PREVENTING PENNSYLVANIA'S NEXT MEDICAL MALPRACTICE CRISIS: IMPLEMENTING A PILOT PROGRAM IN ONE OF THE STATE'S HEALTHCARE SYSTEMS

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I. INTRODUCTION

Providing a healthcare system that imparts optimal outcomes for the greatest number of people in the most cost-effective manner remains a challenge all over the world. If one watches the nightly news, scarcely a night deepens without mention of a dilemma with access to medical care. From the exorbitant costs of novel medications to treat common ailments to the lack of access to vaccinations in impoverished countries, the developed world is understandably consumed with treating disease, extending life, and providing affordable care. Unfortunately, another national healthcare crisis threatens to compound these issues—rising medical malpractice costs and healthcare provider burnout. While it has taken a backseat to the global COVID-19 pandemic that began in 2020, the potential consequences of failing to proactively address the upcoming crisis include a dramatic toll on the most vulnerable. The solution requires bold and innovative action from lawmakers, health policy advocates, patients, and clinicians.

This Comment will discuss the history of the nation's malpractice crises and their effects on healthcare providers and propose the timely implementation of a pilot program that compares various medical-injury patient compensation systems in one of Pennsylvania's largest healthcare systems. This novel project will compare the traditional tort negligence standard utilized throughout the country to three alternative patient compensation systems already used throughout the United States. The baseline for comparison will be established with the traditional tort system with non-economic damage caps. The second comparison will be with an arbitration system with a committee composed of experts selected to resolve healthcare disputes. The third comparison will

be with a no-fault compensation system, which is used on a limited basis in two states, several countries throughout Europe, and the Commonwealth nations. Following the completion of this program, a thorough, scientific analysis will help reveal the benefits and flaws of the different systems. By comparing the benefits to injured patients against the societal cost of providing those benefits, this empirical data can assist stakeholders in their quest to prevent the next malpractice crisis and alleviate the burgeoning provider burnout.

Section II of this Comment will discuss the dichotomy between massive injury payouts and the lack of compensation for allegedly wronged patients. It will also chronicle the history of the national medical malpractice crises that commenced in the mid-1970s and lawmakers' responses. Section II will then evaluate the crises' specific impacts and resulting reforms in Pennsylvania. Section III explores the current market conditions that are rapidly creating the climate for the next crisis in Pennsylvania. A particular focus will be on the state's finances, overworked and departing clinical providers, and the increase in defensive medicine. Finally, Section IV proposes the implementation of a pilot program to evaluate four different methods of compensating medical injury victims with their respective benefits and drawbacks. This prospective, observational study, otherwise known as a cohort study, requires financing and proper logistical support, and this Comment will suggest methods to efficiently provide these requisites.

II. HISTORICAL DEVELOPMENT OF MEDICAL MALPRACTICE ISSUES

The first documented medical malpractice lawsuit in the United States occurred in Connecticut in 1794.[1] A deceased patient's husband sued a physician on a breach of contract claim for his wife's death at the surgeon's hands.[2] The plaintiff-husband recovered forty British pounds, or roughly $1,371 in today's dollars.[3] In contrast to

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[1] C. Joseph Stetler, *The History of Reported Medical Professional Liability Cases*, 30 TEMP. L. Q. 366, 367 (1957).

[2] *Id.*

[3] *Id.*

the meager compensation awarded for the Connecticut patient's death, the largest jury malpractice suit in the history of the nation awarded $229.6 million to a Baltimore-area mother and daughter.[4] In that case, a mother suffered complications during childbirth at John Hopkins Bayview that left her daughter with severe neurological deficiencies.[5] Although the Court of Special Appeals of Maryland reversed the judgment, this case represents the drastic rise in financial compensation for medical malpractice victims over more than two centuries.[6]

The rise in medical tort compensation from 1794 until today correlates with the upsurge in medical malpractice suits.[7] However, prior to the 1960s, medical malpractice claims were uncommon and insignificantly affected doctors' practices.[8] By the 1960s, the frequency and payouts of malpractice increased enough that the medical community began to take notice.[9] A 1969 Senate report noted that the number of claims, suits, settlements, and judgments were quickly increasing.[10]

A. The 1970s–Crisis of Insurance Availability

The United States experienced three distinct periods of rising medical malpractice insurance premiums in the 1970s, 1980s, and 2000s.

i. Premiums Rise and Carriers Exit

In the mid-1970s, the first medical malpractice crisis occurred when many physicians and hospitals were unable to find malpractice

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[4] Johns Hopkins Bayview Med. Ctr., Inc. v. Byrom, No. 1585, 2019 Sept. Term, 2021 WL 321745, *14 (Md. Ct. Spec. App. Feb. 1, 2021).

[5] *Id.* at *5.

[6] *Id.* at *30.

[7] B. Sonny Val, *An Introduction to Medical Malpractice in the United States*, 467 CLIN. ORTHOP. RELAT. RES. 339 (2009).

[8] *Id.*

[9] *Id.*

[10] BAIRD WEBEL, CONG. RSCH. SERV., RL31886, MEDICAL MALPRACTICE INSURANCE: AN ECONOMIC INTRODUCTION AND REVIEW OF HISTORICAL EXPERIENCE 7 (Oct. 2, 2009) (citing the 1969 study).

insurance coverage or affordable coverage.[11] Some blamed a national recession, coupled with investment losses and the rise in malpractice suits and awards, for creating the perfect storm for insurance companies to abandon the medical malpractice market.[12] Others blamed the lack of competition and profitability amongst insurance carriers to cause premium rates to drastically increase.[13] Other experts blamed a significant increase in malpractice suits and their accompanying awards.[14] A fourth group blamed "large underwriting and investment losses [that] made medical malpractice insurance unprofitable."[15] Regardless of the cause, medical malpractice insurers quickly began to exit the market.[16]

This caused a ripple effect throughout the healthcare system.[17] Other healthcare professionals, including dentists and podiatrists, experienced the rise in prices, although not to the same extent as physicians.[18] As a result, these increased expenses were passed on to consumers in the form of higher costs for diagnostic testing and procedures.[19]

Patients barely took notice of what was occurring in the malpractice market since costs were usually distributed to third-party insurers.[20] However, the medical community struggled and took notice.[21] Doctors blamed lawyers, while lawyers blamed doctors and the American culture.[22] The American Medical Association (AMA) pointed fingers at trial attorneys that sued

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[11] Jean LeMasurier, *Physician Medical Malpractice*, 7(1) HEALTH CARE FIN. REV. 111 (1985).

[12] Glen O. Robinson, *The Medical Malpractice of the 1970's: A Retrospective*, 49 L. & CONTEMP. PROBS. 5, 6 (1986).

[13] *Id.* at 8-9.

[14] *Id.* at 16.

[15] LeMasurier, *supra* note 11.

[16] *Id.*

[17] Robinson, *supra* note 12, at 19.

[18] Lawrence K. Altman, *Malpractice Rates Drive Up Doctor Fees*, N.Y. TIMES (July 27, 1975), https://www.nytimes.com/1975/07/27/archives/malpractice-rates-drive-up-doctor-fees-soaring-malpractice-rates.html.

[19] *Id.*

[20] Robinson, *supra* note 12, at 6-7.

[21] Altman, *supra* note 18.

