

2000

More Hippocrates, Less Hypocrisy: Early Offers as a Means of Implementing the Institute of Medicine's Recommendations on Malpractice Law

Jeffrey O'Connell
University of Virginia

Patrick B. Bryan

Follow this and additional works at: <https://engagedscholarship.csuohio.edu/jlh>



Part of the [Medical Jurisprudence Commons](#)

[How does access to this work benefit you? Let us know!](#)

Recommended Citation

Jeffrey O'Connell & Patrick B. Bryan, More Hippocrates, Less Hypocrisy: Early Offers as a Means of Implementing the Institute of Medicine's Recommendations on Malpractice Law, 15 J.L. & Health 23 (2000-2001)

This Article is brought to you for free and open access by the Journals at EngagedScholarship@CSU. It has been accepted for inclusion in Journal of Law and Health by an authorized editor of EngagedScholarship@CSU. For more information, please contact library.es@csuohio.edu.

MORE HIPPOCRATES, LESS HYPOCRISY: “EARLY OFFERS”
AS A MEANS OF IMPLEMENTING THE INSTITUTE OF
MEDICINE’S RECOMMENDATIONS ON MALPRACTICE LAW

JEFFREY O’CONNELL¹
PATRICK B. BRYAN²

I. INTRODUCTION 23
II. THE IOM STUDY 25
III. THE NEED FOR TORT REFORM 35
IV. THE SOLUTION: EARLY OFFERS 44
V. CONCLUSION 51

I. INTRODUCTION

According to disturbing, if admittedly controversial, estimates found in *To Err is Human: Building a Safer Health System*, a 1999 report published by the Institute of Medicine [hereinafter “IOM”], between 44,000 and 98,000 Americans die each year due to preventable medical errors.³ Under these figures, more Americans die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).⁴ Total national costs (lost income, lost household production, disability and health care costs) of medical errors that result in injury are estimated to be between \$17 billion and \$29 billion, of which health care costs represent over one-half.⁵ The increased hospital costs of preventable medication-related errors to patients alone are estimated to be about \$2 billion for the nation as a whole.⁶

As William C. Richardson, chairman of the panel that conducted the IOM study, aptly comments in citing the Hippocratic Oath, “These stunningly high rates of medical errors—resulting in deaths, permanent disability and unnecessary suffering—are simply unacceptable in a medical system that promises first to ‘do no

¹The Samuel H. McCoy II Professor of Law, University of Virginia: B.A., Dartmouth College; J.D., Harvard University.

²B.A., J.D., University of Virginia.

³COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, *TO ERR IS HUMAN 1* (Linda T. Kohn, Janet Corrigan et al. eds., 1999) [hereinafter IOM]. *See also* COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (2001) (outlining the following six broad aims for improving the safety and quality of health care, but without focusing on medical malpractice litigation and its disincentives: safety, efficacy, patient-centered care, timeliness, efficiency and equitability).

⁴*Id.* *But see infra* note 47 and accompanying text.

⁵*Id.* at 1-2.

⁶*Id.* at 27.

harm.”⁷ Significantly, the IOM contends that most medical errors are not caused by the carelessness of individual physicians, nurses, or other hospital personnel; rather, they are the result of the cumulative opportunities for human error that inevitably arise in today’s complex medical system.⁸ One area that clearly shows the systemic root of medical error involves medication errors. For example, pharmacists often have difficulty deciphering the illegible handwriting of doctors who prescribe drugs.⁹ Also, many new drugs have similar names, causing much confusion for doctors, nurses, and patients.¹⁰ Indeed, some 7,000 hospital patients died in 1993 due to medication-related errors alone, more than the number of Americans who die from workplace injuries in an average year.¹¹

The IOM report condemns current systems of dealing with medical mistakes, which include a combination of peer reviews, various state and federal regulations and sanctions, evaluations by private accrediting bodies, and, lastly, malpractice lawsuits.¹² The report goes on to make several recommendations in an effort to lessen these forbiddingly high rates of medical error.¹³ Most salient from a tort law perspective, the IOM calls for the creation of two distinct reporting systems.¹⁴ First, the IOM recommends the establishment of a federal mandatory reporting system for cases where medical error has led to serious injury or death.¹⁵ Medical errors identified through this mandatory reporting system would be open to the public and unprotected by confidentiality rules.¹⁶ Information from this database would thus be open to discovery in a lawsuit. The IOM concedes that liability in tort “serves a legitimate role in holding people responsible for their actions.”¹⁷

The report also suggests that minor medical errors that have not resulted in serious injury or death be collected in a confidential database that would be unavailable to the public.¹⁸ By reducing health care providers’ risk of medical malpractice lawsuits through the confidentiality of this reporting system, the IOM hopes to encourage doctors, nurses, and hospital administrators to be more open about minor medical mistakes that have not led to serious adverse events, thereby

⁷Robert Pear, *Group Asking U.S. for New Vigilance in Patient Safety*, N.Y. TIMES, Nov. 30, 1999, at A1.

⁸See IOM, *supra* note 3, at 3-5.

⁹Pear, *supra* note 7.

¹⁰See Rick Weiss, *Medical Errors Blamed for Many Deaths*, WASH. POST, Nov. 30, 1999, at A01.

¹¹IOM, *supra* note 3, at 27.

¹²See generally *id.* at 1-16.

¹³See *id.* at 5-16.

¹⁴*Id.* at 8-10.

¹⁵*Id.* at 9.

¹⁶IOM, *supra* note 3, at 110.

¹⁷*Id.*

¹⁸*Id.*

giving the medical community greater opportunities to learn from their mistakes and prevent future harm to patients.¹⁹

To remove the fear of personal liability from individual health care workers and eliminate the incentive to hide errors rather than report them, the IOM acknowledges that tort reform of some sort is also needed.²⁰ Since the IOM calls for shifting attention away from the faults of individual care providers to the defects of the system itself, the current tort system's "blame culture" is itself blamed by the IOM for providing an impediment to improving the safety of patients by deterring physicians from reporting their own errors in the first place. However, the IOM's *To Err is Human* does not offer an extensive account of just what tort reform scheme should be pursued. In what follows, the Early Offers plan, created by the first-named author, is urged as particularly well-suited to address the problem of medical errors dealt with in *To Err is Human*. 'Early Offers' is not only designed to promote the reporting of medical errors by reducing the level of fear and pain associated with current medical malpractice law, but at the same time to allow victims of medical error to receive compensation earlier and easier. In so doing, Early Offers promotes a better medical and legal culture by rendering the health care and medical malpractice systems more Hippocratic—and less hypocritical.

II. THE IOM STUDY

Before entering into a legal discussion concerning the benefits of Early Offers in the area of medical malpractice law, this section offers a more detailed account of the IOM study. The need for reform will grow more apparent as more is revealed about the complexity of safety problems facing the nation's health care providers and their patients.

The IOM, a branch of the National Academy of Sciences, is a congressionally chartered, private, nonprofit society of distinguished scholars engaged in scientific research.²¹ Specifically, the IOM acts as an advisor to the federal government, identifying issues of medical care, research, and education.²² Recommendations by the IOM traditionally carry substantial political weight in Washington, D.C.²³ Indeed, within two weeks of the release of *To Err Is Human* on November 29, 1999, Congress began relevant hearings and President Clinton ordered a government-wide study of the feasibility of implementing the report's recommendations.²⁴

The IOM study was released as the first of a series of reports issued with the aim of achieving a "threshold improvement" in health care quality over the next ten

¹⁹See *id.* at 9-10.

²⁰*Id.* at 110-11.

²¹IOM, *supra* note 3, at iii.

²²*Id.*

²³Pear, *supra* note 7.

²⁴Lucian L. Leape, *Institute of Medicine Medical Error Figures Are Not Exaggerated*, 284 JAMA 95 (2000). A group of that nation's largest companies, including General Electric, General Motors, AT&T, and IBM have also taken action in response to the IOM's report by agreeing to use their mammoth health-care buying power to press for stringent new safety standards at U.S. Hospitals. See generally Barbara Martinez, *Business Consortium to Launch Effort Seeking Higher Standards at Hospitals*, WALL ST. J., Nov. 15, 2000, at A3.

years.²⁵ The Committee on Quality of Health Care in America, a subdivision of the IOM that conducted the study on medical error, consisted of various professionals from the medical, business, and academic communities.²⁶ A sampling of those who sat on the panel include William C. Richardson, President and CEO of the W.K. Kellogg Foundation, Dr. Lucian Leape of the Harvard School of Public Health, and Dr. Mark Chassin of the Mount Sinai School of Medicine.²⁷

As outlined in the opening pages of *To Err is Human*, the report seeks to address issues related to patient safety, a subset of overall quality-related concerns, and lays out a national agenda for reducing errors in health care and improving patient safety.²⁸ It should be noted that the IOM's report only reflects empirical data concerning medical error affecting hospital patients.²⁹ Therefore, with more than half of all surgeries today occurring on an outpatient basis, the report's scope can be seen as somewhat limited.³⁰ In making its recommendations, the IOM panel drew largely upon research gathered in two studies: (1) the Harvard Medical Practice Study, a groundbreaking report released in 1991 in which the subject of medical error was systematically examined through information garnered from a 1984 hospital admissions database in New York state; and (2) a 1992 study of Colorado and Utah hospitals using the same methods as the 1991 Harvard study.³¹ Thus, many of the statistics mentioned in *To Err is Human* are extrapolated from prior research conducted in New York, Colorado and Utah.

"Error" is defined by the IOM panel as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim."³² An "adverse event" is an injury caused by medical mismanagement rather than the underlying condition of the patient.³³ An adverse event attributable to error is a "preventable adverse event."³⁴ While "adverse events" result from medical mismanagement, not all are preventable. An example drawn from *To Err is Human* helps to illustrate this point. If a patient has surgery and dies from pneumonia occurring after the operation, it is an adverse event.³⁵ If analysis of the case later reveals that the patient got pneumonia because of poor hand washing or instrument cleaning techniques by

²⁵IOM, *supra* note 3, at xi.

²⁶*Id.* at v.

²⁷*Id.*

²⁸*Id.* at 5.

²⁹Note, however, that the Early Offers plan, outlined *infra*, is not limited to inpatient healthcare settings.

³⁰See Leape, *supra* note 24, at 97 (arguing that the actual number of deaths from medical error is, if anything, more than the estimates of the IOM).

