The JAMES MADISON INSTITUTE
Backgrounder
www.jamesmadison.org Number 69 | November 2011
Trusted Solutions for a Better Florida

Alternative Solutions to Florida's Medical Malpractice System

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Foreword

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For many years the cost of health care in the United States has been rising faster than the rate of inflation. This trend affects families, employers, and governments at all levels — federal, state, and local. The rising cost of care — and of the insurance to pay for it — is a major drag on a struggling economy.

Indeed, a new Kaiser Family Foundation report says the annual cost of an average family's health insurance now exceeds $15,000. For employers who subsidize their workers' coverage, it's a cost that inevitably depresses wage growth. Moreover, when a firm's workload increases, the cost of healthcare coverage is an incentive to cope by extending the hours of existing workers rather than adding new hires.

Some economists argue that inflation in health care is symptomatic of the fact that it's immune to the market forces — the tug of supply and demand, competition as a moderator of pricing — that typically guide a free economy. Others diagnose the ailment differently, arguing that market forces could work in health care, as in other sectors of a free economy, but government policies have snuffed out the chance.

Whatever chance may have existed for market forces to apply to health care was probably lost with the shift to a system in which "other people" pay the bills. With rare exceptions, medical bills are sent to a third party — a traditional health insurance company, an HMO, or a government program such as Medicare or Medicaid. These entities may use their size to bargain for lower prices, but reducing the revenue derived from patients in some groups often results in cost-shifting and higher prices for others.

Given this assessment, can anything be done to rein in the rising cost of health care? Yes, quite possibly. As this study suggests, there may well be creative steps that states can take to moderate some of the costs that providers must pass along to their patients. Among those costs: malpractice insurance, together with the related costs of "defensive medicine" — the use of diagnostic tests and medical procedures that arguably are not necessary except to mount a defense against being sued for negligence.

States have repeatedly attempted various remedies to address problems related to medical malpractice and defensive medicine — particularly when confronted by crises in which malpractice insurance was said to be in danger of becoming unavailable or unaffordable. The challenge now is to act before another crisis arises.

One factor that must be considered is that Florida's courts, in general, have frowned upon proposed solutions that infringe on the right of injured patients to seek redress through the tort system. As this study suggests, however, there are alternatives that better serve the interests of aggrieved patients than a tort system utilizing civil courts that are currently burdened by a high volume of other matters, including property foreclosures.

These alternatives, including a "patient compensation system," could conceivably take less time than the courts to reach a decision and could ultimately direct a greater share of any financial settlement to the aggrieved patient and less to court costs, attorney fees, and other litigation expenses. This study suggests that these alternatives are worth exploring.

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Trusted Solutions for a Better Florida

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Alternative Solutions to Florida's Medical Malpractice System

Beth Ann Fiedler, Ph.D.

Preface

Formulating public policy to provide Florida with alternatives to costly medical malpractice litigation and the overarching problem of excessive healthcare expenditures requires taking into account the standard program-evaluation goals of efficiency, effectiveness, and equity among diverse stakeholders who may well have competing interests.

In conducting this study, the author had to consider anecdotal discussions, conflicting empirical evidence that is often limited to specific medical specialties or regional designations, and an analysis of findings from surveys that have not undergone critical reliability testing.

The study's goal is to evaluate how public restructuring from the existing Florida medical malpractice system that relies on tort law could address recurring problems — increasing costs of medical malpractice insurance, judicial nullification of damage caps, and perceived defensive medicine deployed by practitioners to protect themselves against litigation.

The challenge to policymakers stems from the growing burden of malpractice insurance costs to providers, employers, and ultimately the general public, the rising cost of health care, and the cumulative impact on public health and quality of life.

Alternatives to Florida's medical malpractice litigation model and $1 million cap on non-economic damages (pain and suffering) can have a positive impact on constituent satisfaction, costs, and distribution of services.

Because tort law, by definition, cannot be expected to address issues of effectiveness, efficiency, or equity, alternative solutions must offer low- or no-cost alternatives under Florida's constrained budget while producing options that improve access to legal counsel and health care.

At present, attorneys agree to accept relatively few legitimate malpractice cases that involve comparatively low damages, and access to medical care can be reduced as practitioners become more discerning regarding the addition of patients who may present higher risks.

Ultimately, any proposed solutions must be scrutinized against competing factors [e.g., U.S. Constitution vs. Florida's State Constitution, traditional and innovative tort laws, public policy tool options] while simultaneously protecting patients and professional practitioners.

Statutory rulings and state constitutional amendments provide some guidelines for options in Florida. Failing to explore alternatives to the current situation involving medical malpractice in Florida represents a

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public health problem because the practice of defensive medicine consumes limited resources that could be better deployed for preventive and critical care.

Inaction may result in reduced services, which could in turn lead to further complications stemming from lack of care — complications such as increased mortality and morbidity for expanding at-risk populations. **— BETH ANN FIEDLER**

Introduction

Tort liability and law in the context of medical malpractice is generally acknowledged as a government tool that establishes the individual right of a person to seek compensation in the event of negligence leading to morbidity or mortality due to a violation of a standard of care (Schuck, 2001).

