

# JURY EXCISION



## MEDICAL MALPRACTICE, FORCED ARBITRATION, AND ALTERNATIVE COMPENSATION SYSTEMS

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# **JURY EXCISION: MEDICAL MALPRACTICE, FORCED ARBITRATION, AND ALTERNATIVE COMPENSATION SYSTEMS**

## **EXECUTIVE SUMMARY**

Organized medicine and the insurance industry have pushed for proposals to force or pressure medical malpractice victims to have their disputes resolved entirely outside the court system. These proposals harm patients, weaken accountability for dangerous or incompetent doctors and hospitals, and make our health care more unsafe.

### **FORCED ARBITRATION**

Forced arbitration clauses, which prohibit harmed individuals from suing for medical malpractice in court, are starting to spread in health care despite serious ethical concerns raised by requiring a patient to sign away their legal rights in order to get medical help.

What may be accelerating this trend is the recent takeover of health care by private equity firms that want to avoid jury verdicts and publicity from lawsuits. This is particularly disturbing since private equity ownership is leading to more injuries and deaths.

Forced arbitration clauses have been common throughout the skilled nursing/nursing home industry for years. They are also increasingly being used at surgery centers and clinics, which can be risky places for medical procedures.

### **ALTERNATIVE COMPENSATION SYSTEMS**

#### **Health Care Tribunals**

Health courts and similar proposals, such as the "Patient Compensation Act," are circulating in some states although none have passed. They contemplate replacing the civil justice system with a government agency to resolve all medical malpractice claims. Judges and juries are abolished and replaced by decision-makers who are pulled from the medical and business establishments. They need not follow established common law. Instead, there would be new anti-patient standards of liability and compensation schedules. The costs of such systems would be significant.

#### **Brain-Damaged Infant Funds; Litigation Prohibited**

Florida and Virginia have compensation funds for children born with catastrophic birth-related brain injuries. Both programs promise these children a lifetime of care in exchange for their families having given up their rights to sue the negligent doctor or hospital. However, both funds have had numerous problems. They include: failing to adequately provide for these children; failing to hold accountable even the most dangerous doctors; and serious fiscal issues. Both programs have also been caught by the federal government for illegally raiding Medicaid to pay for children's care.

## **Brain-Damaged Infant Funds; Litigation Required**

New York's Medical Indemnity Fund pays for the future medical care of babies catastrophically harmed due to negligence at birth. This fund kicks in only after a jury verdict or settlement, in other words, *after* the family has endured the time and expense of proving their case in court (or settled). The law condemns the injured child to a lifetime of suboptimal care by limiting reimbursement for therapies to cheap Medicaid rates. In 2016, the law was temporarily amended to address these and other concerns, but those amendments are scheduled to sunset in 2025.

## **OTHER TYPES OF OBSTACLES**

### **Medical Review Panels**

Medical review or screening panel laws force patients to prove their case before a non-judicial panel before they are allowed in court. Panel members often come from or are funded by the health care industry, with clear conflicts of interest. Patients are burdened by extra time and expenses in their quest just to get into court. A number of these laws have been repealed or found unconstitutional.

### **Certificates of Merit**

Some "certificate of merit" laws are not unreasonably burdensome for the patient. Others, however, are onerous and prevent legitimate cases from going forward. For example, certain laws require the patient to verify that malpractice has occurred, which is often impossible before there has been any opportunity for discovery.

### **Safe Harbor/Clinical Practice Guideline Immunity**

These proposals say that doctors who practice "evidence-based medicine" or follow "clinical practice guidelines" should be immune from lawsuits. Both patients and doctors have had problems with such approaches. For example, it is unfair for patients to have their cases judged by liability standards chosen by biased or conflicted medical societies. The few limited state and federal experiments with such proposals, which began and ended in the 1990s, were collectively unsuccessful. None were renewed.

### **"Sorry Works"/Apology/Early Offer Proposals**

Apology laws allow doctors to apologize for their negligence but usually prohibit the apology – essentially an admission of fault – from being mentioned in court (*i.e.*, "apology plus shield"). Many combine apologies with "early offer" programs, also known as "communication and resolution" (C&R) programs. Research shows that if the patient is properly represented by independent counsel during early offer negotiations, the patient fares well. If they are not, they don't. Yet most apology/early offer programs, such as the University of Michigan's, do not require that the patient be represented by counsel. And some punish patients who do not accept offers, including New Hampshire's now-expired program.

# JURY EXCISION: MEDICAL MALPRACTICE, FORCED ARBITRATION, AND ALTERNATIVE COMPENSATION SYSTEMS

## INTRODUCTION

There is a medical malpractice crisis in America. Medical errors are the third leading cause of death.<sup>1</sup> A recent random sample of hospital admissions found that 23.6% resulted in at least one adverse event, 22.7% of which were preventable and 32.3% of which caused serious harm.<sup>2</sup> Women in the United States “have the highest rate of avoidable deaths” when compared to women living in other high-income countries. Nearly 200 in 100,000 deaths could have been prevented or treated with the right care provided at the right time.”<sup>3</sup>

Yet the vast majority of negligent, preventable errors never result in a claim,<sup>4</sup> and medical malpractice lawsuits represent a tiny fraction of cases that make it through the courts each year.<sup>5</sup> When injured patients do choose to sue, their cases are not “frivolous” and patients do not win large awards for insignificant claims.<sup>6</sup> Even the General Counsel for the American Tort Reform Association was forced to admit, “It is ‘rare or unusual’ for a plaintiff lawyer to bring a frivolous malpractice suit because they are too expensive to bring.”<sup>7</sup>

But for nearly 50 years, policy proposals in the area of medical malpractice have centered almost entirely on *doctors* as the victims of medical malpractice instead of the thousands of patients who wind up dead or injured each year. This is well reflected in the hundreds of medical malpractice laws that have passed around the country, virtually all of which are designed to weaken the liability of health care providers.<sup>8</sup> For example, a significant number of states have some kind of cap on compensation to medical malpractice victims.<sup>9</sup> Many states have modified or eliminated joint and several liability, so an injured patient has to cover the cost of an injury instead of a fully-responsible doctor or hospital. Others limit attorneys’ fees so patients cannot access the best attorneys to help them. Indeed, the health care industry already benefits from more liability protections than virtually any other industry or profession in the nation.

While these and other laws have clearly created an uneven liability structure when it comes to medical malpractice disputes, for the insurance and medical industries the legal system has not been lopsided enough. There has been a simultaneous movement by organized medicine to force or pressure medical malpractice victims to have their disputes resolved entirely outside the court system.<sup>10</sup> When cases are resolved this way, many civil justice fundamentals that protect patients in court are eliminated, such as an unbiased judge or jury, rules of procedure and evidence, access to a skilled attorney, transparency, and accountability for the wrongdoer.<sup>11</sup>

This report examines several of the most common proposals that prevent courts from hearing medical malpractice cases. These proposals harm patients, weaken accountability for dangerous or incompetent doctors and hospitals, and make our health care more unsafe.

## FORCED ARBITRATION

Forced arbitration clauses – hidden in the fine print of contracts and written in incomprehensible legalese – prohibit harmed individuals from suing wrongdoers in court. Instead, they must resolve their disputes in a secretive, rigged, private system. In recent years, these clauses have become ubiquitous in everyday contracts like credit card, cell phone, or online shopping “agreements,” as well as in employment contracts. They are considered “forced” because people are required to sign them, almost always unknowingly,<sup>12</sup> in order to get something – a job, a product, an online software update. And consumers and employees almost always lose in disputes resolved in forced arbitration (although it is more common that claims simply disappear<sup>13</sup>). As the American Association for Justice put it, “Americans are more likely to be struck by lightning than they are to win a monetary award in forced arbitration.”<sup>14</sup>

The ethical problems raised by forced arbitration in health care, requiring a patient to sign away their legal rights in order to get medical help, seem glaring. In fact, in 1998, the American Arbitration Association (AAA), the American Medical Association (AMA), and the American Bar Association (ABA) issued a strong policy statement opposing forced arbitration in medical malpractice cases.<sup>15</sup> This was reiterated by the AAA in 2003.<sup>16</sup> Nonetheless, forced arbitration is starting to spread in health care.

If someone is harmed due to medical malpractice and needs compensation, suing in court is not the same as going to arbitration. Arbitrators, the decision-makers, are not required to have any legal training. They may be biased, or even under contract with an insurance company or health care provider. Delays are common. The discovery process, whereby a patient can find out what happened to them and why, is extremely limited. Rules of evidence do not apply. Arbitrators issue no written legal opinions, so no legal precedent or rules for future conduct can be established. Costs often must be split between the injured victim and the insurance company, including arbitrator’s fees which can be hundreds or thousands of dollars per hour. And there is no right to appeal. The impact on severely injured patients is clear. As one researcher reported, “The nature of [forced] arbitration agreements effectively eliminates a patient’s ability to be fully compensated for his or her injuries as ‘comparisons of average awards by arbitrators and courts in...medical malpractice cases show that arbitration claimants receive only about 20 percent of the damages that they would have received in court.’”<sup>17</sup> And that statistic fails to take into account the number of claims that are dropped altogether.

It should be noted that a spattering of older health care organizations, like Kaiser Permanente in California,<sup>18</sup> have for years flaunted the ethical concerns raised by forcing arbitration on injured patients within their health care systems.<sup>19</sup> But what may now be accelerating increased use of forced arbitration across health care is the recent takeover of health care by private equity firms. Over the last few years, there has been a “voracious acquisition of physician practices” by private equity firms.<sup>20</sup> And hundreds of hospitals are now owned by these firms.<sup>21</sup>

As *Business Week* noted, although “since the early 2000s the American Arbitration Association and the American Bar Association have said their members shouldn’t participate in these kinds of cases...the financial industry has long embraced binding arbitration – especially when setting employment policies, a trend that critics say has been used to cover up decades of discrimination and sexual harassment – and has helped fuel the rise of the practice in medicine.”<sup>22</sup> What’s more, “The insurance industry has encouraged this trend by offering better terms to physician groups that can get their patients to preemptively waive their right to a jury trial.”<sup>23</sup>

This is particularly disturbing since private equity ownership is leading to more injuries and deaths. One recent study found that “in the three years after a private equity fund bought a hospital, adverse events including surgical infections and bed sores rose by 25 percent.”<sup>24</sup> In December 2023, the U.S. Senate Budget Committee launched a bi-partisan investigation into private equity ownership of hospitals, led by Chair Sheldon Whitehouse (D-R.I.) and Ranking Member Chuck Grassley (R-Iowa). As Chairman Whitehouse put it, “As private equity has moved into health care, we have become increasingly concerned about the associated negative outcomes for patients....”<sup>25</sup>

For example,<sup>26</sup>

A *Business Week* investigation published in May [2020] found that some private-equity-owned medical practices buy cheaper, and sometimes substandard, medical supplies and hire providers who aren't as well trained as doctors, such as nurse practitioners and physician assistants, to do work that would traditionally have been performed by an M.D. When all this results in substandard care, the arbitration agreements are in place to limit liability.

In fact, the possible availability of forced arbitration in malpractice cases may itself be leading to the private equity takeover of health care. As *Business Week* reported in 2020,<sup>27</sup> forced arbitration may have “helped enable a trend that has very little to do with patients' well-being: the rise of private equity in medicine.” Avoiding jury verdicts is part of the motivation. But also, “arbitration is almost always conducted in private, which means that big brands can avoid the negative publicity that comes with a lawsuit.”