³¹Clemant J. McDonald et al., *Deaths Due to Medical Error are Exaggerated in Institute of Medicine Report*, 248 JAMA 93 (2000).

³²IOM, *supra* note 3, at 4.

³³*Id.* at 28.

³⁴*Id.*

³⁵*Id.* at 4.

the staff, the adverse event was “preventable,” i.e. attributable to error.³⁶ However, an investigation of the incident may conclude that no error occurred, and that the patient’s system simply reacted poorly to the surgery, indicating that the pneumonia was not a “preventable adverse event” and was attributable rather to the idiosyncratic response of the patient himself.³⁷

According to the IOM, the rate of preventable adverse events in the nation’s hospital systems is truly daunting. The data gleaned from the 1984 Harvard study in New York indicate that as many as 98,000 patients may perish each year in American hospitals as a result of preventable adverse events.³⁸ This estimate renders medical error the fifth leading cause of death in the U.S., above such other scourges as pneumonia, diabetes and kidney disease.³⁹ Even by the more conservative estimate of 44,000 deaths per year, the amount generalized from the Colorado/Utah study, medical error would still rank as the eighth single leading cause of death in this country.⁴⁰ Other striking statistics that leap out at the reader, in addition to those recited at the onset of this paper, include the following:

- The costs of medical adverse events are recorded as being higher than the direct and indirect costs of caring for people with HIV and AIDS;⁴¹
- Preventable medication-related adverse errors are dramatically rising: among medication-related outpatient deaths, there was nearly 8.5% increase in frequency between 1983 and 1993; amongst medication-related deaths occurring in hospitals, the rate increased 2.57% over the same time period;⁴²
- 70% of the adverse events that occur in American hospitals are preventable;
- The most common types of these preventable errors include technical errors⁴³ (44%), improper diagnosis (17%), and mistakes in the use of a drug (10%);⁴⁴
- In hospitals, high error rates with serious consequences are most likely in intensive care units, operating rooms and emergency departments;⁴⁵
- The contributions of complexity and technology to these error rates is indicated by the higher rates of errors that occur in the more technical surgical specialties of vascular surgery, cardiac surgery, and neurosurgery.⁴⁶

³⁶*Id.*

³⁷IOM, *supra* note 3, at 4.

³⁸*Id.* at 1.

³⁹Weiss, *supra* note 10.

⁴⁰IOM, *supra* note 3, at 30.

⁴¹*Id.* at 27.

⁴²*Id.* at 32-33.

⁴³This term is undefined in the IOM report.

⁴⁴IOM, *supra* note 3, at 36.

⁴⁵*Id.* For a discussion of the large number of medical errors committed in the intensive care unit at San Francisco General Hospital in the course of an average month, *see generally* Richard Horton, *In the Danger Zone*, N.Y. REV., Aug. 10, 2000, at 30 (reviewing JOHN F. MURRAY, *INTENSIVE CARE: A DOCTOR’S JOURNAL* (2000)).

Critics of the IOM's study point to the panel's alleged abuse of the data collected by the Harvard study.⁴⁷ In particular, some argue that the IOM did not distinguish carefully between those deaths attributable to "preventable adverse events" and those fatalities resulting from mere adverse events, which, as was noted earlier, may not have resulted from actual error or even been preventable in the first place.⁴⁸ However, in rebutting those who charge that the report "exaggerated" the medical errors problem, panel member Dr. Lucian Leape points to the fact that the original Harvard research took into account only hospital patients.⁴⁹ Dr. Leape also argues that with more than half of all surgeries now occurring on an outpatient basis, the IOM report, if anything, underestimates the total number of medical errors.⁵⁰ Indeed, countless other cases of medical errors are committed in contexts other than hospitals, such as nursing homes. For instance, according to a study by the University of Massachusetts Medical School, an estimated 350,000 medication errors occur in U.S. nursing homes each year, more than half of them preventable.⁵¹

As mentioned previously, the IOM report stresses the need to shift the focus from blaming individuals for past errors to creating a better process of medical service by building safer care *systems*.⁵² Contrary to this theme, when asked in one survey about possible solutions to prevent medical mistakes, respondents rated as most effective "keeping health care professionals with bad track records from providing

⁴⁶IOM, *supra* note 3, at 36. These and many more alarming statistics are reported in detail in Chapter 2 of *To Err Is Human*. See *id.* at 26-49.

⁴⁷See McDonald, *supra* note 31, at 93. See also Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors*, 4 JAMA 415 (2001) (questioning the statistical validity of the Harvard study and estimating on their own the rate of deaths attributable to preventable errors as much lower than the Harvard study). The AMA study, like the Harvard study, showed a 6.0% chance that patients would have left the hospital alive had optimal care been given. *Id.* at 415. When Hayward and Hofer considered the three-month prognosis and adjusted for the variability and skewed quality of reviewers' ratings, however, the chance that patients would have left the hospital alive had optimal care been given dropped to 0.5%. *Id.* See also *Study Disputes Report on Fatal Medical Errors*, WASH. POST, July 25, 2001, at A10. Hayward and Hofer summarize their findings as follows:

[W]e found that our physician reviewers often reported medical errors and frequently reported deaths as being preventable by better care (at a rate similar to previous studies). However, three caveats were identified that have implications for preventable deaths: (1) the probability that the error actually caused the death was often considered to be low; (2) reviewer assessment of errors had poor reliability and was usually skewed; and (3) the underlying short-term prognosis of the person who died was often judged to be very limited.

Hayward, *supra*, at 420.

⁴⁸Rick Weiss, *Report on Medical Errors Called Erroneous; Fueling Debate, Researchers Challenge Data Indicating Thousands Die Because of Mistakes*, WASH. POST, July 5, 2000, at A02.

⁴⁹Leape, *supra* note 24, at 97.

⁵⁰*Id.*

⁵¹*Findings: 350,000 Drug Errors*, WASH. POST, Aug. 11, 2000, at A12.

⁵²IOM, *supra* note 3, at 5.

care” (75%), and “better training of health care professionals” (69%).⁵³ The IOM, however, faults the current overall medical care system itself as the primary cause of preventable adverse events in the U.S.⁵⁴ The healthcare system has grown so large, complex, cluttered, and fragmented that it takes nothing less than perfection for physicians and other personnel to complete the process without slipping at some point. For example, according to Dr. Donald Berwick, president of the Institute of Healthcare Improvement and one of the authors of *To Err is Human*, the vast majority of medical mistakes are committed not by bad actors, but by good doctors trying to do the right thing, working under conditions that do not account for the fact that they are only human.⁵⁵

The IOM is not the only party to call for a greater recognition of the complexity of the system and the inevitability of physician error. Michael Millenson, author of a recent book on medical quality, remarks that the “number one cause of medical mistakes is not incompetence, but confusion.”⁵⁶ In his words, most treatment-related errors are caused by poorly designed systems that lack “safeguards to protect against anything less than human perfection.”⁵⁷ Dr. Sherwin Nuland, professor of surgery at the Yale School of Medicine and author of a number of widely read books on medical care,⁵⁸ emphasizes in a Wall Street Journal commentary published soon after the release of the IOM’s findings that able and well-meaning personnel are trapped, “caught up in a system filled with the possibility of misadventure, where the smallest error can have catastrophic consequences.”⁵⁹

⁵³*Id.* at 43.

⁵⁴*Id.* at 4-5. (“Building safety in processes of care is a more effective way to reduce errors than blaming individuals.”).

⁵⁵Sheryl Gay Stolberg, *Do No Harm: Breaking Down Medicine’s Culture of Silence*, N.Y. TIMES, Dec. 5, 1999, at D1.

⁵⁶*Preventing Fatal Medical Errors*, N.Y. TIMES, Dec. 1, 1999, at A30.

⁵⁷*Id.*

⁵⁸*See generally* SHERWIN B. NULAND, *THE MYSTERIES WITHIN: A SURGEON REFLECTS ON MEDICAL MYTHS* (2000); *HOW WE LIVE* (1998); *THE WISDOM OF THE BODY* (1997); *HOW WE DIE: REFLECTIONS ON LIFE’S FINAL CHAPTER* (1994); *MEDICINE: THE ART OF HEALING* (1992); *DOCTORS: THE BIOGRAPHY OF MEDICINE* (1988).

⁵⁹Sherwin B. Nuland, *The Hazards of Hospitalization*, WALL ST. J., Dec. 2, 1999, at A22. For example, experts believe that of the hundreds of cases of wrong-site surgery occurring in the U.S. each year, the vast majority are not due to the fault of any single medical professional but instead are the result of slight errors committed by many different individuals at different stages of the caregiving process and systems in place that do not prevent those mistakes from doing harm. *See* Jennifer Steinhauer, *So, the Brain Tumor’s on the Left, Right?*, N.Y. TIMES, Apr. 1, 2001, at 27. Horrific instances of wrong-site surgery have made headlines across the nation. In New York state alone there were some twenty-eight cases of wrong-site injury in the year 2000. *Id.* Included in these cases were the following nightmarish episodes: two doctors were accused of operating on the wrong side of a patient’s brain; one was found guilty of performing surgery on the wrong section of a person’s spinal cord; another lost his license for (among other things) removing the left kidney of a seventy-nine-year-old man who had a cancerous mass in his right kidney; and another performed surgery on a healthy knee, rather than the injured one. *Id.*

In fact, to a large degree, patients and physicians might be considered victims of the extraordinary successes achieved by biomedical science in the past forty years; successes that have, in turn, generated today's ultra-complex system of health care.⁶⁰ For example, diagnostic and therapeutic methods that were relatively simple until the mid 1950s have become increasingly effective, but, in the process, grown increasingly complicated and sometimes risky to implement.⁶¹ The operating room, in particular, for all its miracles, is on occasion corollarily error-prone due to its inherent makeup in today's high-tech hospitals.⁶² Surgeons at the most technologically advanced hospitals are tempted to rush new techniques into clinical use before appropriate testing has been done.⁶³ All surgeries or drug treatments, no matter how technologically sound or groundbreaking, are not without significant side effects on the body beyond those that are intended.⁶⁴ Keeping complications to a minimum demands a "delicately balanced coordination of multiple influences, every one of which depends on decisions made by fallible human beings."⁶⁵ And in a fragmented system, in which patients are often passed from one medical professional to the next, physicians often do not have complete information about treatments prescribed for their patients by other physicians.⁶⁶

For instance, in any given day a single hospital patient may deal with a number of medical professionals—a nephrologist,⁶⁷ an infectious disease specialist, a pulmonologist,⁶⁸ a cardiologist,⁶⁹ a gastroenterologist,⁷⁰ and three or four members of the department of diagnostic imaging, each of whom is a 'superspecialist' in a distinct branch of that respective discipline.⁷¹ With so many steps and so many people involved in every aspect of care, the possibilities for error multiply, and small lapses can quickly escalate into major tragedies. To quote Dr. Nuland, "If ever there were an example of chaos theory in action, [the modern hospital] is it."⁷²

⁶⁰Nuland, *supra* note 59.