High healthcare costs and medical malpractice conditions experienced in Florida (Appendix Table 1) drove reforms that amended the Florida Constitution in 2004 (e.g., Article X, Section 25: Patients' right to know about adverse medical incidents and Section 26: Prohibition of medical license after repeated medical malpractice).

"High healthcare costs and medical malpractice conditions experienced in Florida drove reforms that amended the Florida Constitution in 2004…"

These amendments were intended to improve on critical problems related to malpractice insurance. These problems were not limited to Florida but were widespread at the turn of the century. The cumulative impact of the volatility in the malpractice insurance market led to difficulty in making reliable financial projections. This and the political climate at the time caused an outcry for immediate attention.

The resulting additions to the Florida Statutes in recent years have led to requirements for pre-suit screening notices (766.106); availability of medical records for pre-suit investigation of medical negligence claims and defenses; penalty (766.204); pre-suit discovery of medical negligence claims and defenses (766.205); voluntary binding arbitration of medical negligence claims (766.207); arbitration to allocate responsibility among multiple defendants (766.208); standard of care statutes (766.102); collateral sources of indemnity (768.76); comparative fault (766.112); punitive damages, limitation (768.73); and liability of healthcare facilities (766.110).

All of these steps were intended to reduce the cost to caregivers and healthcare facilities without compromising the intent of tort law: protection of individuals from injury or, if injury occurs, to ensure full restitution.

The benefit to healthcare providers has been evident in the downward trend of malpractice rates for Florida surgeons and physicians, who have seen an average decline of approximately 8 percent (Florida Office of Insurance Regulation, 2011).

However, there is no mechanism in place to mandate a reduction in the patients' healthcare costs when the providers realize savings, as advocates of capping various kinds of damages had suggested would likely occur.

The standard of care statute (766.102), which has the potential to restore the intent of tort law regarding medical malpractice, lacks teeth in regard to specific diagnostic or treatment criterion for ailments presented to a physician or caregiver.

Florida has experienced numerous attempts to deal with issues related to patient safety and appropriate compensation for medical errors through statutes and/or amendments to the state constitution. Some have been thwarted by medical and legal consortiums with greater capacity to impact the legal environment (Coombs, 2009).

"Medical malpractice reforms to date have not attempted to revamp the underly-

ing structure of the claims process but instead have focused more narrowly on ways to limit liability and the level of awards. A typical legislative reform has been the imposition of limits on the level of noneconomic damages." (Hersch, O'Connell and Viscusi, 2007 p. S232).

In this scenario, capping damages has a moderating effect on healthcare costs and insurance rates. It may also shorten the time required to settle lawsuits and make the pattern of patient compensation more predictable. Necochea (2006, p. 1) eloquently summarizes problematic conditions of the medical malpractice court system:

> *"The shortcomings of the medical tort system are widely acknowledged. First, only a handful of those who sustain medical injuries receive compensation. Second, malpractice cases often take years to resolve and when damages are awarded, compensation amounts are inconsistent. The inefficiency of the tort system is also costly to society—only about 40 cents of every dollar spent on malpractice insurance goes to compensate injured patients (the rest goes to legal fees, court costs, insurance company administration and other costs). Finally, the tort system does not seem to effectively promote patient safety and may actually discourage accurate medical error reporting among health care providers."*

Given Florida's current situation, in which damage caps may be susceptible to judicial nullification, alternatives are being sought that elicit the same stabilizing and reported reduction impact on rates as the reduction experienced in states with caps (AMA, 2011; Kane & Emmons, 2007; Mello, 2006; Kessler & McClellan, 1997).

If Florida's caps are nullified, policy makers must consider other tools beyond uncertain or unproven tort reform alternatives. These policy tools must take into account the heavy caseload currently burdening Florida's civil courts as a result of mortgage loan foreclosures. Among the possible alternatives that would provide a way to bypass the courts is an administrative system similar in some respects to the one used for workers compensation.

A key concern, of course, is whether alternative solutions provide any relative advantage over Florida's current medical malpractice system, which has most recently relied on capping non-economic damages as a policy mechanism.

A complete analysis of the relative advantages and disadvantages of proposed alternatives to the status quo ought to include exploring the implementation of policy tools such as contracting for additional research to learn more about this complex problem; modifying existing administrative systems such as the one currently used for worker's compensation; and gathering more data to provide better metrics to help policy makers can make informed decisions.

The following sections provide specific information on stakeholders, a summary of changes to the tort system, an assessment of judicial nullification on damage caps, the impact of defensive medicine, an overview of the theoretical premise, public policy tool recommendations and evaluation, examples of directed research topics and perspective on important considerations that have been absent from the debate, and concluding remarks.

Stakeholders

Relevant stakeholders include patients/constituent taxpayers, patient advocates, caregivers, providers, litigators, consumer safety groups, insurance companies, product manufacturers, and a consortium of agencies that represent divested interests.

