Should there be specialty courts for medical malpractice litigation?

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Abstract
Medical malpractice suits consume time, money and energy. They strike fears of nightmarishly lengthy, complex litigation in the minds of health care providers. Ill or injured patients filing such suits feel wronged, unsure of what really happened and desperately seek justice and compensation. The current tort system with jury trials, in place in America for over 200 years, is cumbersome, slow, and yields often unpredictable results. Establishing working judicial standards of what constitutes malpractice in specific clinical situations is difficult in the existing system. Specialty health care courts have been proposed as an alternative. In this paper, I look at the scope of the current problem in terms of numbers of suits, costs – both economic and non-economic – and the reality of the current system versus what it is supposed to do. Who currently benefits and which injured parties are left behind are discussed, as are jury limitations. Other examples of specialty courts, such as Delaware’s Court of Chancery for business and the Workman’s Compensation system, will be discussed as precedents for an analogous system for health care. This lays the foundation for a rationale for healthcare specialty courts and a discussion of some proposed systems. Advantages and disadvantages of health care courts are reviewed.

Scope of the problem
Frequency of suits and effects on practice
The American medical liability system is a huge system in terms of size and cost. Estimates of 2008 dollar costs were approximately $55 billion,1 including not only direct payments and legal expenses but also, more importantly, so-called “defensive medicine,” which is medicine practiced in a manner that may not be cost-effective or efficient but which helps avoid liability by, among other things, ordering diagnostic tests to “rule out” conditions. Defensive medicine specifically involves a focus on anticipating legal liability and trying to protect against it. It has become the de facto “standard operating procedure” in most American practices because medical malpractice liability concerns are so commonplace and the threats are real. According to a New England Journal of Medicine study from Harvard that was published in 2011, physician risk of lawsuit averages 7% per year; specialties such as general surgery average 16%, and pediatrics, 3%.2 A study by Seabury indicated that physicians on average spend 11% of their forty-year career with an open malpractice claim, some much more.3 It is estimated that a physician is likely to be sued several times in his career. Such suits take years to resolve and carry heavy financial as well as emotional costs for both defendant and plaintiff.4 Such lawsuits are the specialty focus, or at times, the sole focus of many firms. Advertising by firms is quite commonplace and permeates television, billboards, and phone directory advertising. Lawyers generate the largest number of telephone directory ads, and many of those are personal-injury-related. Most western industrialized nations, including Canada, do not have the medical liability volume in absolute or relative
terms that the United States does. Despite current suit volume, it is believed that the number of suits filed is actually only a small fraction of those that could be filed for injury due to negligent treatment.

**Insurance costs and effect on physician supply**

Liability insurance premiums for physicians, especially for certain high-risk specialties such as obstetrics and neurosurgery that are highly affected by medical liability lawsuits, impact physician supply. Any attempt to measure reforms or improvements to the system must look at the effects on quality of care, indemnity payments, litigation administrative costs, liability insurance costs, defensive medicine impact, and physician supply.\(^5\)

Medical liability premiums vary widely and are usually related to the medical liability climate and risk of a particular specialty and region. In a 2011 survey, a general surgeon paid $190,926 in Dade County, Florida, $15,300 in Fresno County, California, and $11,306 in Minnesota. An obstetrician paid $201,808 in Nassau County, New York, $15,484 in Fresno County, California, and $22,486 in North Dakota.\(^6\) The California Medical Injury Compensation Reform Act (MICRA) is believed to have lead to lower rates in California compared to other states, but rates in California vary widely within the state. For example, general surgeons in Los Angeles and Orange County paid around $45,000 in 2010.\(^7\)

**The reality of suits vs. the ideal**

The main purpose of a medical liability system is to compensate those who are injured due to wrongful acts, usually negligence, and to act as a deterrent and disincentive toward such acts so that practitioners act thoughtfully, skillfully and carefully.\(^8\)

**What percent of injuries come to suit?**

The reality of the current system, however, is that many injured individuals are uncompensated or undercompensated and some plaintiffs are overcompensated. The entire process is often an unwieldy, drawn-out affair that takes years to resolve. It is estimated that only about 1% of medical injuries due to negligence actually result in law suits, based on the Harvard Medical Practice Study of 30,000 charts from 51 New York State hospitals published in 1991.\(^9\) A key factor in why few suits are filed relative to the number of injuries that exist from acts deemed negligent in retrospective reviews is that it is often very difficult for patients to determine what was an injury from a negligent act versus just misfortune and known risk.\(^10\) While “standards of care,” the measure by which negligence is determined, can be defined in general terms, they are very difficult to practically and neatly define in many complex clinical situations. A litigious climate also makes most physicians leery of discussion of medical errors, mishaps and “near-misses,” so patients may know little about what really happened.

