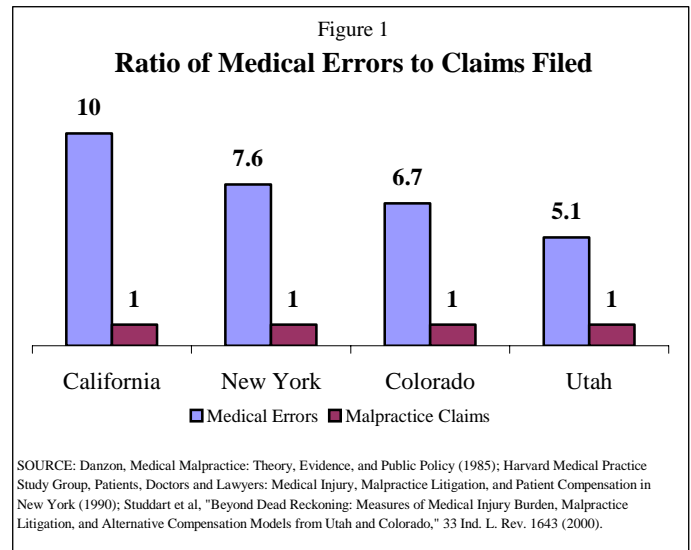


MEDICAL MALPRACTICE: AN OVERVIEW OF FEDERAL AND STATE POLICY OPTIONS

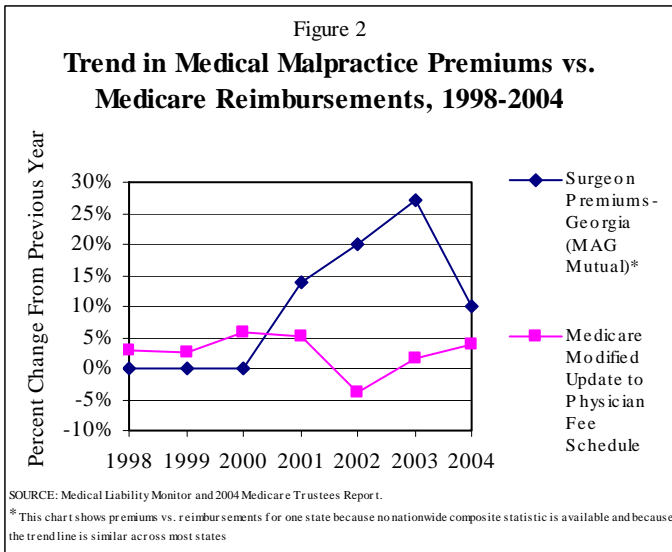
Recent spikes in the cost of medical liability insurance have once again put medical malpractice on the legislative agenda. While the past few years have seen increasing attention given to the medical errors that underlie malpractice lawsuits—an important development for older persons, who are at greater risk for such injuries¹—most of the current focus is on relieving doctors from the financial pressure of premium hikes and on criticizing the way the civil justice system compensates victims.

The most explosive allegations leveled at the tort system—that compensation is routinely paid to plaintiffs whose injuries were not caused by negligence, and that doctors systematically leave or stop practicing in jurisdictions where high-stake lawsuits are more common—have been disputed by some independent researchers.² But other concerns have been given more merit by academic experts:

- The number of medical errors far outstrips the number of claims made by, or awards paid to, injured victims, indicating that most injured patients are never compensated (see Figure 1).
- The threat of lawsuits may create perverse incentives in medical practice, with such results as ordering of unnecessary tests or hiding of information about errors that could be used to develop patient safety systems.