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> *"Innovative reform proposals have suggested federal intervention, implementation of compensation funds for patients, health courts, expansion of insurance risk pools, and defined standards of care."*

Summary of Changes, Options

Medical literature and public reporting provide an abundant summary of changes to state tort law that has impacted medical malpractice litigation across as many as 38 states. Principal changes include traditional reforms that establish conditions for evaluation of patient care quality, introduction of expert witnesses, pre-trial determination of merit, recommendations for alternate dispute resolution, attorney fee caps, damage caps, distribution of indemnity payments across multiple defendants, reduction of claim when plaintiff's injuries were covered by first party insurance, length of time that plaintiffs must wait in order to access court services, and others.

Innovative reform proposals have suggested federal intervention, implementation of compensation funds for patients, health courts, expansion of insurance risk pools, and defined standards of care (AMA, 2011; Behrens, 2011; Kessler, 2011; Mello & Kachalia, 2010; Underwood, 2009; Necochea, 2006; Budetti & Waters, 2005).

Mello and Kachalia (2010) provide a comprehensive assessment of definitions, alternatives with pros/cons, and a summary of the level of empirical evidence supporting traditional and innovative reforms in their report to the Medicare Payment Advisory Commission. This journal article has an additional component in that the authors use multiple outcomes to substantiate their position when information is available. The six key outcomes variables are 1) Claims Frequency and Costs, 2) Overhead Costs, 3) Liability Costs, 4) Defensive Medicine, 5) Supply, and 6) Quality of Care.

In the interest of fairness as opposed to eliciting a general debate, we should note that several consumer groups and literature have rejected the claims that malpractice insurance premiums are the cause of high health costs or that tort reforms have benefitted the consumer (Steiner, Avants, Garvey, Staren, & Van Leer, 2011; American Association for Justice on Medical Negligence, 2009; Coombs, 2009; Public Citizen, 2004). In particular, Coombs (2009) provides a detailed discussion on the impact of the medical malpractice amendments in Florida.

Damage Assessment on Damage Caps

Though the Congressional Budget Office (2006) and Viscusi and Born (2005), have shown that caps on noneconomic damages substantially reduce medical malpractice insurance losses, but the reports often fail to consider the possible impact of other policy measures such as the 1983 implementation of the Prospective Payment System (AMA, 2011) or more current Patient Protections and Affordable Care (Harper, 2011).

Misinterpretation of legal precedent in the U.S. Constitution or state constitutions (von Spakovsky & Park, 2011) has led to judicial nullification of damage caps in Georgia and other states based on their alleged unconstitutionality.

As the Florida Supreme Court deliberates the legality of $1 million limits on litigation awards for pain and suffering, von Spakovsky and Park (2011) bring to light flaws in key legal reasoning in Georgia that have redefined the meaning of the U.S. Supreme Court decision in *Feltner v. Columbia Pictures Television*.

The Georgia Supreme Court argued that the right to trial by jury is established in the Georgia Constitution (Article I, § I, paragraph. XI) and that pecuniary caps violated the right for jurors to determine damages in the absence of trial by jury under *Feltner*. However, "What the U.S. Supreme Court actually said in *Feltner* is

that the right to a jury trial includes the right to have a jury 'determine the amount of statutory damages, if any, awarded to the [plaintiff]' (*Feltner* as cited in von Spakovsky & Park, 2011, p. 4)."

Consequently, von Spakovsky and Park claim that the omission of the word "statutory" in the Georgia Supreme Court's decision also failed to recognize the legitimacy of statutory ranges set forth by Congress through legislation as determined by the U.S. Supreme Court in *Feltner*. In prior deliberations, the power of the Georgia General Assembly to "modify or abrogate the common law" and power to "define, limit, and modify available legal remedies" (von Spakovsky & Park, 2011, p. 5) had been recognized by the Georgia Supreme Court.

Illinois presented a similar argument in their decisions to remove cap on economic damages citing 'separation of power' (Steiner, Avants, Garvey, Staren, & Van Leer, 2011). However, the application of this defense in Florida was rejected in the Estate of McCall v. United States, 663 F. Supp. 2d 1276, 1296 (2009). "The court found that limiting the amount of non-economic damages available in malpractice actions does not equate to directing the outcome of the case. The statute still permits courts to grant remittitur if appropriate." (*Estate of McCall*, 663 F. Supp. 2d 1276 as cited in Steiner, et al., P. 1-10.) For clarity, a remittitur is the traditional power of the courts to reduce damage awards (von Spakovsky & Park, 2011).

Unless Congressionally legislated caps achieve legitimacy, fallout from the Florida Supreme Court and previous state decisions to remove economic caps threatens to exacerbate an inequitable distribution of both medical and legal services, thereby thwarting the goal of patient access and remuneration in exchange for the less-than-optimal standards of care or services under the tort system.

Further, a decision by the Florida Supreme Court to remove the cap on non-economic awards may bring into question the legal validity of administrative systems that base awards and benefits on a predetermined matrix driven by statutes—Workers Compensation, Social Security, the very systems that might provide the existing infrastructure to replace rescinded systems.