[22] *Id.*

doctors on contingency, while attorneys pointed to the American tradition of compensating injury victims.[23]

The situation became so dire that some physicians threatened strikes, while in Alaska, for example, some doctors practiced without malpractice insurance.[24] Other physicians cut back their services.[25] Many stopped practicing altogether, while others moved to regions with more affordable and accessible insurance.[26]

In response to the plight of physicians, state legislatures began to act in hopes of encouraging the reintroduction of malpractice carriers into the market and tempering the steep increases in price.[27] Most analysts believe their efforts succeeded, at least in the short term.[28] The most significant reforms included the placement of limitations on damages and the elimination of the collateral source rule.[29] "The collateral source rule provides that payments from a collateral source shall not diminish the damages otherwise recoverable from the wrongdoer."[30] These two alterations in law quickly reduced the impact of large awards.[31]

In addition, physician-owned insurance carriers entered the market to help drive down costs through nonprofit motives and through the identification of dangerous physicians.[32] Additionally, state-sponsored joint underwriting associations were formed; some still operate today.[33] Legislative action, coupled with the entrance of new carriers into the market, stabilized malpractice insurance rates for the time being.[34]

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[23] *Id.*

[24] *Id.*

[25] *No Doctors' Strike*, N.Y. TIMES (May 31, 1975), https://www.nytimes.com/1975/05/31/archives/ no-doctors-strike.html.

[26] Altman, *supra* note 18.

[27] *Id.*

[28] Robinson, *supra* note 12, at 27.

[29] *Id.*

[30] Johnson v. Beane, 664 A.2d 96, 100 (Pa. 1995) (citing Beechwoods Flying Serv., Inc. v. Al Hamilton Contracting Corp., 467 A.2d 350, 352 (Pa. 1984)).

[31] Robinson, *supra* note 12, at 27.

[32] *Id.*

[33] David Studdert et. al., *The New Medical Malpractice Crisis*, 348 NEW ENG. J. MED. 2281-84 (2003).

[34] Robinson, *supra* note 12, at 27.

Interestingly, at the international level, England and Canada did not experience the same malpractice crisis as the United States.[35] The American Medical Association claimed that while all three countries provided comparable care, attorneys in the United States collected a greater contingency fee than in the other two countries.[36] Opponents of this view claimed that England and Canada, unlike the United States, provided little compensation for pain and suffering.[37]

B. The 1980s–Crisis of Insurance Affordability

Following a steady decline of premiums in the late 1970s and early 1980s, America's next malpractice crisis occurred in the mid-1980s. Insurance premiums rose ten-fold between 1973 and 1983[38] and spiked between 1984 and 1987.[39] For example, in 1986, obstetricians in metropolitan areas paid over $100,000 per year for $1 million/$3 million liability coverage.[40] Some experts attributed rising interest rates in the early 1980s to the decrease in premiums that helped relieve the crisis of the 1970s.[41] They also blamed the striking rise in premiums to a sharp drop in interest rates.[42]

Insurance rates rose at least 50 percent per year, with higher rates for higher-risk specialties.[43] Obstetrician/gynecologists were particularly hit hard.[44] According to a 1985 New York Times article, obstetrician/gynecologists on the Hawaiian Island of Molokai gave up obstetrics to help bring down their malpractice

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[35] Altman, *supra* note 18.

[36] *Id.*

[37] *Id.*

[38] Witte v. Azarian, 801 A.2d 160, 166 (Md. 2002).

[39] J. David Cummins et al., *Cycles and Crises in Property/Casualty Insurance: Causes and Implications for Public Policy*, NAT'L ASS'N OF INS. COMM'RS 70 (1991).

[40] INSTITUTE OF MEDICINE, MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE: VOLUME I, NATIONAL ACADEMIES PRESS 98 (Victoria P. Rostow & Roger J. Bulger eds.,1989).

[41] Cummins, *supra* note 39, at 79.

[42] *Id.*

[43] MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE, *supra* note 40, at 106.

[44] Sharon Johnson, *Malpractice Costs vs. Health Care for Women*, N.Y. TIMES (July 19, 1985), https://www.nytimes.com/1985/07/19/style/malpractice-costs-vs-health-care-for-women.html.

costs.[45] Left without doctors to deliver babies, mothers flew to Honolulu to give birth.[46] A major reason for obstetricians' susceptibility to higher premiums stems from the unpredictability of the potential awards for a malpractice suit.[47] When an infant is injured during childbirth, difficulty arises in calculating the financial compensation required to compensate the child throughout his or her life.[48]

Like in the 1970s, to achieve stability from this unpredictable situation, physicians lobbied for limits on injury awards, and lawmakers responded with a new measure of tort reform legislation.[49] However, unlike in the 1970s, the federal government acted and placed culpability directly on the tort system.[50] In response, the Reagan administration advocated for measures to limit recovery damages and to require a greater burden of proof for a plaintiff to file a claim.[51] Some of these measures were adopted by states across the country and, again, premiums dropped and the market stabilized.[52]

C. The 2000s–A Crisis of Affordability and Availability

Following the stabilization of the 1990s, malpractice carriers again began experiencing losses in the late 1990s and early 2000s, when the average jury verdict doubled to $1 million from 1996 to 2000.[53] After underwriting losses of $940 million in 2001, the

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[45] *Id.*

[46] *Id.*

[47] MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE, *supra* note 40, at 122.

[48] *Id.*

[49] Mohammad Rahmati et al., *Insurance Crisis or Liability Crisis? Medical Malpractice Claiming in Illinois, 1980-2010*, 13 J. EMPIRICAL LEGAL STUD. 188-89 (2016).

[50] Bob Hunter, *The Insurance Industry is to Blame*, WASH. POST (Apr. 13, 1986), https://www.washingtonpost.com/archive/opinions/1986/04/13/the-insurance-industry-is-to-blame/d419e52d-0816-4a24-8b1b-019204ef5a3c/.

[51] *Id.*

[52] Rahmati, *supra* note 49, at 5-6.

[53] *Lawyers vs. Patients,* WAL ST. J. (May 1, 2002), https://www.wsj.com/articles/SB10202072048597559 60?page=1.

nation's second largest malpractice company, St. Paul Companies, abandoned the malpractice business.[54]

St. Paul Companies insured 42,000 physicians and thousands of facilities throughout the country.[55] Other companies soon followed suit.[56] Mississippi went from fourteen carriers to one remaining company willing to write new policies, while Texas went from seventeen carriers to four.[57] Unable to obtain coverage, some physicians in Florida practiced without malpractice insurance and, instead, relied on asset protection.[58] A 2003 Wall Street Journal article reported that a pregnant patient in Las Vegas may have to contact fifty providers before finding one accepting new patients, while a baby was born on the side of the road in Arizona as a mother passed a community hospital that closed the doors to its maternity wing.[59]

Like in the 1980s, the federal government again took notice. President Bush and the American Medical Association (AMA) proposed malpractice reform acts that mirrored California's 1975 Medical Injury Compensation Reform Act (MICRA), which sought to provide relief to physicians and malpractice carriers.[60] Amongst its other provisions, MICRA capped non-economic damages to $350,000 and limited attorney's contingency fees, according to a sliding scale that reduces attorney's contingency percentage as the recovered amount increases.[61] Despite the attempt, the Bush administration was unable to pass any significant tort reform at the federal level.[62] However, multiple states enacted reforms that some experts claimed helped stabilize the market.[63]

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[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] Studdert, *supra* note 33.

[59] *Lawyers vs. Patients III*, WALL ST. J. (Jan. 2, 2003), https://www.wsj.com/ articles/SB1041471655164206433.