- Increasing practice costs, including liability insurance costs, at a time of flat or declining reimbursements make the practice of medicine less profitable (see Figure 2).
- The transaction costs of medical malpractice litigation (attorney fees, expert witness fees, etc.) are high relative to other categories of litigation (e.g., automobile accidents) and other systems of injury compensation (e.g., vaccine injuries).
- The large and unpredictable amounts of money at stake in many malpractice lawsuits can discourage insurers from writing medical liability policies.³



Types of Policy Options

Health policy is often thought to involve trade-offs among three dimensions—cost, quality, and access. Tort law is intended to impose a minimum standard of quality. But medical providers currently assert that the cost to them of complying with tort law is either passed on to patients in the form of higher prices, or is so onerous as to cause the closing of practices, in either case reducing access to care. This Issue Brief examines policy options related to health care cost, quality, and access issues raised by medical errors and injury compensation. Issues of liability insurance rate regulation are discussed separately in Figure 4.

Following is a brief overview of seven broad categories of federal- and/or state-level policy options that have been proposed or implemented in recent years:

- A. Shift some injury costs away from providers and onto claimants and their benefit payors (“*tort reforms*”)

- B. Shift some injury costs away from providers and onto the public as a whole (*subsidy programs*)
- C. *Reduce the transaction costs of litigation*
- D. Change traditional aspects of the tort system to *improve the accuracy and predictability of injury compensation*
- E. Change, or test alternatives to, the tort system to improve the accuracy of its incentive effects (and *reduce any perverse incentives that it creates*)
- F. Accept the existing tort system and seek to reduce the medical errors that underlie lawsuits through *strengthened regulation of medical providers*
- G. Accept the existing tort system and, within the private sphere, *alter providers’ response to medical errors and lawsuits.*

The seven sections following correspond to the italicized category names above. Included in the discussion of each category are descriptions of specific proposals, a short review of the empirical literature on proposals that have been studied by researchers, and discussion of the pros and cons of the approach.

It is important to note that the views held by interest groups and elected officials toward malpractice policy options are greatly influenced by their feelings toward doctors and lawyers, by political affiliations, and by strongly held opinions about the fairness and efficiency of the legal system. While some categories of policy options described below are less controversial than others, there is no consensus as to their adequacy in addressing perceived problems.

A. “Tort reforms”

This category of options, favored by provider groups, is exemplified by California’s 1975 Medical Injury Compensation Reform Act. These measures shift some or all injury costs away from the provider by making changes to the current tort system so as to limit damage awards or strengthen obstacles to filing lawsuits. Specific examples include:

- A cap on non-pecuniary losses, such as pain and suffering or disfigurement. Critics argue that these damages are subjective and result in a “lottery,” a suggestion explored in Section D of this paper. (Some states have capped pecuniary losses, such as lost wages or medical bills, as well.)
- Eliminating awards for damages covered by collateral sources, such as health or disability insurance and sick leave. While the parties paying these benefits can subrogate—seek reimbursement for the payments they made to the victim—it is argued that, in practice, these payors sometimes fail to assert their right, resulting in the plaintiff receiving a “double recovery.”
- Abolition of joint and several liability, the doctrine that allows a successful plaintiff to obtain his or her entire judgment from any joint tortfeasor (doctor, hospital, etc.). Although payors can seek contribution from other tortfeasors, providers argue that they should be held liable only in proportion to their fault.

- Obstacles to filing lawsuits, such as a shortened statute of limitations or caps on attorney fees that discourage lawyers from taking on small or difficult cases.

There is agreement that a cap on non-pecuniary damages reduces payouts to plaintiffs.⁴ Researchers estimate that any resulting reductions in premiums are smaller than the reductions in damage payouts in scale.⁵ Research findings on other tort reform elements are inconclusive.⁶

The economic theory behind the tort system holds that the parties in the best position to avoid causing an injury must bear all the costs of the injury in order to be deterred from unsafe practices. Abolishing joint liability gives hospitals less incentive to screen doctors to whom it grants admitting privileges. Shifting costs to collateral source payors might be efficient in some cases—as where a large company selects its employees’ health care providers—but to date no legislation addressing collateral sources has made this distinction. Caps on non-pecuniary damages raise equity concerns. The highest such damages tend to be awarded to the most severely injured,⁷ and the non-pecuniary element of awards is proportionally higher for female and retired plaintiffs.⁸ Finally, no one suggests that these traditional “tort reforms” have the ability to reduce medical injuries or would improve compensation of victims.

