

NOTES

ONE SIZE DOES NOT FIT ALL: REALITIES OF PENNSYLVANIA'S MEDICAL LIABILITY SYSTEM—AND THE NEED FOR FINDING ALTERNATIVE JUSTICE FOR MEDICAL LIABILITY PLAINTIFFS

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ISSN 0041-9915 (print) 1942-8405 (online) • DOI 10.5195/lawreview.2020.782
<http://lawreview.law.pitt.edu>



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NOTES

ONE SIZE DOES NOT FIT ALL: REALITIES OF PENNSYLVANIA'S MEDICAL LIABILITY SYSTEM—AND THE NEED FOR FINDING ALTERNATIVE JUSTICE FOR MEDICAL LIABILITY PLAINTIFFS

Mary Caroline Nicholas*

This Note will examine issues surrounding medical liability cases, actions taken by the Pennsylvania state legislature attendant thereto, the consequences of those efforts, and the new alternative opportunities for medical malpractice plaintiffs to achieve corrective justice without litigation. This will be presented in five primary parts: Background on Medical Liability, History of Medical Malpractice Legislation in Pennsylvania, Changes in Pennsylvania Law, Effects of Change in Pennsylvania Law, and Alternative Remedies.

I. BACKGROUND ON MEDICAL LIABILITY

Dating back to the Code of Hammurabi, one of the oldest compilations of legal code, society has recognized medical malpractice to be a legal wrong, rather than the

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assumed risk of seeking health care.¹ The civil tort system has grown to encompass a variety of classifications including: negligence, professional negligence, recklessness, and intentional torts.² Medical malpractice, which is a type of professional negligence, occurs when physicians perform their employment with a higher standard of care than other nonprofessional employees.³ The driving forces behind the medical malpractice system are these longstanding social policies: “to deter unsafe practices, to compensate persons injured through negligence, and to exact corrective justice.”⁴

These goals, spearheaded by the patient-safety movement, are often the antithesis of medical malpractice litigation in practice.⁵ The traditional theory behind a malpractice system is that the threat of litigation will cause physicians to practice safer medicine.⁶ Therefore, intersecting with the three primary policies behind medical practice litigation is the concept of transparency, identified by the patient-safety movement.⁷ Transparency encompasses the fostering of discussions about medical mistakes and the subsequent preventative efforts to address these mistakes.⁸ But in practice, the inherent adversarial nature of tort law leads to less transparency between physicians and patients by assigning blame and asking physicians to open up and admit to errors with little promise of legal protection.⁹ Therefore, though the three primary purposes of professional liability claims appear valid on the surface, the realities of medical malpractice litigation prove the policy implications are quite off-target.¹⁰

¹ Joseph S. Kass & Rachel V. Rose, *Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs*, 18 *AMA J. ETHICS* 299, 299 (2016).

² *Id.*

³ *Id.*

⁴ David M. Studdert et al., *Medical Malpractice*, 350 *NEW ENG. J. MED.* 283, 283 (2004).

⁵ *Id.* at 287.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *See id.*

II. REALITIES OF MEDICAL MALPRACTICE LITIGATION

A. *Costs of Litigation*

The reality of medical malpractice litigation is that few claims ever reach trial, and even fewer conclude with a jury verdict.¹¹ The price of attorneys' fees and court costs for litigation generally are enough to dissuade many litigants across the legal system.¹² For example, when an attorney brings a medical malpractice claim, the out-of-pocket costs range from \$15,000–\$25,000 for settlement and nearly double if the client wishes to proceed to trial.¹³ Civil cases over medical liability issues generally involve lawyers who are hired by clients on a contingency-based payment system, where lawyers can only collect their fee if monetary damages are awarded.¹⁴ In most cases, contingency fees are anywhere from about 30%–40% of the awarded settlement.¹⁵ For example in a 30% contingency arrangement,

[a]ssume the case settles for \$100,000. The costs of the litigation were \$10,000. In such a case, the lawyer would be reimbursed for the costs of the litigation out of the settlement money, leaving \$90,000. The lawyer would then take the contingent fee of \$30,000. The plaintiff would be left with \$60,000.¹⁶

Because of this, many have criticized this system for discouraging meritorious claims for plaintiffs whose chances of high monetary recovery are low.¹⁷ Attorneys evaluate the case of each plaintiff by balancing: the costs of bringing the law suit, the estimations of the likelihood of success, and the potential reward.¹⁸ In gauging these factors, lawyers are likely to be inclined to accept the cases with more egregious damages and indisputable physician error.

¹¹ B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPEDICS & RELATED RES. 339, 343 (2009).

¹² SAMANTHA COULOMBE & BARRY BOUGHTON, PUB. CITIZEN, THE FACTS ABOUT MEDICAL MALPRACTICE IN PENNSYLVANIA 34 (2004).

¹³ *Id.*

¹⁴ Bal, *supra* note 11, at 344.

¹⁵ Andrew Suszek, *How Much Will It Cost to Bring a Medical Malpractice Claim?*, ALLLAW, <https://www.alllaw.com/articles/nolo/personal-injury/cost-bring-claim.html> (last visited Mar. 27, 2020).

¹⁶ *Id.*

¹⁷ Bal, *supra* note 11, at 344.

¹⁸ Studdert et al., *supra* note 4, at 284.

The realities of medical malpractice litigation show that the system is inherently unable to achieve the underlying social policies of “deter[ring] unsafe practices, . . . compensat[ing] persons injured through negligence, and . . . exact[ing] corrective justice.”¹⁹ Plaintiffs are not necessarily able to be made whole by monetary compensation for the wrongdoing, and fewer claims appear to lead to less deterrence against unsafe practices, decreased physician accountability, and fewer opportunities for corrective justice.²⁰

B. *Patient Plaintiffs Injured Without Compensation*

Whether it be because of the expense of bringing a medical malpractice claim, the factors that guide attorneys’ decision-making, or that plaintiffs never consider to file a claim, there remains a large percentage of plaintiffs who suffer injuries from medical negligence who go without recompense.²¹ Many have studied plaintiff records involving substandard care and compared them to the number of filed medical malpractice claims. One study found that, of “31,000 patient records from fifty hospitals in New York searching for injuries caused by substandard care . . . less than two percent of persons injured by negligence filed a claim.”²² Not to mention, those individuals who decide to pursue litigation face a “lengthy, expensive and inefficient process.”²³ Even when receiving a jury verdict, medical malpractice plaintiffs tend to only collect 60%²⁴ of their award following an allocation of money because of the expenses of litigation and attorneys’ fees. In addition, plaintiffs are rarely able to win at trial, “prevailing in only 21 percent of verdicts as compared with 61 percent of claims resolved out of court.”²⁵ Moreover, not only do patients who fail to pursue litigation lose any ability to gain monetary compensation, but they lose any opportunity to right the wrong or find relief in knowing the physician will not repeat the same mistake with future patients.

