

MEDICARE MALPRACTICE REFORM

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MEDICAL MALPRACTICE REFORM

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Name	Date
<i>Patie Butten</i>	<i>1/11/96</i>

Melanne Veeber

OA6203 VARA 4448

HARRIS WOFFORD
PENNSYLVANIA

CC: MELANNE

ENVIRONMENT AND PUBLIC WORKS
LABOR AND HUMAN RESOURCES
FOREIGN RELATIONS
SMALL BUSINESS

United States Senate

WASHINGTON, DC 20510-3803

October 20, 1993

*file
malpractice*

Hillary Rodham Clinton
Office of the First Lady
The White House
Washington, D.C. 20500

Dear Hillary,

Thanks very much for our conversation yesterday afternoon. As I hope I conveyed, I think it would be extremely helpful for you to spend twenty minutes before the bill is released with Bob Fogel and Jim Mundy. Bob, as you know, is one of Chicago's most prominent trial lawyers, and Jim is a close friend who was recently president of the Pennsylvania Trial Lawyers Association.

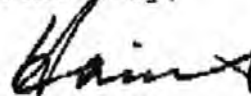
They are true supporters of health care reform and are exceptionally good at spotting landmines. They want to make sure the bill succeeds.

Jim can be reached at 215-568-6190 (work), 215-565-5584 (home) or 215-280-2165 (car). Bob can be reached at 312-236-5207 (work) or 312-337-5948 (home).

Tom Daschle and I had a good session with the Washington press corps this morning and succeeded, I think, in poking some holes in the Republican "plans." I enjoyed a repeat performance this afternoon in debate on the floor with Kit Bond of Missouri. The battle is engaged!

All my best wishes.

Sincerely,



Harris Wofford

HILLARY ALERT

A special project of the American Conservative Union.

file

Dear Fellow American,

Here is your opportunity to do what you couldn't do in 1992...

...vote FOR or AGAINST First
Person Hillary Rodham Clinton.

Please, take out a pen right now and sign the enclosed HILLARY BALLOT. Then rush it back to me today.

Hillary "Rodham" Clinton is now the second, if not the first, most powerful person in the world.

She sits in on Cabinet meetings...

... her lackeys are in charge of, among other things, the Justice Department and the Department of Health and Human Services;

... she has a huge taxpayer-paid staff and flies on U.S. military aircraft at your and my expense;

... her lavish offices take up nearly an entire floor of the West Wing of the White House;

... and even though Hillary is in the process of dictating what health care will be available to you...

... she was elected by no one and is accountable to no one.

You and I didn't have a chance to vote for or against "First Person" Hillary Clinton before.

But you can now. And this time, I'll personally make sure your voice will be heard.

So please, do not delay your response. Complete your HILLARY BALLOT and rush it back to me today. Your HILLARY BALLOT will be tabulated in our national processing center here in Washington. D.C.

Your vote will be kept strictly confidential.

But the overall results will be sent to the White House, Congress, and to the national media.

Our goal: to counter the biased media's ridiculous claim that Americans approve of Hillary and her enormous illegitimate (or illegal) power. What's more, we want to use the results of our HILLARY BALLOTS to force Bill Clinton to rein in his wife before she

can do any serious and long term damage to our nation.

"Billary" (Bill and Hillary) fooled America last November. They deliberately misled voters into believing that Hillary would not have enormous power.

We all know now that this was not true. We know that Hillary's "down home" act and cookie baking were all a charade.

And we know that Hillary intends to rule the White House and our nation with an iron fist.

In fact, that is exactly what she is already doing:

- * Hillary demanded that Bill Clinton pick a woman for Attorney General -- no matter how many times it took to get it right;
- * Hillary played a major role in nearly all Cabinet appointments making sure her friends, such as the ultra-liberal Donna Shalala, were chosen over others;
- * Hillary sits in on all Cabinet meetings, was a major player in the White House/Governors conference, and has already begun lobbying -- and bullying -- Senators and Congressmen from both political Parties.

Do you ever wonder why Bill Clinton caters so much to the radical homosexual crowd?

Why he insists on homosexuals in the military? Or why he wants AIDS infected immigrants to come to America?

Part of the answer is "Queen Hillary."

Her radical agenda includes special privileges for homosexuals, feminists, abortionists and other left-wing kooks.

It also includes... sky-high taxes... oppressive government regulations... a massive redistribution of wealth... an expansion of the welfare state... racial quotas... federally funded pornography... the complete dismantling of the military and the CIA...

... and total control over your life and your income.

That's why she told Bill Clinton to give her the one job in the one area in which she can cause the most damage -- health care.

Nothing frightens me more than Hillary deciding for me and for you what kind of health care we should have. Because despite what she says, Hillary's health care plan will almost certainly lead to:

- * rationed health care;
- * new taxes on Social Security, income and health care benefits;
- * long waiting periods and delays

- in treatment;
* fewer doctors, less drug research,
and poorer health care quality.

This is the future if Hillary is allowed to decide our nation's health care system -- guaranteed.

Guaranteed because Hillary is a pro-socialist, pro-Marxist leftist who will lead our nation down the same path as the Soviet Union, Eastern Europe and other nations who have bankrupted themselves by trying to provide "free" government run health care.

The bottom line my friend is that nothing is "free." One way or another, you and I will always pay for health care.

But with Hillary in charge, the health care we get will be far worse than what we get now.

That's why you and I have to stop her.

And why, I hope I can count on you to join "HILLARY ALERT," a special project of the American Conservative Union (ACU).

My name is David A. Keene. I am Chairman of both HILLARY ALERT and the ACU. The ACU was founded in 1964 by aides to Barry Goldwater's Presidential campaign.

Considered by many to be the most respected and effective grassroots organization in America, the ACU is the one group that truly frightens the liberals.

And for good reason.

From standing up for the "Silent Majority" in the 1960s... to limiting the damage caused by Jimmy Carter in the 1970s.. to helping Ronald Reagan build his conservative "revolution" in the 1980s...

... the ACU has helped make history.

And with your support today, we intend to continue to make history in opposing the socialist agenda of Bill and Hillary Clinton.

We believe in lower taxes... less government... a strong defense... the traditional family values that made America great.

In short, the ACU stands for everything Bill and Hillary detest... God, family, and patriotism.

That's why one of our top priorities is using HILLARY ALERT to limit the power of Hillary "Rodham" Clinton. In many ways, she is far more dangerous than her husband because she fanatically believes her leftist philosophy. And about all that stands in her way right now are you, me, and the taxpayers of America. That's why, in addition to your HILLARY BALLOT...

... I also hope I can count on you to rush the ACU a most

generous donation of \$15, \$20, \$25, \$50, \$100 or more today.

Please, your gift is just as important as your HILLARY BALLOT.

You see, in taking on Hillary Clinton we are taking on the darling of the media, Hollywood, and the entire establishment Left.

To counter this force, we need to:

- * distribute a minimum of 3 million HILLARY BALLOTS nationwide as soon as possible;
- * recruit an army of 100,000 Americans willing to flood the White House, the Congress and the radio talk shows in a sea of petitions, phone calls and letters demanding Bill Clinton rein in his radical wife;
- * create and publish a HILLARY ALERT newsletter which will track and expose every move made by our new "First Person";
- * form an alliance of Congressional leaders who will help us fight Hillary's socialist health care proposals in the House and Senate.

My friend, this is indeed a massive endeavor. And it will take your support, both political and financial to make it work.

But with your help, it can and will work. As long as we begin today, before it's too late.

The ACU needs your completed HILLARY BALLOT today so we can launch a counter strike against her biased allies in the media.

And we need your gift of \$15, \$20, \$25, \$50, or \$100 to fund this counter strike.

So please, complete your HILLARY BALLOT and then rush it back to me today along with your most urgent, most generous donation.

Thank you.

Sincerely,



David A. Keene
Chairman

P.S. In an arrogant and symbolic slap in the face to all Americans, Hillary Clinton changed her name to Hillary "Rodham" Clinton after the election. This use of her maiden name is Hillary's way of saying, "I fooled you in November. Too bad. I'm in power now and there is nothing you can do stop me!".

Please, help me and the ACU prove Hillary "Rodham" Clinton wrong -- today.

UTAH	1	5.2%
GEORGIA	3	3.0%
SOUTH DAKOTA	3	3.0%
NORTH DAKOTA	5	2.7%
COLORADO	5	2.7%
NORTH CAROLINA	7	2.5%
IDAHO	8	2.4%
FLORIDA	9	2.2%
NEVADA	9	2.2%
ALASKA	11	2.1%
TEXAS	11	2.1%
KANSAS	13	2.0%
MINNESOTA	13	2.0%
MONTANA	13	2.0%
OREGON	16	1.9%
MISSISSIPPI	17	1.8%
WISCONSIN	17	1.8%
WEST VIRGINIA	17	1.8%
TENNESSEE	20	1.7%
SOUTH CAROLINA	20	1.7%
ARKANSAS	22	1.6%
ARIZONA	23	1.5%
INDIANA	24	1.2%
OKLAHOMA	24	1.2%
NEW HAMPSHIRE	24	1.2%
MICHIGAN	27	1.1%
ILLINOIS	28	0.9%
KENTUCKY	28	0.9%
MISSOURI	28	0.9%
ALABAMA	31	0.6%
VERMONT	32	0.7%
WASHINGTON	33	0.6%
DELAWARE	33	0.6%
NEBRASKA	35	0.5%
WYOMING	35	0.5%
VIRGINIA	35	0.5%
IOWA	38	0.4%
OHIO	39	0.3%
LOUISIANA	40	0.1%
PENNSYLVANIA	41	0.0%
DISTRICT OF COLUMBIA	42	-0.2%
MASSACHUSETTS	43	-0.3%
MAINE	43	-0.3%
MARYLAND	45	-0.4%
NEW YORK	46	-0.6%
RHODE ISLAND	47	-0.7%
NEW JERSEY	48	-0.8%
HAWAII	49	-1.4%
CALIFORNIA	49	-1.4%
CONNECTICUT	51	-2.1%

IDAHO	1	4.1%
MONTANA	2	3.5%
UTAH	3	3.4%
COLORADO	3	3.4%
ARIZONA	5	3.3%
SOUTH DAKOTA	6	3.2%
ARKANSAS	7	2.9%
NEVADA	8	2.6%
MINNESOTA	9	2.7%
MISSISSIPPI	10	2.6%
KENTUCKY	11	2.5%
WISCONSIN	12	2.2%
NORTH CAROLINA	13	2.1%
GEORGIA	13	2.1%
TENNESSEE	15	2.0%
NORTH DAKOTA	15	2.0%
NEW HAMPSHIRE	17	1.7%
SOUTH CAROLINA	17	1.7%
ALABAMA	17	1.7%
OREGON	20	1.5%
WEST VIRGINIA	20	1.5%
DELAWARE	20	1.5%
WASHINGTON	23	1.4%
TEXAS	24	1.3%
ALASKA	24	1.3%
FLORIDA	26	1.2%
NEW HAMPSHIRE	27	1.1%
INDIANA	28	1.0%
IOWA	28	1.0%
RHODE ISLAND	28	1.0%
KANSAS	31	0.9%
MAINE	32	0.6%
LOUISIANA	33	0.7%
OHIO	34	0.6%
VIRGINIA	35	0.5%
MICHIGAN	36	0.4%
NEBRASKA	37	0.3%
WYOMING	38	0.2%
MISSOURI	39	0.1%
DISTRICT OF COLUMBIA	40	-0.1%
PENNSYLVANIA	41	-0.2%
VERMONT	42	-0.6%
ILLINOIS	42	-0.6%
HAWAII	44	-0.8%
MARYLAND	45	-1.0%
OKLAHOMA	45	-1.0%
MASSACHUSETTS	47	-1.4%
NEW YORK	48	-1.7%
NEW JERSEY	49	-1.8%
CALIFORNIA	50	-2.0%
CONNECTICUT	51	-2.1%

Source: U. S. Department of Labor, Bureau of Labor Statistics

PERSONAL REPLY TO DAVID A. KEENE

Chairman of American Conservative Union (ACU)
Hillary Alert

Dear David,

- ☐ I am angry and frightened by the enormous power that has been given to Hillary Clinton. We must do all we can to rein in this pro-socialist before she can seriously damage our nation. You can count on me. I am completing my HILLARY BALLOT and rushing it back to you today along with my check for:

☐ \$15 ☐ \$20 ☐ \$25 ☐ \$50 ☐ \$75 ☐ \$100
☐ \$250 ☐ \$500 ☐ \$1,000 ☐ Other \$ _____

Please make your check payable to: Hillary Alert or the American Conservative Union.

ACU is a non-profit, grassroots organization. Contributions to the ACU are not tax-deductible. Corporate contributions are welcome.
 Not authorized or printed at government or taxpayer expense.

DO NOT CUT OR SEPARATE. RETURN THIS ENTIRE FORM TODAY.

HILLARY BALLOT

Sponsored by "Hillary Alert"
 A Special Project of the American Conservative Union.

Instructions: Please answer each question. Then place your ballot and your donation check in the enclosed, pre-addressed, return envelope. Thank you.

- 1) Do you approve or disapprove of Hillary "Rodham" Clinton?
☐ Approve ☐ Disapprove ☐ Undecided
- 2) Should Hillary Clinton have a taxpayer funded, White House political staff to help her determine U.S. policy?
☐ Yes ☐ No ☐ Undecided
- 3) Should Hillary "Rodham" Clinton be in charge of our nation's health care policy?
☐ Yes ☐ No ☐ Undecided
- 4) Do you think you were lied to during the campaign about how much power Hillary Clinton would have in the White House?
☐ Yes ☐ No ☐ Undecided
- 5) Do you approve or disapprove of Hillary's decision to use her maiden name, "Rodham," since Bill Clinton was elected President?
☐ Approve ☐ Disapprove ☐ Undecided



Senator Bob Dole

Republican Leader

Dear Friend,

Please complete the enclosed 1993 CONSERVATIVE AGENDA SURVEY and rush it back to me today.

While I can't change last fall's election results, I can make sure that the views of the 57% of voters who voted against Bill Clinton are strongly represented here in Washington.

And with your help, that is exactly what I intend to do.

Your response to the enclosed survey will help me determine how best to advance the conservative agenda and combat the liberals who control Congress. So please, take a moment right now to complete your 1993 CONSERVATIVE AGENDA SURVEY.

Don't get me wrong. Unlike what the liberal Democrats did during President Bush's Administration, we're not going to attack Bill Clinton at the expense of the best interests of the nation. But we must fight the liberals night-and-day to prevent the advancement of their own radical agenda that includes:

- * New taxes on just about everyone and everything;
- * statehood for Washington, DC;
- * government controlled and rationed health care;
- * a lifting of the ban on gays in the military;
- * massive new social welfare spending;
- * new burdensome regulations on small businesses; and more.

The liberals are already advancing this agenda on all fronts. And right now, we need to determine the best way to counter this onslaught against the Reagan Revolution.

So please, complete your 1993 CONSERVATIVE AGENDA SURVEY and rush it back to me today. Your answers will help us determine our priorities for 1993 and beyond.

I believe our ability to push back the coming liberal tidal wave depends on how successful we are in uniting the hundreds and thousands of conservatives across the nation who stood together in 1980, 1984 and 1988. Republicans, Independents and "Reagan Democrats" who share our values must unite in one effort to protect the gains we have made since 1981.

That's why I am hoping we can count on you for much needed support in the difficult weeks and months ahead. Believe me, our struggle against the liberal forces now occupying Washington is going to be long and hard. Think about it! Liberals now control the White

House, Congress, the federal bureaucracy, the media, Hollywood, TV and academia.

And they are moving quickly to turn their election victory into an all out attack on what's left of the Reagan Revolution. Unless we unite and act quickly, we can expect to see:

- * a massive redistribution of income from your pocket to the pockets of those who wish to turn America into one large social welfare state;
- * Governmental policies which, in fact, promote the breakdown of family and patriotic values;
- * a weak foreign policy and military that takes America back to the days when even two-bit Third World dictators laughed at the United States.

Think back to the campaign for just a minute. Bill Clinton promised and promised that no matter what he did he would not increase taxes on the middle class. Any increases, he said, would only apply to those making \$200,000 a year or more. When we looked at his numbers, we concluded that he was, in fact, planning to increase taxes not just on the "rich," but on people making less than \$36,000 a year.

His response then was clear... the charge was a "Dirty Trick" and we were all lying. That was then, of course, and now he admits that under his plan the middle class will have to pay and pay heavily.

Well, I intend to do all I can to prevent this from happening.

But those of us who must fight this battle on the floor of Congress cannot win without outside help... help from people like you and organizations like the American Conservative Union (ACU).

The ACU is America's oldest and most respected conservative public interest organization. It was founded in 1965, and since then has been on the cutting edge of every major policy battle.

The ACU has the determination and the experience necessary to be the point guard in our war against the current liberal regime.

In 1965, the ACU began building a conservative coalition which led to the election of Ronald Reagan in 1980. In 1976, the ACU won a landmark case in the Supreme Court barring OSHA from conducting warrantless searches of small businesses. In 1983, the ACU was the leading organization opposing the national movement for a nuclear freeze.

And now, in its fourth decade, the ACU is one of the leaders in our efforts to return conservative ideologies and candidates to power within the next two to four years.

Again, 57% of the Americans voting last November voted against Bill Clinton. The liberals have no mandate to tax and spend the American people into oblivion. They have no mandate to dismantle the U.S. military. And they have no mandate to assault your individual rights in the name of radical environmentalism, racial quotas or any other left-wing pipe dream.

But they have control of the House and Senate, a sympathetic media and the full support of Hollywood and America's left-wing intellectual elite. That's why you and I have our work cut out for us, and why I hope I can count on you to join me as a full partner in the American Conservative Union.

Just as I need your help, the ACU needs your support. By including a donation of \$25, \$50, \$100 or more to the ACU along with your completed 1993 CONSERVATIVE AGENDA SURVEY, the ACU will be able to help me take the battle to the liberals.

Together we can win. With your help, the ACU will:

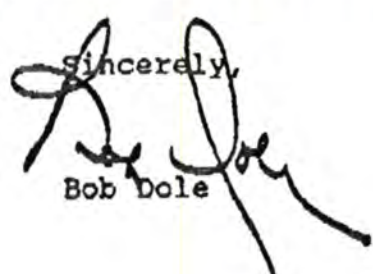
- * build public support against higher taxes on working Americans;
- * form a "Truth Squad" to inform the American people each time the Clinton administration breaks a campaign promise;
- * reunite the political coalition that resulted in three consecutive conservative Presidential landslides;
- * recruit millions of Americans horrified by the liberal left-wing agenda to our conservative army.

These are just some of the steps we must take to prevent the breakdown of America's economic, military, and social fabric during the next four years of liberal occupation. Your completed survey and generous gift are needed to help us get started.

Let's show Bill Clinton and his people in the media that conservatives are not divided; that our movement is not dead.

Together, we can move forward with confidence and courage. We can prove that we stand united and ready to fight the liberals and take back control of the Congress and the White House. Please join me and the ACU in our struggle to keep America strong, free and proud.

Sincerely,


Bob Dole



FROM:

NAME

ADDRESS

CITY

STATE IL

ZIP

Dear Senator Dole,

- ☐ I would be proud to become a part of your "loyal opposition" team working to thwart Bill Clinton's radical left-wing agenda for America. We cannot allow this new liberal regime to totally tear down everything you and I have worked so hard to build.

Therefore, to help you and the American Conservative Union (ACU) unite conservatives into one strong and powerful army, I am completing my 1993 CONSERVATIVE AGENDA SURVEY and rushing it back to you today along with my most generous donation of:

☐ \$15 ☐ \$20 ☐ \$25 ☐ \$50 ☐ \$75 ☐ \$100
☐ \$250 ☐ \$500 ☐ \$1,000 ☐ Other \$ _____

Please make your check payable to: American Conservative Union or the "ACU".

ACU is a non-profit, grassroots organization. Contributions to the ACU are not tax-deductible. Corporate contributions are welcome.

Not authorized or printed at government or taxpayer expense.

DO NOT CUT OR SEPARATE. RETURN THIS ENTIRE FORM TODAY.

1993 CONSERVATIVE AGENDA SURVEY

Part I. Please check off the three issues which are most important to you in 1993 and beyond.

- ☐ Protecting the Social Security system
- ☐ Preventing new tax increases
- ☐ Balancing the federal budget
- ☒ National Health Care
- ☒ Congressional reform
- ☒ Finding a cure for AIDS
- ☐ Ending Abortion
- ☐ Maintaining a strong national defense
- ☐ Family values like school prayer
- ☐ Getting tough on crime
- ☐ Ending drug abuse
- ☐ Maintaining the right to bear arms
- ☐ Preventing special privileges for homosexuals
- ☐ Preventing D.C. statehood

Part II. Answer YES or NO to each of the following.

- 1) Should Washington, D.C. become the 51st state of "New Columbia"?

☒ YES ☐ NO ☐ UNDECIDED

- 2) Do you support national health insurance (socialized medicine)?

☒ YES ☐ NO ☐ UNDECIDED

- 3) If you answered YES to question number 2, would you still support national health insurance if it involved government controlled, rationed health care?

☒ YES ☐ NO ☐ UNDECIDED

- 4) The Democrats are calling for many new tax increases. Which of the following taxes would you support (if any)? New taxes on...

☒ Income ☒ Social Security
☒ Gasoline ☒ Inheritances
☒ Retail sales ☐ None of the above
☒ (Value Added Tax or VAT)

- 5) Which of the following Congressional reform changes should conservatives and Republicans fight for the hardest?

☒ Term Limits
☒ Line Item Veto
☒ A Pay Raise repeal
☒ Reduction of Cong. Pensions
☒ An end to franking privileges
☒ An end to all perks

Other _____

Survey continued on back...

1993 CONSERVATIVE AGENDA SURVEY *Continued*

- 6) Should avowed homosexuals be allowed in the military?
☒ YES ___ NO ___ UNDECIDED

- 7) Do you favor abortion on demand?
☒ YES ___ NO ___ UNDECIDED

- 8) In your opinion, why did President Bush lose the election to Bill Clinton? (You may choose more than one answer.)

☒ Bush not conservative enough
☒ GOP Convention
☒ Bush too conservative
☐ The media
☐ Poor Bush campaign
☐ The economy
☐ Bush's broken "no tax" pledge
☒ Clinton ran superior campaign
☐ People wanted "change"
☐ Other _____

- 9) Should Republicans fight President Clinton and liberals on an issue by issue basis or openly declare war against the Democrats in Washington?

☐ Declare War
☐ Fight one issue at a time
☐ Undecided

- 10) Please write a brief comment on what you believe conservatives and Republicans should do to best combat Bill Clinton and the liberal Democrats.

COMMENTS:

DISBAND THE REPUBLICAN PARTY. IT IS
 TOTALLY OUT OF TOUCH WITH THE MAJORITY
 IN THIS COUNTRY,
 START A NEW PARTY. MINUS, GINGRICH
 HELMS, HYDE, GRAMM, WALKER, DORNAN,
 BURTON, COATS, WEBER, KEMP, BENNETT,
 ROBERTSON, FALWELL, NICKLES, LOTT,
 ARMY, BUCHANAN, SUNUNU, REAGAN,
 QUAYLEBARBOUR, NOVAK, KASICH AND EVERY
 OTHER LUNATIC WHO SAYS HE'S A REPUBLICAN
 INSTALL BARRY GOLDWATER AS CHAIRMAN OF
 THE NEW PARTY. HE'S THE ONLY REPUBLICAN
 THAT MAKES ANY SENSE ANYMORE.
 I FORGOT, BAN THE ENTIRE BUSH FAMILY.

The Medical Malpractice Crisis: Will No-Fault Cure The Disease?

I. INTRODUCTION

Problems surrounding medical professional liability have reached crisis proportion.¹ The frequency and severity of malpractice suits are increasing, resulting in extraordinary surges in insurance premiums.² Some physicians pay as much as \$82,000 per year for malpractice insurance.³ High premiums coupled

¹ The early 1970's witnessed the first crisis in medical professional liability, which spawned a detailed study of the problem by the federal government. See DEP'T OF HEALTH, EDUCATION & WELFARE, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, DHEW Pub. Nos. (OS) 73-88, 73-89 (1973) [hereinafter SECRETARY'S REPORT]. The State of Hawaii also launched its own study of the malpractice problem at that time. See DEP'T OF REGULATORY AGENCIES, MEDICAL MALPRACTICE: ISSUES, DISCUSSIONS AND PROPOSALS FOR CHANGE, STATE OF HAWAII (1976).

Physicians uniformly feel they are presently experiencing a second malpractice crisis. See American Medical Association Special Task Force on Professional Liability and Insurance, PROFESSIONAL LIABILITY IN THE 80's, Reports 1, 2 & 3 (1984-85) [hereinafter AMA REPORT]; *The Malpractice Blues*, TIME, Feb. 24, 1986, at 60; OFFICE OF THE ATTORNEY GENERAL, UNITED STATES DEPARTMENT OF JUSTICE, REPORT OF THE TORT POLICY STUDY GROUP ON THE CAUSES, EXTENT & POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY (1986) [hereinafter TORT POLICY WORKING GROUP]; *Sorry, America, Your Insurance Has Been Cancelled*, TIME, Mar. 24, 1986, at 16-26 [hereinafter SORRY AMERICA, YOUR INSURANCE HAS BEEN CANCELLED].

But see Neubauer, *Medical Malpractice Legislation: Laws Based on a False Premise*, 1985 TRIAL 64 (1985); Blodgett, *Malpractice Crisis?*, 71 A.B.A. J. 18 (1985). The ABA also rejected the AMA's contention that the increase in malpractice insurance rates is a crisis. "This committee believes that although there is a problem in the area of medical malpractice insurance, the term 'crisis' is an overstatement." Silas, *Bitter Medicine*, 72 A.B.A. J. 20 (1986).

² AMA REPORT 1, *supra* note 1, at 6-15. "The St. Paul [Insurance] Companies, with 14.6% of the national medical market, reported 5,870 claims in 1983—2,757 more than in 1979, an increase of 88.6%." *Id.* at 10. In Hawaii, 155 malpractice claims were filed with the Medical Claims Conciliation Panel in 1985, compared to 84 in 1980. J. MARDFIN, MEDICAL MALPRACTICE IN THE STATE OF HAWAII, Dep't of Commerce and Consumer Affairs 14 (Jan. 1986).

³ AMA REPORT 1, *supra* note 1, at 8. See also Blodgett, *supra* note 1, at 18, where premiums as high as \$82,000 were quoted. Hawaii's annual malpractice insurance premium for an obstetrician (\$1 million/\$3 million, claims-made policy) was \$42,783 in August, 1985. (Medical Insur-

with the possibility of subjection to the ordeal of a lawsuit have caused some physicians to either abandon or restrict their practices, particularly in high risk specialties such as obstetrics and neurosurgery.⁴ As a result, some geographic areas have lost certain types of medical services.⁵

The malpractice threat, many doctors believe, has contributed to the erosion of the doctor-patient trust relationship, and to the practice of "defensive medicine."⁶ One estimate placed the cost of defensive medicine at \$15.1 billion per year,⁷ a cost ultimately borne, to a large extent, by the consumer. Are patients unrealistic in their expectations of medical cures, seeking legal redress whenever results are less than perfect?⁸ Is physician carelessness largely responsible?⁹ Or is this unhappy situation the result of the breakdown of the traditional tort system?¹⁰ Whatever the reason, the situation is tragic when one considers

ance Exchange of California data on file at the Hawaii Medical Association, Honolulu, Hawaii).

⁴ AMA REPORT 1, *supra* note 1, at 16-20.

⁵ In Hawaii, obstetric services on the island of Molokai were recently suspended because of unaffordable insurance premiums. Deliveries are currently being performed by a midwife insured under the state hospital's liability policy. Kona and the Kohala area of the Big Island of Hawaii have one remaining obstetrician, down from four. Testimony by Stan Snodgrass, President, Hospital Association of Hawaii, before the House Judiciary Committee in Honolulu, Haw. (Feb. 26, 1986).

On the Hawaiian island of Molokai, pregnant women who want a doctor in attendance when they give birth fly to neighboring Oahu or Maui. The five Molokai doctors who once delivered babies have stopped doing so because malpractice insurance would cost them more than the total of any obstetrical fees they could hope to collect.

Sorry, America, Your Insurance Has Been Cancelled, *supra* note 1, at 16.

⁶ Defensive medicine is the procedure of conducting tests or treatment for legal, rather than medical reasons. See generally Neubauer, *supra* note 1. "Forty percent of responding physicians said they prescribed additional diagnostic tests and 27.2% said they provided additional treatment procedures as a response to the increased risk of a professional liability action." AMA REPORT 1, *supra* note 1, at 16. But see Bernzweig, DEFENSIVE MEDICINE, in SECRETARY'S REPORT app., *supra* note 1, at 40; ("That the phenomenon exists cannot be denied, but to say that all defensive medicine practices are invariably harmful, or that the threat of malpractice litigation is the only reason they occur, is much less supportable, based on the evidence at hand.").

⁷ AMA REPORT 1, *supra* note 1, at 16. By way of perspective, the health care industry expends some \$400 billion annually. Levey, *Bottom-Line Health Care?*, 312 NEW ENG. J. MED. 644 (1985).

⁸ "The promise of expertise must be kept. Humanity has split the atom and walked on the moon. Nothing less than a comparable performance in health care can be considered acceptable. Failure is no longer tolerated." R. POLLACK, CLINICAL ASPECTS OF MALPRACTICE 3 (1980).

⁹ See generally H. JACOBS, THE SPECTER OF MALPRACTICE: THIS BOOK MAY SAVE YOUR LIFE (1978) (Dr. Jacobs places the blame squarely on the shoulders of negligent providers of health care.).

¹⁰ O'Connell, *No-Fault Insurance For Injuries Arising From Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L. J. 21 (1975); O'Connell, *It's Time For No Fault for All Kinds Of Injuries*, 60 A.M.A. J. 1070 (1974); Havighurst & Tancredi, *Medical Adversity Insurance—A No-Fault Approach To Medical Malpractice and Quality Assurance*, 51 MILBANK MEMORIAL FUND

the injured patient's plight. Patient ignorance or misplaced "loyalty" often prevents the filing of meritorious claims.¹¹ Even those who file suit may not prevail because of the difficulty of establishing fault.¹² Moreover, those who prevail are compensated only after many years of litigation.¹³

In medical malpractice litigation, attorneys and expert medical¹⁴ witnesses often derive the greatest financial benefit at the expense of many undercompensated injured patients and the beleaguered physicians.¹⁵ The impact on society is unclear. Society must bear the burden of higher medical costs, maldistribution of medical services, and the specter of the reduced number and quality of medical care providers. To the extent that the tort system deters careless con-

Q. 125 (1973), reprinted in 613 INS. L. J. 69 (1974); TORT POLICY WORKING GROUP, *supra* note 1; AMA REPORT, *supra* note 1.

¹¹ No one knows for certain how often malpractice occurs. Everyone acknowledges, however, that many meritorious claims are never pursued because of misplaced "loyalty" in the treating physician. The usual patient response is "it's God's will." See P. DANZON, MEDICAL MALPRACTICE (1985); Pocinski, *The Incidence of Iatrogenic Injuries*, SECRETARY'S REPORT, app., *supra* note 1, at 50. "Some medical errors are literally buried six feet under ground. These and others also may be buried in medical records. A patient's family may be told by their physician that 'It was an act of God'; 'It was an unfortunate circumstance . . .'" JACOBS, *supra* note 9, at 19.

¹² O'Connell, *It's Time For No Fault For All Kinds Of Injuries*, 60 J. A.M.A. 1070 (1974).

An even worse [than product liability] situation exists for medical malpractice claims. Under the auspices of the Secretary of Health, Education, and Welfare, the Report of the Commission on Medical Malpractice recently documented the cumbersome nature of the legal system in processing medical service claims. Despite soaring liability premiums, few victims are paid for their losses, and those who are suffer long delays while litigants battle over the arcane issues of the propriety of medical procedures.

Id. at 1070. See also Havighurst, *Medical Adversity Insurance—Has Its Time Come?*, 1975 DUKE L.J. 1233 (1975). Professor Havighurst cites the high legal and administrative costs of litigation, the psychic and time costs to physicians, the antagonisms unleashed, defensive medical practice, and the haphazard incidence of claims as mandating a replacement of the present tort system for redressing medical malpractice claims. *Id.* at 1234-35.

¹³ "It takes an average of seven years to adjudicate a malpractice claim." J. COM., Jan. 16, 1984, at 9C, cols. 4-5. "On the average, [in medical malpractice claims] only half are closed within 18 months after they are opened; ten percent remain open 6½ years after they are opened." SECRETARY'S REPORT, *supra* note 1, at 11. In Hawaii, 55% of the claims filed with the Medical Conciliation Claims Panel from 1979 through 1983 were resolved within a half year of filing and 75% were resolved within nine months. However, resolution for 18% took over one year. MARDEFIN, *supra* note 2, at 23-24.

¹⁴ "Personal injury litigation is probably the most lucrative area of law in the United States—dwarfing even the returns from Wall Street firms . . . personal injury lawyers share in the equity from huge verdicts and settlements, earning annual incomes that can approach or exceed \$1,000,000." O'Connell, A "Neo No-Fault" Contract in Lieu of Tort: Preaccident Guarantees of Postaccident Settlement Offers, 73 CALIF. L. REV. 898, 903 (1985).

¹⁵ Medical expert fees generally run between \$150 and \$300 per hour. J. HORSLEY, TESTIFYING IN COURT 117 (1983).

duct, however, society benefits from an improved medical care system.¹⁶

This comment will identify the objectives of an ideal system for handling medical malpractice and explore the reasons why the present tort system has failed to achieve these objectives. Tort reforms, presently considered in many states,¹⁷ will be analyzed within the framework of these objectives. These reforms are likely to prove somewhat effective in curbing runaway costs, but may not ultimately solve the underlying inefficiency, waste, and unfairness. Finally, this comment discusses no-fault as a solution to the malpractice problem, highlighting a proposal for a modified medical no-fault compensation system.¹⁸

II. OBJECTIVES OF AN IDEAL MEDICAL MALPRACTICE SOLUTION

Justice, compensation, and deterrence are the ostensible objectives of the present tort system.¹⁹ Advocates of this system assert that its objectives are equally well accomplished in medical torts as they are in other personal injury situations.²⁰ They contend that negligent conduct can be ascertained, and that fault-based tort actions effectively deter substandard care by a profession that has failed to police itself.²¹

On the other hand, others point to the many problems involved in the use of the tort system for medical injuries. They argue that the present system leads to

¹⁶ When surveyed, physicians indicated that their responses to increased professional liability risk include maintaining more detailed medical records (56.7%), referring more cases to specialists (44.8%), prescribing additional diagnostic tests (40.8%), and spending more time with their patients (35.9%). AMERICAN MEDICAL ASSOCIATION, CENTER FOR HEALTH POLICY RESEARCH (1983).

¹⁷ See AMA REPORT 2, *supra* note 1; TORT POLICY WORKING GROUP, *supra* note 1. The most strongly recommended tort reforms include pretrial screening panels, elimination of the collateral source rule, attorney fee regulation, statute of limitation changes, limitations on liability, and periodic payments of damages. The elimination of joint and several liability has also been advocated.

¹⁸ Professor Jeffrey O'Connell, the "father" of auto no-fault insurance, has written extensively on applying the no-fault approach to other injuries including those arising out of medical care. See generally Moore & O'Connell, *Foreclosing Medical Malpractice Claims By Prompt Tender Of Economic Loss*, 44 LA. L. REV. 1267 (1984). His proposal for a modified medical no-fault compensation system was recently presented to Congress as the Alternative Medical Liability Act. See *infra* note 213.

¹⁹ See W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS §§ 46-52 (5th ed. 1984) [hereinafter PROSSER AND KEETON ON TORTS].

²⁰ "Changing tort law . . . to give special status to any specific professional group or groups would be both inappropriate and unjustified." Silas, *supra* note 1, at 20.

²¹ "[T]he medical profession wreaks its damage largely unpunished . . ." Neubauer, *supra* note 1, at 69. See also *Weeding Out The Incompetents: The Medical Profession Acts To Discipline Dangerous Doctors*, TIME, May 26, 1986, at 57.

unfair and unreasonable results.²² Furthermore, they cite the tort system as the cause for the current widespread insurance liability crisis,²³ of which medical professional liability is but one example.

What should a solution to the malpractice problem ideally accomplish? Consideration of the following four goals appears essential for any acceptable solution to the malpractice problem: (1) just compensation for avoidable injuries; (2) deterrence of bad medical practice; (3) maintenance of insurance affordability and reduction of transaction costs; and (4) preservation of the doctor-patient trust relationship.

A. Just Compensation for Avoidable Injuries

Just compensation can be defined as compensation that is fair, reasonable, and prompt.²⁴ Fairness requires that all truly injured patients be compensated. Compensation should be reasonably predictable for the patient and for the calculation of insurance rates, and it should be commensurate to the extent of loss. Economic losses, including lost wages and medical expenses, can be reasonably calculated, and should clearly be compensable. Noneconomic losses or general damages, on the other hand, are not as susceptible to simple calculation.²⁵ Frequently, the focus in litigation is to elicit the sympathy of the jury to generate high awards.²⁶ Punitive damages are meant to punish the tortfeasor and to deter future wrongdoers from gross negligence and intentional torts.²⁷ Such conduct is perhaps better deterred by licensing board sanctions,²⁸ which are more

²² See *supra* note 10.

²³ See TORT POLICY WORKING GROUP, *supra* note 1; AMA REPORT, *supra* note 1.

²⁴ See generally O'Connell, *supra* note 12; Havighurst, *supra* note 12.

²⁵ Professor O'Connell stated:

[T]ranslating a noneconomic loss such as pain into dollars is an extremely uncertain process fraught with large transaction costs. Highly emotional evidence and arguments are at a premium as both sides try to win the sympathies of the jurors. Michael F. Colley, a leading plaintiffs' lawyer, admits that 'juries vote based on their impressions, their feelings, their biases, and their prejudices, not the facts of the case. . . . The result is often very dissimilar awards for very similar injuries.

O'Connell, *supra* note 14, at 899-90.

²⁶ "Nowhere in all of insurance does violation of the principle of indemnity lead to such rampant waste as does payment for pain and suffering." O'Connell, *supra* note 14, at 900. "In making arguments for pain and suffering awards, both sides attempt to win the jurors' sympathies with highly emotional evidence. A blind plaintiff will receive careful instruction to come to court with his seeing-eye dog and to dab at his eyes with a handkerchief." O'Connell, *Offers That Can't Be Refused: Foreclosure Of Personal Injury Claims By Defendants' Prompt Tender Of Claimants' Net Economic Losses*, 77 NW. U.L. REV. 589, 591 (1982) [hereinafter, *Offers That Can't Be Refused*].

²⁷ Punitive damages have not been awarded for medical malpractice in Hawaii.

²⁸ In Hawaii, the Regulated Industries Complaints Office (RICO) investigates complaints

experienced at understanding the complexities involved in a medical malpractice suit. Finally, an effective system must compensate its victims efficiently and without prolonged delay.²⁹

A key inquiry is whether the present fault-based tort system accurately distinguishes between injuries arising out of negligent care and those that result from judgmental errors or from unavoidable complications. Medical practice is as much an art as it is a science, and professional judgment is pervasive in the clinical care of patients.³⁰ To be sure, there are examples of substandard care such as failing to diagnose a clinically apparent malignancy, or surgically removing the wrong limb or organ.³¹ In many instances, however, medical judgment is an educated guess. Only in retrospect can the decision be vindicated or attacked. For example, a patient with headaches may harbor a brain tumor, but she is far more likely to be suffering from tension headaches or migraine.³² Should a CAT scan³³ be performed to detect the unlikely tumor, even though such a test is expensive and carries with it a small risk of complications including death?³⁴ There is no established community "standard" for this clinical situation.³⁵ Should the physician forego the test if the best clinical judgment so dictates, or is the doctor better off ordering the test anyway to protect against a

against doctors and other professionals, and submits their recommendations to the Board of Medical Examiners for action. HAW. REV. STAT. § 453-7.5 (1985).

²⁹ See *supra* note 13.

³⁰ "In the practice of medicine, the physician employs a discipline which seeks to utilize scientific methods and principles in the solution of its problems, but it is one in which, in the end, both science and art are wedded." G. THORN, R. ADAMS, E. BRAUNWALD, K. ISSELBACHER & R. PETERSDORF, *HARRISON'S PRINCIPLES OF INTERNAL MEDICINE* 1 (8th ed. 1977).

³¹ A jury recently awarded \$5.2 million to a patient whose normal non-cancerous kidney was mistakenly removed, requiring life-long dialysis treatment. *The Malpractice Blues*, *supra* note 1, at 60. For a compendium of cancer malpractice cases, see Annotation, 79 A.L.R. 3d 915 (1977).

³² "About 8 to 10 per cent of the headache patients seen by the generalist are suffering from some type of vascular headache. Two percent of these headache patients have an organic cause for their headache and the remaining 90 percent are diagnosed as having muscle contraction or tension headache." R. RAKEL, *CONN'S CURRENT THERAPY* 732 (1985).

³³ "CAT" stands for computerized axial tomography, an advanced X-Ray technique which reconstructs a three-dimensional view of the body's organs. In 1986, a CAT scan of the brain cost \$427 at Hawaii's Kuakini Medical Center.

³⁴ Adverse reactions to CAT scans average 5%. Four deaths occurred in a survey of 302,083 patients receiving contrast media (used in CAT scans and other radiographic procedures). Shehadi, *Contrast Media Adverse Reactions: Occurrence, Recurrence, and Distribution Pattern*, 143 *RADIOLOGY* 11 (1982).

³⁵ Headache is an extremely common disorder, and the excessive application of expensive and highly technical laboratory procedures to the diagnosis and treatment of benign head pain has been a substantial cause of unnecessary medical costs. Set against this truism is the fact that in some instances a timely CAT scan . . . can give lifesaving information . . .

J. WYNGAARDEN & L. SMITH, *CECIL TEXTBOOK OF MEDICINE* 2060 (1985).

malpractice suit in the event a tumor actually is present?

Unexpected complications from drug therapy is another area where the current tort system does not distinguish between medical judgment and negligent conduct. For example, agranulocytosis³⁶ is a known side-effect of propylthiouracil, a drug effective in the treatment of an overactive thyroid.³⁷ If the risk of this potentially lethal complication, which is less than 0.5%,³⁸ was not specifically discussed with the patient, does the patient have a cause of action? The doctrine of informed consent³⁹ requires the physician to inform the patient of any proposed treatment, as well as alternatives to and material risks associated with the treatment, before obtaining consent to treat.⁴⁰ However, physicians commonly do not discuss all remote risks with their patients, especially those patients who may be unduly alarmed by the information. In *Nishi v. Hartwell*,⁴¹ the Hawaii Supreme Court explicitly recognized this exception to the informed consent doctrine, holding that a physician may withhold disclosure of information regarding any untoward consequences of a treatment where full disclosure will be detrimental to the patient's total care and best interest.⁴² Yet, it is unclear what constitutes a detriment to the patient's best interest.

Finally, suppose a patient suffers a post-operative infection after bowel surgery, subsequently dying from the complication. Such complications are known to occur in a small percentage of cases despite observance of the highest standard of care.⁴³ Still, the issue remains whether deviation from due care was

³⁶ Agranulocytosis is defined as "an acute disease characterized by marked leukopenia and neutropenia [decrease of white blood cells] and with ulcerative lesions of the throat and other mucous membranes, of the gastrointestinal tract, and of the skin." *DORLAND'S ILLUSTRATED MEDICAL DICTIONARY* 48 (1965).

³⁷ Hyperthyroidism is usually treated by propylthiouracil, radioactive iodine, or surgery. E. MAZZAFERRI, *ENDOCRINOLOGY* 144 (1980).

³⁸ *Id.* at 145.

³⁹ Generally, the informed consent doctrine requires the treating physician to inform the patient of the diagnosis and proposed treatment or diagnostic procedure, the alternatives available, and the material risks associated with the procedure. Hawaii's informed consent statute is codified in HAW. REV. STAT. § 671-3(b) (1985). See also Note, *Leyson v. Steurmann: Is There Plain Error in Hawaii's Doctrine of Informed Consent*, 8 U. HAW. L. REV. 569 (1986).

⁴⁰ Does a complication rate of less than 0.5% constitute a "material risk" and therefore required to be discussed with the patient? Or is the risk too remote? In *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965), *aff'd*, 412 S.W.2d 299 (Tex. 1967), a 1% risk of hearing loss required disclosure. *Cf.* *Yeates v. Harms*, 193 Kan. 320, 393 P.2d 982 (1964), *aff'd in part, rev'd in part*, 194 Kan. 695, 401 P.2d 659 (1965) (court ruled that a 1.5% chance of visual loss was insufficient to require disclosure).

⁴¹ 52 Haw. 188, 473 P.2d 116 (1970). In *Nishi*, a stroke occurred as a complication following an invasive x-ray procedure. The plaintiff sued for medical malpractice on the grounds that he was not informed of the risk.

⁴² *Id.* at 191, 473 P.2d at 119.

⁴³ "The majority of wound infections are caused by only a relatively few surgical procedures;

responsible for the complication, an issue easily raised, but not as easily resolved.

The present system of deferring to the community standard⁴⁴ does not always work in practice. Experts define the standard differently depending on whether they are testifying for the plaintiff or the defendant.⁴⁵ In the meantime, a drawn-out malpractice claim with potential adverse publicity stigmatizes the physician irrespective of the final outcome of the claim. Perhaps that explains why less than one case in twenty ends up in court.⁴⁶ Fear of publicity and jury sympathy make out-of-court settlements the preferred solution.

The ease of imputing bad medical results to negligent behavior is therefore apparent, especially if hindsight is used unfairly to penalize competent decision-making. This concern among physicians, however, may be exaggerated, because most claims are adjudicated in favor of the physician, either in pre-trial panels,⁴⁷ or when litigated to verdict.⁴⁸

The problem is no less acute for the victim of true malpractice who does not press her claim for compensation. This injured patient recovers nothing from the negligent wrongdoer. Many more cases of negligent medical care occur than are pursued for legal redress.⁴⁹ The present system ignores these victims with

these infections are likely to occur when operations are long or require extensive resection, or when contamination is unavoidable." HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 767 (1977).

⁴⁴ PROSSER & KEETON ON TORTS, *supra* note 19, § 32, at 187. "The formula under which this usually is put to the jury is that the doctor must have and use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing." *Id.*

⁴⁵ *Id.* at 188-89. Medical "experts" widely advertise their availability in litigation journals, rendering obsolete the accusation of a "conspiracy of silence" among doctors. A recent issue of the ABA Journal contained no fewer than 13 separate such ads. *See, e.g.*, 72 A.B.A. J. 94, 117, 119 (1986). The expert is asked to state, as a matter of reasonable medical probability, whether the standard of care has been breached. Expert testimony is necessary to sustain the plaintiff's case. *See Devine v. Queen's Medical Center*, 59 Haw. 50, 574 P.2d 1352 (1970); *Phillips v. Queen's Medical Center*, 1 Haw. App. 17, 643 P.2d 365 (1980).

⁴⁶ In 1984, only four malpractice lawsuits were litigated in Hawaii courts. One hundred twenty-three complaints were filed with the Medical Claims Conciliation Panel during that year. *J. MARDEFIN, supra* note 2, at 14, 18.

⁴⁷ In Hawaii, of 453 claims heard by the Medical Claims Conciliation Panel from 1979-84, respondents were found liable in 109 claims (24%). *Id.* at 17. The following 26 states have pre-trial screening panels for medical malpractice claims: Alaska, Arizona, Arkansas, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Massachusetts, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Virginia, and Wisconsin. Four other states, Nevada, North Dakota, Rhode Island, and Tennessee, have repealed their provisions for such screening panels. AMA REPORT 2, *supra* note 1, at 20-21.

⁴⁸ Where cases end up in trial, defendant verdicts generally outnumber plaintiff verdicts by more than 2 to 1. "75% of physicians who go to trial in Cook County [Illinois] are vindicated." AMA REPORT 1, *supra* note 1, at 20.

⁴⁹ A 1974 California study suggested that 0.79% of all hospitalized patients suffer adverse

just claims. Even those who recover must bear the substantial costs of litigation including the financial and emotional costs.⁵⁰

At the same time, some malpractice awards appear to be excessive.⁵¹ A significant portion of the damage award is for noneconomic losses such as pain and suffering, which some have argued represents an unquantifiable and easily inflated measure of injury.⁵² These large awards, however, are usually reserved for catastrophic injuries.⁵³ Furthermore, the awards help pay the plaintiff's attorney's fees, and insurance data suggest that the tort system under-compensates rather than over-compensates large losses.⁵⁴

Even for those wrongfully injured, compensation comes, if at all, after a long and frustrating delay. The injury may not be noticed immediately,⁵⁵ suit may not be filed promptly, and preliminary hearings may be mandated by law.⁵⁶ The adversary system of dispute resolution typically proceeds at a snail's pace. In one study, the delay for compensation for medical torts averaged seven years.⁵⁷ Too little for too many, too much for some, and too late for all?

B. Deterrence of Bad Medical Practice

The malpractice solution must at the same time operate to effectively deter wrongful conduct. A properly designed system must effectively deter negligent conduct by medical care providers, because medical injury prevention eventually reduces the cost of medical accidents, thereby leading to optimal economic efficiency.⁵⁸

outcomes arising out of medical misconduct. Only a minority of these cases are ever litigated. Mills, *Medical Insurance Feasibility Study—A Technical Summary*, 128 W.J. MED. 360 (1978).

⁵⁰ Contingency fees typically extract a third of the injured's award. In addition, plaintiff pays expert medical witnesses and court costs. *See supra* notes 14-15.

⁵¹ TORT POLICY WORKING GROUP, *supra* note 1, at 40. Million dollar jury awards for medical malpractice rose from three in 1975 to 71 in 1984.

⁵² *See supra* notes 25-26 and accompanying text.

⁵³ A recent settlement in Hawaii involved a five year old child who suffered a cardiac arrest and subsequent brain damage as she was about to undergo cardiac surgery for an arial septal defect. Total settlement amount: \$4.8 million. *Gutierrez v. Semenza*, Civil No. 70794 (Haw. 1st Cir. 1982), cited in *Medical Malpractice: Verdicts, Settlements & Experts*, Apr. 1986, at 4.

⁵⁴ Danzon, *supra* note 11, at 40. The author reports that awards rise less than in proportion to economic loss. However, errors in statistical analysis made it impossible to determine whether large losses are truly undercompensated.

⁵⁵ Surgical injuries are particularly apt to be discovered late such as a foreign body left behind in a body cavity.

⁵⁶ Screening panels are mandated by law in many states. *See supra* note 46. Hawaii's Medical Claims Conciliation Panel (MCCP) was first created in 1976. *See HAW. REV. STAT. § 671-5(b)* (Supp. 1984).

⁵⁷ *See supra* note 13.

⁵⁸ G. CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* (3d ed. 1986);

According to Dean Calabresi, an optimally efficient accident prevention policy minimizes the total costs of injuries, including the resource and utility costs of the injuries themselves, the preventive costs, and transaction or administrative costs.⁶⁰ Market or general deterrence allows individuals to consider accident costs in choosing among activities. This postulates that individuals are adequately informed about the alternatives, which is usually not the case in the choice and acceptance of medical services. Thus, specific deterrence is needed.⁶⁰ This can take the form of governmental regulation or the traditional tort action in negligence. With reference to medical malpractice, however, Calabresi believes that the current malpractice law is ineffective. Instead, Calabresi favors the establishment of a compensation fund to replace the malpractice suit.⁶¹

Society at large has generally rejected the notion that the medical profession can be trusted to discipline its members.⁶² State-operated professional regulatory boards have therefore been entrusted with the job of overseeing physician licensure and discipline,⁶³ but their success in maintaining competency has been challenged.⁶⁴ For example, in 1982, 14 states reported less than one disciplinary action per 1,000 physicians.⁶⁵ Thus, many assert that the tort system serves as an additional and necessary mechanism to deter physician malpractice.

A medical malpractice suit, or even the threat of one, undoubtedly instills fear, or at least exasperation in the medical practitioner.⁶⁶ Even though most

Posner, *A Theory Of Negligence*, 1 J. LEGAL STUD. 29 (1972). See also Schwartz, *Doctors, Damages and Deterrence*, 298 NEW ENG. J. MED. 1282 (1978).

⁶⁰ G. CALABRESI, *supra* note 58. See also P. DANZON, *supra* note 11, at 10.

⁶¹ G. CALABRESI, *supra* note 58, at 560-65.

⁶² Dean Calabresi professed an aversion to the current state of malpractice law because "it fails utterly to achieve what are its only sensible justifications: a) to induce better medical care, and b) to compensate efficiently those who suffer severe medical maloccurrences. . . ." He suggested establishment of a compensation fund that would take the place of the malpractice suit. "We can only get out of our mess by admitting what is hard to admit, that lots of errors and maloccurrences will occur, that as to all but the grossest, there isn't anything we can do, and that the best we can do is alleviate the suffering of those most severely injured."

Medicine vs. Law: A Deans' Dialogue, YALE ALUMNI MAG., 13 (Feb. 1986).

⁶³ Feinstein, *The Ethics Of Professional Regulation*, 312 NEW ENG. J. MED. 801 (1985). Dr. Feinstein underscores the prevailing societal view that the medical profession cannot be trusted to discipline itself. Although the overwhelming majority of physicians are competent, the few who are not should be identified and disciplined. Dr. Feinstein believes that medical disciplinary meetings should be held in public view to dispel myths about cover-up, and that non-physician members should serve on state medical boards to offer their perspective on the disciplinary process and to allay public anxiety.

⁶⁴ *Id.* See also *supra* note 28.

⁶⁵ Feinstein, *supra* note 62, at 802.

⁶⁶ *Id.* at 803.

⁶⁷ Physician fear of malpractice suits borders on paranoia:

Even the doctor who has never been sued is ever conscious of the sword of Damocles

cases are covered by malpractice insurance and the tortfeasor incurs no direct economic loss, there is nonetheless the matter of loss of self-esteem, adverse publicity, loss of practice time and income, guilt, depression and the threat of discipline by peers and licensure bodies.⁶⁷ In a few instances, there is actual exposure of personal assets, as where there is no insurance coverage, where the damages sought exceed the coverage, or where punitive damages are involved. Physician responses to increased professional liability risk typically include actions that can be construed as providing better medical care, such as spending more time with their patients and making more timely referrals to specialists.⁶⁸

On the other hand, there are factors that detract from effective deterrence. First, the insurance burden of substandard practice is evenly shared by all doctors in a given specialty. Unlike auto insurance, there is usually no experience rating for medical professional liability insurance.⁶⁹ The careful doctor derives no financial rebate from her insurance carrier; the careless doctor pays no surcharge. Second, the stigma that attaches to a malpractice suit is attenuated by widespread physician belief that most malpractice claims are without merit.⁷⁰ Certain high-risk specialties such as obstetrics and orthopedics experience a disproportionate number of claims.⁷¹ Furthermore, "one in five physicians now faces the prospect of a claim or suit today."⁷² Such overinclusion may explain the cynical attitude of doctors toward the probative value of malpractice claims to establish medical incompetence. At the same time, many acts of mal-

hanging over his head. . . . "As a physician, I live in an aura of fear—fear of suit. Fear contributes to hostility and rarely contributes to constructive action. . . ." [I]n my opinion, malpractice litigation is not the best incentive to improvement. It places medicine in an adversary position, and hostilities too often result. . . .

Sokol, *The Current Status Of Medical Malpractice Countersuits*, 10 AM. J.L. & MED. 439, 440-41 (1985) (quoting SECRETARY'S REPORT, *supra* note 1, at 20.)

⁶⁷ Significant psychic trauma results from a malpractice lawsuit. Serious symptoms include depression and suicide. See AMA REPORT 1, *supra* note 1, at 18-20; S. CHARLES & E. KENNEDY, DEFENDANT: A PSYCHIATRIST ON TRIAL FOR MEDICAL MALPRACTICE (1985). "Any suit, even though frivolous, costs the defendant money, time, reputation, and peace of mind. It's the fact that suit was threatened or brought, rather than the jury's decision or the amount of the settlement, that concerns us most." R. POLLACK, *supra* note 8, at XIII.

⁶⁸ See *supra* note 16.

⁶⁹ Schwartz, *supra* note 58, at 1287; SECRETARY'S REPORT *supra* note 1, at 42-44.

⁷⁰ In Hawaii, many malpractice claims are without merit. Hawaii's Medical Claims Conciliation Panel's (MCCP) found liability in only 24% of 453 claims filed during 1979-84. J. MARFIN, *supra* note 2, at 17.

⁷¹ *Id.* at iii.

⁷² AMA REPORT 1, *supra* note 1, at 10. In 1985, 155 claims were filed with the MCCP in Hawaii which has about 2,000 physicians. Typically, multiple defendants are named in each claim. J. MARFIN, *supra* note 2, at 13-16. These additional defendants include consulting specialists, nurses, and the hospitals.

feasance go unreported.⁷³ Because filing of suits and their disposition turn on factors other than physician negligence, errors of both overinclusion and underinclusion make malpractice claims a poor basis for professional discipline.

One also needs to consider the adverse effects of over-deterrence. Defensive medicine is one commonly cited example,⁷⁴ practiced not for proper medical reasons, but rather for medico-legal "protection."⁷⁵ Proponents of the present system contend that defensive medicine increases the quality of medical care. They assert that any test with the slightest utility should be carried out. This conclusion ignores patient cost, adverse complications of testing, and the need for proper medical judgment.⁷⁶

Another undisputed byproduct of over-deterrence is physician frustration. Some retire early to escape the "malpractice roulette,"⁷⁷ while others switch to less risky specialties or limit high-risk practice.⁷⁸ A typical example is that of family practitioners who give up obstetric deliveries because of oppressive malpractice insurance premiums.⁷⁹ The loss to society may be substantial; in certain locales, especially rural areas, the net result may be the total loss of certain medical services.⁸⁰ Regrettably, the tort mechanism for controlling substandard medical practice has, instead, driven competent and experienced doctors away from geographic and medical specialty areas in need of their expertise.