**Suit length**

Suits average about 3 years but can last much longer.\(^11,12\) Suits are often not brought on until a year or more has passed from the time of injury, so the time to adjudication can be, in many cases, five years or more during which the patient has no payment.

**Suit volume and future effect of health care changes**

The volume of malpractice claims while having steadily grown in the last half-century, then leveled off to an estimated 15 claims per 100 physicians per year\(^11\) but later dropped since the early 2000s.\(^7\) The size of awards, however, has continued to rise, doubling in real dollar cost from 1990 to 2001, but has leveled off at around $200,000 median indemnity payments from 2002-2013.\(^7,9\) Paid claims frequencies have decreased for physicians since the early 2000s, dropping from 19 to 10 claims per 1000 MD physicians and 12 per 1000 for DO physicians.\(^7\) High-end awards have also plateaued. Reasons for the
plateau in payments and drop in frequency of claims are complex, debated and uncertain, but the numbers indicate the “malpractice litigation” crisis atmosphere of the 1970-early 2000’s has cooled. Simplistically put, the situation is now “less bad,” but not good.

Healthcare policy and healthcare insurance coverage have changed the manner in which patients receive care compared to ten or more years ago. Lower physician reimbursement rates related to overall health care cost growth have resulted in a greater percentage of patients being cared for by ancillary healthcare practitioners such as physicians’ assistants (PAs) and nurse practitioners (NPs). NPs and PAs cost less than doctors to employ but get paid close to the same reimbursement (80%) by insurance companies. Care by less experienced practitioners, such as these “mid-level providers,” as they are sometimes known, who lack the same degree of training and experience as physicians, is likely to result in greater, rather than lesser, numbers of medical negligence claims. Ultimate liability still typically refers back to physicians employing those PAs and NPs under the doctrine of respondeat superior. Even when care is provided directly by physicians, however, it is common knowledge that the amount of time physicians spend with patients has been diminishing in the past several years. Less time spent taking a history and examining a patient can result in a higher rate of problems being overlooked and hence higher rates of litigation if there is a bad outcome. In addition, partly because of reimbursement factors, many physicians who have an office practice no longer take care of their hospitalized patients, leaving this work for hospital-based specialists (“hospitalists”). Hospitalists do not have the benefit of knowing the patient in advance and developing a rapport with them. While there are certain logistical efficiencies in having hospital-based physicians taking care of hospital patients, there also is a loss of continuity and a greater chance of communication errors between separate outpatient and inpatient doctors. The result is a greater chance of medical issues “falling through the cracks.” Such situations are often fertile ground for more, rather than fewer, malpractice suits and patients are more likely to sue physicians with whom they do not have a long-term relationship.

Economic costs: claim payouts and legal expenses
The average indemnity payout in a study of claims from 1985-2008 from the Physician Insurers Association of America (PIAA) database for so-called low risk medical specialties such as family practice and pediatrics was $267,000 vs. $315,000 for high-risk medical specialties (like surgery and obstetrics). Most cases settle; only 7% go to a jury. Of those that go to a jury trial where the finding is for the plaintiff, jury verdicts offer a median award of $1.2 million. Monies that actually go to the plaintiff are often only about 50% of the court award, with the rest going
*Doctrine that employer is responsible for negligent action of employees committed in course of their employment duties.

**Emotional and other non-economic costs**

The emotional costs are much harder to quantify but are very real. They overshadow the work of doctors, undermine their confidence, and hinder effective day-to-day relationships with patients. Medical malpractice actions often haunt defendants daily. Some physicians come to see patients as potential adversaries and see clinical interaction as risk-ridden opportunities, precipitating defensive medicine practices. Risk-averse behavior by doctors can sometimes work to the detriment of their patients. Obviously, this is highly dependent on the practitioner’s circumstances. There is a common expression in medical malpractice defense that “even when you ‘win,’ you lose,” because of the tremendous time and energy spent in defending actions and the fact that doctors’ reputations are often impaired after a malpractice suit, even if the defendant prevails, as the knowledge of the allegation often lingers for much longer than the knowledge of a not liable verdict. In addition, it is possible for physicians to lose their liability insurance even if they ultimately prevail in an action: they may be dropped by an insurer due to the number of claims being filed even if no liability is ever found, since those claims cost substantial sums to defend.