¹⁹ *Id.* at 283.

²⁰ Lydia Nussbaum, *Trial and Error: Legislating ADR for Medical Malpractice Reform*, 76 MD. L. REV. 247, 257 (2017).

²¹ *Id.* at 257–58.

²² *Id.* at 258.

²³ *Id.* at 259 (footnotes omitted).

²⁴ *Id.*

²⁵ David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2026 (2006).

It is worth noting, then, why plaintiffs commence medical malpractice litigation despite the high expense and low expectation of monetary reward. Though financial compensation and reimbursement for pain and suffering are substantial reasons for choosing to pursue litigation, more often patients pursue litigation in search of acknowledgement for the wrongdoing done against them and assurance that this harm will not be repeated in the future.²⁶ In addition, when asked what could have dissuaded individuals from pursuing litigation against a physician, most patients indicated that an explanation or apology, rather than litigation, would provide a greater sense of recompense.²⁷ Most patients take a claim to trial to uncover information and answers to questions about what transpired in their case and whether the malpractice could have been prevented.²⁸ Based on the three primary purposes of medical malpractice litigation, this would denote that compensation can refer to a financial remedy as well as receiving an explanation or apology from the physician.²⁹ However, with the lack of opportunity for financial compensation at the front end of litigation, fewer individuals are bringing suit, which leads to important information about a physician's practice remaining undiscovered, limiting the physician's accountability. In sum, a financial reward is not a guarantee, and choosing to file a medical malpractice action may not provide wronged patients the compensation they deserve or the other forms of justice they seek.

C. *Failure to Deter Unsafe Practices*

In order for physicians to be deterred from engaging in certain practices, there must be clear expectations and standards set for different practice areas. This is a challenging objective given that physicians' and medical experts' opinions on properly treating various medical conditions can vary widely.³⁰ Physicians with different opinions on treatment and differing review strategies for adverse events may produce varying determinations of negligence.³¹

²⁶ Nussbaum, *supra* note 20, at 259.

²⁷ Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 334 LANCET 1609, 1612 (1994).

²⁸ Nussbaum, *supra* note 20, at 260.

²⁹ See Studdert et al., *supra* note 4.

³⁰ Nussbaum, *supra* note 20, at 260.

³¹ Eric J. Thomas et al., *The Reliability of Medical Record Review for Estimating Adverse Event Rates*, 136 ANNALS INTERNAL MED. 812, 814 (2002).

There are also vast differences between specialties. More high-risk subspecialties that draw disproportionate numbers of malpractice claims depict medical malpractice as an unpredictable and unreliable process.³² The more physicians see the litigious process of medical malpractice as unpredictable and unreliable, the more the system deters open communication between physicians and patients. In fact, “routine physician-patient communication differs in primary care physicians with vs. without prior malpractice claims.”³³ For example, though many physicians tend to express a desire to apologize to a patient following an adverse outcome, “physicians tend to provide minimal information about what happened, what led to the error, or what might be done differently in the future; to choose their words carefully so as to avoid being explicit about the error.”³⁴ The lack of honest communication fails to provide many patients with the apology they are seeking from their physician that could prevent litigation.³⁵ Therefore, the medical liability system does not, in practice, show strong results in deterring certain physician practices. Instead, it appears that physicians begin to engage in defensive communication “primarily to reduce exposure to malpractice liability.”³⁶

In addition to a lack of communication, many experts fear that the medical malpractice system prevents physician accountability because it encourages defensive medicine. Defensive medicine can have both positive and negative connotations, depending on the circumstances.³⁷ For example, positive defensive medicine includes “performing unnecessary diagnostic tests and invasive procedures, prescribing unnecessary treatment and needless hospitalization,”³⁸ while negative defensive medicine includes “avoiding risky procedures on patients who could have benefitted from them, thereby excluding patients from treatment and

³² Nussbaum, *supra* note 20, at 260.

³³ Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553, 553 (1997).

³⁴ Jennifer Robbennolt, *Apologies and Medical Error*, 467 CLINICAL ORTHOPEDICS & RELATED RES. 376, 378 (2008).

³⁵ See Studdert et al., *supra* note 25, at 1612.

³⁶ Sergio Motta et al., *Medical Liability, Defensive Medicine and Professional Insurance in Otolaryngology*, 8 BMC RES. NOTES 343, 343 (2015).

³⁷ M. Sonal Sekhar & Navya Vyas, *Defensive Medicine: A Bane to Healthcare*, 3 ANNALS MED. & HEALTH SCI. RES. 295, 295 (2013).

³⁸ *Id.*

hospital admission.”³⁹ The concern in the context of medical liability law is that physicians are choosing courses of action that limit their potential for litigation instead of making decisions in the best interest of their patients.⁴⁰ Therefore, even though defensive medicine may be successfully dissuading the amount of medical malpractice lawsuits, it is not truly diminishing medical malpractice. To incentivize physicians to change their practices following an adverse outcome, other avenues could be utilized. For example, more open physician and patient discussions could provide not only recompense to the patient, but also the physician’s acknowledgement of responsibility and willingness to change their practice in the future.

D. *Following Legislative Action*

Legislation has focused primarily on the economic compensation prong of medical liability cases and has attempted to remedy these economic challenges within medical malpractice in Pennsylvania for decades. Concerns over whether patients are able to achieve compensation are balanced against the economic viability of insurance companies and drastic increase of insurance premiums as a result of an influx of medical malpractice litigation.⁴¹ Pennsylvania’s legislature has attempted to reform its tort law on multiple occasions.⁴² These reforms then impact a patient—wronged by medical negligence—and their ability to find justice in the tort system.

Two of the most recent legislative changes of methods of tort reform involved a heightened pleading requirement of a Certificate of Merit⁴³ prior to medical practice claims, as well as statute of limitations and discovery rule modifications under the Medical Care Availability and Reduction of Error (“MCARE”) Act in

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Kathryn Zeiler & Lorian Hardcastle, *Do Damages Caps Reduce Medical Malpractice Insurance Premiums?: A Systematic Review of Estimates and the Methods Used to Produce Them*, in RESEARCH HANDBOOK ON THE ECONOMICS OF TORTS 551, 551 (Jennifer Arlen ed., 2013), <https://pdfs.semanticscholar.org/146f/cd0e5d71e8b1ef3c84f6bd46964fa9baa214.pdf>.

⁴² See, e.g., ROGAN KERSH, THE PROJECT ON MED. LIAB. IN PA., THE POLITICS OF MEDICAL MALPRACTICE IN PENNSYLVANIA, 1975–2005, at 2 (2005), https://www.pewtrusts.org/~media/legacy/uploadedfiles/wwwpewtrustsorg/reports/medical_liability/politicsofmedmalinpakersh0206pdf.pdf (detailing Pennsylvania’s history of medical malpractice reform from 1970 to 2005).