Skilled nursing/nursing homes is another area where private equity ownership may be influencing the use of forced arbitration clauses. The U.S. General Accountability Office estimates that as of 2022, “5% of about 14,800 nursing homes enrolled in Medicare had private equity owners.”<sup>28</sup> One recent study found that over a recent 12-year period, private equity-owned nursing homes saw a short-term mortality increase of 10 percent, or 20,150 deaths” in addition to “declines in other measures of patient well-being.” This was likely due to “declines in nursing staff and compliance with standards.”<sup>29</sup>

While use of forced arbitration clauses may be widespread at these increasingly unsafe facilities, such clauses have actually been common throughout the skilled nursing/nursing home industry for years. As a 2022 *New York Times* investigation found, forced arbitration clauses are typically buried in “dozens of pages” of admission forms, which residents and their families are being hit with at a stressful time, “after a hospitalization or health crisis, with limited opportunity to scrutinize documents or consult a lawyer.”<sup>30</sup> There have been steps to ban this practice, including regulations issued by the Obama administration, which Trump reversed,<sup>31</sup> and legislation in Congress.<sup>32</sup> Since 2019, weaker regulations “prohibit nursing homes from requiring residents to sign binding arbitration agreements as a condition for receiving care, and will require nursing homes to inform residents or their representatives that they are not required to sign a binding arbitration agreement.”<sup>33</sup> Yet as the *New York Times* found, “they're still being included in admissions packets, and family members or residents are still being told, ‘Sign the papers’....”<sup>34</sup>

The following recent cases show the impact of these clauses when things go horribly wrong at a skilled nursing facility.

- On September 5, 2019, Susan Sharma was admitted as a patient at York Health and Wellness Centre, a short- and long-term skilled nursing and residential care facility in Los Angeles, following a stroke. A forced arbitration clause was buried in the admissions



paperwork. Susan's doctor assessed her as being "at risk for weight loss because of 'decreased feeding' and 'cognitive impairment.'" Within months, she "had lost 31 pounds, or 19% of her body weight." She also developed severe pressure ulcers and avoidable skin problems that prevented her ability to use her hands. On May 17, 2020, Susan was transferred to the hospital where she died three days later at age 72. Her family filed a lawsuit against York. The court granted York's motion to compel arbitration in October 2021 and the case was thrown out of court.<sup>35</sup>

- In March 2022, the wife of 85-year-old Serafin Pascual, Jr. admitted him to the Huntington Valley Healthcare Center, a short-term rehabilitation and skilled nursing facility in California. Serafin was suffering from a number of maladies making him a fall and bleeding risk, and he went there to recover from some hospital procedures. In order to get him admitted, she was required to sign forms that included a forced arbitration clause. Within weeks of being admitted, Serafin fell and died due to a series of care lapses. Serafin's wife and children sued. In December 2023, the court barred Serafin's wife from pursuing the wrongful death claim and forced all her remaining claims into arbitration. The judge also ruled that his children had to pursue those same claims in arbitration but were permitted to keep their wrongful death claim in court since they were non-signatories to the arbitration agreement. As a result, the victim's family had to pursue the same case in two entirely different venues – court and arbitration – an absurd result.<sup>36</sup>

## SURGERY CENTERS AND CLINICS

Another type of health care facility making increasing use of forced arbitration are surgery centers and clinics. Surgery centers can be risky places for medical procedures. A *Kaiser Health News* and *USA Today Network* investigation discovered hundreds of deaths "after in-and-out procedures at surgery centers across the country," including patients "some as young as 2," and numerous cases "where the absence of trained staff or emergency equipment appears to have put patients in peril."<sup>37</sup> They also found that "surgery centers operate under such an uneven mix of rules across U.S. states that fatalities or serious injuries can result in no warning to government officials, much less to potential patients. ...No rule stops a doctor exiled by a hospital for misconduct from opening a surgery center down the street."<sup>38</sup> Indeed, in 2019, the Leapfrog Group found, "More than 1 in 3 outpatient surgery centers employ doctors who are not board certified in their respective medical specialty...."<sup>39</sup> Recent inspections by the Office of Inspector General for the U.S. Department of Health and Human Services found over 75 percent of surgery centers "had at least one deficiency," with *serious* deficiencies at 25 percent.<sup>40</sup>

Yet patients are finding that holding surgery centers legally responsible for malpractice is becoming increasingly impossible thanks to forced arbitration clauses. Forced arbitration clauses can keep a case out of court even when a hospital system that does not force arbitration sends their patients to a private surgery center that does.<sup>41</sup> As Consumer Watchdog Executive Director Carmen Balber explained, arbitration confidentiality "'has a huge impact on patient safety...because if you see the news of a repeat lawsuit against a private surgery center, you might think twice before going. But you'll never see the news if arbitration is forced and the entire process is conducted behind closed doors with no public records of what might have happened.'"<sup>42</sup>

The following are examples of recent medical malpractice lawsuits against negligent surgery centers or private medical clinics that were kicked out of court due to a forced arbitration clause.

- **Eye damage at a Lasik surgery center.** On September 27, 2017, Carlos Lopez Rivera underwent eye surgery at Lasik Vision Institute in Burlington, Massachusetts. The morning before the procedure, Carlos, whose primary language was Spanish, was asked to sign a stack of documents printed in English and provided by the doctor doing the surgery. One of them was a forced arbitration agreement covering “any and all actions for medical malpractice.” Carlos signed and initialed the document. Following the surgery, his left eye vision was blurred, and there were other complications requiring a second surgery with a new doctor. However, his blurred vision could not be corrected. In September 2020, Carlos sued his first doctor for medical malpractice. The trial court would not compel arbitration since “no one explained the arbitration agreement to Lopez in his primary language (Spanish),” he “lacked a sufficient understanding of English to know what he was signing, and ‘that in signing a stack of multiple forms without translating into Spanish that one of these forms was for binding arbitration, [Lopez] was led to believe that he was signing medical forms.’” In August 2023, a Massachusetts appeals court reversed, finding there was no fraud, duress, or unconscionability to invalidate the arbitration agreement. The Massachusetts Supreme Judicial Court denied review in November 2023.<sup>43</sup>
- **Genetic mutation at a reproductive center.** Jason and Melissa Diaz went to Huntington Reproductive Center Medical Group (HRC) in Pasadena, California for in-vitro fertilization with pre-implantation genetic testing to avoid conceiving a child with the genetic mutations they both carried – his causing a predisposition to heredity diffuse gastric cancer (which carries an over 80 percent risk of stomach cancer that requires stomach-removal surgery), hers substantially increasing chances of breast and ovarian cancer. They were required to sign a forced arbitration clause in order to go forward with these procedures. HRC implanted Melissa with a male embryo with the stomach-cancer mutation despite the couple being told that the embryo had no such mutation. When their baby was ten months old and the couple was planning ahead with HRC for a second child, they learned that their son carried the stomach-cancer gene. They filed medical malpractice and a number of other claims with the American Arbitration Association (AAA). At the same time, they pursued fraudulent concealment and violations of unfair competition law claims in court in March 2023. The AAA refused to adjudicate their claims because the arbitration agreement “included a prevailing-party fee-shifting provision, in violation of California law” and “also because the AAA requested that all parties sign an additional arbitration agreement – which [the Diazes] need not, and would not, execute – to hear the matter.” As a result, in May 2023, Jason and Melissa pursued their medical malpractice and other claims in a separate lawsuit. HRC responded with motions to compel arbitration in both the March and May 2023 cases. In August 2023, the court forced all their claims into arbitration.<sup>44</sup>
- **Burns at a plastic surgery center.** In March 2021, Gabriela Pulido went to Mira Aesthetic Plastic Surgery Center in California to arrange a breast augmentation and abdominoplasty. While there, she was given several papers to sign as a condition of treatment, including an arbitration agreement. Most of the forms were in Spanish, her native language. The arbitration form, however, was not. The procedures burned her leg, left her with permanent scarring, and caused various other physical and emotional complications. When Gabriela filed a medical negligence suit against the Center and doctor, they responded with a motion to compel arbitration. In May 2023, the court forced her claim into arbitration.<sup>45</sup>

- **Facial scarring at a dermatology center.** On June 3, 2021, Danielle Bernstein underwent laser treatment to remove excessive lip hair at True Dermatology in New York City. Two days before the procedure, she was given a tablet with nine different forms to sign while sitting in the waiting room. Among them was a forced arbitration document. Danielle signed all the forms. When the laser treatment left her with facial scarring, she pursued a medical malpractice lawsuit against the doctor and medical facility. They responded with a motion to compel arbitration. In August 2022, the court granted the motion.<sup>46</sup>

## ALTERNATIVE COMPENSATION SYSTEMS

Like forced arbitration, alternative compensation schemes eliminate or greatly weaken the right to civil jury trial in medical malpractice cases. It should be noted that some of these schemes raise constitutional concerns.<sup>47</sup> Courts have struck down far less intrusive measures, like compensation caps, in many states on various grounds, including infringing on the right to jury trial, the right to recourse, and equal protection, *i.e.*, unequal treatment of malpractice victims, especially when the laws under scrutiny are not responsive to an actual problem but rather serve only to disadvantage some population unreasonably.<sup>48</sup>

What's more, laws that expressly take compensation decisions out of courts and place them in administrative, governmental, or political bodies eventually fall victim to influence-peddling and budgetary/solvency considerations that no lawmaker today can control. There are many historical examples of this phenomenon, most notably the workers' compensation system, the fiscal problems of which have been solved by reducing benefits and increasing obstacles for workers.<sup>49</sup> In other words, problems are resolved on the backs of more powerless victims.

## HEALTH CARE TRIBUNALS

Health courts and similar proposals require that all medical malpractice cases be taken out of the court system and placed into an administrative tribunal. Such proposals have circulated in several states<sup>50</sup> (although no state has established them as of yet). For example, a bill has been put forth for a number of years in Georgia called the "Patient Compensation Act."<sup>51</sup> The idea is to replace Georgia's civil justice system for medical malpractice cases with a new government agency called the Patient Compensation System. Any patient with a medical malpractice claim would be forced into this government system with no ability to opt out.

The Georgia bill is in many ways similar to the "health courts" idea, about which a great deal has already been written.<sup>52</sup> It is closely linked to the "tort reform" movement.<sup>53</sup> The main common element of such proposals is the abolishment of judges and juries in medical malpractice cases, with all decisions made by a new government agency. Health court proposals contemplate using specialized "judges," while decision-makers under Georgia's Patient Injury Act would be political appointees and government bureaucrats pulled directly from the medical and business establishments. In both cases, decision-makers would be unanswerable to the common law settled by centuries of court decisions.

These proposals advocate the use of an "avoidability" standard for liability, which requires patients to prove fault (*i.e.*, these are not "no-fault" systems). They would use dictatorial compensation schedules established by a government agency for at least some kinds of damages. In Georgia, compensation would be further limited by an overall fiscal cap, likely leading to dramatic reductions in recoveries for the most seriously injured patients to levels well below their actual losses.

Under both approaches, the tort system's linkage between harm done and compensation paid would be either weakened or eliminated. Under the Georgia proposal, malpractice payments would not be reported to the National Practitioner Data Bank, the national database of physician malpractice and disciplinary records on which hospitals rely in making hiring decisions. In other words, from a patient safety perspective, these schemes would have serious consequences.

Such proposals have strong public relations spins attached to them, promising a fairer, more reliable, and cheaper process for resolving medical malpractice claims. None of this is true. Anti-patient bias is injected at every level of these proposed systems, including the complete removal of the jury system in exchange for giving patients little in return and, in some cases, harming them.