B. Subsidy programs

Some states have attempted to alleviate the immediate financial pressures facing doctors through the use of subsidy programs. These programs spread the cost of liability insurance more widely, usually

by using tax revenue or credits to offset part of premiums or damages.

- Pennsylvania is using cigarette tax revenues to pay a portion of doctors' malpractice premiums.⁹ Maryland has passed a similar law.¹⁰
- Doctors practicing in specialties considered a "high risk" for lawsuits, such as those who perform obstetrical services, are charged higher premiums than other doctors. In 1988, North Carolina enacted the Rural Obstetrical Care Incentive (ROCI) Program to provide state funds of up to \$6,500 per year to pay the additional premium amount for doctors who deliver babies in rural areas.¹¹ More recently, Oregon created a similar program.¹²
- States can sponsor risk-pooling arrangements, such as Kansas' Health Care Provider Insurance Availability Plan. This mechanism, which ensures that every doctor can obtain liability coverage, is subsidized by surcharges on medical liability policies purchased by doctors in the private insurance market.¹³
- Another proposal to deal with the higher premiums charged to practitioners in high-risk specialties is "rate compression," which would narrow the difference in premiums across practice areas by having doctors with a low risk of lawsuits cross-subsidize their higher-risk peers.¹⁴ Advocates of this approach argue that it recognizes that primary care physicians "refer up" high-risk cases to specialists.

- New Jersey assessed a \$3 per employee tax on employers and a \$50 tax on licensed professionals to create a fund that pays awards of non-pecuniary damages in excess of \$300,000.¹⁵
- Another type of program, exemplified by one implemented by the District of Columbia, indemnifies doctors who work in clinics serving low-income patients.¹⁶

Subsidy programs have not drawn much attention either from interest groups or academics, but there has been considerable legislative activity in this area of late. Rural health care experts have called the North Carolina ROCI program an "innovative" response to rising malpractice insurance rates and reduced access to obstetrical care in rural areas, but to date there has been no empirical research on the other programs' implementation.

In theory, lowering providers' costs should keep marginally profitable providers in business. At the same time, the economic theory of tort law suggests that there may be a trade-off in safety to the extent that insulating providers from the cost of the injuries they cause reduces their incentive to practice cautiously.

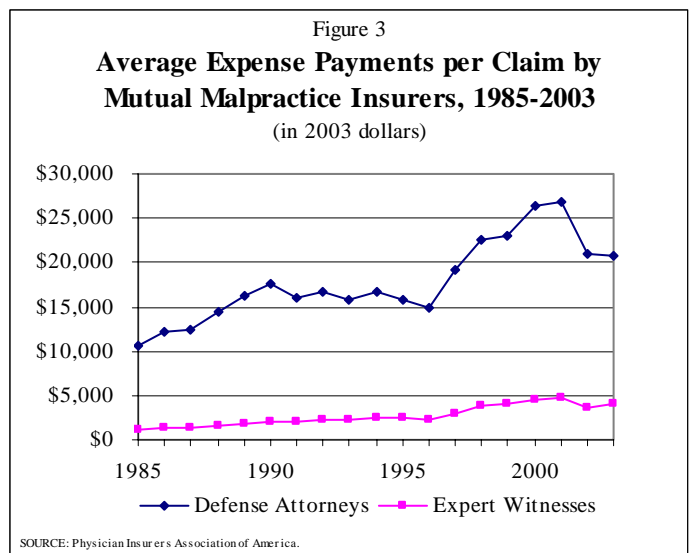
C. Reducing transaction costs of litigation

A large portion of doctors' liability insurance premiums is spent defending claims (see Figure 3), many of which are eventually dropped by plaintiffs' attorneys.¹⁷ The cost of litigating a claim that goes to trial is higher than the cost of one that is settled.¹⁸ Following are examples of measures that have been

enacted to discourage pursuit of non-meritorious claims and to encourage early settlements through alternative dispute resolution (ADR).