⁴³ PA. R. CIV. P. 1042.3.

2002.⁴⁴ Following this, medical malpractice claims decreased due to increased expense and inefficiency.⁴⁵ These requirements for medical malpractice litigation, particularly the Certificate of Merit requirement, are discriminatory against those with a potentially valid medical malpractice claim resulting from physician negligence but with low economic damages and those who are unable to afford the costs and risk associated with paying for expert testimony evaluation.⁴⁶ With lower numbers of medical malpractice claims, there is the reality of less compensation to victims and a lack of physician accountability. Because of these present issues, alternatives to the tort system may need to be implemented in order to improve justice for victims of medical malpractice and increase physician accountability.

III. HISTORY OF MEDICAL MALPRACTICE LEGISLATION IN PENNSYLVANIA

The Pennsylvania legislature has engaged in periodic, wide-ranging legislation rather than gradual policymaking to combat the rise of insurance premiums as well as other issues associated with medical malpractice.⁴⁷ Beginning in the 1970s, Pennsylvania's attempts at reform have included Act 111 (1975), Act 135 (1996), and Act 13 (2002).⁴⁸ The effects of Act 13's amendments are what remain the law in Pennsylvania today.⁴⁹

A. *First Wave of Response*

The Pennsylvania legislature enacted the Health Care Services Malpractice Act (Act 111), in response to concerns about the decline of medical liability insurance availability and rising premiums.⁵⁰ Despite a strong push for a \$250,000 limit on damages, Act 111 ultimately did not include any damage cap measure, primarily due to a requirement that would have required the legislature to first amend the

⁴⁴ Medical Care Availability and Reduction of Error (MCARE) Act, 40 PA. CONS. STAT. § 1303.101 (2020).

⁴⁵ Mary Markle, Note, *How Affidavit of Merit Requirements Are Ruining Arizona's Medical Liability System*, 46 ARIZ. ST. L.J. 407, 416 (2017).

⁴⁶ Marshall Allen & Olga Pierce, *Patient Harm: When an Attorney Won't Take Your Case*, PROPUBLICA (Jan. 6, 2014), <https://www.propublica.org/article/patient-harm-when-an-attorney-wont-take-your-case>.

⁴⁷ KERSH, *supra* note 42, at 2.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.* at 8–9.

Pennsylvania Constitution.⁵¹ Because of this, Pennsylvania created one of the first patient-compensation funds, the Medical Liability Catastrophic Loss (“CAT”) Fund, succeeded by the MCARE Fund under Act 13 in 2002.⁵² The CAT Fund was designed to assist in providing liability coverage to health care providers that was unavailable on the private market.⁵³ However, despite the enactment Act 111, insurance availability and affordability issues remained at the forefront of worries for both patients and physicians.⁵⁴ Headlines became focused on warnings of “physicians retiring early, young doctors avoiding the Commonwealth, wasteful spending on ‘defensive medicine,’ and declining availability of ‘critical specialties’ such as neurosurgery and orthopedics.”⁵⁵

B. Second Wave of Response and Third-Current Wave

In the 1980–90s, healthcare provider premium rates increased upwards of thirty percent.⁵⁶ Physicians threatened mass walkouts calling for a second attempt to pass a bill capping non-economic damages for medical malpractice suits, with no success.⁵⁷ In response, Pennsylvania’s General Assembly passed Act 135, which provides for affidavits of non-involvement requiring medical malpractice suits to be dismissed if a physician swears under oath to their misidentification or noninvolvement in the case.⁵⁸ The Act also provided an expanded list of medical procedures requiring informed consent (*i.e.*, surgery, radiation and chemotherapy, and blood transfusions) and toughened standards for awarding punitive damages.⁵⁹ In response, a large push for patient safety legislation began after years of focus on liability premiums, damage caps, and economic concerns in medical malpractice.⁶⁰

⁵¹ *Id.* at 10–11.

⁵² *Id.* at 11.

⁵³ *Id.*

⁵⁴ *Id.* at 12.

⁵⁵ *Id.*

⁵⁶ *Id.* at 16.

⁵⁷ *Id.*

⁵⁸ See generally Health Care Services Malpractice Act of 1996, 40 PA. CONS. STAT. § 606, amended by 40 PA. CONS. STAT. §§ 1301.101–1301.1006 (1997).

⁵⁹ KERSH, *supra* note 42, at 22 tbl.2.

⁶⁰ *Id.* at 23.

Though none of the proposals were ultimately enacted by Pennsylvania legislature, a new concern for preventable death by physician error and quality of care emerged.⁶¹

Once again, Pennsylvania was experiencing sky-rocketing medical malpractice insurance premiums that began to threaten insurance providers' ability to remain financially viable.⁶² Though these concerns were echoed in other states around the country, Pennsylvania's insurance concerns remained particularly acute.

IV. CHANGES IN PENNSYLVANIA LAW

A. Act 13: The MCARE Act

To address the aforementioned mounting concerns, Pennsylvania passed the Medical Care Availability and Reduction of Error Act ("MCARE Act" or "MCARE") in 2002, which remains the controlling law today.⁶³ The MCARE Act created the MCARE Fund that "pays medical malpractice claims against providers who participate in the CARE Fund after the provider's primary insurance coverage is exhausted."⁶⁴ The MCARE Fund is only one of many other legal effects on medical malpractice litigation established by the MCARE Act. For example, the Act spurred: (1) changes to informed consent requirements, (2) expert witness qualifications, and the (3) discovery rule and collateral source rule.⁶⁵ All of the changes sought to decrease the amount of medical malpractice claims, through minimizing physician error or by providing other defendant-friendly procedural hurdles.

First, MCARE § 504 outlines the informed consent requirements placed on physicians. The Act states that "except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient's authorized representative" before: "(1) [p]erforming surgery (2) [a]dministering radiation or chemotherapy," or "(3) [a]dministering a blood transfusion."⁶⁶ This informed consent provision expanded the list of procedures and situations where informed

⁶¹ *Id.*

⁶² *Id.* at 24.

⁶³ *Id.* at 25.

⁶⁴ Ryan Hart, *A Grim Prognosis? The Collateral Source Rule in Pennsylvania Medical Malpractice Actions After the Affordable Care Act*, 121 PA. ST. L. REV. 529, 537 (2017).

⁶⁵ MCARE Act, 40 PA. CONS. STAT. § 1303.101 (2020).