In addition, the costs of such systems would be significant. In their book *Medical Injustice: The Case Against Health Courts* (2007), Case Western Reserve Professors Maxwell J. Mehlman and Dale A. Nance observed that health courts involve creation of new judicial or administrative bureaucracies. Costs “would certainly be substantial, vastly more than the public (taxpayer borne) judicial costs currently associated with the adjudication of malpractice claims.”<sup>54</sup> Their wholesale dismissal of the jury system, coupled with the creation of an entirely new state governmental agency to handle a relatively small percentage of cases in the courts,<sup>55</sup> as well as the likely costs of maintaining such a system, are the reasons why health care tribunals have gone nowhere in Congress or in any state in the nation.

## BRAIN-DAMAGED INFANT FUNDS; LITIGATION PROHIBITED

### VIRGINIA

Virginia's Birth-Related Neurological Injury Compensation Program (“Program”) was established in the mid-1980s under threat from the state's insurance industry. The state's main insurance provider had stopped providing obstetrical insurance. When asked what would be needed to make them provide insurance again, the provider responded that “if the legislature passes legislation which takes the ‘birth-related neurological injury’ out of the tort system, we will lift the moratorium.”<sup>56</sup>

So that is exactly what happened. Since 1988, the Program has been the exclusive remedy for children born with birth-related brain injury when delivered by a participating OB/GYN and hospital whether or not medical malpractice caused the injury or contributed to its severity.<sup>57</sup> Lawsuits are prohibited. All claims go before an administrative board, established within the state's workers' compensation system. Bias is baked into the system, as the board relies on an “expert” panel of three doctors to determine if the injury is a covered injury. In testimony before the Virginia Legislature, one parent called this program “a generous system of care gone awry, of state-sanctioned impunity for doctors and hospitals, and of the struggle families face caring for society's weakest children.”<sup>58</sup>

Indeed, the Program has had numerous problems. While children were promised lifetime medical care, they also have been forced to “absorb stunning disparities in program benefits because of shifting priorities and cost reductions over which they had no control or voice.” As reported by the *Richmond Post-Dispatch*,<sup>59</sup>

“The program can end up providing very little,” said Christina Rigney, referring to the minimal benefits her family received in the face of her son's traumatic birth and brief life. “We believed there was negligence involved, but nothing ever came of it.” Her son died three years after he was severely injured due to oxygen loss during birth. Because of the birth injury law, the family couldn't file a malpractice suit, the obstetrician was never

even asked to explain what happened, and the family could learn nothing from illegible notes that failed to account for long periods of time.

Undeniably, one of the worst aspects of Virginia's program is that it fails to hold accountable even the most dangerous doctors and allows them to continue practicing. National birth-injury experts have expressed fear about Virginia being a safe harbor for bad doctors because of a lack of disciplinary actions under this law. "The birth-injury cases...are not reported to national databases that track actions against doctors and measure physicians' insurability. With no court action, settlement or disciplinary actions, a doctor's involvement in birth-injury cases can go undetected."<sup>60</sup>

There are other issues as well. The Program does not always adjust to current medical developments or evolving standards about caring for these children.<sup>61</sup> And the Program has struggled fiscally. In 2002, Virginia's Joint Legislative Audit and Review Commission suggested "abandoning or overhauling" the Program<sup>62</sup> and "ridding the board of its heavy presence of medical professionals"<sup>63</sup> and found that the Program could not be made fiscally sound.<sup>64</sup> Indeed, the Program has often been in fiscal crisis.<sup>65</sup> This is so even though a child's non-economic damages are entirely eliminated (i.e., not simply "capped"). When the fund was close to \$130 million short of cash, the legislature decided to fix the problem on the backs of victims and their families by (among other things) capping their benefits, in complete contradiction to the law's original intent, i.e., "by giving up their right to bring suit, families were promised lifelong medical care for eligible children."<sup>66</sup>

Moreover, for years, the fund was ripping off federal taxpayers by improperly requiring families "to apply for Medicaid as a primary source of payment for care" instead of the fund, "even though federal law requires the program to act as 'the payer of last resort.'"<sup>67</sup> Ultimately, the state was forced to reimburse the federal government for \$20.7 million. Unfortunately, "[t]he settlement, and the state's obligation to no longer rely first on Medicaid, means the costs of running the Program will also likely increase."<sup>68</sup> So its fiscal problems are clearly not going away.

## FLORIDA

As in Virginia, Florida lawmakers enacted the Birth-Related Neurological Injury Compensation Act ("NICA") in 1988 after pressure from the insurance industry and organized medicine.<sup>69</sup> Until 2022, little was publicly known about the operation of Florida's program. That year, the *Miami Herald* and *ProPublica* published an award-winning exposé of NICA,<sup>70</sup> finding that Florida's program shared all of Virginia's many problems and more. Titled *Birth & Betrayal*, the series found, among many other things, that "NICA was habitually depriving families of the most basic needs – despite racking up approximately \$1.7 billion in assets."<sup>71</sup>

In the series, reporters found overwhelming evidence that "NICA is indifferent to [families'] fears, anxieties and depression, and hostile to their needs." This manifested in things like "questioning the medical necessity of wheelchairs, medication, physical therapy – and extra feeding bags for a child with a gastrostomy tube."<sup>72</sup> Moreover, "[i]f families push back, the program sometimes spends more money fighting them than it would have cost to provide help.... 'A lawsuit against the physicians would have covered all of these expenses, but that right was taken from us,' wrote one parent, David Morgan, who sought help buying a TV and other equipment for his bedbound, pain-wracked young daughter. The request was denied."<sup>73</sup>

As Sean Shaw, Florida's former chief financial officer's consumer advocate, put it, "NICA is set up like most insurance companies. It's set up to not pay claims."<sup>74</sup> And that's not surprising given who composed NICA's board:

In addition to the chief operating officer of Florida's largest malpractice insurer, The Doctors Company, NICA's unpaid board includes two physicians, a hospital administrator and the board chairman, who is designated as the representative of Florida citizens. His day job is running an insurance agency.

After the series' publication, Florida's Office of Insurance Regulation conducted an audit. Its conclusions were disturbing, finding that NICA had "amassed nearly \$1.5 billion in assets while sometimes arbitrarily denying or slow-walking care to severely brain-damaged children."<sup>75</sup> Moreover, "[a]dministrators developed no system for resolving disputes with angry parents, discouraged parents from appealing denials to an administrative court, and didn't maintain a system for storing and tracking denials or complaints."<sup>76</sup>

What's more, as in Virginia, NICA was illegally raiding Medicaid to cover these children. In November 2022, it settled with the federal government for \$51 million.<sup>77</sup>

Following the *Birth & Betrayal* series, some steps were taken to stop some of the worst abuses of NICA. For example, "NICA's top administrator and its entire board, dominated by healthcare and insurance executives, was replaced. For the first time, seats on the board were set aside for a parent of a child in NICA and an advocate for those with disabilities."<sup>78</sup> Also, "each family in NICA received an immediate \$150,000 stipend from the program – a recognition of the staggering cost of raising a child with severe injuries and of the program's systemic failure to meet those needs."<sup>79</sup>

## BRAIN-DAMAGED INFANT FUNDS; LITIGATION REQUIRED

### NEW YORK

Within weeks of taking office in 2011, then Governor Andrew Cuomo set up a task force under the guise of Medicaid "redesign," primarily as a ruse to give New York's powerful hospital lobby a way to force the enactment of anti-patient medical malpractice "tort reform" laws in New York State. Cuomo's task force team, dominated by his hospital friends who would financially benefit from these laws,<sup>80</sup> met secretly and made recommendations that went straight into the Governor's budget. The task force "recommendations" were two-fold: a \$250,000 cap on non-economic damages and a Medical Indemnity Fund ("MIF") to pay for the future medical care of babies catastrophically harmed due to negligence at birth. By way of full disclosure, the Center for Justice & Democracy filed an ethics complaint against the task force alleging that its secret, biased process violated state law.<sup>81</sup> Although the ethics complaint was unsuccessful, pressure caused Cuomo to pull the damages cap out of his budget. But unfortunately, the MIF became law.<sup>82</sup>

The MIF is not a "no-fault" fund. It kicks in only after a jury verdict or settlement, in other words, *after* the family has endured the time and expense of proving their case in court (or settled). However, when it comes to future medical care for the child, the family is denied the same kind of rights and recourse that every other negligence victim has in the state. Instead of receiving a jury award for future care, the family must ask the MIF to reimburse them after they have incurred expenses. Put another way, despite having won their lawsuit or settlement, the family can only receive compensation for ongoing care by struggling to get bills paid from an unaccountable state entity, adding additional burdens on families who already face unimaginable challenges caring for a profoundly disabled child. Moreover, "once the birth injured child is accepted into the Fund, the defendant is completely relieved of the obligation to

pay any portion of the settlement or judgment attributable to any aspect of future care costs, whether or not the Fund actually pays for or provides the services determined to be necessary by the court.”<sup>83</sup>

Moreover, the law as originally written – which will be law again once past the “sunset” date of December 2025<sup>84</sup> – condemned the injured child to a lifetime of suboptimal care by specifying that reimbursement for therapies would be limited to the cheapest care available: Medicaid rates. This is incredibly unfair to very sick children whose care is only necessitated by medical negligence and who should have access to a level of care that a court judgement would have paid for.<sup>85</sup> In 2016, the legislation was temporarily amended to address urgent concerns of family members about Medicaid rates and other troublesome issues. Whether this amendment is extended past year 2025 remains to be seen.



## OTHER TYPES OF OBSTACLES

### MEDICAL REVIEW PANELS

Medical review or screening panel laws force patients to prove their case before a non-judicial panel before they are allowed in court. Seventeen jurisdictions have such laws.<sup>86</sup> These requirements are fundamentally unfair to patients. Panel members often come from or are funded by the health care industry, with clear conflicts of interest. Patients are burdened by extra time and expenses in their quest just to get into court. That is why “[s]everal states have repealed screening panel laws, either legislatively or judicially.”<sup>87</sup>

Take Montana, where the state’s Medical Legal Panel is funded by the Montana Medical Association, which also supplies the panel’s CEO.<sup>88</sup> As recently described by a former panel employee, while the panel is composed of both lawyers and doctors, “the defense was often given an advantage.”<sup>89</sup> For example,

“We reach out to potential panelists. Some are available, some aren’t,” [Jamie] Bonilla said. “Defense counsel wanted to know who was available for panel before they gave their disqualifications,” she said. “That was communicated to them but not to claimants.”

Bonilla said she began to give the info to both sides and was ostracized at work because of it. She resigned shortly after, citing issues with how the panel was run as her main reason.

“I think the process was well-intentioned initially, but I don’t think it is any more because it’s being run by the Montana Medical Association,” she said. “I absolutely feel like one side is given preference over the other. It’s common practice.”

