error* in Situ*: Implications for Malpractice Law and Policy,* 54 DEPAUL L. REV. 357, 379 (2005).

[192] *Id.* at 368–69 (finding that physicians discussed hundreds of errors at clinical meetings, but failed to file a formal report and even discouraged physicians from doing so: "[a]t orientation, new medical residents were actually told by more senior doctors not to fill out occurrence reports.").

[193] *See* Salganik, *supra* note 186, at 1C.

ity. But state legislatures likely will not be able to craft very sophisticated quality measures in dealing with individual physicians. In order to keep the physicians focused on the incentive, the quality measures will invariably have to be simple and easy to advertise. By contrast, on the institutional level, state legislatures could conceivably craft more complex quality measures without fear of alienating institutional actors. To the extent that state legislatures want to create multifaceted measures of quality, it appears that hospitals will be able to follow them, as they currently comply with serious and complicated regulations from multiple layers of government as well as private parties.[194]

Conclusion

The problem in the current tort reform debate is this: the most prominent reform—general limits on liability—does not work. Such limits fail to reward good behavior or punish misconduct. As a result, general liability limits help protect providers who perform well, but also protect providers prone to incompetence. Yet previous reform-minded commentators have failed to offer a solution that both creates better incentives to behave well and recognizes the political appeal of limits on damages. As an alternative, this Article argues that state legislatures should tie liability limits to conduct and incentivize providers to pursue the best available treatments. Rather than legislating general liability limits, states should seek to reward hospitals that reach a predetermined quality level with a limit on their liability and penalize all others by forcing them to operate in a world of unlimited damages. Accordingly, state legislatures have more to consider than a simple dyad of approving limits on liability or not. They should instead consider tying liability limits to the most valued attribute of medical care: performance.

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[194] *See* Blum, *supra* note 110, at 462 (noting various federal regulations that impact hospitals); Blum, *supra* note 109, at 12 ("[I]t is apparent that few entities have been subjected to more extensive regulatory controls from all governmental levels than the acute care hospital.").