⁷³ Mills, *supra* note 49.

⁷⁴ See *supra* note 6.

⁷⁵ "A U.S. physician will order \$500 worth of tests that will give 98 percent diagnostic certainty rather than \$50 worth of tests that will yield 97 percent certainty." Neubauer, *supra* note 1, at 67. Some commentators argue that the estimated \$15.1 billion cost of defensive medicine is grossly exaggerated. See, e.g., Mills, *Information Please*, 6 J. LEGAL MED. 255, 257 (1985). But see Wertman, Sostrin, Pavlova & Lundberg, *Why Do Physicians Order Laboratory Tests?*, 243 J. A.M.A. 2080 (1980).

⁷⁶ All tests carry a finite risk of an adverse effect. Proper medical decisionmaking requires that a test or treatment be ordered when medically appropriate. Unfortunately, cost-benefit analysis and medico-legal considerations have crept into the definition of appropriateness. See generally AMA REPORT 1, *supra* note 1, at 16; Levey, *supra* note 7.

⁷⁷ Thirty-three percent of doctors thought about early retirement after being sued. AMA REPORT 1, *supra* note 1, at 20. A recent survey of Hawaii's physicians found 190 have taken or are considering taking early retirement, or are considering/have shifted practice specialty because of malpractice concerns. Haw. Med. Asso. Newsletter, Dec. 1985, at 2.

⁷⁸ Two hundred and seven physicians in Hawaii have limited or are considering limiting high risk practice. Haw. Med. Asso. Newsletter, Dec. 1985, at 2.

⁷⁹ Family practitioners on Molokai recently stopped delivering babies because their malpractice insurance premiums rose from \$14,000 to \$22,537 per year. Hawaii Medical Association, *Legislative Roundup*, Feb. 21, 1985 at 3.

⁸⁰ Molokai, for example, no longer has medical obstetric services. The high insurance cost has simply forced family practitioners to give up that part of their practice since there are only an average of 70 births per year on Molokai. A Honolulu obstetrician visits Molokai once a week, and many women are flying to Honolulu for their deliveries. *Id.*

C. Maintenance of Insurance Affordability and Reduction of Transaction Costs

Any solution to the malpractice problem should be affordable and should return to the injured the bulk of the insurance premium dollar with minimal transaction costs.

Premiums written for malpractice liability reached \$1.57 billion in 1983.⁸¹ Losses were \$2.0 billion for that year, surging from \$817 million in 1975, a 145% increase.⁸² Malpractice insurance ultimately costs the patient \$3-4 of each office visit, and \$5 per hospital day.⁸³ The average insurance premium paid by doctors in 1984 was \$8,400; this compares with \$4,700 in 1976.⁸⁴ The premiums paid by a high risk provider such as an obstetrician or a neurosurgeon are particularly shocking; Massachusetts obstetricians, for example, face an average \$51,800 bill this year.⁸⁵ The reinsurance bill is also staggering. For its 350 physicians, the Hawaii Physicians' Indemnity Plan is required to pay \$2.25 million for \$1 million of reinsurance with a \$500,000 deductible.⁸⁶

The malpractice crisis stems from a problem of injuries, rather than of claims.⁸⁷ According to a 1974 California study,⁸⁸ one in 126 hospital admissions resulted in an injury believed by medico-legal specialists to arise from medical negligence.⁸⁹ Statistical extrapolation from other data suggests that only one in ten of these incidents led to a claim.⁹⁰ These results indicate that the cost of injuries due to malpractice far exceeds the cost of claims.⁹¹ Therefore, the problem may not be patient litigiousness or insurance company or lawyer greed.⁹²

⁸¹ AMA REPORT 1, *supra* note 1, at 7.

⁸² *Id.* at 8.

⁸³ S.B. 175, 98th Cong., 2d Sess., 175 CONG. REC. § 290-4 (1985). The bill was introduced into Congress by Senator Inouye under the Health Care Protection Act of 1985. In Hawaii, malpractice costs translate into an increase of nearly \$10 per patient day. Testimony by Stan Snodgrass, President, Hospital Association of Hawaii, before the House Judiciary Committee, in Honolulu, Haw. (Feb. 26, 1986).

⁸⁴ *The Malpractice Blues*, *supra* note 1, at 60.

⁸⁵ *Id.* As a result of escalating premiums, 70% of Massachusetts obstetricians are planning to stop taking new patients. Haw. Med. Ass. Newsletter, Feb. 1986 at 3.

⁸⁶ Testimony of Norman Slaustas, Executive Vice President of Hawaii's Physicians' Indemnity Plan, before the Senate Committee on Health, in Honolulu, Haw. (Feb. 3, 1986) (Hawaii's Physicians' Indemnity Plan insures some 350 physicians).

⁸⁷ Danzon, *supra* note 11, at 18.

⁸⁸ *Id.* at 19. See also Mills, *supra* note 49.

⁸⁹ What constitutes malpractice is not always easy to define. A medico-legal "expert's" characterization of a maloccurrence as malpractice may prove erroneous. The majority of cases of alleged malpractice are decided otherwise by screening panels or at trial. See *supra* notes 48 & 49.

⁹⁰ Danzon, *supra* note 11, at 24.

⁹¹ *Id.* at 25.

⁹² *Id.* at 29.

Despite the high cost of malpractice insurance, the present system returns as little as 28 cents of every premium dollar to the injured victim.⁹³ The insurance carriers lament that underwriting medical liability insurance is unpredictable and unprofitable, and many have withdrawn from the market.⁹⁴ However, critics of the insurance industry suggest that the rate hikes resulted not from higher claims, but from poor premium investment return because of low prevailing interest rates.⁹⁵ Although some of the evidence may support this view, they fail to explain why many commercial carriers are getting out of the malpractice business, to be replaced by doctor-run nonprofit mutual companies, whose rates have also risen dramatically.⁹⁶

Some defense and plaintiff attorneys reap handsome monetary rewards from malpractice cases. The defense bar charges by the hour, which may act as a disincentive to quick resolution of the dispute. Typically, malpractice suits are complex, requiring hundreds of hours of legal work.⁹⁷ The plaintiff's attorney operates on the contingency fee structure, usually accepting a third of the

⁹³ Moore & O'Connell, *Foreclosing Medical Malpractice Claims By Prompt Tender Of Economic Loss*, 44 LA. L. REV. 1267, 1270 (1984). "It is estimated that the medical malpractice tort system returns at most only twenty-eight cents on the premium dollar to injured patients, of which only 12.5 cents reimburses the victim for pecuniary losses not compensated by other sources." Other estimates are slightly higher. See Schwartz, *supra* note 58, at 1282 (35 cents on the dollar); Danzon, *supra* note 11, at 16 (40 cents on the dollar).

⁹⁴ Hawaii, for example, no longer has a commercial carrier to underwrite individual physician malpractice liability. Argonaut Insurance Companies withdrew their services from the medical community in 1984. Hawaii's medical professional liability needs are being provided by the Medical Insurance Exchange Of California (MIEC) and the Hawaii Association Of Physicians For Indemnification (HAPI). Both are doctor-owned non-profit groups. Physicians at the Straub Clinic are still collectively insured by a commercial carrier.

⁹⁵ "What we are witnessing is a manufactured crisis intended to bloat insurer profits and reduce victims' rights." Perlman, *Don't Confuse Me With The Facts*, 22 TRIAL 5 (1986). "By manufacturing a malpractice 'crisis,' the medical and insurance industries have obfuscated their culpability for increased costs and at the same time have succeeded in setting back medical consumer tort remedies." Neubauer, *supra* note 1, at 68.

⁹⁶ The National Insurance Consumer Organization, among others, blames the insurance industry for the liability crisis. Its calculations purport to show that the industry's 6% rate of return in 1985 was too low, and that this figure could have been boosted to 13% by a mere 3% increase in premiums—hardly a justification for its widespread policy cancellations and mammoth price increases. Testimony by Robert Hunter, President, National Insurance Consumer Organization, before the Hawaii State Legislature, in Honolulu, Haw. (Feb. 19, 1986).

Hawaii's internists paid \$1041 in annual premiums in 1975; this figure increased by 469% to reach \$5924 in 1985. Comparable figures for an obstetrician are \$4498 and \$42,783 respectively, a 851% increase. Most of Hawaii's physicians are insured by a non-profit doctor-owned mutual company, the Medical Insurance Exchange of California (MIEC), there being no commercial carrier underwriting malpractice insurance for private practitioners. See *supra* note 94.

⁹⁷ At \$100—\$150 per hour, defense attorneys' bills typically run in the tens of thousands per malpractice case. The costs easily double or triple if the case goes to trial.

award.⁹⁸ Both defense and plaintiff's attorneys are required to use expert medical witnesses to establish the standard of care alleged to have been breached.⁹⁹ These experts take opposing viewpoints regarding the defendant-physician's conduct, and are handsomely remunerated for their efforts. In many cases, several experts are employed by each party. Their individual bills run in the thousands of dollars, adding substantially to the cost of medical negligence litigation.¹⁰⁰

D. Preservation of the Doctor-Patient Trust Relationship

It is well established that the patient must trust her doctor for maximum therapeutic benefit.¹⁰¹ An adversarial relationship between a doctor and her patient is inimical to the healing process. Mutual trust is needed to elicit an accurate medical history and to perform a proper physical examination. Medical advice for testing and treatment has to be freely given and accepted in an atmosphere of confidence. Suspicion, hesitancy, or confrontation can poison the relationship irreversibly.¹⁰²

A significant part of the doctor's healing powers comes from the faith of the patient she treats. Her power to reassure and convince is an integral part of her therapeutic armamentarium.¹⁰³ Suspicion destroys this doctor-patient relationship. The doctor must inform her patient of diagnostic and treatment plans; this is embodied in the doctrine of informed consent, and is codified in many

⁹⁸ If the plaintiff does not prevail, the attorney gets nothing for her efforts. Part of the justification for the plaintiff's lawyer's large contingency fees is to offset these losses. See generally Comment, *Medical Malpractice And Contingency Fee Controls: Is The Prescription Curing The Crisis Or Killing The Patient?*, 19 LOY. L.A.L. REV. 623 (1985); Reames, *Contingency Fees: Victim Or Contributing Cause Of Medical Malpractice Reform Acts?*, 62 CHI.-KENT L. REV. 271 (1985).

⁹⁹ An expert witness is usually needed to establish the customary standard of care, except in cases where *res ipsa loquitur* is invoked. PROSSER & KEETON ON TORTS, *supra* note 19, § 39, at 256-57. In Hawaii, this proposition was enunciated in *Lyu v. Shinn*, 40 Haw. 198 (1953); *Cozine v. Hawaii Caramaran Ltd.*, 49 Haw. 77, 412 P.2d 669 (1966); *Winter v. Scherman*, 57 Haw. 279, 554 P.2d 1137 (1976).

¹⁰⁰ Expert medical witnesses typically charge between \$150—\$300 per hour for time expended in reviewing records, travel, research, attorney discussions, and testifying at depositions and in court. Horsely, *supra* note 15.

¹⁰¹ "In the absence of a sense of trust and confidence on the part of the patient, the effectiveness of therapeutic measures is diminished." HARRISON'S PRINCIPLES OF INTERNAL MEDICINE, *supra* note 30, at 6.

¹⁰² Unfortunately, adversariness is increasingly evident in doctor-patient encounters. "An atmosphere of distrust between the laity and the medical profession is symptomatic of the changing attitudes and expectations of today's society." R. POLLACK, *supra* note 8, at 3.

¹⁰³ "In many instances, when there is confidence in the physician, reassurance alone suffices and is all that is needed." HARRISON'S PRINCIPLES OF INTERNAL MEDICINE, *supra* note 30, at 6.

jurisdictions.¹⁰⁴ The doctor should seek the patient's understanding and cooperation, and assuage the patient's fears.¹⁰⁵ While the treatment goals sought by both patient and doctor are usually identical, the doctor must be allowed her clinical judgment in decisionmaking. An ideal malpractice solution should jealously guard against the erosion of this implicit trust relationship which is essential for the effective delivery of medical care.¹⁰⁶

The threat of litigation adversely affects physician satisfaction in their work. Physicians may feel hurt and betrayed when they are subjected to a law suit.¹⁰⁷ Their attitudes may change, and some may become less involved with and increasingly distant from their patients.¹⁰⁸ Professor Sara Charles, a psychiatrist who has studied the emotional effects of malpractice complaints on doctors,¹⁰⁹ has concluded that "for many physicians, one of the greatest sources of satisfaction in their work—the feeling that they are helping people—has been compromised by the present climate."¹¹⁰

The adversarial nature of the tort system is not well-suited to settling doctor-patient disputes. Because it may be impossible to evaluate and assess fault in certain instances, the physician commonly perceives herself as a victim of hindsight, unjustifiably exposed to adverse publicity.¹¹¹ Initial depression gives way to anger and disappointment over what she perceives as patient ingratitude and greed.¹¹² A doctor's attitude towards and rapport with subsequent patients may

¹⁰⁴ See *supra* notes 39-42 and accompanying text.

¹⁰⁵ See *supra* note 103.

¹⁰⁶ Depersonalization of treatment is properly blamed for much of the loss of doctor-patient rapport.

This development is in part due to the increased specialization of medicine and the decreased amount of time spent with patients. . . . How should this affect your treatment? It means being less greedy. You must make sure that you allot enough time to each patient. Many physicians today simply overload themselves. If a physician tells me that he sees forty patients a day, I know he is breeding a potential malpractice suit.

W. ALTON, *MALPRACTICE: A TRIAL LAWYER'S ADVICE FOR PHYSICIANS* 47 (1977).

¹⁰⁷ Charles, *Why Are Doctors So Upset?*, *MED. MALPRACTICE PREVENTION* 10 (July/Aug., 1986).

¹⁰⁸ *Id.*

¹⁰⁹ See S. CHARLES & E. KENNEDY, *supra* note 67.

¹¹⁰ See *supra* note 107.

¹¹¹ "It may be hard to believe, but we are a frightened profession. The doctor feels put upon. He feels nude on the corner of the Main Street of life" SECRETARY'S REPORT, *supra* note 1, at 20 (quoting Dr. George Northup).

¹¹² One study noted:

More than one-third [of 154 physicians surveyed] admitted to four or five symptoms suggestive of a possible major depressive disorder after the suit and 8% noted the onset of a physical illness. . . . 'It is the litigation process itself that is agonizing and stressful. . . . People have to realize that suing your doctor is not an event that has no repercussions.'

AMA REPORT 1, *supra* note 1, at 20.

suffer from such an unhappy encounter. This erosion of the doctor-patient trust relationship extends to those physicians not directly involved in litigation. Doctors, in general, are increasingly adopting a defensive posture towards their patients out of misplaced or exaggerated fear.¹¹³ Irrespective of whether such behavior is justified, the fact remains that the present fault-based tort system threatens destruction of the traditional doctor-patient relationship.

III. TORT REFORMS: WILL THEY WORK?

Under the present tort system, the injured are compensated randomly and unfairly, prompting some commentators to characterize it as a "lottery."¹¹⁴ Moreover, the lack of affordable medical malpractice insurance has reached crisis proportions.¹¹⁵ The American Medical Association has taken the lead in a "crusade" for tort reform to correct the perceived inequities of the system,¹¹⁶ and many states are currently considering the adoption of these reform proposals.¹¹⁷ Recently, the Tort Policy Working Group established by the U.S. Attorney General has released its findings in strong support of tort reform.¹¹⁸ It concluded that "while there are a number of factors underlying the insurance availability/affordability crisis, tort law is a major cause" ¹¹⁹ The Group recommended eight reforms that should significantly alleviate the crisis.¹²⁰

This section analyzes the fairness and effectiveness of some of the more "popular" tort reforms. A measure of relief will probably result from these reforms, because they serve to restrict the size of the damage awards. These reforms, however, fail to address the fundamentally unjust manner in which victims of medical injuries are compensated. Restricting reforms only to medical torts may also be unjustified. The American Bar Association's Committee on Medical Professional Liability recently announced its opposition to tort reform, believing that "changing tort law rules and procedures to give special status to any spe-

¹¹³ Doctors "now have a new service to identify sue-happy plaintiffs. It is Physicians Alert . . . originally conceived by a lawyer The service enables doctors to learn if a potential patient has a history as a plaintiff in tort litigation." Blodgett, *supra* note 1, at 19.

¹¹⁴ See Moore & O'Connell, *supra* note 93, at 1269.

¹¹⁵ AMA REPORT 1, *supra* note 1.

¹¹⁶ AMA REPORT 2, *supra* note 1.

¹¹⁷ Hawaii is no exception. No fewer than 117 tort reform bills were introduced to the 1986 Hawaii Legislature, which went into Special Session to deal with the tort reform issue. See *infra* note 161.

¹¹⁸ TORT POLICY WORKING GROUP, *supra* note 1.

¹¹⁹ *Id.* at 5.

¹²⁰ *Id.* at 4. The eight reforms that were recommended were: (1) retain the fault-based standard, (2) base causation on credible evidence, (3) eliminate joint and several liability, (4) limit non-economic damages, (5) provide for periodic payments, (6) reduce payments from collateral sources, (7) limit contingency fees, and (8) encourage alternative dispute resolution.

cific professional group or groups would be both inappropriate and unjustified."¹²¹

A. Caps on Noneconomic Losses

This proposal limits the amount recoverable for noneconomic losses such as pain and suffering, but allows for full recovery of economic damages. In 1975, the California legislature enacted a \$250,000 cap on noneconomic loss; this statute has withstood constitutional challenge.¹²² The rationale behind this proposal is to provide some predictability to the amount of damages that can be awarded. Noneconomic damages are difficult to quantify, and jury sympathy may result in unrealistically high payments.¹²³ A 1977 study by the American Bar Association opposed limiting economic losses, but was neutral regarding limiting noneconomic damages.¹²⁴ In contrast, the Tort Policy Working Group recommends restricting noneconomic losses to \$100,000.¹²⁵ Recent data indicate that this measure has been successful in reducing skyrocketing damage awards. A Rand Corporation study estimated that California's noneconomic loss cap reduced claim severity by 19% within two years.¹²⁶

The plaintiffs' bar, however, opposes limiting economic damages. They argue, correctly, that such limits unfairly discriminate against the victim with severe injuries such as the quadriplegic. In the final analysis, it seems a matter of social policy whether pain and suffering is compensable and to what extent. It should also be noted that in the worker's compensation scheme, marked

¹²¹ Silas, *supra* note 1. The ABA's recommendations on medical professional liability were adopted by its House of Delegates on Feb. 11, 1986. See American Bar Association, Special Committee On Medical Professional Liability, Report to the House of Delegates. "Simply put, this committee believes that the medical profession, in seeking changes in the tort law system, has shown a willingness to trade away the rights of individuals in the hope of easing a perceived burden on itself." *Id.* at 43-44.

¹²² *Fein v. Permanente Medical Group*, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368, cert. denied, 106 S. Ct. 214 (1985) (provisions of Medical Injury Compensation Reform Act which limit noneconomic damages in medical malpractice cases to \$250,000 and which modified traditional collateral source rule in litigation are not unconstitutional); *Roa v. Lodi Medical Group*, 37 Cal. 3d 920, 695 P.2d 164, 211 Cal. Rptr. 77 (1985) (statute on restriction of attorney's fees held not unconstitutional as denial of due process or violation of equal protection).

¹²³ O'Connell, *supra* note 14. "Jurors will award substantially less for a seriously injured back or other injury they cannot see, than for a more visually striking injury such as extensive scarring." *Id.* at 900.

¹²⁴ AMERICAN BAR ASSOCIATION, LEGAL TOPICS RELATING TO MEDICAL MALPRACTICE, submitted to U.S. Department of Health, Education and Welfare, Jan. 1977, at iv [hereinafter ABA STUDY].

¹²⁵ TORT POLICY WORKING GROUP, *supra* note 1, at 66-69.

¹²⁶ *An Overview Of The First Five Program Years*, INST. FOR CIV. JUST., RAND CORP., Apr. 1980-Mar. 1985, at 45 [hereinafter RAND STUDY].

restriction of noneconomic payments exists without evoking widespread complaints of unfairness.¹²⁷

B. Abrogation of Joint and Several Liability

Under the doctrine of joint and several liability, every defendant who is determined to be a legal cause of plaintiff's injury may be held responsible for the entire damage award in the event that other defendants cannot be joined or are unable to pay for their proportionate share of fault.¹²⁸ Opponents of this rule argue that it is unfair for a defendant to pay more than a proportionate share of the damages. They assert that the rule encourages the plaintiff to seek a "deep pocket" defendant irrespective of how minimal that defendant's liability may be.¹²⁹

Supporters of the joint and several liability doctrine contend that it is fairer for the tortfeasor to fully compensate the innocent victim irrespective of the degree of fault than for the victim to be undercompensated.¹³⁰ They further emphasize that the minimally negligent tortfeasor is no less a but-for cause of the injury, and therefore the victim should be entitled to full compensation.¹³¹

The American Medical Association is silent on the issue of joint and several liability.¹³² The Tort Policy Working Group, on the other hand, has recommended the doctrine's abrogation, except in the limited circumstance where the plaintiff can demonstrate that the defendants have actually acted in concert to cause plaintiff's injury.¹³³ Because of the inequities involved in the application

¹²⁷ Worker's compensation benefits are awarded in accordance with predesignated schedules. The amounts allowed are considerably less than traditional tort recoveries. Hawaii's workers compensation laws are codified at HAW. REV. STAT. ch. 386 (1976).

¹²⁸ See Prosser, *Joint Torts and Several Liability*, 25 CAL. L. REV. 413 (1937). See also *Kendro, The 1% Law*, 44 HAW. MED. ASSO. J. 248 (1985).

¹²⁹ In medical malpractice, the deep pocket is invariably the hospital, which explains why Hawaii hospitals have recently required physicians to carry liability insurance before granting hospital medical staff privileges.

¹³⁰ See *American Motorcycle Assn. v. Superior Court*, 20 Cal. 3d 589, 578 P.2d 899, 146 Cal. Rptr. 182 (1978). The term "the 1% law" has been used to describe this phenomenon. *Kendro, supra* note 128. Previously, in Hawaii, a 1% liable co-defendant could have been responsible for the entire damage award. Indeed, even if the plaintiff was 50% liable, the 1% co-defendant was liable for the remaining 50% under Hawaii tort law of comparative negligence. Only if the aggregate negligence of all defendants fell below 50% was there no liability. HAW. REV. STAT. § 663-31 (1976). See *infra* text accompanying note 166 for Hawaii's recently enacted law on joint and several liability.

¹³¹ See Comment, *Abrogation of Joint and Several Liability: Should Missouri Be Next in Line?*, 52 UMKC L. REV. 72 (1983).

¹³² AMA REPORT 3, *supra* note 1.

¹³³ TORT POLICY WORKING GROUP, *supra* note 1, at 65. But see AMERICAN COLLEGE OF TRIAL LAWYERS, REPORT OF THE TASK FORCE ON LITIGATION ISSUES 18 (1986).

of joint and several liability, a limitation on the common law doctrine is appropriate.¹³⁴ This would confer predictability and stability on the malpractice insurance industry, which in turn should lead to moderation of the premium spiral.¹³⁵

C. Abolition of the Collateral Source Rule

Under this rule, if an injured person receives compensation for her injuries from a source wholly independent of the tortfeasor, the payment should not be deducted from the tortfeasor.¹³⁶ By making evidence of collateral payments inadmissible, the law creates the situation where the injured victim may be over-compensated.¹³⁷ Abolition of the rule would reduce the damages by an amount equal to collateral payments derived from health and disability insurance and other sources.

Proponents of the collateral source rule contend that a victim should not be penalized for prudence in buying insurance protection. Additionally, subrogation rights already require the victim to reimburse health insurers in the event of tort recovery.

Collateral payments should be subtracted from jury awards to prevent double dipping, because subrogation is not a significant consideration in many tort actions, especially medical malpractice cases.¹³⁸ To support dual insurance coverage for the same injury is to endorse an inefficient system with duplicative premiums.¹³⁹ Some commentators have proposed abolishing subrogation to avoid duplicative premium payments and to lower transaction costs.¹⁴⁰ Initial studies indicate that the elimination of the collateral source rule significantly reduces damage awards. In California, the Rand Corporation estimated that abolition of this rule reduced awards by as much as 50%.¹⁴¹

D. Regulation of Attorney Contingency Fees

The proposal to regulate attorney fees does not eliminate the contingency fee structure, but rather seeks to reduce, on a sliding scale basis, the amounts attor-

¹³⁴ TORT POLICY WORKING GROUP, *supra* note 1, at 65.

¹³⁵ See *infra* text accompanying note 166 for the recent amendment to the application of joint and several liability in Hawaii.

¹³⁶ *Helfend v. Southern California Rapid Transit Dist.*, 2 Cal. 3d 1, 465 P.2d 61, 84 Cal. Rptr. 173 (1970).

¹³⁷ "This procedure amounts to coining money!" O'Connell, *supra* note 14, at 901.

¹³⁸ TORT POLICY WORKING GROUP, *supra* note 1, at 71.

¹³⁹ O'Connell, *Offers That Cannot Be Refused*, *supra* note 26, at 593.

¹⁴⁰ See *supra* notes 138 & 139.

¹⁴¹ RAND STUDY, *supra* note 126.

neys would collect.¹⁴² This reform will return to the victim a larger portion of the damage award or reduce the actual total amount awarded.

The plaintiffs' bar argues that such regulation is unwarranted and intrusive, and deprives the poor man of his "key to the courthouse." They assert that removal of the contingency system is ill-advised, as it robs the poor of litigating a meritorious claim.¹⁴³ Furthermore, the plaintiffs' bar contends that regulation of contingency fees may make it unprofitable to sue, and therefore, jeopardizes the victim's chances of selecting and obtaining competent counsel.¹⁴⁴

Is it reasonable for a plaintiff's attorney to regularly take a third or more of the victim's award as payment? If so, a \$3 million award for a claimant wrongfully injured would net the lawyer \$1 million in fees.¹⁴⁵ Under the present system, a jury that ignores the contingency fee system may inadequately compensate the injured victim. In most situations, the attorney's share is used by the jury to escalate the compensation amount. The inefficiency caused by the present system indicates that some regulation of contingency fees is required to curtail such windfall profits.

E. Other Tort Reforms

Other reform proposals include: (1) mandatory structured payments in which periodic rather than lump-sum payments are made; (2) penalties for the filing of frivolous suits; (3) modified statutes of limitations, reducing the time interval during which suit can be brought for injuries to infants and minors; (4) stricter standards for expert witnesses; and (5) affidavits of non-involvement where the physician can file an affidavit denying involvement, and the plaintiff must present evidence at a hearing that establishes a reasonable basis for instituting an action against the individual doctor.¹⁴⁶ One additional proposal, already in

¹⁴² See AMA REPORT 3, *supra* note 1, at 13; TORT POLICY WORKING GROUP, *supra* note 1, at 72. The following sliding scale contingency fee schedule was recommended by the Tort Policy Working Group: 25% for the first \$100,000, 20% for the next \$100,000, 15% for the next \$100,000, and 10% for the remainder. Thus, for an award of \$1,000,000, plaintiff's attorney would receive \$130,000 rather than \$333,333, assuming a one-third contingency fee.

¹⁴³ Perlman, *supra* note 95, at 5. The author debunks the myth that the contingency fee brings more non-meritorious suits into courtrooms and gives deserving plaintiffs less and lawyers more.

¹⁴⁴ Schwartz, *supra* note 58, at 1288.

¹⁴⁵ The Tort Policy Working Group believes that as the average plaintiff's verdict has increased in recent years, such high contingency percentages become difficult to justify. "Increasingly, there are indications of extraordinary abuses where attorneys receive fees in the hundreds of thousands of dollars for limited work." TORT POLICY WORKING GROUP, *supra* note 1, at 72.

¹⁴⁶ The AMA REPORT notes:

Not infrequently, plaintiffs name everyone remotely connected with the defendant's allegedly negligent treatment when filing a lawsuit. . . . To eliminate this situation, any de-

place in many states, is the mandatory pre-trial screening panel.¹⁴⁷ The objective of such a panel is to weed out at an early stage nonmeritorious, frivolous or nuisance suits. Some of these panels have been found unconstitutional.¹⁴⁸ Although the panels are generally popular among physicians, at least in Hawaii,¹⁴⁹ critics contend that they merely prolong the litigation process, increasing costs without substantial corresponding benefit.¹⁵⁰

F. California's Medical Injury Compensation Reform Act

Many of the above reforms were passed by the California legislature in 1975 under the Medical Injury Compensation Reform Act (MICRA).¹⁵¹ MICRA limits noneconomic recovery in medical negligence cases to \$250,000 and permits juries to be informed of collateral source payments. Attorney fees are placed on a sliding scale so that only a 10% contingency fee for awards over \$200,000 is allowed. The California Supreme Court has recently ruled that these reforms are constitutional since they are rationally related to the legitimate legislative goal of reducing medical costs.¹⁵²

The effect of MICRA is significant. California hospitals are due for a rebate

defendant should be able to file an affidavit denying involvement in the allegedly negligent care. A hearing would be held shortly after the affidavit is filed, during which the plaintiff must present evidence that establishes a reasonable basis for the defendant being named. AMA REPORT 1, *supra* note 1, at 14.

¹⁴⁷ For the states which have such screening panels, see AMA REPORT, *supra* note 1. See also HAW. REV. STAT. § 671-5(b) (Supp. 1984).

¹⁴⁸ See generally Note, *Medical Malpractice Screening Panels: A Judicial Evaluation Of Their Practical Effect*, 42 U. PITT. L. REV. 939 (1981). In *Mattos v. Thompson*, 491 Pa. 385, 421 A.2d 190 (1980), the Pennsylvania Supreme Court found an inefficiently run panel to be an undue burden upon the right to a jury trial.

¹⁴⁹ Ninety-three percent of doctors polled in Hawaii felt that a mandatory pre-suit hearing was helpful in resolving malpractice complaints. J. MARDEFIN, *supra* note 2, at 33.

¹⁵⁰ Hawaii's panel findings are non-binding and inadmissible at trial. The statute allows up to 18 months for a hearing, and suit can only be filed after a panel decision has been rendered. HAW. REV. STAT. § 671-11-16 (1976).

¹⁵¹ MICRA was the most comprehensive legislative package enacted into law during the 1975 malpractice crisis. Medical Injury Compensation Reform Act of 1975, Cal. A.B. LXIX, 1975-76 2d Ex. Sess., ch. 1, 2 Cal. Stat. 3949 (1975). Modification of the collateral source rule is codified under CAL. CIV. CODE § 3333.1 (West Supp. 1986), and noneconomic cap under CAL. CIV. CODE § 3333.2 (West Supp. 1986). Periodic payments are codified under CAL. CODE CIV. PRO. § 667.7 (West 1980), and attorney contingency fees under CAL. BUS. & PROF. CODE 6146 (West Supp. 1986). The joint tortfeasor rule was not modified under MICRA. However, California voters recently approved Proposition 51, a ballot initiative that eliminates "deep pocket" awards for noneconomic damages. Am. Med. News, June 13, 1986, at 1.

¹⁵² *Fein v. Permanente Medical Group*, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368, cert. denied, 106 S. Ct. 214 (1985); *Roa v. Lodi Medical Group*, 37 Cal. 3d 920, 695 P.2d 164, 211 Cal. Rptr. 77 (1985).

on their liability premiums of \$10 million.¹⁵³ A study commissioned by the California Medical Association concluded that MICRA has been effective in holding down claim costs, reducing the rate of increase from 15% in the pre-MICRA years to 7% post-MICRA.¹⁵⁴ The study concluded that repeal of MICRA would cause claim costs to soar.¹⁵⁵ At the present rate of increase, the average annual premium for a California doctor would rise to \$9,000 by 1990; if MICRA had not been enacted, this figure would have been \$25,000.¹⁵⁶

Others have not been as impressed with MICRA's effectiveness.¹⁵⁷ Obstetricians in the Los Angeles area recently paid between \$35,720 and \$61,052 for malpractice insurance.¹⁵⁸ Moreover, the cost is apparently rising.¹⁵⁹ In addition, MICRA has failed to decrease the number of malpractice filings. In California, as in the rest of the nation, the number of claims has risen steadily—from 8 per 100 physicians in 1979, to 17 per 100 in 1983, and 22 per 100 in 1985.¹⁶⁰

G. Hawaii's 1986 Tort Reform

The State of Hawaii recently convened a special legislative session to address the issue of tort reform, finding that "a solution to the current crisis in liability insurance has created an overpowering public necessity for a comprehensive combination of reforms to both the tort system and the insurance regulatory system."¹⁶¹ Some of these reforms enacted into law directly impact medical professional liability.

1. *Premium Rollback*:¹⁶² Reduction of commercial liability policy premiums by 12% is mandated for October 1987 with a further 15% for 1988. However, Hawaii's primary malpractice carrier, the Medical Insurance Exchange of California (MIEC), has expressed concern that it may not be able to obtain reinsurance under this mandated rollback law.¹⁶³
2. *Collateral Source Rule*:¹⁶⁴ The reform protects liens and rights of subrogation

¹⁵³ California Hospitals Split \$10 Million in Refunds, 15 Modern Health Care 46 (1985).

¹⁵⁴ Actuarial Study of Professional Liability Insurance for the California Medical Association, (May 31, 1985) (Future Cost Analysts, Newport Beach, CA.) at 1.

¹⁵⁵ *Id.* at 2.

¹⁵⁶ *Id.*

¹⁵⁷ Rodarmor, *The Other Side Of Medical Malpractice*, 6 CAL. LAW. 38 (1986).

¹⁵⁸ *Id.* at 40.

¹⁵⁹ *Id.* at 39.

¹⁶⁰ National figures indicate an increase of 88.6% in claims frequency between 1979 and 1983. AMA REPORT 1, *supra* note 1, at 10.

¹⁶¹ A Bill For An Act Relating To Liability, (Aug. 4, 1986) [hereinafter Hawaii Tort Reform].

¹⁶² *Id.* § 3, at 3.

¹⁶³ Haw. Med. Asso. Newsletter, Aug. 1986, at 1.

¹⁶⁴ Hawaii Tort Reform, *supra* note 161, § 16, at 20-1.

by requiring payment out of the amount of judgment or settlement to the valid lienholder, less reasonable litigation costs incurred by the claimant. Thus, the new law prevents double dipping,¹⁶⁶ but it does not reduce the total amount of damages.

3. *Joint and Several Liability*:¹⁶⁸ This legal doctrine is preserved for the recovery of economic damages. However, a defendant must be at least 25% negligent to be jointly liable for noneconomic losses. Certain types of torts are specifically exempted under this new law.¹⁶⁷ The exclusion of strict liability and products liability torts results in the continued exposure of the nonnegligent physician to joint and several liability for damages resulting from iatrogenic reactions to drugs, vaccines and medical devices.¹⁶⁸

4. *Limitation of Noneconomic Loss*:¹⁶⁹ The new law limits pain and suffering awards to \$375,000. Pain and suffering is defined as "actual physical pain and suffering that is the proximate result of a physical injury sustained by a person."¹⁷⁰ There is, however, no cap imposed on other forms of noneconomic damages such as "mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and all other non-pecuniary losses or claims."¹⁷¹ Because of the Act's restriction to actual physical pain, this provision is unlikely to significantly reduce damage awards.

5. *Economic Loss*:¹⁷² Under the new tort reform law, after-tax rather than gross income will be used in computing earnings loss for purposes of awarding economic damages. Thus, the law may be expected to reduce most damage awards without unfairly penalizing the claimant.

6. *Statute of Limitations*:¹⁷³ The statute has also shortened the statute of limitations for medical malpractice suits involving minors. Under the new law, they are to be commenced within six years of the injury or by the minor's tenth birthday, whichever is longer. This replaces the old law under which the statute of limitations did not run until the minor reached the age of majority.¹⁷⁴ This reform would provide particular relief to obstetricians and pediatricians.

7. *Mandatory Non-Binding Arbitration*:¹⁷⁵ The tort reform law further mandates arbitration of all civil tort actions having a judgment value up to

¹⁶⁶ See *supra* notes 136-141 and accompanying text.

¹⁶⁸ Hawaii Tort Reform, *supra* note 161, § 17, at 21.

¹⁶⁷ *Id.* at 21-2.

¹⁶⁸ See *supra* note 163, at 2.

¹⁶⁹ Hawaii Tort Reform, *supra* note 161, § 19, at 24.

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.* § 18, at 23.

¹⁷³ *Id.* § 15, at 19-20.

¹⁷⁴ HAW. REV. STAT. § 657-7.3 (Supp. 1984).

¹⁷⁵ Hawaii Tort Reform, *supra* note 161, § 21, at 24-26.

\$150,000. Appeals for de novo trials may follow.¹⁷⁶ Medical torts will presumably continue to be presented before the Medical Claims Conciliation Panel (MCCP) prior to arbitration.¹⁷⁷ In other words, a malpractice claim must go through two separate non-binding adjudication processes before suit can be filed. Whether the additional time and effort expended will result in a fairer judgment or be cost-effective is uncertain.

8. *Subsidy for Obstetricians and Gynecologists*:¹⁷⁸ The new law provides for a one-time \$100,000 subsidy towards obstetrics insurance premiums in areas of limited services. This provision is intended to attract obstetricians to Molokai where obstetrical services are in jeopardy.¹⁷⁹ This subsidy, however, is not extended to family practitioners, and they are the ones who have traditionally provided obstetrical care in Molokai.

9. *Attorneys' Fees*:¹⁸⁰ The Act provides that fees of both plaintiffs' and defense attorneys "shall be limited to a reasonable amount as approved by the court having jurisdiction of the action."¹⁸¹ The contingency fee structure is preserved, with no sliding scale restrictions. Essentially, the new law works no change in the regulation of attorneys' fees.

10. *Periodic Payments*:¹⁸² The legislation applies only to state and county governments for judgments in excess of \$1,000,000, permitting payments to be structured over a five-year period.

Issues surrounding the liability crisis are complex, and no single tort reform package is likely to be embraced by all parties. Although 74% of those polled felt that the liability insurance situation is a significant problem in Hawaii,¹⁸³ more than half did not have a "pretty good understanding of the debate over liability insurance and liability lawsuits."¹⁸⁴ The Hawaii medical community has expressed reservations regarding the new law,¹⁸⁵ suggesting that the reform package "makes too many compromises to offer hope of effective relief from soaring insurance rates."¹⁸⁶

In view of the above, Hawaii's tort reform package will fail to have a palpa-

¹⁷⁶ HAW. ARB. R. 22.

¹⁷⁷ See *supra* note 147.

¹⁷⁸ Hawaii Tort Reform, *supra* note 161, § 23, at 26-27.

¹⁷⁹ See *supra* note 5.

¹⁸⁰ Hawaii Tort Reform, *supra* note 161, § 11, at 16.

¹⁸¹ *Id.*

¹⁸² Hawaii Tort Reform, *supra* note 161, § 14, at 18.

¹⁸³ Keir, *Tort Reform A Problem Hard To Fathom*, Polls Find, Honolulu Advertiser, Aug. 9, 1986, at A1, col. 3.

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

¹⁸⁶ "[T]hese concepts will need to be refined and expanded in order to achieve the meaningful reform that is needed to alleviate the liability crisis and prevent its recurrence." Haw. Med. Asso. Newsletter, *supra* note 163, at 1.

¹⁸⁶ Honolulu Star-Bull., July 31, 1986, at A14, col. 1.

ble effect on the malpractice crisis. The reforms are modest at best, and are considerably less sweeping than those enacted in other states, including California.¹⁸⁷ Additionally, sections of the law relating to premium rollbacks, joint and several liability, and the cap on pain and suffering are scheduled to be repealed in three years.¹⁸⁸ This repeal may be premature, because the effectiveness, if any, of these provisions will take longer than three years to become apparent.¹⁸⁹ Most importantly, these reforms do not address the problem of inefficiency and unfairness in the way in which victims are compensated under the present tort system.¹⁹⁰ A fundamental change in the approach to compensating victims of medical care is needed; one which foregoes fault-finding and returns to the victims most of the insurance premium dollar by virtue of low transaction costs.¹⁹¹

IV. THE NO FAULT SOLUTION

It has been asserted by Professor O'Connell that if the present fault-based tort system is dysfunctional, it is because of the tremendous inefficiency, unfairness, and prohibitive costs which fault-proving engenders.¹⁹² The injured victim is randomly and unjustly compensated. Additionally, the contentiousness and adversarial nature of the proceedings traumatize the physician and the doctor-patient relationship, with grave implications for the medical care system. In many instances, fault simply cannot be ascertained.¹⁹³

Some of these same criticisms led to the introduction of the no-fault concept

¹⁸⁷ Hawaii's largest physician malpractice carrier, the Medical Insurance Exchange of California (MIEC), has characterized Hawaii's newly enacted tort reforms as "no help." MIEC insists that a limitation of contingency fees and non-economic damage awards, and periodic payments, are the most positive and immediately effective legislative actions needed to reduce loss and premiums. *The View From Here*, MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, Dec., 1986, at 1.

¹⁸⁸ Hawaii Tort Reform, *supra* note 161, at 29.

¹⁸⁹ "It will take many years before the effectiveness of this legislation can be measured. . . . [I]t often takes three or more years to bring a claim to resolution." Haw. Med. Asso. Newsletter, Aug. 1986, at 4.

¹⁹⁰ See *supra* notes 12, 93.

¹⁹¹ *Id.*

¹⁹² See *supra* notes 14, 26, 93. See also Havighurst, *supra* note 12; Halley, *Medical Malpractice—1985: Reflections Of A Health Care Provider*, 85 J. KAN. MED. SOC'Y. 323 (1984).

The feasibility of strict liability for compensating medical injuries was favorably explored by the Secretary's Commission on Medical Malpractice in 1973. Roth & Rosenthal, *Non Fault Based Medical Injury Compensation Systems*, SECRETARY'S REPORT app. at 450. However, the Department of Justice has recently condemned the movement of the tort system towards no-fault liability, decrying "compensation often awarded merely for the sake of compensation." TORT POLICY WORKING GROUP, *supra* note 1, at 30-33.

¹⁹³ See *supra* notes 30-45 and accompanying text.

for auto injuries and for injuries arising out of employment.¹⁹⁴ In general, the abolition of fault-finding has resulted in a more efficient system for auto injuries.¹⁹⁵ The no-fault approach does not appear to be associated with an increase in negligent conduct, nor has the cost been burdensome.¹⁹⁶ No one would seriously suggest a return to the traditional fault-based system for these injuries.¹⁹⁷

No-fault patient injury compensation schemes are currently operating in Sweden¹⁹⁸ and New Zealand.¹⁹⁹ It is too early, however, to conclude how successful they have been.

A. The Compensable Event

Injuries arising out of medical care differ in one essential aspect from all other injuries—they may be a natural consequence of the underlying illness or an unavoidable result of medical treatment. To compensate without regard to fault cannot be taken to mean compensating *all* adverse medical events. Rather, medical no-fault must embrace in some fashion the concept of compensating *avoidable* injuries.²⁰⁰ However, if complications arising out of medical care are

¹⁹⁴ J. O'CONNELL & R. HENDERSON, TORT LAW: NO-FAULT AND BEYOND (1975). Hawaii's no-fault auto insurance law was enacted in 1973. See HAW. REV. STAT. § 294 (1973). Hawaii Workers' Compensation Law was enacted in 1963. See HAW. REV. STAT. § 386 (1963).

¹⁹⁵ O'Connell, *Operation Of No-Fault Auto Laws: A Survey Of The Surveys*, 56 NEB. L. REV. 23 (1977).

¹⁹⁶ "There seems to be considerable evidence that, all things considered, no-fault has not only not increased auto insurance costs, but has in fact decreased them, just as was originally promised, despite the inadequacy of the laws passed." *Id.* at 36.

¹⁹⁷ Hawaii's Workers' Compensation Law has come under recent attack because of its high cost. The problems and remedies are addressed in a recent study. Haldi, *Study Of The Workers' Compensation Program Of The State Of Hawaii. Final Report*, Dec., 1984 (presented to the Legislature of The State of Hawaii). However, no recommendation for a return to tort-based recovery was made.

¹⁹⁸ Cooper, *Sweden's No-Fault Patient-Injury Insurance*, 294 NEW ENG. J. MED. 1268 (1976).

¹⁹⁹ Smith, *Compensation For Medical Misadventure And Drug Injury In The New Zealand No-Fault System: Feeling The Way*, 284 BRIT. MED. J. 1457 (1982).

²⁰⁰ If avoidable injuries can be predetermined, a list of compensable events can be drawn up. Such an approach under the rubric of medical adversity insurance (MAI) has been attempted. See Havighurst, *supra* note 12. While acknowledging the complexities of identifying compensable events, and the failure of physician groups to take up the project, Professor Havighurst has nonetheless compiled a list of such events in anesthesiology and general surgery. Examples of compensable events are permanent recurrent laryngeal nerve damage after parathyroid surgery or thyroidectomy, hemolytic reaction following a blood transfusion, and brain injury under anesthesia in patients between six months and sixty years of age undergoing relatively simple operations such as hysterectomy and cholecystectomy. *Id.* at 1257, 1259, and 1261.

MAI anticipates that:

[C]ase-by-case adjudication of medical injuries and exposure to unmanageable costs could be avoided if a highly specified list of compensable injuries were developed in advance and

evaluated for avoidability, a standard approaching that of negligence would result, because an avoidable mishap occurs in the absence of due care. Therefore, the end result will be a return to the tort system.

If all complications of treatment are deemed compensable, including those which are arguably unavoidable, then a true comprehensive no-fault system would exist. This would require differentiating between treatment complications and treatment failures, which may not always be possible. The narrower approach of compensating only *avoidable* injuries is similar to the negligence standard, whereas the broader approach means compensating virtually *all* injuries. This inherent difficulty in assigning a medical event as "compensable" has frustrated efforts to fully develop a workable no-fault patient injury compensation system.²⁰¹ Preliminary and incomplete lists have been proposed,²⁰² but further development has not been forthcoming. The more realistic view is that this hurdle will prove insurmountable. This dilemma presently faces the New Zealand no-fault compensation system. In New Zealand, patients injured as a result of medical "misadventure," are compensated without need to prove fault.²⁰³ Although negligence is not necessary, what constitutes a medical "misadventure" is not defined.²⁰⁴ At the same time, "not all medical negligence come within the scope of medical misadventure," and common law tort actions for medical negligence remain available.²⁰⁵ In short, both fault and no-fault mechanisms exist for compensating the medically injured, without being clearly defined. Therefore, any success of the New Zealand system cannot be solely attributed to the no-fault approach.

incorporated in an insurance policy covering only those injuries, leaving other adverse outcomes to be handled under traditional doctrines and procedures, however they might be modified.

Id. at 1254.

²⁰¹ Professor O'Connell notes:

We can say with some degree of certainty that an automobile accident occurs because the drivers were driving on the road, and not because of some other pre-existing or extrinsic cause. . . . In medical care, however, it is far less clear whether the lack of success from medical treatment is the result of improper medical care or merely from the natural workings of disease.

Moore & O'Connell, *supra* note 93, at 1277.

²⁰² See Havighurst, *supra* note 12.

²⁰³ "What exactly constitutes medical misadventure is slowly being worked out as cases arise and the scheme develops, but the Accident Compensation Commission is quite definite that: 'It is not necessary to show that there has been negligence on the part of a medical practitioner before a claim will lie for medical misadventure.'" Smith, *supra* note 199, at 1457.

²⁰⁴ *Id.*

²⁰⁵ *Id.*

B. Deterrence

Advocates of the traditional tort system contend that a no-fault system will frustrate the objective of deterring wrongful conduct. They assert that a no-fault medical injury compensation system would abolish the independent check on physician quality.²⁰⁶

The tort system, however, does not always achieve its objective of deterrence.²⁰⁷ Further, tort action is not the only mechanism to deter wrongful conduct. A no-fault system could ultimately be more effective than the present tort system in deterring negligent medical practice. Under the present system, only a minority of cases of negligent care result in a complaint.²⁰⁸ Thus, in many instances, the tort system allows negligent conduct to escape detection. Under no-fault, many more events of patient injury will be identified. These adverse patient incidents could be uniformly reviewed by a medical care evaluation committee for the quality of care provided. This mechanism will enable the medical community to accurately assess the performance of its members, and to impose sanctions where appropriate.²⁰⁹

C. Economic Cost

The cost of a no-fault system would be prohibitive if compensation benefits parallel the present fault-based tort system. A 1977 study estimated the cost of a no-fault system for California to be \$800 million, a figure considerably higher than the cost of the fault-based system at that time.²¹⁰ Paying for *all* medical injuries and deaths would be prohibitively expensive, but paying for all *avoidable* injuries may be feasible. Without a workable "compensable event" list, however, no accurate estimate of the economic cost can be constructed.

On the other hand, the savings derived from reduced litigation costs may

²⁰⁶ Present mechanisms for ensuring physician competence include expanded disciplinary procedures against health care providers, more or better post-graduate education, increased emphasis on hospital licensing, hospital staff regulation, and peer review. Halley, *supra* note 192.

²⁰⁷ See *supra* notes 69-80 and accompanying text.

²⁰⁸ Mills, *supra* note 49.

²⁰⁹ Hospitals generally have medical care evaluation and peer review committees. These doctor groups evaluate peer activities in order to approve and renew hospital medical staff privileges. If all events of patient injury were reviewed, a more accurate profile of physician practice may well emerge. The question remains whether peer review will objectively and effectively weed out the careless and the incompetent. In 1985, the Board of Medical Examiners of Hawaii acted on every recommendation presented to it by RICO and the hearing officers, taking action on 6 licensees. Testimony by Dr. William Hindle, President, Hawaii Medical Association, before the 1986 Hawaii Legislature, in Honolulu, Hawaii (Feb. 1986). See also *supra* note 27.

²¹⁰ Mills, *supra* note 75, at 256.

offset the expected increase in claims frequency.²¹¹ Payment could also be restricted to economic losses, and further cost reduction could be achieved by offsetting payments to the extent reimbursable from collateral sources.²¹²

In summary, although "no-fault" would remove the adversarial approach to patient compensation, it suffers from the difficulty of defining the compensable event. A comprehensive no-fault system would result in compensating virtually all adverse outcomes, and would prove prohibitively expensive. Traditional no-fault insurance, which has worked well for auto injuries and in worker's compensation programs, is therefore, unlikely to be effective for dealing with injuries arising out of medical care.

V. THE ALTERNATIVE MEDICAL LIABILITY ACT

The Alternative Medical Liability Act (AMLA) proposes a medical injury compensation system that circumvents the shortcomings of medical "no-fault."²¹³ Moreover, AMLA provides for compensation without invoking fault-finding.²¹⁴

AMLA incorporates the following key features:²¹⁵ (1) the option of the medical provider to tender payment for economic loss within six months of injury; (2) Such tender forecloses future tort action by the injured victim; (3) Compensation benefits for net economic loss include 100% lost wages, replacement service loss, medical treatment expenses and reasonable attorney's fees; (4) Noneconomic losses are not reimbursable; (5) Payment is net of any benefits

²¹¹ O'Connell, *Offers That Can't Be Refused*, *supra* note 26, at 630.

²¹² *Id.*

²¹³ *Alternative Medical Liability Act, 1984: Hearings on H.R. 5400 Before the Subcomm. on Health of the Senate/House Committee on Ways and Means, 98th Cong., 2d Sess., June 28, 1984* [hereinafter cited as AMLA]. Bill H.R. 5400, which covers recipients of Medicare and other federal programs, was sponsored by Congressmen Richard Gephardt and Henson Moore. Testimony in support of the bill was provided by its architect, Professor Jeffrey O'Connell.

The bill was opposed by both the American Medical Association (which favors "tort reform," see AMA REPORT, *supra* note 1) and the Association of Trial Lawyers of America. Without specifically addressing the merits or demerits of AMLA, Mr. Thomas Bendorf, Executive Director and Director of Public Affairs of the Association of Trial Lawyers of America asserted: "Proposals such as we see here today which would make a mere broker of an injured victim, make a victim the simple means of merely subsidizing others for the cost of the wrong, will in the long run so offend the conscience of a nation of free men as to be refuted wherever it appears and this is justly so." AMLA, at 122. Sixty percent of lawyers polled opposed the bill. Reskin, *Lawyers Oppose Medical Malpractice Bill*, 71 A.B.A. J. 40 (1985).

The bill died in committee and was reintroduced in the 99th Congress (July 25, 1985) as the "Medical Offer and Recovery Act," H.R. 3084. This bill was referred to five committees, but no hearings were held.

²¹⁴ Reskin, *Lawyers Oppose Medical Malpractice Bill*, 71 A.B.A. J., at 40.

²¹⁵ See AMLA, *supra* note 213, at 45-48.

from collateral sources; (6) Civil action will not be precluded for compensation rendered for intentional torts and in wrongful death cases; (7) Compensation benefits would be payable not later than 30 days after submission of proof of economic loss; (8) Tort action remains available to any claimant absent provider tender.

The appeal of AMLA lies in its provision for prompt, fair and reasonable compensation benefits without the need to inquire whether the event is "compensable." The financial incentive to tender payment insures that many more injured patients can be expected to be compensated. This incentive derives from the exclusion of noneconomic claims, and the offset provided by collateral source payments. Furthermore, savings from expensive litigation costs will serve as an added incentive. In short, the proposal rids the present system of inefficiency and randomness, replacing it with efficiency and predictability.

By way of illustration of how AMLA might work, consider the case of a worker rendered paraplegic following spinal anesthesia.²¹⁶ The physician has the incentive to tender payment for all economic losses, including all future wage loss, because such tender will foreclose tort action, where the risk of a far larger award may be assessed. All parties further benefit by the non-adversarial nature of the transaction, and by the speedy resolution of the dispute. The patient, in turn, has the security of a prompt award equal to her economic loss, without incurring significant attorney or expert fees. In addition, the patient avoids the uncertainty of a long and costly claim, with potentially no recovery. The physician can return to caring for the sick and dying, and the injured patient can concentrate on rebuilding her future, confident that her economic needs will be promptly and fully met. Under AMLA, minimal disruption of the doctor-patient relationship should result due to the decrease in litigation.

Although AMLA's trade-off is for smaller compensation benefits, this is mitigated to the extent that claimants will no longer bear the burdensome price tag of attorney and expert fees. AMLA will hopefully achieve the goal of fairly compensating the largest number of those injured. Allowing the provider the option of tendering payment further avoids the need for identifying compensable events. In essence, the provider is asked to identify whether a given event is compensable or not. Her incentive for settling lies in the reduced award. Given this powerful incentive,²¹⁷ it can be expected that just compensation benefits

²¹⁶ Kane, *Neurologic Deficits Following Epidural Or Spinal Anesthesia*, 60 ANESTHESIA ANALGESIA 150 (1981).

²¹⁷ Limitation of claimant's choice is believed to be essential for the success of this proposal. Professor O'Connell notes:

The only way to prevent a rejection of a settlement for net economic loss, therefore, is to give one party the power to force the other party to accept the settlement. That party must be the defendant, for the same reason that the general no-fault insurance is not feasible: allowing the claimant to force the defendant to accept the claimant's offer of settlement for

under AMLA will reach most victims of avoidable medical injuries. In fact, some patients injured "unavoidably" may receive compensation as well through provider tender.

Furthermore, AMLA can be used as an effective vehicle for quality assurance and peer review.²¹⁸ Compensated injuries can trigger an automatic medical review, followed by appropriate educational, rehabilitative or disciplinary action. Data generated could also be used as the basis for experience rating in medical professional liability insurance underwriting.²¹⁹ Thus, an effective deterrence against substandard medical practice could be an important byproduct of AMLA. Physicians would not tender compensation for every adverse result since all such tenders will lead to automatic review for substandard care. One caveat: a careful balancing of proper deterrent force and unprincipled accusation needs to be struck lest the incentive to tender compensation is chilled, and the entire system aborted. This responsibility properly resides in the institutional medical care evaluation committee which should develop a fair and objective review process to decide whether the quality of care rendered was acceptable.

Finally, although estimates of the cost of AMLA have not been made, internalization of costs, with funding through insurance premiums paid by the medical provider, appears preferable.²²⁰ Spreading the costs evenly among all patients would be another alternative, but such an approach would destroy the potential use of provider experience-rating to modify premium rates. The adoption of AMLA will not lead to an escalation of insurance premiums. Savings from equitable awards, combined with the abolition of litigation costs and duplicative payments should significantly decrease the cost of insurance. AMLA will also reduce defense costs further by allowing the hospital to tender payments.²²¹ This adoption of "corporate liability"²²² will rid the present situation

the claimant's economic loss would force the defendant to bear losses that society cannot be confident belong on him.

O'Connell, *Offers That Can't Be Refused*, *supra* note 26, at 605.

²¹⁸ See *supra* note 209.

²¹⁹ An experience rating for medical malpractice insurance can be expected to be a powerful deterrence to substandard practice, and may indeed remove the habitual offender from the system altogether. For discussion why it is not in use presently, see *supra* notes 69-73 and accompanying text.

²²⁰ Malpractice premiums are business expenses and are tax-deductible. However, not all of this tax-deductible cost paid for by medical care providers can be passed on to the patient because of governmental fee regulation. Fixed medical charges for hospital and outpatient services are now in effect for both Medicare and Medicaid patients. See, e.g., Classen, *Medicare's Physician Fee Freeze: Short-sighted Reasons?*, 14 LEGAL ASPECTS MED. PRAC. 1 (1986).