- Many, but not all, states require plaintiffs to obtain a certificate of merit from a medical expert before filing suit, in an effort to weed out frivolous claims.
- Some states require plaintiffs to first present their cases to screening panels, in order to give parties an early neutral evaluation of the case. Some panels are purely advisory, while others' determinations are given teeth either by requiring the party with a weaker case to post bond before proceeding to court or by telling jurors the panel's opinion.
- Michigan law allows defendants who claim they were wrongly named in a suit to file an affidavit of noninvolvement, which, if not contradicted, grants them an expedited dismissal from the case.¹⁹ This is intended to discourage plaintiffs from taking a "shotgun" approach of suing every provider present during treatment. New Jersey recently adopted a similar provision.²⁰
- Mediation can be initiated by a court, a regulatory agency, or by the parties themselves. A mediator assists the parties in trying to reach a settlement. Mediation is a voluntary process and, while a party's attendance at a session can be compelled, good faith participation cannot.
- Parties may choose to voluntarily submit a case to arbitration, where an abbreviated, less formal hearing

takes place in lieu of a trial. This must be distinguished from mandatory arbitration, whereby the provider requires prior agreement to arbitration of any disputes as a condition to giving treatment. Arbitration under those circumstances allows the provider to choose the arbitration forum, which gives the provider several advantages.



There is thus far scant evidence that these measures result in substantial savings. Researchers believe that the certificate of merit deters attorneys who do not specialize in malpractice from filing non-meritorious cases, but most malpractice cases are thought to be filed by specialists who regularly consult experts before proceeding.²¹ There is mixed evidence on screening panels, with one research team finding that the panels reduce obstetricians' and gynecologists' premiums by 20 percent²² and others finding that the panels may increase claim frequency by making expert evaluations more accessible.²³ One study seems to

Figure 4

Insurance Regulation and the Malpractice “Crisis”

Trial lawyer associations and consumer groups have argued that the recent hikes in malpractice premiums are rooted in insurance company practices and have suggested that insurance rate regulation should be strengthened. Views on the role of regulation of medical liability insurance fit roughly into three categories.

One school of thought sees major insurance market failures in which insufficient competition or predatory practices lead to excessive insurer profits. According to this view, promoted primarily by the Foundation for Consumer and Taxpayer Rights, only mandatory rate rollbacks and strict procedural standards for rate increases, such as those enacted by California’s Proposition 103 in 1988, can address the high prices of insurance products.²⁸

A second school of thought holds that, during the “soft” phase of the insurance cycle, insurers lower premiums to an unsustainable price to increase their market share, essentially subsidizing premiums with investment income. When returns on investment decline, premium prices must rise dramatically. Another factor that can contribute to sharp spikes in premiums is insurers’ overestimates of the amount of expected losses. According to this view, regulators should smooth fluctuations in prices by mandating higher premiums in the soft phase, and should prevent excessive surplus accumulation by limiting premium increases to the rate of actual growth in paid claims experienced in preceding years.²⁹

The third school of thought holds that the market for professional liability insurance functions well, because doctors are sophisticated, well-organized, and capable of establishing their own mutual insurance companies if for-profit insurers charge too much. Indeed, the majority of doctors are insured by mutual companies, which return any profits to policyholders as dividends,³⁰ and which policyholders ultimately control through their ability to elect the board of directors.³¹

The typical state statutory standard provides that insurance rates “shall not be excessive, inadequate or unfairly discriminatory.”³² The

procedural mechanism for applying that standard varies from state to state, with a few, most notably California, requiring prior approval of rate increases. Some states require prior approval only if the rate increase exceeds a certain increment (usually 25 percent) or if the market is noncompetitive.