⁶¹*Id.*

⁶²*Id.*

⁶³*Id.*

⁶⁴*Id.*

⁶⁵Nuland, *supra* note 59.

⁶⁶Pear, *supra* note 7.

⁶⁷A physician who specializes in dealing with kidneys.

⁶⁸A physician who specializes in dealing with the lungs.

⁶⁹A physician who specializes in dealing with the heart.

⁷⁰A physician who deals with disorders of the digestive system.

⁷¹Nuland, *supra* note 59.

⁷²*Id.* Along with the increased potential for complications due to technological complexities, Dr. Nuland has noted an additional problem physicians face: the often near-divine capacity for healing that society ascribes to doctors. See Gustav Niebuhr, *Believer and Skeptic See Spirituality in Medicine*, N.Y. TIMES, Nov. 18, 2000, at A19. According to Nuland, many physicians themselves come to believe in the image of the divine doctor. *Id.* This superhuman ideal may explain why doctors (and patients) expect perfection in the

Having determined that the high volume of medical error in this country is due primarily to systemic error, the IOM panel advances various formal recommendations to address the situation. For example, to make significant improvements in patient safety, a highly visible center is needed, which will establish goals for safety, develop a research agenda, define prototype safety systems, develop and disseminate tools and methods for educating consumers about patient safety, and recommend additional improvements as needed.⁷³ To that end, the IOM study recommends that Congress create a new federal agency, a Center for Patient Safety, to set detailed national goals for reducing errors.⁷⁴ The agency would set and communicate priorities, monitor progress in achieving these goals, direct resources toward areas of need, and bring visibility to important issues.⁷⁵ In short, the Center for Patient Safety would seek to develop and apply the knowledge that would deliver health care to patients more safely.

The report also stresses the importance of creating an environment that encourages hospitals and other medical care organizations to identify errors, evaluate causes and take appropriate actions to improve performance in the future.⁷⁶ Reporting systems are one mechanism that can enhance the medical community's understanding of errors and the underlying factors that contribute to them.⁷⁷ Accordingly, the IOM recommends that Congress require health care providers to inform state governments of any medical errors that result in serious harm or death to patients.⁷⁸ This mandatory reporting requirement would apply to hospitals only during the trial years, but then later to other institutional and ambulatory care delivery settings.⁷⁹ The IOM believes that the Center for Patient Safety should then receive and analyze reports from state governments to identify persistent safety issues that require more intensive analysis.⁸⁰ As indicated above,⁸¹ the panel contends that reports on medical errors that cause serious harm to patients should be available to the public.⁸²

The IOM goes on to recommend that minor medical errors not resulting in serious injuries or death be collected in a voluntary, confidential database that would

delivery of health care. *See id.* The pressure to live up to this godlike perception may be an additional reason why doctors are reluctant to admit committing medical errors, even though, in actuality, mistakes are inevitable in today's highly complex system of health care delivery. *See Nuland, supra* note 59.

⁷³IOM, *supra* note 3, at 7.

⁷⁴*Id.*

⁷⁵*Id.* at 6-7.

⁷⁶*Id.* at 8. *See also infra* note 112 and accompanying text.

⁷⁷IOM, *supra* note 3, at 8.

⁷⁸*Id.* at 9.

⁷⁹*Id.*

⁸⁰*Id.*

⁸¹*See supra* notes 16-17 and accompanying text.

⁸²*See IOM, supra* note 3, at 10.

not be available to the public for review.⁸³ Such confidential reporting systems could be set up both within individual health care organizations as well as for collaborative efforts among health care organizations.⁸⁴ The IOM also urges that Congress pass legislation to restrict use in litigation of data related to patient safety and quality improvement collected in these voluntary databases and analyzed by health care organizations for internal use or shared with others solely for purposes of improving overall safety and quality.⁸⁵ The hope is that by reducing health care providers' legal exposure and the risk of lawsuits, doctors, hospitals, and others may be more open about their errors, and thus give the medical community a chance to learn from their own mistakes.⁸⁶

These two new reporting systems would operate along with existing national systems already in place, such as the National Practitioner Data Bank. Congress created this federal database in 1986 to afford information on incompetent practitioners who often skip from state to state without accountability.⁸⁷ The database lists medical malpractice payments by physicians as well as state disciplinary actions taken against 135,000 of the nation's 650,000 medical doctors.⁸⁸

⁸³*See id.* at 110.

⁸⁴*Id.*

⁸⁵*Id.*

⁸⁶Weiss, *supra* note 10. In 1997, the U.S. Department of Veterans Affairs instituted a reporting system similar to the programs proposed by the IOM. *See* Robert Pear, *Report Outing Medical Errors in V.A. Hospitals*, N.Y. TIMES, Dec. 19, 1999, at A1. Department officials actively train and encourage medical professionals to abide by the reporting requirements. *Id.* Along the same lines as the IOM's proposed confidentiality requirement, physicians are given assurances that they will not be punished internally for acknowledging mistakes committed in the care of patients. *Id.* In addition, the Department has also created its own National Center for Patient Safety which analyzes reports of reported medical mistakes, looks for patterns and trends, and suggests corrective actions. *Id.* The number of reported errors since has been high since the system took effect: in less than two years, almost 3000 medical errors were documented, causing more than 700 patient deaths. *Id.* Because of these reports, health care executives within the Department are now receiving useful information about problems that need to be fixed and have begun the process of overhauling the system to combat the number of errors, and in the process, save the lives of America's veterans. *See* Pear, *supra*. But the extent to which such a program would in the long run excite medical malpractice claims, especially if instituted for the general public, is unknown.

⁸⁷*Must Mistakes Happen?*, WASH. POST, Dec. 2, 1999, at A38. Also, state governments may already have some reporting scheme in place. New York, for example, requires hospitals to inform the state government whenever an unintended adverse and undesirable development in an individual patient's condition occurs. Jennifer Steinhauer, *Hospitals in City Faulted by State for Failing to Report Many Errors*, N.Y. TIMES, Feb. 13, 2001, at B1. The New York system was designed to enable state officials to better find the cause of medical errors and thus improve the state's medical systems. *See id.* But the New York plan has proven faulty, plagued by underreporting and a reluctance by many hospitals to expose themselves by reporting medical errors to the state reporting system. *Id.* The Early Offers plan, described *infra*, should help to make medical providers more willing to report errors to state and federal databanks.

⁸⁸Sandra G. Boodman, *The Right to Know Still Trying to Open Database on Doctors*, WASH. POST, Mar. 7, 2000, HEALTH (Magazine), at 13.

However, due to pressure by many medical groups, in particular the American Medical Association, Congress has refrained from opening the system to the public.⁸⁹ Consequently, the National Practitioner Data Bank is seen by many as an abject failure, citing, for example, the case of Dr. Michael Swango: In September, 2000, Swango confessed to killing four patients, attempting to kill four more, and committing five felonies during the span of his career as a practicing physician in Ohio, Illinois, Virginia, South Dakota, and New York.⁹⁰ Although he was investigated for murder at the Ohio State University Hospital in 1984, and convicted of poisoning fellow hospital employees at a hospital in Illinois in 1985, events that took place some eight years before he committed his murders in New York, Swango's name never appeared in the data bank.⁹¹

On this issue of openness, one might question why the IOM recommends the imposition of a confidentiality rule to protect reports concerning medical errors that lead to less severe patient harm but not in cases where the mistakes lead to serious injury or death. After all, studies suggest that a plaintiff's degree of disability, rather than a provider's negligence, is what most significantly correlates with tort recovery in medical malpractice suits.⁹² Thus, given that plaintiffs are probably more likely to file malpractice claims in cases where the harm is most extensive, might not the IOM include a confidentiality rule in its mandatory reporting program where physicians and other medical personnel would most need the protection? Indeed, medical professionals probably already have less reason to fear a lawsuit in cases of only minor injury even without the protection of a confidentiality rule, since medical malpractice cases are rarely brought unless serious injuries are involved; the energy and expense for claimant's counsel in bringing a malpractice suit are simply not justified unless the damages are very substantial. A confidentiality requirement, then, might thus seem more appropriate as a feature of the mandatory reporting system than as part of the voluntary program.

Interestingly, the IOM does not address this inconsistency as to reporting, but points to America's aviation industry as a good example of how reporting systems with less emphasis on fault-finding can lead to vast safety improvements.⁹³ Prior to World War II, airplane accidents, like medical mistakes today, were viewed primarily as individually caused; safety meant motivating people to "be safe."⁹⁴ But during the war, military leaders began to realize that planning a broader, systemic approach in operating aircraft was vital.⁹⁵ Thus, the military worked both during the war and in the years subsequent to improve its safety systems through the formation

⁸⁹*Id.* See also *AMA Denounces Databank Effort*, WASH. POST, Sept. 8, 2000, at A17.

⁹⁰James B. Stewart, *Doctors Who Kill*, WASH. POST, Sept. 10, 2000, at B7.

⁹¹*Id.*

⁹²Jeffrey O'Connell & James F. Neale, *HMOs, Cost Containment, and Early Offers: New Malpractice Threats and a Proposed Reform*, 14 J. CONTEMP. HEALTH L. & POL'Y 287, 295 (1998).

⁹³IOM, *supra* note 3, at 71-72.

⁹⁴*Id.* at 71.