[60] Erik R. Barthel et al., *Surgical Malpractice in California: Res Judicata*, 80 THE AM. SURGEON 1008, 1009 (2014).

[61] CAL. CIV. CODE. § 3333.2 (West 2023); CAL. BUS. & PROF. CODE. § 6146 (2021).

[62] Rahmati, *supra* note 49, at 201.

[63] *Id.* at 202.

D. Pennsylvania's Malpractice Crises

Like other states in the union, Pennsylvania suffered from each of the three major malpractice crises, although to a different extent in each era.[64] Pennsylvania mostly escaped the crisis of the 1970s and 1980s, but it was not so fortunate in the 2000s. Four major insurance companies failed during the late 1990s, including the state's largest.[65] The remaining carriers either refused to write polices for new applicants or carefully underwrote for only those with flawless liability records.[66] Physicians relied on other companies and Pennsylvania's Professional Liability Joint Underwriting Association (PPLJUA) for coverage.[67]

i. PPLJUA and the MCARE Act

PPLJUA is a nonprofit organization that was originally established by the Pennsylvania legislature in 1975 and was later re-authorized in 2002 by the Medical Care Availability and Reduction of Error (MCARE) Act.[68] Today, 621 insurance companies participate in the fund through statutory compulsion.[69] PPLJUA "offer[s] medical professional liability insurance to healthcare providers . . . who cannot conveniently obtain medical professional liability insurance through ordinary methods . . . ."[70] The carrier's funding emanates solely from participants' premiums and investments with those assets.[71] As part of the MCARE Act, the MCARE fund helps contribute to victim awards not covered by a provider's medical malpractice insurance.[72]

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[64] Randall R. Bovbjerg and Anna Bartow, *Understanding Pennsylvania's Medical Malpractice Crisis: Facts about Liability Insurance, the Legal System, and Health Care in Pennsylvania*, THE PROJECT ON MED. LIAB. IN PENNSYLVANIA 2 (2003), https://www.urban.org/sites/default/files/publication/58841/1000732-understanding-pennsylvania-s-medical-malpractice-crisis.pdf.

[65] *Id.* at 1.

[66] Studdert, *supra* note 33.

[67] Bovbjerg, *supra* note 64, at 9.

[68] Pa. Pro. Liab. Joint Underwriting Ass'n v. Wolf, 324 F. Supp. 3d 519, 523 (M.D. Pa. 2018) (citing 40 PA. CONS. STAT. § 1303.731 (2002)).

[69] *Id.* at 524.

[70] 40 PA. CONS. STAT. § 1303.732 (2002).

[71] *Pa. Pro. Liab. Joint Underwriting Ass'n,* 324 F. Supp. 3d at 525.

[72] Bovbjerg, *supra* note 64, at 17.

Despite the availability of MCARE and PPLJUA, premiums rose by 50 percent in 2003 and continued to be among the nation's highest; gynecologists' premiums alone surpassed $100,000.[73] The number of insurance carriers dropped from ten to two between 1993 and 2003.[74] The remaining carriers increased rates, denied coverage for new physicians, reduced coverage, and dropped doctors.[75] According to the Pennsylvania Medical Association, at least 900 doctors in the state planned to retire, leave the state, or give up higher-risk procedures.[76] Doctors threatened to stage walkouts if the state did not act to contain premiums.[77] A trauma center in Scranton, PA readied to close its doors, leaving trauma victims to travel seventy miles through the mountains to obtain care in Allentown or Danville.[78] Partly due to the legislative reforms and partly due to factors across the country, Pennsylvania's crisis abated by the middle of the 2000s.[79]

E. Damages Defined

One of the principal methods lawmakers attempted to solve all three crises involved limiting damage awards.[80] This likely stemmed from these restrictions being "the only reform[s] that [have] consistently been shown to have a significant impact on malpractice insurance premiums."[81] During fact-finding sessions, legislatures throughout the country[82] have consistently determined that growing malpractice rates are an impediment to providing quality health care.[83] To comprehend the political popularity of

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[73] Bernard Wysocki, Jr., *Pennsylvania Malpractice Plan Makes State's Insurers Scream*, WALL ST. J. (Jan. 28, 2003), https://www.wsj.com/articles/SB1043703507323053024.

[74] *Lawyers vs. Patients III*, *supra* note 59.

[75] *Id.*

[76] *Id.*

[77] *Id.*

[78] *Id.*

[79] Bovbjerg, *supra* note 64, at 4.

[80] Leonard J. Nelson et. al., *Medical Malpractice Reform in Three Southern States*, 4 J. HEALTH & BIOMEDICAL L. 69, 77 (2008).

[81] *Id.* at 77-78.

[82] M.D. v. United States, 745 F. Supp. 2d 1274, 1275 (M.D. Fla. 2010).

[83] *Id.* at 1279.

restricting damages, it is necessary to discuss the categories and functions of damages.

The three categories of damages include economic, non-economic, and punitive.[84] Economic, or compensatory damages, "are such damages as measure the actual loss, and are allowed as amends therefor."[85] These include both past and future lost wages, medical expenses, long-term care costs, and other financial expenses.[86] They are designed to place the plaintiff in the same financial position as if his or her injury had not occurred.[87]

The second category, non-economic damages, "compensate the plaintiff for the non-pecuniary harm caused by the malpractice," including emotional distress, "pain and suffering, inconvenience, loss of consortium (i.e., marital companionship), and decreased quality of life."[88] They serve "to make a plaintiff whole."[89] Difficulty arises in their precise monetary calculation because they require evaluation of a reasonable person's assessment of recompense for the tort injury.[90]

Finally, punitive awards "are such damages as are in excess of the actual loss, . . . and are allowed in theory when a tort is aggravated by evil motive, actual malice, deliberate violence, or oppression or fraud . . . ."[91] Their award punishes the tortfeasor and aims to deter others from engaging in the same behavior.[92] Punitive damages are rarely awarded in malpractice cases.[93]

If deemed appropriate, these categories of damages are generally awarded via jury award to a plaintiff without regard to any statutory constraints.[94] Once the final award is decided, the judge

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[84] Carly N. Kelly and Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515, 516 (2005).

[85] Bailets v. Pa. Tpk. Comm'n, 181 A.3d 324, 332 (Pa. 2018).

[86] Kelly, *supra* note 84, at 516.

[87] *Id.*

[88] *Id.*

[89] Colodonato v. Consol. Rail Corp., 470 A.2d 475, 479 (Pa. 1983).

[90] Waste Mgmt. of Tex., Inc. v. Tex. Disposal Sys. Landfill, Inc., 434 S.W.3d 142, 145 (Tex. 2014).

[91] *Bailets*, 181 A.3d at 333.

[92] Kelly, *supra* note 84, at 516.

[93] *Id.*

[94] *Id.*

adjusts the amount, if required by law.[95] Most reductions occur through malpractice caps, which generally affect non-economic and punitive damages.[96] Although courts generally do not advise jurors of the existence of the limitations, the jury may already be or may become aware of their existence in the state.[97]

Jurors in approximately thirty states face the prospect of seeing plaintiff awards limited by medical malpractice damage caps.[98] These states do not include Pennsylvania.[99] Pennsylvania's Constitution explicitly prohibits limitations on "the amount to be recovered for injuries resulting in death, or for injuries to persons,"[100] although the Pennsylvania Supreme Court has upheld the constitutionality of statutory caps on damages available from public tortfeasors.[101]

Despite their popularity with lawmakers, not all commentators agree that malpractice caps have decreased overall compensatory damages awarded by juries.[102] Studies suggest juries potentially award higher economic damages to compensate for the cap on non-economic damages.[103] Termed the "crossover theory," Professor Sharkey argues that attorneys, experts, juries, and courts have inflated economic damages to counter the limits on non-economic damages.[104] If accurate, this provides powerful confirmation that an alternative to malpractice caps is required since, as history proves, legislators will likely turn to these measures to tamp down the next crisis.