Despite a compelling case that abuses are rife in the marketing of products directed at vulnerable consumers, such as credit insurance and small-face-value life policies, the case that professional liability insurance suffers from widespread market failures has not been assembled. It is perhaps for this reason that policy initiatives and enactments in this area have been limited in scope. Maryland legislation instructs the insurance commissioner to specifically determine whether an insurer’s surplus is excessive before permitting a rate increase.³³ New Jersey legislation now requires prior approval of rate increases that exceed 25 percent.³⁴ An initiative based on California’s Proposition 103 was placed on the ballot in Nevada but garnered only a 34.7 percent “yes” vote, the poorest performance of any of the eight ballot measures voted on in that state’s 2004 election.³⁵ Oklahoma actually loosened its insurance rate regulation in 2004, in keeping with a general national trend over the past decade.³⁶

What remains unknown is how much more money is retained by or returned to physicians under stricter regulatory scrutiny of rates.

confirm one of the theories behind such panels—that they give parties accurate guidance as to the settlement value of a claim³⁸—but others suggest that this process can add, rather than reduce, costs and delay.³⁹

While there is little evidence that arbitration or mediation reduces litigation cost or delay,⁴⁰ there are many committed activists in the legal community who continue to advocate ADR as a less adversarial means of handling disputes. Some even suggest that such programs could increase patient safety by giving more feedback to providers.⁴¹ Nonbinding ADR is also thought to improve parties' satisfaction with the legal process.⁴² In any event, because these measures do not deprive litigants of any substantive rights, they provoke much less controversy than tort reform approaches.

D. Improving accuracy and predictability of injury compensation

The legal system's handling of malpractice suits is suspect in the eyes of many because it brings few certainties. In every trial, jurors must choose to believe one of two sets of hired expert witnesses who offer diametrically opposed testimony. Jurors are given no guidelines for awarding non-pecuniary damages, which are, by nature, subjective. And the legal standard applied by juries—whether a doctor provided the standard of care customary in the medical community—has been criticized as “unreasonable”⁴³ and “unreliable.”⁴⁴ There are several proposals for addressing these dilemmas:

- Stricter requirements for expert witnesses may prevent unqualified doctors from testifying but can also

be made so restrictive as to make it harder or more expensive for plaintiffs to prove meritorious cases.

- Some states have recently clamped down on “forum shopping”—the practice of filing suits in jurisdictions that are considered more favorable to plaintiffs. In most states, venue laws require suits to be filed in the county where the doctor lives or where the alleged malpractice occurred.
- In recent years, judges have retained independent experts to testify in important product liability cases. To some extent, the screening panels described above have brought independent expertise to bear in malpractice cases. It has been suggested that judges might obtain independent experts for malpractice trials, but it is unclear who would bear the cost.
- Some observers have advocated the creation of guidelines, schedules, or ranges (e.g., graduated caps) for awards of non-pecuniary damages, based on the severity of a plaintiff's injury.
- A jury's discretion to award such damages could also be curbed by a statute, such as New York's, that gives judges authority to modify awards that “deviate materially from reasonable compensation.”⁴⁵ This empowers the judge to compare a verdict with others in similar cases and reduce “outlier” awards.
- Researchers at Harvard Medical School and The Urban Institute urge adoption of an administrative, no-fault compensation system based on occurrence of a preventable adverse event, a

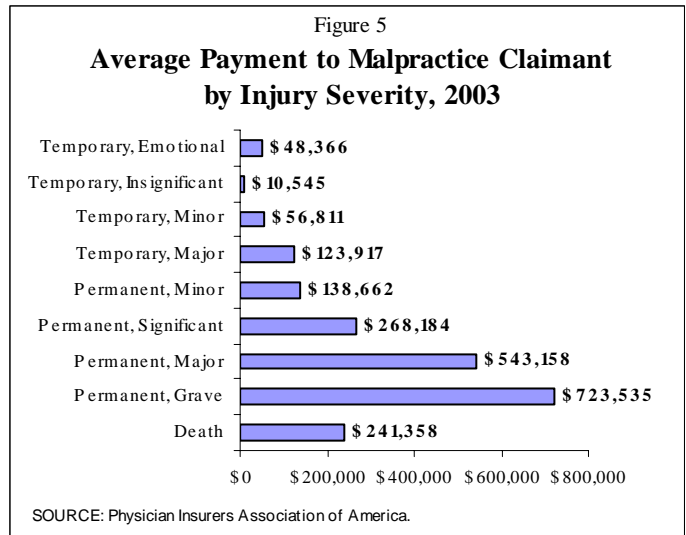
proposal endorsed by the Institute of Medicine.