⁹⁵See *id.* at 71-72.

of several aviation safety centers which took into account that in complicated systems such as aviation human beings may be naturally prone to err.⁹⁶

Building on the successful experience and knowledge of military aviation, civilian aviation has also implemented programs aimed at setting and enforcing standards, accident investigation, incident reporting, and research for continuous improvement. For example, the Federal Aviation Administration [hereinafter “FAA”], part of the Department of Transportation, is charged explicitly with ensuring airplane passenger safety.⁹⁷ Similar to how the IOM-recommended Center for Patient Safety would function, the National Transportation Safety Board [hereinafter “NTSB”], an independent federal agency, conducts investigations of aviation accidents and issues recommendations to the FAA for regulatory action.⁹⁸ But significantly, in further encouraging open and honest discussion between the government and those parties involved in an airplane accident, the Federal Aviation Act provides that no litigant may use any part of a report by the NTSB relating to an accident as evidence in a civil trial.⁹⁹

Also cited in the IOM’s recommendations is ‘incident reporting’ (defined as an occurrence associated with the operation of an aircraft that affects or could affect the safety of operations) conducted through the National Aeronautics and Space Administration Aviation Safety Reporting System [hereinafter “ASRS”].¹⁰⁰ ASRS is a voluntary, confidential reporting system used to identify hazards and latent system deficiencies in order to eliminate or mitigate them.¹⁰¹ Since reports are submitted to ASRS by individuals confidentially, any additional information obtained through

⁹⁶*See id.*

⁹⁷*Id.* at 72.

⁹⁸IOM, *supra* note 3, at 72.

⁹⁹49 U.S.C. § 1154(b) (1994). *See* *Protectus Alpha Navigation Co. v. N. Pac. Grain Growers*, 767 F.2d 1379 (9th Cir. 1985) (holding that NTSB reports are excludable under federal statute to the extent that they express agency views or conclusions as to probable cause of accident); *Fidelity & Cas. Co. v. Frank*, 227 F. Supp. 948 (D. Conn. 1964) (holding that, in an action for damages, all evaluation, opinion, and conclusion evidence must be excluded from parts of investigative reports made by subcommittee of Civil Aeronautics Board—now the NTSB—that might otherwise be admissible as evidence). *But see* *Mullan v. Quickie Aircraft Corp.*, 797 F.2d 845 (10th Cir. 1986) (stating factual portions of NTSB reports may be admitted as evidence in an action for damages and only the use of those portions regarding proximate cause is prohibited, with the result that in an action by a consumer for personal injuries resulting from the crash of an aircraft constructed by the consumer from a kit sold by the defendant manufacturer, the consumer’s expert witness may properly rely on factual portions of the NTSB report, and the fact that the consumer’s expert came to conclusions which were the same or similar to those of the NTSB investigators does not support the inference that the consumer’s expert relied on the NTSB report in an impermissible way); *Kline v. Martin*, 345 F. Supp. 31 (E.D. Va. 1972) (holding that, during discovery depositions in an action for wrongful death of a passenger in an aircraft which crashed, an Air Safety Investigator who conducted a federal investigation at the scene of the crash was required to answer questions so long as the answers did not include opinions as to the ultimate conclusion of the cause of the accident).

¹⁰⁰IOM, *supra* note 3, at 72.

¹⁰¹*Id.* at 95.

follow-up interviews with reporters is also maintained anonymously in the database.¹⁰² Information garnered from the reporting systems has led to the successful research and development of improved safety systems concerning the ways aircraft are operated in the U.S.¹⁰³

In light of the effectiveness of these reporting systems in the field of aviation, the IOM finds that, in order for its own proposed reporting scheme to be successful, a “more conducive [legal] environment is needed to encourage health care professionals and organizations to identify, analyze and report errors without threat of litigation and without compromising patients’ legal rights.”¹⁰⁴ If physicians, hospitals, and insurers are potentially putting themselves in legal jeopardy each time a mistake is reported, it is unlikely that reporting systems will be successful in encouraging the reporting of medical errors in the first place, thereby thwarting efforts to learn from them and thereby improve patient safety. Thus, the IOM urges that legal reform is necessary in order to ensure that any reporting system, voluntary or otherwise, be effective.¹⁰⁵

III. THE NEED FOR TORT REFORM

This section discusses in more detail the shortcomings of the current tort system with respect to the IOM’s recommendations. It highlights how the current tort regime thwarts proposals offered by the IOM to reduce error. In addition, it aims to show the current tort medical malpractice tort regime is largely unsuccessful when it comes to compensating injured patients who are often in desperate need of swift relief.

At the outset, the sheer nature of the often bitter adversarial legal process inevitably discourages forthcoming candor by litigants. A new book entitled *Legal Blame* by law professor Neil Feigenson illustrates at great length how the manner in which personal injury cases are prepared and litigated is really at odds with the IOM report’s emphasis on systemic causes of medical adverse events.¹⁰⁶ Instead of seeking to uncover the systemic origins of accidents which, as alluded to earlier, are multi-causal in today’s highly technological society,¹⁰⁷ personal injury litigation distorts accidents as not only mono-causal but also paints them melodramatically by seeking a histrionically reprehensible causal flaw on the part of some single individual, to the point of not only ignoring but repressing more complex multi-causal factors.¹⁰⁸ Relying on an exhaustive examination of both scholarly literature

¹⁰²*Id.*

¹⁰³*Id.* at 72-73. The IOM emphasizes that through the combined efforts of the aforementioned federal oversight bodies, there have been dramatic declines in the number of airplane accidents and fatalities through the years. *See id.* at 5, 72-73. For example, between 1990 and 1994, the U.S. airline fatality rate was less than one-third the rate experienced in the mid-twentieth century. IOM, *supra* note 3, at 5.

¹⁰⁴*Id.* at 10.

¹⁰⁵*Id.* 110-11.

¹⁰⁶NEIL FEIGENSON, *LEGAL BLAME: HOW JURORS THINK AND TALK ABOUT ACCIDENTS*, (2000).

¹⁰⁷*See supra* notes 56-72 and accompanying text.

¹⁰⁸FEIGENSON, *supra* note 106.

and actual trial transcripts, Feigenson finds that complexity repels jurors, and even judges.¹⁰⁹ Triers of fact are thus much more likely to find liability (or conversely to reject it) if they can be made to focus on a “bad guy” (either plaintiff or defendant), as opposed to intricate, interconnected processes or programs that may, in the particular case, have been amiss.¹¹⁰

Although the IOM believes that the systematic reporting and tracking of safety problems is an important approach to the reduction of medical errors, all reporting systems, especially in the simplistic blame game culture documented by Feigenson, face two bedrock issues: (1) how to motivate health care practitioners and others to candidly (one is tempted to say guilelessly) submit pertinent information, and (2) how to maintain the reported data in a systematic way that is useful to medical practitioners in their efforts to learn from past mistakes.¹¹¹ Since reporting systems may contain information useful to plaintiffs’ counsel in their relentless and often simplistic search for a “bad guy” to blame in a medical malpractice action, fear of legal discoverability or other involvement in the legal process clearly contributes to underreporting of errors.¹¹² Plaintiffs might obtain reporting information from the

¹⁰⁹*See id.*

¹¹⁰*See id.* The irony is that Feigenson, while not only acknowledging but demonstrating the resultant distortions, ends up supporting the personal injury system and admiring the skill of counsel in exploiting it, and jurors in trying to deal with it. With friends like that, who needs enemies? A review of Feigenson’s book is forthcoming by Jeffrey O’Connell and Joseph Baldwin.

¹¹¹IOM, *supra* note 3, at 112.

¹¹²*Id.* at 127. There is widespread belief among health care professionals that the current legal climate creates immense disincentives against candid disclosure. According to Richard Davidson, president of the American Hospital Association [hereinafter “AHA”], “[t]he idea that a mandatory reporting system is going to change behavior is naïve at best. You need to focus on making a cultural change in hospitals, to promote open discussion of errors, and that’s not possible if some plaintiff’s attorney is climbing on your back.” As quoted in Melissa Chiang, *Promoting Patient Safety: Creating a Workable Reporting System*, 18 YALE J. ON REG. 383, 391 (2001) (citing Robert Pear, *Clinton to Order Steps to Reduce Medical Mistakes*, N.Y. TIMES, Feb. 22, 2000, at A1). Similarly, a spokesman for the AHA states, “[w]e have to create an environment in which we learn from failure. This cannot be achieved in an environment of punishment or fear of legal prosecution for doctors, nurses and other caregivers who step forward after an unfortunate mistake is made.” Chiang, *supra* at 391 (as quoted in *Medical Errors: AMA Not in Favor of Mandatory Reporting*, AM. HEALTH LINE, Dec. 14, 1999, LEXIS, Medical & Healthcare Library). Health care providers do not believe that obligatory reports are the answer; they suggest that the best way to encourage reporting is to remove legal disincentives. *Id.* at 392 (citing Robert Pear, *U.S. Health Officials Reject Plan to Report Medical Mistakes*, N.Y. TIMES, Jan. 23, 2000, at A14). *See also id.* at 394-95, n.56 (“In the long run, what is in the best interest of patient safety, to punish and inhibit the reporting of errors, or to encourage error reporting in a nonpunitive system and let individuals go unpunished for making errors? Although I say ‘going unpunished,’ this is actually a misnomer, because there is always self-punishment. . . . [I]n the long run, . . . it is safer to know what is going on, so that you can attempt to fix it, than to punish employees for making errors.”) (quoting Neil M. Davis, *Nonpunitive Medication Error Reporting Systems: Tough to Accept but Safest for Patients*, 31 HOSP. PHARMACY 1036 (1996)).

Fear of liability is often cited as an explanation for practitioners’ failure to report. *See* Chiang, *supra*, at 396 (citing *Hearing on Medical Errors Before the Subcomm. on Health of the House Ways and Means Comm.*, 106th Cong. (2000)) (commenting that the “fear of

three components of a reporting system: (1) the original reporter; (2) the personnel who receive, investigate, or analyze the reports; and (3) the data itself residing in the reporting bank.¹¹³ A database that holds such relevant information as the patient's name, attending physician, date of accident, and institution in which the harm allegedly occurred will be of utmost interest to a plaintiff involved in the case reported. But even if the data are identified by institution or physician, but not by patient, the information may still be useful to a plaintiff in claims against the institution itself in such causes of action as "negligent supervision" or "negligent

litigation is a significant impediment [to reporting] for the majority of health care providers"). See also David J. Cullen et al., *The Incident Reporting System Does Not Detect Adverse Drug Events*, 21 JT. COMM'N. J. QUALITY IMPROVEMENT 541, 547 (1995); Marshall B. Kapp, *Medical Error Versus Malpractice*, 1 DEPAUL J. HEALTH CARE L. 751, 765 (1997) ("[P]hysicians' legal anxieties serve as a powerful barrier to the implementation of a concerted strategy to identify, prevent, mitigate, and correct . . . errors."); Brian A. Liang, *The Legal System and Patient Safety: Changing a Divergent Course: The Relationship between Malpractice Litigation and Human Errors*, 91 ANESTHESIOLOGY 609, 610 (1999) (arguing that potential discovery of information in tort suits "chill[s] reporting of medical error"); J. Bryan Sexton et al., *Error, Stress, and Teamwork in Medicine and Aviation: Cross Sectional Survey*, 320 BRIT. MED. J. 745, 747 (2000) (reporting that 71% of 1033 British practitioner participants find it difficult to acknowledge mistakes because of the threat of malpractice suits).