This seems borne out by the data, which show that, “[f]rom 2012 to 2018, the panel heard 2,033 cases and just 792 lawsuits were filed after – less than 40%. In a majority of the cases, the panel sides with the defendant, saying there was no malpractice.”<sup>90</sup>

As if that weren’t bad enough, screening panels appear to have no impact on so-called “frivolous” lawsuits, which is ostensibly their reason for existing. Or at least, no one has bothered to find out. For example, a recent look at the impact of Utah’s screening panels, which have existed since 1985, revealed that “no one, including state auditors, has been able to show whether they have had a meaningful impact on weeding out frivolous cases or reducing the number of medical malpractice cases filed.”<sup>91</sup>

### CERTIFICATES OF MERIT

Twenty-eight states currently have “certificate of merit” laws that require patients and their attorneys to certify that a case has merit before filing it in court.<sup>92</sup> Some of these laws are not unreasonably burdensome for the patient. However, some are onerous and prevent legitimate cases from going forward. Most laws require that cases be dismissed “with prejudice” if the certificate is not completed and filed as mandated by the law. That is why some state high courts have found certificates of merit to be unconstitutional.<sup>93</sup>

Most certificate of merit statutes use language requiring either that an attorney consult with an expert and certify that such a consultation took place or that the expert themselves certify that the case is reasonable.<sup>94</sup> Some requirements are stricter than those for a testifying expert.<sup>95</sup> Whether or not the expert is identified in the affidavit or, even more onerous, must testify or be deposed, also varies widely in certificate of merit statutes.<sup>96</sup>

In terms of what plaintiffs and their experts must assert, sometimes facts can be “based on available records” (or plaintiff’s version of the facts). However, some laws require the plaintiff to verify that malpractice has occurred, which is often impossible before there has been any opportunity for discovery. Such a requirement led Washington State’s Supreme Court to strike down that state’s law, noting that “[r]equiring plaintiffs to submit evidence supporting their claims before the discovery process violates the plaintiffs’ right of access to courts.”<sup>97</sup>

## SAFE HARBOR/CLINICAL PRACTICE GUIDELINE IMMUNITY

Some proposals at both the state and federal levels have included suggestions that doctors who practice “evidence-based medicine”<sup>98</sup> or, more specifically, follow “clinical practice guidelines”<sup>99</sup> (that may or may not stem from “evidence-based medicine”<sup>100</sup>) should be immune, or presumed to be immune, from lawsuits.

For example, the Trump White House Fiscal Year 2019 budget included this proposal (among other “tort reforms” and alternative systems), recommending:<sup>101</sup>

[A] cap on non-economic damage awards of \$250,000 (increasing with inflation over time); a three-year statute of limitations; allowing courts to modify attorney’s fee arrangements; allowing evidence of a claimant’s payments from other sources (e.g., workers’ compensation, auto insurance) to be introduced at trial; **creating a safe harbor for clinicians following evidence-based clinical practice guidelines**; and authorizing the Secretary to provide guidance to States to create expert panels and administrative health care tribunals to review medical liability cases.

These concepts are “lurking” at the state level as well.<sup>102</sup> For example, a 2009 Connecticut bill, which failed to pass, read as follows:<sup>103</sup>

(c) Notwithstanding any provision of the general statutes, **there shall be no monetary liability** on the part of, and no cause of action for damages shall arise against, a participating provider for a Sustinet Plan member’s injury caused by such provider’s provision of care **when such care was consistent with guidelines approved by the board**. The board shall establish and implement a process for providing a member with no-fault compensation for injuries sustained by such member notwithstanding the fact that the provider’s provision of care was consistent with guidelines approved by the board. Exemption from liability shall not apply to injuries that result from: (1) A mistaken determination by the provider that a particular guideline applied to a particular patient, where such mistaken determination is caused by the provider’s negligence or intentional misconduct, or (2) a failure to properly follow a particular guideline where such failure is caused by the provider’s negligence or intentional misconduct.

Both sides in malpractice litigation currently make limited use of clinical practice guidelines in settlement negotiations, or even to help lawyers decide whether or not to file suits.<sup>104</sup> However, there are two major differences between this approach and more recent proposals, both of which are anti-patient and problematic for safety. First, recent proposals suggest that clinical

guidelines should become the legal standard for deciding liability in medical malpractice cases. Second, the proposals specify that legal use of guidelines would be permitted only by the defense, in order to exculpate a physician. “Inculpatory” use would not be allowed by patients when presenting their cases.

It is already generally recognized that conflicts of interest and specialty bias are inherent problems in the development of clinical practice guidelines. It is obviously unfair for patients to have their cases judged by liability standards chosen by medical and specialty societies, especially since they are written with the knowledge that they will help exculpate fellow physicians.

But even more fundamentally, no matter who writes them, it is impossible to develop single authoritative guidelines for every medical condition, let alone to trust any entity, such as a government or political agency, to suddenly become the sole arbiter of acceptable medical practice.<sup>105</sup> It is estimated that more than 1,400 sets of clinical practice guidelines exist. While some standards, such as those in anesthesia, are clear and easily complied with, others, such as in obstetrical cases, are complicated and can be contradictory. Moreover, as they are written for “average patients” and cannot encompass the huge variation in how patients present, there may be good reason to vary from a guideline’s patient recommendation. Attempting to establish a single authoritative guideline for a medical condition could even result in a loss of confidence in the very guideline.<sup>106</sup> Indeed, the medical profession itself has not accepted clinical practice guidelines as appropriate legal standards, even for exculpatory purposes.<sup>107</sup>

Only a few states have ever attempted to develop and use certain clinical guidelines as legal standards. In the 1990s, Maine established a program that allowed doctors in four specialties – anesthesiology, emergency medicine, obstetrics and gynecology, and radiology – to participate in a program allowing use of guidelines as exculpatory evidence in lawsuits. Other specialties were encouraged to take advantage of this program but did not. The program expired, and the Maine Bureau of Insurance concluded that “the medical demonstration project had no measurable effect on medical professional liability claims, claims settlement costs, or malpractice premiums.”<sup>108</sup>

In 1996, Florida also began a demonstration project for cesarean deliveries, but reportedly “garnered relatively little support among physicians – only 20% of physicians eligible to participate chose to do so and the project ended in 1998.... Three other states (Kentucky, Maryland, and Minnesota) adopted test projects in the 1990s, though none of the projects is fully operational today (the Maryland and Minnesota projects have fully expired).”<sup>109</sup>

It also should be noted that, “[b]etween 1992 and 1996, the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) sponsored development of a series of 19 clinical practice guidelines. These guideline products are no longer viewed as guidance for current medical practice,” so the agency now lists them “for **archival** purposes only” (emphasis in original).<sup>110</sup>

In sum, these limited state and federal experiments, which began and ended in the 1990s, were collectively unsuccessful.

## “SORRY WORKS”/APOLOGY/EARLY OFFER PROPOSALS

Close to 40 states now have provisions allowing medical professionals to “make apologies or sympathetic gestures” to patients whom they have injured or made sick due to medical

negligence.<sup>111</sup> Apology laws usually prohibit the apology – essentially an admission of fault – from being mentioned in court (*i.e.*, “apology plus shield”) even if the provider later lies about their culpability.<sup>112</sup> This is one of the key components of a program known as “Sorry Works!,” whose “leading figures” and board members are insurance executives.<sup>113</sup> A common trend is combining apologies with “early offer” programs, *i.e.*, the medical provider apologizes for the error and makes a settlement offer. Sometimes these are called “communication and resolution” (C&R) programs.<sup>114</sup> These laws have been identified as part and parcel of organized medicine’s “tort reform” agenda,<sup>115</sup> and the American Medical Association has said as much.<sup>116</sup>

Clearly, such programs raise a number of concerns for patients. For example,

Because plaintiffs will receive early offers soon after the adverse event, while still working through the trauma of the injury or loss of a loved one, and before the extent of their future costs are known, plaintiffs will feel an inordinate amount of economic or emotional pressure to accept the offers made. This pressure is likely even when the offers do not cover all of a plaintiff’s economic damages and contain virtually no noneconomic damages.<sup>117</sup>

Indeed, researchers have found that “[a]pology laws spurred a 60% reduction in hospital payments to victims, roughly \$32,000–\$73,000 per case.” However, the cost to sick and injured patients, as well as to patient safety in general, is substantial:<sup>118</sup>

[S]everal apology practices are meant to “create emotional pressure on victims to accept them, a decision that the victim will later come to regret.” Apology programs not only fail to diminish loss, they might even increase risk. Specifically, as healthcare providers know they can easily escape liability by later generating an apology, their incentives to take care decrease. Thus, notably, even if apology programs actually do carry some potential to reduce emotional harm *ex-post*, they still distort doctors’ incentives to take proper care *ex-ante*.<sup>119</sup>

That said, research shows that if the patient is properly represented by independent counsel during early offer negotiations, the patient fares well. If they are not, they don’t. This was the view of one of the original designers of apology/early offer programs at the Department of Veteran Affairs in Lexington, Kentucky.<sup>120</sup> The Lexington VA program’s protocols expressly recognized “the need to advise unrepresented patients to seek legal counsel before confronting them with an apology and a set of decisions that would have legal consequences for them.”<sup>121</sup> Researchers who examined this program in the 1990s found that when lawyers were brought in, patients fared about the same as those who went to court, but with lower litigation costs and quicker compensation.

However, most apology/early offer programs do not require that the patient be represented by counsel, making negotiations extremely perilous for an injured patient. In fact, some programs, like the “Recognize, Respond, Resolve” program developed by Colorado insurer COPIC, exclude patients if they even consult with an attorney.<sup>122</sup> Other recent apology programs lack strong components requiring counsel and seem more designed to pay patients as little as possible.<sup>123</sup> One such program is used by the University of Michigan Health System (UMHS), which began in 2001.

## **UNIVERSITY OF MICHIGAN HEALTH SYSTEM PROGRAM**

UMHS’s program is the “most commonly referenced apology program today.”<sup>124</sup> The American Medical Association calls it “a model for other health systems to replicate.”<sup>125</sup> The program

“purports to provide quick compensation for viable claims” (but it will not “publish their strategy for approaching the negotiations with the patients to whom they apologize”).<sup>126</sup> It is UMHS's Department of Risk Management that “leads the process” in determining if medical negligence occurred. That means, “one must take it on faith that UMHS's risk management department is capable of acting against the facility's own financial interests and fully and fairly compensating injured patients.”<sup>127</sup> In other words, patients, who might be unrepresented, “must trust that risk managers would violate their obligation to their own employer (of keeping overall costs low), in order to give them an appropriate settlement. There is simply no evidence that this has, or will, occur and no program has released any data to that effect.”<sup>128</sup>

In fact, there is at least some anecdotal evidence of patients experiencing difficulties under this program.<sup>129</sup> For example:

[Michelle Hereford's] 44-year-old husband and leukemia patient was killed after his bowel was perforated during surgery at a University of Michigan hospital, and fecal material spread into the rest of his body and gave him sepsis. Michelle tried to get the hospital to respond to increasing symptoms that she witnessed but even with her expertise, she failed. She filed a complaint with the University of Michigan Medical Center, claiming that the perforation in his bowel was diagnosed too late. [UMHS head] Rick Boothman apologized to her but admitted no mistake, instead issuing a patronizing statement that she wasn't in the loop with the other doctors treating her husband. She put it this way: “It was a canned letter. It was not an admission, and it wasn't a denial. They're minimizing their risk.”<sup>130</sup>

As a hospital administrator trained as a clinical nurse, Michelle had more health care knowledge than most. If this could happen to her, it doesn't take much to imagine how a less knowledgeable individual might fare in a similar situation.

## **NEW HAMPSHIRE'S EARLY OFFER PROGRAM**

Another troubling aspect of some early offer programs is that they are “extremely punitive toward patients who do not accept the settlement provided by the hospital. For example, some proposals advocate requiring that fee-shifting penalties attach to a patient who rejects an offer, or would allow the plaintiff to retain the right to sue but with a much higher burden of proof.”<sup>131</sup>

One such program was enacted in New Hampshire in 2012.<sup>132</sup> The legislation was opposed by the Governor (whose veto was overridden),<sup>133</sup> the state's powerful *Union Leader* newspaper, medical malpractice insurers,<sup>134</sup> patients, and attorneys. This incredibly unpopular program sunset in 2020, after being operational for just a few years.<sup>135</sup> Perhaps because it was so universally unpopular, it appears that few if any used the program during its short life. As a result, public data do not exist to evaluate it. However, it was written to work as follows:

- If there was an incident of malpractice, the patient could have been approached to enter into an early offer program. If they did, the patient had to notify the provider that they were entering into the program. The notice to the provider had to be accompanied by the patient's legal waiver and release form, the text of which was written into the law. Such text was written in legalese. The patient would have been required to sign that document before they had any idea what compensation and courtroom rights they were relinquishing.
- Once they had signed away their rights, the patient's ability to collect what would have amounted to severely-capped compensation would have been infected by conflicts of

interest at every step, beginning with allowing the medical provider to choose their own doctor to decide the patient's damages. While those physicians could not be "affiliated" with the provider, they would have been chosen by and paid for by the provider, whose chief motivation would have been to cut costs.