**Effects on physician manpower and specialty choice**

In most states, since liability insurance is required to practice medicine, physicians who lose it are in a difficult bind. Their choices include going out of clinical practice, working in an administrative capacity, or leaving private practice and going to work for a hospital or institution that has an institutional “blanket policy.” The availability and affordability of liability insurance can shape the distribution of physicians by location. It is possible to pay more than $200K per year for liability insurance as an Ob-Gyn. These numbers have an effect on physician practice and availability in communities. For example, many Ob-Gyn physicians have simply stopped doing Ob work. Additionally, the cost for neurosurgeons is so high that many communities have difficulty recruiting them. States that have enacted reforms to try to diminish costs and the likelihood of suit, as a corollary, have seen an influx of physicians. After passing broad tort reform legislation in 2003, Texas, by 2013, had seen its number of physician grow by 100%, a rate double that of the general population growth. Its insurance premiums have fallen 60% in 10 years. What’s more, many of those physicians coming to Texas relocated to it after leaving NY, where liability insurance rates rose 60% in the same time period. Costs such as these truly have profound and diverse consequences.

**Jury limitations**

Approximately seven percent of medical malpractice cases go to trial. When a case goes to trial, the plaintiff must show, in the case of negligence, that the defendant had a duty that was breached, that the breach was the actual and proximate cause of injury, and that damages resulted. Typically, large amounts of scientific and medical evidence are presented. Each side hires and pays its own medical experts who possess knowledge the average juror would not have. Not surprisingly, each side’s experts present evidence favorable to their side. Jurors must evaluate conflicting testimony to come to a conclusion as the “trier of facts” (i.e. determiner of truth) and, not surprisingly, jurors may be left confused.

The question arises as to whether jurors, who typically are chosen for their lack of special knowledge, have sufficient knowledge to adequately weigh specialist scientific and technical evidence presented with conflicting interpretations. Can jurors adequately
determine which expert's testimony is more credible than the other on a scientific basis? Are they able to critically evaluate the experts' credentials? Can they separate “real” science from “junk science?”

Part of the problem of why a jury system is problematic is how experts are selected. An expert is typically chosen by each side long before trial by being asked to give a verbal opinion in private. If the opinion is not favorable to that side, they then try someone else. Thus there is a tendency of “shopping” for an expert. As experts are pre-selected for their opinion, it therefore is not surprising that at trial, different conclusions are reached by each side, different standards applied, and different emphasis applied to the same set of facts. Consequently, lay juries have a hard time sorting these opinions.

When presented with a bewildering array of conflicting evidence, a jury of laypersons may fall back on judgments fashioned on personality and emotion rather than facts. Stephen Sugarman, a Berkeley law professor, points out that “jurors selected in part for their ignorance about the topic” are asked to decide “extremely difficult scientific issues.” Sugarman refers to a 1985 California case against Johnson & Johnson. The plaintiff’s alleged injury from a toxic shock syndrome infection acquired while using a tampon won her $500 million in compensatory damages and $10 million in punitive damages. The trial judge concluded that the plaintiff had not presented sufficient evidence of economic loss to justify the damages and that the jurors acted with passion and prejudice.

Juror critics contend that when jurors lack scientific skills to make sense of evidence, they may resort to alternative means to make a decision. For example, jurors may rely upon sympathy for the plaintiff, especially in cases of serious injury or death. They may neglect to question the defendant's responsibility in contributing to their injury, and they may focus on wanting to help the plaintiff even if the defendant may not have been the cause of injury, or the injury was unavoidable or unpredictable.