In these instances, victims do not have an option for trial by jury guaranteed by the Florida Constitution in the Declaration of Rights, which includes trial by jury under Article I, Section 22. Under Workers Comp, Floridians cannot receive any benefit from non-economic damages, a situation closely resembling the direction of Florida medical malpractice litigation.

The Impact of Defensive Medicine

"Most empirical evidence examines only the effect of medical malpractice in encouraging defensive medicine" (Hersch et al., 2007, p.S233). "Defensive medicine" is defined as an effort to preempt litigation by ordering laboratory tests, exploratory procedures, costly high tech equipment, and other items as a protective measure against medical malpractice suits. This practice incapacitates the systemic response to a community's healthcare needs by inflating the cost of care in order to cover the inflated cost of malpractice insurance.

The chain reaction is unsustainable. Mello, Chandra, Gawande, and Studdert (2010, p. 2) considers the level of empirical evidence and estimates the annual economic impact of costs incurred by the medical liability system at $56.6 billion, with a sizeable proportion of these expenses

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attributed to defensive medicine ($45.59 billion). Others report that the costs of defensive medicine range between $70 billion and $126 billion (Department of Health and Human Services, 2003); $60 billion and $100 billion (Common Good Organization, 2010), and as much as $500 billion to $650 billion (Begley, 2010) annual spending.

Additional studies confirm the potential monetary impact of defensive medicine. Baicker and Chandra (2005, p.30) determined that the use of digital imaging as a defensive measure annually contributes $7.5 billion in unnecessary costs.

"Additional studies confirm the potential monetary impact of defensive medicine."

The Studdert, Mello, and Sage study in Pennsylvania (2005, p. 2609) included 824 physicians practicing in high risk medical specialties (e.g., emergency medicine, general surgery, neurosurgery, obstetrics/gynecology, orthopedic surgery, and radiology). That study indicated that 93 percent of the respondents had participated in the practice of defensive medicine. Some 43 percent of them (435 of 824) reported ordering digital imaging in cases when it was clinically unnecessary.

In an effort to generalize the Studdert et al. study, Keels (2009) applied the same instrument to physicians in Northeast Florida with disappointing results due to a small sample size of 65. Two of the independent variables (medical malpractice burden and confidence in malpractice insurance coverage) were statistically significant but contributed to less than 3 percent of the explanatory variance. This level of contribution is often attributed to "noise" in the data. Though Keels' study did not generate the same level of statistical evidence, the concept to perform local or regional analysis with a consistent instrument has merit.

"Taken as a whole, the Medicare-based research suggests that defensive medicine affects Medicare spending, and that this effect may be concentrated in some disease populations or procedures" (AMA, 2011, p. 8). Baicker and Chandra (2005, p.27) illustrate the regional effect of changes in malpractice insurance premiums in 10 leading states, including Florida.

Other reports indicate that "physician practice patterns and healthcare spending can vary greatly across geographic regions" (GAO, 2003), and the GAO also cited differences attributable to rural vs. urban location, changes in reimbursement, high Medicare/Medicaid caseloads, and the formation of group practices, all of which may have inflated estimates of physician movement in relation to medical malpractice rates.

Granted, defensive medicine is only one among several practices that inflate healthcare costs. Fortunately, it is perceived as a practice where significant reductions are likely to occur, especially in comparison to other categories such as fraud, bureaucracy, lack of consumer responsibility, and fee-for-service excesses. (Harper, 2010).

Evidence to support the regional disparity is shown in a comparative sample of 10 Florida counties: Broward, Miami-Dade, Palm Beach, Hillsborough, Pinellas, Orange, Polk, Duval, Pasco, and Volusia. The average number of medical professional liability claims in those counties was 10,000, but there was a wide range. Orange County (Metropolitan Orlando) had 25,000, followed by Miami-Dade County with 15,000 (Wallings, 2010, p. 4). Injury severity is also more pronounced in Orange County even, against all other 66 remaining counties.

Researchers at the American Medical Association (2011, p.11) illustrated the regional disparity by sampling locations in eight states — California, Connecticut, Florida, Il-

linois, New Jersey, New York, Pennsylvania, and Texas — in three high-risk for litigation medical specialties — obstetrics/gynecology, internal medicine, and general surgery.

Utilizing data from multiple sources, AMA researchers found that rates generally rose during the period from 2000-2004 and that there were notable rate disparities between and within professions, even in those cities with similar socioeconomic conditions.

For example, medical professional liability insurance rates for obstetricians in Florida's Miami-Dade County were $277,241 in 2004 while the rates for obstetricians in Los Angeles, California, were $63,272. The cost of liability insurance for practitioners specializing in internal medicine in Miami were $69,310 vs. $14,237 in Los Angeles. For general surgeons, the respective rates in Miami ($277,241) and Los Angeles ($54,505) in 2004 were comparable to the rates for obstetrics/gynecology.