- Compensation for non-economic loss or lost earning capacity would have been prohibited. To receive any future medical expenses, the patient or their family would have been forced to undergo a burdensome struggle to get bills paid by the medical provider, which would have had a financial incentive to deny claims and/or cut costs. It would have been entirely within the provider's discretion to decide what would be considered "reasonable proof" for a claim. If the patient disagreed with any of this, they could argue their case before a hearing officer paid for by the provider. And if the hearing officer decided that the patient's claim was "frivolous," the patient – who likely would have no legal representation since few patients could afford an attorney for such a hearing – would be forced to pay up to a \$1,000 penalty.
- Because the medical provider would have had so much discretion and cost-cutting motivation to reject portions of a patient's claim, the patient likely would have had no option but to go to court at that point. If the patient finally got to court and won, but the verdict was less than 125 percent of the offer, the patient would have been forced to pay the provider's attorney fees. (In other words, it is probable that no patient would have risked having to pay these costs, rendering their right to access the courts virtually meaningless).

As the *Union Leader* put it in an editorial against the law, it "tilts the playing field heavily in favor of hospitals and physicians."<sup>136</sup> That was putting it mildly.

In fact, the same conclusion can be drawn regarding any program discussed in this report.

## NOTES

<sup>1</sup> Martin A. Makary and Michael Daniel, "Medical error – the third leading cause of death in the US," *BMJ*, May 3, 2016, <http://www.bmj.com/content/353/bmj.i2139>

<sup>2</sup> David W. Bates et al. "The Safety of Inpatient Health Care," *New England Journal of Medicine*, January 12, 2023, <https://www.nejm.org/doi/full/10.1056/NEJMsa2206117>

<sup>3</sup> Commonwealth Fund, *Health and Health Care for Women of Reproductive Age*, April 20, 2022, <https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/health-and-health-care-women-reproductive-age>

<sup>4</sup> "Only about 1% of adverse events due to medical negligence result in a claim." Martin A. Makary and David E. Newman-Toker, "Measuring Diagnostic Errors in Primary Care," *JAMA Internal Medicine*, March 25, 2013, <http://archinte.jamanetwork.com/article.aspx?articleid=1656536>

<sup>5</sup> Medical malpractice cases represented a tiny percentage of state trial court civil caseloads in 2022, ranging from 0.02 to 0.56 percent and a low percentage of state trial court tort caseloads in 2022, ranging from 0.91 to 6.99 percent (with the exception of three outliers at 10.08 percent, 15.94 percent and 18.75 percent). National Center for State Courts, "CSP STAT Civil: Trial Court Caseload Overview, Data Table – Malpractice Medical," <https://www.courtstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil> (data as of November 18, 2023); National Center for State Courts, "CSP STAT Civil: Trial Court Caseload Overview, Data Table – Total Civil," <https://www.courtstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil> (data as of November 18, 2023); National Center for State Courts, "CSP STAT Civil: Trial Court Caseload Overview, Data Table – Total Tort," <https://www.courtstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil> (data as of November 18, 2023).

<sup>6</sup> For example, "Between 2018 and 2022, Coverys opened an average of 2,797 claims per year. ...Nearly half (43%) of all claims were for incidents that resulted in death or high injury severity. This includes major permanent injuries, the need for lifelong care, or a fatal prognosis. These claims accounted for 66% of paid indemnity." Coverys, "How Claims History Can Assist Risk Management," November 21, 2023, <https://www.coverys.com/knowledge-center/How-Claims-History-Can-Assist-Risk-Management>. The Harvard School of Public Health put it this way: Legitimate claims are being paid, non-legitimate claims are generally *not* being paid, and "portraits of a malpractice system that is stricken with frivolous litigation are overblown." David M. Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, May 11, 2006, <https://www.nejm.org/doi/full/10.1056/nejmsa054479>

<sup>7</sup> Mark A. Hofmann, "White House open to medical liability changes," *Business Insurance*, January 30, 2011, <http://www.businessinsurance.com/article/20110130/ISSUE01/301309974>

<sup>8</sup> Heather Morton, "Medical Liability/Medical Malpractice Laws," National Conference of State Legislatures, <https://www.ncsl.org/financial-services/medical-liability-medical-malpractice-laws> (updated July 13, 2021).

<sup>9</sup> Center for Justice & Democracy, "Fact Sheet: Caps On Compensatory Damages: A State Law Summary" (August 2020), <https://centerjd.org/content/fact-sheet-caps-compensatory-damages-state-law-summary>

<sup>10</sup> See, e.g., American Medical Association Advocacy Resource Center, "Issue Brief: Communication and resolution programs" (2017), <https://www.ama-assn.org/system/files/2019-01/ama-issue-brief-communication-and-resolution-programs.pdf.pdf> ("While the AMA supports traditional reforms, such as the caps on non-economic damages that continue to be effective in California and Texas, the AMA is also supportive of the implementation and testing of innovative reforms to see if they can improve the liability climate for patients and physicians. C&R programs, liability safe harbors for the practice of evidence-based

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medicine, health courts and administrative compensation programs are a few of the innovative concepts that the AMA would like to see implemented and tested in states on a broader scale. Further, traditional and innovative reforms can complement one another, which may be the optimal route for states to take.”)

<sup>11</sup> See, e.g., Tom Baker, “The Medical Malpractice Myth” (2005) (“Lawsuits make people work through the system, not against it. Lawsuits take place in the open. Lawsuits provide procedural protections for everyone involved. To win a lawsuit you have to be right. It is not enough just to be angry.... Responsibility lies at the heart of tort law. A tort lawsuit is a public statement that a defendant has not accepted responsibility, coupled with the demand to do so. Malpractice lawsuits ask doctors and hospitals to take responsibility for their mistakes, not just prevent future mistakes or to compensate the patient, but also because taking responsibility is the morally proper thing to do.”)

<sup>12</sup> Legal scholarship, including empirical studies, firmly establishes that consumers do not meaningfully consent to arbitration clauses in boilerplate contracts. Nor do consumers understand the implications of arbitration clauses. See, e.g., Letter from Consumer Law Professors to U.S. Consumer Financial Protection Bureau Director Rohit Chopra re: Petition to Require Meaningful Consumer Consent Regarding the Use of Arbitration to Resolve Disputes Involving Consumer Financial Products and Services, Petition No. CFPB-2023-0047-0001, November 14, 2023, <https://fingfx.thomsonreuters.com/gfx/legaldocs/zgvorxbxypd/frankel-cfpbrule-lawprofletter.pdf>; Roseanna Sommers, “What Do Consumers Understand About Predispute Arbitration Agreements? An Empirical Investigation,” July 23, 2023, <https://ssrn.com/abstract=4521064>; Jeff Sovern et al., “‘Whimsy Little Contracts’ with Unexpected Consequences: An Empirical Analysis of Consumer Understanding of Arbitration Agreements,” 75 Md. L. Rev 1 (2015), <https://digitalcommons.law.umaryland.edu/mlr/vol75/iss1/2/>. Similarly, the U.S. Consumer Financial Protection Bureau found in 2015 that “consumers are generally unaware of whether their credit card contracts include arbitration clauses; ...less than 7% of consumers whose credit card agreements included pre-dispute arbitration clauses stated that they could not sue their credit card issuers in court; [and] most consumers whose [credit card] agreements contain arbitration clauses wrongly believe that they can participate in class actions.” U.S. Consumer Financial Protection Bureau, *Arbitration Study: Report to Congress, pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act § 1028(a)* (March 2015), [http://files.consumerfinance.gov/f/201503\\_cfpb\\_arbitration-study-report-to-congress-2015.pdf](http://files.consumerfinance.gov/f/201503_cfpb_arbitration-study-report-to-congress-2015.pdf)

<sup>13</sup> See, e.g., Jacob Gershman, “As More Companies Demand Arbitration Agreements, Sexual Harassment Claims Fizzle,” *Wall Street Journal*, January 25, 2018, <https://www.wsj.com/articles/as-more-employees-sign-arbitration-agreements-sexual-harassment-claims-fizzle-1516876201>; U.S. Consumer Financial Protection Bureau, *Arbitration Study, Report to Congress, pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act § 1028(a)* (March 2015) [https://files.consumerfinance.gov/f/201503\\_cfpb\\_arbitration-study-report-to-congress-2015.pdf](https://files.consumerfinance.gov/f/201503_cfpb_arbitration-study-report-to-congress-2015.pdf)

<sup>14</sup> American Association for Justice, *The Truth About Forced Arbitration* (September 2019), <https://www.justice.org/resources/research/the-truth-about-forced-arbitration>

<sup>15</sup> In the 1998 report titled, *Health Care Due Process Protocol*, the organizations jointly found that any alternative dispute resolution (ADR) process, like arbitration, must abide by due process considerations and must be fundamentally fair. Specifically, they concluded that “[t]he agreement to use ADR should be knowing and voluntary. Consent to use an ADR process should not be a requirement for receiving emergency care or treatment. In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.” Commission On Health Care Dispute Resolution, *Healthcare Due Process Protocol*, July 27, 1998, [https://www.adr.org/sites/default/files/document\\_repository/Healthcare-Due-Process-Protocol.pdf](https://www.adr.org/sites/default/files/document_repository/Healthcare-Due-Process-Protocol.pdf)

<sup>16</sup> See “AAA® Healthcare Policy Statement,” [https://www.adr.org/sites/default/files/document\\_repository/AAA\\_Healthcare\\_Policy\\_Statement.pdf](https://www.adr.org/sites/default/files/document_repository/AAA_Healthcare_Policy_Statement.pdf) (viewed February 24, 2024) (“In 2003, the American Arbitration Association® (‘AAA’) announced that it would not administer healthcare arbitrations between individual patients and healthcare service providers that relate to medical services, such as negligence and medical malpractice disputes, unless all parties agreed to submit the matter to arbitration *after the dispute arose*.” (emphasis added))

<sup>17</sup> Kaitlin V. Treadaway, “Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims: A Right-Threatening Procedure,” 7 *Stetson J. Advoc. & L.* 164 (2020), [https://www2.stetson.edu/advocacy-journal/wp-content/uploads/2020/08/Treadaway\\_2020.pdf](https://www2.stetson.edu/advocacy-journal/wp-content/uploads/2020/08/Treadaway_2020.pdf)



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<sup>18</sup> David Allen Larson and Dr. David Dah, "Medical Malpractice Arbitration: Not Business as Usual," *Arb. L. Rev.*, May 1, 2016, <https://elibrary.law.psu.edu/cgi/viewcontent.cgi?article=1007&context=arbitrationlawreview> ("The best window on medical arbitration, as it is actually practiced in the United States, is provided by the Kaiser Permanente Health Plan. In California, all Kaiser Permanente enrollees must sign an agreement to arbitrate, among other things, claims of medical malpractice by any Kaiser doctor.")