- A proposal for special health courts would combine an administrative no-fault system for clear-cut medical errors with panels of expert judges to promulgate a new standard of care based on “scientific evidence on the safety and effectiveness of health care.”⁴⁶

To date, there has been no empirical research evaluating these proposals (although no-fault compensation systems limited to birth injuries that have been implemented in Florida and Virginia have been given considerable scrutiny).

Much of the criticism leveled at the civil justice system portrays it as unreliable and prone to awarding extravagant sums of money. But while the Harvard Medical Practice Study found a mismatch between medical errors and claims,⁴⁷ other empirical research has found that very few non-meritorious claims are made or result in payment,⁴⁸ and that damage awards are generally proportionate to injury severity⁴⁹ (see Figure 5). While an ideal legal system should be “reliable” in the sense that it reaches consistent results, experiments in which two or more medical experts have been asked to evaluate cases have found that even randomly assigned, unpaid experts often reach opposite conclusions when presented with identical facts.⁵⁰ As such, “unreliability” may result from human factors that are not unique to the legal system.

Moreover, while variation in awards is seen by some as arbitrary, others see a tailoring of awards to plaintiffs’ individual circumstances, a virtue that would be lost if damages were determined according to rigid schedules.



E. Reducing perverse incentives created by the tort system

Many observers believe that providers’ efforts to avoid legal liability result in inefficiencies, such as tests or procedures performed mainly to deter lawsuits, and inhibit communication about medical errors. Proposed initiatives to counter the practice of “defensive medicine” and to encourage more systematic analysis of medical errors include the following:

- Practice parameters—guidelines representing experts’ consensus as to what tests or treatments are appropriate in various situations—have been proposed as a means of discouraging unneeded care. Under this proposal, which was implemented in Maine in the 1990s, compliance with the guidelines provides doctors with a complete defense to lawsuits based on the failure to perform certain procedures.⁵¹
- The Institute of Medicine (IOM) urges that any reports of medical errors created for use in studying patient safety should be privileged

from discovery in lawsuits. Their belief is that systems, rather than people, are responsible for injuries, and efforts to study systemic problems must not be hampered by legal proceedings.⁵² At present, nearly every state keeps information generated for peer review purposes confidential, but the IOM urges adoption of federal privilege legislation as well (different versions of bills that would do so were passed by the House and Senate during the 108th Congress).

- The IOM has also urged experimentation with no-fault compensation systems for avoidable adverse events, arguing that the tort system creates a culture of “shame and blame” that discourages open discussion of medical errors.⁵³
- Academic experts also believe the deterrent effect of the tort system is inexact, given that its incentive effects are diluted by liability insurance. “Enterprise liability,” by which a hospital or large medical practice is charged with financial responsibility for professional malpractice, combined with experience rating, is proposed as a means of creating institutional incentives to increase patient safety.

Whether “defensive” medical practices are caused by the tort system (note that they exist in countries without strong legal protections as well)⁵⁴ and, if so, how much overutilization they cause,⁵⁵ are questions that remain unsettled. Apart from existing privilege laws and the experiment with practice guidelines in Maine, the implementation of which produced little

analysis,⁵⁶ none of the proposals described above has been tried.

Most experts at the forefront of patient safety are convinced that malpractice litigation has a chilling effect on efforts to analyze the causes of medical errors. On the other hand, it should be noted that collection and analysis of medical injury data is proceeding in six states⁵⁷ and by the American Society of Anesthesiologists despite the continued existence of the tort system.