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[95] *Id.*

[96] *Id.*

[97] David M. Studdert et al., *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFF. 54-67 (2004).

[98] Kevin Sack, *Illinois Court Overturns Malpractice Statute*, N.Y. TIMES, (Feb. 5, 2010), https://www.nytimes.com/2010/02/05/us/05malpractice.html.

[99] Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 N.Y.U. L. REV. 391, 457 (2005).

[100] PA. CONST. art. III, § 18.

[101] Zauflik v. Pennsbury Sch. Dist., 104 A.3d 1096, 1100 (Pa. 2014).

[102] Sharkey, *supra* note 99, at 396.

[103] Studdert, *supra* note 97.

[104] Sharkey, *supra* note 99, at 429.

III. ARE WE THERE YET? PREPARING FOR THE NEXT MALPRACTICE CRISIS INTRODUCTION

Section II provides a historical background of the three major malpractice crises in the United States and a significant one in Pennsylvania that led to important legislative reform. Section III will present a broad overview of major issues currently threatening healthcare access in Pennsylvania and in the United States that are being exacerbated by the ineffectiveness of today's medical tort system.

A. Here We Go Again

Following a steady decline in malpractice premium rates, pricing rose for the first time in fourteen years in 2019.[105] Larger settlement and verdict payouts have partly resulted from declining independent physicians' offices and health provider consolidation.[106] The large organizations continue to employ an increasing share of physicians that previously worked in solo or small-group practices.[107] With the higher insurance limits of these healthcare systems, larger settlement and verdict payouts have resulted.[108] The trend against the independent physician practice shows no signs of abatement.[109]

In addition to these higher malpractice limitations, the upward trends in claims and payouts are unlikely to remit given the uncertainty introduced by the coronavirus pandemic.[110] Claims involving coronavirus are likely in the coming years.[111] Due to the increase in demand for medical services to treat the novel virus,

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[105] Susan J. Forray & Chad C. Karls, *A Hardening Market Arrives in Time to Greet a Global Pandemic,* INSIDE MED. LIAB. (SECOND QUARTER) 46, 46-47 (2020).

[106] *Id.* at 47.

[107] *Id.*

[108] *Id.*

[109] *Id.*

[110] *Id.* at 50.

[111] Maura Keller, *Hardening Medical Malpractice Rates, a Slew of COVID Claims and What it All Means for the Health Care Sector*, RISK & INS. (June 7, 2021), https://riskandinsurance.com/hardening-medical-malpractice-rates-a-slew-of-covid-claims-and-what-it-all-means-for-the-health-care-sector/.

coupled with patients' hesitancy to visit providers in office, there has been a recent explosion of telehealth services as an alternative to in-person clinical services.[112] This new standard of care leaves clinicians and their employers exposed to further liability.[113] The delay of non-emergent services at the demand of government entities also presents a new source of malpractice claims.[114]

These pressures and uncertainties continue to harden the medical malpractice market and have already caused several companies to recently leave the market.[115] In response, prices, limitations, and exclusions for malpractice policies continue to rise.[116] AM Best, an insurance credit rating agency, predicts a difficult market year for malpractice carriers.[117] Despite the pessimism, some experts feel that market stability is imminent.[118] However, the hope of market stability does little to ease the real premium rises that are currently occurring.[119]

Like these national trends, there are warning signs for an upcoming malpractice crisis in Pennsylvania. A 2020 report by the Pennsylvania Insurance Department stated that the MCARE fund possesses a $1.025 billion liability deficit as of December 31, 2019.[120] The Pennsylvania Orthopaedic Society remains concerned that this unfunded obligation will have to be paid by future physicians, and, thus, will keep young physicians out of the state.[121]

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[112] *Id.*

[113] *Id.*

[114] *Id.*

[115] *Id.*

[116] *Id.*

[117] *Best's Special Report: Professional Liability Insurers Navigate Uncertain Terrain Amid Pandemic*, BUS. WIRE (Nov. 12, 2020, 8:48 AM), https://www.businesswire.com/news/home/20201112005647/en/Best%E2%80%99s-Special-Report-Professional-Liability-Insurers-Navigate-Uncertain-Terrain-Amid-Pandemic.

[118] Andrew Vega, *Challenges Faced by Medical Professional Liability Insurers in 2022 and Beyond*, MILLIMAN, https://www.milliman.com/en/insight/challenges-faced-by-medical-professional-liability-insurers-in (last visited Feb. 22, 2023).

[119] *Id.*

[120] *Medical Care Availability and Reduction of Error Fund*, PA. INS. DEP'T. 3 (2020).

[121] *Pennsylvania's Medical Liability Crisis*, PA. ORTHOPAEDIC SOC'Y, https://www.paorthosociety.org/medical-liability (last visited Mar. 14, 2023).

There is more bad news for the state. Beginning in 2016, the Pennsylvania General Assembly passed legislation to loan itself $200,000,000 of PPLJUA's assets.[122] As of 2021, a permanent injunction remains in place to prevent the transfer, but the case continues to work itself through the legal system.[123] Withdrawing over half the funds of the carrier of last resort for Pennsylvania's physicians seems daunting, considering the uncertainty of future losses.[124] An unexpected shortfall of assets that exceed liabilities creates the potential for dramatic premium increases of the state's already costliest plan.

B. Providers are Leaving the State

In addition to the pressures on malpractice carriers, different healthcare professionals are experiencing difficulties in Pennsylvania's current environment. Aside from the pressure on physicians, twenty-nine states face a nurse shortage, with North Carolina and Pennsylvania being among the hardest hit.[125] The physical demands and stresses of the profession are some of the most cited reasons for nurses leaving the profession in Pennsylvania over the next five years.[126] While claims against nurses remain minor compared to those against physicians,[127] the shortage of nurses in the state will predictably lead to more medical errors due to understaffing. Consequently, malpractice claims will rise further, and premiums will respond accordingly upwards.

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[122] Pa. Pro. Liab. Joint Underwriting Ass'n v. Wolf, 509 F. Supp. 3d 212, 220 (M.D. Pa. 2018).

[123] *Id.* at 235.

[124] *Id.* at 219.

[125] Anastassia Gliadkovskaya, *Labor Shortages in Healthcare Expected to Rise as Demand Grows, Report Finds*, FIERCE HEALTHCARE (Sep. 30, 2021, 10:50 AM), https://www.fiercehealthcare.com/practices/labor-shortages-healthcare-expected-to-rise-as-demand-grows-report-finds.

[126] Bureau of Health Planning Division of Plan Development, *2012/2013 Pulse of Pennsylvania's Registered Nurse Workforce*, 6 PA. DEP'T OF HEALTH, 42 (2015).

[127] Jim Sams, *Coverys Report Pinpoints Top Causes of Malpractice Claims Involving Nurses*, CLAIMS J., https://www.claimsjournal.com/news/national/2022/09/12/312635.htm (last visited Feb. 20, 2023).