<sup>19</sup> While forced arbitration clauses cover all claims including premises liability and health care coverage problems, medical malpractice is by far the subject of most claims. See Kaiser Office of the Independent Administrator, *Annual Report of the Office of the Independent Administrator of the Kaiser Foundation Health Plan, Inc. Mandatory Arbitration System for Disputes with Health Plan Members (January 1, 2022 - December 31, 2022)*, <https://oia-kaiserarb.com/pdfs/2022-Annual-Report.pdf>

<sup>20</sup> "New report exposes breadth of physician practices owned by private equity," *Berkeley Public Health*, July 10, 2023, <https://publichealth.berkeley.edu/news-media/research-highlights/new-report-exposes-breadth-of-physician-practices-owned-by-private-equity>; Robert Pearl, M.D., "Private Equity And The Monopolization Of Medical Care," *Forbes*, February 20, 2023, <https://www.forbes.com/sites/robertpearl/2023/02/20/private-equity-and-the-monopolization-of-medical-care/?sh=6d8bb0f0b2bad>

<sup>21</sup> Alan Condon, "386 hospitals now owned by private equity firms: 6 things to know," December 19, 2023, *Becker's Hospital CFO Report*, <https://www.beckershospitalreview.com/finance/386-hospitals-now-owned-by-private-equity-firms-6-things-to-know.html>

<sup>22</sup> Heather Perlberg, "The Doctor Will See You Once You Sign This Binding Arbitration Agreement," *Businessweek*, December 28, 2020, <https://www.bloomberg.com/news/features/2020-12-28/the-doctor-will-see-you-once-you-sign-this-binding-arbitration-agreement>

<sup>23</sup> *Ibid.*

<sup>24</sup> Reed Abelson and Margot Sanger-Katz, "Serious Medical Errors Rose After Private Equity Firms Bought Hospitals," *New York Times*, December 26, 2023, <https://www.nytimes.com/2023/12/26/upshot/hospitals-medical-errors.html>, discussing Sneha Kannan, Joseph Dov Bruch, and Zirui Song, "Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition," *JAMA*, December 26, 2023, <https://jamanetwork.com/journals/jama/article-abstract/2813379>

<sup>25</sup> Office of U.S. Senator Chuck Grassley, "Senate Budget Committee Digs into Impact of Private Equity Ownership in America's Hospitals," December 6, 2023, <https://www.grassley.senate.gov/news/news-releases/senate-budget-committee-digs-into-impact-of-private-equity-ownership-in-americas-hospitals>

<sup>26</sup> Heather Perlberg, "The Doctor Will See You Once You Sign This Binding Arbitration Agreement," *Businessweek*, December 28, 2020, <https://www.bloomberg.com/news/features/2020-12-28/the-doctor-will-see-you-once-you-sign-this-binding-arbitration-agreement>

<sup>27</sup> *Ibid.*

<sup>28</sup> U.S. General Accountability Office, *Nursing Homes: Limitations of Using CMS Data to Identify Private Equity and Other Ownership*, September 22, 2023, <https://www.gao.gov/products/gao-23-106163>

<sup>29</sup> Atul Gupta et al., "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes," NBER Working Paper 28474 (February 2021), [https://www.nber.org/system/files/working\\_papers/w28474/w28474.pdf](https://www.nber.org/system/files/working_papers/w28474/w28474.pdf)

<sup>30</sup> Paula Span, "Arbitration Has Come to Senior Living. You Don't Have to Sign Up," *New York Times*, September 24, 2022, <https://www.nytimes.com/2022/09/24/health/assisted-living-arbitration.html>

<sup>31</sup> See, "CMS Removes Ban on Nursing Homes Arbitration Agreements," *JD Supra*, July 25, 2019, <https://www.jdsupra.com/legalnews/cms-removes-ban-on-nursing-homes-94568/>

<sup>32</sup> See, e.g., H.R. 7119, "Fairness in Nursing Home Arbitration Act" (118th Congress), <https://www.congress.gov/bill/118th-congress/house-bill/7119?s=1&r=1>

<sup>33</sup> U.S. Centers for Medicare and Medicaid Services, "CMS Rules Put Patients First Updating Requirements for Arbitration Agreements and New, Regulations That Put Patients Over Paperwork," July 16, 2019,

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<sup>34</sup> Paula Span, "Arbitration Has Come to Senior Living. You Don't Have to Sign Up," *New York Times*, September 24, 2022, <https://www.nytimes.com/2022/09/24/health/assisted-living-arbitration.html>

<sup>35</sup> *Klaassen v. York Healthcare & Wellness Ctr.*, 2021 Cal. Super. LEXIS 20454 (minute order); *Klaassen v. York Healthcare & Wellness Centre, LP*, Case No. 21STCV07956 (L.A. County Superior Ct., Cal.) (complaint, March 1, 2021).

<sup>36</sup> *Pascual v. Huntington Valley Healthcare Ctr.*, 2023 Cal. Super. LEXIS 106832 (opinion); *Pascual v. Huntington Valley Healthcare Ctr.*, Case No. 30-2023-01313685-CU-MM-NJC (Orange County Superior Ct., Cal.) (complaint, March 15, 2023).

<sup>37</sup> Christina Jewett and Mark Alesia, "As surgery centers boom, patients are paying with their lives," *Kaiser Health News/USA TODAY*, March 2, 2018, <http://www.philly.com/philly/health/as-surgery-centers-boom-patients-are-paying-with-their-lives-20180302.html>

<sup>38</sup> Christina Jewett and Mark Alesia, "Lax Oversight Leaves Surgery Center Regulators and Patients in The Dark," *Kaiser Health News/USA TODAY Network*, August 9, 2018, <https://khn.org/news/lax-oversight-leaves-surgery-center-regulators-and-patients-in-the-dark/>

<sup>39</sup> Ken Alltucker and Jayne O'Donnell, "Patient safety report: Same-day surgery center doctors not all not board certified," *USA TODAY*, October 22, 2019, <https://www.usatoday.com/story/news/health/2019/10/21/patient-safety-some-outpatient-surgery-centers-missing-some-basics/4030887002/>, discussing Leapfrog Group, *Same-Day Surgery in the U.S.: Findings of Two Inaugural Leapfrog Surveys* (2019), [https://www.leapfroggroup.org/sites/default/files/Files/NationalReport\\_Final.pdf](https://www.leapfroggroup.org/sites/default/files/Files/NationalReport_Final.pdf)

<sup>40</sup> Cheryl Clark, "OIG Report: Ambulatory Surgery Center Inspections Lag," *MedPage Today*, October 2, 2019, <https://www.medpagetoday.com/publichealthpolicy/healthpolicy/82522>, discussing Office of Inspector General, U.S. Department of Health and Human Services, *Medicare's Oversight of Ambulatory Surgery Centers*, September 13, 2019, <https://oig.hhs.gov/oei/reports/oei-01-15-00400.asp>

<sup>41</sup> Kate Alexandria, "A UCLA Surgeon Almost Killed Me, but I Can't Sue," *Knock LA*, February 10, 2023, <https://knock-la.com/a-ucla-surgeon-almost-killed-me-but-i-cant-sue/>

<sup>42</sup> *Ibid.*

<sup>43</sup> Eric T. Berkman, "Arbitration agreement enforceable in med-mal case vs. eye surgeon," *Massachusetts Lawyers Weekly*, September 14, 2023, <https://masslawyersweekly.com/2023/09/14/arbitration-agreement-enforceable-in-med-mal-case-vs-eye-surgeon/>; *Rivera v. Stetson*, 493 Mass. 1103 (2023); *Rivera v. Stetson*, 103 Mass. App. Ct. 187 (2023); *Rivera v. Stetson*, 2022 WL 18780629 (opposition brief of plaintiff-appellee).

<sup>44</sup> *Diaz v. Huntington Reprod. Ctr. Med. Group*, 2023 Cal. Super. LEXIS 53568 (opinion); *Diaz v. Huntington Reprod. Ctr. Med. Group*, 2023 Cal. Super. LEXIS 53687 (opinion); *Diaz v. Huntington Reproductive Center Medical Group*, Case No. 23STCV09822 (L.A. County Superior Ct., Cal.) (complaint, May 2, 2023); *Diaz v. Huntington Reproductive Center Medical Group*, Case No. 23STCV04530 (L.A. County Superior Ct., Cal.) (complaint, March 1, 2023).

<sup>45</sup> *Pulido v. Mirrafati*, 2023 Cal. Super. LEXIS 28549 (minute order); *Pulido v. Mirrafati*, Case No. 30-2022-01250273-CU-MM-CJC (Orange County Superior Ct., Cal.) (complaint, March 17, 2022).

<sup>46</sup> *Bernstein v. Spizuoco*, 2022 WL 3574145 (decision/order); *Bernstein v. Spizuoco*, Case No. 0505324 (Kings County Sup. Ct., NY) (complaint, February 22, 2022).

<sup>47</sup> See, e.g., Amy Widman and Francine Hochsberg, "Federal Administrative Health Courts are Unconstitutional: A Reply to Elliott, Narayan, and Nasmith," 33 *J. Health Pol., Pol'y & L.* 799 (2008), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1857048](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1857048); Amy Widman, "Why Health Courts are Unconstitutional," 27 *Pace L. Rev.* 55 (2006), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1856042](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856042)

<sup>48</sup> See, e.g., *Estate of McCall v. United States*, 134 So.3d 894 (Fla. 2014); *Estate of McCall v. United States*, 642 F.3d 944 (11th Cir. 2011); Amy Widman, "Why Health Courts are Unconstitutional," 27 *Pace L. Rev.* 55 (2006), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1856042](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856042). The Florida Supreme Court stated,

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“[T]he statutory cap on wrongful death noneconomic damages does not bear a rational relationship to the stated purpose that the cap is purported to address, the alleged medical malpractice insurance crisis in Florida.... [E]ven if there had been a medical malpractice crisis in Florida at the turn of the century, the current data reflects that it has subsided.... At the present time, the cap on noneconomic damages serves no purpose other than to arbitrarily punish the most grievously injured or their surviving family members.” *Estate of McCall v. United States*, 134 So.3d 894 (Fla. 2014). See also *Hilburn v. Enerpipe Ltd.*, 442 P.3d 509 (Kan. 2019); *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 218 (Ga. 2010), *Ferndon v. Wisconsin Patients Compensation Fund*, 682 N.W.2d 866 (Wisc. 2005); *Hoem v. State*, 756 P.2d 780 (Wyo. 1988); *Boucher v. Sayeed*, 459 A.2d 87 (R.I. 1983). The Wyoming Supreme Court stated, “‘The continued availability and vitality of causes of action [against health care providers] serve an important public policy – the preservation of quality health care for the citizens of this state.’” ...“‘Constitutional protections exist for litigants regardless of market conditions for insurance companies and the medical industry; concerns about the latter cannot be allowed to overrun the former at the expense of those injured by acts of malpractice.’” *Hoem v. State*, 756 P.2d 780 (Wyo. 1988).