Furthermore, it has been empirically found that providers do not respond to mandatory systems. See Chiang, *supra*, at 393 ("At least a third of states had mandatory systems in place at the time of the IOM report. Despite their 'mandatory' nature, 'underreporting . . . plague[d] all programs.'") (quoting IOM, *supra* note 3, at 22). For example, in Pennsylvania, which requires reports for "gross" (i.e., severe) events such as deaths due to injuries, suicides or malnutrition, the Department of Health received only one report for the one-year period that ended in June 1999. *Id.* (citing Andrea Gerlin, *Philadelphia's Largest Hospitals Failed to Report Medical Errors*, PHILA. INQUIRER, Jan. 22, 2000, at A1). Philadelphia's hospitals alone probably encountered thousands of reportable errors. The story in Pennsylvania is not unique. North Carolina's mandatory reporting system received only fifteen reports in its first year and Colorado received only seventeen reports in two years. *Id.* (citing Charles Billings, *Incident Reporting Systems in Medicine and Experience with the Aviation Safety Reporting System*, in A TALE OF TWO STORIES: CONTRASTING VIEWS OF PATIENT SAFETY, app. B, at 55 (1998)). See also *id.* at 394 ("[I]n some form, in one way or another, all incident reporting becomes voluntary. It either becomes voluntary because of inertia on the part of reporters, or it becomes voluntary because of constraints within the establishment and the environment, or it becomes voluntary because hospitals decide that they are not required to report this particular event because of the fine print in that particular incident reporting regulation or statute.") (quoting Charles Billings, *supra*, at 55).

For a recent report on the concept of "root cause analysis," see Janet Conley, *RCA 101: Introduction to Root Cause Analysis*, LOSS MINIMIZER, July 13, 2001, at 1. The Joint Commission on Accreditation of Healthcare Organizations recently issued a new standard that requires hospital management and risk managers to investigate not only a *sentinel event*—"any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof," but also the root causes of all actual and potential injuries, with an eye toward total candor in rooting out causes of past and future iatrogenic injury. *Id.* at 2. While Conley's article emphasizes the importance of candor in reporting, it acknowledges the incompatibility of fear of litigation and candid reporting. See *id.* ("The focus on individual blame and subsequent individualized correction and retribution cannot continue to exist in an environment truly committed to improving patient care.").

¹¹³IOM, *supra* note 3, at 113.

credentialing.”¹¹⁴ Even data that has been cleared of all personal and organizational identification could still be used to prove the “causation” elements of certain types of negligence actions. For example, information in the database might show that injuries similar to the ones sustained by the plaintiff were caused by the same mechanism as the reported event, thereby demonstrating causation. Or a plaintiff’s lawyer might use the anonymous information in the databank to show a defendant-physician’s breach of the duty of reasonable care toward the plaintiff-patient by pointing out that the defendant-physician had reason to know of the risks posed by a certain process or device based on information in the reporting system databank.¹¹⁵

The authors of *To Err Is Human* contend that there are two avenues available to protect each of the three components of a reporting system from use by a plaintiff’s attorney in a lawsuit: the enactment of new laws that prevent pretrial discovery of reported data, and so-called practical methods that would render the reporter unidentifiable or the data unhelpful to the plaintiff.¹¹⁶ In analyzing the first avenue, the enactment of laws aimed at preventing discovery of reported information, one need look no further than to the laws of evidence to note the inadequacies of the current legal regime in supporting the aims of the IOM’s reporting systems: Most often, the question of whether a plaintiff can obtain access to reported data or have such information admitted as evidence at trial depends on the general rules of evidence and civil procedure of the particular state in which the malpractice claim is filed.¹¹⁷ The basic legal principal governing whether evidence can be admitted by a plaintiff into the record at a civil trial is the rule of “relevance.”¹¹⁸ Most states’ rules of evidence comport with the standard of relevance used in the federal court system: evidence is relevant if it has “any tendency” to make any element of the cause of action in question more or less likely.¹¹⁹ Moreover, trial judges are accorded broad discretion in judging whether an item of evidence is “relevant,” as they make these determinations on a case-by-case basis.¹²⁰ In fact, practically speaking, a piece of evidence is relevant to a particular case if the judge says it is, unless there is no arguable basis at all for its relevance.¹²¹

Information on errors could be relevant to a malpractice lawsuit in at least three ways. First, if the information recorded in the database pertains to the particular case

¹¹⁴*Id.* at 112.

¹¹⁵*Id.* at 112-13. The problems of underreporting and fear of litigation would arguably only be compounded by a decision to open up the National Practitioner Data Bank to the public, which is periodically urged by legislators and public advocacy groups. *See, e.g., Prepared Testimony of the Honorable Fred Upton Before the House Commerce Committee Subcommittee of Oversight on Oversight & Investigations*, FED. NEWS SERV., Mar. 1, 2000.

¹¹⁶IOM, *supra* note 3, at 113.

¹¹⁷*Id.*

¹¹⁸*See* GRAHAM C. LILLY, AN INTRODUCTION TO THE LAW OF EVIDENCE § 2.1 (3d ed. 1996).

¹¹⁹IOM, *supra* note 3, at 114.

¹²⁰*Id.*

¹²¹*Id.*

in dispute, every piece of data would be undoubtedly relevant.¹²² Second, data about similar occurrences to the case in dispute could be relevant in lawsuits that allege not merely one negligent occurrence, but negligence in a practitioner's engaging in a certain activity at all.¹²³ Third, reported information on similar occurrences might also be relevant in showing certain elements of the malpractice action, such as causation.¹²⁴ For example, if there were a dispute whether a particular instrumentality could have caused an injury, evidence that the same instrument caused similar injuries in other cases would be relevant.¹²⁵

Furthermore, the potential for pretrial discovery of data concerning medical errors is even greater than already indicated above. Generally, the "relevance" standard that most state courts use in allowing a plaintiff access to discovery materials is whether the information in question *could lead* to admissible evidence at the subsequent trial.¹²⁶ Indeed, relevance for discovery purposes is broadly and liberally construed; if there is doubt about relevance, judges will generally permit discovery.¹²⁷ Thus, a report of a medical error that might not be admissible at trial could still be discoverable by a plaintiff and could direct the plaintiff toward other relevant facts needed to prove his case at trial.

Thus, in general, state rules regarding evidence admissible at trial and information open to discovery indicate that plaintiffs in a medical malpractice action can readily obtain information on medical errors recorded in databanks open to the public. So long as information stored in the error databases can be used in litigation against physicians and hospitals, it seems inevitable that fear of legal exposure will cause the number of cases recorded to severely underrepresent the actual number of medical mistakes taking place.¹²⁸ The panel argues, however, that the creation of a national peer review privilege is one promising source of legal protection for data on medical errors.¹²⁹ Currently, every state except New Jersey statutorily protects from discovery various records and deliberations of peer review committees.¹³⁰ These statutes vary greatly from state to state, however. Some states have specific requirements for what qualifies as a peer review committee under the terms of the relevant statute.¹³¹ For example, some states restrict the privilege to in-hospital

¹²²*Id.*

¹²³*Id.*

¹²⁴IOM, *supra* note 3, at 115.

¹²⁵*Id.*

¹²⁶*Id.*

¹²⁷*Id.*

¹²⁸*Id.* at 112.

¹²⁹*See* IOM, *supra* note 3, at 10. Recall that the IOM only recommends protecting information concerning errors that do not lead to serious injury or death; the IOM recommends that information on errors resulting in serious injury or death should be fully accessible to the general public. *See supra* notes 76-86 and accompanying text.

¹³⁰IOM, *supra* note 3, at 119.

¹³¹*See id.* at 119-20

committees or committees of professional societies.¹³² But many statutes do not cover collaborations among institutions even if all are within an integrated delivery system, and no states have laws that expressly cover systems or collaborations that reach beyond state lines.¹³³ To compensate for such shortcomings, the IOM formally recommends that Congress pass federal legislation to provide peer review protections to all data related to patient safety and quality improvement that are collected in voluntary reporting databases and analyzed by health care organizations for internal use or shared with others solely for purposes of improving safety and quality.¹³⁴

Although peer review information might qualify for this privilege, data from databases might nevertheless be discoverable under some circumstances.¹³⁵ For example, even in those states that have enacted peer review statutes similar to the federal model recommended by the IOM, reported information may not be protected for causes of action for “negligent supervision” or “negligent credentialing by an institution” against hospitals and other medical centers, because the performance of the peer review process is itself what is at issue in such claims.¹³⁶ Indeed, as the IOM panel members point out, some state medical licensing boards have already gained access to peer review information for disciplinary purposes.¹³⁷ Moreover, some state court systems compromise on the protection offered by peer review statutes by conducting a balancing test in determining whether a plaintiff should have access to facts contained in peer review documents. In such tests, the court balances how crucial the need of the relevant information is to the plaintiff against how much trouble and expense it imposes on the defendant.¹³⁸ In addition, many state statutes, as well as the IOM’s recommended federal statute, that prevent a plaintiff from compelling a member of a medical institution’s peer review committee to testify in a lawsuit do not prevent a member of a peer review board from testifying voluntarily.¹³⁹

There are thus loopholes even in the statutory protections recommended by the IOM. Furthermore, the IOM study does not even address the problem of how to encourage medical personnel who might have committed an error that has led to a patient’s death or serious injury to report their mistakes, as they would be required to do if the IOM recommendations were to take effect. In point of fact, more than reporting systems is needed to provide adequate incentives to doctors and others to report any action that might have resulted in injury to a patient. As the IOM authors themselves suggest, the contentiousness and myopia that dominate our present tort system must give way to a new legal culture that seeks to promote patient safety

¹³²*Id.* at 120.