C. Defensive Medicine Continues

Approximately 93 percent of Pennsylvania's high-risk specialists practiced defensive medicine in 2003.[128] Defensive medicine involves "diagnostic or therapeutic measures conducted primarily as a safeguard against possible subsequent malpractice liability."[129] However, it also includes an avoidance of high-risk patients and procedures to further insulate a clinician from liability.[130] Moreover, patients are sometimes referred to other practitioners to broaden the risk.[131] Through these measures, clinicians drive up the costs of health care and unnecessarily burden patients.

The burden on patients occurs through monetary and personal health detriments. A 2010 Harvard study estimated that defensive medicine costs the American healthcare system 2.4 percent of overall healthcare spending, or $55.6 billion in 2008 dollars.[132] Additionally, unnecessary diagnostic testing is prescribed to rule out unlikely conditions.[133] Often in the form of irradiating imaging, these investigative exams increase a patient's lifetime risk of certain cancers.[134] Furthermore, extra procedures consume a patient's time and carry their own health risks.

In addition to protecting the clinician from liability through additional diagnostic tests and procedures, medical professionals often practice defensive medicine by avoiding certain patients, procedures, and locations that provide additional risk. For example, an orthopedic surgeon may elect to avoid patients with an unwelcoming personality, multiple co-morbidities, and those at

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[128] David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. AM. MED. ASS'N 2609, 2609 (2005).

[129] *Defensive Medicine*, STEDMAN'S MED. DICTIONARY, https://stedmansonline.com (last visited May 13, 2023).

[130] Sams, *supra* note 127, at 2609.

[131] *Id*.

[132] Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFFS. 1569-77 (Sept. 2010).

[133] Studdert et al., *supra* note 128.

[134] Martha S. Linet et al., *Cancer Risks Associated with External Radiation from Diagnostic Imaging Procedures*, CA: A CANCER J. FOR CLINICIANS (Aug. 3, 2013).

trauma centers.[135] Disagreeable patients are more likely to seek litigation remedies for actual or perceived injuries.[136] Patients with numerous health conditions suffer substandard outcomes that lead to lawsuits. Although disproved by a 2005 study, physicians perceive a higher malpractice risk with trauma care.[137] These avoidance factors result in decreased access to care.[138]

A 2015 study published in *Neurosurgery* surveyed 1,026 neurosurgeons and their use of defensive medicine.[139] Doctors in high-risk states were 50 percent more likely to practice defensively versus those in low-risk states.[140] Alternatively, a 2019 systemic review concluded that tort reforms reduced physicians' practice of defensive medicine, reduced healthcare spending, and increased the numbers of physicians in reform states.[141] However, the authors noted that these measures did not improve the quality of patient care.[142] This demonstrates the necessity to directly study alternative methods of reform through the pilot program proposed in the following section.

IV. SOLUTIONS AND IMPLEMENTATION OF PILOT PROGRAM

Fairly and appropriately compensating injured patients, improving access to care, and enhancing medical outcomes remain the objectives of policy reforms. Most policy proposals are aimed at achieving these goals. However, most fail to consider the effects on the clinicians actually providing patient care. By embracing the free-market principles that have created American exceptionalism with the regulatory models of developed nations with exceptional

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[135] Joseph Bernstein et al., *Topics in Medical Economics: Medical Malpractice*, 90 J. BONE & JOINT SURGERY 1777 (Aug. 2008).

[136] *Id.*

[137] Ronald M. Stewart et al., *Trauma Surgery Malpractice Risk: Perception Versus Reality*, 241 ANNALS OF SURGERY 969 (June 2005).

[138] *Id.*

[139] Timothy R. Smith et al., *Defensive Medicine in Neurosurgery: Does State-Level Liability Risk Matter?*, 76 NEUROSURGERY 105 (Feb. 2015).

[140] *Id.*

[141] Rajender Agarwal, *The Impact of Tort Reform on Defensive Medicine, Quality of Care, and Physician Supply: A Systematic Review*, 54 HEALTH SERV. RSCH. 851, 857 (2019).

[142] *Id.*

healthcare systems easily available to all, Pennsylvania can create a patient compensation system that is equitable to patients and clinicians alike.

The balancing act between the affordability, availability, and quality of health care continues to sway citizens and lawmakers to consider different policies. The cyclical nature of the malpractice insurance market presents unique challenges. Based on the recent data discussed in Section III, Pennsylvania and the nation may be entering a hard market. Malpractice caps represent the most popular form of riding out the market's rough waves and will likely be lawmakers' initial solution. Section IV of this Comment examines solutions implemented by other nations, states, and private entities and evaluates their successes and failures. This Section also suggests creating a pilot study in Pennsylvania and compares different patient compensation programs. This will assist to guide the modification of existing malpractice laws to smoothly sail through the inevitable stormy malpractice market downturn. Perhaps malpractice damage caps will remain the most popular and effective solution, or, maybe, a radical socialized system will demonstrate superiority.

A. To Cap or Not to Cap, that is the Question

The most popular method of malpractice reform in the United States has been the implementation of damage caps on pain and suffering damages.[143] Several states currently have malpractice ceilings on specific categories of damages and on amounts of compensation.[144] A study published in 2005 evaluated county-level data from all fifty states from 1985 until 2000.[145] The researchers concluded that states with malpractice caps had an increased number of physicians per capita in urban and rural counties compared to states without caps.[146] Rural counties possessed a greater number

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[143] William E. Encinosa & Fred J. Hellinger, *Have State Caps on Malpractice Awards Increased The Supply of Physicians?*, 24 HEALTH AFFS. W5-250-51 (2005).

[144] *Id.* at W5-253.

[145] *Id.* at W5-250.

[146] *Id.*

of physicians per capita than urban counties compared to states without the limits.[147]

This result is highly significant. Rural residents tend to be poverty-stricken and less healthy than their urban counterparts.[148] Attracting physicians to treat these rural patients remains a struggle for a myriad of reasons. According to the Center for Rural Pennsylvania, a legislative agency, forty-eight rural counties and nineteen urban counties encompass the Commonwealth based on population density.[149] Data from 2003 indicated that only 10 percent of the state's physicians served the 21 percent of residents that make up these rural counties.[150] More recent data revealed that urban areas employed nearly double the number of physicians per capita than urban areas.[151] Moreover, rural areas have a greater percentage of physicians over seventy-five years of age.[152] These older physicians are likely to leave medicine sooner than their younger counterparts. This is likely to amplify the physician shortage. Implementing damage caps effectively increased the number of obstetrical-gynecologists and surgical specialists in these rural areas.[153]

i. California and Louisiana

California and Louisiana provide valuable models for legislative malpractice cap designs. As insurance premiums rose and malpractice insurance carriers departed the market nationally in

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[147] *Id.* at W5-255.

[148] PA. RURAL HEALTH ASS'N, STATUS CHECK VI PENNSYLVANIA RURAL HEALTH CARE (Nov. 2016), https://paruralhealth.org/post/_docs/Status-Check-VI.Final.pdf.

[149] *Id.* at 58.

[150] CTR. FOR RURAL PA., TRENDS IN RURAL PENNSYLVANIA (2023), https://www.rural.pa.gov/getfile.cfm?file=Resources/fact-sheets/Trends_in_Health_Care.pdf&view=true.

[151] Andrew Shelden, *Addressing Health Equity in Rural Pennsylvania*, PA. RURAL HEALTH (Spring 2021).