<sup>49</sup> Without belaboring in extreme detail the problems with workers' compensation systems, it is widely accepted that over the years they have worked more and more poorly for the permanently disabled, those most analogous to the participants who would be most hurt by medical malpractice proposals. Permanently disabled workers today do not receive enough compensation, and the compensation duration is too short as states chip away at benefits in direct response to pressure from insurance carriers and businesses. In many states, the process workers must go through to make claims and receive compensation has become longer, less efficient, and ultimately less successful in terms of its original goals. See “Worker’s Comp: Falling Down on the Job,” *Consumer Reports* (2000) (discussing legislative reforms of the 1990s and the resulting profits for workers' compensation insurance providers); RAND Research Brief, *Compensating Permanent Workplace Injuries* (1998). According to one legal scholar who studied workers' compensation, “[I]njured workers often face denials and delays of apparently legitimate claims, high litigation costs, discrimination, and harassment by employers and coworkers.... [M]any reports suggest that recent reforms have substantially increased injured workers' financial burdens.” Martha T. McCluskey, “The Illusion of Efficiency in Workers' Compensation ‘Reform,’” 50 *Rutgers L. Rev.* 657 (1998). In sum, having ceded their right to jury trial at a time when the law would have left most of their injuries uncompensated, these workers now face serious disadvantages relative to those with access to the judicial system. See Center for Justice & Democracy, *Workers' Compensation – A Cautionary Tale* (2006), [http://centerjd.org/lib/Workers'Comp\(NY\).pdf](http://centerjd.org/lib/Workers'Comp(NY).pdf)

<sup>50</sup> See, e.g., Ann W. Latner, “Several states consider new system for medical malpractice claims,” *Clinical Advisor*, February 22, 2016, <https://www.clinicaladvisor.com/home/my-practice/legal-advisor/several-states-consider-new-system-for-medical-malpractice-claims/>. Some of these proposals are the brainchild of corporate executive Richard Jackson, who runs the health care staffing company Jackson Healthcare. “The Truth Behind ‘Patients for Fair Compensation,’” *Lawsuit Funding News*, January 28, 2023, <https://lawsuitfinancial.legalexaminer.com/legal/miscellaneous/the-truth-behind-patients-for-fair-compensation/>

<sup>51</sup> See, e.g., SB 86, “Patient Compensation Act” (2015-2016), <https://www.legis.ga.gov/legislation/43366>; James Swift, “Sen. Brandon Beach Reintroduces Patient Compensation Act,” *Georgia Watch*, February 26, 2015, <https://georgiawatch.org/sen-brandon-beach-reintroduces-patient-compensation-act/>

<sup>52</sup> See, e.g., Amy Widman and Francine Hochsberg, “Federal Administrative Health Courts are Unconstitutional: A Reply to Elliott, Narayan, and Nasmith,” 33 *J. Health Pol., Pol’y & L.* 799 (2008), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1857048](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1857048); Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007); Amy Widman, “Why Health Courts are Unconstitutional,” 27 *Pace L. Rev.* 55 (2006), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1856042](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856042)

<sup>53</sup> The “health courts” idea was developed by a group called Common Good, which was founded by Philip K. Howard, senior counsel of the corporate law firm Covington & Burling, one of the principal architects of the “tort reform” movement. Amy Widman, “Liability and the Health Care Bill: An ‘Alternative’ Perspective,” *California Law Review Circuit*, September 21, 2010, <https://ssrn.com/abstract=1856033>. For more on this history, see Carl Deal and Joanne Doroshov, *The CALA Files: The Secret Campaign By Big Tobacco And Other Major Industries To Take Away Your Rights*, Center For Justice & Democracy (2008), <https://centerjd.org/content/cala-files-secret-campaign-big-tobacco-and-other-major-industries-take-away-your-rights>

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<sup>54</sup> Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007).

<sup>55</sup> Medical malpractice cases represented a tiny percentage of state trial court civil caseloads in 2022, ranging from 0.02 to 0.56 percent and a low percentage of state trial court tort caseloads in 2022, ranging from 0.91 to 6.99 percent (with the exception of three outliers at 10.08 percent, 15.94 percent and 18.75 percent). National Center for State Courts, "CSP STAT Civil: Trial Court Caseload Overview, Data Table – Malpractice Medical," <https://www.courtstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil> (data as of November 18, 2023); National Center for State Courts, "CSP STAT Civil: Trial Court Caseload Overview, Data Table – Total Civil," <https://www.courtstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil> (data as of November 18, 2023); National Center for State Courts, "CSP STAT Civil: Trial Court Caseload Overview, Data Table – Total Tort," <https://www.courtstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil> (data as of November 18, 2023).

<sup>56</sup> See David G. Duff, "Compensation for Neurologically Impaired Infants: Medical No-Fault in Virginia," 27 *Harv. J. on Legis.* 391 (1990) (citing Letter from Gordon D. McLean, Executive Vice-President, The Virginia Insurance Reciprocal to Ronald K. Davis, Virginia Surgical Associates, chairman of MSV's Professional Liability Committee, January 13, 1987 (on file at *Harv. J. on Legis.*)).

<sup>57</sup> Va. Code Ann § 38.2-5001, <https://law.lis.virginia.gov/vacode/title38.2/chapter50/section38.2-5001/>

<sup>58</sup> Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.

<sup>59</sup> *Ibid.*

<sup>60</sup> Bill McKelway, "Brain Injuries Spur No Action; Case Review, Required by Law, Is Not Being Done, Va. Study Found," *Richmond Times-Dispatch*, January 14, 2003.

<sup>61</sup> Bill McKelway, "Old Rules Deny New Benefits; Children Rejected for Brain-Injury Program," *Richmond Times-Dispatch*, June 5, 2003.

<sup>62</sup> Liz Szabo and Elizabeth Simpson, "Birth Injuries Get 'Minimal Review; State Report Says Board Must Hold Doctors Accountable,'" *Virginian-Pilot*, November 15, 2002; Bill McKelway, "Study Faults Program for Brain-Injured; Shortcomings Found in Care for Children," *Richmond Times Dispatch*, November 13, 2002.

<sup>63</sup> Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times-Dispatch*, November 16, 2002.

<sup>64</sup> *Ibid.*

<sup>65</sup> See, e.g., Bill McKelway, "Plan could restore financial soundness," *Richmond Times-Dispatch*, September 17, 2007.

<sup>66</sup> *Ibid.*

<sup>67</sup> Michael Martz, "Family's ordeal leads to state paying U.S. \$20.7 million settlement over birth-injury program," *Richmond Times-Dispatch*, January 11, 2019, [https://richmond.com/news/local/government-politics/familys-ordeal-leads-to-state-paying-u-s-20-7-million-settlement-over-birth-injury/article\\_f2c6b33c-fe2e-50b2-bf3d-eea8110af4f8.html](https://richmond.com/news/local/government-politics/familys-ordeal-leads-to-state-paying-u-s-20-7-million-settlement-over-birth-injury/article_f2c6b33c-fe2e-50b2-bf3d-eea8110af4f8.html)

<sup>68</sup> *Ibid.*

<sup>69</sup> See generally Florida's Birth-Related Neurological Injury Compensation Act, Fla. Stat. §§ 766.301-766.316, [http://www.leg.state.fl.us/statutes/index.cfm?App\\_mode=Display\\_Statute&URL=0700-0799/0766/0766.html](http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0766/0766.html)

<sup>70</sup> The series, "reported and written by Carol Marbin Miller and Daniel Chang with photos and videos by visual journalist Emily Michot – received the University of Florida College of Journalism and Communication's 2022 Collier Prize for State Government Accountability." Carli Teproff, "Miami Herald's 'Birth & Betrayal' wins UF's Collier Prize for accountability reporting," *Miami Herald*, April 28, 2022, <https://www.miamiherald.com/news/politics-government/state-politics/article260830062.html>

<sup>71</sup> Carol Marbin Miller and Daniel Chang, "When Births Go Horribly Wrong, Florida Protects Doctors and Forces Families to Pay the Price," *Miami Herald/ProPublica*, April 8, 2021,

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<https://www.propublica.org/article/when-births-go-horribly-wrong-florida-protects-doctors-and-forces-families-to-pay-the-price>

<sup>72</sup> Ibid.

<sup>73</sup> Ibid.

<sup>74</sup> Ibid.

<sup>75</sup> Carol Marbin Miller and Daniel Chang, "'These Findings Boggle My Mind': Audit Rips Apart Florida Program Created to Aid Brain-Damaged Kids," *Miami Herald/ProPublica*, October 22, 2021, <https://www.propublica.org/article/these-findings-boggle-my-mind-audit-rips-apart-florida-program-created-to-aid-brain-damaged-kids>

<sup>76</sup> Ibid.

<sup>77</sup> Carol Marbin, "A Florida Fund for Injured Kids Raided Medicaid. Now It's Repaying \$51 Million," *Miami Herald/ProPublica*, November 15, 2021, <https://www.propublica.org/article/miami-nica-settlement-medicaid-repay>; U.S. Department of Justice, "Florida Birth-Related Neurological Injury Compensation Plan and Association to Pay \$51 Million to Resolve False Claims Act Allegations," November 14, 2022, <https://www.justice.gov/opa/pr/florida-birth-related-neurological-injury-compensation-plan-and-association-pay-51-million>

<sup>78</sup> Carli Teproff, "Miami Herald's 'Birth & Betrayal' wins UF's Collier Prize for accountability reporting," *Miami Herald*, April 28, 2022 <https://www.miamiherald.com/news/politics-government/state-politics/article260830062.html>

<sup>79</sup> Ibid.

<sup>80</sup> "Gov. Cuomo Has Put Friends In High Places," *Associated Press*, February 27, 2011, <https://www.cbsnews.com/newyork/news/gov-cuomo-has-put-friends-in-high-places/>

<sup>81</sup> "Group files Medicaid ethics complaint against Gov. Cuomo," *New York Post*, March 8, 2011, <https://nypost.com/2011/03/08/group-files-medicaid-ethics-complaint-against-gov-cuomo/>. See Letter from Joanne Doroshow, Center for Justice & Democracy, to Barry Ginsburg, Esq., Executive Director, Commission on Public Integrity, March 8, 2011, <https://centerjd.org/system/files/MRTEthicsComplaint3.pdf>

<sup>82</sup> New York State Medical Indemnity Fund, N.Y. Pub. Health Laws, Title 4, Ch. 45, Art. 29-D, <https://www.nysenate.gov/legislation/laws/PBH/A29-DT4>

<sup>83</sup> Michael W. Kessler and Matthew Fahrenkopf, "The New York State Medical Indemnity Fund: Rewarding Tortfeasors Who Cause Birth Injuries by Rationing Care to their Victims," 22 *Alb. L.J. Sci. & Tech.* 173 (2012), <https://www.albanylawscitech.org/article/19349-the-new-york-state-medical-indemnity-fund-rewarding-tortfeasors-who-cause-birth-injuries-by-rationing-care-to-their-victims>

<sup>84</sup> See New York State Medical Indemnity Fund, N.Y. Pub. Health Laws, Title 4, Ch. 45, Art. 29-D, <https://www.nysenate.gov/legislation/laws/PBH/A29-DT4>

<sup>85</sup> See, e.g., Thomas A. Moore and Matthew Gaier, "New York State Medical Indemnity Fund Experience," *New York Law Journal*, April 5, 2016, [https://kdlm.com/wp-content/uploads/2019/12/nylj\\_april2016.pdf](https://kdlm.com/wp-content/uploads/2019/12/nylj_april2016.pdf)

<sup>86</sup> These are: Alaska, Delaware, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Massachusetts, Montana, Nebraska, New Hampshire, New Mexico, the U.S. Virgin Islands, Utah, Virginia, and Wyoming. Heather Morton, "Medical Liability/Malpractice ADR and Screening Panels Statutes," National Conference of State Legislatures, <https://www.ncsl.org/financial-services/medical-liability-malpractice-adr-and-screening-panels-statutes> (updated August 10, 2021).

<sup>87</sup> Amy Widman, "Liability and the Health Care Bill: An 'Alternative' Perspective," *California Law Review Circuit*, September 21, 2010, <https://ssrn.com/abstract=1856033>

<sup>88</sup> Casey Conlin, "Malpractice in Montana: Is the Montana Medical Legal Panel working?" January 2, 2024, KTVQ, <https://www.ktvq.com/mtn-investigates/malpractice-in-montana-is-the-montana-medical-legal-panel-working>

<sup>89</sup> Ibid.

<sup>90</sup> Ibid.