¹³³*Id.*

¹³⁴*Id.* at 10.

¹³⁵IOM, *supra* note 3, at 120.

¹³⁶*Id.*

¹³⁷*Id.*

¹³⁸*Id.* at 120-21.

¹³⁹*Id.* at 121.

rather than to pinpoint blame.¹⁴⁰ Otherwise, the goal of promoting honest and accurate reporting of medical errors remains out of reach.¹⁴¹

The current medical malpractice tort regime not only fails in promoting the IOM's goal of decreasing the rate of medical errors in accord with the IOM recommendations, but also often fails to live up to the tort system's own prime goal in this context: justly compensating victims of medical error.¹⁴² According to a Harvard study, only one in eight negligently injured plaintiffs files a tort claim, and only one in sixteen negligently injured plaintiffs is eventually compensated.¹⁴³ Even if a victim is successful in accessing the tort system, the average tort lawsuit reaches trial years after it is filed.¹⁴⁴ An injured plaintiff's financial needs may often be most acute during this waiting period, as lost wages, medical bills, and low morale begin to take their toll. Whether or not the case eventually makes it to trial, studies show that tort law's transaction costs consume half or more of all the dollars that defendants pay in tort settlements and verdicts.¹⁴⁵ Indeed, up to forty percent of any award is immediately diverted to plaintiff's own attorney's fees.¹⁴⁶

As Harvard Law School Professor Paul Weiler notes, when it comes to just compensation the current malpractice regime "has major flaws," as tort benefits are "doled out in a rather arbitrary manner to some—but not most—deserving victims, and also to those . . . who are not even 'deserving' within tort law's fault-based frame of reference."¹⁴⁷ According to one source, fifty percent of plaintiffs' attorneys see little or no evidence of malpractice in more than half of the cases they themselves file.¹⁴⁸

¹⁴⁰IOM, *supra* note 3, at 4-5.

¹⁴¹For a recent article iterating the inconsistency of fault-finding tort litigation with implementation of injury prevention regimes, see David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries*, 286 JAMA 217 (2001). But the article's advocacy of a no-fault medical malpractice regime poses the problems discussed later herein. See *infra* notes 165-69 and accompanying text. Studdert and Brennan also advocate a regime of enterprise liability whereby, for example, hospitals would assume the entire tort liability of their medical professionals much as airlines' liability for their air crashes in fact replaces that of individual pilots. See Studdert, *supra*, at 221. But that solution still leaves intact the intractable problems of payment based on fault for both economic and noneconomic damages – a very partial solution at best. See *infra* notes 170-73 and accompanying text.

¹⁴²See PETER A. BELL & JEFFREY O'CONNELL, *ACCIDENTAL JUSTICE: THE DILEMMAS OF TORT LAW* 51 (1997).

¹⁴³O'Connell, *supra* note 92, at 294.

¹⁴⁴BELL, *supra* note 142, at 59.

¹⁴⁵*Id.* at 67.

¹⁴⁶O'Connell, *supra* note 92, at 295.

¹⁴⁷*Id.* (citing Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 915 (1993)).

¹⁴⁸Michael B. Van Scoy-Mosher, *An Rx for the Malpractice Explosion*, L.A. TIMES, June 28, 1983, at 4 (reviewing D. FLASTER: A GUIDE TO THE LEGAL RIGHTS OF PATIENTS AND DOCTORS (1983)).

As a result, although the current system often undercompensates deserving claimants, it also can grossly overcompensate other claimants. Most serious disputes about damages in tort law focus not so much on payments for actual economic damages resulting from an injury (i.e., lost wages and medical expenses), but on the validity of payments for the plaintiff's non-economic, or intangible, harms.¹⁴⁹ Tort law traditionally awards plaintiffs money for the "pain and suffering" that accompanies their physical injuries; today damages for pain and suffering may also include compensation for the despair, humiliation, and "loss of life's pleasures" (so-called "hedonic damages") that a bodily injury causes a plaintiff to endure.¹⁵⁰ The law recognizes that no precise dollar value can be automatically put on physical and psychological hurt, but generally the more economic losses a plaintiff suffers the more non-economic damages the plaintiff will likely receive.¹⁵¹ This potential for high awards can often lead a plaintiff to needlessly or even fraudulently pad claims by setting up superfluous medical appointments, tests and treatments, running up wage losses in the process, so as to increase a jury's estimation of pain and suffering damages. According to the Rand Institute for Civil Justice, pain and suffering awards based on the amount of economic loss incurred for health care (often paid by one's own or governmental health insurance) produce huge and unnecessary health care expenditures.¹⁵²

Granted, for those truly injured victims who are able to survive the lengthy process, a large monetary award, substantially based on pain and suffering damages, may offer some relief. But in the end, even high awards will often not alleviate the emotional and economic hardship that plaintiffs may feel not only during their long battle for compensation, but for the remainder of their lives. A graphic illustration of the frustrations associated with the current tort system's compensation mechanism is contained in Barry Werth's book *Damages*.¹⁵³ Based on actual deposition transcripts, medical records, and interviews with the individual plaintiffs and defendants, hospital staff, lawyers, and expert medical witnesses, Werth provides a comprehensive account of the malpractice lawsuit that Donna and Tony Sabia filed in 1986 in Connecticut state court against the obstetrician and hospital that delivered their severely impaired child.¹⁵⁴ Perhaps the most poignant aspect of the Werth's depiction is the sense of sadness that the plaintiffs feel when their lawsuit finally ends with a large settlement some seven years after the filing of their claim and almost ten years after the birth of their child.¹⁵⁵ Parents who, like the Sabias, seek an explanation and an apology from a defendant often go away frustrated, given that

¹⁴⁹BELL, *supra* note 142, at 42.

¹⁵⁰*Id.* at 43.

¹⁵¹*Id.* at 64.

¹⁵²*Id.* at 163.

¹⁵³*See generally* BARRY WERTH, *DAMAGES* (1999).

¹⁵⁴*See generally id.*

¹⁵⁵*See generally id.*

only three to four percent of lawsuits filed actually go to trial.¹⁵⁶ Tony Sabia exclaimed after the settlement proceedings: “You mean I’m going to walk out of here with a check and that’s going to be it? Is that all it means?”¹⁵⁷

The data compiled by tort scholars and the stories of disillusioned plaintiffs such as the Sabias demonstrate that the current tort scheme does not adequately address malpractice claims. The one party most effective in defending today’s tort regime is the Association of Trial Lawyers of America [hereinafter “ATLA”], the organization of plaintiffs’ personal injury lawyers. ATLA has successfully thwarted reform efforts at both the state and federal levels through the years, garnering support among America’s elected officials often through their large campaign contributions to political candidates—especially Democrats.¹⁵⁸ ATLA donated \$3,632,450 to federal candidates in the November 2000 elections, with Democrats receiving 90% of these funds.¹⁵⁹ When compared to other legal groups that offered PAC money to federal candidates for the 2000 elections, ATLA was by far the year’s largest single contributor in that category.¹⁶⁰ Historically, “between January 1989 and December 1994 contributions from individual plaintiffs’ lawyers to all congressional candidates totaled \$18,066,433.”¹⁶¹ Combining this figure with the amount of PAC monies donated by the ATLA over the same period, “a total of more than \$30 million came from plaintiffs’ lawyers for federal elections.”¹⁶² To put this amount into perspective, “the five largest labor union contributors since 1989 contributed a total of \$29,727,165” to federal congressional campaigns; “the ‘big three’ automakers (GM, Ford, and Chrysler) contributed \$2,195,233” over the same period, “with ten of the largest oil and gas companies in the U.S. giving a total of \$6,975,764.”¹⁶³

The Institute of Medicine, although recognizing the need for legal reform in the area of medical malpractice litigation, does not formally endorse any particular alternative to the current tort law model. In the next section, we discuss various tort reform models, focusing principally on the Early Offers model. We attempt to show that Early Offers works best to serve the goals of the IOM’s report—namely, to reshape the current legal environment by promoting patient safety through encouraging reporting, recording and study of medical errors, while by no means overlooking injured patients’ needs for prompt receipt of both monetary

¹⁵⁶Committee for Economic Dev., *Breaking the Litigation Habit: Economic Incentives for Legal Reform* (2000), available at <<http://www.ced.org/projects/legal.html>> [hereinafter CED].

¹⁵⁷WERTH, *supra* note 153, at 369. For additional perceptive writing by the same author on the uncertainty of dissecting medical care to ascertain malpractice, see generally Barry Werth, *A Marine’s Private War*, NEW YORKER, Dec. 18, 2000, at 64.

¹⁵⁸BELL, *supra* note 142, at 182-83.

¹⁵⁹Center for Responsive Politics, *Lawyers/Law Firms: Top Contributors*, at <<http://www.opensecrets.org/industries/contrib.asp?Ind=K>>.

¹⁶⁰*See id.*

¹⁶¹BELL, *supra* note 142, at 183.

¹⁶²*Id.*

¹⁶³*Id.*

compensation and a candid acknowledgment and explanation of what, if anything, went wrong.

IV. THE SOLUTION: EARLY OFFERS

Although it does not formally endorse any particular mode of tort reform, the IOM mentions two possible alternatives to the current tort regime: no-fault compensation and enterprise liability.¹⁶⁴ But, there are flaws with both reforms that render them less effective than the IOM report would have it.

In the no-fault compensation model, defendants would provide claimants, regardless of any fault, with compensation for injuries received from medical care.¹⁶⁵ Generally, no-fault schemes can compensate victims more quickly and consistently than does the current tort system, and at a lower overall cost to society.¹⁶⁶ No-fault systems are seen as effective in other contexts, most notably workers' compensation and automobile insurance.¹⁶⁷ But comparing a person's physical health prior to an auto accident and identifying injuries caused by that accident are relatively easy tasks compared to determining similar facts in a medical malpractice case. Prior to suffering negligently inflicted injury, most patients already suffer from a condition serious enough to warrant significant treatment or even invasive surgery; many would suffer some lingering infirmity regardless of whether their health care providers were negligent.¹⁶⁸ In other words, distinguishing between the injuries caused by supposed negligent treatment and those caused by the patient's underlying condition or 'presenting complaint' will often be simply infeasible. Establishing the "causation" element in a no-fault medical services regime is thus much more problematic than in employment or auto accident injuries. Therefore, the medical services arena would retain unmanageably complex questions under a no-fault system, undermining its goal of administrative simplicity.¹⁶⁹

Likewise, the enterprise liability theory suffers from flaws that would seem to render it unsuccessful as a reform to encourage reporting of errors: in an enterprise liability system, legal liability for medical injuries is shifted from physicians to health care institutions.¹⁷⁰ For example, under this model a hospital is exclusively liable in a malpractice lawsuit for any medical errors committed in the hospital by physicians practicing there.¹⁷¹ By removing the fear of personal liability from individual health care workers, the IOM indicates that an enterprise liability system might eliminate the incentive to hide errors and thus induce physicians and other caregivers to register mistakes with the appropriate reporting system.¹⁷² But the IOM

¹⁶⁴IOM, *supra* note 3, at 111.