²²¹ So long as any one member of the health provider team tenders payment for the injury at issue, tort action is foreclosed. Thus, by allowing the hospital as well as the physician to tender payments, AMLA provides an even greater opportunity to compensate the injured without resorting to litigation.

of the wasteful practice in which, for a single injury, multiple defendants are typically joined as parties, each requiring separate defense counsel. Mechanisms regarding contribution from physician tortfeasor(s) could be implemented, including the possible use of an objective review panel.

Restricting wage loss payments could additionally curtail costs. However, this should be carefully weighed against the impact on the injured.²²³ Modifying wage loss payments from 100% to 80% is a reasonable solution that would encourage individuals to return to work.²²⁴

VI. CONCLUSION

As applied to medical professional liability, the present tort system is an inefficient and inequitable method of resolving medical disputes. The asserted objectives of compensation and deterrence are thwarted by skyrocketing costs and excessive awards. As a result, society pays more for its health care. The present system extracts an additional toll on the health profession by frontally attacking its credibility and injuring its essential doctor-patient trust relationship.

Despite positive reform, recently enacted tort legislation is not expected to result in substantial improvement over the long term. These reforms, however, may be useful as temporary remedies, providing a measure of predictability and stability that is needed for continued function of the system.

A broad no-fault compensation scheme for medical injuries would remove inefficiency, adversariness and unpredictability, but at prohibitive costs. Moreover, the threshold question of compensable events is impossible to define, except in a few narrow areas. Thus, a true no-fault approach to medical injuries is impractical.

The Alternative Medical Liability Act provides a workable solution to correct the inequities of the present system. This proposal invites tender by medical care providers for economic loss in return for foreclosure of tort action. The proposal has the appeal of simplicity and efficiency, avoiding the need of pre-

²²³ Curran, *A Further Solution To The Malpractice Problem: Corporate Liability And Risk Management In Hospitals*, 310 N. ENG. J. MED. 704 (1984). "There has developed in the United States a quiet revolution in malpractice liability. . . . It is the movement to assign responsibility for all types of professional malpractice, including acts of independently practicing physicians, to the hospital corporation itself." *Id.* at 704.

²²⁴ Professor O'Connell suggests that the more affluent can cover their wage losses above \$2000 per month through insurance. O'Connell, *Offers That Can't Be Refused*, *supra* note 26, at 621.

²²⁵ Hawaii's Worker's Compensation Program was recently evaluated. See Haldi, *supra* note 197. Among the recommended changes was the use of after-tax earnings as the basis for benefit payments. The amount of wage loss was pegged at 80% of after-tax earnings. *Id.* at 70.

identifying the compensable event, yet achieving the goal of just compensation in a non-adversarial setting. A non-statutory alternative where the parties contract for this mode of injury compensation might also be effective.²²⁸ By identifying many more cases of maloccurrence, AMLA presents the unique opportunity to fashion an effective peer review process and to identify areas for risk management and loss prevention activities. Improved patient care would ultimately result. Whether the system can operate economically remains to be seen. At the very least, AMLA represents a viable and powerful alternative which deserves close study.

S. Y. Tan*

Kaeo v. Davis: Informing Juries of the Effects of Their Special Verdicts Under the Law of Joint and Several Liability

I. INTRODUCTION

In *Kaeo v. Davis*,¹ the Hawaii Supreme Court held that, when a jury is charged with apportioning negligence among multiple tortfeasors under a special verdict, the trial court may allow a jury instruction regarding the operation of joint and several liability.² With this holding, the court appears to have carved out an exception to the common law 'blindfold' rule against informing juries of the effects of their special verdict findings on the rights of the parties to recover.³

This note discusses the blindfold rule generally, and the Hawaii Supreme Court's treatment of it in *Kaeo*. Section III outlines the blindfold rule's historical application and rationale. Sections IV and V discuss and analyze the Hawaii

¹ 68 Haw. ____, 719 P.2d 387 (1986).

² *Id.* at ____, 719 P.2d at 396.

³ A primary purpose behind the use of special verdicts, or special interrogatories charged in conjunction with a general verdict, is to limit the jury to factfinding, and leave to the court the task of determining the relevant law and applying it to the facts. 9 C. WRIGHT & A. MILLER, *FEDERAL PRACTICE AND PROCEDURE: CIVIL* § 2503, at 488 (1971) [hereinafter *FEDERAL PRACTICE AND PROCEDURE*]. See Smith, *Comparative Negligence Problems with the Special Verdict: Informing the Jury of the Legal Effects of Their Answers*, 10 LAND AND WATER L. REV. 199, 201 (1975); Note, *Informing the Jury of the Effect of Its Answers to Special Verdict Questions—The Minnesota Experience*, 58 MINN. L. REV. 903, 905 (1974) [hereinafter Note, *The Minnesota Experience*]. See also *Skidmore v. Baltimore & O.R.R.*, 167 F.2d 54 (2d Cir. 1948) (exhaustive discussion of history and merits of special verdicts as compared with general verdicts). More specifically, the goal is to "obtain to the greatest extent possible the decision of the jury without reflection of the [jury's] . . . bias or prejudice." Annotation, 90 A.L.R.2d 1040, 1041 (1963). To achieve this goal and insure that the jury answers fact questions as objectively as possible, several early courts recognized the necessity of withholding from jurors information about the effects which their answers might have on the ultimate rights or liabilities of the parties. See *infra* notes 22-27 and accompanying text. Certain exceptions to the rule have been recognized, but informing juries of the effects of their findings under joint and several liability has not been among them. See *infra* note 31 and accompanying text.

²²⁸ O'Connell, *supra* note 14.

* In addition to being a third year law student, the author is an Associate Professor of Medicine, John A. Burns School of Medicine, University of Hawaii.

ance could provide funds for risk pools or reimbursement allocation schemes. Massachusetts has adopted a plan to provide universal health coverage to all state residents. Employers will be taxed to underwrite the program but the cost of worker insurance, if provided, is deductible from the tax. An insurance pool will be financed from the revenues, with the uninsured obtaining insurance on a sliding-scale fee.²⁷⁵ Placing a tax on hospital bills of insured patients could furnish revenues for either a provider or uninsured pool.²⁷⁶ Looking outside the existing framework to taxing consumption on commodities like alcohol or tobacco to underwrite health care offers a certain logic.²⁷⁷ After all, illnesses generated by abuse of these substances result in a huge cost to society in absolute and financial terms.

Ultimately, all these solutions to the dumping problem merit close scrutiny. But none of these solutions is a panacea. Clearly, at some point, society must grapple with the real problem, who will pay for indigent health care?²⁷⁸ But until that occurs, many of these suggested measures, in concert with COBRA, could provide an adequate interim remedy to the dumping problem.

CONCLUSION

Dumping poses a serious challenge to indigent health care. Current state statutes and enactment of COBRA represent significant attempts at a remedy. However, despite legal prohibitions, there are still strong financial motivations for economically strapped hospitals within a competitive market to continue dumping. Properly directed financial incentives can discourage this conduct and strengthen existing legal rules. Alternatively, the relief could focus on the class of patients most likely to be harmed. A commitment to funding would be the most unequivocal solution, but is unlikely given the current economic landscape. Broadly extending the private attorney general provision of COBRA offers the dual advantages of allowing the affected injured to assert their rights while simultaneously enforcing the statutory guidelines. Some combination of these options is capable of modifying provider behavior and reaffirming our social commitment to health care for the indigent.

²⁷⁵ Lund, *States Use Pools and Tax Credits to Help Uninsured*, Am. Med. News, Sept. 9, 1988, at 3.

²⁷⁶ Wilensky, *supra* note 65, at 59.

²⁷⁷ *Id.*

²⁷⁸ Reiman, *supra* note 72, at 579.

1988 Letourneau Award

NO-FAULT LIABILITY AND MEDICAL MALPRACTICE

A VIABILITY ANALYSIS

Ronald S. Latz, J.D.*

INTRODUCTION

Regardless of whether a medical malpractice insurance crisis plagues the health care system,¹ a medical injury crisis surely does.² Although malpractice premiums as a percentage of gross physician income declined from 4.4% in 1976 to 4.0% in 1984 and those premiums total only 1% of the nation's \$500 billion bill for personal health care services,³ up to 7.5% of hospital patients suffer a medical treatment-caused injury during care and only 0.7% of injured hospital patients receive compensation.⁴ Tort reforms aimed at insurance premiums have been both largely ineffective and hostile to consumers. The time may have arrived to consider an alternative system of liability and compensation—no-fault liability insurance.

* Special Assistant Attorney General, State of Minnesota. This article does not reflect the views of the Attorney General of Minnesota. Address correspondence to Mr. Latz at 6850 Harold Avenue, Golden Valley, MN 55427.

¹ Medical injuries also are described by commentators as iatrogenic injuries.

² For a recent report concluding that there is no crisis in claims or payments, see MINNESOTA DEPT OF COMMERCE, MEDICAL MALPRACTICE CLAIM STUDY 1982-1987, at 17-19 (Feb. 1989). Minnesota Commerce Commissioner Michael Hatch attributes the premium crisis to over-reserving on the part of insurers, a lack of competition in the insurance market, use of poor investment strategies by insurers, and allegations of claims rate increases by insurers rather than acknowledgement of investment mistakes and absorption of losses. Telephone interview, Michael Hatch (July 13, 1989).

³ Law, *A Consumer Perspective on Medical Malpractice*, 49 LAW & CONTEMP. PROBS. 305, 308 (1986); P. Weiler, *Legal Policy for Medical Injuries: The Issues, the Options & the Evidence* 241 (Draft, Jan. 1988); GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: INSURANCE COSTS 29 (GAO/HRD-86-112, Sept. 1986).

⁴ Brook, Brutoco, & Williams, *The Relationship Between Medical Malpractice and Quality of Care*, 1975 DUKE L.J. 1197, 1208.

The recent advent of catastrophic no-fault liability plans for birth-related medical injuries in Virginia and Florida suggests that a society imbued with the notion of individual common-law rights to sue in tort may be loosening its resistance to abrogation of those rights beyond automobile and workplace injuries.

It is not the purpose of this article to assess whether problems exist with the tort system. This article assesses the viability of a no-fault system as an alternative to the tort system. Considerations of compensation and deterrence dominate the assessment, preceded by a summary of criticisms of the tort system, tort reform effectiveness, and the proposed no-fault alternatives. These proposals are Statutory Neo-No-Fault Early Compensation plans, Pure No-Fault (Third Party) and Medical Maloccurrence Insurance (First Party) plans, and the limited no-fault or specified event systems. Limited no-fault plans consist of statutory Medical Adversity Insurance, Virginia and Florida's Birth-Related Neurological Injury Compensation plans, and the private voluntary contractual Elective No-Fault and Contractual Neo-No-Fault. This study is almost entirely theoretical, conducted in a virtual vacuum of hard data on the tort system and focusing on alternatives which are mostly proposals.³

A number of criticisms have been leveled against the traditional tort-based medical malpractice system.⁴ There are high administrative costs for claims processing and fault-finding. Charges of professional negligence, and use of the litigation process to evaluate those charges, have real psychic and time costs to physicians. The system creates antagonisms between physicians and patients, physicians and attorneys, and physicians and the law. It discourages full discussion with patients of risk and alternative treatments. The threat of litigation encourages the defensive practice of medicine, with unnecessary use of medical resources to protect against suit and refusal to provide care or adopt new methods of treatment for fear of increased liability exposure. Finally, the system does a poor job of deterring medical injury, with random and haphazard claims

³ For one study in the process of filling that vacuum, see HARVARD MEDICAL PRACTICE STUDY GROUP, *MEDICAL CARE & MEDICAL INJURIES IN THE STATE OF NEW YORK: A PILOT STUDY* (1987) [hereinafter *A PILOT STUDY*]; HARVARD MEDICAL PRACTICE STUDY GROUP, *MEDICAL CARE & MEDICAL INJURIES IN THE STATE OF NEW YORK: AN INTERIM REPORT* (1988).

⁴ See Pollack, *Medical Maloccurrence Insurance (MMI): A No-Fault Insurance Proposal for Resolving the Medical Malpractice Controversy*, 23 *TORT & INS. L.J.* 552, 557-88 (1988); Havighurst, *Medical Adversity Insurance—Has Its Time Come?*, 1975 *DUKE L.J.* 1233, 1234-37; Tancredi, *Designing a No-fault Alternative*, 49 *LAW & CONTEMP. PROBS.* 277, 278-80 (1986); Sugarman, *Doing Away with Tort Law*, 73 *CALIF. L. REV.* 555 (1985).

incidence,⁷ unsystematic compensation, inequitable decisions from inconsistent results on similar facts, fortuity of proof of provider fault, no experience rating of liability insurance,⁸ reliance on stigma and publicity, and undue focus on the process rather than the outcome of medical care. The result, critics assert, is many uncompensated injuries, much unpoliced negligence, uncontrollably excessive insurance premiums and a failure of due process.⁹ These criticisms have spurred efforts both to reform elements within the tort system and to abdicate the tort system for an alternative such as no-fault.

I. THE INEFFECTIVENESS OF TORT REFORMS

In 1974, the first "crisis" hit the medical malpractice insurance market. Premiums skyrocketed and carriers threatened to withdraw from the market. Many states responded with legislative reforms of the tort system. This section summarizes these early statutory reforms and reviews their effectiveness in alleviating the perceived causes of the crisis.¹⁰

Legal reforms enacted by states focus on four main facets of the tort system. They affect the filing of claims, determining the amounts

⁷ But see Danzon, *Why Are Malpractice Premiums So High—Or So Low?*, The Rand Corp. Rep., No. R-2623-11CFA (1980); P. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* (1985).

⁸ But see *infra* text accompanying notes 175-87.

⁹ For a response to the traditional criticism of the medical malpractice system, see Bovbjerg, *Medical Malpractice on Trial: Quality of Care Is the Important Standard*, 49 *LAW & CONTEMP. PROBS.* 321, 328-35 (1986); Bennett, *Pluses of Malpractice Suits*, N.Y. TIMES MAG., July 24, 1988, at 3.

¹⁰ Few statistical analyses with national databases have assessed the effectiveness of statutory tort reforms. Danzon's analyses focused on nationwide closed claims data from 1970 and 1975 through 1984. P. DANZON, *supra* note 7 (a compilation of her earlier research); Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 *LAW & CONTEMP. PROBS.* 57 (1986) [hereinafter *New Evidence*]; Danzon, *The Frequency and Severity of Medical Malpractice Claims*, 27 *J. L. & ECON.* 115, 137 (1984). Danzon & Lillard, *The Resolution of Medical Malpractice Claims: Research Results and Policy Implications*, The Rand Corp. Rep., No. LR-2793-1CJ (1982); Danzon, *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims*, 1988 *PERS. INJ. REV. ANN.* 142. Sloan, Mergenhagen, and Bovbjerg are currently updating Danzon's research on claims frequency and severity. Sloan studied malpractice premiums paid by physicians from 1974 through 1978. Sloan, *State Responses to the Malpractice Insurance Crisis of the 1970s: An Empirical Assessment*, 9(4) *J. HEALTH POLITICS, POL'Y & L.* 629 (1985). Zuckerman and Bovbjerg are updating this research. Preliminary results are consistent with earlier findings, with the additional conclusion that premiums are responsive not to urbanization as Danzon explained, but to other unmeasured factors. Telephone interview with Frank Sloan, Centennial

recoverable, defining the standards of care or burden of proof, and access to the courts.¹¹ Reforms that affect the filing of claims include shortening the statute of limitations and limiting attorneys fees. As of December 31, 1988, all 50 states and the District of Columbia had laws modifying the statutes of limitations.¹² Danzon found that an average shortening of one year for adults was marked by corresponding reductions in claim frequency of 8% and in frequency of paid claims of 6-7%.¹³ Sloan found that statute of limitations modifications had no statistically significant effect on premium levels.¹⁴

Caps on the contingent fees of claimants' attorneys took the form of sliding scales, specified percentages, or court determinations of "reasonable" fees. As of March 15, 1989, they were in place in 20 states.¹⁵ Danzon concluded that contingent fee limits had no systematic impact on

Professor and Chairman, Department of Economics, Vanderbilt University, (May, 1989). No studies have yet assessed the impact of the recent trend toward modifying or abolishing joint and several liability, or increasing sanctions for frivolous suits.

Several studies have assessed the impact of changes in common-law doctrine on premiums, claims rates, severity, and costs. At best, common-law changes were associated with and probably contributed to pro-plaintiff outcomes of litigation and physician premium hikes. Reader, *An Economic Analysis of Medical Malpractice*, 5 J. LEGAL STUD. 267, 287-89 (1976); Feldman, *The Determinants of Medical Malpractice Incidents: Theory of Contingency Fees and Empirical Evidence*, 7 ATL. ECON. J. 59, 62 & 64 (1979); Adams & Zuckerman, *Variations in the Growth and Incidence of Medical Malpractice Claims*, J. HEALTH POLICS, POL'Y & L. 475, 484-85 (1984).

¹¹ GENERAL ACCOUNTING OFFICE, *MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OR SOLUTIONS* 77 (GAO/HRD-86-50, Feb. 1986). Constitutional challenges to tort reforms have been abundant in the aftermath of legislative activity. For summaries and analyses of the results, see Comment, *The Constitutionality of Medical Malpractice Legislative Reform: A National Survey*, 18 LOY. U. CHI. L.J. 1053 (1987); Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981); ASSOCIATION OF TRIAL LAWYERS OF AMERICA, *CONSTITUTIONAL CHALLENGES TO TORT REFORM* (1988). An especially useful analysis is P. Weiler, *supra* note 3, at 56-70. See also Smith, *Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws*, 38 OKLA. L. REV. 195 (1985); Reddish, *Legislative Responses to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEXAS L. REV. 759 (1977).

¹² Tallies of states implementing tort reforms were compiled from information provided by the Association of Trial Lawyers of America (ATLA) and the American Tort Reform Association (ATRA). The few successful constitutional challenges have attacked limitation periods which began running upon the performance of the negligent act, rather than from the date of injury or discovery of the injury. See, e.g., *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980).

¹³ *New Evidence*, *supra* note 10, at 71.

¹⁴ Sloan, *supra* note 10, at 640.

¹⁵ Regulation of attorneys fees in medical malpractice litigation almost uniformly survives a constitutional challenge. See, e.g., *Roa v. Lodi Medical Group, Inc.*, 37 Cal. 3d 920, 211 Cal. Rptr. 77, 695 P.2d 164, *appeal dismissed*, 474 U.S. 990 (1985); *Johnson v. St. Vincent Hosp., Inc.*, 273 Ind. 374, 404 N.E.2d 585 (1980).

claim frequency or severity.¹⁶ Another commentator suggested the statutory contingent fee may be greater than or equal to the current market rate and thus did not interfere with attorneys' incentives to take cases.¹⁷ This analysis is supported by Sloan's finding that contingent fee reforms had no statistically significant effect on malpractice premiums.¹⁸

Another major area of reform focuses on determining the amounts a claimant may recover. Caps on damages, mandatory offsets of collateral sources, required periodic payments, and elimination of the *ad damnum* clause have been common. Statutory reforms have limited damages by either capping the whole award, capping only the non-economic portion of the award, or capping provider liability and supplementing the award from a patient compensation fund.¹⁹ As of March 15, 1989, 30 states had enacted damage caps.²⁰ The recent trend is toward courts not tolerating low ceilings that sometimes effectively restrict compensation for actual medical expenses and lost wages.

Danzon found that statutes capping all or part of the plaintiff's recovery cut total awards by 23%.²¹ This average effect, however, masks significant differences among the cases. The caps do not affect the majority of cases, but do have impact on the few large awards substantially greater than average. Since large awards account for a disproportionate fraction of total damage outlays,²² severe caps drastically cut the large awards and have a big impact on both average and total money paid.²³

¹⁶ *New Evidence*, *supra* note 10, at 78.

¹⁷ Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS. 5, 29 (1986).

¹⁸ Sloan, *supra* note 10, at 640.

¹⁹ In addition, many states have specifically limited or eliminated punitive damage claims and awards, which generally are not covered by insurance.

²⁰ The question of the constitutionality of damage caps has split state courts. The Washington Supreme Court recently overturned the state's 1986 cap on non-economic damages. *Sofie v. Fibreboard Corp.*, 112 Wash. 2d 636, 771 P.2d 711 (1989). Other courts finding caps unconstitutional include *Condemarin v. University Hosp.*, 775 P.2d 348 (Utah 1989); *Kansas Malpractice Victims Coalition v. Bell*, 243 Kan. 333, 757 P.2d 251 (1988); *Lucas v. United States*, 757 S.W. 2d 687 (Tex. 1988); *Smith v. Department of Ins.*, 507 So. 2d 1080 (Fla. 1987); *Wright v. Central DuPage Hosp.*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976). Cases upholding caps on damages include *Etheridge v. Medical Center Hosps. Inc.*, 376 S.E.2d 525 (Va. 1989); *Fein v. Permanente Medical Group*, 38 Cal. 3d 137, 211 Cal. Rptr. 368, 695 P.2d 665, *appeal dismissed*, 474 U.S. 892 (1985); *Prendergast v. Nelson*, 199 Neb. 97, 256 N.W.2d 657 (1977).

²¹ *New Evidence*, *supra* note 10, at 76.

²² Five percent of the cases are responsible for 49% of the total money paid to claimants. *Id.* at 77.

²³ *Id.* Critics of damage caps also point out that the most severely injured individuals—presumably the most deserving of compensation—bear the greatest burden of the attempt to remedy the perceived insurance crisis.

The collateral source rule traditionally bars the court from considering sources of compensation not associated with the defendant when awarding damages to the claimant. Statutory reforms of the collateral source rule focus on mandating offset of awards by the amount of collateral coverage, or by admitting evidence of collateral sources for the fact-finder to consider. Thirty states had enacted such statutes as of March 15, 1989.²⁴ Danzon found that mandatory offset resulted in a 50% reduction in award amounts, but simply admitting evidence of collateral sources had no effect.²⁵ This suggests that juries tend to agree with the original intent of the collateral source rule. Danzon's updated study reports that the frequency of claims drops 14% with both optional and mandatory offset and mandatory offset might reduce average severity by 30-40%.²⁶

Another frequent statutory reform, enacted by 26 states by March 15, 1989, was mandating periodic payments of future damages.²⁷ This reform is intended to eliminate uncertainty about the extent of future, continuing losses, protect the plaintiff against premature or improvident exhaustion of funds, and protect the defendant when losses end unexpectedly early due to patient recovery or death. Danzon reported that periodic payments had no effect on claim frequency or severity.²⁸

Elimination of the *ad damnum* (damage request) clause by 26 states as of December 31, 1988²⁹ was intended to avoid prejudicing the jury with vastly inflated damage requests in the plaintiff's complaint. The reform is estimated to have had significant negative impact on total claim cost, but not individually on frequency or severity.³⁰

Statutes affecting the definition of standards of care or burden of proof constitute the third broad grouping of tort reforms. No empirical

studies appear to have assessed the effect of standards of care or expert witness reforms. As of July 1985, 10 states had prohibited or clarified the circumstances for the use of the doctrine of *res ipsa loquitur* to shift the burden of proof to the defendant.³¹ *Res ipsa loquitur* is traditionally invoked in cases of obvious error, such as when surgical instruments are left in the body, and is also common for cases in which the evidence is solely in the hands of the provider, where the patient, often anesthetized, could not have intervened or identified the person or process of medical treatment. Danzon found that restrictions on the use of *res ipsa loquitur* had no effect on claim frequency or severity.³² Sloan found that such restrictions had no effect on premiums.³³

The last general category of tort reforms are those aimed at reducing the use of the court system and the costs of litigation—voluntary or mandatory pre-trial screening panels and voluntary binding arbitration. As of December 31, 1988, 24 states had pre-trial screening panels intended to screen out non-meritorious claims.³⁴ Both of Danzon's studies reported that neither voluntary nor mandatory panels had systematic effect on total number of claims filed or paid or on the amount paid.³⁵ She added that such panels may even encourage filing claims by reducing plaintiff's costs of obtaining expert testimony, since the panel's conclusions are usually admissible at trial. Sloan found that mandatory pre-trial screening panels reduced premiums.³⁶

Voluntary binding arbitration provisions were in force in eight states as of December 31, 1988. Danzon found that arbitration tends to increase the frequency of claims filed and paid,³⁷ though another study concluded that arbitration reduced claims frequency by an average 11%.³⁸ Danzon found that severity of cases which used voluntary binding arbitration instead of litigation was 20% lower than on average, attracting smaller (less severe) claims by providing a less expensive recourse for claims. However, total claims costs are probably greater in arbitration, with the

²⁴ Legislation modifying the collateral source rule has survived constitutional challenge in almost all cases. See, e.g., *Fein v. Permanente Medical Group*, 38 Cal. 3d 137, 211 Cal. Rptr. 368, 695 P.2d 665, appeal dismissed, 474 U.S. 892 (1985); *Bernier v. Burris*, 113 Ill. 2d 219, 497 N.E.2d 763 (1986).

²⁵ P. DANZON, *supra* note 7, at 78.

²⁶ *New Evidence*, *supra* note 10, at 72 & 77.

²⁷ Most of the state courts that have reviewed their periodic payment provisions have found them constitutional. See, e.g., *Fein*, 695 P.2d at 665; *Bernier*, 497 N.E.2d at 763.

²⁸ P. DANZON, *supra* note 7, at 78. But it does significantly reduce the cost to insurers, who can buy an annuity much cheaper and keep the rest and, therefore, could reduce the premiums.

²⁹ The constitutionality of eliminating the *ad damnum* clause is established. See, e.g., *Everett v. Goldman*, 359 So. 2d 1256 (La. 1978).

³⁰ P. DANZON, *supra* note 7, at 78. Again, Sloan reported that none of the attempts to limit the amount of recovery had statistically significant impact on provider premiums. Sloan, *supra* note 10, at 640.

³¹ GAO REP., *supra* note 11, at 80.

³² P. DANZON, *supra* note 7, at 78.

³³ Sloan, *supra* note 10, at 640.

³⁴ Most courts considering the question have concluded that properly designed and implemented pre-trial screening panels pass constitutional scrutiny. See, e.g., *Attorney Gen. v. Johnson*, 282 Md. 274, 385 A.2d 57 (1978), cert. denied, 439 U.S. 805 (1978); *State ex rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 261 N.W.2d 434 (1978).

³⁵ *New Evidence*, *supra* note 10, at 72 & 78.

³⁶ Sloan, *supra* note 10, at 640.

³⁷ *New Evidence*, *supra* note 10, at 72.

³⁸ Zuckerman, Koller, & Bovbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS. 85, 103 (1986).

reduction in claim severity more than offset by the rise in claim frequency.³⁹ Moreover, although significantly faster than litigation,⁴⁰ arbitration to decision costs 17% more than pre-verdict settlement.⁴¹ This is consistent with Sloan's finding that arbitration tended to increase premiums.⁴²

At best, tort reforms have had moderate success in curbing increases in the frequency and severity of malpractice claims. Danzon found that shorter statutes of limitations, mandatory collateral source offset, caps on damage awards, and arbitration statutes were somewhat effective in easing the rise in claim frequency and severity. Sloan found that only mandating pre-trial screening panels led to a cut in premiums. However, collectively, the legislative reforms had no impact on premium inflation.⁴³ Some commentators concluded that the single most important factor influencing victory is whether the insurer views the case as one with legal merit.⁴⁴

None of the reforms addressed the fact that only a very minimal proportion of negligently caused adverse medical outcomes ever reach the stage of claim filing, let alone recovery.⁴⁵ Perhaps the most important issue in the systematic policy debate is whether the tort system better compensates and more effectively prevents the occurrence of iatrogenic⁴⁶ injuries, including those negligently induced, than could a proposed alternative system.

II. MEDICAL MALPRACTICE NO-FAULT LIABILITY PROPOSALS

Proposed no-fault alternatives to the medical malpractice tort system focus on replacing the tort system for adverse medical outcomes. The key factors distinguishing the various proposals are the range of adverse

outcomes subject to the distinct treatment of the new system, the extent to which fault remains part of the system, and the balance between compensation and deterrence mechanisms. The alternatives fall into three major categories: (1) Neo-No-Fault Early Compensation schemes; (2) Pure No-Fault systems; and, (3) limited no-fault plans utilizing specified events. Preliminarily, a brief analysis of the recent American Medical Association (AMA) proposal is warranted.

A. Administrative Fault

The AMA and the Specialty Society Medical Liability Project⁴⁷ propose a fault-based, administrative system, modeled after the National Labor Relations Board, to completely replace the tort litigation system. The proposal consists of three basic components: (1) an administrative mechanism consisting of a Medical Board, Office of General Counsel, and staff for determining the compensability of adverse medical outcomes and for monitoring health care provider performance, with the power to discipline when appropriate; (2) retention of the fault standard for determining liability and compensability; and (3) modification of some legal elements of medical liability. The proposal is receiving state legislative consideration in Utah, Vermont, and Wyoming.

The administrative mechanism consists of several de novo reviews of the merits of the claim,⁴⁸ one administrative appellate review using the substantial evidence standard of review, and judicial appellate review.

The plan poses major difficulties for claimants. A claim deemed "meritorious" must follow an arduous negligence determination process that only the most obvious or egregious instances of fault-induced medical injury will survive. Among other things, it is likely that younger attorneys will work in the Medical Board's Office of General Counsel and will face experienced defense attorneys.⁴⁹ Furthermore, Office of General Counsel attorneys may be forced into a conflict of interest situation by the proposed requirement to settle claims if the attorney, not the claimant, finds the settlement offer "reasonable." Cases in which fault is uncertain

³⁹ *New Evidence*, *supra* note 10, at 72 & 77.

⁴⁰ Zuckerman, Koller, & Bovbjerg, *supra* note 38, at 104.

⁴¹ P. DANZON, *supra* note 7, at 202.

⁴² Sloan, *supra* note 10, at 640.

⁴³ *Id.* at 642. Other tort reforms, as yet too recent for their impact to have been studied empirically, include limitations on joint and several liability, additional penalties for filing frivolous lawsuits and patient catastrophic compensation funds.

⁴⁴ Zuckerman, Koller, & Bovbjerg, *supra* note 38, at 98.

⁴⁵ One possible exception is arbitration. See text accompanying notes 47-51 (AMA Proposal).

⁴⁶ As used herein, "iatrogenic injuries" or "iatrogenesis" refers to patient injuries caused by medical treatment.

⁴⁷ AMA/SPECIALTY SOCIETY MEDICAL LIABILITY PROJECT, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED ADMINISTRATIVE SYSTEM (1988).

⁴⁸ A claim must be found meritorious in each of four successive de novo reviews to secure compensation. Investigation and review for merit is conducted first by a claims reviewer, thereafter by a Medical Board member, then by one or two physician reviewers, and subsequently by a hearing examiner. *Id.* at 21-32. Settlement procedures are mandated.

⁴⁹ See P. Weiler, *supra* note 3.

might well be deemed to lack merit and significant barriers preclude further pursuit of a claim in such situations.⁵⁰

There are some elements of the administrative fault tribunal that have merit. A relatively simple filing process initiates a claim and investigation of facts without resource expenditure by the claimant. The expedited process would resolve claims faster. The expertise, experience, and written rulings of the Medical Board probably would result in more consistent and well-reasoned conclusions regarding liability and a growing body of knowledge about the elements of medical injury.⁵¹ Moreover, the information generation, continuing education, and disciplinary procedures merit implementation.

In the final analysis, however, the administrative fault mechanism replaces one series of barriers to recovery with another. Given the incidence of malpractice, the process should expand, not constrict, compensation for meritorious claims.

B. Neo-No-Fault Early Compensation (Statutory)

The early compensation alternative, originally proposed by O'Connell,⁵² has seen legislative consideration in at least Massachusetts, California, and the United States Congress.⁵³ These plans have been labeled Statutory "Neo-No-Fault" plans because they envision broader

⁵⁰ To pursue such a claim beyond the second screening level, a claimant must pay for a private attorney and secure a medical expert's opinion, recourse which the AMA makes clear they believe is unlikely.

⁵¹ See P. Weiler, *supra* note 3, at 225.

⁵² O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U.L. REV. 589 (1982) [hereinafter *Offers*]. See also O'Connell & Guinan, *An Irrational Combination: The Relative Expansion of Liability Insurance and Contraction of Loss Insurance*, 49 OHIO ST. L.J. 757 (1988); O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS. 125 (1986) [hereinafter *Neo-No-Fault*].

⁵³ Both the Massachusetts and California bills failed to pass the legislatures. H.R. 3084, 99th Cong., 1st Sess., 131 Cong. Rec. H6353 (1985), discussed in Moore & Hoff, *H.R. 3084: A More Rational Compensation System for Medical Malpractice*, 49 LAW & CONTEMP. PROBS. 117, 118 (1986), was first introduced in 1984 as H.R. 5400. It was not reintroduced in the 100th Congress. Supporters are looking for a principal sponsor in the 101st Congress.

A modified proposal under consideration by proponents is designed to alleviate concern about the harshness of totally precluding tort litigation. The plaintiff could accept the offered compensation, or reject it and litigate, subject to either a damage cap or a different standard of proof, such as gross negligence or proof beyond a reasonable doubt. This would leave to the tort system the more egregious cases. Telephone interview with John Hoff (May 4, 1989) (Attorney Hoff assisted Rep. Moore in preparing the legislative initiative).

availability of automatic indemnification for net economic loss while retaining the fault standard, rather than a total displacement of the fault system.⁵⁴

The unifying element of these plans is that, following any iatrogenic injury, the provider has a limited period of time⁵⁵ during which a potential or actual claim may be foreclosed by offering the victim compensation for the full net economic loss suffered and for reasonable legal fees. The inclusion of legal fees is necessary, since there will be no award for pain and suffering that is generally the source of fees in traditional tort litigation. The net economic loss consists of medical expenses and wage loss less any payment from collateral sources.

The provider's determination of cases deserving compensation is based on its own assessment of liability. The victim has a limited time during which to accept or reject the offer, but has no tort claim alternative once the provider extends the offer. Should the provider elect not to offer economic compensation, or in cases of death or intentional injury, the victim has all rights that now exist to proceed in tort.⁵⁶ Annuity payments would be made periodically rather than in a lump sum. Arbitration would resolve disputes over the amount of compensable loss.

The primary rationale for these Neo-No-Fault proposals has been the partial preemption of the tort system without abandoning the fault basis of liability. This retains intact the three tenets of tort law as a system of deterrence, compensation, and corrective justice, while reducing much of the transaction costs, delay, and uncertainty encumbering the tort system. According to proponents, the system also encourages the tender of benefits in marginal cases based upon a cost/benefit analysis.⁵⁷ The plans also have the advantage over no-fault plans of deflecting the issue of defining which adverse medical outcomes are covered.⁵⁸ The provider independently assesses responsibility rather than relying on a predelineation of compensable outcomes.

⁵⁴ *Neo-No-Fault*, *supra* note 52, at 129.

⁵⁵ The time limit should provide the defendant sufficient time to investigate the circumstances of the incident giving rise to the claim. O'Connell's original proposal had a 60 day limit. The legislative proposals call for a 180 day limit.

⁵⁶ In H.R. 3084, if a provider failed to offer compensation, the victim could go to arbitration over the issue of provider fault, recovering only net economic loss if successful. Moore & Hoff, *supra* note 53, at 119.

⁵⁷ *Neo-No-Fault*, *supra* note 52, at 130.

⁵⁸ Moore & Hoff, *supra* note 53, at 118.

C. Pure No-Fault

A Pure No-Fault system would statutorily mandate liability for iatrogenic injuries without regard to fault. The victim would receive compensation for any injury arising out of medical care, whether the result of negligence or a risk of normal care. Causation becomes the sole determinant of whether compensation is provided. Negligence is no longer a variable. Compensation would come from either: the provider or the mandatory third party insurer of the provider;⁶⁰ or, the injured party's mandatory first party insurer.⁶¹ The Third Party Pure No-Fault system for medical injuries is essentially a strict provider liability regime.⁶² It resembles workers compensation. The First Party Pure No-Fault insurance resembles automobile no-fault compensation.⁶²

At least two proposals for First Party No-Fault insurance exist.⁶³ Under Pollack's Medical Maloccurrence Insurance (MMI), "[s]tate law would require patients entering a hospital for treatment either to show proof of private maloccurrence insurance or to purchase a policy covering that particular course of treatment."⁶⁴ Insurance purchased on admission to the hospital would be added to the hospital bill for a payment either by private health care insurers or by Medicare or Medicaid. An assigned risk pool could sell insurance to those patients unable to acquire private health insurance or unqualified for Medicare or Medicaid ("bad risks"). A

⁶⁰ See Ehrenzweig, *Compulsory "Hospital-Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice"*, 31 U. Chi. L. Rev. 279 (1964); Roth & Rothstein, *Non-Fault-Based Medical Injuries Compensation Systems*, in U.S. Dep't of H.E.W. (No. OS-73-89), App. to REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 462-63 (1973); S. 215, 94th Cong., 1st Sess. (1975), 121 Cong. Rec. 641 (Jan. 17, 1975) (the "Inouye-Kennedy No-Fault Proposal," national medical injury compensation insurance); Grad, *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, 36 CASE W. RES. L. REV. 1058, 1090-97 (1986).

⁶¹ See Dornette, *Medical Injury Insurance—A Possible Remedy for the Malpractice Problem*, in MEDICINE, LAW AND PUBLIC POLICY 26 (N. Kitzie, H. Hirsh, & G. Wegner, eds. 1975); Pollack, *supra* note 6; Pollack, *No Finding of Fault: Taking a New Approach to Malpractice Insurance*, 11 LEGAL TIMES 24 (Apr. 1989).

⁶² See R. EPSTEIN, *A THEORY OF STRICT LIABILITY: TOWARD A REFORMULATION OF TORT LAW* (1980).

⁶³ Both of these no-fault schemes contrast with a true social insurance approach which is administered by a government agency, funded by general revenues, and may compensate for injury without regard to cause. Countries with such approaches include Great Britain, Australia, Sweden, Finland, and New Zealand. For some proposals directly applying to the United States, see, e.g., Roth & Rothstein, *supra* note 59; Sugarman, *supra* note 6.

⁶⁴ See Dornette, *supra* note 60; Pollack, *supra* note 6.

⁶⁵ Pollack, *supra* note 6, at 578.

minimum level of benefits would be mandated, covering economic loss and a specified level of non-economic damages.⁶⁵

If coverage is disputed, routine arbitration panels would determine whether a particular outcome of medical treatment was a covered maloccurrence and would "separate the sequelae of medical treatment from the sequelae of the patients' condition by applying a standard of avoidability on an ad hoc claim by claim basis, rather than in advance."⁶⁶ Avoidability is defined as whether the disability was more likely than not attributable to health care management. If yes, then provider causation—iatrogenicity—would be established. Then a presumption of iatrogenicity shifts the burden of proof, applying "unless the outcome was an unavoidable consequence of a preexisting condition or an unavoidable reasonably anticipated result of the best treatment or alternative."⁶⁷ Though focusing almost exclusively on compensation, MMI proposes to help prevent maloccurrences by experience rating providers and adjusting premiums for patients accordingly.

Dornette's system would be financed by premiums paid by each patient.⁶⁸ An appealable administrative review of causation would determine whether an adverse outcome is considered a compensable event. Professed advantages particular to First Party No-Fault insurance include the following: improving actuarial credibility in determining premium rates; consequent reduction in rate volatility; systemic viability enhanced by the significant excess of premium income from the larger pool of policies over the increased number of claims; attorney support for receiving post hoc fee awards from the insurer for arbitrated claims, even for unsuccessful bona fide claims; elimination of the provider-middleman insurance transaction costs; patient choice of policy coverage and premiums; and, insurer collection of maloccurrence incidence data for ratings of providers, both for premium levels and for consumer information.⁶⁹

A Third Party Pure No-Fault system would be administered by the provider or its insurer. The extent to which causation becomes a contested

⁶⁵ *Id.* at 578-79.

⁶⁶ *Id.* at 581.

⁶⁷ *Id.*

⁶⁸ Dornette, *supra* note 60, at 30-36. Dornette & MMI are similar in their essential characteristics, so a detailed analysis of First Party No-Fault will be limited to the more recently developed MMI proposal.

⁶⁹ *Id.*; Pollack, *supra* note 6, at 580, 583-86.

issue depends on the clarity of the definition of medical injury.⁷⁰ Awards would be scheduled according to the injury suffered, and could include most components traditionally present in litigation. It could be more narrowly restricted to include some or all of past and future medical expenses, lost wages, pain and suffering, and legal fees. It may or may not include an offset for collateral source compensation. A particular advantage of Third Party Pure No-Fault is the imposition of insurance costs directly on the provider for strict liability.

Justification for the abdication of the tort system in favor of a Pure No-Fault system, as in the Neo-No-Fault proposals, rests primarily on the grounds of efficiency, effectiveness, and equity. Replacing litigation expenses with a more cost-efficient and predictable administrative procedure permits more timely compensation of more victims of both negligence and normal risk. Advocates argue that no deterrence is lost since the tort system offers little anyway, with the prevalence of inconsistent findings of fact and with the "moral hazard" created by liability insurance.⁷¹ Defensive medicine would be reduced. No-fault would be a necessary constitutional quid pro quo for limiting damage awards.⁷² No stigma would attach to compensation since payment would be on the morally neutral ground of "accident." Other system advantages include consistency of decisions and awards, accessibility for claimants, assured payment of the award, predictability of systemic costs, avoidance of duplicate payment (if no collateral source rule), and enhanced medical injury data collection and analysis.⁷³

D. Limited No-Fault: Specified Events Schemes

In recognition of the difficulties encountered by open-ended no-fault plans, especially with regard to determining which medical conditions are consequences of medical intervention and not of the condition that prompted medical care, more limited forms of no-fault insurance have been proposed. These plans would automatically compensate patients

⁷⁰ Causation is an especially sensitive issue due to the complication of the preexisting condition which prompted medical care. See *infra* notes 188-200.

⁷¹ Grad, *supra* note 59, at 1091; Pollack, *supra* note 6, at 567. See also P. DANZON, *supra* note 7, at 91 & 214.

⁷² *Id.* However, the very existence of defensive medicine, to the extent that it does not substantially elevate risk, supports the notion that deterrence does in fact result from the threat of tort suits.

⁷³ Roth & Rothstein, *supra* note 59. Roth & Rothstein envision a government-affiliated no-fault commission, more akin to a social insurance scheme. These advantages adhere to both private and public no-fault schemes.

who suffered adverse outcomes specifically pre-determined to be compensable. The list of compensable outcomes would be determined statutorily or contractually on the basis of their relative avoidability or on the likelihood of having arisen from medical error. The tort system would remain in place for outcomes not included as automatically compensable.

Various rationales are advanced in support of a specified compensable events mechanism. Prior specification of compensable outcomes preempts litigation over cause. In addition, limiting no-fault compensation to a narrower range of events reduces the costs relative to more inclusive no-fault schemes. Furthermore, compensation is linked to quality assurance and injury prevention by retaining provider financial responsibility and by focusing on the patient's highest priority, the outcome, rather than the inputs.⁷⁴ System flexibility is enhanced by beginning with a more limited initial list of compensable outcomes, expanding the list with experience on data and cost, and updating the list in light of medical advances and experience with preventability.⁷⁵ Finally, the system encourages innovation to improve medical care and does not penalize a patient or provider any more than if the original technique had failed.

1. Statutory Schemes

a. Designated Compensable Events

Havighurst and Tancredi have proposed a statutory scheme in which health care providers would purchase from private insurers a policy of "medical adversity insurance" (MAI) to automatically indemnify a patient suffering a designated compensable event (DCE).⁷⁶ Patients would receive compensation for all medical and hospital expenses, and for lost wages up to a pre-determined maximum. A floor is imposed on wage loss compensation, and a minimum claim amount level would exist.⁷⁷ A statutory board of medical experts and consumer representatives would determine inclusion of outcomes on the list of compensable events based upon their relative avoidability. Providers would pay premiums rated for

⁷⁴ NATIONAL ACADEMY OF SCIENCES, INSTITUTE OF MEDICINE, BEYOND MALPRACTICE: COMPENSATION FOR MEDICAL INJURIES 38 (1978); Tancredi, *supra* note 6, at 282.

⁷⁵ *Id.*

⁷⁶ Havighurst & Tancredi, *Medical Adversity Insurance—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 613 INS. L.J. 69, 71 (1974); Tancredi, *supra* note 6; ABA COMMISSION ON MEDICAL PROFESSIONAL LIABILITY, DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY (1979).

⁷⁷ *Id.*

claims experience. The plan retains the collateral source rule, but subrogates those first party sources to the patients' rights to recover from the providers. Within a specified time after recognition of a potential claim, providers must inform a patient of the existence of a claim, or be personally liable for the claim, perhaps within the traditional tort system.⁷⁸

The primary rationale behind the statutory DCE mechanism is the combination of no-fault compensation to victims with a strong financial incentive to deter iatrogenic injuries. Outcomes covered are avoidable relative to other adverse outcomes.⁷⁹ Wage loss limitations reflect the expectation that high income persons would self-insure, and that this would not distort providers' quality incentives. A minimum wage loss entitlement would protect people like stay-at-home spouses.

Retention of the collateral source rule together with first party insurance subrogation avoids a windfall to the patient while preserving the financial incentive for quality care, and encourages first party insurers to inquire as to the existence of a compensable event. This commensurately reduces the cost of health and disability insurance and employer sick pay plans.⁸⁰ Experience rating premiums retains an element of provider responsibility, focuses attention on specific risks, and does not automatically force the cost-reimbursement system of financing health care to pick up providers' insurance premiums.⁸¹ The disclosure requirement corrects for the fact that many claims are never filed due to patient ignorance of the provider's role in the adverse outcome.⁸² Disclosure also

⁷⁸ *Id.* at 72-73.

⁷⁹ Havighurst & Tancredi, *supra* note 76, at 77, 79 & 82. See also *infra* notes 232-44. A sample list for orthopedic care includes outcomes found to be negligently caused in a "great majority" of reviewed cases. *Id.* at 75. See also Tancredi, *Identifying Avoidable Adverse Events in Medicine*, 12 MED. CARE 935 (1974). Two difficulties in determining appropriately compensable outcomes are obtaining a consensus of medical experts and ascertaining relative avoidability due to variation in responses of patients to medical intervention. NATIONAL ACADEMY OF SCIENCES, *supra* note 74, at 38.

⁸⁰ *Id.* Some of these savings could fund a reinsurance risk pool.

⁸¹ For more discussion of experience rating, see *infra* notes 175-87 and accompanying text. The cost-reimbursement system for financing health care is the process whereby the health care provider incurs the cost of providing medical treatment and then bills the patient or insurer for reimbursement.

⁸² The GAO estimates that, in only .9% of all claims files opened, did the practitioner, the hospital, or the insurance company notify the patient of a malpractice incident. Payment was made to the patient in 99% of these cases, suggesting that providers initiated the process only when they knew they would be sued and intended to resolve the issue quickly and inexpensively. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984, GAO/HRD-87-55, at 36 (Apr. 1987).

improves quality feedback for measuring the system and provider performance, by ensuring data collection on the frequency of various outcomes.

b. Catastrophic No-Fault: Virginia & Florida Birth-Related Neurological Injury Compensation Acts

Virginia in 1987, and Florida in 1988, became the first two states to pass medical malpractice no-fault programs.⁸³ What may be termed "Catastrophic No-Fault" plans, the Birth-Related Neurological Injury (BRNI) Compensation Act in each state⁸⁴ creates a compensation fund to cover participating physicians and hospitals for severe brain and spinal cord injuries resulting from obstetrical care. The statutes exclude common-law tort remedies for qualifying cases.⁸⁵

Successful claimants recover compensation for "medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel," subject to collateral source offset, and reasonable expenses incurred in filing the claim, including attorneys fees. Virginia compensates for loss of earnings after the child reaches 18 years of age, and Florida awards up to \$100,000 to parents to compensate for lost derivative actions, replacing wage recovery.⁸⁶

Funding in Virginia is provided by annual assessments upon participating obstetricians (\$5000), participating hospitals (\$50.00 per delivery, up to \$150,000), all practicing physicians (\$250.00), and, if necessary, casualty insurers doing business in the state. In Florida, up to \$40 million is available from the state before assessing casualty insurers.⁸⁷

⁸³ A North Carolina commission is studying the issue.

⁸⁴ VA. CODE ANN. § 38.2-5000 to -5021 (Supp. 1989); FLA. STAT. ANN. § 766.301 to .316 (West Supp. 1989).

⁸⁵ The Virginia Act specifies the qualifying medical condition as a live birth infant "permanently non-ambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living." VA. CODE ANN. § 38.2-5001 (Supp. 1989). The Florida Act covers live birth infants over 2500 grams rendered "permanently and substantially mentally and physically impaired." FLA. STAT. ANN. § 766.302(2) (West, Supp. 1989). Both acts define cause as "oxygen deprivation or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital." *Id.* Each law excludes disability or death caused by genetic or congenital abnormality. VA. CODE ANN. § 38.2-5014 (Supp. 1989); FLA. STAT. ANN. § 766.302 (West Supp. 1989).

⁸⁶ VA. CODE ANN. § 32.2-5009(1), (3), & (4) (Supp. 1989); Comment, *Virginia's Birth-Related Neurological Injury Compensation Act: Constitutional and Policy Analyses*, 22 U. RICHMOND L. REV. 431, 435 (1988); FLA. STAT. ANN. § 766.31(1)(a)-(c) (West Supp. 1989); Tedcastle & Dewar, *Medical Malpractice: A New Treatment for an Old Illness*, 16 FLA. L. REV. 535, 588-89 (1988).

⁸⁷ VA. CODE ANN. § 38.2-5019(A) (Supp. 1989); FLA. STAT. ANN. § 766.314(4) (West Supp. 1989).

In both states, claimants file petitions and all documentation supporting the claim with a commission. A physician panel makes a non-binding recommendation as to whether the claim is a qualified injury. The commission makes a final determination of qualification and the amount of compensation to be awarded.⁸⁸ All claims are automatically forwarded to a board of medical review and the department of health for quality of care review, with a mandate to impose sanctions for substandard care.⁸⁹

Objectives of the Virginia and Florida plans include the following: compensating profoundly damaged infants and aiding their families by providing more certain and immediate compensation for expenses not covered by collateral sources; bringing private insurers back to provide coverage for obstetricians; stabilizing or reducing premiums by removing catastrophic cases from the tort system; and, creating an incentive to hospitals and obstetricians to care for Medicaid and indigent patients.⁹⁰

2. Elective No-Fault

Frustration with the legislative process and belief in private initiative has led to several limited no-fault proposals designed for private implementation by health care providers, their insurance companies, and patients, without statutory mandate. These plans rest on elective contractual relations between patients and providers.

Tancredi has proposed one such program, a private means for implementing what is essentially the MAI proposal.⁹¹ O'Connell also has proposed an Elective No-Fault system.⁹² Under Elective No-Fault, health care providers would define all the adverse medical outcomes for which fault-based claims would be foreclosed by automatic compensation. Patient choice of a provider brings with it the liability system as defined by the provider. Claims would be paid on an occurrence basis, with no

⁸⁸ VA. CODE ANN. § 38.2-500.3 to -500.8 (Supp. 1989); FLA. STAT. ANN. § 766.304-.309 (West Supp. 1989).

⁸⁹ VA. CODE ANN. § 38.2-500.4(B), (C) (Supp. 1989); FLA. STAT. ANN. § 766.304(4), (5) (West Supp. 1989).

⁹⁰ HARVARD SCHOOL OF PUBLIC HEALTH, NO-FAULT COMPENSATION FOR NEUROLOGICALLY IMPAIRED INFANTS: AN EXPLORATION OF THE ISSUES FOR THE INSURANCE PANEL 16-17 (1987). See Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 VA. L. REV. 1451 (1988); O'Connell, *Pragmatic Constraints on Market Approaches: A Response to Professor Epstein*, 74 VA. L. REV. 1475 (1988); Comment, *supra* note 86, at 436-50.

⁹¹ Tancredi, *supra* note 6, at 277.

⁹² O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries*, 60 MINN. L. REV. 501, 522 (1976) (probably O'Connell's most comprehensive and persuasive advocacy of the no-fault concept).

specific determination of causation or legal culpability.⁹³ Patients would receive compensation for out-of-pocket losses only. Compensation would be determined in a final administrative procedure with no provision for appeal. Fault-based litigation would remain for outcomes not agreed to be automatically compensable.

The rationale for Elective No-Fault focuses primarily on the goal of compensation, saving enough tort money to make it attractive to both patient and provider, and providing simple access to compensation.

3. Contractual Neo-No-Fault

More recently O'Connell has proposed a Contractual Neo-No-Fault plan. The provider obligates itself to offer economic compensation within 90 days of the occurrence of any adverse events specified in the provider-patient contract. The victim then has the option to accept the tender of compensation or pursue the claim in tort. The purpose of this plan is to circumvent some of the legal difficulties provider-patient contracts might encounter, such as adhesion and unconscionability issues.⁹⁴

Critics of contractual schemes argue that contracts really absolve providers of liability, and consumers in the market for health care services are often uninformed, lacking the capacity to compare providers prior to illness and lacking the time to compare at the moment of illness.⁹⁵ The cost savings achievable by reducing malpractice premiums, which are only 1% of total health care costs, are insufficient to induce informed patients to accept a reduced standard of care. Private contract really results in no provider liability.

III. COMPENSATION

No-fault liability systems as compensation mechanisms rest on three principles:⁹⁶ payment without regard to fault; payments by private enter-

⁹³ Presumably, with the use of a compensable events system, the causation issue is resolved with the decision to include an adverse outcome on the list.

⁹⁴ O'Connell, *A Neo-No-Fault Contract in Lieu of Tort: Preaccident Guarantees of Postaccident Settlement Offers*, 73 CALIF. L. REV. 898 (1979); *Neo-No-Fault*, *supra* note 52. Congress recently has enacted legislation mandating tender of economic loss for vaccine-related injuries. The victim then has the option of accepting tender or pursuing a tort claim. See 42 U.S.C.A. § 300aa-10 (Supp. 1989) (National Childhood Vaccine Injury Compensation Program); Comment, *National Childhood Vaccine Injury Act of 1986*, 63 WASH. L. REV. 149 (1988).

⁹⁵ For a full discussion, see Law, *supra* note 3, at 316-17; P. Weiler, *supra* note 3, at 169-220.

⁹⁶ Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 601 & 603 (1973).

prise insurers; and, private no-fault payments as the chief source of compensation for the victim whose injuries fall within the scope of the insurance contracts. This presumes a corollary of partial or total provider exemption from liability based on negligence. No-fault is intended to achieve at least one primary objective of a compensation system, equity—between the beneficiaries and the cost-bearers, among beneficiaries, and among the cost-bearers.

A. Fairness and Rationality of Compensation

One of the most vociferous criticisms of the tort system is the alleged lack of rational connection between the quality of care and the incidence of claims and resulting awards or settlements. Critics attack claims and awards as random and irrational.⁹⁷ The validity of this assertion is relevant to consideration of moving to a more highly specified award system guaranteeing coverage for at least economic loss. Pure No-Fault (both Third Party and MMI), the limited specified events schemes, and the Contractual Neo-No-Fault plan guarantee coverage for all economic loss resulting from covered events, rendering compensation highly predictable and rationally related to the loss incurred.⁹⁸ The Statutory Neo-No-Fault scheme preserves for the provider discretion to offer compensation. The decision to tender will include consideration of the particular patient's likelihood to sue. The fairness and rationality of awards is greater in the non-discretionary tender schemes.

B. Range of Covered Outcomes: Breadth

The extent to which a no-fault scheme replaces the tort system depends on the proportion of all iatrogenic injuries the scheme deems compensable. Broader schemes better distribute losses by passing more costs through to all of society, protecting the individual victims from the full burden of the loss.

The incidence of iatrogenic injuries is startlingly high. Estimates range from 4.65% to 7.5% of all hospital inpatient stays resulting in

⁹⁷ See, e.g., *Offers*, *supra* note 52. See also J. O'CONNELL, *THE LAWSUIT LOTTERY* (1979). For a summary of research suggesting that awards are strongly related to injury severity, but over-compensate lower economic losses and under-compensate higher economic losses, see Zuckerman, Koller, & Bovbjerg, *supra* note 38, at 98-100. Claim frequency is affected not only by technical care, but also by the demeanor of the physician, the physician-patient relationship, and patient ignorance both of injury occurrence and legal rights.

⁹⁸ This is untrue for cases in which there is great pain and suffering but little economic loss.

injuries, negligent or otherwise, which are potentially compensable events. In 17% of these cases, or .8% of all patients, evidence of negligence was present.⁹⁹

The Statutory Neo-No-Fault proposals are likely to cover more adverse outcomes than does the tort system, but fewer than would no-fault. Compensation would be tendered in clear liability cases, when there is a reasonable probability of suit or claim, when net out-of-pocket costs are less expensive than full economic damages plus pain and suffering and the costs of the tort system, and when the provider can avoid the personal costs in emotion, time, and professional reputation involved in protracted litigation. In cases of unclear liability, advocates of Neo-No-Fault argue that providers' distrust of the litigation process and the opportunity to present the offer in a "nonadversative, healing spirit" would induce tender.¹⁰⁰

Success of the specified events proposals depends largely on the ability to define compensable events. The scope of coverage must be broad enough to obviate a substantial proportion of current claims or dramatically reduce the dollar costs of the fault system. MAI focuses on the areas hardest hit by malpractice claims, which are those injuries of definitive character and avoidability which facilitate easy delineation as compensable events.¹⁰¹ However, the easily delineable events also are those claims that settle early and avoid trial costs. Thus, the expansion of the coverage to include those less obvious, less avoidable outcomes would be necessary for significant improvement over the administrative costs of the tort system, in spite of the difficulties of defining compensable events.¹⁰²

The BRNI plans reach directly into this more difficult range of outcomes, often the potentially catastrophic ones. The Florida BRNI uses a broader injury definition than Virginia, but excludes premature births, an exclusion which ultimately restricts eligibility more than the Virginia

⁹⁹ See P. Weiler, *supra* note 3, at 107-08. The Harvard Pilot Study, admittedly skewed somewhat to test the survey instrument, found a 4.8% to 6.9% injury rate. See A. PILOT STUDY, *supra* note 5, at 59.