⁶⁶ *Id.* § 1303.504(a).

consent was required. In addition, it broadened the description of what constituted effective informed consent.⁶⁷

Second, MCARE significantly changed the qualifications for expert witness testimony.⁶⁸ MCARE outlined that no person will be eligible to offer expert medical testimony in a medical malpractice action against a physician unless that person meets the education and training requirements set forth by the Act.⁶⁹ The expert testifying must: (1) possess an unrestricted medical license and (2) be engaged in or only retired within the past five years from active practice or teaching.⁷⁰ In addition, the testifying expert witness must be substantially familiar with the applicable standard of care for specific care at issue, practice in the same subspecialty as the defendant physician, and be board certified by the same or similar approved board as the defendant physician.⁷¹ These elements have not been without controversy within the courts. For example, in *Price v. Catanzariti*, a patient filed a medical malpractice claim against their podiatric surgeon, claiming the surgeon improperly performed surgery.⁷² The pivotal question in the case surrounded the expert witness selected by the plaintiff, an orthopedic surgeon, and whether he could be qualified as an expert witness under the MCARE Act, given that orthopedics is a subspecialty.⁷³ The court cited to *Wexler v. Hecht*, which found the standards of care for a podiatric surgeon and an orthopedic surgeon are substantially different.⁷⁴ However, the court in *Price* distinguished between the weight of the evidence and the admissibility of the evidence.⁷⁵ Therefore, because defendant was a podiatrist, not an orthopedic surgeon, the “certificate of merit pursuant to Pa. R.C.P. 1042.3, . . . [was] not required to meet the heightened standard for admission of expert medical

⁶⁷ *Id.* § 1303.504(b).

⁶⁸ *Update on Medical Malpractice in Pennsylvania Under the New Medical Care Availability and Reduction or Error Act*, FINDLAW (Jan. 17, 2017), <https://corporate.findlaw.com/litigation-disputes/update-on-medical-malpractice-in-pennsylvania-under-the-new.html>.

⁶⁹ 40 PA. CONS. STAT. § 1303.512(a).

⁷⁰ *Id.* § 1303.512(b)(1)–(2).

⁷¹ *Id.* § 1303.512(b)–(c).

⁷² *Price v. Catanzariti*, 138 A.3d 8, 9 (Pa. Super. Ct. 2016).

⁷³ *Id.* at 8–10.

⁷⁴ *Id.* at 10 (citing *Wexler v. Hecht*, 847 A.2d 95, 100 (Pa. Super. Ct. 2004)).

⁷⁵ *Id.* at 13.

testimony under section 512 of the MCARE Act.”⁷⁶ Although *Price* was appealed to the Pennsylvania Supreme Court and the order was vacated and remanded based on issues of waiver,⁷⁷ it demonstrates the existing uncertainties regarding the full application of certain medical malpractice litigation requirements.

Third, MCARE § 1303.508 altered the collateral source rule.⁷⁸ Traditionally, the collateral source rule states that “payments from a collateral source shall not diminish the damages otherwise recoverable from the wrongdoer.”⁷⁹ The MCARE Act creates a more defendant-oriented rule that prevents a plaintiff in a medical malpractice action from recovering past medical expenses or lost wages if the plaintiff’s health insurance already paid those expenses.⁸⁰

In addition, the MCARE Act modified the discovery rule exception to the statute of limitations. Traditionally, in Pennsylvania, plaintiffs were able to file suit within two years of the date when it was reasonable for them to have discovered the injury due to negligence of their physician.⁸¹ Under the MCARE Act, a medical liability action may not be filed more than seven years from the alleged incident, regardless of the time of discovery.⁸² Though the Act does find exceptions for injuries to minors and injuries caused by a foreign object unintentionally left in the body, there is no exception for failure to diagnose cases.⁸³ This alteration provides another example of the legislature’s attempt to minimize the amount medical malpractice cases in order to address rising insurance premiums without capping damages.

⁷⁶ *Id.* at 12.

⁷⁷ See *Price v. Catanzariti*, 158 A.3d 65 (Pa. 2016).

⁷⁸ MCARE Act, 40 PA. CONS. STAT. § 1303.508 (2002).

⁷⁹ *Johnson v. Beane*, 664 A.2d 96, 100 (Pa. 1995); see also RESTATEMENT (SECOND) OF TORTS § 920A(2) (AM. LAW. INST. 1979) (“Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor’s liability, although they cover all or a part of the harm for which the tortfeasor is liable.”).

⁸⁰ Ryan Hart, Comment, *A Grim Prognosis? The Collateral Source Rule in Pennsylvania Medical Malpractice Actions After the Affordable Care Act*, 121 PA. ST. L. REV. 529, 536 (2017).

⁸¹ *Colonna v. Rice*, 664 A.2d 979, 980 (Pa. Super. Ct. 1995); *Citsay v. Reich*, 551 A.2d 1096, 1097 (Pa. Super. Ct. 1988).

⁸² 40 PA. CONS. STAT. § 1303.513(a).

⁸³ *Id.* § 1303.513(b)–(c).

B. *Changes to Pennsylvania Rules of Civil Procedure—the Certificate of Merit*

Though the MCARE Act appears to be the predominant attempt made by the Pennsylvania legislature to impact the prevalence of medical malpractice litigation, in 2003, the year following MCARE's enactment, an equally impactful change was implemented by the Pennsylvania Rules of Civil Procedure § 1042.3.⁸⁴ This rule change, known as the Certificate of Merit requirement, was a further attempt by the Pennsylvania legislature to reduce the amount of medical malpractice claims within the state.⁸⁵ In practice,

a certificate of merit is a procedural requirement applicable in medical liability actions . . . [where] a defendant is not required to file an answer to the complaint until the certificate of merit is filed. . . . The purpose of the certificate of merit is to confirm that an appropriately licensed professional (certifying expert) has reviewed the medical records and supports the plaintiff's allegation that the medical care at issue fell below the applicable standards of care.⁸⁶

The certificate of merit requirement further separated medical profession liability claims from other types of injury-related claims.⁸⁷ In addition, this requirement is generally seen as one of the largest procedural hurdles that must be overcome in order to reach the alleged benefits of a successful medical liability claim.⁸⁸ This Certificate of Merit requirement goes hand-in-hand with the expert witness qualifications of the MCARE Act. For example, though the certifying expert does not have to be the expert that ultimately testifies at trial, the certifying expert must nonetheless meet the same qualifications outlined in § 512 of the MCARE Act.⁸⁹

⁸⁴ PA. R. CIV. P. 1042.3; *see also* David Goguen, *Medical Malpractice Lawsuit Requirements in Pennsylvania*, LAWYERS.COM (Feb. 12, 2019), <https://www.lawyers.com/legal-info/medical-malpractice/medical-malpractice-basics/medical-malpractice-lawsuit-requirements-in-pennsylvania.html>.

⁸⁵ PA. R. CIV. P. 1042.3 (carrying the title "Certificate of Merit").

⁸⁶ Joseph L. Hoynoski III, LEGAL INTELLIGENCER, HEALTH CARE SUPPLEMENT, THE CERTIFICATE OF MERIT STATUS QUO HAS TO GO 1 (2015), https://marshalldennehey.com/sites/default/files/pdf-articles/O%20346%20by%20J.%20Hoynoski%20%282.17.15%29%20The%20Legal_0.pdf.