[152] Sharon DeJoy & David Doorn, *Access to Maternity and Obstetric Care in Rural Pennsylvania*, CTR. FOR RURAL PA. (Apr. 2022).

[153] Encinosa & Hellinger, *supra* note 143.

the mid-1970s, Northern California took one of the hardest hits.[154] The state responded by passing the nation's first model for capping non-economic damages.[155] California's Medical Injury Compensation Reform Act (MICRA), passed in 1975, limits a plaintiff's recovery to $250,000 for non-economic damages.[156]

In the years preceding the crisis that affected California, insurance premiums in Louisiana spiked over 300 percent.[157] By 1975, only two carriers remained in the Louisiana malpractice insurance market, and even they considered ceasing their product offering.[158] Louisiana lawmakers quickly responded with legislation that remains law today.[159] The legislation states that damages "for all malpractice claims for injuries to or death of a patient, exclusive of future medical care and related benefits" are capped at $500,000 "plus interest and cost," and the personal liability of "health care provider[s]" is capped at $100,000 "plus interest."[160] Punitive damages are not available as legal relief, unless allowed by statute.[161] The Louisiana Patient Compensation Fund (LPCF), another legislative product of 1975, provides payments for future medical costs that exceed the $500,000 cap and for liability against providers that exceed the $100,000 cap.[162] Despite these reforms, Louisiana continues to be one of the leading states per capita for malpractice claims.[163]

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[154] U.S. GOV'T ACCOUNTABILITY OFF., GAO-87-21, UNITED STATES GENERAL ACCOUNTING OFFICE: MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS (1986).

[155] Agarwal, *supra* note 141, at 852.

[156] Fein v. Permanente Med. Grp., 695 P.2d 665, 669 (Cal. 1985).

[157] Emily Townsend Black Grey, *The Medical Malpractice Damages Cap: What is Included*, 60 LA L. REV. 547, 547 (2000).

[158] *Id.* at 548.

[159] *Id.*

[160] LA. STAT. ANN. § 40:1231.2(B)(1)-(2) (2023).

[161] McCoy v. Ark. Nat. Gas Co., 175 La. 487, 497 (1932).

[162] *Louisiana Patient's Compensation Fund*, LHA TR. FUNDS, https://lhatrustfunds.com/patients-compensation-fund (last visited May 13, 2023).

[163] Tony Tramontana, *Louisiana Medical Malpractice Rates are 3rd Highest in U.S.*, J. ANTONIO TRAMONTANA, https://tramontanalaw.com/louisiana-medical-malpractice-rates-high/ (last visited May 13, 2023).

B. Arbitration

In addition to damage caps, arbitration remains a viable method of controlling malpractice costs. Arbitration refers to "the investigation and determination of a matter or matters or differences between contending parties, by one or more unofficial persons chosen by the parties, and called arbiters or referees."[164] Entering into the process is voluntary, but its findings are binding, barring few exceptions.[165] Arbitration agreements are common in sale agreements, credit card agreements, cell phone bills, and other purchase contracts.[166] They are uncommon in the medical sector.[167] This may be due to a lack of understanding. A rare example of the use of arbitration agreements occurs with health maintenance organizations (HMOs) in California that employ them as a measure to control costs.[168]

Implementing arbitration into injury claims often begins as part of the admissions' process.[169] A patient voluntarily signs a pre-dispute arbitration agreement as part of his or her intake paperwork.[170] In the case of an untoward medical event, this agreement serves as the source of the dispute resolution.[171] The injured "contact[s] the treating physician, risk manager or other administrator, or a plaintiff's attorney[,]" and the process commences.[172]

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[164] John A. Donahue & Son v. Barclay White Co., 9 Pa. D. & C. 303, 304 (Pa. D. & C. 1927).

[165] *Id.*

[166] Kenneth A. DeVille, *The Jury is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims Law, Ethics, and Prudence*, J. LEGAL MED. 333, 333 (2007).

[167] *Id.*

[168] White v. FH & HF-Torrance I, LLC, No. BC660196, 2017 Cal. Super. LEXIS 8976, at *3.; Barry Meier, *In Fine Print, Customers Lose Ability to Sue*, N.Y. TIMES (Mar. 10, 1997) In Fine Print, Customers Lose Ability to Sue - The New York Times (nytimes.com).

[169] DeVille, *supra* note 166, at 333.

[170] *Id.*

[171] Sarah Sachs, *The Jury is Out: Pre-Treatment Arbitration Clauses in Patient Intake Contracts*, J. DISP. RESOL. 117, 117 (2018).

[172] DeVille, *supra* note 166, at 336.

Experienced attorneys and retired judges familiar with the law often serve as arbitrators.[173] By focusing on the facts, the law, and limiting emotions, these mediators can rule on the merits of the injured party's case.[174] This results in lower settlement amounts.[175]

The main advocates of arbitration remedies include the medical community and insurance industries.[176] They argue for arbitration's efficiency and maintenance of the patient-clinician relationship compared to the traditional negligence-based torts through the courts.[177] Moreover, smaller damage cases receive equal footing in front of decision-makers, versus in the traditional model where only larger damage cases are worth bringing to trial.[178] Finally, unlike in the negligence-tort system, physicians' reputations are better preserved, unless a ruling against a physician occurs.[179] In that case, the State Board of Medical Examiners and National Practitioner Data Bank receive the arbitration results.[180] Despite this reporting standard, opponents of arbitration in medical malpractice cases, including plaintiffs' attorneys and consumer protection advocates, argue that the system's shortcomings outweigh any benefits.[181] These critics claim patients lack adequate knowledge to willingly execute an arbitration contract written to benefit the medical professional and his or her insurer.[182]

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[173] Glenn Feldman, *Alternative Dispute Resolution–The Basics*, GLENN FELDMANN, https://www.glennfeldmann.com/alternative-dispute-resolution-the-basics/ (last visited May 13, 2023).

[174] Deville, *supra* note 166, at 373.

[175] *Id.* at 376.

[176] *Id.* at 333.

[177] *Id.*

[178] Fillmore Buckner, *A Physician's Perspective on Mediation Arbitration Clauses in Physician-Patient Contracts*, 28 CAP. U. L. REV. 307, 313 (2002); Marshall Allen & Olga Pierce, *Patient Harm: When an Attorney Won't Take Your Case*, PROPUBLICA (Jan. 6, 2014, 10:06 AM), https://www.propublica.org/article/patient-harm-when-an-attorney-wont.

[179] Alan B. Morrison, *Can Mandatory Arbitration of Medical Malpractice Claims Be Fair*? *The Kaiser Permanente System*, J. DISP. RESOL. 35, 50 (2015).

[180] Deville, *supra* note 166, at 377.

[181] Morrison, *supra* note 179, at 35.

[182] Sachs, *supra* note 171, at 1.