¹⁰⁰ Moore & Hoff, *supra* note 53, at 120.

¹⁰¹ Havighurst, *supra* note 6, at 1270. Examples include hospital accidents, surgical mishaps, and anesthesia consequences. One item listed on a sample list of anesthesiology events was responsible for 61% of the dollars paid for claims.

¹⁰² Such difficulties could lead to litigation over the definition of an iatrogenic event, litigation which would be avoided if a less ambitious strict liability system were adopted. Havighurst, *supra* note 6, at 1270.

definition. However, both may be too narrow to preempt a substantial degree of litigation.¹⁰³

Elective No-Fault schemes and the Contractual Neo-No-Fault proposal are likely to result in narrower coverage than MAI. While it is true that providers will reap benefits from covering marginal cases of liability by avoiding expensive litigation and the possibility of huge damage awards, providers will not voluntarily purchase coverage for avoidable outcomes that rarely become claims due to difficulties in discovering or proving negligence.¹⁰⁴ Except to the extent that group health plans bargain with providers and their insurance companies, Elective No-Fault is viable only as providers see a benefit to themselves when designing their lists. There is fear of specialty societies designing uniform insurance contracts offered to patients on a take-it-or-leave-it basis.¹⁰⁵

MMI, like MAI, defines coverage by avoidability, but relies on case-by-case determination. The presumption of avoidability would expand coverage beyond negligently caused injuries and well into some subset of additional injuries.

Pure No-Fault by definition covers all iatrogenic injuries. The Swedish No-Fault system, for example, covers injury related to treatment but not necessarily to the health problem for which treatment was sought. Injuries which are the expected result of the prior medical condition are not covered.¹⁰⁶

C. Extent of Coverage: Economic Loss

The extent to which an injured person is compensated for loss implicitly reflects a decision on the protection, enhancement, and wise allocation of society's human and financial resources.¹⁰⁷ Critics of the tort system argue that excessive awards for pain and suffering losses are the primary threat to the system's financial viability and perversely discourage rehabilitation. Commitment to economic loss reimbursement

¹⁰³ "The incidence of neurologic injury did not approach the prevalence of severe mental retardation and cerebral palsy," outcomes which commonly result in malpractice suits regardless of evidence of malpractice. Brown & Faulkner, *Injured Infants Act: Study Compares Definition, Newborn Records*, VA. MEDICAL, Mar. 1989, at 114 & 116-17.

¹⁰⁴ Havighurst, *supra* note 6, at 1276.

¹⁰⁵ *Id.* at 1270.

¹⁰⁶ See Brahm, *The Swedish "No Fault" Compensation System for Medical Injuries*, 138 NEW L. J. 15 (Jan. 1988).

¹⁰⁷ Kecton, *supra* note 96, at 603.

encourages providers to pay for rehabilitation to mitigate future medical expenses, especially in catastrophic cases.¹⁰⁸

Under Neo-No-Fault, economic loss is offset by collateral payments, thus covering out-of-pocket expenses for continued medical and hospital care, rehabilitation, nursing care, unlimited wage loss, housekeeping services, adapting the patient's house and car, and reasonable attorneys fees. MAI covers all medical and hospital expenses, limited wage loss, and reasonable attorneys fees without collateral offset. The Elective No-Fault proposal covers all out-of-pocket losses. Individual provider contracts could include a ceiling on benefits with possibly large deductibles creating a floor below which the tort system would still operate.¹⁰⁹

MMI covers a minimum net economic loss and a standard non-economic loss payment. Patients may purchase additional coverage as part of the policy. BRNI covers collaterally offset medical, rehabilitative, long-term care, and claim filing costs, including attorney expenses, plus limited wage loss (Virginia) or a capped non-economic award (Florida).

One controversial aspect of no-fault schemes generally is the elimination of compensation for pain and suffering. Damages for pain and suffering, loss of enjoyment of life, and so on, are regarded in common law as compensation for losses.¹¹⁰ Pain and suffering awards are the traditional source of attorneys fees, without which many suits could not be brought. Often they serve as the corrective justice component of damages. No-fault advocates argue that since few victims receive compensation even for pecuniary loss, it is socially more desirable to use the elimination of pain and suffering damages as a quid pro quo to guarantee economic loss compensation to more victims.¹¹¹

The objective need for out-of-pocket expense reimbursement, and the fear of an exception creating a systemic loophole, mitigate against inclusion of pain and suffering compensation in a no-fault scheme. Compensation for reasonable attorneys fees are necessary to replace pain

¹⁰⁸ O'Connell & Beck, *An Update of the Surveys on the Operation of No-Fault Auto Laws*, 674 INS. L.J. 129, 136 (1979).

¹⁰⁹ NATIONAL ACADEMY OF SCIENCES, *supra* note 74, at 42. Since the tort system effectively precludes small claims as too expensive to litigate, deductibles leave a patient with no recourse, but, of course, less economic loss.

¹¹⁰ For a discussion of the pros and cons of pain and suffering damages, see Law, *supra* note 3, at 319; O'Connell, *A Proposal to Abolish Defendants' Payment for Pain and Suffering in Return for Payment of Claimants' Attorneys' Fees*, 1981 U. ILL. L. REV. 333, 339, 347.

¹¹¹ O'Connell, *supra* note 110, at 356; Moore & Hoff, *supra* note 53, at 123.

and suffering damages, or the system effectively would bar access in disputed cases to those unable to afford an attorney.

Foreign no-fault models are illustrative in their coverage.¹¹² New Zealand provides coverage for the following: all accidental personal injuries, up to \$17,000 for permanent loss or impairment of any bodily function; \$10,000 maximum for loss of amenities or capacity to enjoy life, including disfigurement and pain and suffering; and, limited earnings-related losses up to age 65. Sweden covers treatment costs and a pain and suffering payment, for a maximum of \$500,000 total compensation, though it imposes a minimum need of two weeks of hospitalization or sick leave, permanent disability or death, for no-fault benefits to apply.

D. Ease of Achieving Recovery

The ease with which a patient can secure compensation for covered losses depends upon how a patient becomes aware of a possible loss, the likelihood a provider will offer compensation, and the energy a patient must expend to secure compensation. Under the tort system, the responsibility for pursuing compensation rests entirely with the patient. The discovery of medically-induced injury can occur during follow-up care years after the initial treatment, or may be immediately obvious to the layperson. The exhaustion of first party insurance benefits may precipitate a malpractice claim.

The specified events no-fault schemes—MAI, BRNI, Elective No-Fault, and Contractual Neo-No-Fault—provide for automatic indemnification for losses from covered adverse outcomes. MAI obligates the provider to notify the patient within a prescribed time of a potential claim for a covered injury. The patient then files a claim. To discourage providers from resisting payment in cases of questionable occurrence, the provider can be required to pay attorneys fees for successful claimants. Under the BRNI plans, claimants file comprehensive petitions with the workers compensation commissions. Claimants will want private attorney assistance to pursue discovery, since defendants no doubt will be represented. At the hearing, the Commission(er) applies a rebuttable presumption of birth-relatedness and determines if causation and result fit the statutory definition.¹¹³

Contractual Neo-No-Fault obligates tender of compensation within a

¹¹² Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (New Zealand)*, 73 CORNELL L. REV. 170, 194 (1988). See also Brahm, *supra* note 106.

¹¹³ VA. CODE ANN. § 38.2-5007 (Supp. 1989); FLA. STAT. ANN. § 766.309 (West Supp. 1989).

specified time period following an injury claim, giving the patient the option to accept or reject such tender. Advocates of the proposal argue that acceptance of tender is likely since victims of serious injuries, even when liability is relatively clear, are risk-averse enough to the uncertainty of tort recovery that they will accept certain, immediate benefits.¹¹⁴ Elective No-Fault contracts similarly would mandate tender of losses, but also would mandate acceptance.

Statutory Neo-No-Fault schemes make optional the tender of economic losses and the accompanying foreclosure of a patient's tort right. The opportunity to foreclose large tort claims could encourage providers to set up comprehensive injury discovery procedures, and tender would be near certain in cases of clear liability. In cases of marginal liability, an economic cost/benefit analysis would lead to tender of compensation when a lump sum payment is greater than the anticipated litigation costs and the size of the likely recovery, discounted by its probability. The opportunity to avoid the anguish and adverse publicity of litigation, and the power to seek contribution from other parties potentially jointly and severally liable by extending immunity to them, also would encourage tender of loss.¹¹⁵

Under a Pure No-Fault (Third Party) plan, patients would initiate claims with assistance in filing from an impartial review procedure.¹¹⁶ This procedure could be part of the hospital grievance procedure, or part of an exceptional or standard review of medical files upon discharge. MMI (First Party) envisions routine insurer indemnification for injuries, with disputed issues addressed by standard arbitration procedures.¹¹⁷ As with MAI and Elective No-Fault, the parties are obligated to tender and accept payment, with no tort option for those injuries.

Patient utilization of an attorney to achieve recovery also adds to patient costs. The more automatic the compensation, the less the need for an attorney.¹¹⁸ For example, under the Michigan and California auto-

¹¹⁴ *Neo-No-Fault*, *supra* note 52, at 131-32. O'Connell cites the fact that 20 of 21 seriously injured high school athletes accepted tender under a similar plan. The other had fully recovered with small economic loss but with the possibility of a pain and suffering recovery.

¹¹⁵ *Id.* at 130. The statutory erosion of the joint and several liability doctrine in many states reduces this incentive.

¹¹⁶ Roth & Rothstein, *supra* note 59, at 464-65.

¹¹⁷ Pollack, *supra* note 6, at 580-81.

¹¹⁸ One potential advantage of the AMA proposal, *supra* note 47, is that the burden of claim investigation rests with the administrative agency rather than the claimant, and then an attorney is provided for the claimant if merit is found.

mobile no-fault laws, 10% of claims utilized attorneys for filing, down from 50% of claims in the tort system.¹¹⁹

However, a poor victim will have trouble finding an attorney to take a contingent fee case without commensurate reward for the risk of losing. In New Zealand, claimants generally are paid their costs regardless of outcome. Therefore, persons file claims freely without becoming entangled in expense.¹²⁰ This may be an option worth considering.

E. Promptness of Payment

A major criticism of the medical malpractice system has been the delay in resolving claims. Medical injuries may not be discovered until several years after the treatment (the long tail effect). It then may take years after a claim is filed to resolve it.

Each of the proposed alternatives to the tort system explicitly addresses the issue of delay. The Neo-No-Fault proposals would require loss tender within 180 days of discovery of the injury, either as mandated tender or to foreclose potential tort claims. MAI also anticipates a limited period during which the provider must notify the patient of a potential claim. MMI, BRNI, Elective No-Fault, and Pure No-Fault schemes rely on the patient to initiate claims. The primary vehicle for achieving reduction in the time needed to resolve claims would be the substitution of an administrative for a litigation process of compensation.¹²¹

Automobile no-fault, most analogous to MMI, successfully has reduced transaction time from 57.6% of tort claims paid within 180 days of accident to 84.8% of no-fault claims paid. Department of Transportation figures show that the time lapse from receipt of medical expense documentation to the first no-fault medical payment was four to seven days in over 50% of the cases, within one month for 80% of the cases, and within 180 days for 97.9% of the cases.¹²² Clearly, an administrative procedure could significantly improve early compensation over the current tort system.

¹¹⁹ Rolph, Hammitt, & Houchens, *Automobile Accident Compensation: Who Pays How Much How Soon?*, 52 J. RISK & INS. 667, 680-81 (1985).

¹²⁰ Gellhorn, *supra* note 112, at 195.

¹²¹ The AMA proposal relies quite heavily on this advantage to recommend it over the tort system, but specifies no time limit for the process. AMA PROPOSAL, *supra* note 47, at 20-32.

¹²² O'Connell & Beck, *supra* note 108, at 141.

F. Systematic Financial Viability

The overall financial viability of a no-fault compensation system depends on all of the above factors as well as the specific factors discussed below.

1. Proportion of Injuries Compensated

The incidence of iatrogenesis is quite high. In the tort system, many more treatment-induced adverse outcomes occur than result in claims and/or compensation. Only one malpractice claim is filed for every 10 potentially valid claims, and even for major, permanent, partially negligent injuries (the group with the highest probability of bringing suit), only about one in six injuries (17%) is followed by a claim. One in two of these received some payment (one in twelve (8%) of the "potentially litigable events"). According to some estimates, less than 4% of negligently injured hospital patients, and 0.7% of all injured hospital patients, receive any compensation.¹²³ Patients are either unaware of the mishap, unaware of their rights, or accept the adverse outcome.

The range of covered outcomes varies with each proposal.¹²⁴ A comparison with workers compensation, a system quite similar to third party medical no-fault, is equivocal about whether the quid pro quo trade-off of pain and suffering damages for broader compensation of economic loss significantly improves the victims' lot.¹²⁵

Automobile No-Fault evidently has been more successful at achieving this goal.¹²⁶ The New York plan covers up to \$50,000 medical

¹²³ P. Weiler, *supra* note 3, at 104-11; P. DANZON, *supra* note 7, at 20-25; Danzon, *supra* note 7, at 23; Pocinski, Dogger, & Schwartz, *The Incidence of Iatrogenic Injuries*, 11EW REP., APP. 50 (1973); Mills, *New Malpractice Reform Legislation: The 17 Percent Solution*, 12 LEGAL ASPECTS MEDICAL PRAC. 1 (July 1984). These figures are based on mid-1970s data. Seventy-eight percent of paid claims resulted from injuries in hospitals. Zuckerman, Koller, & Bovbjerg, *supra* note 38, at 94. Research in progress will gather current data. See *supra* note 5.

¹²⁴ See *supra* text accompanying notes 99-106.

¹²⁵ The negligence system is better for small losses (high probability, low cost accidents). Workers compensation is better for large losses. Both compensate for significantly less than one-half of the total loss. Ashford & Johnson, *Negligence Versus No-Fault Liability: An Analysis of the Workers' Compensation Example*, 12 SETON HALL L. REV. 725, 755-62 (1982). Other wage loss compensation came from social insurance (16%) and employer/union or union pension and disability plans (3%). This leaves 72% of loss uncompensated and thus borne by the victims. *Id.* at 755-57.

¹²⁶ O'Connell & Joost, *Giving Motorists a Choice Between Fault and No-Fault Insurance*, 72 VA. L. REV. 61, 73 (1986).

expenses plus wage loss, provided at one-half the cost of \$30,000 of traditional liability insurance based on fault. The experience in New Jersey, which covers unlimited medical expenses plus \$5,000 wage loss, is similar.¹²⁷

2. Administrative Costs

Administrative costs are the lightning rod for criticism of the tort system, and the great repository other than pain and suffering damages of additional no-fault compensation resources. Most estimates of the cost of operating the tort system put the amount of premium dollar actually paid to claimants at 18% to 50%.¹²⁸ This is clearly less return on the dollar than workers compensation (55%-70%) or first party health insurance (85%-90%).¹²⁹

The no-fault proposals by definition eliminate one of the most expensive parts of the tort system—the determination of fault—and replace it with a more cost-efficient administrative procedure.¹³⁰ The specified events schemes, except for BRNI, will incur large start-up costs in designing, refining, and updating the list of compensable events, but will find marginal costs drop as adverse events are automatically reimbursed. However, the lists focus on readily definable events, which are not the focus of most malpractice litigation.

As the list is expanded to preempt litigation of more ambiguous, less avoidable outcomes, litigation over the list may ensue. Net administrative costs depends on whether such list litigation, combined with automatic compensation for most of those events is, in the aggregate, less expensive than tort litigation of claims for those events. Statutory Neo-No-Fault retains the negligence judgment, shifting it from the court to the provider. This would reduce litigation expenses for cases where compensation was offered, but probably not as much as with specified events schemes.

MMI has the potential to outshine other proposals for administrative

¹²⁷ *Id.* For a highly useful summary of research, see Rea, *Economic Analysis of Fault and No-Fault Liability Systems*, 12 CAN. BUS. L.J. 444, 462-64 (1987).

¹²⁸ Kakalik & Pace estimate that 42% of the premium dollar is paid to the non-auto tort victim. J. KAKALIK & N. PACE, *COSTS AND COMPENSATION PAID IN TORT LITIGATION* (1986). Weiler estimates 40-45% of medical malpractice premium dollars remain for the victims. P. Weiler, *supra* note 3, at 129.

¹²⁹ Zuckerman, Koller, & Bovbjerg, *supra* note 38, at 100.

¹³⁰ Under New Zealand's comprehensive accident no-fault act, 93% of the collected premium dollar goes to the victim. Gellhorn, *supra* note 112, at 193 n.67 (citing *Report of the Accident Compensation Corporation* 11 (1987)).

cost reduction, if the arbitration mechanism for resolving coverage disputes is not overused. This depends upon the insurer's demeanor and clarity of guidelines for pre-arbitration coverage determination. At this juncture, Dornette's proposal for an Iatrogenic Complications Registry, to disseminate to arbitration panels and insurance companies information on recurring iatrogenesis, would be an important addition to the MMI proposal.¹³¹

"After start-up [the Virginia BRNI program] expects to spend \$125,000 annually for adjudicating and processing claims and operating the Board."¹³² Although not a total cost accounting, this represents .6% of the \$20 million anticipated compensation to infants. It remains to be seen whether this real world test passes financial scrutiny.

3. System Costs

Total system costs depend on the interdependent factors thus far discussed in addition to some broader cost concerns of the various no-fault proposals. The costs of the Statutory Neo-No-Fault plans depend partly on the provider's assessment of negligence (a costly process itself, though less so than litigation), and the decision to tender compensation. Insurance companies may limit liability for high risk cases by prompt tender and resist all others in court. Or they may settle non-meritorious claims quickly based upon a cost/benefit analysis, paying full economic loss and pushing up claims frequency and premiums.¹³³ It is likely that insurance companies will try to set a few examples by resisting claims, then loosen up and see where costs go, approaching what is in effect a limited no-fault scheme.

Compensable events schemes have a particular problem with breadth of coverage, since the cost of trading off tort remedies for predictable but limited administrative remedies is not obviously positive or negative. The outcome of cost/benefit analysis is unpredictable without data on injury incidence, severity (economic loss suffered), and claim rates.¹³⁴ At some point, presumably, as a scheme gets broader, it compensates for more injuries than would be financed by reduction in tort system inefficiencies and awards, rendering the whole system more expensive.

¹³¹ Dornette, *supra* note 60.

¹³² HARVARD SCHOOL OF PUBLIC HEALTH, *supra* note 90, at 16.

¹³³ Robinson, *supra* note 17, at 33-34.

¹³⁴ This data currently is being gathered. See A PILOT STUDY, *supra* note 5.

The narrow BRNI plans are testing the viability of Catastrophic No-Fault. Virginia estimates an incidence of 40 qualifying children at a cost of \$500,000 per child, so the projected \$14,050,000 in revenues fell short of the \$20 million in costs. Florida estimates a minimum incidence of 60 qualifying children at a cost of \$400,000 to \$1 million per child, leaving provider assessments of \$22,250,000 short of the projected \$45 million claims costs.¹³⁵ The difficulty of predicting net financial results is exemplified by the fact that provider participation in the plans is low, and claims incidence thus far is negligible.¹³⁶

The concept of Catastrophic No-Fault plans gains credence when one considers that "[w]hile only about 16% of all iatrogenic injuries were attributed . . . to provider negligence, the latter was true of fully 52% of all major permanent disabilities."¹³⁷ As more consumers begin to exercise their litigation rights, it becomes clear that retaining the tort system is increasingly risky to providers, and the move to Catastrophic No-Fault is a smaller step than adopting full No-Fault. Concentrating compensation on catastrophic losses prompted by longer-lasting or permanent disabilities, leaves the larger proportion of injuries with short term disability and more moderate losses to be borne by the injured party's personal resources.¹³⁸

MMI is designed so that every patient is covered by loss insurance. Presumably, all avoidable adverse medical outcomes are covered, but large administrative savings are envisioned to permit this expansion. The balance is hard to predict,¹³⁹ although the relative efficiency of first party insurance generally is accepted. An unknown variable here is the extent of use of arbitration panels to determine coverage. More precise actuarial

¹³⁵ FLORIDA SENATE COMMISSION ON COMMERCE, FLORIDA MEDICAL MALPRACTICE REFORM AND A REVIEW OF COURT-ORDERED ARBITRATION 114-16 (Jan. 1988). Florida explicitly provides \$40 million in backup revenues. Both states have final resort to the state's general revenues.

¹³⁶ Provider participation includes two-thirds of obstetricians and three-fifths of hospitals in Virginia. Telephone Interview, Virginia BRNI Compensation Board (Apr. 26, 1989), and one-half of obstetricians in Florida. Legislation (S.B.1027) mandating obstetrician participation died in the Florida 1989 legislative session. Telephone interview, Florida BRNI Compensation Association (Apr. 1989). After more than one year in operation, the Virginia BRNI Compensation Board was aware of only two qualifying cases, neither of which had filed claims.

¹³⁷ P. Weiler, *supra* note 3, at 312.

¹³⁸ A PILOT STUDY, *supra* note 5, at 71.

¹³⁹ Dornette estimated that, based on 1968 data, modest premiums charged patients would net sufficient resources to satisfy the claims made under the tort system plus additional claims, in the amount of anywhere from 4½ to over 17 times the net resources available under the tort system. Dornette, *supra* note 60, at 30.

prediction based on larger risk pools will tailor premiums to costs and spread costs more. Inequities creep back in as wealthier consumers become increasingly able to afford minimum coverage and can purchase broader coverage. But at least coverage is guaranteed for those who otherwise might never receive any compensation.

Contract schemes have a particular problem with steady or high income patients who are usually covered by collateral sources. Under Neo-No-Fault, these patients would refuse to accept provider tender of compensation. Under an Elective No-Fault option covering only out-of-pocket expenses, these patients either would avoid treatment by the provider altogether or litigate coverage, looking for a large tort award to supplement their collateral sources.¹⁴⁰ Both Neo-No-Fault and Elective No-Fault could minimize costs by utilizing deductibles to limit payment for non-serious injuries more easily absorbed by the patient.

Compensating additional victims is simply a socialization of private costs. Third party payments to collateral sources, such as health and disability insurers and employer health plans, reduce their costs, transforming lost wages and medical costs into physician and hospital fees and charges.¹⁴¹

Some commentators conclude that, under a Pure No-Fault plan, efficiency savings would be far outweighed by higher overall costs. These are the administrative expense of litigating iatrogenicity (a problem mostly avoided by specified events schemes), the necessity of insuring against maloccurrences not worth avoiding, and the high reserves due to risk uncertainty.¹⁴² Yet, one workers compensation study concluded that employers pay less than under the negligence system.¹⁴³ Some studies indicate that, for automobile no-fault, states with relatively high tort thresholds or verbal thresholds have seen premiums either drop significantly or increase much less than in non-no-fault states.¹⁴⁴

¹⁴⁰ Havighurst, *supra* note 6, at 1274 n.121. Subrogated first party insurers may prevent this opportunity in the health insurance contract.

¹⁴¹ Havighurst & Tancredi, *supra* note 79, at 89-90.

¹⁴² Keeton, *supra* note 96, at 615. This last concern, however, ought to disappear with experience.

¹⁴³ Ashford & Johnson, *supra* note 125, at 765. But, wage loss benefits to workers have not risen, suggesting that the costs of the negligence system have been redistributed to the workers. *Id.* at 765.

¹⁴⁴ Maroney, *No-Fault Automobile Insurance: A Success or Failure After Eleven Years*, 51 INS. COUNS. J. 75, 79 (1984). But, auto no-fault in California has cost more than the tort system. Mills, *Information Please*, 6 J. LEGAL MED. 255 (1985); Tan, *The Medical Malpractice Crisis: Will No-Fault Cure the Disease?*, 9 U. HAWAII L. REV. 241 (1987).

IV. DETERRENCE

It is unrealistic to expect that medical care never would lead to iatrogenesis. Proposed alternatives to the medical malpractice system which focus primarily on compensation view the prevention of adverse medical events as either impossible, a desirable side effect, or an obstacle to the compensation goal.¹⁴⁵ However, the analysis in this article treats the promotion of quality medical care, or conversely, the prevention of poor medical care, as at least equal in importance to compensating the victims.¹⁴⁶ By cutting back on patients' rights without substituting effective regulatory or market-oriented replacements, some reforms may inhibit valid as well as invalid claims and weaken existing quality incentives.¹⁴⁷

Goals for a better system of medical quality ought to include increasing the number of liability claims, since few of the valid claims are brought today.¹⁴⁸ Other goals should be reducing the expense and agony of each case and strengthening other quality control mechanisms. Factors influencing the care provided to the patient include the original medical condition of the patient and the source of payment for patient care, hospital and physician characteristics, expected liability perceived by providers, and conditions of local health care markets.¹⁴⁹ "If a deterrent effect is operative, liability should induce modifications in care that reduce the probability of adverse outcome."¹⁵⁰ From the patient's perspective, outcome considerations of mortality, morbidity, disability, or psychosocial functioning are the most valid assessment of quality of care.¹⁵¹

Mechanisms for deterring adverse medical events vary in type and focus. Financial incentives, such as exposure to risk through tort liability, experience-rating premiums, and cost-sharing, focus on the outcome of care. Professional review and government regulation focus on the process of health care delivery. This section of the article assesses the potential

effectiveness of the various no-fault proposals in preventing medical injury.

A. Regulation, Moral Psychology, and Financial Incentives

Professional review, such as standards delineation,¹⁵² peer review, and disciplinary action, may be initiated by physician groups or, as in the case of Peer Review Organizations, by the government. Other government regulation includes medical licensure, accreditation of facilities, and certification.¹⁵³ Peer review generally is favored by physicians as a less intrusive quality assurance mechanism than government regulation or tort law. However, peer review is "inevitably dominated by the professional colleagues of the doctors whose behavior they are asked to review."¹⁵⁴ This is an inherent disincentive to animating the disciplinary process. Also, reviewers face the real risk of defamation or antitrust suits.¹⁵⁵ One observer concluded: "Policymakers . . . should not accept all professional self-regulation at face value."¹⁵⁶

Furthermore, a move to no-fault liability, by reducing outside public scrutiny of physician and hospital staff behavior and subsequent condemnation of unsafe and inappropriate practices, diminishes that proportion of the deterrent impact in the fault-based tort system which derives more from moral psychology than from monetary responsibility.¹⁵⁷

Thus, for quality of care purposes, no-fault liability plans assume that medical injuries are at least in part deterrable by employing financial incentives. Little empirical evidence considers this assumption. Many physicians deny the effectiveness of such incentives. They believe instead that "good doctors practice good medicine" and "bad doctors practice

¹⁴⁵ NATIONAL ACADEMY OF SCIENCES, *supra* note 74, at 84; Keeton, *supra* note 96, at 603; O'Connell, *supra* note 92, at 553.

¹⁴⁶ Comment, *Toward an Efficient Model of Malpractice Liability for For-Profit Health Care Providers*, 30 ST. LOUIS U.L.J. 949, 984 (1986); Furrow, *Iatrogenesis and Medical Error: The Case for Medical Malpractice Litigation*, 9 LAW, MED. & HEALTH CARE 5, 7 (Oct. 1981).

¹⁴⁷ Bovbjerg, *supra* note 9, at 322. Many reform "packages" now include strengthened peer review and licensing mechanisms such as the Virginia and Florida BRNI plans. *But see* Comment, *supra* note 86, at 452.

¹⁴⁸ Handling more claims is an explicit goal of no-fault plans. Bovbjerg, *supra* note 9, at 322, 340.

¹⁴⁹ A PILOT STUDY, *supra* note 5, at 145.

¹⁵⁰ *Id.* at 144.

¹⁵¹ Brook, Brutoco, & Williams, *supra* note 4, at 1203.

¹⁵² Setting standards for proper medical care is one means of deterring sub-standard care without utilizing the tort system. HARVARD SCHOOL OF PUBLIC HEALTH, *supra* note 90. See, e.g., Eichhorn, Cooper, Cullen, Maier, Philip, & Seeman, *Standards for Patient Monitoring During Anesthesia at Harvard Medical School*, 256 J.A.M.A. 1017 (1986).

¹⁵³ Federal and state regulatory mechanisms incorporate strengthened medical review boards and mandatory reporting of malpractice litigation outcomes and disciplinary actions. See, e.g., Health Care Quality Improvement Act, Pub. L. No. 99-660, §§ 411-432 (1986). Physicians' professional integrity and caring, as well as the Hippocratic Oath, compel quality care.

¹⁵⁴ A PILOT STUDY, *supra* note 5, at 124.

¹⁵⁵ See, e.g., Taylor, *Doctors Can Sue for Peer Reviews: Court (Peer Review Committees Not Absolutely Immune from Antitrust Suits)*, Chi. Daily L. Bull., May 17, 1988 at 1.

¹⁵⁶ C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION 441 (1982). See also Wolfe, Bergman, & Silver, *Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform*, Public Citizens Health Research Group (1985).

¹⁵⁷ A PILOT STUDY, *supra* note 5, at 16.

bad medicine" regardless of external threat.¹⁵⁸ Others believe, however, that deterrence depends on the economic consequences of imposition of liability, which in turn depends on the internalization of costs. The leakage from internal to external cost-bearers occurs as premiums get passed on through patients to government and health insurance.¹⁵⁹ The highly inelastic demand for medical services ensures that up to 75% of premium costs get passed through.¹⁶⁰

Financial incentives encourage physicians to seek consultative advice and continuing education as well as to reexamine practice methods and to limit practice to health problems the physician is capable of handling. Financial incentives also encourage followup with patients to check compliance and problems. Such incentives supplement the necessity of sanctioning powerful professionals resistant to outside interference.¹⁶¹

B. Risk Exposure

A traditional tenet of the medical tort system has been the deterrent effect of exposure to risk. Critics of this tenet argue that the malpractice system has a "miniscule" impact on quality of care compared to other factors.¹⁶² Advocates of Statutory Neo-No-Fault plans add that what little deterrence the tort system has is preserved with fault rules as the ultimate basis of responsibility. They also point out that the abandonment of fault liability in workers compensation and automobile no-fault has had no adverse effects on deterrence, and that more non-tort protections of quality exist in the health care field than in other areas in which fault has been dropped. Neo-No-Fault deterrence is further enhanced by the incentive to uncover actionable events within a prescribed time period to foreclose tort liability.¹⁶³

However, acceptance of the premise that tort deterrence is ineffectual renders meaningless the subsequent guarantee of preserving tort incentives. Statutory Neo-No-Fault may be a slight improvement in deterrence over the current system due to the limited optional tender period.

¹⁵⁸ Zuckerman, Koller, & Bovbjerg, *supra* note 38, at 111; Havighurst, *supra* note 6, at 1243. This is supported by the notion that much of medical practice is an art. Mistakes are a natural part of the practice.

¹⁵⁹ This is Pollack's premise for MMI's almost exclusive concentration on compensation.

¹⁶⁰ Sloan, *Economic Issues in Medical Malpractice*, reprinted in FLORIDA MEDICAL ASSOCIATION, MEDICAL POLICY GUIDEBOOK 41-43 (Manue ed. 1985).

¹⁶¹ Havighurst, *supra* note 6, at 1247.

¹⁶² Brook, Brutoco, & Williams, *supra* note 4, at 1222; Moore & Hoff, *supra* note 53, at 122.

¹⁶³ *Id.*

However, it is unlikely to have the cost-imposition deterrence effect inherent in true full or limited no-fault/strict liability schemes or in schemes explicitly affecting cost by deterrability, such as MAI and MMI.

In truth, Statutory Neo-No-Fault is an attempt to reduce the costs of malpractice without affecting tort deterrence. If costs are in fact reduced, then it either will be the result of reduced administrative costs, which would not affect tort deterrence, or by elimination of the threat of large damage awards, a primary component of tort deterrence. Certainly, the large damage award threat is eliminated, since providers will tender compensation in such cases.

If tort liability fails to deter, then it does not matter from where the reduced costs come. Assuming tort damage awards to deter (a notion supported by common sense, economic theory, and some case histories, but very little hard data),¹⁶⁴ then Statutory Neo-No-Fault would have a negative impact on the quality of medical care to the extent the positive incentive of the time-limited tender provision does not offset the effect of reducing damages. The negative impact could be quite significant. It may be unwise to abandon effective tort deterrence without a strict liability replacement ensuring provider responsibility for medical injuries.¹⁶⁵

MMI's First Party No-Fault liability effectively segregates the health care provider from the financial burden of unsafe health care. For BRNI, the potential for overflow allocation of insurance costs to unrelated lines of insurance carriers dilutes any strict liability deterrent effect by spreading costs well beyond parties with responsibility for and ability to reduce the incidence of adverse medical outcomes.¹⁶⁶ Yet, tort deterrence still has some impact upon the physician, who will be unable to discern with certainty at the time of delivery whether an infant's injuries qualify for compenation under the BRNI plan.¹⁶⁷

Pollack's MMI proposal repeatedly attacks the alleged failure of the current system to adequately spread provider costs. If the sole purpose of an injury payment system were to compensate victims and spread that

¹⁶⁴ Zuckerman, Koller, & Bovbjerg, *supra* note 38, at 111.

¹⁶⁵ Another way to increase the deterrent effect is to require that tender include reimbursement of collateral sources for their outlays. *Neo-No-Fault*, *supra* note 52, at 140. However, this would alter the provider's tender decision by necessitating a higher benefit—the preclusion of a greater potential jury award—to offset the higher cost of tender. This would reinforce the tendency of providers to tender only to the seriously injured with high damage risks and thus narrow the range of injuries likely to benefit from the plan.

¹⁶⁶ Epstein, *supra* note 90, at 1471.

¹⁶⁷ Note, *Innovative No-Fault Reform for an Endangered Specialty*, 74 VA. L. REV. 1487, 1503 (1988).

loss as widely as possible throughout society, then perhaps first-party insurance such as MMI would be the best way to achieve that goal. However, financial incentives are an essential element of preventing iatrogenesis. The failure of providers to spread costs of such injuries as evenly as first-party insurance presumably could is, from a deterrence perspective, an advantage of the current tort system.

Such advantage would be retained in third party no-fault or partial no-fault insurance through strict liability and experience rating of providers. One need only look to the meteoric rise of risk management programs within health care institutions to confirm the impact of potentially catastrophic malpractice awards and consequent premium hikes in making health care delivery a safer process.¹⁶⁸ Removing any financial onus on providers when they fail to provide safe health care is precisely the wrong direction to take as market-oriented economics and dollar-focused bottomline profitability become a central focus of for-profit and not-for-profit private and public health care corporations.¹⁶⁹ Indeed, "[c]redentialing and peer review . . . have surely been strengthened by the increasing liability of hospitals for injuries caused by physicians on their staffs."¹⁷⁰

C. Strict Liability

Commentators generally agree that a system based on strict liability principles operates more effectively as a deterrent than does a negligence system. Forcing someone to pay for accidents regardless of fault is an extraordinary incentive to safe conduct on the part of potential defendants.¹⁷¹

No-fault's *raison d'être* is to increase claims frequency, systematically covering all practitioners, including those who are incompetent and whose patients most need the coverage.¹⁷² The unsystematic

¹⁶⁸ Tort liability is not the only factor. Health care professionals accept the burden of long years of training and long hours on the job to provide society with quality care.

¹⁶⁹ The converse argument could be made, though less effectively.

¹⁷⁰ Danzon, *Medical Malpractice Liability*, in *LIABILITY: PERSPECTIVES AND POLICIES* 125 (R. Litan & C. Winston eds. 1988). This complements the increasing institutionalization of health care. For a more comprehensive discussion of the advantages of institutional liability, see P. Weiler, *supra* note 3, at 239-48. See also Curran, *A Further Solution to the Malpractice Problem: Corporate Liability and Risk Management in Hospitals*, 310 NEW ENG. J. MED. 704 (1984).

¹⁷¹ F. HARPER, F. JAMES, & O. GRAY, *THE LAW OF TORTS* § 13.5 (2d ed. 1986); O'Connell, *Operation of No-Fault Auto Laws: A Survey of the Surveys*, 56 NER. L. REV. 23, 50 (1977). Although this may be less true for health care professionals than for ordinary tortfeasors, it is not likely to be wholly untrue.

¹⁷² *Id.* at 551; Bovbjerg, *supra* note 9, at 340.

compensation afforded under the tort law system suboptimally deters injuries, even those that would be compensable under its own restrictive rules.¹⁷³ In this regard, systematic imposition of costs on providers would eliminate this shortfall of the tort system. Any increase in health care costs probably would be offset with gains in quality.

The predictability of no-fault liability also facilitates the establishment of a wide-scale safety monitoring system to measure safety improvements. Data feedback achieved by increased accountability for medical injuries, otherwise largely unattainable except through expensive post-hospitalization patient follow-up interviews, would significantly enhance safety programs' effectiveness.¹⁷⁴ Cost imposition on those able to organize to do safety research fits well with the increased institutionalization of the health care system. Resulting data would facilitate experience rating of premiums.

Elective No-Fault contracts and Contractual Neo-No-Fault plans relieve providers of psychic and financial burdens, but neither plan is explicit about incentives for quality health care. However, their strict liability contractual obligation to tender compensation solves the chief problem found in Statutory Neo-No-Fault (the tender decision). Although premiums for Pure No-Fault, Elective No-Fault, and Contractual Neo-No-Fault probably will be substantial, providing some incentives, costs still will be passed through. The BRNI plans establish separate state funds that are liable for awards. Although claims are automatically referred for quality review, health care providers face no direct financial consequences.

The prevalence of cost-shifting suggests the importance of including deterrence as an explicit focus of no-fault insurance. Internalizing costs by imposing them on providers retains accountability and financial responsibility while relieving the psychic and other burdens of the tort system. Even strict liability regimes have no deterrent effect if all liability costs can be shifted or passed on. A no-fault plan, then, ought to include experience rated premiums or cost-sharing provisions.

D. Experience Rating

Until recently, rating medical liability insurance premiums for provider claims experience has been dismissed as impractical and ineffective—impractical for statistical and political reasons, ineffective

¹⁷³ Tancredi, *supra* note 6, at 278.

¹⁷⁴ *Id.*

due to the perceived randomness of claims. Changes in the health care marketplace and the liability crisis now have spurred efforts to tie liability coverage to deterrence. Hospital insurers frequently base premiums on malpractice loss experience.¹⁷⁵ Institutional providers, who pay the largest share of premiums, have begun experience rating and risk retention through self-insurance and physician-owned (captive) insurance companies. Risk management programs have begun to translate malpractice experience into effective preventive measures. Legislators, regulators, and commentators have concluded that rates should reflect quality, regardless of scheme—fault, partial-fault, or no-fault.¹⁷⁶ Some insurers apply experience (merit) rating to individual providers in the form of surcharges.

Strong and growing research concludes that experience rating of individual physicians' medical liability insurance premiums is both statistically feasible and "extremely valuable in setting appropriate premium rates."¹⁷⁷ Claim incidence and severity are not random, as underlying claim rates vary significantly within specialty class. Moreover, those physicians with high claim rates also had claims that were 2.3 times larger than their colleagues.¹⁷⁸ Since insurance premiums are based

¹⁷⁵ GENERAL ACCOUNTING OFFICE, *supra* note 3, at 14.

¹⁷⁶ Bovbjerg, *supra* note 9, at 334, 341; Posner, *Trends in Medical Malpractice Insurance, 1970-1985*, 49 LAW & CONTEMP. PROBS. 37, 42-44 (1986); DEPARTMENT OF HEALTH & HUMAN SERVICES, REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE 151 (Aug. 1987); Tan, *supra* note 144; Gellhorn, *supra* note 112. The state statutes and regulations are designed to require or permit implementation of medical malpractice insurance experience rating. See, e.g., MASS. GEN. LAWS ch. 175 § 5A (Supp. 1989) (constitutionality upheld in *Massachusetts Medical Soc'y v. Commissioner of Ins.*, 402 Mass. 44, 520 N.E.2d 1288 (1988)); N.Y. COMP. CODES R. & REGS. tit. 11, § 152 (1986). The Massachusetts Division of Insurance is unaware of any studies assessing the success of experience rating. Telephone Interview with Mark Leymaster, Division of Insurance, State of Massachusetts (May 19, 1988).

¹⁷⁷ Nye & Hofflander, *Experience Rating in Medical Professional Liability Insurance*, 55 J. RISK & INS. 150, 151 (1988) [hereinafter Nye & Hofflander]. Accident propensities of individual physicians are stable over time, so past malpractice experience is a good predictor of future malpractice experience, and physicians vary in individual accident propensities. *Id.* at 154-55 (citing Venezian, Nye, & Hofflander, *The Distribution of Claims for Professional Malpractice—Some Statistical and Public Policy Aspects*, Proceedings of the Casualty Actuarial Society). See also Nye & Hofflander, *Economics of Oligopoly: Medical Malpractice Insurance as a Classic Illustration*, 54 J. RISK & INS. 502 (1987). For a comment critical of the actuarial definitiveness of Nye and Hofflander's work, see Klugman, *Experience Rating in Medical Professional Liability Insurance: Comment*, 56 J. RISK & INS. 329 (1989). For a response, see Nye & Hofflander, *Authors' Reply*, 56 J. RISK & INS. 333 (1989).

¹⁷⁸ Rolph, *Some Statistical Evidence of Merit Rating in Medical Malpractice Insurance*, 48 J. RISK &

on expected claim rates and anticipated claim severities, experience rating probably would lead to substantial differences in premium levels, making it good financial and public policy for insurers to merit rate.

Since claims experience is at least as important to pricing as knowing the physician's medical specialty, two commentators recommend "mandatory collection of experience information on a centralized basis as a measure critical to the long run health of the medical malpractice insurance industry."¹⁷⁹

If merit rating would be effective in concentrating the cost of injuries on poorer quality providers,¹⁸⁰ insurers could implement it by grouping all providers together, forcing hospitals, physicians, and those providers subject to particular adverse outcomes to bargain over who is best able to monitor and avoid medical injuries. Insurers also could group providers along functional lines of economic and professional interest, such as a hospital and its staff, or within risk groups as is done currently, since different specialties of practice have different degrees of risk.¹⁸¹ Retrospective dividend adjustments seem to represent the appropriate mechanism for implementing merit rating, given the long-tail of medical losses, though some insurers presently utilize surcharges. Cost-sharing by deductibles, coinsurance or non-coverage of specific procedures are other options.¹⁸² Allowing a maximum threshold number of claims before experience rating took effect would accommodate a few normal accidents or random claims, so only providers who are prone to adverse outcomes pay the price.¹⁸³

Experience rating would improve the deterrent efficacy of both the tort system and no-fault. All of the proposals discussed herein could apply it. The BRNI plans contain no provisions for experience rating.

Properly implemented, merit rating of first party no-fault insurance could fit in well with the private incentives in the current market-oriented health care system. MMI could substantially add to the information the health care consumer has about potential providers. For example, first-party insurer ratings of providers for frequency and severity of maloccur-

INS. 247, 249 & 259 (1981); Schwartz & Komesar, *Doctors, Damages & Deterrence*, 298 NEW ENG. J. MED. 1282, 1287 (1978).

¹⁷⁹ Nye & Hofflander, *supra* note 177, at 150-51.

¹⁸⁰ See Study, *Few Doctors Cause Most Lawsuits*, Chi. Daily L. Bull., Mar. 3, 1987, at 1.

¹⁸¹ Bovbjerg, *supra* note 9, at 342.

¹⁸² HHH REP., *supra* note 176, at 151.

¹⁸³ Havighurst, *supra* note 6, at 1251.

rence claims could well steer patients away from providers with high maloccurrence rates and toward providers of safer medical care.¹⁸⁴ Of course, this function need not necessarily be performed solely by first-party insurance companies. Any institution or payor that in some way bears the costs of medical maloccurrence or iatrogenesis would have an incentive to collect this information. Such bodies would include unions and employers that provide health insurance for employees, and government acting on behalf of society.¹⁸⁵ However, the antitrust and defamation implications of publicizing information, steering patients or refusing coverage for patients treated at certain institutions, would have to be fully explored.

Explicitly subsuming MMI premiums into health care insurance is possible and may reduce administrative costs. In some cases, like HMOs, first and third party insurers would be one and the same—the health care insurer is also the provider. Although this does impose the cost directly on providers, somewhat expanding their liability, first-party insurers already ultimately bear much of the cost. For HMOs, subsuming MMI premiums would eliminate the risk incentive of catastrophic tort awards without adequate replacement.

Whether first-party or third party merit rating would be more successful depends upon the degree of first-party insurer influence on consumer choice (for example, does it recommend certain providers or refuse coverage?). This is especially true when balanced against personal physician recommendations and institutional staffing privileges. Experience rating MAI is an explicit part of the proposal. It would complement and enhance the incentives built in through the relative avoidability criterion of reimbursable event choice. But patient choice of provider is unlikely to be based on the insurance arrangements between the provider and insurer.¹⁸⁶ unless experience rating forces a provider out of business. Ultimately, experience rating or cost-sharing forces the medical profession to carry its own liability costs.¹⁸⁷

¹⁸⁴ Pollack recommends this for MMI, though not as explicitly. It is particularly effective with causation based on avoidability. Pollack, *supra* note 6, at 567 n.93.

¹⁸⁵ One dramatic example of the impact of publishing information to facilitate consumer choice was the Federal Aviation Administration's publication of on-time percentages for the nation's airlines. Almost immediately, the airlines reacted by adjusting their schedules to reflect more realistic flying times so that they would rank higher on the FAA list.

¹⁸⁶ Havighurst, *supra* note 6, at 1275.

¹⁸⁷ Taken together, conclusions of studies of the deterrent effect of workers compensation and automobile no-fault is that there is neither more nor less injury than under tort liability. See

E. Causation and Identifying Compensable Events

In all no-fault schemes, compensability, or inclusion on the list of compensable events, depends on establishing a causal link between provider care and the adverse outcome. Causation in the medical injury context poses particularly difficult technical problems due to the complication of the underlying adverse health condition for which the patient originally sought treatment by the provider. Compensation for all cases in which the patient leaves the provider's care in a condition worse than prior to the care would condemn all providers to the role of guarantors of good health regardless of the natural path of human physiology. A system of law that fails to use a concept of causation "may not respond to ordinary views on individual blame and accountability."¹⁸⁸

Legal theory recognizes four types of causation: (1) but-for causation; (2) necessary and sufficient causation; (3) the substantial factor test; and, (4) Tancredi's concept of relative avoidability. The tort system relies primarily on necessary and sufficient causation, which focuses on deterrence but would yield a very narrow list of compensable events. Substantial factor causation is akin to absolute liability, an overall health insurance system focusing on compensation. But-for causation is only a little broader than necessary and sufficient causation. Relative avoidability attempts to balance the goals of supplying compensation, assigning accountability, and providing feedback for prevention. It recognizes the difficulty in forming a chain of causation. Factors determining relative avoidability are iatrogenicity, preventability, treatability, detectability, and the consequences of designating events as relatively avoidable, such as mitigating expected but unavoidable side effects. Relative avoidability causation is a key aspect of MAI deterrence.¹⁸⁹

A highly specified statutory list of compensable events addresses concerns about a factual causation litigation bottleneck for a strict liability regime for medical injuries. Relative avoidability, by removing actual

Fishback, *Liability Rules & Accident Prevention in the Workplace: Empirical Evidence from the Early Twentieth Century*, 16 J. LEGAL STUD. 305 (1987); Zador & Lund, *Re-Analysis of the Effects of No-Fault Auto Insurance on Fatal Crashes*, 53 J. RISK & INS. 226 (1986). But see Chelius & Kavanaugh, *Workers Compensation and the Level of Occupational Injuries*, 55 J. RISK & INS. 315 (1988), finding lower workers compensation benefit levels associated with, and probably the cause of, lower frequency of injuries.

¹⁸⁸ R. EPSTEIN, *supra* note 61, at 10.

¹⁸⁹ This analysis, developed for MAI, could apply to all compensable events plans. See Havighurst & Tancredi, *supra* note 76, at 77-82; ABA, *supra* note 76.

fault as an objective, permits broader compensation to be perceived as fair, even if an outcome is arguably unavoidable. It also helps shield providers from imputation of fault whenever a patient suffers a compensable harm.¹⁹⁰ The minimum degree of avoidability required for compensation would depend on whether the benefit of retaining the opportunity for fault-related inquiry is worth the fault-based costs of frequent provider exculpation, proof problems, and defensive medicine.

Such costs would justify a substantial degree of apparent arbitrariness in a no-fault system. Evolutionary expansion of covered outcomes would bolster incentives to find methods to avoid outcomes previously considered unavoidable while attaining the social insurance goals of distributing cost and eliminating tort system financial and psychic costs. Yet, there may be an optimal level of injuries beyond which expenditures for prevention exceed the liability value.¹⁹¹

Another criterion for specifying the list of compensable events is the impact on the quality of care.¹⁹² The specification of compensable events ought not distort the physician's choice of treatment in the patient's best interests.¹⁹³

The third specification criterion is administrative simplicity, essentially the ease of recognizing compensable events.¹⁹⁴ The list often will sacrifice relative avoidability and accurate assignment of risk for the sake of administrative simplicity. This criterion finds application in the BRNI plans.¹⁹⁵

Finally, consideration of patients' compensatory needs would focus coverage on areas where claims usually arise, since those injuries are less likely already to be covered by other compensation sources.¹⁹⁶ This criterion is only useful if compensation were not reduced by the amount of available collateral sources, because such a reduction would reduce the

¹⁹⁰ See Havighurst & Tancredi, *supra* note 76, at 77-78 nn.2 & 3 (full discussion of the fairness dimension).

¹⁹¹ For example, is the cost of leaving a sponge in a body after surgery in 1 of 100 surgeries less than the cost of increased diligence to ensure that it does not happen even once?

¹⁹² *Id.* at 79.

¹⁹³ Greater distortion now exists with a physician facing personal catastrophe for a variance from standard practice.

¹⁹⁴ *Id.* at 82.

¹⁹⁵ Epstein cites the difficulty of distinguishing serious injuries caused during pregnancy or the birthing process from those caused by birth defects, as well as referring to serious injuries potentially caused by intermittent drug use (for example, cocaine use), which is indistinguishable from statutorily defined compensable injuries and which may be untraceable. Epstein, *supra* note 90, at 1469.

¹⁹⁶ Havighurst, *supra* note 6, at 1255 n.66.

incentive effect of fully accounting for injury cost within the compensable events insurance system and would distort the incentive effect by the fortuity of patients' coverage or lack of it.¹⁹⁷

MAI explicitly focuses on deterrence, emphasizing the avoidability of adverse outcomes complemented by merit rating of provider liability insurance premiums, boosting its credibility as a viable no-fault alternative to the tort system. Presumably, in the compensable events proposals of Elective No-Fault and Contractual Neo-No-Fault, the list of compensable events would be based on a straightforward risk analysis of potential tort liability.

In the MMI proposal, the standard for defining causation (and thereby, medical maloccurrences or compensable events) is not addressed until coverage is disputed and an arbitration panel determines causation. Before arbitration, the defining factors are presumably left up to the parties to the contract—the insurer and the patient. The relatively poor bargaining power of consumers vis-a-vis insurers raises the contract of adhesion specter, especially when the consumer lacks leverage and is forced to accept government mandated insurance coverage rather than being able to walk away to the tort system.¹⁹⁸ If a coverage issue goes to arbitration, the arbitrator applies the avoidability test.¹⁹⁹ The "more probably than not" version establishes iatrogenicity upon a conclusion that the outcome was 51% likely to be the causal result of health care treatment. It then presumably shifts the burden of proof by creating a presumption of iatrogenicity unless a determination of "unavoidability" could be made, raising the issue of what percentage of risk is deemed "unavoidable."²⁰⁰

CONCLUSION

No-fault alternatives to the tort system vary in the application of similar basic principles. They vary in the degree to which they displace

¹⁹⁷ Sample lists of general surgery and orthopedic compensable events were developed by the American Bar Association in a detailed study analyzing such a system's feasibility. ABA, *supra* note 76. See also Havighurst & Tancredi, *supra* note 6, at 82 (for lists of reactions from blood transfusions and orthopedic injuries); Havighurst, *supra* note 6, at 1256 (for lists of anesthesiology and general surgery outcomes).

¹⁹⁸ Questions of regulation and insurance market competitiveness factor into this calculus.

¹⁹⁹ Pollack, *supra* note 6, at 581.

²⁰⁰ In New Zealand, the debate over causation has centered around the issue of "remoteness," considering whether the risk of worsened physical condition for medical treatment is significant enough to constitute a "misadventure." Gellhorn, *supra* note 112, at 190-91.

the tort system, meet the compensatory needs of injured patients, and create incentives to prevent injuries.

The purest application of the no-fault principle covers all medical injuries regardless of fault. As a compensatory mechanism, Pure No-Fault promises the broadest coverage, but only while jeopardizing systematic financial viability. Not only might the broad coverage of Pure No-Fault (Third Party) be exceptionally expensive, but litigation over causation would ensue in any but the most generous, social insurance-type systems. Medical Maloccurrence Insurance (First Party) would significantly spread the funding and actuarial base, but in so doing would compromise deterrence by separating provider from cost-bearer. The Pure No-Fault (Third Party) strict liability regime unifies those elements, but most of the costs would be passed on to the government, third party insurance, or patients.

The smallest departure from the tort system is the Statutory Neo-No-Fault Early Compensation plan. As such, it retains most of the fault system's deficiencies. Its chief advantage is deferral of the issue of defining compensable events. Its utility as a compensation system depends on the providers' cost/benefit analyses and decisions to tender compensation. Compensation is virtually guaranteed to severely injured patients, those who have catastrophic losses and are most likely, though still unlikely, to sue. Providers might gamble on avoiding a claim altogether. One also must judge an alternative to the tort system on its ability to improve compensation for those left out of the tort system and not solely on the effect on insurance premiums. Under Statutory Neo-No-Fault, coverage much beyond the litigious grievous cases is unlikely. In addition, it removes the tort system's primary deterrent, the threat of large awards, and replaces it with less-than-guaranteed, time-limited economic tender.

Of the elective options, Contractual Neo-No-Fault is the most attractive to the patients. It binds the provider to tender compensation for defined injuries without binding the patient to accept. This avoids the unconscionability and adhesion concerns of mutually binding contracts and does not forcibly preempt the tort system for seriously injured patients. However, providers are unlikely to voluntarily purchase a "guaranteed offer" insurance policy for injuries that fall along the hazy negligence borderline unless they see a clear net savings, narrowing the breadth of compensation coverage. The plan successfully merges the threat of large awards through tort with strict liability for defined injuries,

retaining deterrence for borderline injuries. Overall, Contractual Neo-No-Fault is a relatively attractive proposal but inherently too narrow for systemic medical malpractice reform.

Even narrower in scope, and adding the contractual difficulties, Elective No-Fault will find that providers are unlikely to voluntarily accept coverage for events rarely compensated in the tort system. It fails to provide the necessary legal quid pro quo while leaving uncompensated a vast portion of iatrogenic injuries. Strict liability will encourage quality care but with incentives limited only to defined injuries.

The fairness of contract depends heavily on consumer education and information. It is ineffective when choice of provider often is based on facility reputation for care, emergency convenience, and consumer inability to assess adequately the available information. Blind faith will not ensure the patients' best interests in an era of providers that must focus on the bottom line. Elective No-Fault is really only viable to the extent providers see a benefit to themselves as they design the list of compensable events. Consumer protection in the form of legislative determination of compensable events would go a long way toward remedying this problem.

By contrast, the Catastrophic No-Fault plans of Virginia and Florida, the Birth-Related Neurological Injury Compensation plans, hold the promise of alleviating tort stress while providing fair and simple compensation within their narrow targets. But, the promise will remain unrealized if the injury definitions are too narrow and provider assessments are not somehow linked to provider experience.

This is why, of the limited specified events no-fault schemes, Medical Adversity Insurance holds the best promise of effectively combining compensation and deterrence objectives. Like the other plans, MAI risks compensating too narrow a range of injuries. Unlike the others, MAI's statutory basis gives it the flexibility to accommodate concerns about equity and efficiency by expanding the list of designated compensable events to include some relatively unavoidable outcomes (such as severe birth-related injuries). It protects consumers by avoiding contracts and ensuring non-provider participation in defining compensable events. MAI deterrence builds in experience rating of provider insurance premiums and defines the compensable events by their avoidability. MAI defines a closer relationship between the incidence and cost of bad outcomes (patient losses), and the cost to providers (premiums), by unifying the bearer of the cost (the provider) with the cause of the outcome

(the provider). Financial interests and professional responsibilities closely coincide.

However, MAI will be difficult to translate into an operational solution to the medical malpractice crisis. It requires highly detailed data on malpractice claims to appraise, refine, and extend MAI's impact, and then requires government administrative implementation. The feasibility of identifying compensable events has been demonstrated.

Although its developers view MAI as a nonregulatory attack on the problem of obtaining quality medical care and affordable insurance premiums, this author considers it a proper regulatory use of financial incentives to achieve social goals. Regardless of ideological labeling, MAI represents (as do all these no-fault proposals) a significant departure from the current tort system.

An intermediate implementation step would be a state administrative determination of compensable events and the use of incentives to encourage providers to join the system. This proposal will encounter increasingly independent providers wary of subjecting themselves to further state regulation. However, carefully designed incentives to join would avoid loosening patient protections built up over many years, while offering the advantages of no-fault insurance to providers and patients alike.