Due to the “collateral source” rule, jurors are supposed to make decisions and awards irrespective of whether the plaintiff has insurance coverage for the damages. Jurors by law are not supposed to be told if the defendant had insurance coverage concerning the services provided to the plaintiff. In reality, the jurors almost always know that such coverage is typically required and exists. They therefore know that insurance rather than the defendant will likely pay awards to the plaintiff, which may influence the likelihood of an award being made. Professor Havighurst of Duke writes,

*Although it is customary in an adversary system to regard a jury trial as 'black box', the outcomes of which (on non-legal questions) are granted a powerful presumption of legitimacy, realism compels recognition that juries are often poorly positioned to choose reliably between the well-argued, but often highly confusing, theories of the two sides' experts. As a result, they often fall back on such irrelevancies as the witnesses' demeanor and style of presentation or sympathy for the plaintiff's plight or the defendant's reputation.*

Professor Neil Vidmar of Duke takes issue with the assumption that juries are poorly capable of arriving at rational logical decisions in technical matters. He cites evidence from studies conducted by Mark Taragin analyzing 8,231 New Jersey cases between 1977 and 1992. In those studies, physicians’ non-discoverable assessments of liability were compared with the jury verdicts. Cases were classified as defensible, indefensible, or unclear regarding the standard medical care, and they were also classified according to the severity of injury. There was a substantial correlation between insurance company evaluations of liability and jury verdicts. Plaintiffs won 21% of cases deemed defensible by expert panel but 91% of the cases deemed indefensible by insurance.
company physicians. In “unclear” cases, plaintiffs won 59% of the time. Another later study of 1,452 malpractice claims from five different insurers in different parts of the country came to a similar conclusion after independent physician review, but those reviewers were not blinded as to which plaintiffs got payment. In this study, the likelihood of medical error was graded from one to five. In cases where there was “little or no evidence” of medical error, the plaintiff prevailed 19% of the time, and in cases where there was a high level of evidence of medical error, the plaintiff prevailed 84% of the time. In “close call” but less than 50-50 chances, the plaintiff prevailed 52% of the time; in “close call” but greater than 50-50 chance, the plaintiff prevailed 61% of the time. Thus the margin of error is still sizable, but jurors get it right most of the time compared to expert reviewers.

It is also argued that jurors, by only hearing one case, lack the experience of multiple cases in which to judge liability and evaluate evidence. While the same criticism can be weighed in all jury trials, it appears particularly relevant in medical malpractice trials since the cases involve judgments that go beyond day-to-day experience. If the persons weighing evidence had greater experience, the ability to judge more accurately would be strengthened. Juries typically do not receive instruction in how other cases have been handled or decided in terms of either verdict or damages and essentially work in a vacuum of that case.

In medical malpractice litigation, as in other torts (civil, non-criminal wrongs), the goal is to provide equitable treatment under similar circumstances to similar individuals in different trials. An additional goal should be to provide similar treatment for similar degrees of injuries in different cases. The current system does not do this well. While malpractice claims with a dubious basis are commonly filed, there also are many real injuries that go uncompensated and unrecognized as malpractice.

**Proposed solutions**

Those who feel that the existing jury system falls short have proposed specialized malpractice courts.

Specialized courts are by far not the only solutions proposed. So called “tort reform without special courts” has been proposed, which includes the following ideas:

- a) barriers to bringing suits such as prescreening panels, certificate of merit requirements, expert witness certification, and limits on attorney fees
- b) limiting compensation (caps for non-economic damages)
- c) changing how damages are paid such as periodic vs. lump sum payments, and eliminating “joint and several liability”.

“Joint and several liability is the concept that each defendant is responsible for paying a judgment if other defendants do not have the means to pay, irrespective of the proportion of liability that the party that is able to pay. It favors plaintiffs where one of the defendants has “deep pockets.”

Success of these reforms has been limited. A recent review by Mello et al. in JAMA concluded that “controlled studies encompassing 50 states suggest that on average, these approaches are associated with reductions in claims payment by 20-30% but have only a modest relationship with insurance premiums.”

Non-traditional liability reforms include “communication and resolution” programs in which providers (usually large medical centers) discuss unfavorable and unanticipated outcomes with patients and families before litigation is raised or threatened and may offer compensation in a non-legal proceeding. It is beyond the scope of this paper to discuss these programs in detail, but they were co-pioneered by the Lexington, Kentucky VA and the University of Michigan Hospitals, and can have a niche role in liability reforms in selected large centers.
where all or most physicians are employees of the involved institution. While providing transparency and closure, these programs also have some pitfalls. These programs are not feasible for individual or small practice providers. Insurers may try to recoup third party insurance payments made on behalf of patients for care, if the patient receives compensatory funds through such non-litigation means after an adverse event, which may thus negate the value of such compensation delivered via a communication and resolution process outside the legal system to the patient.13

**Specialized courts rationale**

Specialized courts can potentially obviate the problems discussed earlier. Specialized courts with narrowly focused jurisdictions offer judges with special knowledge and experience in certain areas of law and handle only certain types of cases in contradistinction to general courts, which handle a wide gamut of cases.