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

The heightened expense of providing a certificate of merit can reach up to several thousand dollars.⁹⁰ This is an example of an upfront litigation cost that must either be funded by the client or the attorney in anticipation of a payout in a settlement or favorable verdict.⁹¹ If an attorney is dubious as to the likelihood of a favorable verdict or the possibility of large settlement, the attorney may be reluctant to up front the starting costs for the certifying expert.⁹² If this is the case, and the client is unable to afford the payment themselves, the client will be unable to proceed with litigation regardless of the validity of their claim.⁹³ Though the intention of this heightened pleading requirement might have initially been to dissuade frivolous medical liability claims,⁹⁴ in practice it can cause a significant reduction in valid claims by patients who are unable to afford this newfound expense of litigation.⁹⁵ In addition, because the expert certification is only one of the many expenses of medical liability cases, there is greater reluctance on the plaintiff's attorneys in the profession to risk excess expense without ascertaining a level of assurance of a favorable outcome.⁹⁶

Other states, including Oklahoma, Ohio, Arkansas, and Washington have attempted to, or successfully did, strike down their certificate of merit provisions on equal protection grounds.⁹⁷ However, Pennsylvania's statutory requirement for a certificate of merit remains intact. The only recent successful challenge in court was in *Bruno v. Erie Insurance Co.*, where the court held that "a certificate of merit is not . . . required for professional liability actions brought by plaintiffs who are not

⁹⁰ Anthony Ben Schwartz, *How Much Does it Cost to Prosecute a Medical Malpractice Case?*, SCHWARTZ & SCHWARTZ (Nov. 30, 2016), <https://www.schwartzandschwartz.com/cost-prosecute-medical-malpractice-case/>.

⁹¹ *Id.*

⁹² *Certificate of Merit Requirement in a Medical Malpractice Case*, ALLLAW, <https://www.alllaw.com/articles/nolo/medical-malpractice/certificate-of-merit-requirement.html> (last visited Apr. 10, 2020).

⁹³ *Id.*

⁹⁴ Catherine T. Struve, *Expertise and the Legal Process*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* 173, 174 (William M. Sage & Rogan Kersh eds., 2006).

⁹⁵ *Id.*

⁹⁶ Catherine T. Struve, *Improving the Medical Malpractice Litigation Process*, 23 *HEALTH AFF.* 33, 36 (2004).

⁹⁷ AMY WIDMAN, *CTR. FOR JUSTICE & DEMOCRACY, CERTIFICATES OF MERIT AND MEDICAL MALPRACTICE: WHAT'S AT STAKE FOR STATES 3* (2009), <https://centerjd.org/content/certificates-merit-and-medical-malpractice-whats-stake-states>.

patients or clients of a licensed professional.”⁹⁸ However, this limitation does not affect individuals filing claims against professionals in the health care profession, given that the client is almost always the patient who was wronged, or family member filing a claim on their behalf.

C. *Challenges Under Current Law*

The legislative initiatives enacted to combat rising premiums and the overall expense of medical malpractice litigation might have been successful in lowering the number of medical malpractice lawsuits, but that does not in fact lower the prevalence of medical malpractice. In other words, though the number of individuals who file their claims with the court or seek legal advice has substantially diminished, these efforts have not impacted the number of wronged patients who have fallen victim to medical malpractice. There are two groups of individuals that suffer from efforts to minimize their opportunity for justice in medical malpractice litigation: (1) individuals with insufficient monetary damages to justify an attorney taking their case and (2) individuals with a potentially valid claim and adequate damages but with an inability to make the investment in an attorney and pay legal fees associated with acquiring a certificate of merit to pursue the case.⁹⁹ These subgroups of individuals represent two portions of the population who are unaffected by the supposed assistances of medical malpractice legislation. Therefore, unless one is able to afford the upfront costs or there is a high likelihood of a large sum of damages, attorneys will be skeptical and litigation is not likely to be an option. For the subset of the population who does not seek redress in the tort system for medical wrongs, they are not advancing the primary goals of justice and compensation for victims or the inducement of physicians and hospitals to take necessary precaution measures in future dealings.¹⁰⁰

V. EFFECTS OF CHANGE IN PENNSYLVANIA LAW

A. *Studies Following Changes in Pennsylvania Law*

Pennsylvania’s adoption of the MCARE Act, as well as their modification of the Rules of Civil Procedure, have had a statistically significant impact on medical malpractice litigation. In the decade following the implementation of these reforms,

⁹⁸ Bruno v. Erie Ins. Co., 106 A.3d 48, 74 (Pa. 2014).

⁹⁹ Allen & Pierce, *supra* note 46.

¹⁰⁰ Joanna Shepherd, *Uncovering the Silent Victims of the American Medical Liability System*, 67 VAND. L. REV. 151, 158 (2014).

medical malpractice filings have dropped from 2,904 in 2002 to 1,463 in 2014.¹⁰¹ In addition to this near 50% drop in filings over 10 years, in 2014 only 129 medical malpractice claims resulted in jury verdicts and 98 of those 129 verdicts favored the defendant's case.¹⁰² This is in contrast to the 326 verdicts reached in 2003, prior to the enactment of legislative reforms.¹⁰³ In Allegheny County specifically, in 2014, of the seventeen cases resulting in a jury verdict, four were in favor of the plaintiff.¹⁰⁴ The statewide downward trend in medical malpractice claims has continued to the present. In 2017 and 2018, only 102 and 106 medical liability cases reached a jury verdict, respectively.¹⁰⁵ This marks an additional nearly 10% drop from the previous year.

The MCARE Act and the certificate of merit requirement were originally implemented to fight the intertwined issues of overwhelming medical malpractice insurance rates and the threat of large jury awards. The expense of medical liability litigation drove legislatures to enact these reforms to decrease the quantity of claims brought to court. However, as noted above, the purpose of medical liability litigation is not solely for financial compensation of wronged patients, but also for “deterrence against unsafe practices . . . and exact corrective justice.”¹⁰⁶ With the number of medical liability cases plummeting, the price of financially saving physicians and insurance companies will come at the cost of successful deterrence against unsafe practices and corrective justice for patients.

In contrast to the 129 medical malpractice claims that resulted in 2014 jury verdicts, the *Journal of Patient Safety* estimates “between 210,000 and 440,000 patients each year who go to the hospital for care suffer from some type of

¹⁰¹ Bill Toland, *Pennsylvania Med-Mal Filings at 14-Year Low, Docs on the Rise*, PITTSBURGH POST-GAZETTE (May 17, 2015), <https://www.post-gazette.com/business/healthcare-business/2015/05/17/Pa-med-mal-filings-at-14-year-low/stories/201505170088>.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ UNIFIED JUDICIAL SYS. OF PA., MEDICAL MALPRACTICE JURY VERDICTS: JANUARY 2017 TO DECEMBER 2017, <http://www.pacourts.us/assets/files/setting-771/file-7457.pdf?cb=e4f49b> (last updated Feb. 19, 2019); UNIFIED JUDICIAL SYSTEM OF PENNSYLVANIA, MEDICAL MALPRACTICE JURY VERDICTS: JANUARY 2018 TO DECEMBER 2018 (2019), <http://www.pacourts.us/assets/files/setting-771/file-8223.pdf?cb=2baa9d>.