The new health care system of competition, profit, and institutionalization may need a strict liability system in which the provider bears the complete cost of injury, with explicit emphasis on financial incentives for quality care. This will motivate providers to minimize injuries for strictly business reasons, and give the provider freedom to adopt cost-effective innovations to improve care quality. Contract-based health plans encourage single provider experimentation as long as unions or employers bargain for health care consumer rights. The institutionalization of health care delivery encourages large-scale organization of and investment in quality-enhancing research and other measures. Whatever one thinks of health care deregulation in the abstract, no-fault could play a healthy role in it.

As an additional consideration, it is recommended that in all the proposals there be a requirement that the provider give to the patient written notification of likely medical mishap. Consumer ignorance of medical causation often leads to no claim at all, a fate suffered disproportionately by the unempowered. No-fault generally allows physicians and patients to form relationships of caring and mutual self-interest

rather than antagonism. Failure to acknowledge and notify patients of human error, negligent or accidental, continues the provider deception fostered by the tort system. Most people simply cannot be vigilant consumers while in fear and pain and under anesthesia. When injury occurs, patients need a psychological healing process just as they need physical healing. A grievance procedure for the injured's communication with the physician and hospital would assist the patient to work through the injury, providing congenial personal empowerment where the tort system offers little but antagonistic empowerment.

No-fault offers a strong opportunity for improving health care quality and reducing the burden of medical injuries for individual patients and for providers. Medical Adversity Insurance provides the best balance of compensation and prevention. After all, no one wants to suffer medical injury.

Yet, a decision to abdicate the tort system in favor of a no-fault system must recognize that no-fault, for all its surface appeal, contains administrative, actuarial, and sociological complexities of its own. The extent to which no-fault "intervenes in the free market" escapes easy philosophical definition, but its departure from the traditional common-law tort principle of fault is a major step indeed. If done correctly, no-fault can improve individual lives, social justice, and quality health care. Two bold legislatures have taken the first step. It remains for others to follow.

example, do not perform surgery in such a manner that one physician attempts to undermine the work of another. But lawyers advocate in a contentious arena for the vindication of a particular party, recognizing that the quest to obtain justice for one in fact preserves the rights of all. Attorneys must be ever mindful that when they advocate the causes of their clients they need not — indeed must not — rely upon unprofessional conduct of any sort. Our common law tradition does not require it, our ethical canons do not suggest it, and our system of justice cannot afford it.

The renaissance of professionalism in trial advocacy may not be accomplished by one lawyer or by one law class or by one bar association. But it is said that a journey of a thousand miles begins with the first step. So let us begin.

THE NO-FAULT ALTERNATIVE TO MEDICAL MALPRACTICE LITIGATION: COMPENSATION, DETERRENCE, AND VIABILITY ASPECTS OF A PATIENT COMPENSATION SCHEME

by David S. Starr*

I. INTRODUCTION

A perceived medical malpractice crisis¹ has caused state legislatures throughout the nation to enact a variety of statutes which are intended to cope with this problem.² The crisis actually began in the early 1970's when the number of medical malpractice claims,³ as well as the size of awards granted to successful plaintiffs, began to

* M.D., J.D., FACS, FRACS, FRCS(C). The author worked 16 years in surgery before attending law school during a long period of convalescence from personal illness. He graduated J.D. (*magna cum laude*, Order of the Coif) from University of Toledo in Ohio in 1988. He is presently working as a medical consultant and attorney at Bankston, Wright and Greenhill in Austin, Texas. Principal areas of interest are malpractice defense and legal medicine.

1. Several writers have recognized the "medical malpractice crisis". See Danzon, *The Frequency and Severity of Medical Malpractice Claims*, 27 J.L. & ECON. 115 (1984); Winter, *Medical Malpractice: Will Jumbo Awards Spark Another Insurance Crisis?*, 68 A.B.A. J. 1545 (1982). Other authorities believe that there is no actual crisis. See, e.g., Londrigan, *The Medical Malpractice "Crisis": Underwriting Losses and Windfall Profits*, 21 TRIAL 22 (May 1985) (arguing that factors relating to insurance company investments and interest rate changes have produced funding problems); Kelner & Kelner, *Medical Malpractice: Is There a Crisis?*, N.Y. L.J., Feb. 8, 1984, at 1 (arguing that a false crisis has been orchestrated to cover other problems).

2. As early as 1976, forty states had enacted legislation aimed at curbing increases in medical malpractice litigation. See Grossman, *A State-by-state Summary of Legislative Activities in Medical Malpractice*, in A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE 12 (1976) (compiling legislative efforts in all 50 states). Legislative activity continued in the intervening years to the present. See generally Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1417 (providing a general guide as to the preparation and evaluation of legislation dealing with the law of medical malpractice).

3. See generally Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489, 490 (1977) (noting the dramatic increase in the number of medical malpractice claims); Adams & Zuckerman, *Variation in the Growth and Incidence of Medical Malpractice Claims*, 9 J. HEALTH POL. POL'Y & L. 475, 475-81 (1984) (noting that the frequency of medical malpractice claims increased greatly between 1976 and 1981); Danzon, *The Frequency and Severity of Medical Malpractice Claims*, 27 J.L. & ECON. 115, 115 (1984) (noting the increase in frequency and severity of malpractice claims); Witherspoon, *Constitutionality of the Texas Statute Limiting Liability for Medical Malpractice*, 10 TEX. TECH L. REV. 419, 419 (1979) (finding the national health care crisis manifested by increase in medical malpractice claims filed).

increase.⁴ This increase in disbursements forced the insurance companies that issued medical malpractice policies to substantially increase the premium charged to each policyholder,⁵ while some companies decided to completely discontinue offering medical malpractice insurance.⁶

Legislative response has often been initiated by actual or threatened withdrawal of the insurance companies from the market⁷ or,

4. See Comment, *Medical Malpractice in Perspective: Nebraska Hospital-Medical Liability Act*, 59 NEB. L. REV. 363, 363 (1980) (noting that in mid-1970's there was a dramatic increase in the amount of damages awarded to successful plaintiffs in medical malpractice actions); Comment, *Recent Medical Malpractice Legislation — A First Checkup*, 50 TUL. L. REV. 653, 658 n.22 (1976) (finding the national average of claims awarded to successful plaintiffs in medical malpractice actions rose from average of \$6,705 in 1969 to \$12,535 in 1974).

The trend appears to be continuing. In August 1987, Secretary Bowen of the Department of Health and Human Services released a study showing that the average malpractice insurance premium for American Physicians rose 81% from 1982 to 1985, while increasing 113% for hardest hit specialty obstetrics, and gynecology. See *Bowen Calls for States to Act on Malpractice*, N.Y. Times, Aug. 9 1987, § 1, at 21, col. 1.

5. Gray, *The Insurer's Dilemma*, 51 IND. L.J. 120, 120 (1975) (noting that when malpractice coverage is available, it is offered at an increased rate). Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 760 (1977) (noting that physicians in some states experienced an increase of more than 100% in their malpractice insurance premiums). Note, *The Michigan Malpractice Act's Requirement of a Physician on the Panel Violates the Due Process Right to a Fair and Impartial Tribunal*, 28 WAYNE L. REV. 1843, 1843 n.3 (1982) (finding that the average malpractice insurance rate of surgeons has increased 949%).

6. See e.g., Redish, *supra* note 5, at 760 n.4 (noting that nationally the number of insurance carriers writing such insurance has decreased). Segar, *Is Malpractice Insurable?*, 51 IND. L.J. 128, 132 (1975) (finding that some insurance companies would prefer to abandon the business entirely).

7. See Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS. 2, 5 (1986). Such major companies as Wausau, Hartford, Fireman's Fund, USF&G, and Travelers have withdrawn from the medical malpractice insurance market since the mid 1970's. *Id.* at 9 n.23.

Threatened withdrawal was a major factor in initiating recent legislation in Virginia. "[I]n mid-1987] a federal court case overturned the state's \$1 million cap on malpractice judgments and awarded \$8.3 million to a brain-injured child, who died only 6 weeks after the verdict. At the same time, the Virginia Insurance Reciprocal, the state's largest professional liability insurer, decided not renew coverage for obstetricians, affecting one-quarter of all OB's on the state. The bill [providing a patient compensation scheme for brain-damaged babies] was passed in an atmosphere of near-hysteria." Ohio Hospital Insurance Company, 7 QA/RM BULL. 2 (1987).

A similar 1987 threat of withdrawal by the large malpractice insurers, St. Paul and Cigna, initiated premium increases and a promise of a "special session of the [Florida] legislature." Nisonson, *A View From Miami: Surgeons vs. Legislators*, BULL. AM. C. SURGEONS, Aug. 1987, at 27.

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occasionally, withdrawal of the doctor's medical services.⁸ The "recent crisis had led to experimentation with alternative methods of evaluating claims and adjudicating facts" that makes it difficult to generalize the bewildering array of legislative responses to the perceived need.⁹ The majority of schemes, however, have focused on the areas of compulsory claim arbitration,¹⁰ limitation of attorney's contingency fees,¹¹ limitation on health care provider liability,¹² shortening the statute of limitations,¹³ and abrogation of the collateral source rule.¹⁴

Several authors have suggested the greater equity and efficiency of a no-fault system.¹⁵ This paper addresses three areas of contention: (1) the features of a no-fault alternative to the present tort system based on workers' compensation;¹⁶ (2) provisions for the deterrence of substandard care under a no-fault alternative;¹⁷ and (3) the overall desirability of a radical change in the present system.¹⁸ After exploring the financial uncertainties of the no-fault scheme, the conclusion is that the continued modification of the present tort system is more desirable than total replacement with a no-fault scheme.

8. Withdrawal of services has to this point been individual and spasmodic. For example, in Broward County, Florida, following a dramatic increase in malpractice insurance premiums, "[t]he number of emergency rooms in the county accepting trauma patients with head and spinal cord injuries dropped to 4 from 16" *Doctors Hit Insurance Rates*, N.Y. Times, July 4, 1987, § 1, at 6, col. 5. In Brunswick, Georgia, obstetricians and gynecologists refused to care for plaintiff's attorneys and their top aides. N.Y. Times, May 14, 1987, § 1, at 1, col. 2.

Perhaps more troubling from a long-term perspective is the reported reduction in practicing obstetricians, especially in rural areas. According to the American College of Obstetricians and Gynecologists, "[m]alpractice-insurance rates and the fear of lawsuits are driving [one] of every [eight] obstetricians from the field" *OB/GYN Doctors are Fewer*, U.S.A. Today, Mar. 2, 1988, § D, at 1, col. 2.

9. Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1417, 1455 (1975).

10. *Id.* at 1456.

11. *Id.* at 1443.

12. *Id.* at 1418, 1425.

13. *Id.* at 1429.

14. *Id.* at 1447.

15. An early and influential proposal is found in Ehrenzweig, *Compulsory—"Hospital Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice"*, 31 U. CHI. L. REV. 279 (1964). There are many articles along the same lines. See, e.g., Havighurst, *"Medical Adversity Insurance"—Has Its Time Come?*, 1975 DUKE L.J. 1233 (1975).

16. See *infra* text accompanying notes 61-140.

17. See *infra* text accompanying notes 140-62.

18. See *infra* text accompanying notes 163-240.

II. SEPARATING THE COMPENSATORY AND DETERRENT FUNCTIONS OF THE TORT SYSTEM

The putative function of the tort system is to compensate the injured patient. However, the tort system is inadequate to compensate the injured patient because of its breadth of coverage, its amount of compensation, and its form of compensation. There are significant elements of chance involved when the injured patient attempts to contract with the appropriate attorney in hopes of prevailing at trial or reaching a settlement,¹⁹ a phenomenon evoking the term "tort lottery."²⁰ In approximately seventeen percent of the cases where medical patients sustain an adverse outcome while under treatment, the injury is traceable to provider negligence.²¹ Around ten percent of all injured patients filed a claim, while only about four percent actually received compensation for their economic or non-economic losses.²² Even successful plaintiffs must still pay significant transactional costs in terms of time, money, and psychological stress.²³ Less

19. An injured patient was more likely to seek legal consultation if the injuries were severe, if the injuries involved significant economic losses, if the patient had had a previous experience as a plaintiff, or if the injured patient was black. J. PETERSON, *CONSUMER'S KNOWLEDGE OF AND ATTITUDES TOWARD MEDICAL MALPRACTICE* 659, 691 (U.S. Dept. of Health, Education and Welfare No. 73-89 1973).

A random sampling of private practice attorneys showed a 50% rejection rate of malpractice cases brought to them. A second survey, involving attorneys specializing in malpractice litigation, showed a rejection rate of less than 30%. In both surveys, cases were rejected most commonly for reasons of 'no liability' under present tort rules or for 'economic reasons' (i.e., insufficient potential recovery to justify the attorney's time). *Id.* at 889-99.

20. The term "tort lottery" arose in the 1960's in connection with criticisms of tort compensation for traffic victims and was later adapted to "malpractice lottery" in order to suit the medical context. Both terms are associated with Professor O'Connell's writings. See, J. O'CONNELL, *THE LAWSUIT LOTTERY* (1979).

21. A study of patient injuries from all causes in 23 California hospitals estimated that the overall incidence of "disability caused by health care management" was 5% and this increased with patient age. CAL. MED. ASSOC. & CAL. HOSP. ASSOC., *REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY* 65 (D. Mills ed. 1977) [hereinafter D. Mills Report]. Of each 100 injured patients studied, 17 had an injury due to medical negligence (i.e., compensable under the tort system). *Id.* at 70. The report concluded that the liability system acts effectively to reduce the total payments since many more injuries occur than are ever compensated. *Id.*

22. These estimates are maximum figures, extrapolated from claims data covering the same period as the D. Mills Report, *supra*, note 21. Although compensation through the malpractice system was predominantly through settlement, the expected award amount was an important indicator in determining whether a claim was filed. P. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 23 (1985).

23. Delay is a feature of the tort system and often a defense tactic. For claims closed in the period 1975-1978, the average time from incident to disposition was 41 months for paid

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than fifty percent of the premiums paid by medical providers are returned to the injured patients as compensation, a figure which compares unfavorably to other forms of insurance.²⁴ Transactional costs may cause the amount which is eventually delivered to the plaintiff to be inadequate,²⁵ and the lump-sum form of payment creates other difficulties for the plaintiff.²⁶

The second putative function of the medical tort system is to deter substandard medical care. Despite voluminous literature,²⁷ the

claims and 32 months for unpaid claims, with an average of 36 months. NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, *MALPRACTICE CLAIMS* 2(2) (1980). The delays are skewed: 21% closed within a year of the incident, 40% within 2 years, and 15% took more than 5 years. *Id.*

The greatest expense for the plaintiff is the contingent fee which is commonly one-third of the residual award after deducting costs but may increase to 40% through trial and appeal. Some attorneys alter the contingent fee according to the amount recovered. Contingent fees are increasingly regulated as part of tort reform legislation. See generally Schwartz & Mitchell, *An Economic Analysis of the Contingent Fee in Personal Litigation*, 22 STAN. L. REV. 1125 (1970) (discussing the use of contingent fees in personal injury cases including medical malpractice suits).

The psychological stresses of litigation impose further real but intangible costs on the plaintiff: "You turn to lawyers and courts to seek a remedy, if remedy there be In the hands of the law, lawyers, legalism, of procedures, delays, and tactics, you are no longer yourself or even your own master. Abruptly, you are a part of this too But this is the way of the law and courts" W. OURSLER, *FAMILY STORY* 279-80 (1963).

24. Estimates as to the proportion of premium dollars returned to the injured parties vary from the lowest estimate of 18% to an upper limit of 25-50%. Zuckerman, Koller & Bovbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS. 2, 100 (1986) [hereinafter Zuckerman]. Based on these estimates, "malpractice insurance clearly returns less of its premium dollars in the form of benefit payments than either workers' compensation [55 - 80%] or first pay—health insurance [85-90%]. *Id.*

25. See R. KEETON & J. O'CONNELL, *BASIC PROTECTION FOR THE TRAFFIC VICTIM: A BLUEPRINT FOR REFORMING AUTOMOBILE INSURANCE* 69-70 (1965).

26. Along with the award, the successful plaintiff assumes significant financial and investment risks. "Under the present system the risk of investment of large lump-sum payments for future damages is forced on the accident victim. Many claimants lack the financial expertise to handle and invest large sums of money. Services of others can be obtained, but there is always a risk of improvident investments and usually a fee is involved." Henderson, *Periodic Payments of Bodily Injury Awards*, 66 A.B.A. J. 734 (1980) (commenting on a proposed Model Act for Periodic Payments of Judgments).

27. See generally R. POSNER, *ECONOMIC ANALYSIS OF LAW* 83-83 (1973) (outlining the role of economic deterrence in tort litigation); Diamond, *Single Activity Accidents*, 3 J. LEGAL STUD. 107, 108 n.2 (1974) (criticizing the Posner model as applied to auto (and presumably medical) accidents). Ignoring non-monetary influences arguably leads to "weakly developed and inherently implausible theories of man." B. WARD, *WHAT'S WRONG WITH ECONOMICS* 50 (1972). In addition, disciplinary and regulatory liability may be inherently more effective as a deterrent than civil (e.g., malpractice) litigation. See Epstein, *The Social Consequences of Common Law Rules*, 95 HARV. L. REV. 1717, 1743-44 (1982) (arguing that common law tort

value of the tort system, in this regard, remains undetermined.²⁸ The tort system does alter provider behavior but probably in a complex way which is poorly understood.²⁹ There remains the real issue as to whether these changes reduce the incidence of substandard care. In some cases, such as the overuse of diagnostic x-rays, the behavioral changes are positively harmful to the patients.³⁰ In other cases, competent physicians may appropriately alter behavior while careless doctors "go bare." Thus, the deterrence of particular instances of substandard practice or of individual doctor incompetence is questionable. Also, deterrence may reduce the number of competent practitioners in a field with a high incidence of litigation.³¹ Moreover, in view of the high transactional costs of the tort system, its protagonists have the burden of showing not only a theoretical possibility, but also a real and substantial deterrent effect. Otherwise, other forms of insurance having much lower transactional costs, such as first party insurance,³² are the obvious economic choice to pay the costs of medical injuries.

A. Unresolved Areas

Several areas of interest are notable for a lack of accurate information. First, the absence of empirical data noted above makes it impossible to assess the deterrence effect of malpractice litigation, or even tort litigation generally.³³ Clearly, if the primary reason for

deterrence is less likely to create incentives when compared to the direct regulation); see also Bovbjerg, *Medical Malpractice on Trial: Quality of Care is the Important Standard*, 49 LAW & CONTEMP. PROBS. 2, 321 (1986) (arguing that the principal function of tort litigation is not to compensate but to maintain quality of care through deterrence).

28. In a meticulous review of empirical data relating to the compensatory and deterrence functions of malpractice litigation, no studies relating to the efficacy of the deterrent function could be found. Zuckerman, *supra* note 24, at 99-100. Thus, the relationship between malpractice litigation and deterrence remains, at best, undefined.

29. The aggregated changes in physician behavior have been collected under the rubric of "defensive medicine," but what constitutes such practice, and how it is regarded, vary with the commentator.

30. One identifying feature of defensive medicine commonly suggested by medical providers is the use of diagnostic tests more frequently than would be indicated on a traditional medical risk-benefit or a more modern cost-risk-benefit analysis.

31. Large awards against obstetricians for babies born with brain damage have been associated with a rapid increase in malpractice premiums for this specialty group resulting in a net loss of one in eight practicing obstetricians, mainly in rural areas. See *supra* note 8 and accompanying text.

32. See *supra* note 24.

33. See *supra* notes 27-32 and accompanying text.

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retention of tort litigation is its putative deterrence effect, then a demonstration of its effectiveness becomes important. Second, the present incidence of patient injury both inside and outside hospitals, the fraction of injuries due to "substandard care", and the societal cost of those injuries have not been studied recently.³⁴ Third, financial projections of the potential cost of a no-fault patient compensation scheme are impossible at present, mainly because of the lack of basic data.³⁵ Fourth, whether the actual savings flowing from the reduction of transactional costs would be enough to pay for the expanded coverage of such a scheme remains an uncertainty that only experience will resolve.³⁶

Despite these uncertainties, there appears to be adequate reason to separate the traditional dual functions of compensation and deterrence, and achieve each through less ineffective means. This paper accepts as basic the proposition that the likelihood of achieving either is improved by separating them, and targeting each through different mechanisms. Thus, the primary purpose of the patient compensation scheme should be compensation, and the mild economic deterrence of experienced-based premiums to support the scheme must be supplemented by a separate, more effective, monitoring and disciplinary system.

There may be other reasons for emphasizing compensation over deterrence in such a scheme. A society under the growing influence of humanism is more likely to believe that the first reason for compensating individuals injured during medical treatment should not be reprisal or deterrence,³⁷ but "the civilized reasons of humanity."³⁸ Such motivation is already recognized to a degree by

34. The only definitive study to date is the Mills Report conducted in 1972. See *supra* note 21.

35. The obvious guide to the financial requirements of such a scheme may initially appear to be the New Zealand no-fault Injury Compensation Scheme. However, judicial interpretation of the scheme has imposed a fault requirement for compensation of medical injuries. G. PALMER, *COMPENSATION FOR INCAPACITY* 256 (1979). The decision "exclude[d] situations where the treatment simply does not achieve the required result, does not improve the patient's condition or worsens it, or where the change results from infection, bodily reaction, or other complication." *Id.* at 258.

36. See *infra* note 43.

37. However, juries under the present system are more likely to give large awards if motivated by anger or a desire to punish. See J. O'CONNELL, *THE LAWSUIT LOTTERY* 56 (1979).

38. G. PALMER, *supra* note 35, at 56. Palmer is an academic attorney who was instrumental in the adoption of the New Zealand Injury Compensation Scheme. He was a professor of law who later became a member of the New Zealand parliament.

workers' compensation statutes,³⁹ no-fault schemes,⁴⁰ and the New Zealand injury compensation scheme.⁴¹

In view of the strong theoretical justifications for a patient compensation scheme based on the no-fault principle, the question then becomes one of efficient implementation.

B. Elements of a Patient Compensation Scheme

Ideally, such a scheme would compensate rapidly, appropriately, and without the attribution of fault. A central feature is that most or all injured parties would be given some degree of compensation.⁴² To limit the economic burden of the scheme to medical care providers, and eventually to society as a whole, such a scheme must focus on minimizing transactional costs, as well as limit recovery to the injured patients.⁴³ In economic terms, the scheme would seek to distribute the majority of the risk over the resources of the community.⁴⁴

Limited recovery may seem a basic inequity in the scheme unless it is realized that the present system limits recovery to nothing at all for most injured patients,⁴⁵ and to less than adequate amounts for

even prevailing plaintiffs.⁴⁶ A patient compensation scheme that limits recovery would be a large step toward a recognition that the "injured [individual] has a moral claim . . ."⁴⁷ and that "compensation for injury is a community responsibility."⁴⁸ Although such a scheme would not be completely fair, it is within the context of limited societal resources fairer than the one which exists at present.⁴⁹

Other provisions may be less contentious ethically, but provoke a strong response from special interest groups.⁵⁰ Reducing the transactional costs of patient compensation would require control and reduction of attorney compensation,⁵¹ replacement of the trial process by a tribunal approach to decision-making,⁵² payment of the award in kind where appropriate,⁵³ payment made as the need occurs rather than a lump sum,⁵⁴ and compensation based on net economic loss rather than gross figures.⁵⁵ Delay and uncertainty, features of the present system, would be significantly reduced by the administrative simplicity and automatic application of the scheme.⁵⁶

Deterrence of substandard medical practice is separated from patient compensation, and provided by economic incentives built into

39. M. FRANKLIN, *INJURIES AND REMEDIES* 789 (1985).

40. See R. KEETON, *BASIC PROTECTION FOR THE TRAFFIC VICTIM* 241-72 (1965) (discussing the social rationale of the no-fault system).

41. See G. PALMER, *supra* note 35, at 55-56.

42. For a discussion of the broad issues of public policy leading to universal but limited compensation under the no-fault principle, see R. KEETON, *supra* note 40, at 243-50.

43. Compensating a much larger number of injured patients within realistic limits of societal resources implies leaving some of the risk of medical treatment allocated to the patient. In addition, limiting recovery to injured patients could serve as an economic deterrent to malingering.

The probable economic burden of such a scheme may be estimated from available data: of each 100 patients who suffer an injury during and related to medical treatment, 17 have injuries falling within the present concepts of provider negligence. Of these, only 4 receive any compensation. See Mills Report, *supra* note 21. Thus a scheme compensating all 100 injured patients could cost about 25 times as much as the present system; a scheme compensating only the 17 injuries due to provider fault would cost about 4 times as much. Assuming a dramatic increase in system efficiency, resulting in only 30% of the premium dollars being lost in transactional costs, the scheme would cost only 3 to 17 times as much as presently. Assume further that only economic losses of 1.7 to 1, costs would increase to 1.8 to 10 times present levels. See Zuckerman, *supra* note 24, at 100. Thus the economic realities require patients to carry some of the risk of injury.

44. Payment for the costs of medical injuries differs from that associated with traffic accidents in that the complex cost-shifting arrangements between government, industry and medical providers makes segregation and allocation of the costs of medical injury difficult or impossible. In contrast, conscious allocation of the costs of traffic accidents is possible through statute. R. KEETON, *supra* note 40, at 266.

45. See *supra* notes 21-22 and accompanying text.

46. See *supra* note 25 and accompanying text.

47. COMPENSATION FOR PERSONAL INJURY IN NEW ZEALAND, REPORT OF THE ROYAL COMMISSION ON INJURY (WOODHOUSE REPORT) 20 (Dec. 1967) quoted in C. CHAPMAN, *PHYSICIANS, LAW AND ETHICS* 130 (1984). See generally Sugarman, *Doing Away with Tort Law*, 73 CAL. L. REV. 555 (1985) (discussing whether incomplete and incremental reforms can realistically ever be expected to achieve a more rational and fair system).

48. *Id.* These views of the presiding judge (J. Woodhouse) are more widely shared in the tiny welfare state of New Zealand than in the United States.

49. The question once again arises, are such partial solutions morally satisfactory? It seems that the substantial risk of financial failure of a full compensation, no-fault system justified proposals for the "partial justice" of a limited no-fault redress for medical injuries. See Sugarman, *supra* note 47, at 662.

50. It is often difficult to separate legitimate professional concerns of the doctors, attorneys, and insurance companies from their more narrow self interest, since many of their objections, are framed in terms of public policy but lack a broad societal perspective.

51. See *infra* notes 91-98 and accompanying text.

52. See *infra* note 99 and accompanying text.

53. See *infra* notes 102-103 and accompanying text.

54. See *infra* notes 110-18 and accompanying text.

55. See *infra* note 121 and accompanying text.

56. See Reisenfeld, *Basic Problems in the Administration of Workmen's Compensation*, 36 MINN. L. REV. 119, 133 (1952) (discussing the inefficiency of then existing compensation schemes).

The "automatic" application of the scheme would of course depend upon the entry criteria. Perhaps the present transactional costs associated with access to the tort system would be reduced because providers would perceive the scheme as non-adversarial, and facilitate the entry of injured patients.

the insurance rates,⁵⁷ by giving public notice of high claim providers and areas of practice,⁵⁸ and by liaison between compensation administrators and licensing authorities.⁵⁹ These provisions would effectively maintain accountability of the medical providers without distorting the compensation process.⁶⁰

III. DESCRIPTION OF THE ELEMENTS

A. Limitation of Injuries Covered

Workers' compensation statutes generally apply to injuries "arising out of" and in "the course of employment."⁶¹ An analogous patient compensation scheme would cover only injuries "arising out of and in the course of medical treatment."⁶² The well developed case law interpreting the worker's compensation requirement could well be applied to a patient compensation scheme, providing a ready common law framework upon which the scheme could rest.⁶³

Problems of interpretation would arise mainly where no clear parallel existed in workers' compensation law, such as the distinction

57. See *infra* note 141 and accompanying text.

58. See *infra* note 150 and accompanying text.

59. See *infra* notes 154-58 and accompanying text.

60. See J. O'CONNELL, *THE LAWSUIT LOTTERY* 49 (1979) (providing a graphic description of the distortions of the compensation process and the role of lawyers in the distortion).

61. M. FRANKLIN & R. RABIN, *TORT LAW AND ALTERNATIVES* 692 (1983). The use of the workers' compensation scheme is limited by the problems experienced by many states. A 1972 National Commission noted serious deficiencies and laws that were neither "adequate nor equitable". *THE REPORT OF THE NATIONAL COMMISSION ON STATE WORKMEN'S COMPENSATION LAWS* 24-25 (1972) [hereinafter *WORKERS' COMPENSATION REPORT*]. The fear of federal intervention following this report stimulated significant reforms in many states. See G. PALMER, *supra* note 35, at 39.

62. Suggested entry criteria for patient compensation schemes vary widely. The simplest form paraphrases the workers' compensation definition: "injuries arising out of and in the course of medical treatment." HEW REPORT, *supra* note 19, App at 460.

A more elaborate attempt defines a compensable injury as any physical harm, bodily impairment, disfigurement or delay in recovery which (i) is more probably associated in whole or in part with medical intervention rather than the condition for which the intervention occurred and (ii) is not consistent with or reasonably to be expected as a consequence of such intervention or (iii) is a result of medical intervention to which the patient has not given his informed consent.

Id.

63. Although an impressive body of law has been developed in the area of workers' compensation litigation, the complexities of applying that law can frustrate the search for administrative simplicity. See Riesenfeld, *Basic Problems in the Administration of Workmen's Compensation*, 36 MINN. L. REV. 119, 133 (1952).

between complications resulting from the treated condition, and an injury caused by the medical treatment.⁶⁴ In many cases, the injury could result from either, thus presenting an issue of causation similar in difficulty to the familiar problems of causation in the present tort system.⁶⁵ However, there already exists a substantial body of authoritative medical literature on the natural history of disease processes and on complications of treatment which would guide the tribunal in its determinations.⁶⁶ In the last resort, causation could be apportioned between compensable and non-compensable injuries.⁶⁷

B. Limited Recovery

In accord with its basic purpose, a patient compensation scheme would, above all else, seek to prevent economic hardship.⁶⁸ Thus, recovery for non-economic losses and punitive damages become secondary considerations, to be awarded from resources left over after all economic losses have been satisfied.⁶⁹ In practice, this may mean that non-economic losses receive little or no compensation.⁷⁰

As regards economic losses, the experience with worker's compensation schemes is a useful model.⁷¹ Payments are based on the

64. This difficulty led Professor Keeton to compare automobile accidents with malpractice injuries and conclude that the efficiency achieved by no-fault auto plans could not be expected in the malpractice area. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 591-600 (1973).

65. *Id.* at 594. The problems of determining causation of the medical injury and damages are discussed at some length. *Id.* Another concern is that the no-fault system might induce doctors to reject difficult cases, and refrain from necessary but high risk procedures. *Id.* at 599.

66. In many medical situations, the various complications of interventions and their rate of occurrence is well documented. One suggestion is to use this information to determine objectively when a medical injury should be compensated using statistical techniques. J. O'CONNELL, *ENDING INSULT TO INJURY* 191 (1975).

67. An analysis similar to the comparative negligence analysis used in present tort law could be employed to estimate the contribution of the disease process itself compared to injury produced by medical intervention. Unfortunately, such determinations would result in retaining the present inefficiencies and failures of the fact-finding process. See *supra* note 66.

68. Although seldom specifically stated, this premise underlies most of the suggested schemes for medical malpractice reform. See *supra* note 15.

69. A strict ordering of priorities requires that the more important are fully satisfied before the lesser are addressed.

70. Financial projections on available data suggest that a patient compensation scheme would cost 2 to 10 times as much as the present scheme, thus using all presently available funds to compensate economic losses alone. See *supra* note 43.

71. Professor O'Connell argues that the experience with worker's compensation encourages one to avoid a similar scheme for injured patients. J. O'CONNELL, *ENDING INSULT TO INJURY* 95 (1975).

severity of the disability, the duration of the disability, and the previous earnings of the injured worker.⁷² The severity of disability is classified as one of 1) temporary partial disability, 2) temporary total disability, 3) permanent partial disability, 4) permanent total disability, and 5) death.⁷³

Workers with temporary partial disability may recover all medical expenses, but are often excluded from recovery of lost wages because of a statutory waiting period, usually one week.⁷⁴ Patients with injuries in this group could expect similar treatment, with full payment for medical expenses associated with the injury, but more restricted recovery for wages.⁷⁵

Most workers' compensation cases are in the second group, workers with temporary total disability.⁷⁶ The experience with patients should be similar, since the usual result of an adverse outcome is to extend the time required for the patients to recover and return to work.⁷⁷

The third group, permanent partial disability, is usually divided into two categories: "scheduled" and "non-scheduled" injuries.⁷⁸ The former involve the loss, or loss of function of, an anatomically discrete part of the body, such as an arm, and usually award is made from a statutory schedule.⁷⁹ The latter is related to less definite injury.⁸⁰ Compensation for the two categories is interdependent, and a complex system of calculating awards has been developed.⁸¹ Patient compensation could be defined in similar terms, using the broad parameters of the workers' compensation system, but with appropriate modifications.⁸² The concept of "designated compensable

72. M. FRANKLIN, *INJURIES AND REMEDIES* 776 (1979).

73. *Id.*

74. *Id.*

75. The rationale for partial recovery in workers' compensation schemes is to allocate some of the risk of injury to the worker in order to reduce compensation costs, minimize malingering and deter unsafe work practices. Only the first two reasons would appear to apply to the medical injury situation. *Id.* at 781.

76. *Id.* at 777.

77. *Id.* at 853.

78. *Id.* at 777.

79. *Id.* at 778.

80. *Id.*

81. *Id.* at 781.

82. Defining and classifying the injuries as a guide to compensation has been criticized as arbitrary and inappropriate, and may generate administrative haggling: "[the use of]

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events" for patient injuries would then correspond with the system of "scheduled" injuries.⁸³

The group with permanent total disability are generally compensated under the same guidelines as the third group, but with extended benefits.⁸⁴ Many workers' compensation schemes allow recovery only for a limited number of weeks, and rely on federal disability schemes to continue the support after that period.⁸⁵ Similarly, a patient compensation scheme could discontinue benefits after disability benefits become available.⁸⁶

Workers' compensation schemes provide death benefits for the families of employees.⁸⁷ Since most employees have dependents, this provision satisfied important public policy in providing for the families of wage earners who die from work-related injuries.⁸⁸ Patient injury may take place in very different circumstances, and there may be no dependents for the scheme to protect.⁸⁹ Accordingly, the claim would only survive the patient where there are such dependents. This

[s]cheduled benefits under workers' compensation [is inequitable and has caused] prodigious infighting [over classification]." J. O'CONNELL, *ENDING INSULT TO INJURY* 190 (1975). Applying this system to medical injuries would have its own difficulties: "Trying thus by bureaucratic command . . . to formulate an appropriate amount of compensation for every medical treatment—or even for major injuries from major forms of treatments—would indeed be an incredibly difficult task." *Id.* at 189.

83. A proposed "designated compensable events" system would effectively remove cases involving major injury from the present fault system. In order to recover under this scheme, the patient would have to show that he had suffered a listed, compensable event. Havighurst, "Medical Adversity Insurance"—*Has its Time Come?*, 1975 *DUKE L.J.* 1233. The principle has been included in recent tort reform legislation in Virginia and Florida, for compensating brain-damaged babies.

84. M. FRANKLIN, *INJURIES AND REMEDIES* 780 (1979).

85. The lowest maximum in 1979 was \$36,500 and the briefest time span was 300 weeks. *Id.*

86. Disability benefits are normally available through the Social Security scheme if the disability is expected to last more than one year.

87. Death benefits are available in all jurisdictions. The amount of the award varies with the earnings and number of dependents, and varies widely from state to state. M. FRANKLIN, *INJURIES AND REMEDIES* 781 (1979).

88. *Id.* The cessation of benefits upon remarriage in many states is consistent with this rationale. *Id.*

89. Some of the largest jury awards predictably involve individuals with no dependents, such as babies. A recent case illustrates how a patient injury can provide a windfall to the nondependent family. Six weeks after the award of \$8.3 million for a birth defect, the baby died, leaving the award amount to the baby's family as the heirs. 7 *Q.A./R.M. BULLETIN* 1, 2 (1987).

policy avoids creating hardship for the patient's family, while avoiding a windfall to non-dependent heirs.⁹⁰

C. Reducing Transactional Costs: Attorney Compensation

The contingency fee system is unique to the United States and has become a symbol of its legal system.⁹¹ Proponents of the contingency fee argue that it provides competent counsel for those with meritorious claims but no financial resources.⁹² Opponents claim it encourages litigation of "frivolous" claims and deprives the successful plaintiff of a large portion of his award.⁹³ The contingency fee indisputably represents a substantial transactional cost in malpractice cases, roughly equal in amount to defense costs.⁹⁴ A tribunal system would reduce litigation costs on both sides, but specific statutory limits to contingency fees should be indicated to limit the reduction of patient awards.⁹⁵ Since the administrative system would require less in the way of proof, attorney skill, and preparation, the reduction in attorneys' fees would be accomplished by a reduction in the work needed to pursue the claim.⁹⁶

Workers' compensation statutes allow for attorneys' fees, which range from thirteen to thirty percent of the award amount.⁹⁷ Experience has shown this range is adequate, allowing client representation without inordinate reduction of the award.⁹⁸

90. This would be a radical alteration of the present tort law principle, where a claim for wrongful death, and usually the tort claim itself, survives the individual. Workers' compensation schemes, because of the age of the individuals covered, generally do not have this problem.

91. F. MACKINNON, *CONTINGENCY FEES FOR LEGAL SERVICES* 39-41 (1964).

92. See, e.g., Note, *In re Swartz: Judicial Regulation of Excessive Contingent Fees in Arizona*, 27 ARIZ. L. REV. 539, 542 (1985).

93. F. MACKINNON, *supra* note 91, at 325-28.

94. Defense fees approximate plaintiff's costs, although the mode of payment is different: "the average hourly fee [in 1970] for plaintiff's lawyers came to \$63, compared to an average of \$50 for defense lawyers." HEW REPORT, *supra* note 19, at 33.

95. Such statutory limitations on contingency fees are already a feature of tort reform legislation in several states. See *supra* note 2.

96. The same rationale is used to justify controls on lawyers' fees in workers' compensation cases. However, the recovery allowed is rather generous, varying from 10 to 30%. See *infra* note 97.

97. Virtually all workers' compensation statutes place restrictions of some sort upon the amount an attorney may charge a claimant. In some states, the amount is awarded on a case by case basis by the agency or the court. 4 A. LARSON, *THE LAW OF WORKER'S COMPENSATION* App 8-188-5 (1987).

98. In many cases, attorneys' fees are also awarded. *Id.* The fee is usually subject to review as to reasonableness. *Id.*

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D. Reducing Transactional Costs: Administrative Awards

The replacement of the traditional trial by jury with an administrative system is typical of the workers' compensation schemes and represents an important reduction in transactional costs.⁹⁹ The use of administrative agencies is made possible by the imposition of strict liability on the employer.¹⁰⁰ Similarly, a patient compensation scheme would be effective only if the vagaries of the jury were avoided, allowing consistent awards on the basis of strict liability.¹⁰¹

E. Reducing Transactional Costs: Payment in Kind

One of the main transactional costs in the existing tort process is the requirement to change medical services into cash, which is then paid to insurance companies in the form of premiums, invested more or less wisely, and then changed back into cash as needed to satisfy an award.¹⁰² A significant saving could be achieved in a patient compensation scheme by allowing the medical provider to supply the medical services directly to the injured patient as needed.¹⁰³

This proposed provision corresponds to the states whose workers' compensation statutes allow the employer to designate the medical provider used, or even provide medical care directly.¹⁰⁴ The advantage of this arrangement is that the employer's self-interest is in the

99. A few states have retained the court system rather than allowing a specialized agency to handle claims. In contested cases, the states which use administrative agencies attempt a simple, informal fact-finding procedure with the result subject to judicial review. *Id.* at 405-12. "It would be impossible to overemphasize the importance of effective administration to the success of any worker's compensation law." *Id.* at 399. "For forms of government let fools contest; Whate'er is best administered is best." III A. POPE, *AN ESSAY ON MAN* 303-04 (1733).

100. Compensation . . . represents a compromise in which each party surrenders certain advantages in order to gain others which are more important to him and to society. The employer gives up [the fault principle of tort] and the employee surrenders his former right to full damages and accepts a more modest claim for the essentials, represented by compensation The statutes vary a great deal; with reference to the point of balance.

4 A. LARSON, *THE LAW OF WORKER'S COMPENSATION* App 8-188-5 (1987).

101. See J. O'CONNELL, *THE LAWSUIT LOTTERY* 84-106 (1979).

102. These transactional inefficiencies cost more than 50 cents of each premium dollar. See *supra* note 24.

103. Savings would result both from reduction of the transactional costs and the cost reduction to the medical provider resulting from dilution of fixed expenses and being able to supply services at cost. See *supra* note 101.

104. M. FRANKLIN, *INJURIES AND REMEDIES* 782 (1979).

effective treatment and early rehabilitation of the injured employee, especially in the case of serious injuries.¹⁰⁵

Several problems stand in the way of this proposal when applied to a patient compensation scheme.¹⁰⁶ The patient, having suffered one adverse outcome at the hands of the medical provider, may be reluctant to undergo further treatment by the same party.¹⁰⁷ Second, the reports to the patient compensation tribunal may be colored by the provider's self-interest in minimizing the injury.¹⁰⁸ Third, the provider in this situation may retain some hostility toward the patient, especially if the patient is thought to be malingering, and this hostility may interfere with effective treatment.¹⁰⁹

F. Reducing Transactional Costs: Payment As Needed

At present, awards are paid in a lump sum, a practice which leads to several problems.¹¹⁰ First, there is the difficulty of the insurance company estimating and setting aside an appropriate "loss reserve" to be available in cash if the plaintiff prevails.¹¹¹ Second, the high liquidity of insurance company investments made necessary by this practice is one reason for the generally poor investment results achieved by insurance companies.¹¹² Third, the award of a single lump sum presents the payee with the problem of preservation and

105. *Id.*

106. This paragraph assumes a patient compensation scheme incorporates the essential features of a worker's compensation scheme.

107. This speculation finds some support in the patient frustration and anger that motivates many malpractice suits. HEW REPORT, *supra* note 19, at 769, 813. In a study of 414 medical "consumers," 83% stated they went to a different provider after a negative medical experience. *Id.* at 674.

108. This is one of a variety of barriers to rehabilitation discussed in J. TURNBULL, C. WILLIAMS & E. CHEIT, *ECONOMIC AND SOCIAL SECURITY* 339-41 (1968).

109. *Id.*

110. See *supra* note 26 (discussing a recipient's problems); Halpen, *Structured Settlements in Policy Limit Cases*, TRIAL, July 1986, at 80 (discussing a plaintiff's perspective).

111. The technical task of estimating future claims is increasingly difficult due to the atmosphere of uncertainty. Nash, *Calculating Risk is a Riskier Business Now*, N.Y. Times, May 25, 1986, § 4, at 18, col. 4.

112. Investment performance of insurance company is partly related to the interest rate cycle, which therefore partly determines the premium levels. However, internal operating expenses are a major factor in the low investment performance of insurance companies and need closer examination. To some extent, accounting rules are used to produce losses which do not reflect reality and are also used to conceal poor investment returns. Hunter & Borzilleri, *The Liability Insurance Crisis*, TRIAL, April 1986, at 42.

investment of the amount, a problem with considerable transactional costs of its own.¹¹³ Last, it seems more reasonable to compensate ongoing medical expenses and economic losses by ongoing payments rather than a single speculative amount.¹¹⁴ This allows adjustment of the award as the economic consequences of the injury become apparent, a principle used in most worker's compensation schemes.¹¹⁵

Thus, a savings in transactional costs would result if compensation for losses were made as they accrued.¹¹⁶ This is merely a logical extension of the principle of "periodic payments," where large awards are paid over a scheduled period rather than as a lump sum.¹¹⁷ However, it seems more logical to make payments as the need arises, rather than to an arbitrary schedule.¹¹⁸

This proposal raises the question of award review.¹¹⁹ As in most workers' compensation schemes, a system designed to minimize the economic impact of patient injury would allow review and update of both the severity of the disability and the amount of the award.¹²⁰

G. Reducing Transactional Costs: Basing Compensation on Net Economic Loss

The traditional tort system disregards other sources of economic protection in calculating award amounts, a practice known as the "collateral source" rule.¹²¹ Tort reform has modified this rule in

113. "[I]t is an open secret among plaintiffs' lawyers that the awards they recover for their clients are rarely invested and used so as to provide for the injured person's long-term needs." R. KEETON, *supra* note 25, at 354. See generally Elligett, *The Periodic Payment of Judgments*, 46 INS. CONS. J. 130, 131-32 (1979) (discussing the pitfalls of lump sum judgments).

114. M. FRANKLIN, *INJURIES AND REMEDIES* 781 (1979).

115. *Id.*

116. *Id.* at 782.

117. See *supra* note 26.

118. Periodic payments are usually paid by means of an annuity purchased by the defendant or the insurance company. The annuity consists of uniform yearly payments. See *id.*

119. Award review would be applicable to the case of increasing disability, or unexpected recovery, following a medical injury. Award review is consistent with the principle of avoiding economic hardship and limited recovery of losses: the greater the losses, the greater the recovery should be, within the limits of avoiding economic hardship. M. FRANKLIN, *INJURIES AND REMEDIES* 781-82 (1979).

120. In some workers' compensation schemes, once a lump sum payment has been made, the board may not reconsider it. Most states, however, provide for review of benefits. *Id.* Benefit review would seem most appropriate to a patient compensation scheme.

121. The collateral source rule is a common law rule under which "compensation . . . from a source wholly independent of the tort-feasor . . . should not be deducted from the

many states.¹²² If the basic purpose of the patient compensation scheme is to prevent economic hardship, then awards for patient injuries must be integrated with other community resources so that the total recompense from the community is appropriate and consistent from patient to patient.¹²³ Thus, unemployment, federal disability payments, health insurance, and workers' compensation payments should be considered in calculating the award amount.¹²⁴ To do otherwise would increase the waste and inequities resulting from the overlap of supportive schemes.¹²⁵

H. Reducing Delay: Administrative Simplicity

A major challenge to a patient compensation scheme would be to reduce the delays associated with the tort system.¹²⁶ The experience with state workers' compensation schemes suggests that some improvement in claim processing time is possible, but that over the years, bureaucratic complexity tends to expand and frustrate these initial gains.¹²⁷ On the other hand, the present lag times associated with worker's compensation are substantially shorter than those in the tort system.¹²⁸

damages" BLACK'S LAW DICTIONARY 238 (5th ed. 1979). The rationale is that the defendant tortfeasor should not benefit from the plaintiff's recovery from other sources. *Id.* Common collateral sources are health, life or disability insurance, and employers' sick-pay plans.

122. Six states provide for reduction of the damages award if collateral source payments have been made to the defendant, although the amount of the reduction varies. Five states allow the jury to consider benefits already paid.

123. "[O]ne of [society's] evils . . . is waste, and one of the areas of waste is overlapping reparation." R. KEETON, *supra* note 40, at 68. There is a growing amount of compensation for injuries from other than tort sources. The integration of these payments through tort modification is explored in Conard, *The Economic Treatment of Automobile Injuries*, 63 MICH. L. REV. 279 (1964).

124. The only reason for their present exclusion in calculating the award for damages appears to be historical. Tort law was developed before other significant loss-shifting programs existed. Conard, *supra* note 123, at 306-08.

125. Modification of the collateral source rule has had a statistically significant impact on award amounts. States mandating the offset of compensation from collateral sources had 50% lower awards within two years, while states allowing evidence of collateral compensation without mandating offset had no discernible effect. P. DANZON, *supra* note 22, at 78.

126. See *supra* note 23.

127. For a discussion of the successive problems encountered by workers' compensation schemes over the years, and attempted solutions, see Riesenfeld, *Basic Problems in the Administration of Workmen's Compensation*, 36 MINN. L. REV. 119 (1952).

128. There is an average delay of 30 days between approval and payment in the state

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I. Reducing Uncertainty: Strict Liability

Workers' compensation schemes impose strict liability on the employer in return for limiting employee recovery.¹²⁹ Similarly, a patient compensation scheme should elevate the community interest in preventing economic hardship over the attribution of fault by imposing strict liability on the medical provider in return for limited patient recovery.¹³⁰ Avoiding the fault-finding process would allow faster claim administration.¹³¹ The relative certainty of compensation also reduces the human and psychological costs associated with the uncertainties of the tort system.¹³²

Strict liability implies that once the patient falls within a certain well-defined group, recovery is ensured.¹³³ In order to reduce uncertainty and its associated costs, the entry criteria should be clear and specific enough for the lay person to be able to predict eligibility.¹³⁴ This has proven a major source of difficulty with the workers' compensation scheme, and thus is a source of concern in the design of a patient compensation scheme.¹³⁵ In the current judicial climate,

worker's compensation systems. NATIONAL COMMISSION ON STATE WORKMEN'S COMPENSATION LAWS, COMPENDIUM ON WORKMEN'S COMPENSATION 35 (1973). The delay between the injury and subsequent payment, however, was not known. *Id.*

129. M. FRANKLIN, *INJURIES AND REMEDIES* 764 (1979).

130. See Vandall, *Applying Strict Liability to Professionals: Economic and Legal Analysis*, 59 IND. L. J. 25, 38-39 (1983) (arguing in favor of imposition of strict liability in medical malpractice cases). Only a few courts have overtly imposed strict liability in malpractice cases. See, e.g., *Helling v. Carey*, 883 Wash. 2d 514, 519 P.2d 981 (1974); *Clark v. Gibbons*, 426 P.2d 525, 58 Cal. Rptr. 125 (1967), *opinion vacated*, 66 Cal.2d 399, 58 Cal. Rptr. 125, 426 P.2d 525 (1967).

Posner criticized courts which are led to "disregard the customary standard of care and to substitute their own conception of due care." Landes & Posner, *The Positive Economic Theory of Tort Law*, 15 GA. L. REV. 851, 919 n.150 (1981).

131. Other arguments in favor of strict liability are the putative stronger deterrent effect, the greater reflection of the cost of patient injuries in the cost of medical services and more adequate compensation for injuries. M. FRANKLIN, *INJURIES AND REMEDIES* 62-63 (1979).

In addition, increased efficiency would result from avoiding "the almost Byzantine nature of trying to [establish] fault in malpractice litigation [because of esoteric and involved factual issues]." J. O'CONNELL, *THE LAWSUIT LOTTERY* 179 (1979).

132. The psychological traumas associated with litigation have been relatively neglected in the academic literature. See *supra* note 23.

133. Essentially, strict liability imposes liability without any finding of negligence.

134. It would be unjustifiable to replace the fault-finding process with no-fault eligibility requirements which were in effect even more complicated.

135. The entry criteria for worker's compensation have proved a fertile source of litigation. See W. MALONE, *CASES & MATERIALS ON WORKER'S COMPENSATION AND EMPLOYMENT RIGHTS* 55-56 (2d ed. 1980).

the patient compensation statutes probably would be "construed liberally to accomplish [their] economic and humanitarian objects" ¹³⁶ The statute, then, should be defined narrowly, to compensate and allow for broad judicial interpretation. ¹³⁷ A suitable balance might be struck by requiring a medically recognized compilation of treatments, which would allow the tribunal and its officers to use standard texts for the assessment of claims. ¹³⁸ Alternatively, the regulations could designate adverse outcomes from standard treatments and use these as a basis for claim evaluation. ¹³⁹

The legislative process of each state must find an appropriate balance in the entry criteria in order to properly define the breadth of the compensation scheme. ¹⁴⁰

J. Maintaining Deterrence: Economic Incentives

It seems intuitively fair that providers should be required to contribute to the compensation fund in relation to their loss experience. ¹⁴¹ Such an arrangement also creates a classic economic deterrent by increasing the cost of injury-causing behavior to the party who has the most control over that behavior. ¹⁴² Thus, a deterrent effect is created without the stigma of assigning fault. ¹⁴³ As with workers'

136. *Hudstead v. Seneca Steel Serv. Inc.*, 41 N.Y.2d 140, 145, 359 N.E.2d 673, 391 N.Y.S.2d 78 (1976).

137. A contrary position is taken by Palmer, originator of the New Zealand scheme. The experience in that country has been that the administrators of the scheme held to a narrow interpretation, despite the generous drafting of the Act, because of concern with financial viability. See G. PALMER, *supra* note 35, at 226.

138. This would introduce the vexed question of "authoritative texts" into the administrative process. A determination of what is to be considered a result of medical treatment, and what an inherent part of the original disease process, remains a weakness of the scheme.

139. Similarly, the task of designating a comprehensive schedule of compensable injuries could prove impracticable. But see *supra* note 87.

140. Each state must find its own point of balance between the imposition of liability upon the medical provider and the adequate compensation of the injured individual. The same principle is broadly acknowledged to account for interstate differences in workers' compensation statutes. See *supra* note 136.

141. Current insurance company policy does not use loss experience to determine premium levels for malpractice insurance. This practice may act to insulate providers of substandard care from the deterrent effects of tort suits. Apart from utilitarian considerations of effective economic deterrence, basing premiums on loss experience is inherently more fair than the present system of loss distribution.

142. See *supra* note 27.

143. The strong negative feelings evoked in doctors by malpractice litigation are related as much to the personal stigmatization of the doctor defendant as an incompetent, "bad doctor", as to other factors, e.g., financial burden, loss of time.

compensation, the contribution could be based initially on the class norms, but then as experience accumulates, the premium is altered accordingly. ¹⁴⁴ In effect, this would penalize high-risk providers and allow low-risk providers to benefit from policies that avoid patient injury. ¹⁴⁵

Since economic deterrence acts to inhibit all behavior perceived by the actor to cause the economic penalty, ¹⁴⁶ a scheme linking economic penalties to medical injuries by adjusting premiums on loss experience could have dramatic effects on the way medicine employs high technology. This follows from a growing perception among doctors that patient injuries are not so much the result of substandard care but are the inevitable result of the dangerous nature of high-tech medicine. ¹⁴⁷

If injuries are perceived as inherent in the use of interventional technology, then a general deterrent effect would act to inhibit such use. Presumably, there would be less inclination on the part of doctors to utilize new technology which has significant risks, despite a corresponding potential for dramatic beneficial results.

The overall effect would be a decline in the use, introduction, and development of new interventional medical technology, resulting in a slower growth of medical costs. ¹⁴⁸ This would be a dramatic

144. Premiums for workers' compensation insurance are related to employer loss experience in all 50 states, and with both private and government insurers.

Collation of loss experience can be used to deter substandard care in two ways. First, economic deterrence would be produced by relating premium levels to prior loss experience. See *supra* note 27. Second, that same loss experience could be used by the disciplinary system as a screening tool to detect possible instances of repeated substandard care. See *infra* text accompanying notes 154-58.

145. The workers' compensation experience suggests that the premiums would not be strictly related to loss experience, but that low-risk activities would pay more than their proportionate share. Despite this spreading of losses from low-risk to high-risk activities, there is a possibility that loss-related premiums would unduly inhibit socially useful but high-risk specialties (such as obstetrics, emergency neurosurgery, and orthopedics).

The question then becomes how this extra risk should be allocated between the doctor, the patient, and the state. Possibly some portion of the premium in certain specific situations should be paid by the state, rather than absorbed by the doctor or patient. An alternative approach would be to set the legislation so that incremental risk would be spread among the other providers.

146. See *supra* note 27.

147. Although seldom overtly stated, this concept is inherent in the statistical discussions of treatment failures and complication rates.

148. Cost increases are related principally to the use of new medical technology. Schwartz & Aaron, *A Tough Choice on Health Care Costs*, N.Y. Times, Apr. 6, 1988, at A 23, col. 2.

reversal of the current preference for such interventional technology. High utilization rates have been attributed to doctors' financial motives, misplaced scientific enthusiasm, and attempts to avoid malpractice liability ("defensive medicine").¹⁴⁹ Lower utilization of expensive and advanced technology may well be an unexpected side-effect of economic deterrence through a patient compensation scheme.

K. Maintaining Deterrence: Public Notice

Using standard insurance techniques, the accumulated information from the scheme could be presented to show the "risk experience" of each area of medical practice, or possibly of each provider.¹⁵⁰ Making the information public would result in an optimal deterrent to "high-risk" behaviour if the information could be presented without prejudicial effect and misinterpretation.¹⁵¹ The danger in this suggestion lies in the possibility of inappropriate attribution of fault and the deterrence of high risk but socially desirable behavior.¹⁵² Nevertheless, the public release of risk experience, however presented,

149. See, e.g., Sislowitz, *Doctors' Faustian Deal*, N.Y. Times, Jan. 7, 1988, at A 27, col. 1 (noting that doctors' overcharging causes health care cost increases); Califano, *The Health-Care Chaos*, N.Y. Times March 20, 1988, § 6 (Magazine), at 44, col. 1 (outlining the variety of political and waste factors that increase health care costs).

150. Injury experience could be presented to show the risk of a single procedure, of a group of procedures, the risk of a given diagnosis, or of an individual provider for each procedure.

Although risk experience for each occupational group is available for worker's compensation schemes, and is used to partly determine premium levels, such data is not available for medical malpractice claims. Statistics relating to claim frequency and severity for medical malpractice cases has only been available since 1975. P. DANZON, *supra* note 22, at 61.

151. Doctors are sensitive to their community image as providers of "quality medical care." However, there is at present little information in the public sector as to individual malpractice loss experience or other indices of provider competence. Many patients judge their medical providers on their association with prestigious institutions or anecdotal information from other patients.

On the other hand, release of raw data without statistical correction for non-relevant variables such as patient mix can result in misleading and prejudicial conclusions being formed by the press and public. The 1986 release of mortality statistics for HEW's Medicare patients undergoing coronary artery bypass, without controlling for operative risk, created considerable protest among providers. See, e.g., *Report of the Ad Hoc Committee on Risk Factors for Coronary Bypass Surgery*, 45 ANNALS THORACIC SURG. 348 (1988).