Expected benefits are: 1) improved and more precise decision making due to greater judicial knowledge and expertise in areas of complex subject matter, and 2) reduced case backlog and faster adjudication. In contrast to general courts, supplying extensive, specific background material might be unnecessary to specialist courts, where such knowledge is already assumed on the part of officers. This could save time and reduce costs. Greater knowledge and familiarity with similar cases can also result in greater uniformity and consistency of decision-making. Greater familiarity with subjects facilitates better case management, in terms of setting realistic and practical time frames for task goals in a trial. Greater uniformity of court decisions can also result in diminished benefits from so-called “forum shopping,” wherein plaintiffs look for a court or jury venue where the climate will be more favorable to their position.

There are many precedents for specialized courts in the United States including Bankruptcy Court, Tax Court, Juvenile and Family Court.

Delaware’s Court of Chancery, established in 1792, is an example of a very well established, successful, nationally recognized specialty court based on the English Court of Chancery, an equity court. Delaware, although small with a population of under one million, has the largest percentage of large-company incorporations of any state in the nation. One reason for this incongruity is the Delaware Chancery Court, which deals with corporate governance issues such as mergers and acquisitions, derivative shareholder actions, and other complex corporate litigation where specialized knowledge and experience is accorded great value. Corporations come to Delaware to be incorporated because of their satisfaction with this system and the extensive case law precedents set by this administration. There are few judges, known as Chancellors, and hence each is involved in a large number of cases and has broad commercial experience.

Other states have imitated Delaware in creating Chancery Courts, including Illinois and New Jersey.

**Health care court proposals**

Due to problems with juries, technical demands of dealing with scientific evidence, and cost and time considerations, alternatives to juries have been proposed in several forms, notably the AMA’s 1988 proposal. The AMA proposal involved several levels of independent medical review to determine merit. Initially, a pre-hearing application screening is performed to preliminarily evaluate merit. For claims with perceived merit, the case is sent to a specialty expert physician to further judge merit and help the patient evaluate a settlement offer. If not settled, the case then goes to a “hearing examiner” who makes a determination and assesses damages. A unique feature is that blind settlement offers are required pre-hearing
by each side: if defendant’s offer is greater than plaintiff’s request, the case settles; if not, it goes forward. To discourage rejecting reasonable offers, if a hearing produces a lower award than the other side previously offered as a settlement pre-hearing, the side that rejected the offer may be subject to sanctions.

The plaintiff is provided with a Medical Board funded attorney free of charge. Appeals are heard by a three member Medical Appeal Board. Appeal of the Medical Board decision in turn is to the State appellate court, but appeals are limited to issues of whether the board followed its own rules in arriving at its decision. The AMA proposals never were implemented or achieved much acceptance, but the concept of health care courts continues to attract interest. Common Good, founded by lawyer Philip Howard in conjunction with the Harvard School of Public Health, also proposed a health court system. The Progressive Policy Institute, linked to Common Good, has a related plan.

Health care court concepts typically eliminate juries. Decision-making is instead vested in special judges with scientific/medical training. In the AMA and Common Good plans, experts are chosen by the court rather than by each side so that there are no competing experts each with an allegiance to one side.

In the health care court strategy, there is no civil jury and instead the judge is the one who evaluates the evidence and judges its truthfulness. The judge listens to one set of presumably “neutral” experts. The expert judge would have a better ability to evaluate the evidence than a typical juror would.

Appeals in the Common Good and Progressive Policy Institute health care non-jury court proposal are to a special “Health Care Appeals Court.”

Medical malpractice cases, in order to be proven, require a demonstration of a violation of a standard of care by the defendant. In a health care court, standards of care could be set as procedural matters by the judge more specifically than the current “generic” definition of standard of care, which is what a physician with the usual skills exhibited by a reasonably prudent member of the profession would do under similar circumstances. In traditional courts, the standard of care is often presented differently by each side. With the target more firmly defined in a specialty court, the ability of the court or administrative body to determine if there indeed has been a violation of the standard of care would be more easily achieved.