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<sup>91</sup> Jessica Miller, "Utah's Secretive Medical Malpractice Panels Make It Even Harder to Sue Providers," *ProPublica/Salt Lake Tribune*, April 10, 2023, <https://www.propublica.org/article/secretive-medical-malpractice-panels-make-it-hard-to-sue-providers-utah>

<sup>92</sup> Heather Morton, "Medical Liability/Malpractice Merit Affidavits and Expert Witnesses," National Conference of State Legislatures, <https://www.ncsl.org/financial-services/medical-liability-malpractice-merit-affidavits-and-expert-witnesses> (updated August 11, 2021).

<sup>93</sup> For example, "In 1979, Missouri's Supreme Court ended its panel process after finding it caused a 'useless and arbitrary delay.' And in 2019, Kentucky's high court struck down its law after it had been in effect for just a year, finding it caused an unconstitutional delay in people's ability to access the courts." Jessica Miller, "Utah's Secretive Medical Malpractice Panels Make It Even Harder to Sue Providers," *ProPublica/Salt Lake Tribune*, April 10, 2023, <https://www.propublica.org/article/secretive-medical-malpractice-panels-make-it-hard-to-sue-providers-utah>. See also Amy Widman, "Liability and the Health Care Bill: An 'Alternative' Perspective," *California Law Review Circuit*, September 21, 2010, <https://ssrn.com/abstract=1856033>, citing Washington, Oklahoma, and Ohio cases.

<sup>94</sup> According to the National Conference of State Legislatures, "Thirty-three states and Guam have provisions regarding minimum qualifications for expert witnesses who testify in medical liability and malpractice cases." Heather Morton, "Medical Liability/Malpractice Merit Affidavits and Expert Witnesses," National Conference of State Legislatures, <https://www.ncsl.org/financial-services/medical-liability-malpractice-merit-affidavits-and-expert-witnesses> (updated August 11, 2021).

<sup>95</sup> See Amy Widman, "Liability and the Health Care Bill: An 'Alternative' Perspective," *California Law Review Circuit*, September 21, 2010, <https://ssrn.com/abstract=1856033>

<sup>96</sup> *Ibid.*

<sup>97</sup> *Putnam v. Wenatchee Valley Med. Ctr.*, 216 P.3d 375 (Wash. 2009); "Unfettered access to the courts," *Seattle Times*, September 20, 2009, <https://www.seattletimes.com/opinion/unfettered-access-to-the-courts/>

<sup>98</sup> Evidence-based medicine is "defined as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." Arnold J. Rosoff, "Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines," *26 J. Health Pol. Pol'y & Law* 327 (April 2001).

<sup>99</sup> As defined by the Institute of Medicine, clinical practice guidelines are "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." Andrew L. Hyams et al., "Practice Guidelines and Malpractice Litigation: A Two-Way Street," *Annals of Internal Medicine*, March 15, 1995.

<sup>100</sup> "[Evidence-based medicine] EBM can show up in forms other than [clinical practice guidelines] CPG – for example, in journal articles, unpublished studies, and expert testimony. Conversely, CPGs are not necessarily based upon EBM – although the vast majority of the CPGs being generated nowadays are, or at least purport to be. Cynthia Mulrow and Kathleen Lohr's essay recognizes that guidelines generated primarily through a professional consensus process – the traditional approach – may differ from those based more directly on hard, empirical evidence – the EBM approach." Arnold J. Rosoff, "Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines," *26 J. Health Pol. Pol'y & Law* 327 (April 2001).

<sup>101</sup> White House, *An American Budget: Major Savings and Reforms* (2018), <https://www.govinfo.gov/content/pkg/BUDGET-2019-MSV/pdf/BUDGET-2019-MSV.pdf>

<sup>102</sup> Amy Widman, "Liability and the Health Care Bill: An 'Alternative' Perspective," *California Law Review Circuit*, September 21, 2010, <https://ssrn.com/abstract=1856033>

<sup>103</sup> Conn. H.B. No. 6600, "An Act Concerning the Establishment of the Sustinet Plan" (2009), <https://cga.ct.gov/2009/ACT/PA/2009PA-00148-R00HB-06600-PA.htm>

<sup>104</sup> Andrew L. Hyams et al., "Practice Guidelines and Malpractice Litigation: A Two-Way Street," *Annals of Internal Medicine*, March 15, 1995.

<sup>105</sup> See Arnold J. Rosoff, "Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines," *26 J. Health Pol. Pol'y & Law* 327 (April 2001).

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<sup>106</sup> Ibid.

<sup>107</sup> Ibid. ("In 1993, former AMA President Richard F. Corlin, M.D. testified, 'At the present time, insufficient evidence exists to show that clinical practice guidelines can be developed in a manner specific enough to be introduced as an affirmative defense in medical liability litigation.' He urged instead 'that they be used only as evidence of the customarily observed professional standard of practice and that their degree of authority be dependent upon the degree of their acceptance among medical practitioners.'...It is notable that the AMA's reservation about CPGs was stated even in the context of their defensive use.")

<sup>108</sup> Linda L. LeCraw, Esq., "Use of Clinical Practice Guidelines in Medical Malpractice Litigation," *Journal of Oncology Practice* (September 2007).

<sup>109</sup> Ibid.

<sup>110</sup> Agency for Healthcare Research and Quality, "Clinical Practice Guidelines Archive," <https://www.ahrq.gov/prevention/guidelines/archive.html> (viewed February 24, 2024).

<sup>111</sup> Heather Morton, "Medical Professional Apologies Statutes," National Conference of State Legislatures, <https://www.ncsl.org/financial-services/medical-professional-apologies-statutes> (updated August 2, 2021).

<sup>112</sup> Massachusetts law uniquely makes an apology admissible in court if, during a later court proceeding, the provider makes "a contradictory or inconsistent statement as to material facts or opinions, purposes." Mass. Gen. Laws Ch. 233, § 79L, <https://malegislature.gov/Laws/GeneralLaws/PartIII/TitleI/Chapter233/Section79L>

<sup>113</sup> Ronen Avraham and Ariel Porat, "The Dark Side of Insurance," *19 Review of Law & Economics* 13 (February 2023), <https://www.degruyter.com/document/doi/10.1515/rle-2022-0054/html>

<sup>114</sup> See, e.g., American Medical Association Advocacy Resource Center, "Issue Brief: Communication and resolution programs" (2017), <https://www.ama-assn.org/system/files/2019-01/ama-issue-brief-communication-and-resolution-programs.pdf>

<sup>115</sup> Gabriel H. Teninbaum, "Be skeptical about the state's medical apology program," *Boston Globe*, May 1, 2012, <https://www.bostonglobe.com/opinion/2012/05/01/skeptical-about-state-medical-apology-program-sorry/Y8HWohymEAvW4eMTGSL87H/story.html>. See also Ronen Avraham and Ariel Porat, "The Dark Side of Insurance," *19 Review of Law & Economics* 13 (February 2023), <https://www.degruyter.com/document/doi/10.1515/rle-2022-0054/html>

<sup>116</sup> See, e.g., American Medical Association Advocacy Resource Center, "Issue Brief: Communication and resolution programs" (2017), <https://www.ama-assn.org/system/files/2019-01/ama-issue-brief-communication-and-resolution-programs.pdf>

<sup>117</sup> Amy Widman, "Liability and the Health Care Bill: An 'Alternative' Perspective," *California Law Review Circuit*, September 21, 2010, <https://ssrn.com/abstract=1856033>

<sup>118</sup> Ronen Avraham and Ariel Porat, "The Dark Side of Insurance," *19 Review of Law & Economics* 13 (February 2023), <https://www.degruyter.com/document/doi/10.1515/rle-2022-0054/html>

<sup>119</sup> Ibid.

<sup>120</sup> Gabriel Teninbaum and Steve Kraman, "Essay, Disclosure and Offer at Twenty-Five: Time to Adopt Policies to Promote Fairly Negotiated Compensation," *1 Suffolk U. L. Rev. Online* 1, February 25, 2013, <http://www.suffolklawreview.org/teninbaum-kraman> (This article was co-written by Dr. Steve Kraman, Professor, Division of Pulmonary, Critical Care, and Sleep Medicine, Department of Internal Medicine, University of Kentucky, and "the former chief of staff of the Lexington, Kentucky VA Medical Center. Together with medical center counsel, he started and managed that facility's disclosure-and-offer program.")

<sup>121</sup> Gabriel H. Teninbaum, "How Medical Apology Programs Harm Patients," *15 Chapman L. Rev.* 307 (2011), [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1912876](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1912876)

<sup>122</sup> Ibid. See also COPIC, *3R's, Physicians Participation Manual*, January 1, 2024, [https://www.callcopic.com/docs/default-source/patient-safety-and-risk-management/3rs-program/final\\_3rs\\_program\\_physparticipationmanual\\_01-2024.pdf](https://www.callcopic.com/docs/default-source/patient-safety-and-risk-management/3rs-program/final_3rs_program_physparticipationmanual_01-2024.pdf) ("EXCLUSIONS [INELIGIBLE INCIDENT TYPES]: Patient death; Attorney involvement; Request for action from state licensing board; Summons and Complaint or Notice of Claim; Written demand for compensation; Medicare patients.")

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<sup>123</sup> See also Gabriel Teninbaum and Steve Kraman, "Essay, Disclosure and Offer at Twenty-Five: Time to Adopt Policies to Promote Fairly Negotiated Compensation," 1 *Suffolk U. L. Rev. Online* 1, February 25, 2013, <http://www.suffolklawreview.org/teninbaum-kraman>

<sup>124</sup> Gabriel H. Teninbaum, "How Medical Apology Programs Harm Patients," 15 *Chapman L. Rev.* 307 (2011), [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1912876](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1912876)

<sup>125</sup> See, e.g., American Medical Association Advocacy Resource Center, "Issue Brief: Communication and resolution programs" (2017), <https://www.ama-assn.org/system/files/2019-01/ama-issue-brief-communication-and-resolution-programs.pdf.pdf>

<sup>126</sup> Gabriel H. Teninbaum, "How Medical Apology Programs Harm Patients," 15 *Chapman L. Rev.* 307 (2011), [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1912876](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1912876)

<sup>127</sup> *Ibid.*

<sup>128</sup> *Ibid.*

<sup>129</sup> Lisa Rein, "Blaming the Hospital, A Widow Turns Activist; She Says the Staff Was Unresponsive," *Washington Post*, July 21, 2009, <http://www.washingtonpost.com/wpdyn/content/article/2009/07/20/AR2009072002298.html>

<sup>130</sup> *Ibid.*

<sup>131</sup> Amy Widman, "Liability and the Health Care Bill: An 'Alternative' Perspective," *California Law Review Circuit*, September 21, 2010, <https://ssrn.com/abstract=1856033>, citing Bernard Black et al., "The Effects of 'Early Offers' in Medical Malpractice Cases: Evidence from Texas," 6 *J. Emp. Legal Stud.* 723, 727 (2009).

<sup>132</sup> N.H. Rev. Stat., Title LIII, Ch. 519-C, <https://law.justia.com/codes/new-hampshire/2012/title-liii/chapter-519-c/>

<sup>133</sup> Bill Smith, "Legislature overrides Lynch on tort reform," *New Hampshire Union Leader*, June 27, 2012; Office of New Hampshire Governor John Lynch, "Governor's Veto Message Regarding SB 406," June 20, 2012.

<sup>134</sup> See testimony by Coverys submitted to the N.H. House Judiciary Committee, April 13, 2012.

<sup>135</sup> N.H. Rev. Stat., Title LIII, Ch. 519-C, <https://law.justia.com/codes/new-hampshire/2020/title-liii/>

<sup>136</sup> "'Early offer': Try again next year," *New Hampshire Union Leader*, June 26, 2012.