It should be noted that high risk for litigation in medical specialties such as obstetrics and gynecology often reflects the conflicting documentation for the use of common procedures such as the non-clinically required use of an episiotomy or Cesarean section. The main concern is that practitioners opt to ameliorate potential damages because, based on the condition of certain mothers, a birth canal delivery often represents a higher risk than a Cesarean.

However, medical literature also suggests that the decision process is not consistent in relation to what is now a common surgical procedure and that these alternatives contain some inherent risks of their own, especially infection. (Frakes, 2010; Wu, 2010; Merrill & Steiner, 2006); Steiner, Elixhauser, & Schnaier, 2002).

Cost reduction isn't the only reason more research is needed into the impact of defensive medicine, although cost reduction is one of the desired long-term objectives. The most significant outcome of research in this field would be to improve the ability to document "correct" standards of care and to provide specific diagnosis and treatment guidance in relation to the International Classification of Diseases, which categorizes illness and injury.

Determining the right thing to do will eliminate the overutilization of resources in favor of more highly defined standards of practice. Though defensive medicine has been hailed as the starting point of reform in an endless list of untested solutions (Hermer & Brody, 2010) and refuted by Studdert, Mello, & Brennan (2010), it may have the most potential to influence caregiver changes that lead to evidence-based practice.

Still, Mello and Brennan (2009 as cited in Studdert et al., 2010, p. 381) indicate that "More promising in achieving the objectives Hermer and Brody outline are more innovative reforms that alter providers' and liability insurers' responses to medical injury and provide legal protection for adhering to evidence-based practice." In an atmosphere where logic is often circular, defensive medicine may be a practical place to begin.

Theoretical Premise

The issue at hand involves several practical considerations, including the ability of alternative methods to address the root causes of medical malpractice, the overarching cost of health care in relation to defensive medicine responses by physicians, and whether innovations can elicit appropriate level of services to the patient population.

A substantial argument can be made for

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the application of two appropriate theories —Transaction Cost Economics and Strategic Management-Competitive Advantage (Table 1). These theories recognize the relevance of an open-systems approach for multiple practical reasons, with the greatest potential to elicit informed outcomes with ethical mechanisms to balance their emphasis on cost reduction and efficiency. The goal is 1) to ensure maximum participation through secure cross-functional engagement, 2) to locate the best human and capital resources at the lowest cost, and 3) to achieve value through business and public service development.

Research Questions (RQs) stemming from the theoretical premises are summarized as follows:

RQ_1: Do medical malpractice reforms adopted as alternatives to the tort system improve quality of service to the stakeholders (effectiveness)?

RQ_{2a}: What is the administrative cost impact of restructuring medical malpractice from the tort system to alternative policy tools (efficiency)?

RQ_{2b}: What is the administrative cost impact of restructuring medical malpractice from tort system to increased current infrastructure utilization (efficiency)?

RQ_3: Do medical malpractice reforms adopted as alternatives to the tort system establish equitable distribution of services (equity)?

The researcher concedes that an accurate efficiency measure is beyond the scope of this paper due to the lack of hard evidence on traditional and untraditional tort alternatives except as otherwise indicated in comparatives by Mello and Kachalia (2010). Consequently, more emphasis will be placed on the potential for effectiveness and equity in alternative solutions that demonstrate consistency in “liability decisions,” “compensation,” and “patient safety data” that elevate “standard of care as a measure of law” (Harper, 2010) whose legal perspective is subjectively implied to demonstrate all three health measurements approved by the Institute of Medicine (2001) to establish health quality: effectiveness, efficiency, and equity.

Public policy tool recommendations, evaluation, discussion

Public policy tool selection is supported by multiple theoretical premises

Table 1: Broad View of Selected Theoretical Frameworks

Theory	Definition	Benefits	Concerns
Transaction Cost Economics (Coase, 1932; Williamson, 1981)	Relational contracting that mitigates risks and costs of outsourcing	Can compare alternative delivery systems, potential to stabilize economy	Monetary focus, potential for social neglect, requires long term agreements so low flexibility. Negatives can be offset by formal review of potential for consumer contracts.
Strategic Management-Competitive Advantage (Porter, 2004)	Utilizes macroeconomic business drivers: Bargaining power supplier/ customer; new entrants; substitute products-power relationships.	Analysis leads to cost and differentiation advantage	Monetary markets, not social interests. Negatives can be offset with ‘corrective justice’ premise of tort law or ethical argument under Social Justice (Rawls, 1971).

that engage private enterprise and civic concern in the delivery of public goods and services. Several specific public tools were selected as key mechanisms that provide solutions to improve quality, efficiency, and equity deficits generated from the present medical malpractice litigation system in Florida. Appropriate tools include Contract, Grants, Public Information, Administrative Systems, and Tort Reform (Table 2).

Because a major consideration in policy development is political feasibility, the proposed options have a conditional opportunity to succeed if practitioners and other stakeholders can be influenced by the mutually beneficial features: the high levels of effectiveness, efficiency, and equity inherent in pre-determined contractual terms.