Compensation schedules for various injuries could also be established by special healthcare courts, so there would be greater uniformity in compensation for similar injuries to different persons. Of course, no two cases are completely alike and some discretion would still need to be exercised, but compensation schedules would establish some benchmark in place of the current system where wide variances exist.

Advantages of health courts

Judicial and legal efficiency
Medical malpractice litigation is complex with much technical detail. Delegating these cases to a special court honed in such areas unburdens the general court from such subjects. The special court is likely better and more quickly able to negotiate the difficulties of such litigation due to its experience.

Judicial expertise
Specialized judges would, by nature of the narrow scope of their work, have greater expertise. They would likely be better at evaluating scientific evidence and less dependent on experts to formulate a judgment.

Uniformity of decision making
Special courts, staffed with a smaller number of judges and tasked with one specialty, are more likely to have greater uniformity of judgment and rulings.
Predictability of judgment for a given set of facts would be an advantage.

**Avoid forum shopping**

The existence of a specialized court, by creating greater uniformity of judgment and application of law, is likely to diminish forum and jury demographics shopping. Certain venues such as Philadelphia, Brooklyn, NY or the Bronx, NY are favored by plaintiffs because of the lower income jury pool from which they draw, which is felt to favor the plaintiff in an injury case.

**Larger number of injury awards but smaller size of average awards**

The current jury system of malpractice litigation results in few compensated patients. This may in part be because only a small percent seek to pursue litigation or even know if there has been a possible malpractice committed. Part of this is because it is difficult and costly to initiate a law suit. The AMA, Common Good and Progressive Policy Institute systems are similar to Workman’s Compensation whereby a claimant starts by filling out a simple form, which would not necessarily require a lawyer and would be far simpler than filing a law suit. This would then go to an administrative board for preliminary evaluation. The use of compensation tables and the lack of unpredictable juries as the claim moves forward would likely make average rewards smaller for individuals, but at the same time allow a significantly larger number of injured patients to be compensated with fewer hurdles.

**Greater coordination of compensation benefits to injured parties**

The existing general court system is not well-suited to administering the distribution system of payments over the lifetime of an injured party. Most settlements or awards are not structured to provide for ongoing care of an injured individual over his remaining lifetime. A lump sum award, typical in most courts, is often left to the plaintiff’s management. A specialized health court may be better able to coordinate and administer extended care compensation plans, organizing facets of care among insurers, hospitals and other health care providers. This may be analogous to Family Court being better able to manage domestic matters. This would help avoid situations where a plaintiff, because of poor planning, might run out of money several years after the award and then become dependent on public resources.

**Establishing judicial parameters for standards of medical care and typical levels of compensation**

Healthcare courts, could, over time, establish precedents regarding standards of care for given medical services under a variety of scenarios. This in turn could set both plaintiffs’ and doctors’ expectations concerning what is and is not malpractice, a task the existing system does not do well. They could facilitate the development of databases concerning patient injury to encourage open and accessible knowledge of injuries and to develop patient safety protocols. The current system of (often) sealed settlements discourages dialogue and shedding of light. Improved patient safety is not currently as prominent of a side benefit of medical malpractice suits as it should be. Contrast this with the airline industry after an accident—public scrutiny is probably one reason for the difference as well as the scale of the injury.

**Disadvantages of health courts**

*Perceived lack of jury as being unfair*

While the value of not having a jury has been discussed, the public perceives disadvantages of jury-less trials. Americans are accustomed to jury trials, typically seen as friendly to the “little guy” and as more sympathetic to the injured plaintiff than an administrative panel or judge. The potential chance for a large award may be seen as substantially greater.
with a jury than with a judge. In most malpractice litigation cases, the plaintiff insists on a jury trial for that very reason. As discussed earlier, juries have been criticized for their lack of experience in dealing with medical malpractice litigation, lack of technical knowledge, and ability to be swayed by emotion when unable to make a decision on scientific grounds. Jury fairness remains a debatable issue.

**Challenges to constitutionality**
The seventh amendment to the Constitution guarantees jury trials for matters over the amount of $20, but this only pertains to Federal courts, not State courts, which is where most medical malpractice actions are heard. Disputes involving private health insurance plans covered by the Employment Retirement Income Security Act of 1974 (ERISA) are heard in Federal court, and there are no jury trials allowed. There is therefore a well-established precedent for non-jury trials in medical error matters. Thus, a challenge to the constitutionality of non-jury trials would ultimately fail, but culturally it is deeply ingrained in our custom.