152. Common areas of such risk arise as a result of "high risk" obstetrics and injuries incurred in traffic accidents and the ensuing neurologic and orthopedic treatment of such injuries. All three areas carry a statistically high risk of claims. This has been attributed to the poor results in these areas of practice.

is a useful way of providing notice to patients as to the relative injury potential for a given procedure or provider.¹⁵³

L. Maintaining Deterrence: Liaison With Licensing Authorities

One of the principal defects of the current licensing procedure is the lack of information available to the licensing authority regarding the competence of the provider.¹⁵⁴ The risk experience could readily be used by the licensing authority to assess not who to discipline but who to investigate, if only to the extent of requesting an explanation of a persistently high rate of claims.¹⁵⁵ Such provisions relating to malpractice claims have recently been introduced in some states but the allegations of incompetence that commonly accompany malpractice actions lends a punitive aspect to this reporting requirement.¹⁵⁶ In this sense, these regulatory provisions are viewed as prejudicial by many doctors.¹⁵⁷ Information relating to the loss experience of all providers, with the underlying assumption of no attribution of fault, lacks this prejudicial aspect, therefore encouraging provider cooperation.¹⁵⁸

153. A possible compromise between the advantages of public disclosure and the negative effects noted above is the release of individual claims to the licensing boards but release only of aggregated information grouped by specialty to the public. At the same time, the individual patient could be protected by a provision that allowed inspection of the provider's risk experience on request.

154. Until recently, licensing boards have not collected any ongoing information on the quality of practice of medical providers. Recent legislation in many states provides for notification of the licensing board on the filing of a malpractice claim against the medical provider.

Most states have continuing education requirements as a condition of yearly relicensure.

155. Worker's compensation schemes allow for annual review of loss experience and adjust premiums in relation to that experience. In addition, unusually high accident rates trigger notification of the occupational safety authorities and an investigation or request for an explanation.

156. These statutory provisions usually mandate notification of the licensing board on the filing of a medical malpractice claim. The problem here is that because only a minority of injured patients file claims, and the factors that lead to filing or failure to file are not related to medical competence, such a scheme selectively underreports the provider experience with patient injury.

157. In reality, however, there is no lesser state interest in notification of malpractice claims against medical providers than the "point" system of license revocation for multiple driving offenses.

158. Under the patient compensation scheme, the risk experience of all providers, not just a selected few, would be forwarded to the board for review. This provision should combine with the general no-fault aura of the scheme to reduce the stigma and suspicion of such a notification procedure.

M. Deterrence and the Present System

Even without implementation of a comprehensive patient compensation scheme, it may initially seem fairer and more efficient to implement deterrence of substandard care through the licensing and regulatory agencies, rather than relying on the questionable deterrence of the tort system. A system relying primarily on disciplinary measures, however, could not function effectively without the comprehensive statistical information on patient injuries¹⁵⁹ and the economic deterrence¹⁶⁰ generated by a patient compensation scheme. Otherwise, the same factors of chance that determine deterrence under the tort system would operate with a similarly unfair result. Thus, deterrence through licensing and regulatory agencies based on the inadequate information from the tort system should be applied cautiously¹⁶¹ and with a pervasive awareness that factors of chance ultimately determine which instances of substandard care result in successful malpractice claims.¹⁶²

IV. PROBLEMS ASSOCIATED WITH PATIENT COMPENSATION SCHEMES

Despite the advantages previously mentioned, patient compensation schemes have several problems. The first is the scope of such a scheme. There is an underlying tension between the need for broad compensation and the unwelcome fact of limited societal resources.¹⁶³ The second problem, somewhat related to the first, is maintaining the economic viability of such a scheme when humanitarian impulses direct ever larger awards and broader interpretation of the regulating statutes.¹⁶⁴ Third, a patient compensation scheme may be found unconstitutional on the basis of state or federal constitutions.¹⁶⁵ Finally, the legislative passage of such schemes face severe political difficulties.¹⁶⁶

A. Who Should be Covered: The Basic Dilemma

This problem flows from the fundamental considerations of equity that provide the original justification for abrogating the tra-

159. See *supra* notes 150-53 and accompanying text.

160. See *supra* notes 141-49 and accompanying text.

161. See *supra* note 155 and accompanying text.

162. See *supra* notes 19-29 and accompanying text.

163. See *infra* notes 180-85 and accompanying text.

164. See *infra* text accompanying notes 186-200.

165. See *infra* notes 203-22 and accompanying text.

166. See *infra* notes 223-31 and accompanying text.

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ditional tort process.¹⁶⁷ If injury is a community responsibility, then logically, the compensation process should be extended not only to patients who have suffered an injury as a result of medical treatment but to all injured people, regardless of cause.¹⁶⁸ The fact that a patient compensation scheme would stop short of this ideal robs such a scheme of moral force.¹⁶⁹ On the other hand, worker's compensation was gladly embraced at the time to solve an immediate problem.¹⁷⁰ The mere fact of a scheme representing only part of a total moral solution and being only an increment in the path of a larger community concern does not vitiate this basic principle.¹⁷¹ Thus, the scheme does not purport to be totally fair, only fairer than the present arrangement.¹⁷²

Nevertheless, the immediate problem is whether a patient compensation scheme should seek to benefit all those who experience injury from an adverse event or result while under medical treatment, or only those who suffer such an injury as a consequence of, and while under medical treatment.¹⁷³ The difference would have profound ramifications in terms of eligibility since the former group would include the whole spectrum of natural bodily decay in the aging

167. See G. PALMER, *supra* note 35.

168. Sugarman criticized "tailored accident-compensation schemes" and the role of "politics and personal preference" in their implementation. See Sugarman, *supra* note 47, at 635. "One steps back and asks why [compensate] these victims and not others?" *Id.* at 626. "I see little reason to single out [one type of accident] for special treatment. I do not see why, as an initial proposition, today's law should care how a limb was broken, . . ." Franklin, *Replacing the Negligence Lottery: Compensation and Selective Reimbursement*, 53 VA. L. REV. 774, 777 (1967).

169. See Sugarman, *supra* note 47, at 633 (reviewing the theoretical and practical attempts which overcome this problem by the design of comprehensive compensation plans).

170. The problem addressed by worker's compensation statutes was that industrial development around the turn of the century was producing increasing numbers of severe and often uncompensated injuries among workers. Employers were effectively using the common law defenses of fellow servant rule, contributory negligence, and assumption of the risk to avoid liability. See generally W. MALONE, *WORKER'S COMPENSATION AND EMPLOYMENT RIGHTS* 27 (1979).

171. "Some argue that major reform will emerge only as the final product of a series of smaller steps. [Other authors] have doubts about tailored [restrictive application] plans as stepping stones to wider reform." Sugarman, *supra* note 47, at 627.

172. See *supra* note 49.

173. The stringency of the entry criteria essentially determine the breadth of the whole scheme because of the imposition of strict liability on the provider. As with worker's compensation, entry criteria can be expected to provide much of the litigation associated with the scheme. The desirability of designing simple criteria is apparent. See *supra* note 62.

process.¹⁷⁴ Thus, every injury would have redress but only for economic losses.¹⁷⁵ Whether a scheme with such broad scope to redress injury would have economic or even political viability is an unanswered question.¹⁷⁶ The only Western country with such a broad scheme differs drastically from the United States with respect to political traditions and social values. The arguments of community and social responsibility for all injuries that accompany its introduction are not widely accepted in the United States.¹⁷⁷

In summary, the acceptance of a limited scheme to compensate only those patients whose injuries arise during the course of medical treatment and are related to that treatment is more likely than compensation of all injuries and complications, whether related to medical treatment or not.¹⁷⁸ Perhaps here, in the absence of other deciding factors, considerations of political acceptability will determine the form of the scheme.¹⁷⁹

B. Maintaining Economic Viability

A problem common to many government administered benefit schemes is the preponderance of factors tending to increase expense.

174. A compensation scheme which accepted every injury or disease would be extremely broad in application. One which limited its application to injuries 'caused' by medical treatment would encounter the same difficulties in determining causation as the present system has in correctly attributing fault.

Even in the tiny welfare state of New Zealand, a "laboratory of social experiment," judicial interpretation of the comprehensive New Zealand Accident Compensation Act limited its application to "medical misadventure" to cases where fault could be shown, and thus "exclude[d] situations where the treatment simply does not achieve the desired result, does not improve the patient's condition or worsens it, or where the change results from infection, bodily reaction, or other complication." G. PALMER, *supra* note 35, at 258. Of course, the National Health Service would take care of medical expenses without further costs.

175. See *supra* notes 68-70, and accompanying text (discussing the rationale for limiting recovery to economic losses).

176. Most authors apparently doubt the political viability of a broad scheme if only by ignoring the possibility. Some specifically reject the idea. "Perhaps eventually we will move to such an ambitious, expensive, and revolutionary new scheme for medical compensation. But the sweep and scope and expense of such a proposal augurs, at the least, interminable delay in its adoption." J. O'CONNELL, *ENDING INSULT TO INJURY* 193-94 (1975).

177. See Sugarman *supra* note 47, at 633.

178. G. PALMER, *supra* note 35, at 40-54.

179. Even a limited scheme confronts significant difficulties in design and enactment. See *supra* notes 163-66 and accompanying text.

ditures.¹⁸⁰ This places a strain on limited and finite societal resources, and may threaten the economic viability of the scheme.¹⁸¹ A patient compensation scheme would be exposed to this danger.¹⁸²

To fulfill its goals, a patient compensation scheme must be broad in its application.¹⁸³ However, a broad application, when combined with generous construction of the limiting provisions, can threaten the financial solvency of a scheme,¹⁸⁴ or place an undue burden on the contributing doctors to the point of affecting the availability of medical services.¹⁸⁵ A study of the various factors influencing the fiscal balance of similar plans, such as workers' compensation schemes, is instructive.

A variety of factors tend to increase the size and availability of awards in workers' compensation.¹⁸⁶ The "remedial" nature of the scheme itself encourages a construction of eligibility requirements and awards in favor of the recipient.¹⁸⁷ There is a natural sympathy for the injured worker, and any doubts tend to be resolved in the worker's favor.¹⁸⁸ Perception of these programs has changed from that of an insurance scheme that abrogates the common law to a

180. Changes made to accommodate special interest groups, however, can negate the whole effectiveness of the proposed scheme. In the case of no-fault auto insurance, "willingness to compromise the theory behind no-fault in order to make the proposal more politically palatable" vitiated many of the advantages of the no-fault principle. Sugarman, *supra* note 47, at 617.

181. See *supra* note 43.

182. Expenditure growth in existing schemes is partly to blame for the present federal budget deficit, currently hovering around \$200 billion a year.

183. As history demonstrates, attempts to establish social equity or total justice through government schemes can create severe economic and social dislocation if the limitations of finite societal resources are disregarded.

184. The Commission governing administration of the New Zealand Accident Compensation Scheme were wary of this tendency. It feared "a progression of claims until the scheme was covering most deaths and incapacities resulting from disease." G. PALMER, *supra* note 35, at 255. See Sugarman *supra* note 47, at 633-36 (review of theoretical and practical attempts to overcome this problem by the design of comprehensive schemes).

185. An increased financial burden on providers will not necessarily result in decreased availability of medical services. See Vandall, *Applying Strict Liability to Professionals: Economic and Legal Analysis*, 59 IND. L. REV. 25, 33-4 (1983).

186. See generally, M. FRANKLIN, *INJURIES AND REMEDIES* 764 (1979). The 50 year history of workers' compensation in the United States has been notable for increasing coverage and expense. At present, approximately 90% of workers are covered, with disbursements rising from \$600 million in 1950 to \$7.5 billion in 1976.

187. "[T]he Workmen's Compensation Law, being remedial in character, is to be construed liberally to accomplish the economic and humanitarian objects of the act." *Husted v. Seneca Steel Serv., Inc.*, 41 N.Y. 2d 140, 146, 391 N.Y.S. 2d 78, 82 (1976).

188. M. FRANKLIN, *INJURIES AND REMEDIES* 766 (1976).

government benefit program supported by employer taxation.¹⁸⁹ This implies greater scope and benefits in the state schemes, following a comprehensive Commission report in 1972.¹⁹⁰

Despite these financial pressures, state workers' compensation schemes have managed to achieve a fragile fiscal security.¹⁹¹ Factors important in achieving a secure plan are the greater ability of manufacturers to pay increasing premiums;¹⁹² a gradual loss of "high risk" manufacturing and industrial jobs and their replacement with lower risk office jobs;¹⁹³ the greater concern with safety;¹⁹⁴ and an emphasis on rehabilitation by some sectors of the industry.¹⁹⁵

Applying the above to a patient compensation scheme, there appears to be no easy method of ensuring fiscal stability.¹⁹⁶ A codification of covered injuries and their corresponding benefits might be clumsy, but could reduce judicial and administrative discretion and the inevitable drift toward generosity.¹⁹⁷ However, other historical forces are reducing the ability of the medical provider to pay,¹⁹⁸ but new technology increases the risk of an adverse result.¹⁹⁹

189. P. BARTH & H. HUNT, WORKERS' COMPENSATION AND WORK-RELATED ILLNESSES AND DISEASES 280 (1980).

190. WORKERS' COMPENSATION REPORT, *supra* note 63, at 13.

191. *Id.* compendium on Workers' Compensation 101.

192. Worker productivity has increased over the last fifty years. Many labor-intensive jobs have become partly or fully automated. See generally M. CETRON, JOBS OF THE FUTURE (1986).

193. Many manufacturing jobs, and their accompanying risks, have been "exported" since World War II. There has been a corresponding increase in "service industry" office positions. This trend is projected to continue into the next century. While 26% of the workforce in the United States were employed in manufacturing jobs in 1980, if the present trends continue this will fall to 10% by the year 2013. M. CETRON, JOBS OF THE FUTURE 110 (1986).

194. Scientific studies of occupational hazards have led to better understanding, which has resulted in greater awareness of safety among employers, private insurers and regulators. See P. BARTH & H. HUNT, WORKERS' COMPENSATION AND WORK-RELATED ILLNESSES AND DISEASES 48-54 (1980).

195. Adequate rehabilitation has an important and neglected role in an effective workers' compensation scheme. COMPENSATION REPORT, *supra* note 63, at 38, 39.

196. The factors which have reduced injury losses in the workers' compensation schemes either do not apply to patient compensation schemes, or are not under statutory control. Presumably in a situation of steadily rising and uncontrolled costs, a point would be reached where the premiums for the scheme are so high as to inhibit the activity responsible for generating the injuries. The theoretical endpoint of economic deterrence occurs when no injuries are created because the basic activity has ceased.

197. But see Franklin, *supra* note 74, at 781.

198. See generally J. CHRISTIANSON & K. SMITH, CURRENT STRATEGIES FOR CONTAINING HEALTH CARE EXPENDITURES (1987). (discussing a variety of methods for limiting payments to doctors and other health care providers).

199. See Schwartz & Aaron, *supra* note 147 (discussing the role of high technology in increasing the risk of an adverse result).

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This remains a major weakness of a patient compensation scheme.²⁰⁰

C. Fraud, Abuse, and Malingering

As with any government benefit scheme, the potential and reality of abuse must be recognized.²⁰¹ A particular problem of workers' compensation schemes is the potential for malingerers to obtain or increase benefits by simulating or exaggerating injuries. Patient compensation schemes have this same potential. Patients wishing to defraud the scheme while under treatment could simulate or exaggerate injuries, especially those which require few or no objective findings, and rely on the administrative fact-finder's sympathy to overcome evidentiary weaknesses. There appears no general solution to the overall problem of abuse or the more subtle problems of economic disincentives to productivity.²⁰²

D. Constitutionality of Patient Compensation Schemes

There are several possible modes of constitutional challenge to a patient compensation scheme. The statutory classifications and administrative provisions of the schemes may be challenged on due process and equal protection grounds,²⁰³ or the removal of the right to jury trial could be challenged as a violation of many state

200. The inability to operate within the limits of economic and political reality while providing adequate compensation, and inability of the schemes to reduce transactional costs are the two major shortcomings of present worker's compensation schemes.

201. See generally PRESIDENT'S PRIVATE SECTOR SURVEY ON COST CONTROL (GRACE REPORT) (1984) (providing analysis and figures on government costs and expenditures).

202. Recent estimates by the General Accounting Office put the amount of welfare fraud and abuse at \$1 billion per year. *Fraud in Welfare Put at \$1 Billion*, N.Y. Times, Dec. 7, 1987, § I, at 25, col. 1. There has also been a growing recognition by Congress that the present structure of the welfare system fosters dependency. Johnson, *House Approves Overhaul of Welfare System*, N.Y. Times, Dec. 17, 1987, § I, at 28, col. 1.

203. Challenges based on equal protection or due process would be grounded in the fourteenth amendment to the United States Constitution (or an equivalent state provision), which provides:

No State shall make or enforce any law which shall abridge the privileges or immunities of the citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny any person within its jurisdiction the equal protection of the laws.

U.S. CONST. AMEND. XIV, § 1.

constitutions.²⁰⁴ The most likely outcome of a constitutional challenge to a patient compensation scheme can be interpolated by studying the fate of workers' compensation statutes, no-fault auto insurance, and tort reform legislation.²⁰⁵

The decisions relating to workers' compensation, though dated, are in other ways more analogous to patient compensation schemes than no-fault insurance or tort reform.²⁰⁶ Despite an initial successful challenge by New York employers in the *Ives* case,²⁰⁷ constitutional challenges to state workers' compensation schemes have been uniformly unsuccessful since 1917 when the United States Supreme Court handed down decisions that three such state schemes²⁰⁸ were valid exercises of the state police power supported by strong public policy considerations.²⁰⁹

No-fault auto insurance is less analogous to a patient compensation scheme because most schemes supplement, rather than replace,

204. "In Suits at common law . . . the right of trial by jury shall be preserved . . ." U.S. CONST. AMEND. VII. The United States Supreme Court has not ruled on whether the seventh amendment right to jury trial in civil cases is applied to the states through the fourteenth amendment. See generally Redish, *Seventh Amendment Right to Jury Trial: A Study in the Irrationality of Rational Decision Making*, 70 NW. U. L. REV. 486 (1975) (discussing the impact of the seventh amendment on the federal court system).

The present presumption is that the right to jury trial in state civil cases is determined by state law: "As the Seventh Amendment to the United States Constitution applies only to civil trials in federal courts, the states are free to develop their own body of law concerning the right to trial by jury in civil matters." *Hiatt v. Yergin*, 152 Ind. App 497, —, 284 N.E.2d 834, 849 (1972).

However in civil actions in which damages alone are sought, most state courts have found for a right to jury trial, either on the basis of the state constitution or the rules of civil procedure. See 4 WINSTEN, KORN & MILLER, *NEW YORK CIVIL PRACTICE* § 41.007 (discussing New York provision).

In the early part of the 20th century, seven states amended their constitutions to permit the enactment of workers' compensation legislation. DODD, *ADMINISTRATION OF WORKERS' COMPENSATION* 33 (1936).

205. The preferable analyses are those used for worker's compensation schemes or the recent analysis of no-fault auto insurance statutes. The New Zealand Injury Compensation Scheme was not subjected to constitutional scrutiny because the Parliament is the arbiter of constitutionality in the British, and New Zealand, systems.

206. Unlike present no-fault schemes or tort reform, most workers' compensation statutes impose strict liability on one party; abolish a common-law tort claim entirely; employ the use of administrative processes; and often employ the use of schedules.

207. *Ives v. South Buffalo Ry.*, 201 N.Y. 271, 94 N.E. 431, 140 App. Div. 921 (Ct. App. 1911).

208. *New York C. R.R. v. White*, 243 U.S. 188, 206 (1917); *Hawkins v. Bleakly*, 243 U.S. 210, 218 (1917); *Mountain Timber Co. v. Washington*, 243 U.S. 219, 243-44 (1917).

209. See, e.g., 243 U.S. at 206.

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the existing tort system.²¹⁰ However, the schemes have, with limited exceptions, been upheld by the courts' findings that no fundamental right has been affected in applying minimal standards of scrutiny.²¹¹ The retention of jury trial for serious injuries has been important in the acceptability of these schemes to the state courts.²¹²

Lastly, tort reform legislation has had a varied experience under constitutional challenge. While the early statutes, which tended to apply broad restrictions to malpractice litigation, were generally struck down by the state courts,²¹³ a recent California decision upholding a \$250,000 limitation on non-economic damages may represent a watershed in the modification of the common law in regard to medical negligence.²¹⁴

210. Generally no-fault traffic accident schemes automatically compensate personal injuries caused by the accident, if the costs incurred are less than the statutory threshold amount. No state has yet entirely eliminated fault-based tort liability. See M. WOODRUFF, *AUTOMOBILE INSURANCE AND NO-FAULT LAW*, 441-69 (1974).

211. In a leading Florida case upholding the state no-fault statute against a due process challenge, the court cited the traditional test for economic rights: "... whether the statute bears a reasonable relation to a permissible legislative objective and is not discriminatory, arbitrary or oppressive." *Lasky v. State Farm Ins. Co.*, 296 So. 2d 9, 15 (1974). A similar test was used in an early Massachusetts case upholding the state's no-fault statute against a plaintiff's challenge that due process was violated by requiring that he insure himself through a private entity and limit his common-law recovery. *Pinnick v. Cleary*, 60 Mass. 1, 6, 271 N.E.2d 592, 596 (1971). The court presumed legislative objectives of reducing the explosion in litigation and consequent congestion of the court system. *Id.* at 20, 271 N.E.2d at 602-03.

212. Generally, courts have inquired whether the legislature has provided a reasonable alternative to the cause of action it has restricted, and have accepted no-fault as such a reasonable alternative for small claims.

The courts of Colorado, Connecticut, Georgia, Kansas, Kentucky, Massachusetts, Minnesota, New Jersey, New York, and Pennsylvania have upheld the constitutionality of no-fault statutes. The Illinois statute was struck down as unconstitutional because "flawed provisions were not severable" from the remainder of the act. *Grace v. Howlett*, 51 Ill. 2d 478, 283 N.E.2d 474 (1972). Single provisions of the Florida and Michigan acts have been struck down as too restrictive on common-law tort claims.

213. See e.g., *Wright v. Central DuPage Hosp. Ass'n*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976). *Contra Jones v. State Bd. of Medicine*, 97 Idaho 859, 555 P. 2d 399 (1976), cert. denied, 431 U.S. 914 (1977). The subsequent diversity of opinions was discussed by an Ohio Appellate Court. See *Duren v. Suburban Comm. Hosp.*, 24 Oh. Misc. 2d 25, 27, 495 N.E.2d 51, 55-56 (1985).

214. *Fein v. Permanente Medical Group*, 38 Cal. 3d 137, 162, 695 P.2d 665, 679-84, 211 Cal. Rptr. 368, 383 (1985), appeal dismissed, 474 U.S. 892 (1985). The California Supreme Court under Chief Justice Bird, widely perceived as a progressive and liberal court, voted 4-3 to uphold a \$250,000 limit on damages for non-economic losses. See *id.* See generally Note, *The Constitutionality of Statutory Caps on Noneconomic Damages*, 11 S. Ill. U.L.J. 1269 (1987) (discussing the significance of the *Fein* decision).

Retention of jury trial,²¹⁵ more careful drafting of the statutes,²¹⁶ and a growing judicial recognition of the need to restrain juror generosity²¹⁷ are factors which make the acceptance of the statutes more probable. The final determination of such constitutionality lies in the future, and will depend largely on the analysis used by the courts to make the determination.

Consideration of the common features of the three groups of cases discussed above suggests that in order to survive constitutional scrutiny, a patient compensation scheme must first incorporate a substantial quid pro quo for the replacement of jury trial.²¹⁸ Both the worker's compensation and no-fault analyses suggest that the imposition of strict liability on the provider, combined with a fair process for administering claims, would prove sufficient.²¹⁹ Other common factors relate to the social need and significance of the respective scheme,²²⁰ the protection of vulnerable parties,²²¹ and the consonance of the provisions with other areas of legal change.²²² In all these areas, the suggested design of the scheme would probably satisfy these requirements.

E. Legislative Passage and Political Difficulties

Apart from the above problems in the overall design, funding and constitutionality of a patient compensation scheme, the enact-

215. In an Illinois case, the court held that the intangible benefits of "lower insurance premiums and lower medical care costs for all recipients of medical care" were an inadequate quid pro quo for the abolition of common-law jury trial and its replacement with limited recovery in medical malpractice. *Wright v. Central DuPage Hosp. Ass'n*, 63 Ill. 2d 313, 328, 495 N.E.2d 736, 742. By contrast, the court referred to workers' compensation schemes as providing for strict liability, but considered it adequate because it provided an adequate quid pro quo between the worker and the employer. *Id.* at 329, 347 N.E.2d at 742.

216. By paying careful attention to the concerns of the invalidating court, the legislature may be able to revise the statutes so as to avoid constitutional problems. A similar process, together with pressure from public opinion, led to constitutionally acceptable workers' compensation statutes in the post-lives period. See *supra* note 208 and accompanying text.

217. See *Danzon, supra* note 1, at 115-19 (discussing the impact of increasing frequency and amount of jury awards and settlements).

218. See *supra* note 215.

219. See *supra* notes 206, 212.

220. Legislative studies have generally confirmed the perceptions of a "malpractice crisis" and found the need for new legislation in this area.

221. The courts considering these schemes have tacitly placed greater emphasis on protecting the interests of the parties in inferior bargaining positions, in this case the patients.

222. The growth of the no-fault concept has led inevitably to suggestions for its application to areas of product liability and medical malpractice. See, e.g., *Sugarman, supra* note 47, at 659-61.

ment of such a scheme presents substantial problems. First, there appears to be little public concern over the malpractice "crisis," and a corresponding lack of legislative interest.²²³ The problem is perceived by many as an internecine squabble based on the conflicting economic interests of three privileged groups: lawyers, insurance companies, and doctors.²²⁴ None of the three groups seems to generate much public sympathy, despite substantial attempts at publicity.²²⁵

Second, legislatures historically contain a strong representation of attorneys.²²⁶ Legislative schemes reducing litigation and controlling contingency fees would probably meet with an unsympathetic reception from attorney-legislators.²²⁷ At best, their natural sympathies would lie with arguments against such legislation, and at worst, it would be opposed through simple self-interest.²²⁸

Third, even if the individual legislators were in favor of such measures, the party machinery responsible for their election contains an undue proportion of plaintiff's attorneys, often placed in strategic positions.²²⁹ Thus, even assuming the requisite political will on the part of the legislators, the strong and strategically placed special interest group of plaintiff's lawyers could effectively abort the political process.²³⁰ It is possible that the wave of "tort reform" is spent,

223. The general public apparently does not support the most commonly proposed legal reforms, except for limitations on attorney's fees. McCoy, *Public is of Two Minds About Limiting Plaintiff's Right to Get Rich in Court*, Wall St. J., May 20, 1986, at 18, col. 1.

224. A penetrating analysis of the mutual hostility and distrust between the two professions is found in Morris, *Professional Interface: Doctors vs. Lawyers*, 49 *INS. COUNS. J.* 514, 515 (1982).

225. See Rubin, *Law, Medicine and the Mass Media: Uneasy Partners*, 4 *COMMENT* 389 (1981-82).

226. See, e.g., Murphy, *Some Thoughts on Lawyer/Legislators In the Georgia House of Representatives*, 23 *GA. ST. B. J.* 110 (1987) (reporting that over the history of the Georgia state legislature, 17 to 22% of the legislators have been lawyers); see also Schmalz, *How State Lawmakers Can Benefit From Ties*, N.Y. Times, March 9, 1986, § 1, at 38, col. 1 (reporting that N.Y. state lawmakers are engaged in a variety of professional and investment activities that are directly affected by legislation they enact and by officials whose appointments they confirm).

227. Formal opposition has come through the influential American Trial Lawyers Association ("ATLA"), while informal influence has come through the close association of lawyers with political parties.

228. For an analysis of the political forces involved in modifying contingency fees see F. MAC KINNON, *CONTINGENCY FEES FOR LEGAL SERVICES* (1964).

229. Plaintiff's lawyers occupy key positions in the administrative machinery of both political parties, often as campaign or finance chairmen. J. O'CONNELL, *THE LAWSUIT LOTTERY* 158 (1979).

230. The impulse for no-fault insurance and tort reform generally has been blunted by the

and will recede as the above influences become better organized, and negate through their political influence what remains after constitutional challenge.²³¹

To summarize, significant difficulties would face the passage of a patient compensation scheme, both from a lack of public demand for such change, and the effective influence of the plaintiff's bar. Even if such a scheme had significant public support, its legislative passage would not be certain.

F. Foreseeable Consequences

The foreseeable consequences of such a scheme would include a marked reduction in attorney involvement in patient injury cases,²³² a reduced monetary recovery by a larger number of injured patients,²³³ and a greater participation by government in the compensation of injured parties.²³⁴ There would be much greater amounts of information generated and available both to the licensing agencies, and the general public.²³⁵ In cases where treatment for the injury was continued by the provider as a payment-in-kind, there would be greater awareness of the injured patients progress by the provider.²³⁶

G. Other Consequences

In any such enterprise, there remain incalculable effects. Such schemes could possibly suffer from rampant abuse and financial shortages from their inception, and be responsible for "malpractice

effective political influence of plaintiff's lawyers through the American Trial Lawyers Association (ATLA) with a "clear pattern of trial lawyers' campaign spending which rewards those who oppose [reform] and punishes those who favor it." J. O'CONNELL, *THE LAWSUIT LOTTERY* 159 (1979) (quoting L. Sutcliffe).

231. Since the organization in 1975 of the ATLA fund to fight tort reform and no-fault, there have been no new no-fault traffic accident laws. An attempt to pass a federal bill failed in the U.S. House Commerce Committee in August 1978 by 22-19 vote. J. O'CONNELL, *THE LAWSUIT LOTTERY* 158 (1979) (citing Rich, *No-Fault Again Crashes to Defeat*, Wash. Post, Aug 2, 1978, at A-12, col. 1). In 1977 the headquarters of ATLA was moved from Boston to Washington, D.C. in order to fight federal no-fault. J. O'CONNELL, *THE LAWSUIT LOTTERY* 159 (1979).

232. See *supra* note 96 and accompanying text.

233. See *supra* note 43 and accompanying text.

234. See *supra* note 99 and accompanying text.

235. See *supra* notes 150-62 and accompanying text.

236. See *supra* notes 102-09 and accompanying text.

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malingering."²³⁷ The fate of statistically high-risk activities would be uncertain: the suggested incentives may be too generous, or not generous enough, thus creating shortages or excesses in these areas.²³⁸ On the other hand, the effect on medical malpractice may be anti-climactic, and medical life may go on just as before, as in New Zealand.²³⁹

The greatest uncertainty must remain the overall cost and usage of the scheme, since so much would depend on shifting community attitudes and administrative efficiency, both uncertain commodities.²⁴⁰

V. SUMMARY

Significant increases in litigation frequency and award amounts,²⁴¹ coupled with cost containment pressures on medical providers,²⁴² have directed attention to the wider problem of minimizing the economic impact of medical injuries on the patient.²⁴³ The failure of the tort system to adequately compensate medical injuries²⁴⁴ and its undefined role in deterring substandard care²⁴⁵ are becoming more apparent and less tolerable.

The use of high technology in medicine, as well as incidents of substandard care, have created a statistical incidence of medical injuries that are a societal burden.²⁴⁶ One method of distributing that burden is a patient compensation scheme based on a worker's compensation scheme, and focusing mainly on compensation of injury rather than its deterrence. Because of this, it would need to be linked

237. Third party benefit schemes are infamous for fraud and abuse, of which malingering is one form. The problems are seemingly inherent in the system and merit more discussion than space allows here. See *supra* notes 201, 202.

238. See *supra* text accompanying notes 141-45.

239. Organized medicine made only a perfunctory submission to the 1974 Select Committee which preceded the introduction of the New Zealand scheme, and has made no formal suggestions since then. However, this apparent lack of interest in a scheme which turned malpractice litigation into an administrative process is accounted for by the virtual absence of malpractice litigation in that country. G. PALMER, *supra* note 35, at 258. Interest in such changes would be significantly higher in the U.S.

240. See *supra* note 43 (estimating costs).

241. See *supra* notes 3-4 and accompanying text.

242. See *supra* note 198.

243. See *supra* note 15.

244. See *supra* notes 19-26 and accompanying text.

245. See *supra* notes 27-32 and accompanying text.

246. See *supra* note 147 and accompanying text.

with more effective quality control through the licensing system.²⁴⁷

The patient compensation scheme discussed here would offer reduced transactional costs, greater net awards to patients, and would compensate a greater number of injured patients than the existing system.²⁴⁸ However, the vexing questions of how broad such a scheme should be, the design of simple entry criteria, and the financial uncertainties are significant weaknesses in its design.²⁴⁹

Constitutional²⁵⁰ and political challenges²⁵¹ would threaten the viability of a patient compensation scheme, but even if it survived them, its future would be uncertain. Foreseeable and unforeseeable difficulties would hover, never far away, threatening its function of basic compensation and medical care for the injured patient.

VI. CONCLUSION

Major uncertainties and their corresponding risk of failure surround the implementation of a patient compensation scheme. Rather than radical change, a more effective and certainly safer method of dealing with the inefficiencies and inequities of the present medical negligence system is a policy of incremental change, implementing modifications in the existing tort system that have been demonstrated to reduce system costs, and adding others which have a high likelihood of effectiveness.²⁵² The former measures are restrictions on plaintiff recovery,²⁵³ deducting collateral recovery from damage awards,²⁵⁴ and limitations on attorney's fees.²⁵⁵ The latter include

247. See *supra* notes 150-62 and accompanying text.

248. See *supra* Part III, DESCRIPTION OF THE ELEMENTS.

249. See *supra* Part IV, PROBLEMS ASSOCIATED WITH PATIENT COMPENSATION SCHEMES.

250. See *supra* notes 203-22 and accompanying text.

251. See *supra* notes 223-31 and accompanying text.

252. A careful statistical appraisal of the effectiveness of specific provisions commonly found in tort reform legislation found "mixed effects of the tort reforms enacted in response to the 1975 crisis." Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS. 57, 58 (1986). While limitations on recovery and mandatory offset of collateral benefits appeared to have slowed claim growth by 1978, none of the other changes, such as pre-trial screening panels, showed any impact. *Id.* However, long-term measures affecting the "long tail" of claims, such as a shorter statute of limitations, would not be expected to show such early effects. *Id.* The principle of emphasizing empirically effective measures, however, is apparent. *Id.*

253. See *supra* notes 68-90 and accompanying text.

254. See *supra* notes 121-25 and accompanying text.

255. See *supra* notes 91-98 and accompanying text.

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payment in kind rather than cash²⁵⁶ and payment as needed rather than lump sum or scheduled payments.²⁵⁷ Together, these proposals offer the greatest reduction in transactional costs with a minimum of disruption to the present system, and also offer the prospect of increasing net benefit to the injured patient without substantially increasing overall system cost.

At first glance, it may also seem fairer and more efficient to implement deterrence of substandard care through the licensing and regulatory agencies,²⁵⁸ independent of a patient compensation scheme. However, such a system could not function effectively without the comprehensive statistical information and economic deterrence generated by a patient compensation scheme.²⁵⁹ Deterrence through these agencies based on the inadequate information derived from the tort system should be applied cautiously,²⁶⁰ with a pervasive awareness that factors of chance ultimately determine which instances of substandard care result in successful malpractice claims.²⁶¹

256. See *supra* notes 102-09 and accompanying text.

257. See *supra* notes 110-20 and accompanying text.

258. See *supra* notes 154-58 and accompanying text.

259. See *supra* notes 159-62 and accompanying text.

260. See *supra* note 151.

261. See *supra* notes 19-20 and accompanying text.

normal costs.³⁸¹

VII. CONCLUSION

The goal of this Article has been to sort out descriptively what the Court does in applying the Constitution to penalties that are not labeled "criminal," and to provide some sort of analytic framework that might make decisions in this area more predictable, consistent, and articulate. The Article does not purport to provide definitive answers about the constitutional outcomes that should obtain in particular cases, but instead offers an overview and a framework of analysis. Nor is it meant to suggest that the overview provided here is necessarily the only one which the Court could responsibly use. One might perhaps retain the description of penalties and forfeitures as "quasi-criminal" and still explain in functional terms why certain provisions of the Constitution, such as the self-incrimination clause, are "broader" than other provisions, such as the sixth amendment. One might also, for example, formulate a view of "punishment" that avoids reference to purpose altogether and instead employs a balancing test.

If space permitted, certain issues raised by this Article would clearly warrant more extended consideration. The question whether reference to "purpose" in the first amendment cases contributes more to analysis there than does the balancing language currently employed is an intriguing issue whose full exploration is beyond the scope of this Article. At a less general level, the questions raised in the last section of this Article about the procedural attributes of civil penalty proceedings are only adumbrated. They in particular deserve more extended analysis.

Nonetheless, it is hoped that this effort will at least serve to stimulate more detailed examination of these and other issues upon which the Article touches. If the use of civil penalties proliferates, as it seems likely to, the need to explain and justify their constitutional treatment will become increasingly critical. This Article may at least serve to facilitate that task.

381. See *Boddie v. Connecticut*, 401 U.S. 371 (1971) (emphasizing the fundamental nature of the interest at stake (marriage) and the judicial monopoly over the grant of divorce). But see *United States v. Kras*, 409 U.S. 434 (1973) (no waiver of fees in federal voluntary bankruptcy cases). Also reaching the conclusion that the bond requirement in forfeiture cases is unconstitutional is Note, *Forfeiture Proceedings—In Need of Due Process*, 3 FORDHAM URB. L.J. 347, 355-57 (1975), which further points out that certain federal statutes may be defective in failing to provide for notice of seizure to owners of property worth less than \$2500. *Id.* at 353-55.

An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries†

Jeffrey O'Connell*

The inadequacies of tort liability as it applies to personal injury have become commonplace knowledge in recent years. David Sanford's incisive summary of the present system's unwieldy mixture of insurance, law, technology, and emotion—largely leading to frustration—is as follows:

Newspapers in March [1975] reported the sad story of Gail Kalmowitz, a nearly blind college student, who had undertaken to sue for negligence two doctors and the hospital where she had been born prematurely. She asserted that the defendants' failure to provide her adequate care following her birth in 1953 had caused her loss of sight. While the jury in her case was deciding its verdict, she became anxious about the outcome and accepted a \$165,000 settlement offered her by the defendants' insurance company. A few minutes later the jury returned and she learned that had she not settled she would have won \$900,000. Was she a fool?

The insurance company evidently expected a big verdict in her favor, but Miss Kalmowitz was merely playing the odds. . . . [After all] the majority of plaintiffs in malpractice . . . suits end up with nothing. Moreover, even if Miss Kalmowitz had waited for the jury, the defendants could have appealed and might, after years and expense to her, have won a reversal. Miss Kalmowitz chose a sure thing and that may not have been a mistake.^[1]

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* Professor of Law, University of Illinois.

1. For an excellent description of the frustrations to doctors from a case like *Kalmowitz*, see N.Y. Times, Apr. 27, 1975, at 1, cols. 2-3. They are summarized in the following letter to the editors of *Newsweek*:

[The case of] . . . Gail Kalmowitz . . . is a classic example of the malpractice malaise threatening the health professions. Two physicians, practicing medicine according to the then current standards of care, preserve the life of a premature infant, who later becomes blind as a consequence of the high oxygen concentration that made her very survival possible. Twenty-two years later, the physicians are held retroactively accountable to a different and changing standard.

When it was discovered that the eyes of some infants were more sensitive than others to high oxygen concentrations, there

Ideally, an inept or careless physician should be made to pay the costs of the damage he does; likewise the manufacturer of a faulty or dangerous consumer product. Guilt should be fixed and punished and the fellow who makes the shabby power tool that ends up putting out someone's eyes should have to pay for the doctors, for the loss of a career, and for the lifetime support of the blinded consumer. "Ideally" is the key word, of course, because retribution is an inexact science. Some products are inherently hazardous—a chain saw for example—and if the user saws off his arm is it because the machine was faulty and the user was not warned of the peril, or is it because the victim operated the saw carelessly and in flagrant disregard of its operating features and instructions?

Nor is this common ambiguity the only problem. Whatever the circumstances of an accident, the lawyers for the contending parties, in our adversary system of laws, will arrive in court prepared to present, as theatrically as a judge will tolerate, the "best" case for their clients. Extraneous matters are introduced into proceedings to sway jury verdicts. Indeed, lawyers try during the empaneling of juries to select persons who, by dint of certain stereotypes, are likely to be more—or less—inclined to find in favor of one party or the other. A plaintiff's lawyer might prefer jurors who are young, or Jewish, or black, or who work in blue-collar jobs, and who are presumed to be generous in their impulses toward the injured. The lawyer representing the doctor accused of malpractice is likely to want on the jury retired persons living on fixed incomes and "tight with a buck," middle-management types, or a highly diverse group liable to squabble and unlikely to grant a large award.

Once a trial is underway the plaintiff and the defendant, each in his own ways, will try to win the sympathies of jurors with irrelevancies. The blind plaintiff might be encouraged to come to court with his seeing-eye dog and to dab at his eyes with a handkerchief. The corporation's lawyer might dress shabbily and play the rube and sit in court next to a "goat"—[an] . . . official of the sued company who, it is heavily implied, will personally suffer an adverse verdict [whereas in fact an insurer will almost always pay any verdict].¹ On the defense side

was a concerted effort to lower oxygen concentrations in incubators to what were then considered less toxic levels. Predictably, there was a drop in the incidence of retrolental fibroplasia. Ironically, however, recent evidence in the United States, England and elsewhere now indicates that lowering oxygen concentration to prevent the rare occurrence of blindness has been accomplished at the cost of an increase in mental retardation of oxygen-deprived premature infants. It could be argued that Miss Kalmowitz might have grown up retarded instead of blind—had she in fact survived at all without the extra oxygen. This is a hard dilemma, but one we must face daily in our imperfect world. We can't have it both ways, and the burdens of choice are not eased by having to second-guess what interpretations will be placed on our actions by an emotion-charged jury twenty years after the fact.

Letter from Joseph Leaser, M.D., Hershey, Pa., in *NEWSWEEK*, May 12, 1975, at 4, 6, quoted in Epstein, *Medical Malpractice: The Case for Contract*, 1976 A.B.F. RES. J. 87, 114-15 n.54.

2. Cf. James & Law, *Compensation for Auto Accident Victims: A Story of Too Little and Too Late*, 26 CONN. B.J. 70, 78-79 (1952).

there will be expensive technical experts offering abstruse testimony that the product at issue was not unreasonably dangerous, that it was not the product but something else that caused the injury, that the product was not defective when sold, that the injured person had been negligent in the maintenance or use of the product, that the manufacturer had amply warned of the hazards involved, and so forth.

The injured plaintiff in these cases is allowed to sue not only to recover the actual expenses incurred as a result of his accident—medical bills, lost wages, etc.—but for intangible pain and suffering. Thus a judgment can run into the hundreds of thousands of dollars or more, and the lawyer for the plaintiff, working on a contingency-fee basis, will collect a percentage, usually a third, of the money won in court. Doctors, particularly, are quick to argue that one of the reasons there are so many malpractice suits is that aggrieved patients are egged on by attorneys hoping to get rich. A third of a million dollars is quite a . . . fee. Product liability suits and malpractice cases do seem to reward lawyers generously . . .

Whatever the virtues of the fault system and of law suits, it remains true, according to . . . the National Product Safety Commission, that "most injuries to consumers go uncompensated" . . . Trials are expensive, and it's not worth a lawyer's while to sue for damages of less than \$5,000 or \$10,000. Perhaps two-thirds of those injured never pursue a claim beyond writing an unacknowledged letter to the firm whose product was involved in an accident.

The problem is immense. The Product Safety Commission estimates that 20-million people in the United States are injured each year "as a result of accidents connected with consumer products." These are, quite frequently, architectural glass, color television sets, fireworks, floor furnaces, glass bottles, bicycles, hot water vaporizers, household chemicals, infant furniture, ladders, power tools, lawnmowers, toys, gas heaters. There are perhaps 500,000 product liability cases in the courts each year.

Medical malpractice suits are even more of a problem, given the near impossibility of proving negligence and the reticence of doctors to testify against one another. Malpractice is a nightmare to doctors as well as to patient litigants: a doctor may resort to expensive and needless procedures (for instance, X-rays) only to establish later in court, if need be, that he had done everything he could to diagnose and treat illness. Insurance companies want to get out of the malpractice business; they say it isn't profitable. Doctors are carping about malpractice insurance rates, now commonly as high as \$12,000 or more a year for a physician . . .³

Some idea of the waste the tort liability insurance system generates is gained by examining just how much of the premium dollar ever reaches accident victims. While defenders of tort

3. Sanford, Book Review, *N.Y. Times*, Aug. 10, 1975, § 7, at 4, cols. 1-4 (summarizing the first three chapters of J. O'CONNELL, *ENDING INSULT TO INJURY: NO-FAULT INSURANCE FOR PRODUCTS AND SERVICES* (1975)).

liability seem always to be offended by appraisals of the system from this vantage,⁴ surely the thrust of even the common law has been to recognize increasingly the rights of accident victims to share in tort liability insurance proceeds.⁵

Professor Robert Keeton of the Harvard Law School has compiled the following table:

Where the Automobile Bodily Injury Liability Insurance Premium Dollar Goes ⁶	
General Overhead ⁽⁷⁾	33 cents
Claims Administration Cost	
Defense Side ⁽⁸⁾	13 cents
Claimants' Side ⁽⁹⁾	10 cents

4. See, e.g., Kalven, *A Schema of Alternatives to the Present Auto Accident Tort System*, 1 CONN. L. REV. 33, 34-35 (1968).

5. See, e.g., R. KEETON, *INSURANCE LAW—BASIC TEXT* 223-28, 522-27 (1971); J. O'CONNELL, *THE INJURY INDUSTRY AND THE REMEDY OF NO-FAULT INSURANCE* 22 (1971).

6. From P. KEETON & R. KEETON, *TORTS: CASES AND MATERIALS* 514 (1971) (footnotes renumbered).

The principal sources of data relied upon in making this computation are the following: the American Insurance Association [AIA] Cost Study [AIA, SPECIAL COMM. TO STUDY AND EVALUATE THE KEETON-O'CONNELL BASIC PROTECTION PLAN AND AUTOMOBILE ACCIDENT REPARATIONS, REPORT 13-16 (1968)] . . . ; the Michigan Study of Conard and his colleagues [A. CONARD, J. MORGAN, R. PRATT, C. VOLTZ, & R. BOMBAUGE, *AUTOMOBILE ACCIDENT COSTS AND PAYMENTS—STUDIES IN THE ECONOMICS OF INJURY REPARATION* (1964)] . . . ; Harwayne, *Automobile Basic Protection Costs Evaluated* (1968); and Harwayne, *Insurance Costs of Basic Protection Plan in Michigan*, 1967 U. ILL. L. FORUM 479 (1967), also published in *Crisis in Car Insurance* 119 [(R. Keeton, J. O'Connell, & J. McCord eds. 1968)]. Harwayne is a Fellow of the Casualty Actuarial Society and an independent consulting actuary. His studies were conducted under the sponsorship of the Automobile Claims Study at Harvard Law School, in which the Basic Protection Plan was developed.

The calculations presented here were published in a 1969 pamphlet, under the same title as this chapter. [Compensation Systems—The Search for a Viable Alternative to Negligence Law]. They were thereafter cited and independently confirmed in N.Y. Ins. Dep't Report 34-37 (1970).

Id. at 513 n.17.

7. General overhead, as used here, refers to all overhead other than claims administration costs. It includes agents' fees and other marketing costs (variously referred to in the insurance industry as production or acquisition costs), home office expenses, taxes, and profit. . . . Harwayne's study sustains the estimate, used in this chart, that actual general overhead comes to 33 cents of the premium dollar.

Id. at 514 n.18.

8. Harwayne observes that in recent years national stock company averages for defense claim costs have varied from 12.8 to 13.3 per cent and national mutual company averages from 16.2 to 16.6. The chart presented here uses a figure of 13 cents as a very conservative figure for the industry as a whole on a national basis.

Id. n.19.

9. Earlier field studies . . .—particularly studies by Professor

Total Claims Administration Cost	23 cents
Total Overhead	56 cents
Net Amount Paid to Victims Above Losses (in theory for Pain and Suffering) ⁽¹⁰⁾	21.5 cents
Paid to Compensate for Losses Also Compensated from Other Sources (including income tax saving) ⁽¹¹⁾	8 cents

Conard and his colleagues at the University of Michigan—show these costs to be about 10 cents of the premium dollar. This figure is used in the chart. It is, of course, an average for all claimants—representing a mean between lower claims costs for those without attorneys and higher claims costs for those with attorneys, who also generally receive higher total payments.

These claims costs on the claimants' side are paid out of the gross sum the insurance companies pay to settle claims, whether paid before or after a trial. Under the AIA figures that amount is 55 cents; under the adjusted figures used in this chart, 54 cents.

Id. at 514-15 n.20.

10. The AIA study found that the total amount paid in settlement of a bodily injury claim under the tort liability system is on the average 2.4 times the amount of economic loss.

When we divide 2.4 into 54 cents of gross payment for claims, we find that 22.5 cents go to compensation for economic losses of those victims to whom payments are made. Deducting this 22.5 cents and the 10 cents for claimants' attorneys from the total of 54 cents, we find that 21.5 cents go to compensation above both economic loss and attorneys' fees.

In theory this is compensation for pain and suffering, though it is not all that is paid on this theory. That is, at least part of the amount that goes to pay claimants' attorneys' fees (the 10-cent figure) can also be said to have been awarded on the theory of damages for pain and suffering, since claimants are not entitled to recover compensation for their attorneys' fees as such.

Id. at 515 n.21.

11. The AIA report shows that other available sources of compensation such as Blue Cross, Blue Shield, accident and health coverage, and the like amount to at least 11 per cent of the total tort recoveries. That is, this is the amount they found in duplicated payments. This would amount to 6 cents of the premium dollar (11 per cent of 54 cents).

The Harwayne study calls attention to the fact that the AIA study obtained from claimants themselves the data reported as compensation from other sources than automobile liability insurance. It seems likely indeed that data collected in this way would not reflect the full extent of other payments. Moreover, such data do not reflect the overlapping of compensation that results from the fact that a claimant is excused from paying income tax on the compensation he receives for the amount of wages lost, on which he would have had to pay a tax if he had received that amount as wages.

A figure of 8 cents seems a very conservative estimate of overlapping compensation (including the income tax saving), and this figure is used in the chart.

For 1969, and even more so as to later years, this figure of 8 cents is a conservatively low estimate of overlapping compensation for another reason beyond those so far stated—payments of compensation from sources other than liability insur-

Paid to Compensate for Losses
Not Compensated from Other
Sources^[12]

14.5 cents

Net Paid to Victims Altogether

44 cents

100 cents

Genuine dollar losses are what most people want to insure against. Apart from tort liability insurance, there is no market for pain and suffering coverage in insurance that people buy on themselves. As Professor Alfred Conard of the University of Michigan Law School has put it:

Did you ever hear of anyone voluntarily buying insurance against pain and suffering? Everybody I know would rather keep his premium money and bear his suffering without balm. If no one in his right mind would voluntarily buy insurance against pain and suffering, it is silly to require everyone to buy it compulsorily.¹³

Yet only 14.5 cents of the automobile tort liability insurance dollar goes to meet that essential insurance need of payment for dollar losses not otherwise compensated.¹⁴

Similar inadequacy is found in compensating injury in at least two other situations—personal injury from medical malpractice and from defective products.

Extrapolating (conservatively) the auto liability and other figures¹⁵ to medical malpractice, we get the following figures:

Hypothesis of Where the Medical Malpractice
Liability Insurance Premium Dollar Goes

General Overhead¹⁶

30 cents

ance have been rising rapidly, and the trend is expected to continue.

Id. n.22.

12. This figure—showing the amount paid in compensation for losses not compensated from other sources—is derived simply by subtraction. After accounting for other purposes to which all the rest of the premium dollar is committed, we find that only 14½ cents go to compensating for losses not otherwise compensated.

Id. n.23.

13. Conard, *Insurance Rates and Regulation*, 15 U. MICH. L. QUAD. NOTES, Fall 1970, at 14. But see J. O'CONNELL, *supra* note 5, at 104-05; J. O'CONNELL & R. SIMON, PAYMENT FOR PAIN AND SUFFERING 29-34 (1972), also printed in O'Connell & Simon, *Payment for Pain and Suffering: Who Wants What, When & Why?*, 1972 U. ILL. L.F. 1, 29-34.

14. J. O'CONNELL, *supra* note 5, at 36; note 12 *supra* and accompanying text.

15. See note 16 *infra*.

16. This figure is based on those provided by insurers to Insurance Services Offices (ISO). ISO is a statistical and rating body organized by property and casualty insurers. The insurance industry figures were submitted to the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, chaired by Senator Edward M. Kennedy, in

Claims Administration Cost¹⁷

Defense Side
Claimants Side

24 cents

18 cents

Total Claims Administration
Cost

42 cents

response to written interrogatories from the Subcommittee. Washington Insurance Newsletter, Dec. 8, 1975, at 7 [hereinafter cited as Newsletter]. According to another estimate for medical malpractice insurance, "Approximately 25 percent of a physician's malpractice insurance premium . . . is consumed by the . . . insurer [exclusive of legal fees]." Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141, 1155 (1975) (citing Remarks of G. Parrella, Medical Malpractice Insurance, Connecticut Medical Society House of Delegates, Nov. 20, 1974; on file with the Yale Law Journal). But that same estimate is much higher for legal fees: "An additional estimated 50 percent of the premium is consumed by lawyers in the form of fees for services in medical litigation." *Id.* For a similar estimate of "more than 50 cents" of the insurance dollar going to lawyers, "less than 25 cents" to patients, and the remainder to insurers' expenses, see PHYSICIANS CRISIS COMMITTEE [OF DETROIT], COURT DOCKET SURVEY 2 (1975).

17. The figure of 24 cents for costs of administering defense claims is the response of the insurance industry to one of the Kennedy Subcommittee questions. Newsletter, *supra* note 16, at 7.

Medical malpractice cases (like product liability cases) are much more difficult to prepare and try for both plaintiff and defense lawyers, so that it is safe to assume more is spent on legal fees by both sides for medical malpractice claims than for automobile liability claims. J. O'CONNELL, ENDING INSULT TO INJURY: NO-FAULT INSURANCE FOR PRODUCTS AND SERVICES 29-30, 41 (1975) [hereinafter cited as J. O'CONNELL]. Also given their complexity, it is much more likely that a claimant in a medical malpractice or product liability case will retain a lawyer. Admittedly, estimates vary widely:

One insurance company told the subcommittee [of the Senate Committee on Government Operations] that of the total [loss] costs from its malpractice business, only 30 percent of these funds actually go the patient; 15 percent goes to the plaintiff's attorney; and 55 percent is taken by defense attorney fees and defense investigation costs.

Another said that 38 percent of each claims loss goes to the patient; 35 percent goes to the plaintiff's attorney; and 27 percent is taken by defense attorney fees and defense investigation costs.

It is readily apparent, then, that the amount of claims and judgments paid represent only a portion of the costs generated by malpractice actions. Furthermore, the lion's share of the expense goes to the legal community.

SUBCOMM. ON EXECUTIVE REORGANIZATION OF THE SENATE COMM. ON GOVERNMENT OPERATIONS, 91ST CONG., 1ST SESS., MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN 10 (Comm. Print 1970).

Without certainty about whether plaintiff's or defendant's counsel ends up with a different ratio of the total money going to counsel fees in medical malpractice liability insurance as opposed to automobile liability insurance, I have assumed the same ratio (13:23 = 24:42; 10:23 = 18:42). See text accompanying notes 8-9 *supra*. Actually, given the greater resistance to medical malpractice claims compared to auto liability claims, see J. O'CONNELL, *supra* at 29-30, it might be safe to assume defense lawyers receive even more of the premium dollar

Total Overhead ¹⁸	72 cents
Net Amount Paid to Victims Above Losses (in theory for Pain and Suffering) ¹⁹	8.8 cents

vis-à-vis plaintiff's lawyers. Note that the total figure of 42 cents roughly corresponds with the estimate in a generally astute appraisal of medical malpractice insurance by journalists Stephen Cain and Clark Hallas: "For every dollar collected by a patient who successfully sues a doctor or hospital for medical malpractice, the attorneys representing both sides of the suit collect an estimated \$2." Cain & Hallas, *Possibility of Fraud Is Probed in Medical Malpractice Suits*, Detroit News, Oct. 10, 1974, at 1, cols. 2-4 (which, for the purposes of this Article, involved a comparison of the figures for claims administration cost for both the defense side and the claimants' side and for the net paid to victims altogether).

Representatives of the insurance industry, in response to a Subcommittee question, stated: "A . . . breakdown between plaintiffs' attorney fees and benefits to the claimant is not available from insurance statistical data. However, if the commonly quoted estimate of one-third of the settlement as the fee for the plaintiff's attorney is assumed, then \$.153 [of the premium dollar] would go to the attorney and \$.305 to the claimant." Newsletter, *supra* note 16, at 7.