¹⁶⁵O'Connell, *supra* note 92, at 307.

¹⁶⁶*Id.*

¹⁶⁷CED, *supra* note 156, at 15.

¹⁶⁸O'Connell, *supra* note 92, at 307-08.

¹⁶⁹*Id.* at 308.

¹⁷⁰IOM, *supra* note 3, at 111.

¹⁷¹*See id.*

¹⁷²*Id.*

fails to recognize that other considerations might well deter a physician from reporting an error in an enterprise liability system. Would not health care institutions resist newborn candor from doctors who are their employees or with whom they have a contractual relationship? For instance, with some thirty million Americans belonging to Health Maintenance Organizations [hereinafter “HMOs”], many of which are owned by caregiving physicians, or in which they have a stake of one kind or another, medical professionals within an HMO maintain strong economic incentives for not reporting medical mistakes that might expose the enterprise to liability.¹⁷³

But the most serious objection to the enterprise liability model is that it is still based on fault and still allows for pain and suffering damages. These two variables are the principal problems of the current system. As long as they are largely retained unchanged, reform efforts will remain largely futile. Thus, enterprise liability would mire doctors, medical institutions and patients in the same old legal swamp.

Could a somewhat different breed of statutory reform, first proposed by the senior author of this article, an Early offers plan, offer a promising solution? This “neo-no-fault” plan is similar to a no-fault scheme in that compensation is paid periodically as new losses accrue for economic (excluding non-economic) loss and delivered more swiftly with less hassle than under the current tort system. But Early Offers differs considerably from traditional no-fault regimes such as workers’ compensation and no-fault auto insurance statutes: Early Offers avoids the impractical task of pre-accident definitions of when no-fault payments kick in for adverse results from medical care. It does this by simply creating a device whereby any defendant of a medical malpractice claim is given the option within 120 days after a claim is filed of offering to make no-fault-like periodic payment of a claimant’s net economic loss—120 days being a relatively prompt time frame compared with the current tort system.¹⁷⁴

The early payment offer must cover any costs, including medical and rehabilitation expenses as well as wage loss (beyond any collateral sources such as health or disability insurance already payable to the claimant), plus a reasonable hourly fee for the claimant’s lawyer, which would be much less than the normal thirty to forty percent, given the quick resolution of cases disposed of by early offers. But no compensation would be paid for non-economic losses such as pain and suffering. A crucial feature of the plan is that a defendant who promptly offers to thus pay a claimant’s net economic losses forecloses further pursuit of a normal tort claim for non-economic losses. In this way, the parties forgo the insurmountable problems mentioned above of separating *ex ante* the adverse effects caused by health care from the patient’s presenting complaint. On the other side of the coin, offers can be turned down by a victim but only in the event that the defendant’s injurious acts are the result of intentional or wanton misconduct provable beyond a reasonable

¹⁷³ABCNews.com, *FAQs About HMOs*, at <<http://abcnews.go.com/sections/us/DailyNews/hmofaq990712.html>>. See generally GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* (1996) (discussing the growth in number and power of Health Maintenance Organizations).

¹⁷⁴BELL, *supra* note 142, at 213. The plan can be drafted to apply as well to other than medical malpractice claims, such as product liability. See *infra* note 185 and accompanying text.

doubt (or at least by clear and convincing evidence). Thus, a crucial element of the tort system's deterrence mechanism is retained: needy plaintiffs can still win suitably large monetary awards under the Early Offers model through the recovery of both economic and non-economic damages in egregious cases of medical misconduct.

To qualify as an "early offer" under the plan, the offer must be made in accordance with a formula for calculating damages for economic losses similar to those paid under no-fault schemes that would be set forth in an Early Offers statute passed either at the state or federal level. In fact, the Early Offers plan has already been incorporated in a piece of federal legislation proposed in 1996 by Kentucky Republican Senator Mitch McConnell.¹⁷⁵ Because the early offer compensates only for actual economic damages, some injured claimants, such as the elderly, homemakers, or the unemployed, might not stand to receive substantial payment under the system. Hence, compensation for economic damages alone could underdeter defendants in the event one of these individuals were injured. However, a simple solution to this problem would be to stipulate an alternative of a substantial minimum amount to which all early offers covering serious injuries (rigorously defined in the statute) would be subject.¹⁷⁶

Because health care providers would not be required to define before the adverse event the conditions under which they would make an early offer, the question thus arises: When would a defendant be inclined to make such an offer? One obvious example of when *not* to make an offer would be when a defendant determines upon considering the disputed incident that the claimant was never even treated by the practitioner or medical center in question. But apart from such stark cases, although the health care provider might not believe the accident was its fault, it would be prompted to calculate what it would likely cost to pay the claimant periodically for the net medical expenses and lost wages brought about by the injury. If that sum turns out to be less than what the defendant would pay to defense lawyers, plus its likely tort exposure—with the whole panoply of possible payment of collateral sources and non-economic damages figuring into the equation—the defendant might well decide that it is worthwhile to make the early offer. Given the huge costs of defending tort cases and the gamble of having to pay large sums already paid by collateral sources, and for intangible losses, many defendants would be prompted to pay for net economic losses not just in cases they are sure to lose but even in many cases in which the issue is legitimately in doubt. One leading defense lawyer has hypothesized that of the 250 medical malpractice cases his large office was then defending, all in various stages of litigation, he would advise making an early offer in 200 (or eighty percent) of those cases if such a law were in effect.¹⁷⁷

Indeed, implementation of the Early Offers system would bring with it many benefits. Perhaps most importantly, since the plan requires defendants to make any offer early in the dispute process, it ensures that victims can receive rapid and essential compensation when they need it most. Both parties avoid protracted litigation. In addition, the Early Offers plan crucially reduces the possibility that

¹⁷⁵S. 1861, 104th Cong. (1996); CED, *supra* note 156, at 17.

¹⁷⁶O'Connell, *supra* note 92, at 312.

¹⁷⁷BELL, *supra* note 142, at 214.

injured parties will interpret a settlement offer as merely an opening bid in negotiations and as a signal that they could eventually recover much more; such a possibility would simply spur further litigation, with all its attendant waste and frustrations. A prompt offer under the plan can also reduce the transaction costs for defendants (and their insurers) by paying their own lawyers for far fewer hours of work. Indeed, early offers could be expected to be generated in-house by insurers. The Insurance Services Office has estimated that insurers' legal defense costs account for fourteen percent of total operating costs of malpractice litigation.¹⁷⁸ But it is not so much the insurance companies that feel the sting of these high costs for legal defense in tort suits—it is the American public that must absorb the resultant high liability premiums. Thus, the Early Offers program should actually work to lower the cost of insurance that doctors need to purchase since the legal exposure of health care providers under Early Offers would be dramatically reduced by the reductions (1) in attorneys' fees (on both sides), (2) in payment for amounts already paid by collateral sources and (3) in pain and suffering awards.

Furthermore, it can also be argued that Early Offers will enhance public safety along the very lines urged by the IOM in *To Err is Human*. Particularly relevant to IOM concerns, the need to make quick offers under the plan will encourage rapid reporting of adverse events within an organization, since the opportunity to make a qualifying offer can be lost if not made promptly after an adverse event.¹⁷⁹ In today's medical malpractice lawsuits, where the vast majority of medical injuries are not the result of "wanton," nor certainly "intentional," acts but at best only some variant of "negligence," the Early Offers system thus provides incentives for both the claimant and defendant to agree to a binding early settlement, which, in turn, will provide a key incentive for the health care provider to reveal and report any medical mistakes that might have occurred in the course of a claimant's treatment. Indeed, an Early Offers statute could require a health care provider, after an early offer is accepted, to offer to meet with patients and/or their families to explain as fully as feasible, the circumstances surrounding the adverse result. Moreover, to the extent that health care providers might fear that making an early offer under the plan would be included in the National Practitioner Data Bank, which lists medical malpractice payments and settlements by individual practitioners,¹⁸⁰ the Early Offers statute could specify that payments made through the Early Offers system be noted in the Practitioner Bank as subject to special exonerating consideration.

Thus, in keeping with the goal of the IOM report, implementation of the Early Offers system would help to lessen the often myopic and counterproductive blame culture that permeates current tort law. Early Offers would work to calm the animosities of the parties in an accident claim rather than inflaming them, as the current litigation culture now does, by giving defendants a healthy incentive to promptly acknowledge any problems and even to discuss what happened. Under the current adversarial tort regime, claimants rarely receive an apology, admission of fault, or even an explanation of the adverse event.¹⁸¹ As the case involving the Sabia

¹⁷⁸*Id.* at 218.

¹⁷⁹CED, *supra* note 156, at 18.

¹⁸⁰*See supra* notes 86-90 and accompanying text.

¹⁸¹CED, *supra* note 156, at 19; *see also* WERTH, *supra* note 153.

family suggests,¹⁸² many times if a simple apology or explanation by the defendant could be safely tendered, it could assuage the emotions of an injured party more effectively than a mammoth, long-delayed monetary award for pain and suffering damages. Such open and candid discussions can provide the accident victim with another form of valuable compensation often overlooked by the judicial system—peace of mind. In fact, researchers report that feelings of forgiveness and compassion have been proclaimed as therapeutic for accident victims because they reduce the anxiety and stress associated with continuing anger and resentment.¹⁸³ The Early Offers plan induces the parties to discuss what happened rather than forcing them to engage in the combat of the current “blame game” of tort litigation. In so doing, Early Offers thus promotes understanding, cooperation and swift compensation rather than contentious, hostile, and dilatory legal proceedings.