The ability to utilize existing structures to promote standards of care through empirical research may push the rate of acceptance for such tools. Protection of equitability is premised on the perspective that the system ought to maximize the welfare of the least advantaged. In this case, changes to the system must ensure the corrective justice of restitution for claimant harm.

A cost analysis was not performed on the alternatives for two reasons: 1) because of the limits on existing empirical evidence, and 2) because the main objective emphasizes claimant protection under the tort system, protection that is not necessarily limited to monetary issues.

Because tort implementation is currently directed through attorneys acting on behalf of litigants, directed research with flawed methodologies and inaccurate conclusions may sometimes play a significant role as empirical evidence that the courts use to establish a legal precedent.

This is a costly problem in tort law. To counter it, the state could allocate funds

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Table 2: Summary of Public Policy Tool Selection and Evaluation

Tool	Coercive	Directness	Automaticity	Visibility	Measure
Purchase of Service Contract[1] (Pre-determined risk allocations, S p.486)	⬇	⬇	⬆	⬆	Low manageability, medium legitimacy with high effectiveness, efficiency and equity in direct cases.
Grants[2]	⬇	⬇	⬆	⬆	Medium manageability, high legitimacy with low effectiveness, efficiency and equity moderated by targeted research population.
Public Information	—	⬆			Political feasibility, manageable, no cost.
Tort Reform[3]	⬇	⬇	⬆	⬇	Low manageability, high legitimacy with arguable political feasibility if reform change moves towards patient safety, evidenced-based practice, and system errors. Low efficiency, effectiveness and equity.
Administrative Systems (Direct Government)	⬆	⬆	⬇	⬆	High manageability, low legitimacy, low efficiency, high equity and effectiveness.

Key: ⬇ = low; ⬆ = high; - = moderate, can vary dependent on particular situation.
Sources: [1]Kelman (2002); [2]Beam & Conlan (2002); [3]Schuck (2002).

"Generating interest in medical malpractice reform requires a venue for open didactics for the laymen."

and/or offer access to data to independent researchers. Development and consistent use of a highly reliable questionnaire tested for accuracy can initiate the process and may lead to further results from meta analysis.

Giving public notice to all institutions in the state would offer an incentive to researchers in public health and/or related programs who agree to develop and complete a thesis or dissertation in required areas. In addition, the state could offer Continue Educating Units (CEUs) to physicians as an incentive to participate in the various studies so that the population is measured accurately. CEUs are used to maintain physician credentials. Additional requirements may include the use of Dillman's Tailored Design Method (Dillman, Smyth, & Christian, 2009) that has been known to increase survey response rates.

Though risk allocation has been a prevalent factor in insurers' contracts with physicians and other healthcare providers, the same consideration has not occurred for the relationship between physicians and patients. With the advent of patient advocacy and growing awareness of personal health status, the time for predetermination of risk allocation in the event of injury may help reduce uncertainty in the physician/patient relationship.

Generating interest in medical malpractice reform requires a venue for open didactics for the laymen. A concerted effort by the state to encourage university students to perform research applicable toward their degrees would also give them an opportunity that many say they seek: to become active participants in change.

Contractual agreements between practitioners and patients may garner the necessary changes in the medical malpractice system that elevate patient safety to its appropriate priority level. At minimum, a review of existing contract law and the potential application to medical liability through existing statutes in Florida may provide the necessary kick to move from *ad hoc* solutions to those that acknowledge the greater legal and political environment.

Though contractual agreements may have difficulties in political feasibility, balancing patient rights against the sizeable lobbyist movement from professional organizations may be necessary in order to amicably settle the long-standing debate.

Given the low probability that physician/patient contractual agreements will ensue in a timely fashion and the high probability that directed research grants in Florida will elicit more data from which to draw conclusions, planning to evolve the medical malpractice liability system in Florida may need to rely instead on proposals that modify existing state compensation systems to take advantage of directed research results.

The Georgia proposal seeks to develop changes that ultimately lead to patient-centric, evidenced-based practices that build standards of care. The draft proposition is consistent with sufficient legal influence needed to promote equity in compensation (perhaps through the promotion of collateral estoppel and predetermined compensation schedules), which has the potential to eliminate costly "case by case" conditions typically found under tort law.

The proposition also could lead to a reduction of administrative fees, utilization of existing injury metrics to compensate for injuries on a consistent basis, and centralized patient safety data. The relatively low number of medical liability claims can be easily absorbed into the existing system (Table 3). Though both "medical professional liability and workers compensation

insurance offer fewer claims" in comparison to homeowners or automobile claims, they also have "higher average severity, longer settlement lags, higher legal defense costs and larger insured's" (Walling, 2010, p. 2).

Critics say that an administrative system such as the Patient Compensation Option may present unsatisfactory limits on claimants inasmuch as many state workers compensation systems do not award non-economic damages. In addition, if conditions of the Patient Compensation Option are contingent on employment, this approach may not offer a universal standard unless criteria is established for those who are unemployed, privately insured, and/or under government programs such as Medicaid/Medicare and therefore under directives to use U.S. Department of Health and Human Services "early offer" programs for remuneration in the event of injury or death. However, these issues can be remedied through modifications to the current processes.