18. According to other estimates, this figure understates total overhead (including claimants' administration costs) and, as a corollary, overstates the net amount paid to claimants. For example, in a preview of a study by the Institute of Interdisciplinary Studies in Minneapolis, Minnesota, under a research grant from the National Institute of Health, it has been indicated that "only sixteen to twenty-seven cents [of the present medical malpractice premium dollar] reaches the patient whereas of the automobile liability insurance dollar, forty-four cents reaches the victim and in Workmen's Compensation sixty-four to ninety-three cents reaches the injured workman." Morris, *Medical Report: Malpractice Crisis—A View of Malpractice in the 1970's*, 1971 INS. COUNS. J. 521, 523. Subsequently, Rick Carlson of the Institute opined that only "between sixteen and seventeen cents of the premium dollar ends up as benefits to victims of medical injuries." MEDICAL MALPRACTICE: A DISCUSSION OF ALTERNATIVE COMPENSATION AND QUALITY CONTROL SYSTEMS 5 (D. McDONALD ed. 1971) (Center for the Study of Democratic Institutions Occasional Paper). According to still another study, 16 to 25 per cent of the premium dollar is eventually paid to patients. CAL. ASSEMBLY SELECT COMM. ON MEDICAL MALPRACTICE, PRELIMINARY REPORT 5-6 (1974), cited in Note, *supra* note 16, at 1155 n.75. Apparently relying on PHYSICIANS CRISIS COMMITTEE [OF DETROIT], *supra* note 16, consumer columnist Sylvia Porter has reported that in Michigan 23 cents goes to the patient, with 55 cents being spent on lawyers and litigation expenses and the remaining 22 cents on insurance overhead. Sylvia Porter's column, December 8, 1975. According to Ms. Porter, the situation is "even worse in some other states." *Id.* On the other hand, the insurance industry estimate, in reply to a Subcommittee question, was 31 cents as net payment to victims and 69 cents to total overhead. Newsletter, *supra* note 16, at 7.

19. The ratio, under tort liability, of pain and suffering payment (including plaintiffs' attorneys' fees) to out-of-pocket losses (including those compensated from other sources) is about 1.4:1. See P. KEETON & R. KEETON, *supra* note 6, at 515 n.21 (reporting that "the total amount paid in settlement of a bodily injury claim under the tort liability system [for auto accidents] is on the average 2.4 times the amount

Paid to Compensate for Losses Also Compensated from Other Sources (including income tax saving) ²⁰	6.7 cents
Paid to Compensate for Losses Not Compensated from Other Sources ²¹	12.5 cents
Net Paid to Victims Altogether ²²	28 cents
	100 cents

Here, then, for all the agony caused by the medical malpractice tort system, we find that it returns at the most only 28 cents of the premium dollar to injured patients, and, of that, only 12.5 cents reimburses the patient for dollar losses not otherwise compensated.

In this regard, Phillip Corboy, a prominent personal injury lawyer, has recently referred to the testimony of a nurse in a case involving severe burns caused one Jake Crouch when a transformer on which he was working exploded and spewed burning

of economic loss," which is another way of saying that the ratio is 1.4:1.) It might be argued that—given stouter resistance to claims and especially fewer nuisance claims under medical malpractice insurance, see J. O'CONNELL, *supra* note 17, at 29, 38-41—less is paid for pain and suffering arising from medical malpractice liability than from auto bodily injury liability. But for indication that most medical malpractice claims are for relatively minor injuries and for small amounts (\$2000 or less in one-half of all paid claims), thus justifying an inference that insurance companies prefer a nominal settlement rather than the expense of defending its insureds, see King, *A Commentary on the Report of the Malpractice Commission*, 29 RECORD OF N.Y.C.B.A. 294, 295 (1974) (based on, but not specifically citing, Rudov, Myers, & Mirabella, *Medical Malpractice Insurance Claims Files Closed in 1970*, in APPENDIX, REPORT OF SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 1 (U.S. Dep't of Health, Education, and Welfare Pub. No. (OS) 73-89, 1973)). According to one estimate, over half of medical malpractice cost is related to awards for "pain and suffering." Address by Steven Resnick, conference entitled "The Medical Malpractice Crisis: Managing the Costs," University of Maryland School of Law, Nov. 21, 1975 [hereinafter cited as Conference]. Also it is the low limits of automobile liability insurance (often only \$20,000) that often cause little to be paid for pain and suffering in severe cases. Medical malpractice limits would often be \$300,000 higher. Thus I have used Professor Keeton's ratio to arrive at the figure of 8.8 cents ($28 + 18 = 46 \div 2.4 = 19.2 + 18 = 37.2; 46 - 37.2 = 8.8$). See note 10 *supra*.

20. I have calculated this figure on the basis of the Keeton formula explained in note 11 *supra*: [(11 percent of 46 cents) = 5 cents] + [$(\frac{1}{3} \times 5 \text{ cents}) = 1.7 \text{ cents}$ to account for income tax savings] = 6.7 cents. The result, as in the Keeton calculation, is no doubt a very conservative estimate.

21. "After accounting for other purposes to which all the rest of the premium dollar is committed, we find that only [12.5] cents go to compensating for losses not otherwise compensated." Note 12 *supra*.

22. See note 18 *supra*.

boy's purpose apparently is to illustrate the real-
to justify the law's attention to compensating
the nurse describes in detail the extensive (and, one
gathers, hugely expensive) treatment of the patient, including
the careful professional application of Sulfamylon cream plus ex-
tensive and professionally supervised administration of whirlpool
treatments. She then testifies:

[Jake] very soon after he was admitted [to the hospital] became
aware of the fact that the treatment would be a long one. . . .
He would look to the future and getting out of the hospital and
the possibility of getting back to work. . . . [H]e liked to be out
in his job and he felt this wasn't going to be possible and this
was a factor in his depression, that his life style would have
to change. He often discussed with me what would happen to
his family. He worried about how they were making out . . .
as far as financial arrangements . . . and I would say a great
deal of time he was severely depressed²³

The patient in this case was awarded \$650,000 after, as Cor-
boy indicates, a lengthy trial (he does not tell us the length of
time between injury and trial). But Jake Crouch was one of
the lucky ones in being paid at all from the tort liability system.
As the nurse's testimony poignantly indicates, what he needed
was treatment—both physical and psychiatric (for his depres-
sion)—and assurances that his family would be cared for. In
short—as with most of us if seriously injured—he was primarily
concerned with payment for his out-of-pocket losses, not for his
pain and suffering.

Discussion of a products liability case raises the point that
the figures for products liability insurance have not been devel-
oped with even the precision of those available for medical mal-
practice insurance, not to speak of the relatively exhaustive fig-
ures available for automobile liability insurance. But products
liability cases share characteristics with medical malpractice
cases. In both, liability turns on very complicated fact situations
with concomitantly extraordinary expense and delay, and the de-
fendants take offense to attacks on their professional or entrepre-
neurial pride and therefore are inclined to resist settlement more
strongly than, say, the insured motorist-defendant.²⁴

23. *Couch v. Central Maloney Transformer Corp.*, No. 75871 (King
County, Washington Superior Court, Apr. 24, 1974) (transcript on file
at the law offices of Philip H. Corby and Associates, 33 N. Dearborn
St., Chicago, Ill. 60602), noted in Corboy, *The Expanding Universe of*
Jeffrey O'Connell: Backing into a "Brave New World" 1976 U. ILL. L.F.
100 n.63.

24. J. O'CONNELL, *supra* note 17, at 17-18, 29.

Extrapolating (once again, conservatively) from both the
auto liability and medical malpractice figures, we get the follow-
ing figures:

Hypothesis of Where the Bodily Injury Product Liability Insurance Premium Dollar Goes		
General Overhead ²⁵		30 cents
Claims Administration Cost ²⁶		
Defense Side	18.5 cents	
Claimants' Side	<u>14 cents</u>	
Total Claims Administration Cost		<u>32.5 cents</u>
Total Overhead ²⁷		62.5 cents
Net Amount Paid to Victims Above Losses (in theory for Pain and Suffering) ²⁸	16 cents	
Paid to Compensate for Losses Also Compensated from Other Sources (including income tax saving) ²⁹	7.5 cents	
Paid to Compensate for Losses Not Compensated from Other Sources ³⁰	<u>14 cents</u>	
Net Paid to Victims Altogether ³¹		<u>37.5 cents</u>
		<u>100 cents</u>

25. I have used the medical malpractice figure on the ground that
such coverage, in its complexity and marketing, more closely resembles
that for malpractice liability than for auto liability.

26. I have assumed that the amounts spent for both defendants' and
claimants' legal expenses for products liability lie halfway between the
amounts spent on auto liability and medical malpractice claims. There-
fore, for the defense side 24 cents (medical malpractice) minus 13 cents
(auto liability) = 11; $11 \div 2 = 5.5$; $24 - 5.5 = 18.5$. On the claimants'
side, 18 cents minus 10 cents = 8 cents; $8 \div 2 = 4$; $18 - 4 = 14$.

27. Cf. note 18 *supra*.

28. As with medical malpractice, see note 19 *supra*, I have used
the Keeton formula to determine the amount spent to compensate for
pain and suffering: $(37.5 + 14 = 51.5 \div 2.4 = 21.5 + 14 = 35.5$;
 $51.5 - 35.5 = 16)$. See note 10 *supra*.

29. Here also I have used the Keeton formula explained in note 11
supra: $[(11 \text{ percent of } 51.5 \text{ cents}) = 5.7 \text{ cents}] + [(\frac{1}{2} \times 5.87 \text{ cents}) =$
 $1.89 \text{ cents to account for income tax savings}] = \text{approximately } 7.5 \text{ cents.}$
As with the earlier calculation, this is probably a very conservative esti-
mate. In fact, since so many product liability cases are also covered by
workers' compensation (with its unlimited medical benefits and sub-
stantial wage loss payments), the figure is probably even more con-
servative for products liability than for medical malpractice or auto
liability.

30. "After accounting for other purposes to which all the rest of
the premium dollar is committed, we find that only [14] cents go to
compensating for losses not otherwise compensated." Notes 12 and 21
supra.

31. Cf. note 18 *supra*.

Here, too, for all the expense and agony caused by the tort system we find it returns only 37.5 cents of the premium dollar to injured victims and, of that, only 14 cents reimburses victims of malfunctioning products for dollar losses not otherwise compensated.

I. HOW VALUABLE IS COMMON-LAW TORT LIABILITY?

Perhaps the most distressing aspect of the common law's system of personal injury insurance is that it compounds the problem by, in effect, requiring everyone to buy such largely worthless but horrendously expensive insurance.

Suppose, instead, that one were given the choice when one buys a power tool or undergoes an operation:

"Do you wish to buy tort liability insurance?"

"What's that?"

Any decent truth-in-insurance bill would then require the buyer to be told:

Your chances of being paid any benefits under the insurance are extremely small. Most people who are injured (by this procedure/by this product) are not paid from this insurance. In point of fact about (75/85)³² percent of the premium is used up by insurance overhead and legal expenses on both sides. And even if you are one of the rare ones who ever collects under this insurance, you would only be paid after about two years or more has elapsed after you had put in your claim. Also there is a strong chance that before you are paid you would have to appear in court (at least in a lawyer's office for pretrial proceedings under oath) not only to tell your story but to be sharply cross-examined by the insurance company's lawyer who, frankly, will often be out to cast doubt on your credibility and reliability. That can be a very humiliating experience. In addition even if you go to trial and win, it is very likely that there will be an appeal—or several appeals—which can take from an additional year or two before you would be paid, assuming you win the appeal.

Of course, we lawyers have seen to it that no one is forced to explain the dubious value of insurance covering tort liability. And, in a measure, there is no point in telling the consumer/patient of the relatively worthless nature of such insurance inasmuch as he is not allowed to reject it even if he discovers its worthlessness. On the contrary, because tort liability is imposed by common law, tort liability insurance must be bought by everyone who buys a product or undergoes medical treatment since any reputable manufacturer, retailer, or health care provider will

buy such insurance and add the cost of it to the overall cost of the product or service. The cases are replete with pronouncements from judges that any manufacturer, retailer, or health care provider who tries to dispense with tort liability in the sale of a product or service will not be allowed to do so.³³

A. PATCHWORK REFORM

What to do about all of this? One could in essence maintain the present system for lack of any other alternative. Such maintenance could, it is true, probably be accompanied by some window dressing changes. But none of those so far suggested would likely change things except in the slightest way—and possibly for the worse.

One reform often advanced as a solution is *arbitration* of medical malpractice claims. As a practical matter, however, the problem of the present system is not *who* is hearing these claims but *what* is being heard. Replacing a judge or juries with lawyers and other panelists dressed in business suits will help only marginally at best. As two insurance executives have put it: "Arbitration cases appear to require the same preparation and negotiating processes of other claims and may thereby increase the actual preparation cost of claims by the addition of arbitration fees to the other legal fees."³⁴

A second proposal frequently offered is the so-called "*claims made*" system. In the words of Dean Richard Rosett of the Graduate School of Business of the University of Chicago, however:

A change from policies that insure the physician forever against claims arising from treatment given this year to a [claims made] policy that insures him against claims that arise this year from treatments ever given is not fundamental. It eliminates—or at least reduces—the forecasting problems unpredictable inflation poses, but in a reasonably predictable economy, steady-state cost of insurance will be the same either way. Under the present system, for example, the insurance company charges the physician now for claims that will arise 15 years from now and that premium is part of the physician's expense and is reflected in what he charges for treatment. Under the suggested change he would know that insurance would be needed 15 years hence to protect him against claims arising from treatment given now. A proper counting of his expense now will include provision for that future premium. It does not matter whether the insurance company must set something aside

33. See, e.g., *Tunkl v. Regents of University of California*, 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963); *Hunter v. American Rentals, Inc.*, 189 Kan. 615, 371 P.2d 131 (1962).

34. Greenfield & Hoffman, *No-Fault or Arbitration Proposed as Solutions to Malpractice Woes*, BUS. INS., Feb. 4, 1974, at 33.

32. See text accompanying notes 16-18, 25-27 *supra*.

now to meet future claims or whether he must set something aside to buy insurance in the future. The cost should be the same.³⁵

Thus, in addition to generating no cost savings, by requiring a doctor to forecast his future cost to cover his costs after he retires (or the costs to his estate after he dies), a claims made policy shifts the most unpredictable risks to those far less able to predict and prepare for those risks than insurance companies. What this probably would mean as a practical matter is that the typical doctor, far from setting aside reserves this year to pay for future claims arising from this year's services, would be paying in future years (and then forcing his patients to pay) for the liability arising from his services rendered this year—a sort of deficit financing, if you will, with the greater problems this would present to doctors and their families on retirement or death.

A third suggestion is that limits be placed on *contingent fees* that can be charged by plaintiff's lawyers. Curiously enough, nothing is concomitantly said about curbing defense lawyers' fees. Since the problem of medical malpractice stems from litigation between two sides, why is an equitable solution to limit what one side can spend on litigation while ignoring the other? As long as we keep a system—like the fault system—that depends on litigation, how much sense does it make to limit by statute either side's (or both sides') access to litigation?

B. ABANDONMENT OF TORT LIABILITY

An alternative to maintaining, with minor adjustments, the present tort liability system for medical malpractice and products liability litigation would simply be to abolish the tort liability system as it applies to such areas and let anyone who so desires buy his own coverage for his own loss. At first blush, the solution seems too extreme to be seriously proffered or considered. But weigh the following exchange between Congressman Bob Eckhardt, Democrat from Texas, and former Dean Erwin N. Griswold of the Harvard Law School, certainly a conservative, careful legal scholar, concerning a no-fault law that would similarly simply abolish tort liability and leave anyone who so desires free to buy his own coverage for his own loss:

MR. ECKHARDT. . . . In H.R. 10 [a federal no-fault automobile insurance bill], there is a provision [eliminating] tort liability with respect to property losses altogether. Then H.R. 10 provides for optional coverage under no-fault [for] property

35. Remarks of Richard Rosett, Conference, *supra* note 19.

damage. So the result would be that an individual would either have to elect to accept . . . no-fault liability by buying no-fault insurance, which must be offered to him but which is not mandatory, [or not] . . . be covered at all [since] H.R. 10 broadly limits tort liability in any event.

[I]t seems to me that when the statute merely gives a person the opportunity to elect coverage by insurance, thus not establishing a complete system of reparation, and at the same time broadly wipes out tort liability, there may be a serious constitutional question.

MR. GRISWOLD. . . . I don't, myself, find that question very difficult. I would think that Congress, under the commerce power, if it chooses to do so, for whatever reasons that appear to warrant it, could entirely eliminate property damage liability. That is, in effect, what H.R. 10 does.

If that were done, then persons who own automobiles or other property may well want to consider the question of whether they should obtain insurance for that. As I understand it, that is the effect of H.R. 10.

MR. ECKHARDT. Well, Dean, suppose we did not pass any no-fault statute, but the United States Congress decided that all tort liability was too burdensome and too costly and simply provided that tort liability for . . . property damages . . . shall henceforward be wiped out in the Union[;] could you do that constitutionally[?]

MR. GRISWOLD. Congressman Eckhardt, in my opinion, Congress could do that if it chooses to do so.³⁶

Of course, Dean Griswold was discussing the abolition of tort liability for property damage. One can make the case, however, that if a legislature could abolish tort liability for property damage, a fortiori, it could do the same for tort liability for personal injury arising out of the use of manufactured products or medical treatment. It is not without significance that a lower Michigan court has found the Michigan no-fault auto law abolishing tort liability for property damage invalid on the ground that the old common-law tort system, coupled with the availability of collision insurance, had been working sufficiently well that such abolition of tort liability was unconstitutional.³⁷ Perhaps, then,

36. *Hearings on H. Con. Res. 116 Before the Subcomm. on Commerce and Finance of the House Comm. on Interstate and Foreign Commerce*, 93d Cong., 2d Sess., ser. 115, pt. 2, at 1207-08 (1975).

37. *Shavers v. Kelley*, No. 73-248-068-C2 (Mich. Cir. Ct., May 30, 1974), CCH Auto. Ins. Cas. ¶ 8308 (1974), in J. O'CONNELL & R. HENDERSON, *TORT LAW, NO-FAULT AND BEYOND: TEACHING MATERIALS ON COMPENSATION FOR ACCIDENTS AND AILMENTS IN MODERN SOCIETY* 462 (1975). The court viewed the issue as one of due process, concluding that the abolition unreasonably deprived property owners of their common-law right to sue for damages. The intermediate appellate court opinion, affirming the trial court on these points, has not yet been published. The

a tort system working as poorly as does that for product liability and medical malpractice should be viewed as more subject to such legislative abolition.

Thus it is that several states have recently put "caps" or limits on what can be obtained in medical malpractice actions. For example, in California, the limit is \$250,000 (for pain and suffering); in Idaho, \$150,000; in Indiana, \$500,000; in Illinois \$500,000; in Ohio, \$200,000 (for pain and suffering).³⁸ Two trial courts—one in Idaho³⁹ and the other in Illinois⁴⁰—have recently ruled these statutes unconstitutional. Admittedly, therefore, there is grave doubt about how courts will view a simple abolition of the tort remedy for medical malpractice or products liability, given doubts about the lesser step of limiting the amount of tort liability. In a measure, however, the courts' willingness to strike down such limitations as unconstitutional, while never questioning the constitutionality of limits of, say, \$5000, \$10,000, or \$20,000 uniformly prevailing in the United States for tort liability insurance for auto accidents, demonstrates how totally unrealistic are the courts in their attitudes toward insurance and torts. Limitations on the amount of insurance that motorists must carry have a pervasively devastating effect on how much is in fact available for accidents involving negligence in that jurisdiction (especially since a claimant may be unable to discover the limits of insurance carried by any motorist).⁴¹ A limit of \$500,000 on medical malpractice verdicts, on the other hand, in a jurisdiction like Indiana will probably affect no claimant for years, if ever, and indeed, will rarely affect any claimant in any jurisdiction. Yet the latter is quickly struck down and the former goes unquestioned for generations!⁴² Constitutions may no longer be color-blind, but their eyesight still seems woefully weak.

matter is yet to be decided by the Michigan supreme court. See also *Kluger v. White*, 281 So. 2d 1 (Fla. 1973).

38. For a chart (with current supplements) of such laws, along with other laws (such as those altering statutes of limitations or eliminating *ad damnum* clauses), see AMERICAN INSURANCE ASS'N, COMPARATIVE ANALYSIS OF LEGISLATIVE CHANGES RELATED TO MEDICAL MALPRACTICE chart II (1975) (available from American Insurance Association, 85 John Street, New York, N.Y. 10038).

39. *Jones v. State Bd. of Med.*, Civ. No. 55527 (Idaho Dist. Ct., Sept. 23, 1975), in 18 ASS'N TRIAL L. AM. NEWS LETTER 365 (1975).

40. For a newspaper report on the Illinois case, see Associated Press Release, Nov. 28, 1975.

41. See *Mecke v. Bahr*, 177 Neb. 584, 129 N.W.2d 573 (1964); *Hardware Mut. Cas. Co. v. Hopkins*, 105 N.H. 231, 196 A.2d 66 (1963); Annot., 13 A.L.R.3d 817 (1967).

42. I am indebted to Professor Robert E. Keeton for suggesting this difference in attitudes toward insurance limits.

Thus, given the relatively worthless nature of tort liability insurance as an insurance mechanism, one forced to choose between retaining the present system and simply abolishing it, (at least as applied to personal injury for products liability and medical malpractice), would probably more sensibly abolish it than retain it. In addition to all the money spent on overhead costs and legal fees,⁴³ one must take account of the substantial amounts of money and energy spent by the medical profession trying to avoid tort liability in a manner that, far from helping the patient, hurts him. Dr. James Potchen, head of the Michigan State University Radiology Department and chairman of the Committee on Radiology of the American Medical Association, tells us that around one billion dollars a year is being spent nationally for largely unnecessary X-rays that physicians now order to protect themselves from potential malpractice claims:

Potchen . . . said that in many cases doctors ordering the X-rays know that they will be of little medical value in making a diagnosis.

However, Dr. Potchen . . . said doctors are "beginning to feel that if they don't perform these tests they'll get sued for malpractice."

He cited as an example a skull X-ray which is almost always ordered for youngsters when they are brought to emergency rooms for head injuries even though studies have shown the X-rays are all but useless.

Even though this is widely known, Dr. Potchen said, the skull X-ray has become standardized in the law as a medical practice and therefore doctors are afraid to do away with it.

Overall, about 11 per cent of all X-rays given patients are a result of so-called defensive medicine—medicine that may itself have no value other than to forestall the possible lawsuit, he

He estimated that the cost to consumers could be between \$200 million and \$1 billion yearly, with the higher figure more likely.⁴⁴

Not only are the services superfluous, but—given the dangers of exposure to radiation—they lead to needlessly added injuries!

Admittedly, however, many will be concerned about the occasional claimant who, after tort liability for medical malpractice and products liability has been abolished, has no major medical or other catastrophic insurance coverage but who nonetheless would have had a valid tort claim against a health care provider or product manufacturer. Perhaps the only answer to this di-

43. See notes 16-18 *supra* and accompanying text.

44. *Baltimore Sun*, Nov. 22, 1975, § B, at 1-2, cols. 4-5. See also Remarks of James Potchen, Conference, *supra* note 19.

lemma is to keep in mind how few and fortuitous are such claims; and if, as is likely, it is the poor who are most likely to be without their own coverage against catastrophe, keep in mind, too, that it is the poor who seem least likely to pursue a tort remedy and who certainly derive the least benefit from the tort system. In the words of H. Laurence Ross, a sociologist who has studied the tort liability system:

[T]ort law in action may . . . be termed inequitable. It is responsive to a wide variety of influences that are not defined as legitimate by common standards of equity. The interviews and observations I conducted convinced me that the negotiated settlement rewards the sophisticated claimant and penalizes the inexperienced, the naive, the simple, and the indifferent. Translating these terms into social statuses, I believe that the settlement produces relatively more for the affluent, the educated, the white, and the city-dweller. It penalizes the poor, the uneducated, the Negro and the countryman.⁴⁵

Others will be concerned about the effect on deterrence if tort liability is simply abolished for products liability and medical malpractice. This worry, too, probably fails to stand up. Despite exhaustive attempts to identify them, little, if any, deterrent effects of the present product liability system could be discovered by the National Commission on Product Safety.⁴⁶ And while medical malpractice liability may lead to defensive and even unsafe medicine, no one seems able to point to any evidence of the present system acting as a deterrent and thereby leading

45. H. ROSS, *SETTLED OUT OF COURT: THE SOCIAL PROCESS OF INSURANCE CLAIMS ADJUSTMENTS* 241-42 (1970). Consider the following table:

Table 3.25. Relationship of Family Income to Serious Injury and Fatality [Automobile] Cases, to Retention of Counsel, and to Reparations Received.

Family income (1)	Percent retaining counsel (2)	Ratio of net reparations to economic loss (3)
Under \$5,000	30.0	0.38
\$5,000-9,999	36.7	0.52
\$10,000 and over	41.9	0.61
Total	35.0	0.49

1 U.S. DEP'T OF TRANSPORTATION, *ECONOMIC CONSEQUENCES OF AUTOMOBILE ACCIDENT INJURIES* 54 (1970) (Automobile Insurance and Compensation Study). The reparations received figures include both tort and nontort sources, with "[a]bout one-third" of recovery [for bodily injury and property damage] from tort." *Id.* at 2.

46. See 9A NATIONAL COMM'N ON PRODUCT SAFETY, *HEARINGS* 311-18 (1970) (testimony of Herbert Denenberg); Whitford, *Products Liability*, in 3 *SUPPLEMENTAL STUDIES, PRODUCT SAFETY LAW AND ADMINISTRATION: FEDERAL, STATE, LOCAL AND COMMON LAW* 221, 228-29 (National Commission on Product Safety 1970). For a summary of the preceding commentary, see J. O'Connell, *supra* note 17, at 22-24.

to safer medicine. Even Guido Calabresi, perhaps the leading advocate of imaginative use of the tort and insurance systems to achieve deterrence, recently concluded that there is no basis for believing that the present tort liability system promotes quality medical care.⁴⁷ In short, when a system is as highly wasteful and arbitrary as is the present tort system, the burden rests heavily on those who would maintain it to demonstrate its effectiveness as a deterrent, not on those who would abolish it to prove that such abolition would have no unsalutary effect on deterrence. That is a burden that defenders of the status quo manifestly have been unable to meet, except by intuition and anecdote.⁴⁸

Even granted the failings of tort liability, however, one must admit that for political, practical, and constitutional reasons the revolutionary solution of simply abolishing it without any substitute should be avoided, if possible. Bear in mind it has been assumed by many courts—state and federal (arguably erroneously in light of Dean Griswold's testimony, for example)⁴⁹—that a substituted remedy, such as mandated no-fault benefits, must be provided if common-law tort rights are to be abolished.⁵⁰ There are similar political, practical, and constitutional obstacles to a proposal advanced by Professor Richard Epstein of the University of Chicago, urging much greater tolerance by the courts for contractual arrangements to abandon or limit tort liability. Under Professor Epstein's proposal, health care providers would be allowed to impose all or most of the risks of medical procedures on patients under the doctrine of assumption of risk; they would be allowed, for example, to limit their liability to, say, gross negligence, or to put tight limits on the dollar amount of their tort liability. "Private agreements of free individuals," he

47. Remark of Guido Calabresi, Conference, *supra* note 19.

48. See, e.g., Cartwright, *Therapeutic Effect of Tort Law*, 18 *ASS'N TRIAL L. AM. NEWS LETTER* 2 (1975).

49. See text accompanying note 36 *supra*.

50. See, e.g., *Pinnick v. Cleary*, 360 Mass. 1, 21-23, 271 N.E.2d 592, 605-06 (1971). Although the requirement that an adequate and reasonable substitute for the abrogated tort recovery must be provided was enunciated by the Supreme Court in *New York Cent. R.R. v. White*, 243 U.S. 188, 201 (1917), "it is doubtful that the Court would find the test necessary today. Nonetheless, the dictum has given the reasonable substitute test considerable impetus in state courts. All cases examining the constitutionality of no-fault legislation on due process grounds have applied this test." Note, *Due Process Problems of Property Damage No-Fault Insurance*, 8 U. MICH. J.L. REFORM 646, 649 & n.25 (1975). But see *Montgomery v. Daniels*, 81 Misc. 2d 373, 367 N.Y.S.2d 419 (Sup. Ct. 1975).

argues, "promise the best solution to the problems of medical malpractice in a world in which no perfect solution is possible."⁵¹

If then, there is little sense in retaining with minor adjustments the tort system of compensation for personal injuries arising from malfunctioning products or medical services, and if it is not practical to abolish that system, what can be done?

II. ELECTIVE NO-FAULT REFORM FOR MEDICAL MALPRACTICE AND PRODUCTS LIABILITY

A. APPLICABILITY OF WORKERS' COMPENSATION AND AUTOMOBILE LIABILITY REFORMS

The basic difficulty with present medical malpractice and products liability insurance is fundamentally a replication of the difficulties that plagued industrial accident insurance before workers' compensation and automobile liability insurance before no-fault auto insurance. In each case, traditional tort liability demanded (as it still does) answers to the intractable questions of (1) who is at fault (or whose product is defective) in causing the accident, and (2) what is the monetary value of something essentially untranslatable into dollars and cents—pain and suffering.

The solution for industrial and auto accidents has long been seen as relatively simple: Structure the insurance system so that it pays (1) for losses regardless of fault and (2) only for out-of-pocket losses (essentially, medical expenses and wage loss, which are readily reducible to dollars and cents, and not pain and suffering, which are not).⁵² Thereby, in one simple stroke these two questions that plague the system are eliminated, with payment for more claims financed by the savings from simplifying the insured event (by not having to pay either (1) for determination of fault and the monetary value of pain and suffering

51. In a way, the proposals examined in this Article can be arranged in the following spectrum:

(1) Legislative abolition or limitation of tort liability.
(2) Epstein's proposal for contractual abolition or limitation of tort liability.

(3) My proposal for elective no-fault insurance as a substitute for tort liability, relatively loosely supervised by the courts and insurance commissioners. See notes 55-56 *infra* and accompanying text.

(4) Professor Clark Havighurst's proposal for no-fault insurance as a substitute for tort liability, pursuant to tightly structured governmentally mandated standards to protect patients. See notes 57-58, 126 *infra* and accompanying text.

52. See J. O'CONNELL, *supra* note 17, chs. 2, 4, 10.

or (2) for pain and suffering itself). Applying this solution to medical malpractice insurance is somewhat more complex because it is more difficult to define the no-fault insured event for medical maloccurrences than for industrial or auto accidents. Under a no-fault system the employer pays an employee-victim injured in an accident "arising out of or in the course of employment,"⁵³ regardless of anyone's fault; the motorist pays any motorist victim injured in an accident "arising out of the ownership, maintenance or use of a motor vehicle,"⁵⁴ regardless of anyone's fault. But it is not feasible simply to force the health care provider similarly to pay any patient "injured in the course of medical treatment," regardless of anyone's fault. The problem is how to define whether the patient was injured in the course of medical treatment, as opposed to suffering injury due to his own prior condition that sent him to a health care provider in the first place (his so-called presenting complaint). Assume that a patient goes to a doctor with a thyroid condition: the doctor treats him (perhaps by an operation)—the patient gets worse. A health care provider could not realistically be asked to pay for *any* worsened condition after treatment; but determining which worsened conditions are due to the doctor's intervention and which to the patient's presenting complaint would be as intractable as determining the criteria for payment under the present negligence criterion. As indicated in the report of the [HEW] Secretary's Commission on Medical Malpractice:

At the outset, the Commission members wrestled with the virtually impossible task of defining the "compensable event" which results from a "medical injury". Every effort to date on this subject has met with the same lack of success. Although we have a reasonable understanding of the terms "work injury" and "automobile accident injury", we have no real mental picture that covers the field of medical injuries. Does a "medical injury" occur when a physician fails to heal his patient or fails to heal him quickly, in the face of the joint hopes by the physician and the patient that an early recovery can be obtained? Illness and accidental injury become inextricably intertwined when fault issues are ignored.⁵⁵

To be sure, other similar problems attend defining the compensable event for products liability. Ladder manufacturers

53. This language appears in a typical workers' compensation statute. 1 A. LARSON, WORKMEN'S COMPENSATION LAW § 6.00 *et seq.* (1972).

54. R. KEETON & J. O'CONNELL, BASIC PROTECTION FOR THE TRAFFIC VICTIM 303 (1965).

55. SECRETARY'S COMM'N ON MEDICAL MALPRACTICE, MEDICAL MALPRACTICE: REPORT 131, 132-33 (U.S. Dep't of Health, Education, and Welfare Pub. No. (OS) 73-88, 1973) (statement of Richard M. Markus).

would undoubtedly find it overwhelming to be asked to pay for all injuries resulting from falls from ladders regardless of the users' negligence or a lack of any defect in the ladder; similarly, stove manufacturers would find absurd a demand for compensation for all injuries resulting from burns from stoves.

While for this reason no-fault insurance cannot be applied across the board to all adverse results of medical treatment and manufacturing (the way in which it can be applied across the board to all industrial or auto accidents), this is not to say that it could not be applied to many such adverse effects of both. Health care providers and manufacturers can probably identify hundreds of maloccurrences that can be readily isolated and for which it would be feasible to apply the no-fault bargain: prompt payment for out-of-pocket losses in return for waiver of the right to sue based on alleged fault for possible, but by no means certain, payment for out-of-pocket loss *plus* pain and suffering. For such identifiable injuries, the savings realized from eliminating payment for (1) insurance overhead and legal fees and (2) pain and suffering could be used to finance prompt and expeditious payment regardless of fault. Moreover, the bargain should include no payment under no-fault insurance that would duplicate payment already made from other sources, such as Blue Cross and employer-paid sick leave. The advantages to insureds and their insurers thus would be (1) potentially lower premiums; (2) greater certainty of the extent of potential liability, in that liability would no longer turn on the vicissitudes of unpredictable common-law liability but rather on defined, predictable compensable events; (3) avoidance of stigmatization or paying a windfall gain solely because of fortuitous injury; (4) use of insurance dollars to pay genuine losses, as opposed to devoting large amounts to payment of legal fees and company overhead; and (5) good will arising from prompt payment to customers/patients versus ill will stemming from resistance to claims for injuries attributable to the use of products or services.

As examples of the way elective no-fault liability would work, a manufacturer of a power tool could elect to take out a no-fault policy to pay for out-of-pocket losses—medical expense and wage loss—whenever an amputation results from use of the power tool. Just as no-fault auto insurance pays without regard to anyone's negligence, so payment would be made in this instance without regard to the victim's possible carelessness or the lack of any defect in the tool. Similarly, a doctor who knows the inevitable risks of, say, cardiac arrest occurring in even nor-

mal patients in the course of a given surgical procedure could agree to pay for out-of-pocket losses stemming from such an adverse result of an operation regardless of anyone's fault. In both cases, the prior agreement to make such no-fault payments would wipe out any claim based on fault, just as happens under no-fault auto insurance.⁵⁶

B. DEFINING COMPENSABLE EVENTS

In a 1974 article, Clark Havighurst and Lawrence Tancredi listed some examples of likely adverse results arising from surgical treatment that might be selected as compensable events under a no-fault plan: They included, for example, postoperative infections, thrombophlebitis and embolism, catheter infections, allergic and toxic reactions to antibiotic and other drugs, blood transfusion reactions, foreign bodies, growth deformity secondary to bone injury, Volkmann's contracture and other consequences from casts, and failure of healing of fractures (including malunion, nonunion, and delayed union).⁵⁷ This list was compiled

56. Note, too, the flexibility possible under elective no-fault liability. For example, electors might be allowed to experiment with no-fault liability for products produced during a given period. In addition, the elector might be allowed to limit the amount of no-fault benefits for which he is liable to multiples of \$10,000, assuming the enabling legislation authorized a corresponding tort exemption measured against both out-of-pocket loss and pain and suffering. For example, if no-fault benefits of \$20,000 are provided, no tort suit could be maintained for out-of-pocket loss less than \$20,000, nor for pain and suffering less than \$20,000. See J. O'CONNELL, *supra* note 17, at 104-06. For more extensive discussions of elective no-fault insurance generally, see J. O'CONNELL, *supra* note 17. For a precis of the book, see O'Connell, *Elective No-Fault Liability Insurance for All Kinds of Accidents: A Proposal*, 1973 INS. L.J. 495; for a draft statute, with commentary, implementing the proposal, see O'Connell, *An Elective No-Fault Liability Statute*, 1975 INS. L.J. 261; for a discussion of implementing the proposal by contract, with or without an enabling statute, see O'Connell, *Elective No-Fault Liability by Contract—With or Without an Enabling Statute*, 1975 U. ILL. L.F. 59, printed in slightly different form in O'Connell, *No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others*, 1975 INS. L.J. 531.

For other articles on the subject by the author (set out in approximate chronological order of appearance), see O'Connell, *Elective No-Fault Insurance for Many Kinds of Accidents: A Proposal and an "Economic" Analysis*, 42 TENN. L. REV. 145 (1974); O'Connell, *It's Time for No-Fault for All Kinds of Injuries*, 60 A.B.A.J. 1070 (1974); O'Connell, *The Frustrations of Insurance*, 43 U. CIN. L. REV. 847 (1974); O'Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21 (1975).

57. Havighurst & Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 1974 INS. L.J. 69, 76.

after informal consultation with a group of orthopedists. Other specialties could compile similar lists—and all would be much more extensive than the exemplars listed above.

Indeed, Professor Havighurst has himself more recently compiled a more technically ambitious list of adverse results of general surgery and anesthesiology that might be candidates for compensable events under no-fault insurance. He indicated that the list for general surgery "was compiled by reviewing the most common surgical complications and considering them in light of the following questions:"

1. To what extent is the incidence of this complication related to the technical skill, judgment, or attentiveness of the surgeon?
2. Is this complication a clinically distinct entity? Can its existence be readily substantiated?
3. How early in the postoperative period is this complication detectable?
4. How costly are the sequelae of this complication?
5. Would an incentive to minimize the occurrence of this complication bias the choice of treatment in unfortunate ways?⁵⁸

It is clear that Professor Havighurst focuses in item 1 on compensating for adverse results most likely to have been caused by physician error—to adverse results relatively avoidable, in the aggregate, by a health care provider. But items 2 through 5 do not necessarily thus limit compensable events. Even unavoidable events may meet the criteria of items 2 through 5 and might thus be included as compensable events under elective no-fault insurance. In other words, both avoidable and unavoidable re-

58. Remarks of Clark Havighurst, Conference, *supra* note 19, in Havighurst, "Medical Adversity Insurance"—Has Its Time Come?, 1975 DUKE L.J. 1233, 1256 n. 71 [hereinafter cited as Havighurst].

The suggested compensable events in the original [Havighurst-Tancredi no-fault] . . . proposal [see notes 57-58 *supra* and accompanying text] were merely illustrative of possibilities. The only set of events carefully considered at that time was blood transfusion reactions [. . . which were deemed appropriate for compensation under a hospital-purchased [no-fault] . . . policy even in the case of certain hepatitis reactions which were neither clearly avoidable nor clearly caused by the transfusion]. Although the [Havighurst-Tancredi] . . . proposal contemplated extensive professional investigation of numerous events which were candidates for the list, no professional groups have taken up the project, and it has not been possible to involve physicians extensively in subsequent investigations. The results of further specification efforts are therefore still highly tentative.

Our recent efforts toward compiling a definitive list of compensable events have concentrated on anesthesiology and general surgery. *Id.*, 1975 DUKE L.J. at 1256.

sults might be subject to no-fault compensation.⁵⁹ Indeed, to otherwise limit no-fault compensation (with its lower pay-out) would be to undercut the bargain of no-fault insurance: less payment to more people in return for abandoning the fault criterion. After all, we did not institute no-fault insurance for industrial or auto accidents only for those injuries most likely avoidable through the exercise of due care by the employer or motorist. Nor need we do so for medical maloccurrences. The bargain, then, of no-fault insurance is that the insurer agrees to pay for both avoidable and unavoidable injuries instead of only for avoidable injuries; the savings from (1) not having to distinguish between the two and (2) not paying as much per case (by, for example, eliminating payment for pain and suffering) serve to finance payment for unavoidable as well as avoidable injuries.

What follows, then, is Professor Havighurst's more extensive list of compensable events. The only caveat one must keep in mind in perusing it is that although it is limited to events that, in the aggregate, are relatively avoidable, an ultimate list would not have to be thus limited. That aside, the list illustrates the flavor of what at least some items on such a list would be.

1. General Surgery⁶⁰

General

1. Foreign bodies acquired intraoperatively
2. Burns acquired intraoperatively
3. Injury resulting from severance of an indwelling plastic catheter⁶¹
4. Neurological deficit resulting from intramuscular injection
5. Injury resulting from mistaken identity
6. Injury resulting from inadvertent intravascular injection of local anesthetic

59. See *id.*, 1975 DUKE L.J. at 1273-77.

60. List from *Id.* n. 71, 1975 DUKE L.J. at 1257-60.

The primary source consulted [for the general surgery list] was C. F. Ariz & J. B. Hardy, eds., *MANAGEMENT OF SURGICAL COMPLICATIONS* (3d ed., 1975).

Id.

61. The relative avoidability of this complication is illustrated by the striking diminution of its incidence as practitioners have become more aware of the technical mistake which creates the difficulty. "Such occurrences can be minimized by careful attention to the management of the catheter and the catheter site as well as the utilization of radiopaque catheters and the careful measurement of the length of the catheter before insertion and after removal." Moncrief, *Complications of Parenteral Fluid Therapy*, in *MANAGEMENT OF SURGICAL COMPLICATIONS*, *supra* note [60], at 68, 75.

Id. n.72, 1975 DUKE L.J. at 1257 n.72.

7. Postoperative wound dehiscence in noncarcinoma-tous patient under age forty-five⁶²

8. Tetanus infection subsequent to treatment of wound

9. Severe reaction to administration of tetanus anti-toxin [On irreversible neurological damage or death fol-lowing intraoperative cardiac arrest or spinal anesthesia, see *Anesthesiology* below.]

Procedure-specific

Parathyroid surgery or thyroidectomy

10. Permanent recurrent laryngeal nerve damage⁶³

11. Postoperative hypoparathyroidism exceeding two weeks' duration⁶⁴

Thyroidectomy or tonsillectomy

12. Death in the immediate postoperative period⁶⁵

Cholecystectomy

62. "Studies have shown that a few surgeons will have many wounds with dehiscence and others will have extremely few. Surgical technique is important." Hunt, *Wound Complication*, in *MANAGEMENT OF SURGICAL COMPLICATIONS*, *supra* note [60], at 21, 25. A number of technical errors are known to increase the likelihood of dehiscence. Other variables, such as age and condition of the patient and the type of operation performed, also affect the incidence of this complication. Restricting compensa-bility to patients under forty-five would help to screen out the effects of the principal variables that lie beyond the surgeon's control.

Id. n.73, 1975 DUKE L.J. at 1257 n.73.

63. "In the hands of competent surgeons experienced in expos-ing the recurrent laryngeal nerves, permanent nerve injury oc-curs in less than 1 per cent of cases." Hardy, *Complications of Thyroid and Parathyroid Surgery*, in *MANAGEMENT OF SURGICAL COMPLICATIONS*, *supra* note [60], at 291, 300. Technical skill and attentiveness are probably the key variables determining the in-cidence of the complication. Permanent abnormal phonation and serious respiratory obstruction are the sequelae involved.

Id. n.74, 1975 DUKE L.J. at 1257-58 n.74.

64. If all four parathyroid glands are inadvertently removed during surgery, hypocalcemic tetany will result, and lifelong drug therapy will be necessary to compensate for the activity of the removed glands. "In a review of 600 cases of thyroid surgery . . . 17 (2.8 per cent) cases of transient postoperative hypocalcemic tetany and nine (1.5 per cent) cases of permanent hypoparathyroidism [were found]." [Hardy, *supra* note 63, at 300.] Preserving the parathyroids during total thyroidectomies for thyroid malignancy is a difficult technical feat; for this rea-son some may suggest that compensability be restricted to pa-tients without thyroid malignancy. Others may argue that pre-cisely because of the difficulty of the procedure, the adverse out-come should be made compensable to deter less technically com-petent surgeons from attempting the operation.

Id. n.75, 1975 DUKE L.J. at 1258 n.75.

65. Careful observations in the postoperative period will pre-vent the fatal consequence of uncontrolled hemorrhage. "The most distressing fact is that, though this hazard and possible se-quelae are well known on all active surgical services, every 3 or 4 years in most general hospitals some patient loses his life from this cause." [Hardy, note 63, at 296.] Designating "death"

13. Injury to common bile duct⁶⁶

Venous stripping

14. Injury from inadvertent stripping of femoral artery

Gastrointestinal procedures

15. Inadvertent gastroileostomy⁶⁷

16. Duodenal stump leakage following gastric resec-tion⁶⁸

17. Instrumental perforation of esophagus⁶⁹

*Gynecology*⁷⁰

18. Perforation of uterus during dilatation and curet-tage

19. Vesicovaginal, ureterovaginal, rectovaginal, or en-terovaginal fistula following gynecological procedure on noncarcinomatous patient

20. Permanent damage to ureter

Prostatectomy

21. Rectal injury

22. Permanent urinary incontinence

Treatment of fracture

23. Nerve paralysis following treatment with straps, splints, or casts⁷¹

as the compensable event rather than "postoperative hemor-rhage" serves three goals: (1) Death is obviously not subject to the definitional problems inherent in a term like "hemor-rhage." (2) Hemorrhage promptly noticed and controlled will not result in injury significant enough to compensate. (3) While the hemorrhage itself is of questionable avoidability, the surgeon can affect the consequences of hemorrhage by careful postopera-tive monitoring.

Id. n.76, 1975 DUKE L.J. 1258 n.76.

66. Careless dissection and blind clamping of bleeding vessels can produce an injury to the common bile duct. "Perhaps less than half of those who sustain a stricture due to operative injury survive for 10 years." Glenn, *Complications Following Opera-tions Upon the Biliary Tract*, in *MANAGEMENT OF SURGICAL COM-PLICATIONS*, *supra* note [60], at 501, 521.

Id. n.77, 1975 DUKE L.J. 1258 n.77.

67. This technical error can be avoided by careful identification of anatomical structures. Its occurrence necessitates reopera-tion.

Id. n.78, 1975 DUKE L.J. 1258 n.78.

68. Duodenal stump leakage is the most serious common com-plication and the main source of mortality in gastric resections. Surgical judgment, technical skill, and postoperative manage-ment are among the variables affecting its incidence.

Id. n.79, 1975 DUKE L.J. 1258 n.79.

69. As the use of instrumentation in the treatment of GI condi-tions has increased, instrumental perforation of the esophagus has emerged as a serious complication. This outcome is rela-tively avoidable.

Id. n.80, 1975 DUKE L.J. 1258 n. 80.

70. These complications are highly avoidable.

Id. n.81, 1975 DUKE L.J. 1259 n.81.

71. "Delayed nerve paralysis is practically always secondary to faulty treatment." Hampton, *Complications of Common Frac-*

24. Function-impairing deformity from malunion of fracture⁷²

Blood transfusion

25. Hemolytic reaction⁷³

26. Bacterial sepsis

27. Serum hepatitis⁷⁴

Nephrectomy

28. Nephrectomy in the absence of a normally functioning contralateral kidney

2. Anesthesiology

In anesthesiology, highly detailed specification of events compensable under [no-fault insurance] . . . such as has been attempted for general surgery, is appropriate for dental and peripheral nerve injuries occurring under anesthesia, and such injuries should be included on the list covered by the anesthesiologist's [no-fault] . . . policy. This piecemeal approach seems inadequate, however, to manage the most serious adverse consequences of anesthesia, namely death or irreversible central nervous system damage occurring in a wide variety of surgical circumstances. . . .

. . . Thus, it is tentatively proposed to make compensable any death or irreversible central nervous system injury under anesthesia occurring in a patient between six months and sixty years of age undergoing any of the following procedures: tonsillectomy, cholecystectomy, hysterectomy, dilatation and curettage, repair of inguinal or hiatal hernia, abortion, sterilization, uterine suspension, venous stripping, thyroidectomy, mastectomy, and gastrectomy.

The task of defining compensable events would be even easier for manufacturers of many products—especially those that tend to inflict simple, traumatic, easily identifiable injuries (such as those from power tools).⁷⁵

tures, in *MANAGEMENT OF SURGICAL COMPLICATIONS*, *supra* note [60], at 699, 708.
Id. n.82, 1975 DUKE L.J. 1259 n.82.

72. "The term 'malunion' really implies union of a fracture in a function-impairing deformity which could have been prevented by more skillful management of the fracture." [Hamp-ton, *supra* note 71, at 709-10.]
Id. n.83, 1975 DUKE L.J. 1259 n.83.

73. See Havighurst & Tancredi, *supra* note 57, at 83.

74. See *id.* at 83-88.

75. On a point beyond the scope of this Article, perhaps the most promising area for elective no-fault liability is owners' and occupiers' liability insurance since smaller, nuisance claims are most likely to arise from injuries occurring in one's house or apartment or business establishment, and the automobile universe has shown that it is where such claims abound that no-fault can be implemented most easily. The reason this is so is that where nuisance claims abound the tort liability system is most wasteful: more is paid for pain and suffering and more is paid for amounts already paid from collateral sources. Both of these excess pay-outs can be eliminated by no-fault insurance. But except for lessors

III. NO-FAULT REFORM AS UNCONSTITUTIONAL OR UNCONSCIONABLE?

No-fault reform for medical and product injuries could be instituted by legislation authorizing substitution of no-fault for traditional tort liability in the case of given injuries,⁷⁶ or it could be instituted without enabling legislation by contract between patients and health care providers, signed before treatment, or between consumers and product manufacturers or retailers, signed before purchase.⁷⁷ Already hospitals contract with patients to resort to arbitration, rather than common-law litigation, to resolve disputes arising from hospital treatment;⁷⁸ no-fault agreements could readily be added to such arbitration contracts. Of course, treatment should not be refused if a patient chooses not to sign a no-fault agreement; nor should such agreements be used for emergency cases, lacking statutory authorization.

To be sure, the argument will be made that such contracts by health care providers, manufacturers, or retailers would be unconstitutional if authorized by legislation,⁷⁹ or unconscionable

dealing with lessees, it will be impossible to impose such liability by contract without enabling legislation since there is no contract in which to incorporate the no-fault agreement. For this reason, though, elective no-fault liability for slips and falls and other injuries *should* be implemented in leases.

76. For draft legislation, see O'Connell, *An Elective No-Fault Liability Statute*, 1975 INS. L.J. 261.

77. For a discussion of the enforceability of such contracts, see O'Connell, *Elective No-Fault Liability by Contract—With or Without an Enabling Statute*, 1975 U. ILL. L.F. 59, printed in slightly different form in O'Connell, *No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others*, 1975 INS. L.J. 53.

78. See note 34 *supra*.

79. For extensive discussion of the constitutionality of such legislation, see O'Connell & Souk, *Is It Constitutional?*, in J. O'CONNELL, *supra* note 17, at 204. Basically, the arguments against the constitutionality of an elective no-fault statute are: (1) due process is denied when common-law rights are thus abrogated, especially at the option of a potential tortfeasor or who substitutes for common-law liability a right to elective no-fault benefits, see *id.* at 205-14; and (2) equal protection is similarly denied because of different treatment of similarly situated accident victims depending once again on private elections, albeit pursuant to statute, by potential tortfeasors. See *id.* at 214-23. Problems may also arise under other constitutional provisions, such as section 54 of the Kentucky Constitution: "The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property." See J. O'Connell, *supra* note 17, at 223-27. For discussion of the particular circumstances under which these problems may arise and the reaction at the trial court level, see notes 38-40 *supra* and accompanying text.

if implemented without enabling legislation.⁸⁰ Since the contracts would probably have a greater chance of being upheld by the courts if instituted under the aegis of legislative authorization, let us examine whether such contracts are unconscionable as a sort of ultimate test of their validity.

In the words of Professor Arthur Leff of the Yale Law School:

What is the function of [the] . . . unconscionability concept . . . ? Briefly, it appears to be one technique for controlling the quality of a transaction when free market control is considered ineffective. It is one method for substituting government regulation for regulation by the parties. The theory of classical contract, paralleling classical economics, was that ordinarily the market mechanism should maximize the welfare of the parties.

. . . [But] no market is perfect. . . . First, there may be monopolistic or oligopolistic powers in that market, either "natural," conspiratorial, or government sanctioned [as in the case of health care providers]. Second, the information necessary for market choice may not be available at reasonable cost with respect to any particular consumer product [or service], especially when a consumer [or patient] has to process information about a vast array of goods [or services]; consumers [or patients] notably lack the expertise that comes from buyer specialization. Third, with respect to consumer "contracts," most of the boiler plate is about contingencies, things that will become important only if the product or deal breaks down [such as the product or service resulting in unexpected personal injury]. It is hard to focus attention on what should not ordinarily happen, or at least to focus as carefully as upon what will happen for sure; i.e., the price and the nature of the goods [or services]. In any event, for these and other reasons, it has been persuasively argued that the market bargaining process will not protect consumers from a large variety of injuries in a huge array of transactions. And if not, some other device to supply that protection may have to be designed. The natural step is to look to government intervention; i.e., to invoke the political "market" instead of the economic one to correct the latter's alleged imperfections.

. . . Even having made that decision, however, one has barely begun the intellectual struggle such an apparent insight should set off. If the government is to intervene, what form should that intervention take? Should it be legislative and administrative, legislative and judicial?⁸¹

So, one can regulate insurance contracts by administrative rulings (through an insurance commissioner), through legislation (witness New York State's rigorously precise statutory delineation

tion of insurance contract terms),⁸² or "by the government via the judicial bureaucracy, on an ad hoc case-by-case basis, essentially unrestrained by legislative or administrative guidance"⁸³ (this, of course, is what courts do when they decide which contract clauses are unconscionable). The premise of the market, however, is that parties to a contract know what is best for them; the premise of governmental intervention, including that by the courts in ruling contracts unconscionable, is that a governmental bureaucracy, whether administrative, legislative, or judicial, rather than the parties, knows what is best for them.

If the courts were to strike down all elective no-fault insurance contracts, they would in effect be saying that the purchase of tort liability insurance is so much in the interest of consumers as a class that they will not be allowed to buy any other form of insurance. But how much sense does it really make to say that tort liability insurance is so valuable to potential accident victims that the market will not be allowed to substitute any other form of insurance? Especially dubious is this position when one takes account of how much the public seems to favor no-fault insurance over fault insurance. The consumer movement seems almost unanimous in its support of no-fault insurance.⁸⁴ Keep in mind that the effect of common-law tort decisions is that all buyers of goods and services must *automatically* buy from manufacturers or service providers insurance policies that cover personal injury caused by faulty or defective products or services. Theoretically, that may well make sense, but also keep in mind that the effect of such an insurance policy is that (1) expenses already paid for are paid all over again and (2) payment is based on fault or defect, with additional amounts being paid for pain and suffering, so that the premium is primarily used for legal expenses and insurance overhead—payment is thus usually nonexistent and, even if made, often nonutilitarian and always long delayed.⁸⁵ Why, then, should providers of goods or services be precluded from experimenting with other forms of insurance, arguably more efficient?

At least under elective no-fault insurance some providers of goods and services would be offering an alternative to the tort system. If it were protested that *all* providers of goods and serv-

80. See note 77 *supra*.

81. Leff, *Unconscionability and the Crowd—Consumers and the*

Common Law Tradition, 31 U. PITT. L. REV. 349, 350-51 (1970).

82. See, e.g., N.Y. INS. LAW §§ 140-74 (McKinney 1966).

83. Leff, *supra* note 81, at 353.

84. See, e.g., J. O'CONNELL, *THE INJURY INDUSTRY AND THE REMEDY OF NO-FAULT INSURANCE* 3-4, 95-96 (1971). But see text accompanying note 157 *infra*.

85. See notes 1-23 *supra* and accompanying text.

ices would elect no-fault and thus leave no choice to the consumer, that is no different from the present system where all are forced into offering (or buying) insurance based on fault. Unanimous election of no-fault would also be an indication that the new system is universally seen by providers of goods and services as better for them (and presumably their customers) than liability based on fault. If it were further protested that providers of goods and services are likely to make a decision inimical to the interests of their customers, at least in this instance, such a criticism seems unfounded in light of the inadequacies of the system based on tort. Should a court insist that such marketing and professional decisions are unconstitutional (if made pursuant to a statute allowing provider choice) or unconscionable (if made without statutory authorization)?

It is interesting to note that when the government intervenes in overruling or displacing market decisions,

[i]t is more active in situations where the failure of self-protection through market mechanisms might have serious and irreversible consequences for the buyer. For instance, where the failure to shop carefully and intelligently might lead to death, sickness or serious bodily injury, the government is more likely to intervene to stipulate at least minimum standards for the goods. . . . [E]g., . . . auto-safety standards. . . . Only rarely does the government intervene, except through information-generating devices like expanded notions of fraud, or through devices like the Prospectus requirement of the Securities Act of 1933 . . . when the danger is merely that the buyer will get less than he might otherwise have received. In other words, government is most likely to intervene directly when the risk to the buyer goes beyond the value of the thing bargained for [; in other words, beyond just being bilked by worthless or shoddy goods such as a power lawn mower that won't start, one stands to lose a foot when the mower does work. Obviously, that loss of a foot is beyond the value of the thing bargained for (the lawn mower).] When one looks at the cases . . . it appears, though dimly, that the court's "using" [unconscionability] . . . may already have started, though not very consciously, implementing some such criterion as "risk beyond the value of the bargain" as an unacknowledged touchstone for those contract clauses needing for their validation (if ever validatable) some form of super-assent [from a court]. The clearest instance is with respect to warranty disclaimers, where elimination by "contract" of recourse against the seller or manufacturer means not only that one may get defective or worthless goods, but that one may also sustain uncompensated personal injuries.⁸⁶

Note that crucial word "uncompensated." The law should not just stop after asserting that the loss of the foot exceeds the value of the bargain, and, therefore, the manufacturer will

not be allowed to bargain away his tort liability for the loss of that foot. In effect, as we have seen, decisions such as *Henningesen v. Bloomfield Motors, Inc.*⁸⁷ require the manufacturer to sell—and the purchaser to buy—insurance for personal injury stemming from a defect in the product.⁸⁸ But if we are focusing on bargains we have to ask, do we not, how good is that bargain mandated by the judicial bureaucracy? How likely is it that the injury *will* be compensated under the insurance mandated by the courts? Is the bargain of getting tort liability insurance so good—and the assurance of compensation so great—that the courts should allow no other remedy or insurance to be substituted for it? Looked at that way, the answer would clearly seem to be negative. The National Commission on Product Safety,⁸⁹ after exhaustively examining the current product liability system, opined that "[t]o advise a battered consumer to sue may simply add insult to injury."⁹⁰

Another argument in favor of permitting elective no-fault insurance contracts is derived from history: compensation for personal injury stemming from products, at least, has been for a century and a half a fascinating minuet between tort and contract.⁹¹ First, in 1842, in order to limit payment for personal injury, contract (specifically, the doctrine of privity) was used in a product liability case to get around the inadequacies of tort (specifically, the almost unlimited liability in tort to almost anyone);⁹² then, in 1916, in order to ensure more ready payment for personal injury, tort (specifically, liability for negligence regardless of the lack of privity) was used to get around the inadequacies of contract (namely privity);⁹³ then, once again in order to ensure more ready payment for personal injury, contract (specifically, the doctrine of warranty) was used increasingly in products liability cases to get around the inadequacies of tort (specifically, such requirements as proof of negligence and the

87. 32 N.J. 358, 161 A.2d 69 (1960).