In summary, Early Offers seems to be a well-suited reform in the context of medical malpractice law, especially in light of the recommendations proposed by the IOM in *To Err is Human*. The Early Offers plan fosters the goals of the IOM report in that it helps to create a different legal culture in which the reporting of errors is fostered while promoting prompt and fair compensation for injured patients. Reviewing again the mechanics of the system, claimants have the right to deny an early offer if they think it can be proved that the health care provider engaged in wanton or intentional misconduct. Although the burden of proof is higher in such cases, if a health care provider’s level of care is so bad as to legitimately raise the question of whether maltreatment was egregious, then that would presumably be a case where simply paying for economic loss is not enough. Similarly, prolonged and extensive litigation in such cases would seem to be worth it. Note too that just as health care providers have the option to refuse to make an early offer if they do not believe any claim is justified, in such instances plaintiffs have the option to pursue a tort claim under preexisting standards of proof, care, and damages. Finally, if so many cases result in claims being pursued for wanton misconduct that the Early Offers plan seems counterproductive, those early offers can simply not be tendered. But this scenario seems unlikely given the experience under workers’ compensation laws, where few employees are successful in suing employers for gross negligence.¹⁸⁴

In all these ways, the plan is principally designed to motivate providers and claimants to resolve potential lawsuits early in those cases where proof of medical error is at least a realistic possibility as the cause of a patient’s injury. By resolving disputes early without risk of fostering litigation, medical institutions and professionals would not be nearly so deterred in reporting adverse events to the medical error databanks proposed by the IOM. Early Offers thus greatly reduces fear in acknowledging possible medical errors, allowing for greater cooperation between the medical profession, patients, and the legal community. With the legal culture shifted through the Early Offers program, medical researchers will also be

¹⁸²See *supra* notes 153-57 and accompanying text.

¹⁸³Neal R. Feigenson, *Merciful Damages: Some Remarks on Forgiveness, Mercy and Tort Law*, 27 *FORDHAM URB. L.J.* 1633, 1647 (2000).

¹⁸⁴See Jason S. Johnston, *Punitive Liability: A New Paradigm of Efficiency in Tort Law*, 87 *COLUM. L. REV.* 1385, 1411-12 (1987); Jeffrey O’Connell, *Two-Tier Tort Law: Neo No-Fault & Quasi-Criminal Liability*, 27 *WAKE FOREST L. REV.* 871, 880 (1992).

able to learn more from past medical mistakes and work to design better systems of providing care to myriad patients across the nation.

Critics of the Early Offers plan (most likely personal injury lawyers) might raise various objections to the Early Offers system. One objection might be that the program is too quick in dismissing the value to a plaintiff of so-called intangible damages, overlooking the salutary effects that “pain and suffering” damages can often provide a plaintiff and society in general. After all, in some rare cases, a claimant’s economic loss is exiguous compared with potential recovery of large non-economic damages. For example, there are times when a given injury will not induce a plaintiff to accrue medical expenses or inhibit a plaintiff’s earning potential, but rather, will result principally in a loss of love and consortium from one’s spouse and children, coupled with other severe non-economic injury. Admittedly, with the higher standards of proof in place under the Early Offers plan that allows for recovery of non-economic damages only in cases of wanton or intentional misconduct by the defendant, many such plaintiffs will not receive monetary compensation for such intangible harms. Even though money cannot solve all emotional problems, surely it can provide some comfort. Moreover, for some plaintiffs perhaps receiving pain and suffering damages might serve other important functions beside fair compensation. Recovery for non-economic damages may well enable the injured patient to feel more rectified, instilling faith in the judicial mechanism and a sense that the system is for “the little guy,” as well as providing for amenities that may alleviate the injured condition.

To appease some critics, the Early Offers plan could conceivably be amended to mandate some payment of an amount for pain and suffering under all early offers, perhaps on a scheduled basis tied to degree of disability, as under workers’ compensation. In deciding whether to include such provisions in the law, however, it must be remembered that the more requirements for payment of non-economic damages are added to the Early Offers scheme, the fewer early offers for payment of economic loss will be made in the first place.¹⁸⁵ After all, Early Offers in its pure

¹⁸⁵CED, *supra* note 156, at 18. Actually, even this exception may turn out to be too generous in that it is generally only the seriously injured who can pursue medical malpractice claims. See BELL, *supra* note 142, at 10 (commenting that many tort lawyers, working on a contingency fee basis, will not represent a claimant unless the injury is very serious because a lawyer’s costs in bringing a medical malpractice case are too great for it to be financially worthwhile otherwise). Thus, it may be wiser to use precious dollars to cover economic versus non-economic dollars even in serious cases given how much uncompensated economic loss exists in such cases, even after collateral sources are paid. See PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE 77-80, 97-101 (1993).

A similar phenomenon applies to product liability claims, to which Early Offers could also be applied. See *supra* note 174. Today, more and more people injured by defective products are not compensated for their harms, as plaintiffs lawyers now generally agree to represent only those clients with severe injuries such as quadriplegia, paraplegia or some other form of paralysis. See Greg Winter, *Jury Awards Soar as Lawsuits Decline on Defective Goods*, N.Y. TIMES, Jan. 30, 2001, at A1. Since the cost of bringing a product liability action has grown so expensive, with huge fees going to pay expert witnesses, people with less serious injuries are generally left without adequate legal representation; plaintiffs’ attorneys are more frequently finding such cases not worth the risk of assuming the substantial monetary costs that it will take to prepare such cases. See *id.* While fewer injured people are receiving compensation than in years past, those few able to bring successful product liability claims are receiving larger monetary awards from juries than ever before. See *id.*

form works through a balance: a victim's net economic losses are compensated quickly and without further litigation in exchange for his giving up the chance to sue for intangible damages. This tradeoff provides incentives for both parties to settle swiftly. The more these incentives are impeded by adding amendments to include recovery for more than net economic losses, the less likely the advantages brought on by Early Offers, which include the improvements in America's medical care system that the plan—and the IOM—promote, will take effect.

Even so, it is undeniable that patients who do not work or who have low-wage jobs, thereby suffering little or no economic damages when injured, have less economic earnings to recover, along with their opportunity to recover non-economic damages being foreclosed if an early settlement is reached. Thus, the specter is raised that the Early Offers program unfairly discriminates against injured patients who are retired or poor or both.

In response, first it should be noted that under the current tort system, poorer plaintiffs are often in a more vulnerable state than they would be under an Early Offers regime. Since recovery for non-economic damages is usually based, in part at least, on lost earning potential, a plaintiff not in the higher income brackets is often not able to collect as much for "pain and suffering" as would a similarly injured claimant making a higher salary. Moreover, poorer and aged plaintiffs feel the sting of delayed compensation under the current regime more severely than other claimants. Early Offers, though not a perfect system in promoting equality amongst people of different economic classes, does provide poorer as well as older medical malpractice victims with significant improvements over the current tort system. Early Offers promotes the compensation of lost wages or medical expenses when those affected (especially less wealthy victims of medical error, or older ones with less time to wait) need the money the most—in the days and months immediately following a serious injury.¹⁸⁶

If an Early Offers system is enacted, it might also be argued that so many more injured patients will seek quick settlements that insurance rates will rise for health care providers. Any added cost of medical malpractice insurance would then be passed to patients. Thus, the Early Offers system, so the objection goes, would end up costing the average American citizen more than the current tort system.

But, in reply, highly questionable or smaller claims are after all unlikely to receive an early offer in the first place—recall that the decision whether or not to make an offer rests with defendants.¹⁸⁷ Medical providers (and their insurers) will not make an offer unless they believe doing so is more advantageous than spending their money for defense costs under the tort system and taking the risk of losing the case and ultimately paying collateral sources and large non-economic damages.¹⁸⁸

¹⁸⁶Even so, a concession along these lines of equity has already been included in the proposal in that the alternative mentioned earlier of a substantial lump payment under the Early Offers plan for serious injuries applies to everyone, whether rich, poor, or neither. *See supra* notes 175-76 and accompanying text.

¹⁸⁷No money would be saved by encouraging claims by those not bringing them previously. *See supra* note 185 and accompanying text. For an explanation of why the plan confines initiating early offers to defendants, *see* Jeffrey O'Connell, *Offers That Can't Be Refused*, 77 NW. U. L. REV. 589, 604-06 (1982).

¹⁸⁸CED, *supra* note 156, at 20.

But even in the unlikely event of higher premiums as more claims are filed by injured patients and more settlements are provided under the Early Offers system, this arguably would still be a vast improvement over the current legal system in which patients are often wrongly compensated, if at all, either too much or too little, and always too late. Given in particular the high rate of iatrogenic injuries documented by the IOM report, if more apparently wrongfully injured people are compensated more expeditiously for their genuine economic losses, with much less money going to pay transaction costs of litigation and payment of less essential non-economic damages, that result can be viewed as a real gain for society.¹⁸⁹

V. CONCLUSION

A high rate of medical mistakes in this country poses serious problems worthy of bold remedial measures. We are all vulnerable to the devastation that these systemic errors can create. The recommendations by the Institute of Medicine's 1999 report provide a roadmap toward a safer health system. But turning around the current high rates of medical mistakes, and the injuries and deaths resulting therefrom, is a mission not only for America's medical community but for the legal establishment as well. The current tort system does not adequately promote patient safety, nor does it fulfill the goal of swiftly and justly compensating injured patients. The Early Offers plan provides efficient and readily achievable legal changes to abet the recommendations of the IOM while compensating injured patients for tangible losses with much less delay, frustration, and animosity than under the current legal regime. Early Offers encourages patients, health care providers and medical researchers to come together in a spirit of cooperation and understanding to deal with the problems associated with medical errors in a fair and dignified manner. Accordingly, the hypocrisy of the current tort system, seeking but in fact subverting equity, should give way to the promise of Early Offers. As stated by the IOM, it may be part of human nature to err, but it is also part of human nature to create solutions, find better alternatives, and meet challenges.¹⁹⁰ Through the Early Offers approach, physicians (and indeed lawyers, too) will be much better able to work toward the primary goal of the Hippocratic Oath in serving their patients (and clients)—to “do no harm.”

¹⁸⁹*Id.* The Early Offers solution would arguably apply much better to HMOs than either the status quo of trying to insulate them from medical malpractice claims or, on the other hand, expanding the presently unworkable malpractice regime to apply to HMOs. See generally O'Connell, *supra* note 92.

¹⁹⁰IOM *supra* note 3, at 15.