¹⁰⁶ Bashir Mamdani, *Medical Malpractice*, 1 INDIAN J. MED. ETHICS 57, 57 (2004).

preventable harm that contributes to their death.”¹⁰⁷ These numbers place medical errors as the third leading cause of death following heart disease and cancer.¹⁰⁸ The contrast between these numbers indicates that while medical liability claims may be plummeting and relieving financial burdens on insurance companies, thousands of patients suffering from preventable harm are not deriving any benefits of the existing tort system. The solution then could lay outside the tort system all together, and may not be to require certificates of merit to file claims or to legislate damage caps.

VI. ALTERNATIVE REMEDIES

There are two possible ways for medical malpractice plaintiffs to garner a sense of justice for being wronged by the medical profession without the need for litigation. These include an alteration to the Pennsylvania Rules of Evidence regarding the admissibility of physician apology, and a communication resolution program to establish a more efficient and transparent means to disclose information and be compensated for patients’ adverse medical outcome.

A. *Change to the State Apology Laws and Rules of Evidence*

As noted above, when asked, many patients indicated that an explanation or an apology regarding their medical outcome would minimize their likelihood of pursuing litigation.¹⁰⁹ However, even though many patients would have their frustrations eased with a simple apology and physicians “may feel the need to apologize after an adverse medical event,” the reality is that “physicians’ gut instincts to apologize are often hampered by the fear that their statements will be used against them in court.”¹¹⁰ This common sentiment amongst physicians led the Pennsylvania legislature to enact the Benevolent Gesture Medical Professional Liability Act in 2013.¹¹¹ This legislation followed behind over thirty other apology laws enacted

¹⁰⁷ Marshall Allen, *How Many Die From Medical Mistakes in U.S. Hospitals?*, NPR (Sept. 29, 2013), <https://www.npr.org/sections/health-shots/2013/09/20/224507654/how-many-die-from-medical-mistakes-in-u-s-hospitals>.

¹⁰⁸ *Id.*

¹⁰⁹ Vincent et al., *supra* note 27.

¹¹⁰ Erika R. Davis, Note, *I’m Sorry I’m Scared of Litigation: Evaluating the Effectiveness of Apology Laws*, 3 TENN. STUDENT LEGAL J. 70, 71 (2016).

¹¹¹ See 35 PA. CONS. STAT. §§ 10228.1–10228.3 (2020).

across the country.¹¹² The purpose of these laws are to protect certain actions and statements by the physician to the patient following medical error in an effort to minimize the pitting of the doctor and the patient against one another.¹¹³ Though the purpose behind these laws are the same, there can be variations in the language of the text that alter the ultimate scope of the law. Apology laws are broken into *partial* and *full* variations.¹¹⁴ For example, states such as Colorado and Connecticut enacted full apology laws thereby including in their law protections shielding physicians from admissions of fault.¹¹⁵ Pennsylvania's law protects "[a]ny action, conduct, statement, or gesture that conveys a sense of apology, condolence, explanation, compassion or commiseration emanating from human impulses."¹¹⁶ Pennsylvania, unlike Colorado and Connecticut, does not shield physicians from apologetic statements indicating an acknowledgement of fault regarding the outcome. Though seemingly similar, the difference between these two variations of the law can have a substantial impact on the need for subsequent medical malpractice litigation.

To understand the discrepancy between the full and partial apology laws, what makes an apology effective at deterring medical malpractice litigation must be examined. As noted, "patients often sue their doctors out of anger, or as a way to receive information about what happened to them."¹¹⁷ If doctors are able to more effectively convey an apology with additional adequate disclosure of the circumstances, patients may not feel so inclined to proceed with litigation. An "effective apology" is defined as a "statement by an offender to the offended saying the offender acknowledges responsibility for an act and also expresses regret for that act to the offended individual."¹¹⁸ Because of this, offenders enter a state of vulnerability through their admission of fault, therefore making an apology effective.¹¹⁹

¹¹² Alicia Gallegos, *Pennsylvania Joins States with 'I'm Sorry' Laws*, CHEST PHYSICIAN (Oct. 30, 2013), <https://www.mdedge.com/chestphysician/article/78599/health-policy/pennsylvania-joins-states-im-sorry-laws>.

¹¹³ *Id.*

¹¹⁴ See Vincent et al., *supra* note 27, at 85–86.

¹¹⁵ See Gallegos, *supra* note 112.

¹¹⁶ 35 PA. CONS. STAT. § 10228.3 (2020).

¹¹⁷ Davis, *supra* note 110, at 78.

¹¹⁸ *Id.* at 73–74.

¹¹⁹ *Id.* at 74.

An effective apology consists of four primary components.¹²⁰ These include “(1) acknowledging and accepting responsibility for the offense; (2) expressing remorse with forbearance, sincerity, and honesty; (3) explaining the understanding of the offense; and (4) willingness to make reparations.”¹²¹ The first component of acknowledging and accepting responsibility for the offense, though included in statutes similar to those in Colorado and Connecticut, is absent in the Pennsylvania’s apology law.¹²² Acknowledging fault will generally show patients an acceptance of responsibility and therefore a willingness to make a cognizant change to the unsafe practice in the future, and deterrence against unsafe practices is one of the inherent policy goals of medical malpractice litigation.¹²³ However, even with the attempted protections of partial apology laws, “the driving force behind doctors’ unwillingness to communicate with patients about medical errors is presumably a concern about the confidentiality and legal discoverability of the information they convey.”¹²⁴ It is ironic that if state apology laws are crafted to work as intended, physicians would be less susceptible to the litigation they seek to avoid by withholding their apology.¹²⁵ Studies on effective apologies law and states with more physician disclosure and transparency, show that “anger and need for more information may be subdued, litigation may be reduced, and settlement may be promoted when the injured individual seeks a legal remedy.”¹²⁶ Therefore, in addition to an attempt to completely deter patients from seeking litigation, for those cases that do result in a medical malpractice claim, a full disclosure and effective apology can make a patient more willing to settle rather than pursue their claim throughout the long process of trial.¹²⁷

Therefore, an ultimate solution for Pennsylvania, would be to alter the current Benevolent Gesture Act from a partial to full apology law. A change to the Federal

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² See 35 PA. CONS. STAT. § 10228.3 (2020).