All but the first proposal in this category are designed to improve patient safety and/or injury compensation.

F. Strengthening regulation of medical providers

Health care providers have historically been self-regulated and have staunchly resisted increased government intervention relating to quality or safety. Nevertheless, there are measures that government could take that do not affect injury compensation but are intended to reduce the underlying problem of medical errors:

- Doctor discipline can be strengthened by increasing the resources given to licensing boards, by lowering the standard of proof for disciplinary action from “clear and convincing evidence” to “preponderance of evidence,” and by altering the board’s composition to include more consumer representation.⁵⁸
- Licensing boards could implement continuing competency assurance programs that require doctors to periodically demonstrate their ability to deliver quality patient care.⁵⁹

- Mandatory error reporting has been recommended by the IOM, along with establishment of patient safety centers to analyze the error reports. Twenty-one states have adopted error reporting laws, though far fewer have created patient safety centers to analyze the reports.⁶⁰
- Because hospitals are deemed to meet state regulatory requirements by virtue of having private accreditation by specific organizations, so-called “command and control”-type regulations by states are the exception. But examples of these exist in California, which mandates nurse staffing levels,⁶¹ and New York, which places limits on residents’ work hours.⁶²
- Another regulatory approach increases consumers’ access to information about errors and malpractice committed by providers, under the theory that market incentives will force improvements. In New York, doctors’ malpractice awards and settlements are included in profiles on a state website.⁶³ A recently approved initiative in Florida requires that medical error data that the state currently collects be publicly disclosed at the facility level.⁶⁴
- The Medicare Payment Advisory Commission has recommended the increased use of autopsies to learn more about medical errors.⁶⁵ Options include reinstating the mandate for minimum hospital autopsy rates (which was repealed in 1970) or making a minimum rate a condition of participation in Medicare.

As yet, there is no empirical research analyzing the efficacy of any of these proposals in reducing malpractice premiums or medical errors.

In many states, regulatory measures such as these have been offered as counter-proposals to tort reform bills.

G. Private-sector initiatives altering providers’ responses to medical errors and lawsuits

Some of the more innovative medical institutions and physician insurers are experimenting with novel ways of reducing their malpractice costs. These approaches are similar in both philosophy and practice to the no-fault model envisioned by the Institute of Medicine, yet take place within the framework of the tort system. As such, legislatures may be able to encourage these private efforts without major changes to tort law.

- “Apology” programs are based on the premise that injured patients are often motivated to sue more by a desire for full disclosure and assurance of future corrective measures than by hopes of winning a “jackpot” award. In these programs, the doctor or hospital apologizes for the injury and offers a modest amount of compensation to dissuade the patient from filing suit. These programs can be facilitated by legislation prohibiting the introduction of such “benevolent gestures” as evidence against the provider in any suit the patient may choose to file at a later time.⁶⁶
- Voluntary resolution programs are intended to lower the cost of defending lawsuits and to use

claim information to develop patient safety measures. The institution or insurer creates an internal panel of experts to screen claims and immediately initiates settlement offers when the provider's conduct is deemed indefensible. Laws requiring disclosure to the patient of medical errors, such as the one recently enacted by Pennsylvania, might encourage adoption of this approach.⁶⁷

The "apology model" has been followed by the Veterans Affairs hospital in Lexington, Kentucky⁶⁸ and by COPIC, the physician insurer in Colorado.⁶⁹ The voluntary resolution model has been used by the Los Angeles County⁷⁰ and University of Michigan⁷¹ medical centers. Anecdotal accounts suggest that providers' claims costs are reduced by these programs but, as yet, there is no empirical research on costs or benefits either to providers or to patients.

Some experts believe that programs like these constitute virtual no-fault compensation systems. In addition to showing promise in lowering providers' costs, if the programs succeed in reducing providers' fear of lawsuits and feed back information that facilitates the development of patient safety measures, the goals of the no-fault proposals could be achieved without dismantling the tort system. A caveat is that no one knows whether these initiatives result in injured patients relinquishing their legal rights to their detriment.