Directed Research Suggestions on Items Missing from Current Debates

Alternative solutions must embrace issues that have yet to be debated such as the impact of collateral estoppel or issue preclusion; the merits of early offer reform; the role of insurance reserves; the impact of first party insurance as a collateral resource; the efficacy of a Florida Health Court; and the universal application of federal procedures/law against state statutes. These issues and others such as the impact of physician distribution or the concentration of attorneys, which are not discussed here, may provide the basis for future research.

Collateral estoppel or issue preclusion: Unless the plaintiff conditions are the same, outcomes of tort law cases cannot be used to establish case precedent since judgment is based on the particular circumstances of an individual claimant. Hence, defendants may be subject to repeated claims under similar circumstances under 'collateral estoppel' or 'issue preclusion.'

The complex nature of these doctrines has been a considerable deterrent in balancing the individual right to receive compensation for injury against the cost burden of defense. Therefore, this important aspect of tort law has not been scrutinized for reform but may represent a future opportunity to establish that a particular procedure or implementation of procedure induced harm at which point, only the particular type of injury would have to undergo scrutiny for compensation.

The merits of early offer reform: Early offer reform has been indicated to reduce plaintiff litigation costs by $100,000-200,000 and waiting time for indemnity payment by two years according to Hersch *et al* study (2007) using data from Texas (1988-2002) and Florida (1974-2002). However, this method is problematic because of conditions that require claimants to release claims on

"The complex nature of these doctrines has been a considerable deterrent in balancing the individual right to receive compensation for injury against the cost burden of defense."

Table 3: Aggregated Claim Counts Comparative Coverage, Aggregated Data 2004-2008

Type of Coverage	Average Annual Claims
Workers Compensation	5,004,000
Medical Malpractice	148,000

Source: Walling, 2010.

non-economic damages, infers benefits to insurance companies, and cannot guarantee full compensation for the claimant since no limits on attorney fees have been included in the proposition.

Furthermore, if this method is considered and rejected, an additional condition is added to the burden of the claimant: They must prove that "provider's conduct was grossly negligent" where tort law currently requires only "a preponderance of evidence," defined as "more likely than not." This is in contrast to criminal law's "beyond a reasonable doubt" (Salamon, 2002, p.470). It should be noted that Florida's certificate of merit program has direct application to defendant(s). Specifically, in the event that the defendant rejects a claim, the defendant must submit a medical expert's written opinion to support their assertion of a lack of realistic grounds for a medical malpractice suit.

The role of insurance "reserves": Individual injury or death claims in states such as Florida that experience seasonal weather (e.g., flooding, tornado, hurricanes) may limit claimant awards when reserve assets are prioritized for disaster response. However, there appears to be few or limited guiding principles for providers for discretionary consideration of payments.

The impact of first party insurance as collateral resource: A key question is this: Who should pay for the medical care of a claimant whom a court has ruled was injured as a result of medical error? If the aforesaid claimant has health insurance, should it pay or should the malpractice insurer pay? Will anything change if the U.S. Supreme Court rules that the Patient Protection and Affordable Care Act ("Obamacare") is constitutional, including the act's individual mandate requiring everyone to purchase health insurance?

"A key question is this: Who should pay for the medical care of a claimant whom a court has ruled was injured as a result of medical error?"

Historically, indemnity payments to plaintiffs have been reduced by the amount covered by the claimant's own insurance. Even though the individual mandate requiring health coverage has been a contentious issue, there is reason to believe that this aspect of health reform, if upheld, might reduce patient claims *if* awards subtracted reasonable amounts from expected coverage.

Even so, the more compelling question is whether a claimant's health insurance coverage should even be used to pay for damages incurred because of the actions of the defendant. Moreover, in these scenarios, there is also a risk that additional litigation may be generated by lawsuits from first party insurance claims against liable defendants. This could have the end result of shifting costs instead of eliminating them.

Health courts: Although health courts are a viable option, and successful examples of such programs exist — including The Florida Neurological Injury Compensation Association (1988) — the efficacy of other existing specialized courts in Florida has been subject to scrutiny. Moreover, the judicial system, like all of state government, has seen its funding reduced during the recession. Unfortunately, this has coincided with a large increase in civil courts' caseloads because of the numerous lawsuits related to mortgage foreclosures. Therefore, establishing a system of dedicated health courts at this time is unlikely to be deemed economically feasible. As economic conditions improve and more data can be collected concerning the functioning of health courts in other jurisdictions, perhaps the issue can be revisited.

Universal application of federal procedures/law: The Florida Statute 768.76 Collateral sources of indemnity. The pertinent section of this clause in this context is that

"there shall be no reduction for collateral sources for which a subrogation or reimbursement right exists." In other words, can The Contract Disputes Act, Public Law 95-963, 41 USC Section 601, be used in favor of claimant's protection against being placed in the position of liability simply because he has insurance?