¹²³ Mamdani, *supra* note 106, at 57.

¹²⁴ Davis, *supra* note 110, at 78.

¹²⁵ See generally Benjamin Ho & Elaine Liu, *Does Sorry Work? The Impact of Apology Laws on Malpractice*, 43 J. RISK & UNCERTAINTY 141, 141–67 (2011).

¹²⁶ Davis, *supra* note 110, at 79.

¹²⁷ *Id.*

Rules of Evidence (“FRE”) could ultimately effectuate this change.¹²⁸ The ideal rule would reflect the full apology law enacted by the Colorado legislature stating: “[A]ll statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense benevolence . . . shall be inadmissible as evidence of an admission of liability.”¹²⁹

Because states generally follow the rules proposed in the FRE, this approach would have a greater chance at impacting this change across many different states.¹³⁰ This rule would join the five other specialized relevance rules in the FRE: 407, 408, 409, 410, and 411.¹³¹ Each of these rules are a reflection of public policy rationales to “discourage bad behavior, incentivize good behavior, and foster and protect the positive side of human nature.”¹³² For example, FRE 407 states that “[w]hen measures are taken that would have made an earlier injury or harm less likely to occur, evidence of the subsequent measures is not admissible to prove: negligence [or] culpable conduct.”¹³³ The rationale behind this rule is to incentivize people to take subsequent remedial measures to prohibit injury from occurring again in the future. If individuals could have their subsequent actions following a harm used against them, they would be less inclined to take precautions.¹³⁴

Similarly, an alteration to the FRE to include protection for physicians in their efforts to apologize and disclose the circumstances of an unexpected adverse outcome to a patient will incentivize this type of behavior rather than leave physicians fearful of redress through litigation. Failing to include a full protection for physicians in their efforts to apologize to patients is the equivalent of punishing a homeowner for putting up a fence after their dog ran out and bit a passerby, which would be protected under FRE 407. Following this logic, the homeowner would refuse to take a measure to protect the next passerby and risk a second attack out of fear that their subsequent remedial measure would be used as an admission of culpability at trial. To incentivize the positive behavior of providers, there could either be an addition to the FRE with the expectation of its implementation in both the Commonwealth of Pennsylvania and other states, or the Pennsylvania legislature

¹²⁸ *Id.* at 98.

¹²⁹ COLO. REV. STAT. § 13-25-135(1) (2020).

¹³⁰ *See* Davis, *supra* note 110, at 98–99.

¹³¹ *Id.* at 99.

¹³² *Id.*

¹³³ FED. R. EVID. 407.

¹³⁴ *Id.* cmt.

can amend the current partial apology law to mirror that of Colorado. Whichever avenue is chosen, the theory is that the more protections afforded to physicians in their attempts to apologize and engage in full disclosure to patients, the less likely patients are to file medical malpractice claims against their provider out of anger or for the primary purpose of seeking information regarding their case.

B. Communication and Resolution Programs

Changing the FRE will attempt to both minimize the total number of medical malpractice claims filed as well as meet the goal of deterring physicians from certain practices by allowing them to accept responsibility for unwanted outcomes. But in addition to this avenue for change, some state legislatures have implemented Communication and Resolution Programs (“CRPs”). CRPs seek to “address the problems of uncompensated patient injuries, poor communication between patients and providers, and the missed opportunities to deter future medical mistakes.”¹³⁵ The CRP model unites injured patients, their families, and the physician for a voluntary discussion regarding the adverse outcome.¹³⁶ These new programs seek to change how physicians and patients deal with unfavorable outcomes by “prioritiz[ing] transparency over secrecy with a focus on preventing system errors rather than finding individual fault.”¹³⁷

The adversarial tort system is founded on the idea of finding or attributing fault to one party or another. Particularly in medical malpractice claims, once a patient files their suit against their provider the endgame becomes finding fault within the physician’s practice or decision-making. Because of this, the patient safety movement shifted their sights to focus on how to truly prevent patients being harmed by preventable medical error.¹³⁸ The question then became, what is the best way to prevent errors and encourage early communication and provide patients adequate compensation¹³⁹ without the adversarial process.

Before understanding the procedure of CRPs, it is helpful to understand the theory behind their inception. One of the primary theories behind CRPs is to shift the focus from individual fault to system failures as a whole.¹⁴⁰ This solution would

¹³⁵ Nussbaum, *supra* note 20, at 283.

¹³⁶ *Id.* at 290.

¹³⁷ *Id.* at 282.

¹³⁸ *Id.* at 283–84.

¹³⁹ *Id.* at 284.

¹⁴⁰ *Id.* at 285.

depart from the current medical liability system that is founded on placing blame on an individual provider. The CRP process involves seven missions acting together:

- 1) reporting incidents of harm immediately;
- 2) conducting a rapid investigation of what happened;
- 3) sharing a full and complete explanation about the event with the patient and family;
- 4) providing psychosocial support for the patient, family and involved clinicians;
- 5) offering apologies;
- 6) proactively offering compensation for care that was found to be below the standard of care; and
- 7) ensuring that lessons are learned to prevent recurrences.¹⁴¹

These missions are accomplished when the protocol of the CRPs is adhered to, and understood, and the implementation is prioritized by the corporate entity.¹⁴² For example, the CRP protocol involves operational steps including, the initial response, patient safety and quality improvement activities, continued patient engagement and movement toward resolution, and post-event dissemination of patient safety and quality improvement lessons learned.¹⁴³ Under these operational steps, following a recognition of an adverse event, the institution must be immediately informed via official report.¹⁴⁴ Also engagement with the patient and family must occur as soon as possible to establish priorities and expectations.¹⁴⁵ The CRP protocol also requires that the plans for preventing recurrences of the event must be developed and implemented, and the institutions must have a discussion with the patient and family

¹⁴¹ COLLABORATIVE FOR ACCOUNTABILITY & IMPROVEMENT, COMMUNICATION AND RESOLUTION PROGRAMS (CRPs): WHAT ARE THEY AND WHAT DO THEY REQUIRE? 1, http://communicationandresolution.org/pix/Collaborative_CRP_Essentials.pdf (last visited Mar. 28, 2019) [hereinafter CRPs: WHAT ARE THEY?] (“Communication and Resolution Programs (CRPs) are a principled, comprehensive, and systematic approach for responding to unintended patient harm.”).