**Chance for special interest groups to have undue influence**
A health care court, with a select number of judges and a limited group of qualified attorneys who are likely to appear repetitively, leaves the potential opportunity for courtroom bias by judges who become very familiar with the attorneys practicing before them. Attorneys also gain an advantage by getting to know the judges well and learning what works and does not work with them, which can lead to an advantage for those practitioners appearing before the court. This is possible in other existing specialized courts, as well. Finally, there is a chance for special interest groups, such as bar associations, hospitals unions, and liability insurers to exert undue influence on the selection process for such judges.

**Limited number of courts and locales**
Specialized courts would almost always be less plentiful than general courts and further apart geographically, which could cause access problems, especially for those with constrained finances or in more rural areas.

**Judge retention and attraction**
A specialized court may have limited appeal for a judge seeking to advance his or her career. Most of the highly prestigious judicial appointments are seats on general benches such as in Courts of Appeal or the Federal administration. The ability to recruit and retain high-quality judges may be limited except for those with a special interest in the area. Judges with special interests in malpractice litigation may bring agendas to their decisions that favor plaintiffs or defendants.

**Lessons from other countries**
Other countries have different medical liability systems than the US: Sweden, New Zealand, and Denmark, among others, have been studied. A feature of New Zealand's system is a move away from a 'negligence standard' compensation for injury arising from medical error or "medical mishap" and toward the use of the term "treatment injury" to describe an outcome that is not an "ordinary" part of treatment. New Zealand's system is similar to, but not quite, a "no fault system". A lawyer is not needed to file a claim, but a physician or hospital is needed. It not only covers a broader range of injuries than the US tort negligence-based system, but surprisingly, it also costs less. This may be due to technical factors such as universal health coverage and lack of a "collateral source" rule exclusion in those countries, so that expenses covered by outside means are deducted from the awards. Whether such a system would work in the US is unclear due to greater US cultural heterogeneity, more litigious legal traditions, and a non-centralized, non-government-run healthcare system.
Sweden’s health care system is a socialized medicine single payer model with most health care provided by publicly funded hospitals or providers on government contract and a complex social welfare system that covers 80% of lost wages due to illness or injury, something not covered in the US by health insurance. A mutual insurance company (LOF) owned by the county and regional government may provide additional compensation to injured patients above and beyond existing government benefits after evaluating the individual merits. Providers are required to purchase insurance via this mutual insurance company. Non-economic damages are capped. Those not satisfied by the mutual insurance company decision can appeal to a patient claims panel but would need to prove injury was “avoidable.”

Denmark’s system is similar to Sweden’s. By law (Patient Injury Act of 1992) regional hospital authorities are obligated to pay malpractice award costs. A regional association of hospitals and insurers evaluate claims in a manner similar to Sweden.

Conclusions
The American medical malpractice tort system:
• a) is cumbersome and costly.
• b) is lengthy, with approximately three years to resolution for most cases.
• c) brings only a small fraction of medical injuries to litigation, in part because it is difficult for the plaintiff to truly know if malpractice has occurred.
• d) is imperfect in that at least 15% of litigants who very likely had injuries from negligence are not compensated, while a similar percentage of those who were probably not victims of negligence are compensated.

If the system for filing and litigating claims were simpler, such as with proposed health courts analogous to the Workmen’s Compensation system, it is likely that a much larger percentage of patients who were injured by medical negligence would be compensated but at a lower rate than is currently the case.

A specialty court system that establishes a more precise precedent body of law for standards of care for various illnesses would result in greater uniformity of decision making, greater predictability and consequently greater faith in the system from both healthcare practitioners and patients.

The elimination of juries is controversial. In decision-making that hinges on complex medical issues, where competing experts are selected for how much their opinion is likely to help one side, and where those experts serve different masters, it is likely that more good would be gained than lost by eliminating juries and substituting expert judges to be the trier of facts. I conclude that, given the existing problems with medical malpractice litigation and little likelihood that this problem will improve if the system is left alone, health care courts would be a significant asset in administering justice and equity to injured parties.

It also would discourage, or at least rapidly dispose of, suits with little real basis that currently lead to substantial expenditures that could better be used for other purposes.

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