C. No-Fault Compensation

Aside from the arbitration model, a no-fault compensation system, similar to that used throughout Europe and New Zealand, provides an alternative to Pennsylvania's current negligence-based tort system. One of the most successful adopters of this model, Denmark, boasts a higher life expectancy than the United States, spends less of their GDP on health care than the United States, and has a solvent healthcare budget, according to 2015 statistics.[183] The goal of the Danish medical injury compensation model is to compensate aggrieved patients instead of punishing clinicians and deterring future behavior.[184] According to the Danes, the supervision and reprimanding of clinicians rests with regulatory bodies.[185]

Following a series of highly-publicized medical injury cases, in which victims failed to obtain compensation, Denmark enacted the Patient Insurance Act (PIA).[186] Under today's version of the PIA, an aggrieved party files a claim within ten years of the injury with a Patient Insurance Consortium.[187] He or she is assigned a caseworker that guides him or her through the process, and the hospital or physician must provide a response.[188]

Legal and medical experts serve to resolve patients' injury claims outside of the Danish courts.[189] Monetary awards result if the experts find that "the care could have been better, or if the patient experienced a rare and severe complication that was 'more extensive

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[183] *Denmark: Country Health Profile 2017*, OECD (Nov. 23, 2017), https://www.oecd.org/health/denmark-country-health-profile-2017-9789264283343-en.htm; UNITED HEALTH FOUNDATION AMERICA'S HEALTH RANKINGS ANNUAL REPORT 2016 (2016) https://assets.americashealthrankings.org/app/uploads/ahr16-complete-v2.pdf.

[184] Ann Ulrich, *An Evaluation of the Danish No-Fault System for Compensating Medical Injuries*, 3 ANNS. HEALTH L. 243-82, 278 (1994).

[185] *Id.* at 280-81.

[186] *Id.* at 247-48.

[187] *Id.* at 248, 271.

[188] Olga Pierce & Marshall Allen, *How Denmark Dumped Medical Malpractice and Improved Patient Safety,* PROPUBLICA (Dec. 31, 2015, 10:54 AM), https://www.propublica.org/article/how-denmark-dumped-medical-malpractice-and-improved-patient-safety.

[189] *Id.*

than the patient should reasonably have to endure.' "[190] Guidelines establish the upper limits for economic and non-economic damages.[191]

If a patient's claim is rejected, he or she may appeal for free to a panel of doctors, patient representatives, attorneys, and representatives from the Danish healthcare system.[192] After an unsuccessful appeal, patients may petition the Danish district court for review.[193]

i. Virginia

During the medical malpractice crisis of the late 1980s, Virginia enacted legislation in 1987 to provide no-fault compensation for infants who suffered a severe neurological injury during childbirth.[194] This first-of-its-kind program in American medicine was modeled to function with the workman's compensation system to help stabilize the obstetrician market after physicians ceased providing obstetrical care.[195] Rural counties were especially affected, and some counties completely lacked obstetrical providers.[196]

To receive compensation, an infant must suffer a neurological injury causally linked to the baby's delivery, and the medical services must have been provided by a participating hospital or provider.[197] If these two criteria are met, compensation is provided through the program without the need to prove malpractice.[198] The infant's family waives its right to bring a medical malpractice suit

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[190] *Id.*

[191] Ulrich, *supra* note 184, at 245.

[192] Pierce & Allen, *supra* note 188.

[193] *Id.*

[194] David Studdert et al., *The Jury is Still In: Florida's Birth-Related Neurological Injury Compensation Plan after a Decade*, 25 J. OF HEALTH POL. 499, 501, 524 (June 2000).

[195] JOINT LEGIS. AUDIT & REV. COMM'N REVIEW OF THE VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM (2003), https://vabirthinjury.com/wp-content/uploads/2012/08/rpt2841.pdf.

[196] *Id.* at i.

[197] *Id.* at ii. A neurological injury is one "to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation . . . ." *Id.* at 5.

[198] *Id.* at ii.

against the participating doctor and hospital when it chooses to obtain the services of a participating entity.[199]

Virginia's Birth-Related Neurological Injury Compensation Program demonstrated clear short-term results.[200] One major medical malpractice carrier re-entered the obstetrical care market as soon as the legislation was signed, and obstetricians resumed providing child-rearing services throughout the state.[201] These immediate outcomes provided great optimism for the program and, over time, have benefited the injured children, obstetricians, facilities, and malpractice carriers.[202] However, according to a 2003 Legislative report, the program failed to ameliorate the lack of access to obstetrical services, especially to those in rural communities.[203]

ii. Florida

Like Virginia, Florida also enacted legislation during the medical malpractice crisis of the late 1980s in response to market stresses for obstetrical care.[204] Established in 1988, the Florida Neurological Injury Compensation Association (NICA) "provide[s] compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation."[205] Eligibility criteria emulate Virginia's requirements, but award amounts differ.[206]

Upon admission into the program, the family of the injured child receives an initial payment of $250,000.[207] Subsequently, the fund provides yearly compensation for expenses required to provide

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[199] *Id.* at 5.

[200] *Id.* at 25.

[201] JOINT LEGIS. AUDIT & REV. COMM'N, *supra* note 195, at 25.

[202] *Id.* at 1, 32.

[203] *Id.*

[204] Gil Siegal et al., *Adjudicating Severe Birth Injury Claims in Florida and Virginia: The Experience of a Landmark Experiment in Personal Injury Compensation*, AM. J. L. MED. 493, 494 (2008).

[205] FLA. STAT. ANN. § 766.301(2) (LexisNexis 2021).

[206] Siegal, *supra* note 204, at 495.

[207] *About NICA*, NICA, https://www.nica.com/about-nica/ (last visited May 13, 2023).

for the child's medical stability and quality of life.[208] Like Virginia, physicians and hospitals participating in the program receive immunity from civil suits for the claim.[209]

After NICA's implementation, malpractice insurers resumed providing widespread coverage for obstetrical services, and obstetricians increased access to their services.[210] "Several [commentators noted] a causal link between NICA's introduction and [the re-stabilization of the obstetrical market]."[211] A 2015 report from the American Congress of Obstetricians and Gynecologists noted an average malpractice premium savings of $57,535 for obstetricians and gynecologists and $1,041 for all other physicians due to the program.[212]

According to the same report, the fund continues to be solvent and the savings over the tort system are dramatic.[213] Cases handled through the traditional court system yield jury awards that can exceed $100 million, while NICA's cases average $4.9 million over the child's lifetime.[214] Despite the dramatic difference in financial awards, NICA's participant families "generally report higher satisfaction rates" than families that "were eligible for NICA but [chose to pursue tort compensation]."[215]

Although a widespread no-fault compensation system appears unlikely in the United States, many states, including Pennsylvania, have instituted no-fault auto insurance and workman's compensation programs.[216] On the medical side, the National

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[208] *See id.* at 52.

[209] *Id.* at 4.

[210] Studdert, *supra* note 194, at 500.

[211] *Id.*

[212] AM. CONG. OF OBSTETRICIANS AND GYNECOLOGISTS DIST. XII FLA., NICA UPDATE 2015: THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS DISTRICT XII FLORIDA TASK FORCE REPORT ON THE FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION (July 2015), https://www.nica.com/wp-content/uploads/2021/09/ACOG-District-XII-Task-Force-Report.pdf.

[213] *Id.*

[214] *Id.*

[215] *NICA Responds to Miami Herald Series*, NICA (Apr. 8, 2021), https://www.nica.com/news/nica-responds-to-miami-herald-series/.

[216] Gary T. Schwartz, *Auto No-Fault and First-Party Insurance: Advantages and Problems*, 73 S. CAL. L. REV. 611, 661-62 (2000).

Vaccine Injury Compensation Program, or VICP, provides compensation to those injured by vaccinations as an alternative to the tort system.[217] Providers are granted limited civil immunity for administering vaccines that cause injuries.[218]

D. Implementing Existing Models into a Pilot Program

Like other states, Pennsylvania's tort system has historically failed to adequately control malpractice costs, broadly provide compensation for injured patients, and maintain stable levels of healthcare providers. To drive down malpractice premiums, attract the best and brightest providers, and fairly compensate the injured, Pennsylvania's stakeholders should facilitate the implementation of a prospective comparative pilot program in one of the state's major healthcare institutions.