¹⁴² *Id.*

¹⁴³ *Id.* at 2.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

to share results from analysis to prevention plans.¹⁴⁶ This information must then be shared with other healthcare institutions.¹⁴⁷

It is important to note that patients remain able to seek legal representation at any time,¹⁴⁸ unless their final compensation offer is contingent on their release of future claims.¹⁴⁹ However, as discussed above, litigation can be an expensive and lengthy process that is not always likely to result in the outcome the patient seeks. Therefore, CRPs offer a more efficient way to have patients' voices heard. They also allow those patients the comfort of knowing that there are actions being taken to acknowledge a system failure and initiate change to limit this failure in the future. However, in order for these programs to be successful, senior leaders within the sponsoring institution (*i.e.*, healthcare organizations or malpractice insurance companies)¹⁵⁰ must establish commitment to the CRP and provide the "necessary financial, personnel, and other resources to support the CRP."¹⁵¹

There are two primary models of CRPs; the "early settlement model" and the "limited reimbursement model."¹⁵² In the early settlement model, the program includes many of the practices outlined above. The process begins with the adverse outcome being reported by hospital staff or the patient.¹⁵³ The trained CRP staff will then investigate to determine whether a system error occurred and, if there was an error, the cause of that error.¹⁵⁴ Then the CRP staff will meet with the patient and "discuss the results of the investigation, explain what happened, admit any errors, and apologize for injuries caused."¹⁵⁵ The primary element of the settlement model is that if an investigation uncovers an error, the hospital will negotiate with a patient to reach a mutually agreed upon compensation.¹⁵⁶ The CRP staff will determine a

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ See Nussbaum, *supra* note 20, at 290.

¹⁵⁰ *Id.* at 289; see CRPs: WHAT ARE THEY?, *supra* note 141, at 2–3.

¹⁵¹ See CRPs: WHAT ARE THEY?, *supra* note 141, at 3.

¹⁵² See Nussbaum, *supra* note 20, at 290.

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

compensation amount by assessing what the traditional litigation damages would be or what would be required to meet the needs of the patient.¹⁵⁷ This compensation, as noted above, may require the patient to waive any future claims against the hospital or physician,¹⁵⁸ unless the compensation is only reimbursing for small expenses such as waiver of professional fees or hotel bills.¹⁵⁹ However, if no error is identified, there will be no offer for compensation.¹⁶⁰ One of the benefits of this type of CRP model, on the providers' side, is that in many of the early settlement programs, the error will not be disclosed to the National Practitioner Databank ("NDPB").¹⁶¹

The second CRP model is the "limited reimbursement" model. The limited reimbursement model is by definition more "limited" than the early settlement model. For example, "cases are excluded from CRP if the patient has experienced severe injury or if the family has taken any steps toward litigation."¹⁶² In other words, this model is reserved for the more simple, straightforward cases. For the cases that are accepted, the CRP staff will determine whether the adverse outcome was due to the medical care provided or from the patient's own underlying condition, but there is no investigation into systematic fault or error.¹⁶³ There also is much less discussion and disclosure between the investigative personnel and the patients themselves. If it is found that compensation is necessary, payouts are capped at \$30,000.¹⁶⁴ Furthermore, providers may opt to waive their medical bills, and unlike the early settlement model, the patient will not be required to release their right to sue by accepting the compensation, unlike the early settlement model.¹⁶⁵ However, similar

¹⁵⁷ Michelle M. Mello et al., *Communication-and-Resolution Programs: The Challenges and Lessons Learned from Six Early Adopters*, 33 HEALTH AFF. 20, 22 (2014).

¹⁵⁸ See Nussbaum, *supra* note 20, at 290.

¹⁵⁹ See Mello et al., *supra* note 157, at 21.

¹⁶⁰ See Nussbaum, *supra* note 20, at 290.

¹⁶¹ See Mello et al., *supra* note 157, at 22. Established by Congress in 1986, "[t]he National Practitioner Data Bank (NPDB) is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers." *About Us*, NAT'L PRACTITIONER DATA BANK, <https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp> (last visited Nov. 8, 2020) ("The National Practitioner Data Bank is a limited-access federal repository for adverse information about health care providers, such as malpractice awards.").

¹⁶² See Mello et al., *supra* note 157, at 21.

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

to some models of the early settlement CRP, because there are no written claims by the patients in limited reimbursement models, in no circumstance will a payout be reported to the NPDB; this is not the case in every early settlement model.¹⁶⁶

These models, similar to other alternative models to the tort system, are not without their critics. Many believe that as patients become aware of certain systematic errors through their disclosure with CRP personnel and open discussions with providers, they will be more inclined to take that information and file a medical malpractice claim.¹⁶⁷ Because of this, two main hurdles arise: physicians are unable and unwilling to fully educate themselves on the CRP program and physicians remain skeptical about the CRP's effectiveness. These obstacles are prevalent throughout many of the noted efforts made to address issues with medical malpractice. In discussing different state's apology laws, many issues surrounded physician's unwillingness to trust that the law will truly protect their statements from the wrath of litigation (though a valid concern in states with partial apology laws).¹⁶⁸ Overcoming these hurdles will require more research and education on the best models of CRPs as well as other alternatives to medical malpractice litigation.

VII. CONCLUSION

The purposes behind the medical malpractice classification of tort litigation are to deter unsafe physician practices, find compensation for the injury, and exact corrective justice.¹⁶⁹ And though certain patients that have suffered from clear physician error or that experience high monetary damages are able to achieve adequate compensation through the tort system, this is not the case for a large percentage of patients. Many of those with valid claims who seek monetary compensation for lost wages or medical expenses are unable to receive compensation if their damages do not reach a certain threshold desired by medical malpractice attorneys.¹⁷⁰ In addition, lack of transparency and inadequate apologies by physician to patients following adverse outcomes lead to resentment of the medical profession, a greater inclination to sue for information and a desire for retribution against seemingly unapologetic physicians.¹⁷¹

¹⁶⁶ *Id.* at 21–22.

¹⁶⁷ See Nussbaum, *supra* note 20, at 291.

¹⁶⁸ *Disclosure of Errors*, PATIENT SAFETY NETWORK, <https://psnet.ahrq.gov/primer/disclosure-errors> (last updated Sept. 2019).

¹⁶⁹ Studdert et al., *supra* note 4, at 283.

¹⁷⁰ Nussbaum, *supra* note 20, at 257–58.

¹⁷¹ See Davis, *supra* note 110, at 79.

There are alternative options to establish a sense of justice for patients with valid medical malpractice claims that do not meet the necessary thresholds to be compensated or receive recompense in the tort system. States, including Pennsylvania, can choose to implement changes to apology laws or rules of evidence or elect to initiate early dispute resolution programs such as CRPs. In doing so, the theory is that patients will experience a sense of justice and feel compensated through having their grievances heard and receiving an acknowledgement that they were wronged. Legislative efforts in Pennsylvania prove a level of awareness of the notion that the current system is not without its flaws. However, the yardstick with which we measure the success of legislative efforts cannot be the decrease in medical liability claims filed. Simply because the claim numbers decrease does not speak to the lessening of the number of patients that are harmed by physician negligence and error. The Pennsylvania legislature may be well-intentioned in their efforts to decrease medical malpractice claims, but people would be best served by focusing more keenly on strategies to minimize medical malpractice.