One commentator has criticized some apology initiatives as offering "performative utterances" that don't

amount to repentance but are merely "an instrument of tort reform."⁷²

Conclusion

Tort reforms are at the top of the medical malpractice legislative agenda because they are the preferred option for doctors and part of the political program of the party currently controlling the White House and Congress. Consumer advocates have reacted by demanding measures to improve patient safety, such as increased regulation of providers and reporting of medical errors. In many states, enactments have included some of both types of these measures. But, as this report demonstrates, tort reforms and increased provider regulation are only two of at least seven categories of policy options.

Two options that have gained momentum but largely remained out of the public eye are subsidy programs and private sector programs that alter provider response. Subsidy programs have been popular with pragmatic legislators because, in political scientist Douglas Arnold's terminology, they offer concentrated interest-group benefits but highly diffused costs to the public. Hospitals and insurers have applied ingenuity to adapt to a changing tort climate by experimenting with apology programs and voluntary resolution programs. These programs may represent the wave of the future and deserve more study.

Tort reforms, and caps on damages in particular, are controversial because they shift injury costs onto victims without regard to the merits of the victim's case or the physical and emotional consequences of the medical error. But other policy options are available that either do not shift costs (such as alternative dispute

resolution) or shift them less dramatically (such as subsidy programs); that make the tort system more efficient (such as certificate-of-merit laws, no-fault compensation systems, and enterprise liability) or curb its excesses (such as ranges for awarding non-pecuniary damages and tougher venue laws); or that are purely voluntary (such as mediation or apology programs). These measures offer potential win-win outcomes, but they have few advocates outside of academia. Indeed, advocating win-win measures would require doctors, trial lawyers, consumer groups, and politicians to abandon their long-standing public positions.

A conclusion that clearly emerges from a review of the literature is that there is a need for better data. Policy analysis in this area is complicated by the lack of a comprehensive public database of malpractice claims data (although a private database is maintained by the Physician Insurers Association of America). If insurers would open nationwide claims data to researchers, it might be possible to gauge the effects of state ADR programs and certificate-of-merit laws. Legislatures and insurance regulators should consider mandating uniform public reporting of closed malpractice claims data. Finally, it should be noted that analysis of closed claims files by the American Society of Anesthesiologists has resulted in important patient safety advances. Legislatures could speed up such analysis by allowing insurers to share *open* claims files with patient safety researchers without waiving the insured's attorney/client privilege.

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⁴⁴ Philip K. Howard, "A Case for Medical Justice," *The Philadelphia Inquirer* (May 16, 2004).

⁴⁵ C. Struve and W. Sage, "Caps aren't the cure in malpractice cases; Better guidance for juries is one answer," *Philadelphia Inquirer* (March 21, 2004).

⁴⁶ Progressive Policy Institute, *Health Courts: Fair and Reliable Justice for Injured Patients* (February 2005).

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⁴⁸ Taragin et al., supra note 1. This study looked at a malpractice insurer's claims files and compared the outcome of the claim (payment or no payment) to the insurer's physician reviewers' judgment as to

whether the care given by the defendant was “defensible” or “indefensible.” The researchers concluded that unjustified payments are probably uncommon, in that payment occurred in only 21 percent of cases deemed defensible and in 91 percent of cases deemed indefensible. See also Sloan et al., “Medical Malpractice Experience of Physicians: Predictable or Haphazard?” *Journal of the American Medical Association* 262 (1989): 3291. Another study that, like the Harvard study, attempted to match malpractice claims to errors identified during hospitalizations, found that, among 13 claims filed by the 1047 patients tracked, only one claim did not involve an error that had been identified by hospital personnel during clinical meetings or in an occurrence report. L. Andrews, “Studying Medical Error *in situ*: Implications for Malpractice Law and Policy,” 54 *DePaul L. Rev.* 357 (2005).

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