Experimentation with alternative compensation models is not a novel concept. During the malpractice crisis of the 2000s, part of the federal government's proposed solutions included pilot programs.[219] A bipartisan Senate bill introduced in 2005 by Senators Max Baucus (D-MT) and Michael Enzi (R-WY) provided grants to help states study alternatives to the current tort structure.[220] In the House of Representatives, Representative Mac Thornberry (R-TX) introduced legislation to authorize the attorney general to promulgate awards to states to evaluate the feasibility of healthcare tribunals.[221]

Pennsylvania must take similar, bold measures to proactively implement solutions to fend off the next malpractice crisis and permanently repair a broken tort system. A voluntary program in a major healthcare system like the one implemented in Michigan can render valuable data. Following the crisis of the early 2000s, the

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[217] Harding v. Sec'y Dept. Health and Hum. Serv., 146 Fed. Cl. 381, 405 (2019).

[218] Peter H. Meyers, *Fixing the Flaws in the Federal Vaccine Injury Compensation Program*, 63 ADMIN. L. REV. 785, 788 (2011).

[219] Sheryl Gay Stolberg, *Next Steps on Obama's Medical Malpractice Offer?*, N.Y. TIMES (Sept. 10, 2009, 5:50 PM), Next Steps on Obama's Medical Malpractice Offer? - The New York Times (nytimes.com).

[220] Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. (2005).

[221] Medical Liability Procedural Reform Act of 2005, H.R. 1546, 109th Cong. (2005).

University of Michigan Health System (UMHS) adopted an injury compensation system that primarily focuses on medical error transparency with settlement offers.[222] UMHS strives to rapidly compensate patients that have been injured by medical errors outside of the traditional tort system.[223] Moreover, it aims to support injured patients and their families—whether or not they have been affected by these errors—and decrease patient injuries through abundant transparency.[224] Although it continues to evolve, the Michigan model has been noted as a successful alternative to the tort system that has allowed the UHMS to self-insure itself.[225]

Following UHMS's lead, Pennsylvania stakeholders can initiate a program with different details but similar goals as UHMS in one of Pennsylvania's largest healthcare systems. This pilot program should offer patients four options for any potential injury compensation. First, patients can elect to be treated under the current negligence-driven tort model. Second, patients can elect to obtain treatment under a negligence-driven tort model that imposes caps on awards. Third, patients can have the option of signing up for a binding, pre-dispute arbitration agreement. Fourth, patients can elect to participate in a no-fault compensation system. By analyzing the results of this pilot study, Pennsylvania policymakers can gauge whether to pursue alternatives to the current system.

This Comment suggests that the results of this pilot study should not be binding on patient awards. Patients can continue through the traditional tort system. Besides the difficulty in passing legislation to authorize making any of the alternatives binding, there would be a strong moral component against committing patients to a novel system before they undergo a medical procedure.

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[222] Richard C. Boothman et al., *Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions*, 28 FRONTIERS HEALTH SERV. MGMT. 13, 13 (2012).

[223] *Id.* at 17.

[224] *Id.*

[225] *Id.*

E. Potential Pitfalls and Proposed Solutions

Establishing a novel initiative with the potential to disrupt a malpractice market that is centuries old and has the backing of proponents with cash surpluses does not come without difficulties. Who will finance and staff such an operation? This next section proposes a few possibilities.

i. Financing and Staffing

Like other involved endeavors, funding often determines success. Financing a controversial program that has the potential to disrupt a massive market representing billions of dollars will not come easily. Asking taxpayers to foot the bill comes at great political risk to lawmakers, while seeking help from the private sector involves pulling at their already-strained purse strings. A compromise between private and public monies may satisfy both sectors without causing havoc on lawmakers' re-election hopes.

The first source of funding could come from the healthcare institution itself where the study will occur. Healthcare systems often face the prospect of decreasing reimbursement rates and potential penalties from government regulators. Running a pilot study with the ability to revolutionize the malpractice industry can create brand name value. Proposing investment in this program can be presented along with the potential to elevate the brand of an already established healthcare system.

Aside from the marketing value, obtaining funds from a healthcare institution can save this same establishment money in the future from lawsuits. If Pennsylvania can adopt one of the alternative reforms, all healthcare facilities and providers stand to gain from the decrease in settlement and jury awards. Also, the cost of fighting suits potentially decreases. The money saved from awards and litigation expenses can then be re-invested in the facility and patient care.

The next source of funding could arise from malpractice carriers. One of the major sources of premium increases results

from the unpredictability of plaintiff awards.[226] Further, the increasing size of judgments places a direct strain on the company's holdings. The potential future savings from successful tort reform presents a unique opportunity for a malpractice carrier, or multiple carriers, to invest in a project that may reward them with predictability and lower judgments in the future.

The final type of funding could come from the public sector. Federal grants represent an important financial source for research projects. The federal government spends approximately half a trillion dollars on research grants to local and state governments.[227] By tapping into this source, Pennsylvania lawmakers can bring dollars into their districts without directly using Pennsylvania taxpayer funds.

Besides financing, there is a concern for the need for human talent to carry out such an ambitious project. Involving a healthcare system with a major university affiliation provides experienced professionals, eager students, and gifted professors likely willing to involve themselves in this venture.

ii. The Aftermath

Following the completion of this multi-year study, a detailed analysis of its results should be undertaken to compare the number of awards given to injured patients, the amount given to injured patients, the speed of the process, and patient satisfaction with the procedure. This data can then be compiled against the results of actual patient recovery awards. By comparing the data sets, a final summary can be prepared to present to lawmakers.

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[226] *See* U.S. GOV'T ACCOUNTABILITY OFF., GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (June 2003), https://www.gao.gov/assets/gao-03-702.pdf.

[227] CONG. RSCH. SERV. FEDERAL GRANTS TO STATE AND LOCAL GOVERNMENTS: A HISTORICAL PERSPECTIVE ON CONTEMPORARY ISSUES (May 22, 2019), https://sgp.fas.org/crs/misc/R40638.pdf.

V. CONCLUSION

The next malpractice and healthcare provider crisis may already be present. If it is not, it will present itself in the next decade if history's lessons are valid. Although flying under the radar based on today's competing healthcare dilemmas, the next crisis presents an opportunity, if lawmakers have concrete evidence they can rely on to formulate a comprehensive legislative solution.

As discussed in Section II of this Comment, the atrophy of a state's healthcare providers can be detrimental to the health of its citizens. Moreover, the likely sufferers include the most vulnerable and innocent. All three major crises in the United States have greatly impacted this segment through their impact on gynecological and obstetrical care. Due to the high costs and risks of providing obstetrical care, ensuring that this population has sufficient healthcare providers that do not feel they are at financial risk of being driven out of their communities remains critical to the future of the state.

Although there likely will never be a perfect solution that appeases all stakeholders, providing lawmakers with scientific, unbiased data free of political spin will serve to direct the state's next solution and provide a reproducible model for the rest of the nation. Like California in the mid-1970s and Virginia and Florida in the late 1980s, Pennsylvania has a unique opportunity to transform its healthcare system by implementing a comparative prospective pilot study in one of its major healthcare systems that can provide valuable data for its lawmakers and for those around the country.