This also brings into question the validity of the application of other federal directives such as Public Law 191, §261 and §1177, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to promote health information systems while protecting individuals against wrongful disclosure of personal information. Hence, a federal solution for civil liability reform (Behrens, 2011) may benefit from existing U.S. Constitutional guidance, which has helped the Department of Health and Human Services to create a successful early offer pilot program for Medicare/Medicaid recipients. The problem may become more apparent as the impact of Health Reform affects employee contribution costs.

Table 4 provides the current percentage of employee/employer contribution for the average family in Florida compared to national averages. Already there is a +4% difference in the amount of employer contribution compared to the national average.

Conclusion

This study provides the basis for policy makers to begin taking steps to create an alternative to Florida's overburdened courts as a means of resolving issues related to medical malpractice.

The current system causes problems for injured patients and their healthcare providers alike. Patients who do go to court may face long delays before their case is heard and their claim is paid. Meanwhile, practitioners must deal with the high cost of malpractice insurance — especially within some medical specialties and in some litigious regions. To protect themselves, they also engage in the practice of "defensive medicine." These factors combine to increase the costs that practitioners must pass along to their patients.

Unfortunately, any factors further inflating healthcare costs — even marginally — could hardly come at a worse time. The pending phase-in of various provisions of the Patient Protection and Affordable Care Act will further accelerate healthcare inflation -- unless the U.S. Supreme Court blocks the law. Therefore, any steps states can take to rein in costs while protecting the interests of patients and practitioners should be explored.

One promising alternative is an administrative system akin to, but necessarily not identical to, the administrative system used for workers compensation. Some advocates refer to it as a "Patients' Compensation System," a phrase that conveniently conveys its nature as an administrative system. However, the nomenclature is less important than the details that policy makers work out going forward. Among them: How to finance such a system, how to discipline errant providers, and how to structure a system that can pass muster with the courts and various stakeholders.

To summarize, this study's key recommendations are for the state (1) to take the steps to create an effective and equitable solution to medical malpractice reform through an administratively based "patients compensation system," and (2), to build standards of care to guide practitioners, as well as those charged with the responsibility of adjudicating claims of medical malpractice.

"There is no doubt that the medical malpractice system in Florida faces tremendous challenges…"

Table 4: 2010 Employer-Based Health Premium Contribution for the Average Family

	Florida	United States
Average Cost of Family Insurance Premium	$15,032	$13,871
Percent Employer Contribution	69%	73%
Actual Cost Percent Employer Contribution	$10,372	$10,126
Percent Employee Contribution	31%	27%
Actual Cost Percent Employee Contribution	$ 4,660	$3,745

Source: Kaiser Family Foundation, www.statehealthfacts.org.

"Of course, evidence-based medicine must be able to follow clear standards of care that are well disseminated, understood, and accepted"

About the Author

Dr. Beth Ann Fiedler received her master's degree in operations management from Kettering University in Flint, Michigan, and her Ph.D. from the College of Health and Public Affairs at the University of Central Florida in Orlando. Her research interests include healthcare quality management and the development of policies to improve community health and fiscal conditions. Her professional and academic career has included experience in management improvement projects involving medical simulation, biological response, U.S. military logistics, and integrated management systems for use in manufacturing. She resides in Winter Park.

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Appendix Table 1. Selected Comparative Summary of Conditions Driving Urgent Agent Prior to 2004 Tort Reform in Florida, 1999-2003

State	1993-2003 Annual Average Medical Malpractice Payments[1a]	Percent Movement
Florida[b]	$302.32 (L $235.0 1999; H $389.9 2003)	66%
Indiana[c]	$59.84 (L $11.8 2002; $125.6 2003)	145%
Kansas[c]	$20.24 (H $26.3 1999; $19.4 L 2003)	< 26% >
Employee Sponsored Health Premiums[2]		
	1999	**2003**
Single Coverage	$2,196	$3,383
Family Coverage	$5,791	$9,068
Health Care Expenditure Per Capita by State[3]		
	1999	**2003**
Florida	$4,044	$5,117
United States	$3,829	$4,973

Sources: [1]Budetti & Waters, 2005, p. 22-23; [2]Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011, p. 22; [3]Kaiser Family Foundation Statehealthfacts.org.
Notes: [a]Millions, [b]High expenditure state, [c]Low expenditure state.

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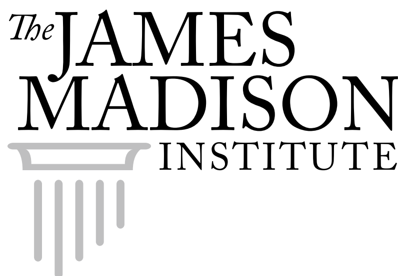

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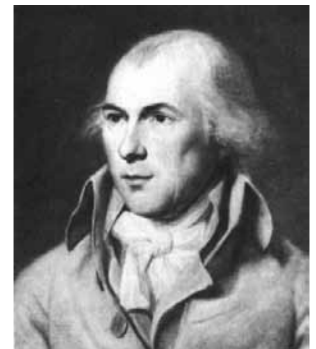

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