88. See text accompanying note 33 *supra*.

89. The chairman of the Commission was Arnold Elkind of the New York City Bar, a prominent personal injury lawyer.

90. NATIONAL COMM'N ON PRODUCT SAFETY, FINAL REPORT 74 (1970).

91. See Franklin, *When Worlds Collide: Liability Theories and Disclaimers in Defective-Product Cases*, 18 STAN. L. REV. 974 (1966). As to the mixture of tort and contract in the origins of health care provider liability, see 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE § 8.03, at 194-200 (1973).

92. Winterbottom v. Wright, 10 M. & W. 109, 152 Eng. Rep. 402 (Ex. 1842).

93. MacPherson v. Buick Motor Co., 217 N.Y. 382, 111 N.E. 1050 (1916).

absence of contributory negligence);⁹⁴ then, in order to ensure still readier payment, tort (specifically, the doctrine of strict liability) was used to get around the inadequacies of contract (specifically, such requirements as privity and notice under the doctrine of warranty);⁹⁵ so now, in turn, to ensure readier payment still, contract (specifically, elective no-fault liability as a warranty) should be used to get around the inadequacies of tort (specifically, such requirements as proof of defect under the doctrine of strict liability).⁹⁶

Bear in mind that the proposal for elective no-fault insurance follows closely the provisions of the Uniform Motor Vehicle Accident Reparations Act (UMVARA), the no-fault auto law drafted at the behest of and endorsed by the Commissioners on Uniform State Laws.⁹⁷ Elective no-fault allows those liable in tort for personal injuries to substitute to the maximum extent possible no-fault benefits for out-of-pocket losses.⁹⁸ Concerning this trade-off, consider the following remarks of Professor Robert E. Keeton:

(1) Under the existing [auto tort] system, the package is \$25,000 per person/\$50,000 per accident liability insurance coverage, with the assurance (by uninsured motorist coverage) of the collectibility of one's valid claims against other drivers up to at least that same amount. This package . . . [provides] each person with the right to recover for both economic loss and [pain and suffering] when there is a valid claim based on negligence, but no right to recover either kind of damages in other cases. . . .

(2) The other package is UMVARA, with guaranteed lifetime coverage, no overall limit and relatively liberal internal

94. See W. PROSSER, *LAW OF TORTS* § 97 (4th ed. 1971).

95. See *id.* § 98.

96. See O'Connell, *No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others*, 1975 *INS. L.J.* 531, 541.

97. NATIONAL CONF. OF COMM'RS ON UNIFORM STATE LAWS, *UNIFORM MOTOR VEHICLE ACCIDENT REPARATIONS ACT* (Nov. 1, 1972 ed.).

98. See note 76 *supra*. Even if contracts are used without enabling legislation, the provisions of the no-fault draft bill should be the basis on which insurers draft elective no-fault provisions. In addition, approval of elective no-fault insurance contracts by an insurance commissioner might well be viewed as necessary under the law of some states. R. KEETON, *INSURANCE LAW—BASIC TEXT* 71-72, 543-45, 550-53 (1971). A regulator might well use the terms of the draft bill as a basis for prescribing, proscribing, or permitting specific policy provisions. Note that approval of elective no-fault insurance contracts by an insurance commissioner would probably enhance the likelihood of a contract being upheld by the courts, in that approval by a public official is arguably inconsistent with unconscionability. For more on safeguards against unfair contracts being imposed on the public, see J. O'CONNELL, *supra* note 17, at 155-56.

limits (\$200 per week for wage loss and a semi-private rather than a private room when hospitalization is needed). Subject to these internal limits, this package provides total coverage for economic losses sustained in automobile accidents regardless of negligence, but no chance of recovering general damages for noneconomic detriment (such as pain and suffering) unless the injury is severe.

Which package would you choose?⁹⁹

To further illustrate the huge amounts now being misspent under traditional tort liability that could be shifted to prompt payment of out-of-pocket losses under no-fault insurance, consider the following figures from Michigan: Coverage under Michigan's no-fault auto laws pay unlimited medical expenses, plus \$36,000 of wage losses, and residual tort liability (beyond the tort exemption under the no-fault law) of \$20,000, all for a cost no greater—and substantially less for those willing to forego payment if already paid from Blue Cross or employer-financed sick leave, for example—than the costs of only \$20,000 under traditional tort liability coverage.

As suggested earlier, because of the difficulty of identifying all insured events we cannot mandate the no-fault bargain across the board to all medical or product injuries.¹⁰⁰ But since the advantages of no-fault protection are so dramatic compared to liability based on fault or defect, why not allow anyone potentially liable in tort to put the advantages of no-fault to work? Recently, the prestigious Special Advisory Panel on Medical Malpractice, appointed by Governor Carey of New York and chaired by President William McGill of Columbia University, stated as its first of 17 recommendations:

Inasmuch as the present tort law/liability insurance system for medical malpractice will eventually break down and costs have and will continue to rise to unacceptable levels, fundamental reform of the present tort law/liability insurance system should be undertaken. . . . [T]he overriding concern should be to create a system of compensation for adverse medical outcomes resulting from medical treatment, whether or not caused by negligence.¹⁰¹

99. R. Keeton, *Compensation Systems and Utah's No-Fault Statute*, 1973 *UTAH L. REV.* 383, 399. For further similarly persuasive arguments based on comparisons between tort liability insurance protection and that afforded under a federal no-fault standards bill currently before Congress, see *Hearings on H. Con. Res. 116 Before the Subcomm. on Commerce and Finance of the House Comm. on Interstate and Foreign Commerce*, 93d Cong., 2d Sess., ser. 114, pt. 1, 402-19 (1975) (testimony of Robert Keeton) [hereinafter cited as *Hearings*].

100. See text accompanying note 55 *supra*.

101. STATE OF NEW YORK, SPECIAL ADVISORY PANEL ON MEDICAL MALPRACTICE, REPORT 4, 57-63 (1976); *N.Y. Times*, Jan. 7, 1976, at 11, col. 1.

port did not advert specifically to no-fault, but *ac-*
New York Times:

Supporters of the Panel recommendation have shied away from the no-fault label because they feel it will frighten off the insurance companies and lawyers who fought no-fault automobile insurance. . . .¹⁰²

There are at least two responses, however, to any attempt to shy away from the label "no-fault." First, if that term accurately describes the plan, there is little, if any, hope that this well-known term can be avoided. The press and the public will inevitably call the proposed reform by such a widely known label, if it fits. It is not without significance that the proponents of no-fault insurance did not invent the term; it was apparently coined by the press as a convenient term that would fit into headlines. Once introduced by the press, it took on a life of its own for both the press and the public, and no term could have supplanted it.¹⁰³ Second, if one is urging reform, perhaps the greatest advantage

102. See N.Y. Times, Feb. 22, 1976, at 38, col. 3. The Times also reported that an additional fear of the no-fault label was that "people will feel that doctors guilty of negligence will not be penalized." *Id.* As to this objection, see notes 145-59 *infra* and accompanying text.

103. Perhaps the following exchange illustrates something of the problem. A letter from a very thoughtful and eminent law professor, long interested in automobile insurance reform, was received by proponents of no-fault automobile insurance in October of 1970:

Dear . . . :

Along with the continuing newspaper discussion of the advances and distortions of no-fault insurance, I saw a bumper sticker the other day! It said "No fault no pay." I surmise that is a production of the Trial Lawyers Association.

Anyway, it led me to reflect that "no-fault" is not a very positive kind of slogan, and that it may also have been captured and diluted. How about "self-protection insurance"? This phrase has obvious connotations of self-reliance and security. It can also easily be put in an active voice: "Insure to protect yourself."

I hereby give you . . . a free license to do what you will with this idea.

In answer:

Dear . . . :

Concerning your provocative note . . . on another name for reform than "no-fault" insurance, I have found that one does not control these things at all . . .

Rather, for reasons that are not at all clear, newspaper people and then the public latch on to a given name and one is stuck with it. The most important thing to my mind at this point is that reform is identified by a catch phrase that millions of people recognize. As you can probably appreciate, that is an inestimably important step. Once you've achieved it, almost no matter how disadvantageous you think the term to be, one is ill-advised to try to change the terminology because (a) you give away the big advantage of identification and (b) the chances are overwhelming you won't succeed in changing the name adopted anyway.

All I am trying to say is that if this were a rational process, I might go along with you in trying to steer the terminology

one can have, next to a valid idea, is widespread recognition of the substance of the proffered idea. In the commercial world, enterprises would gladly spend millions—perhaps hundreds of millions—to gain the kind of instant recognition that the term "no-fault" now excites in the United States, and indeed all over the world. To try to avoid its use for an idea of which it is descriptive seems both naive and wasteful.) Elective no-fault may be a controversial and somewhat complicated reform, but unconstitutional and unconscionable it is not.

IV. TORT COSTS AS THE BASE LINE FOR REFORM

One objection to elective no-fault insurance is that it uses the costs of the present tort system as a base line. In other words, it is the cost of the present system that sets the parameters for the operation of no-fault insurance in that it is expected that providers of goods and services will check their tort liability costs against the possible costs of no-fault insurance. Based on that comparison, they will decide whether it is "profitable" for them to elect no-fault insurance. In the words of Professor Havighurst:

[E]lective no-fault, having its base line in the existing system and being designed by providers primarily for their own benefit, would be viable only to the extent that physicians perceive a benefit to themselves, in terms of cost and avoidance of unpleasantness, in establishing compensable categories.¹⁰⁴

Professors Walter Blum and the late Harry Kalven of the University of Chicago Law School have more extensively criticized this common-law base line as a limitation of no-fault plans:

The upshot of a [no-fault] plan is to effect a shift from a redress perspective to an insurance perspective. As a result, one is liberated from being controlled by . . . common law [damages] . . . , and even from being much guided by them.

. . . Are the [new] award levels to be set on the assumption that there is a more or less fixed aggregate pool to be distributed as unconditional [no-fault] reparations to the victims, or on the assumption that the size of the pool is not a given, but is to be determined by notions of what the award levels ought to be? It is our impression that in almost all discussions [of no-fault] it is implicit that there is a more or less determined limit to the pool, and that this sense of limit is

toward the kind of advantageous terminology you suggest. But it ain't.

Cordially,

Jeffrey O'Connell

As a further illustration, the name Professor Keeton and I applied to our original plan, "Basic Protection," was rarely used by others.

104. Remarks of Clark Havighurst, Conference, *supra* note 19, in Havighurst, *supra* note 58, 1975 DUKE L.J. at 1256.

perhaps the controlling factor in determining the award structure.

One does not have to look far for an explanation. A chief point of rhetoric in the advocacy of plans has been that they will offer a better product, dollar for dollar, than the motorist is now buying; in brief, under a plan, a motorist's total insurance premiums will not increase, but will in all likelihood decrease. It follows that the maximum size of the pool to be distributed in unconditional [no-fault] awards has to be set by the size of the "pool" that is generated under the common law tort-insurance system. Whatever the need to acknowledge the political imperatives, an anomaly lurks here. The award potential under a plan is being largely determined by a factor which is irrelevant to the aspirations of a plan. The aggregate amount the common law "collects" for distribution to victims is crucially affected by the fact that the law is not intended to pay all victims, but only those who qualify under common law liability rules. A principle point of every plan in mandating unconditional [no-fault] reparations is to reject those common law criteria of eligibility for compensation. Yet in effect the outcome is to permit these rejected criteria to limit how much a plan will do for victims. This almost automatic acceptance of the size of the common law "pool" as a limitation may be a key clue in explaining why the discussion . . . under [no-fault] plans has been so little concerned with theory. Once it is assumed that the size of the pool is already determined, many genuine issues . . . are readily short-circuited.

. . . Throughout [this Article] we have recognized that the auto [no-fault] plan is a new institutional concept. Something new has been brought in to replace something old. At the heart of every plan is the replacement of conditional redress [based on fault] keyed to corrective justice, by unconditional [no-fault] reparations keyed to insurance. One might have thought that a change so conceived would have been able to break sharply with the common law and its legacy of traditions, expectations, and concepts. The most interesting impression with which we are left is that the common law, *even in the case of the most ambitious plans*, still makes its presence felt. Once again, Maitland's aphorism is corroborated: auto [no-fault] plans, too, might be said to be ruled from the grave.

. . . The most obvious instance, made explicit in the public rhetoric, is tying the cost of the new arrangement to the cost of the old. Almost universally the base line for assessing the cost of a plan to the motorist is provided by the cost to him of the common law tort-insurance system. Use of the common law as a baseline is exemplified again in justifying . . . the limitations on reparations. This time the reference is not to what the common law costs, but to what the common law affords as redress. The justification may be seen in terms of a "bargain" in which old common law rights are traded for new unconditional [no-fault] reparation rights—a justification which would be without foundation in the absence of any common law rights.¹⁰⁵

105. Blum & Kalven, *Ceilings, Costs, and Compulsion in Auto Compensation Legislation*, 1973 UTAH L. REV. 341, 346-47, 376. While these

Of course the point is well taken; even more than with auto plans, elective no-fault insurance plans for medical malpractice and products liability use the present tort liability cost as a base line—but not necessarily for every compensable event. It might well be that providers of goods and services would, on occasion at least, decide to include no-fault benefits that would increase costs, on the ground that they and their customers/patients are better off with such expeditious compensation. A doctor might decide, for example, that automatic payment for additional costs attributable to complications arising from a thyroid operation merit at least offering the patient a higher cost option for insurance.¹⁰⁶ A manufacturer might similarly consider that automatic payment of benefits for amputation resulting from the use of his power tool justifies a higher price.¹⁰⁷ Admittedly, given strong beliefs that present liability insurance costs are too high, this may not happen too often. On the other hand, feelings that costs are too high under present common-law tort liability may well stem from the sense of how little anyone but lawyers benefits from those high costs; when a better insurance option is available providers of goods and services may well sense their customers/patients will be willing to pay more for better insurance protection.

Nevertheless, this question of tort liability costs as the base line for no-fault insurance is worthy of examination. There were many no-fault auto plans proposed between 1932 and 1965, but none really focused on what would be the costs vis-à-vis the tort system.¹⁰⁸ Not surprisingly, it was only with the detailed structuring of auto no-fault in such a way that actuarial opinions could offer reassurance that costs would not rise and indeed would probably decline that the no-fault idea took hold.¹⁰⁹ Without offering assurances as to cost, a reformer was in the position of going to a legislature and saying, "I can improve auto insur-

remarks were addressed to auto no-fault plans, they apply equally to elective no-fault for other forms of accidents.

106. Whether the higher price would be mentioned to—and bargained over with—the patient would probably, in practice, turn on whether the particular doctor now mentions—and bargains over—differences in expense for various modes of treatment. Doctors often don't do that—but dentists do.

107. On the reluctance of merchants to publicize potential injuries from the use of their products, however, see J. O'CONNELL, *supra* note 17, at 100.

108. Cf. O'Connell, *Industry and the Academic Researcher*, 53 IOWA L. REV. 1269, 1277-79 (1968).

109. E.g., Harwayne, *Insurance Costs of Basic Protection Plan in Michigan*, 1967 U. ILL. L.F. 479, 486-87, in *CRISIS IN CAR INSURANCE* 119, 126-27 (R. Keeton, J. O'Connell, & J. McCord eds. 1968).

ance, but it will cost more," to which a ready, if simplistic, reply might have been "Who couldn't?" It was the offering of better insurance protection at the same or lower price that caught the public eye. Remember that auto insurance everywhere is, in effect, a compulsory purchase—as is, in effect, product liability and medical malpractice insurance. Thus changes in the insurance system that increase costs are seen as very offensive since all are required to pay more regardless of their desires. Thus, in turn, using present costs as the base line for reform does not seem so illogical.

Elective no-fault insurance seems to evoke essentially two main (inconsistent, but understandable) fears: first, insureds will elect compensable events in such a way that compensation to customers/patients will be drastically and unfairly reduced, compared to tort litigation; second, the costs of paying on a no-fault basis will be drastically increased, compared to tort litigation.

A. AN UNFAIR REDUCTION IN COMPENSATION?

As to the fear of reduced compensation, Professor Keeton and others have pointed to the enormously increased pay-outs possible under no-fault insurance compared to the tort system.¹¹⁰ Professors Blum and Kalven have analyzed it this way with reference to no-fault auto plans:

It is often argued that the internal savings in administering unconditional [no-fault] reparations, as measured against administering conditional [fault/defect] reparations, should be sufficient to pay for the additional coverage of victims ineligible for recovery at common law. The ratio of savings to pay-out declines as the amount of reparations goes up. It may be possible to locate a sort of optimal point for a ceiling—the point at which the internal savings just meet the pay-out on coverage of the additional victims. It is not clear, however, that this line of thinking has ever been [explicitly] used as a rationale for a [no-fault auto] . . . plan.¹¹¹

But, of course, that is precisely the line of thinking undergirding elective no-fault liability—that providers of goods and services will be encouraged to find the optimal point "at which the internal savings just meet the pay-out on coverage of the additional victims."¹¹² Critics of elective no-fault, however, have pointed to the distinct possibility that insureds will not nec-

essarily be encouraged to find that particular optimal point. Rather, insureds will be induced to carefully pick as compensable events those accidents likely to have already resulted in tort verdicts or settlements, thereby eliminating collateral payment and payment for pain and suffering while not greatly, if at all, increasing the pay-out to previously ineligible victims. In other words, they will be inclined to find an optimal point that eliminates tort pay-outs but fails to increase nontort pay-outs.

That costs may be cut too much at the price of eliminating valid tort claims raises a variant of what Professor Robert Keeton has spoken of in another context as the cost/equity dilemma.¹¹³ We cut costs at the price of doing equity. But keep in mind that the equity that is sacrificed is the "equity" of the tort system, which, in the aggregate, provides precious little equity. Nevertheless, Dean Richard Roddis of the University of Washington Law School has expressed the fear of a skewed cost/equity bargain as follows:

Uncontrolled experimentation by elective no-fault could be most unfortunate from a consumer standpoint. The providers will make a series of calculated economic choices about what to cover and their choices may not be the ones that I, as a health care consumer, would like to have made. At the least, I suggest that any elective no-fault system should subject the scope and terms of provider elections to external public control calculated to achieve reasonable uniformity, avoid confusion and conflicts among the elections of different providers in a particular treatment situation, and prevent unreasonable limitations in the elections.¹¹⁴

Dean Roddis, then, would seem more comfortable if the legislature or insurance commissioner (presumably upon legislative delegation) defined compensable events under the no-fault system so that an optimal point more favorable to customers/patients would be ensured.

The question can be starkly posed: Given the admittedly difficult job of defining compensable events (which drives us to elective no-fault in the first place), whom do you trust more to do the job? A legislature and/or government agency on the one hand or providers of goods and services on the other? One can make a strong case for starting with the providers of goods and services since they are in a better position to decide what is best for them and their customers/patients than are the wisest gov-

113. R. KEETON, *VENTURING TO DO JUSTICE: REFORMING PRIVATE LAW* 136-39 (1969).

114. Roddis, *Could No-Fault Malpractice Insurance Work?*, *MED. WORLD NEWS*, Oct. 6, 1975, at 102, 103.

110. See note 143 *infra*.

111. Blum & Kalven, *supra* note 105, at 354 n.20.

112. *Id.*

ernment officials. Granted that there will be some overreaching, we will, on the whole, get a more flexible working arrangement through decentralization by letting the market for goods and services determine the optimal level of compensation for injuries from goods and services.¹¹⁵

Admittedly there is already a great deal of distrust of the manner in which, for example, health care providers decide on appropriate treatment. This deep distrust has indeed led to the establishment of so-called Professional Standards Review Organizations (PSROs), ordained by congressional enactment.¹¹⁶ Under the statute, regional review boards are being established, each "charged with defining acceptable norms of medical aid and insuring that individual physicians and hospitals meet specified standards of performance."¹¹⁷ Each PSRO develops guidelines for a given illness, injury, or health condition, specifying, for instance, when hospitalization is necessary and the appropriate length of stay required in the course of proper care.¹¹⁸ On the other hand, PSROs are the subject of bitter criticism by the medical profession on the ground that such massive bureaucratic intervention (once again, it will be noted, supposedly to correct the market between health care providers and their patients)¹¹⁹ will not end up benefiting patients.¹²⁰ Professor Calabresi has recently commented that never before have

115. We reach here application of a principle of intense contemporary controversy. President Kingman Brewster of Yale, in delivering the annual Churchill Lecture to the English Speaking Union of the Commonwealth on Thanksgiving Day, 1975, in London, said:

[T]he general attitude which should inform our attack [on the problem of preserving "the rights of Englishmen," namely the rights of free people] . . . should [first] exhaust ways of encouraging private decisions in the public interest before resorting to government allocations or regulations. Brewster, *The Rights of Englishmen*, Wall St. J., Nov. 28, 1975, at 6, cols. 3-6.

Similarly, United States Ambassador to the United Nations Daniel Patrick Moynihan, in a speech at about the same time, stated: "What is going on is a systematic effort to create an international society in which government is the one and only legitimate institution." Moynihan, *A Diplomat's Rhetoric*, HARPER'S, Jan. 1976, at 40, 41. See notes 166-75 *infra* and accompanying text.

116. Act of Oct. 30, 1972, Pub. L. No. 92-603, tit. 2, § 249F(b), 86 Stat. 1429 (codified at 42 U.S.C. § 1320c (Supp. IV, 1974)).

117. Winsten, *Imposing Controls on Doctors*, Wall St. J., Dec. 6, 1973, at 14, cols. 3-6.

118. For a good survey of PSROs, see A. GOSFIELD, *PSRO's: THE LAW AND THE HEALTH CONSUMER* (1975).

119. See text accompanying note 81 *supra*.

120. See A. GOSFIELD, *supra* note 118, at 2 n.9; Winsten, *supra* note 117.

such extensive result-oriented safety regulations of conduct as PSROs ended up working. "We end up," he said, "with building codes."¹²¹ In the case of PSROs selecting appropriate treatment—as with selecting compensable events when treatment goes awry—it is by no means clear that a governmental official ought necessarily to step between the doctor and his patient.¹²²

Of course, the choice is not simply a stark one between market or governmental determinations of compensable events. Arguably, an insurance commissioner's approval will be required before elective no-fault insurance policies are marketed.¹²³ Indeed, I have also suggested that advisory committees of professional and business persons should be established to assist an insurance commissioner in approving given types of elective no-fault policies.¹²⁴ Moreover, elective no-fault contracts will be subject not only to administrative scrutiny by insurance commissioners but to judicial scrutiny by courts as they apply the doctrine of unconscionability to identify particular instances of overreaching by providers of goods and services.¹²⁵

121. Remarks of Guido Calabresi, Conference, *supra* note 19. See notes 137-41 *infra* and accompanying text. For a detailed description, incidentally, of the corruption now thriving in New York City as a result of building codes and other safety regulations, see N.Y. Times, June 26, 1972, at 1, cols. 1-3; *id.*, June 27, 1972, at 1, cols. 6-7.

122. A clear example of where we have resorted to governmental regulation, rather than physician discretion, in health care matters is in the prescription of new drugs. Under the Pure Food and Drug Act, 21 U.S.C. § 1 *et seq.* (1970), no drug can be prescribed by a physician until it has been tested and approved by the Food and Drug Administration (FDA). *Id.* § 355. With PSROs, we are, in effect, moving to arguably similar governmentally imposed constraints on physician discretion. But there seems to be strong evidence that such governmental restraints on drug prescriptions have cost more in adverse effects than they have provided in benefits to the public. Studies by Sam Peltzman and Dr. William Wardell indicate that, on balance, we have suffered more in keeping beneficial drugs off (or delaying them from) the market than we have benefited in banning unsafe drugs. Indeed, for all the restraint "it is not at all clear that present regulations would prevent a thalidomide from being marketed." V. FUCHS, *WHO SHALL LIVE? HEALTH, ECONOMICS AND SOCIAL CHOICE* 115-19 (1974) (citing Peltzman, *An Evaluation of Consumer Protection Legislation: The 1962 Drug Amendments*, 81 J. POL. ECON. 1049 (1973) and Wardell, *Introduction of New Therapeutic Drugs in the United States and Great Britain: An International Comparison*, 14 CLIN. PHARM. & THERAP. 773 (1973)).

123. See note 98 *supra*.

124. J. O'CONNELL, *supra* note 17, at 155. Indeed, most of Professor Havighurst's criteria might be used. See notes 58-59 *supra* and accompanying text.

125. It will be essential for courts to weigh the fairness of the bargain as of a time before injury—and as it applies to consumers/patients as a group. J. O'CONNELL, *supra* note 17, at 118-19.

An additional fear related to overreaching by health care providers, in particular, is the fear (reflected in Professor Havighurst's fifth criterion—"Would an incentive to minimize the occurrence of this complication [as a compensable event] bias the choice of treatment in unfortunate ways?")¹²⁶ that doctors might skew the treatment offered to lessen the likelihood of insurance payment being required. If, for example, no-fault benefits seem particularly likely to be paid to a given patient following a certain procedure, a different procedure might therefore be employed.

Here, too, however, participation of the insurance commissioner¹²⁷ in applying a criterion such as that developed by Professor Havighurst would aid in avoiding allowance of manipulable compensable events that would entail such skewed treatment. Furthermore, skewed treatment itself might be the subject of a malpractice suit. Finally, query the degree to which we need be uniquely worried that doctors are going to improperly skew their treatment for the purposes of insurance any more than they will skew treatment for other improper purposes.¹²⁸ In the case, then, of improper treatment to increase fees or to lessen insurance pay-out, there is cause for some fear of unethical behavior, but structuring bureaucratic remedies to prevent such behavior ought not to be lightly undertaken.

What operates here is the traditional tripartite spectrum for controlling improper behavior: Conscience/Market/Fiat. As economist James Buchanan has so succinctly put it: "The market economy's socio-political function is that of *minimizing* the necessity of resorting to internal ethical constraints on human behavior and/or external legal-governmental-political restrictions."¹²⁹ To continue our focus on the health care provider,

126. Remarks of Clark Havighurst, Conference, *supra* note 19, at n.71, in Havighurst, note 58, 1975 DUKE L.J., at 1256.

127. See notes 123-24 *supra* and accompanying text.

128. Recently, for example, a prominent physician urged that surgeons be receiving salaries rather than charging fees that might tempt them to perform unnecessary operations. Dr. George Crile, Jr., emeritus consultant in surgery of the Cleveland Clinic, stated, "A surgeon deciding whether or not a patient should be operated on is acting as a judge. When he knows he will be paid \$500 if he operates and nothing if he doesn't, the surgeon is faced with a conflict of interest." *Chicago Sun-Times*, Dec. 14, 1975, at 98, cols. 1-5. But what, for example, will be the effect of reimbursement only by salary on the availability of necessary surgery?

129. Buchanan, *Good Economics—Bad Law*, 60 VA. L. REV. 483, 486 (1975).

That the parties should be allowed to vary by contract the manner in which the law would otherwise impose loss is pivotal to the seminal

we find there exists already a great deal of ethical constraint on human behavior. In the words of Harvard economist Kenneth Arrow:

The medical profession's code of ethics may not be universally followed, but is practiced widely enough to create a popular presumption that each doctor acts with the patient's welfare in mind—that he will not, say, order unnecessary tests or operations. The code protects patients, to be sure, but it also benefits doctors by maintaining the public's trust in the entire profession.¹³⁰

Similarly, according to Harvard sociologist Nathan Glazer: "In all systems, one must depend heavily on the professional ethic of the doctor to provide good and responsible care."¹³¹

In any case, of course, we do not depend on ethical constraints alone for anyone in our society. Even so, granted that the market for health care providers is *very* imperfect,¹³² I would nevertheless be cautious about deciding that the market, *coupled* with ethical constraints, is so inadequate that on the whole it

theories of Professor Ronald Coase of the University of Chicago Law School. Coase, *The Problem of Social Cost*, 3 J. LAW & ECON. 1 (1960). See also Demsetz, *When Does the Rule of Liability Matter?*, 1 J. LEGAL STUDIES 13 (1972). Under the Coase theorem, optimal allocation of resources need not depend on law-imposed rules (whether by court, legislature or administrative agency). Rather, regardless of the manner in which the law imposes liability for losses, if the parties are allowed to bargain over reshifting the loss, they will arrive at an optimum allocation of resources. Coase assumes no transaction costs—which include, for example, information costs, as well as the costs of lawyers or others in negotiating over the redistribution of losses between the parties. But that "fairly heroic" assumption of no transaction costs, see *Gilmore, Products Liability: A Commentary*, 38 U. CHI. L. REV. 103, 105 (1970), does not alter the brilliance of Coase's insight. And, for our particular purpose, the transaction costs to producers of goods and services in bargaining over compensation rights with their customers/patients, with whom they are already in a contractual relationship, would be relatively low.

Thus, to the extent the courts refuse to allow bargaining to reshuffle losses imposed by law, the more they blunt the parties' attempts to arrive at a more sensible solution and allocation of resources than may have been arrived at by merely relying on the law. To be sure, there is the danger that the parties will then arrive at a grossly inequitable bargain. The crucial question thus becomes which does one trust more—governmental fiat or private bargaining? It is the thesis of this Article, of course, that the imposition of personal injury liability under the tort system has proved to be so socially counterproductive that the Coase theorem must be applied: the courts should be receptive to more efficient arrangements worked out by the parties themselves.

130. Wall St. J., Feb. 14, 1974, at 16, col. 3.

131. Glazer, *Perspectives on Health Care*, 31 PUB. INT. 110, 122 (1973).

132. See V. FUCHS, *supra* note 122, at 62, 102.

need be overbalanced by further tight, restrictive governmental controls either prescribing or proscribing norms for (1) treatment or (2) payment for injury arising from treatment.

In significant measure, then, rejection of elective no-fault insurance or a corresponding insistence that compensable events initially be defined by a legislature or insurance commissioner might replicate the fallacy of the courts if they were to strike down any and all elective no-fault contracts as contracts of adhesion or, if authorized by statute, as unconstitutional.¹³³ In both cases, resort would be had to governmental fiat rather than the market to define compensable events. In each instance, a governmental agency (the courts or the legislature or an insurance commissioner) would be insisting that the line protecting the consumer/patient be drawn at a certain place—and, more specifically, at a point other than where providers of goods and services (who, in the aggregate, have to think about pleasing the consumer/patient) might have drawn it. All I'm suggesting is that—at least to start with—it might be best to rely primarily on providers of goods and services to draw that line at an appropriate place (with some relatively loose—and tolerant—supervision from courts and insurance commissioners), even though they will make some mistakes (and probably in their own favor). In the words of economist Harold Demsetz, speaking at a conference on the economics of products liability:

We would like to go on the premise that freedom of action is something that is good. We would like to have it produced, but it is not producible without costs. One of the costs of producing freedom is that people are going to make mistakes in using their freedom. Even from their own viewpoint they are going to make mistakes.

... It is not [, however,] a question of no mistakes versus some mistakes[;] it is a question of having mistakes of one kind versus mistakes of another kind. Obviously, no one has perfect knowledge.¹³⁴ Somehow you must decide when you are going to stop trying to rectify the mistakes that arise from people's exercise of freedom. And maybe the line is not drawn in the right place. Maybe you want to shove it one way or another, but merely citing the fact that some people [make] ... mistakes

133. See notes 81-100 *supra* and accompanying text.

134. Economist George Stigler has observed: "We [talk] ... about how the market acquires information and how people react to it, but on the other hand, [one cannot] ... presume that the legislature gets free, accurate, and immediate information on new developments and that it has an efficient bureaucracy to enforce its policies." Remarks of George Stigler, AAS-AEA Conference on Products Liability, in Manne, *Edited Transcript of AAS-AEA Conference on Products Liability*, 38 U. CHI. L. REV. 117, 134 (1970).

that ... hurt third parties is not in itself a convincing argument to me that we ought to draw the line someplace else.¹³⁵

In thus relying on the marketplace, one echoes the sentiments of many economists—and others—who question ever more regulation of the marketplace. At the same products liability conference, Melvin Reder, a Stanford University economist, argued as follows:

Part of what the economists have been saying is in fact what the students have been saying. No "*in loco parentis*." What we are saying is that, given the way people get information, they are going to do as good a job, as far as they are concerned, as some other person or agency can do for them. However poor this may be, the alternative to having individuals make their own individual decisions is to have them made by some other mechanism, and, in general, what we [economists] are saying is that in practice most people will indicate that ... this is inferior.¹³⁶

As to mistakes stemming from governmental fiat, especially in the area of insurance, Dean Spencer Kimball of the University of Wisconsin, the country's leading authority on insurance regulation, has characterized the "typical American insurance code [of laws as] a rubbish heap without parallel in the law-making of modern man."¹³⁷ And Professor Robert Keeton has been quick to point out that insurance terms dictated by public fiat are by no means necessarily framed in the public interest:

To say that a policy form is prescribed by statute or by administrative regulation is not to say that the initiative for modification ... is ... with the legislature or administrator. In fact the initiative is more often elsewhere.

[W]ith respect to forms prescribed by administrative regulation [for example] it appears that proposals for change more often come from insurers than from any other source, including the office of the administrator. ... [T]he administrator gets most of his information about new needs through insurers, and in most instances his action on proposed forms is based to a large extent on information presented by them in support of proposed changes.¹³⁸

A good example of the public interest in insurance matters being perverted by governmental fiat lies in legislative and administrative prohibitions across the country against the writing of group auto insurance—insurance that normally would be provided automatically as a part of one's employment, with the premiums paid in whole or in part by the employer. Despite the fact that the greatest percentage of health insurance in the United States is sold under such group policies—with similarly

135. Remarks of Harold Demsetz, *id.* at 138-39.

136. *Id.* at 138.

137. Kimball, *Introduction: Unfinished Business in Insurance Regulation*, *Symposium on Insurance Regulation*, 1969 WIS. L. REV. 1019.

138. R. KEETON, *INSURANCE LAW—BASIC TEXT* 71 (1971).

huge amounts of life insurance being sold in the same manner—"[g]roup merchandising of automobile insurance is almost unknown in the United States."¹³⁹ Supposedly, prohibitions against group auto insurance are designed to protect the public, but, in fact, they are a naked example of featherbedding by insurance agents (fearful of losing commissions) and small, local auto insurance companies (fearful of losing business to large multi-line national companies who already write group life and health). Dean Kimball and his colleague, Herbert Denenberg, have labeled the theoretical underpinning of these restrictive rules, which are supposedly in the public interest, as "silly"¹⁴⁰ and "absurd"¹⁴¹—the rules nevertheless were universally adopted.¹⁴² The point is, if doctors and insurance companies are intent on ripping off the public, insurance regulations may be a thin shield of protection.

B. AN UNMANAGEABLE INCREASE IN COSTS?

Some fear exists that, far from costing too little (with concomitant unfairness to those who should be paid), elective no-fault insurance will cost too much. Again, in the words of Dean Roddis:

I doubt that an adequate no-fault program for medical "maloccurrence" compensation will cost providers or their insurers less . . . [I]ndeed, it probably will cost more than the present system. . . .

. . . If the elections result in an acceptably broad net of no-fault coverage, then I surmise that the total dollars paid in claims will be as much as and probably even greater than at present. I do not dislike such a result for I suspect that there are a great many people now who experienced an adverse result from the treatment process and should have been accorded compensation for economic loss but did not receive it.¹⁴³

139. *Hearings on S. Res. 233 Before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary*, 90th Cong., 2d Sess., pt. 14, at 8323 (1968) (testimony of Bernard Webb).

140. S. KIMBALL & H. DENENBERG, *MASS MARKETING OF PROPERTY AND LIABILITY INSURANCE* 62 (1970) (U.S. Dep't of Transportation Automobile Insurance and Compensation Study).

141. National Underwriter: Prop. & Cas. Ins. Ed., April 10, 1970, at 50.

142. See note 140 *supra* *passim*.

143. Roddis, *supra* note 114. For another pessimistic view of the costs of no-fault medical maloccurrence insurance compared to present medical malpractice premiums, see R. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590 (1973). But, of course, as medical malpractice premiums skyrocket, the attraction of elective no-fault insurance also increases dramatically, in that more and more funds are available to be shifted from fault to no-fault payment.

But this, of course, is precisely the virtue of the elective feature of no-fault insurance. As *Forbes* magazine has reported, "[Elective no-fault] . . . can be applied where it works and ignored where it doesn't. An accurate check on costs and benefits can be kept at each step of the way."¹⁴⁴ Indeed, since by definition there is no compulsion to offer such coverage, it lends itself perfectly to the so-called "stop loss" device under which, once insurers have committed a given amount of loss reserves to no-fault payment, they need not offer any further no-fault contracts. That way insurers and insureds need not fear the uncertainties normally accompanying novel and untried coverages, especially those mandated by statute or regulation.

V. THE EFFECT OF ELECTIVE NO-FAULT ON DETERRENCE

While recognizing that the present system of tort liability ill serves deterrence of unsafe medicine, for example, many will nonetheless insist that any substitute system must clearly lead to deterrence. Here, too, is an issue of real bite. Since several observers have already expressed fears that unless a no-fault compensation system as applied to medical injuries can be seen as a quality control device, it will either not get off the ground or fail to function properly, the following analysis will focus on medical malpractice. But most of the points are applicable to products liability as well. Those who fear the effect of no-fault insurance on deterrence have no illusions that the present tort system is effective in encouraging quality control. Nevertheless, they fear that if other quality-assurance incentives are not substituted for the loss of the *in terrorem* feature of malpractice law, elimination or significant weakening of the common-law fault system may prove difficult despite the clear benefits to be derived. Such fears are often expressed at conferences and hearings on medical malpractice when a switch from fault to no-fault insurance is proposed. Professor Havighurst's original proposal for Medical Adversity No-Fault Medical Maloccurrence Insurance (written with Lawrence Tancredi) had as its primary emphasis forcing the compensation scheme to function as an incentive to encourage quality control. His subsequent approach, reflected in his conference remarks, is significantly less theoretical and more practically oriented, but is still focused on quality control.¹⁴⁵ And, in the words of Dr. John Ball of the Department of Health, Education, and Welfare:

144. *Sue! Sue!*, *FORBES*, Sept. 1, 1975, at 63, 64.

145. See notes 57-60 *supra* and accompanying text.

In its most basic sense, [liability for medical malpractice] . . . acts as a control on the quality of medical care in that the patient, unsatisfied with a medical care outcome, can sue the provider of care. Thus, malpractice is a mechanism of control on the quality of outcomes of care, perhaps the only such control. It is, of course, generally accepted that it is not a good control, and it may owe its existence as a control in that it is the only such mechanism at that end of the spectrum of care with which the consumer is most concerned.

Aside from its historical background in tort laws, [the] malpractice [claims system] may exist in medical care in a sense because it is the only game in town. That is, it is the only control on the outcome of medical care, it is one method of physician discipline, and it is the primary mechanism of patient compensation. While it may be inefficient, unjust, or inadequate in all these uses, it exists at least in part because of the absence of alternatives. It exists also because it is the only present mechanism which takes into account the interest of the consumer. Any alternative to the malpractice system must therefore also speak to those interests.¹⁴⁶

Bear in mind, however, that no one can demonstrate that a no-fault system necessarily serves as a deterrent less well than does a fault system. In the case of workers' compensation, for example, it is not thought that turning to no-fault payment by employers to injured employees encouraged carelessness on the part of employers. Indeed, the converse has been postulated. In the words of perhaps the leading treatise on tort law by Professors Fowler Harper and Fleming James of Yale Law School: "The question is whether the tendency to [promote safety and reduce accidents] will be greater if the fault principle is retained, or if the principle of [no-fault] . . . liability is substituted for it. We believe that the tendency would be stronger under a system of [no-fault] . . . liability."¹⁴⁷ In support of this conclusion, the authors argue that forcing someone to pay for accidents regardless of fault encourages safer conduct in that, as Professor Warren Seavey has written, "If the law requires a perfect score in result, the actor is more likely to strive for that than if the law requires only the ordinary precautions to be taken."¹⁴⁸

146. Remarks of John Ball, Conference, *supra* note 19.

147. 2 F. HARPER & F. JAMES, *THE LAW OF TORTS* § 12.4, at 755-56 (1956).

148. Seavey, *Speculations as to "Respondeat Superior,"* in *HARVARD LEGAL ESSAYS* 433, 447 (1934); cf. *Arizona Employers' Liability Cases*, 250 U.S. 400, 432-33 (Holmes, J., concurring). Indeed, there may well be resistance and resentment of health care providers to no-fault liability on the ground that it is somehow unfair to have to pay when one is not at fault. Thus one doctor, upon hearing of the no-fault plan with

Nor should the allegedly large amount of incompetent medicine being practiced by incompetent doctors¹⁴⁹ be seen as an argument against no-fault insurance.¹⁵⁰ After all, it has never been the case that only safer employers have been allowed coverage under no-fault workers' compensation. Indeed, the less safe is a provider of goods or services or jobs, the more the need to guarantee payment for injuries stemming from his actions. Also, the less skillful or prudent is a provider of goods or services or jobs, the less we probably need fear his ability to control or manipulate his accident risks so as to unfairly arrange lesser payment under his insurance.¹⁵¹

On the other hand, notwithstanding the optimism expressed by Harper and James, confidence that no-fault insurance will not lessen deterrence is probably about as far as we can go—at least for the present. Blum and Kalven suggest:

Economists have urged that the chief function of [an insurance payment] . . . system is to provide incentives that will serve to alter behavior so as to optimize accident costs in the society. . . . The argument over the degree to which the deterrence objective offers criteria for designing [insurance-payment] . . . systems has not been resolved. . . . [W]e are disposed to hazard the guess that deterrence strategies cannot, for both practical and political reasons, be executed through . . . highly differentiated insurance [mechanisms]. . . .¹⁵²

its elimination of payment for pain and suffering, stated: "It sounds like the only people we're going to preserve pain and suffering for are the doctors." Remarks of Dr. Torrey C. Brown of the Johns Hopkins University Medical School faculty, Conference, *supra* note 19, in the *Baltimore Sun*, Nov. 22, 1975, § B, at 2, col. 8. This view seems mistaken, but it nevertheless indicates that payment under no-fault insurance will still entail some emotional as well as financial penalty. Indeed, Professor Robert Keeton suggested at the University of Maryland Conference, *supra* note 19, that one means of avoiding any stigma attaching to no-fault payment is to place all the patients of a health care provider (whether doctor, hospital, or clinic) under a (floating) group insurance contract so that payment takes on a "first party" aspect and does not come directly from the health care provider or its insurer. Even so, the nexus between the provision of health care services and ultimate payment will probably furnish as much deterrence as we realistically can hope for, at least at the outset of elective no-fault insurance.

149. See, e.g., *N.Y. Times*, Jan. 26-30, 1976, at 1.

150. Especially given the haphazard, episodic, and dilatory way malpractice is discovered and proven. See notes 1-3, 145-46 *supra* and accompanying text. In addition, it is common knowledge that often the safest doctors and hospitals—who undertake the most difficult cases and procedures—face the most malpractice suits and the highest malpractice costs. See *N.Y. Times*, May 10, 1976, at 23, cols. 2-5.

151. See notes 113-14, 126-27 *supra* and accompanying text.

152. Blum & Kalven, *Ceilings, Costs, and Compulsion in Auto Compensation Legislation*, 1973 *UTAH L. REV.* 341, 380 n.44.

It may not be without significance that after generations of experience, insurers are still apparently totally frustrated in trying to encourage industrial safety through variations in insurance rating techniques under workers' compensation insurance. As Professor Patrick Atiyah has written:

The [National Commission on State Workmen's Compensation Laws] studied the industrial accident level in States with very different levels of workmen's compensation benefits. On the basis of economic theory, it might have been supposed that in states where the benefits and therefore the premiums were higher, employers would take more care (and spend more money) to minimize accident costs by keeping the accident levels as low as possible. However, no systematic relationship was discovered between accident levels and benefit levels.¹⁵³ Even when comparisons were made between states with similar industrial backgrounds there was no observable correlation between accident levels and benefit levels. For example, Virginia, Georgia and Alabama had similar benefit levels but widely different accident levels; Pennsylvania and New Jersey had very similar accident levels but vastly different benefits levels. The Commission concluded that the evidence suggests that "workmen's compensation insurance rates are not the strongest force affecting the frequency of accidents."¹⁵⁴

... Although it would be wrong to overlook altogether the broad effect of market deterrence on accident cost . . . the details of the argument seem to depend too much on forms of fine tuning which are inappropriate to the circumstances. Thus, any suggestion that an elaborate system, placing carefully calculated accident costs attributable to each activity onto that activity, would be justifiable, seems quite unacceptable. Indeed, crude though the tort system itself may be, it is by no means certain that other systems of distributing accident costs will be any improvement from the point of view of [market] . . . deterrence. As we have seen, tort law does at least have the virtue from this point of view that it places some accident costs on those who cause accidents, and some on those who suffer them. From the point of view of [market] . . . deterrence this is a reasonable result, even though "fine tuning" might suggest a much more elaborate way of dividing the costs. The case against tort law, and the case for its replacement, do not depend on considerations of these kinds.

The difficulty of calculating social costs, and evaluating noneconomic costs and benefits, of allocating different costs to different activities, and of assessing the effect of [market] . . . deterrence in face of a market distorted [for example] by taxation, are such that [market] . . . deterrence can usually only operate in a rough and ready way at best. . . . Since the whole exercise can only proceed on the basis of approximations and

153. Citing NATIONAL COMM'N ON STATE WORKMEN'S COMPENSATION LAWS, REPORT 97, fig. 5.5 (1972).

154. Citing *id.*

guesses anyhow, there is little purpose to be served in . . . [using] delicate instruments.¹⁵⁵

On the question of deterrence, one involved in the struggle to enact no-fault auto insurance has a sense of *deja vu*: As to auto insurance reform, there were those who insisted that the real problems of auto insurance were with unsafe drivers or unsafe cars or unsafe roads or all three. The true solution to the problem of auto insurance therefore was seen in restructuring the system to somehow encourage greater safety (more energetic criminal prosecution of motorists, more refined merit rating, and more regulation of the design of the automobile, for example). Similarly, it was often said that paying people regardless of fault would lessen deterrence of unsafe driving. In point of fact, the variables of achieving or encouraging traffic safety are so vast that there is vigorous dispute about what steps to take.¹⁵⁶ No-fault auto insurance has proved successful because its goal was kept narrowly focused: bettering compensation, and this to be done by simplifying the insured event through eliminating payment that had not only been based on an unmanageable criterion (fault) but that had included compensation for an item with an equally unmanageable criterion (pain and suffering). By eliminating those two cumbersome variables, it has been possible to use insurance dollars with vastly greater efficiency and expedition to pay for actual economic losses. This had also been the narrow focus that enabled workers' compensation to successfully replace tort liability for industrial accidents over a half century before.

Nevertheless, the same emphasis, not on reform of the tort system, but on eliminating underlying causes is being urged for medical malpractice. Testifying before Congress, Dr. Sidney M. Wolfe, Director of the Health Research Group of Public Citizens, an organization sponsored by Ralph Nader, stated:

[In] . . . working toward resolution of the malpractice crisis, the primary attention must be directed toward the [over-

155. P. ATIYAH, ACCIDENTS, COMPENSATION AND THE LAW 550-51, 555-56 (2d ed. 1975). But see Remarks of Clark Havighurst, Conference, *supra* note 19, in Havighurst, *supra* note 58, 1975 DUKE L.J. at 1263-69. For further discussions of the difficulties of achieving precise instruments of market deterrence through variations in insurance rates, see Atiyah, *Accident Prevention and Variable Premium Rates for Work-Connected Accidents* (pts. I & II), 1975 INDUS. L.J. 1, 89.

156. Witness, for example, the arguments pro and con about the efficacy of federal regulation of automobile design. See R. NADER, UNSAFE AT ANY SPEED (2d ed. 1972). But see Peltzman, *The Effects of Automobile Safety Regulation*, 83 J. POL. ECON. 677 (1975). For a report on the dispute, see Wall St. J., Feb. 23, 1976, at 3, cols. 3-6.

all] health care system as the real source of the crisis. . . . The public is now faced with treating this expensive, wasteful, and often lethal disease called malpractice. Shall the treatment be symptomatic, or shall it get to the heart of the problem. Not surprisingly, virtually all of the solutions proposed thus far [such as no-fault insurance] avoid the central causal problems of poor quality and the deteriorated doctor (provider)/patient relationship and, instead, try to manipulate symptoms.¹⁵⁷

But to the extent that we abandon the narrow focus that has worked for industrial and auto accidents—to the extent that we let ourselves (at least at this point) be distracted by attempts primarily to encourage better or cheaper health care—we are very unlikely to achieve what can be achieved, namely, beneficial change in the tort system as applied to injuries in the course of medical treatment. This is not to say we should not, in structuring no-fault liability, be at all concerned about achieving greater safety or that we should scorn separate efforts aimed at that goal. Rather, we must keep in mind that safety is a very distant and difficult goal compared to the immediately beneficial results that can be gained by eliminating, wherever feasible, insurance payments based on fault and for pain and suffering. Lacking any clear indication that it will lessen deterrence (and the workers' compensation and auto no-fault experience certainly foretell no such result), we should get on with eliminating these counterproductive payments whenever and wherever possible. And we should be chary of encumbering a proposal that would accomplish this goal with controversial—and probably unworkable—governmentally mandated provisions designed to alter the methods of a very learned, proud, and entrenched profession.¹⁵⁸

157. Hearings on S. 482, S. 215 and S. 188 Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare, 94th Cong., 1st Sess. 670, 674 (1975).

158. Consider the analogy to Health Maintenance Organizations (HMOs). An HMO, such as the Group Health Co-operative of Puget Sound, is "an organization which provides comprehensive medical care, including preventive, diagnostic, outpatient, and hospital services, to a voluntarily enrolled consumer population in return for a fixed, prepaid amount of money." Elwood, *Restructuring the Health Delivery System: Will the Health Maintenance Strategy Work?*, in HEALTH MAINTENANCE ORGANIZATIONS: A RECONFIGURATION OF THE HEALTH SERVICES SYSTEM 3 (1971) (University of Chicago, Center for Health Administration Studies), quoted in V. Fuchs, *supra* note 122, at 138. But also consider, for example, the effect on such organizations of tight governmental regulation, the supposed purpose of which is to ensure that they operate in the public interest. (And in reading the following, one might hypothetically substitute for "HMOs" the phrase "no-fault insurance for defined compensable events.")

In other words, perhaps we can do something about encouraging safer and cheaper medicine, but let us not delay making changes in the tort liability system that have worked elsewhere in order to pursue other—much less immediately attainable—goals.

If, however, it turns out that in order to gain public acceptance, some substitute for the *in terrorem* role of medical malpractice is seen as necessary, one might turn to some form of uninsurable "tort fines"¹⁵⁹ or mandatory deductibles¹⁶⁰ in

For a time . . . the general support that the HMO idea commanded from virtually every direction except that of the American Medical Association (AMA), seemed to ensure a substantial commitment from the federal government. Only a few years later, however, while HMOs in various forms continue to grow in communities around the country, they no longer represent a major element in federal health policy. Politically, they have fallen victim not to new arguments or new evidence, but to a mixture of perseverance among their opponents [and] overzealousness among their friends Out of these influences has come internally incoherent legislation, presumably intended to stimulate the development of prepaid plans, but in fact something of an impediment to their growth. The original purpose of the HMO strategy, which was to create self-regulating institutions and thereby minimize federal involvement, has been utterly frustrated by the most elaborate regulation imposed by Congress on any part of the health system. . . . While some of these troubles may be temporary, . . . [t]hey are . . . suggestive, in a more general way, of the difficulties in changing an industry as resilient and politically resourceful as medical care. Starr, *The Undelivered Health System*, 42 PUB. INT., Winter 1976, at 66, 67-68.

159. As yet unenacted in any state, tort fines are, as the term implies, a hybrid of tort and criminal law. Conceptually, a wrongdoer inflicting injury would be "fined" an amount appropriate to his wrongdoing (and not necessarily related to the victim's losses) with the proceeds going to injury victims and with insurance disallowed. See A. EHRENZWEIG, "FULL AID" INSURANCE FOR THE TRAFFIC VICTIM—A VOLUNTARY COMPENSATION PLAN 33 (1943), also published in a slightly revised version in 43 CALIF. L. REV. 1, 41 (1955).

160. Of course, to the extent that no-fault compensable events are not limited to "avoidable" consequences, see notes 58-59 *supra* and accompanying text, the occasions for physician pay-out will be highly fortuitous and not so much within the control of the physician. If that is so, why use deductibles? But even if compensable events were limited to avoidable consequences, I would leave the question of deductibles to the market, at least initially. Picking the right level of deductible that would sufficiently "punish" the doctor and yet do so "fairly" would be awesomely tricky business. Query whether government officials, either legislators or administrators, can pick the right figure for various specialties and procedures and keep them current.

Keep in mind, too, the problems created by deductibles under conventional liability insurance. If the deductible is large enough to "jolt" the insured, he will be tempted to veto any settlement, especially if he carries a large amount of coverage above the deductible. After all, settlement means certain liability, while litigation means at least a chance

order to chastise the health care provider who "causes" compensable events.¹⁶¹ My only point is that working out such impossibly innovative devices is fraught with perils, and we should do so only as a last resort.

of avoiding payment and, even if the litigation is lost, no responsibility on the part of the insured for payment above the deductible amount. This is really the mirror image of the situation—about which there has been much writing and even litigation—where an insurer has written low limits on an insured. In that situation, the insurer may be inclined to refuse settlement on the ground that settlement means certain payment, while litigation means at least a chance of avoiding payment and no responsibility for payment beyond the policy limits. R. KEETON, *INSURANCE LAW—BASIC TEXT* § 7.8 (1971). Also, to the extent that physician resistance to insurer settlement is now a problem, see J. O'CONNELL, *supra* note 17, at 17, 29, 40, even though the insurer pays the whole settlement under present medical malpractice insurance, doctors' reaction might well be exacerbated under a system requiring them actually to pay some of the settlement. If the amount of the deductible were very substantial (which it would have to be in order to serve as a deterrent), one could not expect health care providers to be bound by the insurer's decision to settle. It would be anomalous that while under the present system, supposedly premised on genuine fault, there is no requirement that health care providers bear a portion of payment, under a system not turning on fault there would be.

All this might be avoided by requirements, for example, that insureds bear all or a portion of litigation expenses when they veto an insurer's decision to settle; but structuring such arrangements would still be very tricky. Better, perhaps, to let the parties do it, if at all, by voluntary arrangements than by inflexible fiat from governmental officials, whether legislative or administrative.

161. It is very significant, is it not, that so few criminal prosecutions are pressed against doctors arising out of malpractice or against businessmen arising from defective products. This would seem to indicate very few heinous acts, would it not, since a "butchering" doctor or brutal manufacturer would be an attractive target for a district attorney. Perhaps even more significant is how relatively rare are claims—and a fortiori successful claims—against doctors for punitive damages in civil cases for personal injury. That, too, tells us a great deal about how relatively rare are heinous acts by health care providers or businessmen.

O'Connell, *No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others*, 1975 *INS. L.J.* 531, 536.

One might delineate certain acts—such as operating on the wrong side or the wrong organ—for which tort exemptions could never be gained. But, of course, the longer such a list becomes the shorter will be the list for which prompt no-fault benefits can be paid. Nor should one attempt to divide the line for no-fault purposes between ordinary negligence (which could be the subject of no-fault benefits with a corresponding tort exemption) and gross negligence (for which a tort action always remains possible). Such a line will simply escalate the level and bitterness of accusation—as has happened, for example, under automobile guest statutes, where an accusation of gross negligence becomes a prerequisite to payment. See J. O'CONNELL, *supra* note 17, at 154-55; W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 186-87 (4th ed. 1971).

VI. FURTHER RESEARCH FOR IMPLEMENTING ELECTIVE NO-FAULT

What further research is necessary as a prelude to instituting elective no-fault insurance (either by statute or contract)? Initially, still using medical maloccurrences for purposes of illustration, funds might be obtained to finance meetings involving doctors in various specialties, hospital officials, lawyers, insurance executives, underwriters and actuaries, and possibly representatives of the National Association of Insurance Commissioners to formulate usable and representative lists of compensable events for various medical specialties and hospitals. Once such lists are compiled, it will be necessary to determine the effect that paying for such events will have on insurance costs. That, in turn, must be done by researching the effect of such payment on the costs of claims (average claim cost) and on the number of claims (claim frequency). As to average claim cost, it must be determined what savings are effected by not paying for (1) legal and insurance expenses incurred in determining fault and the monetary value of pain and suffering, (2) pain and suffering itself, and (3) amounts already paid by other sources, such as Blue Cross and sick leave. As to claim frequency, it must be determined how many more claims must be paid once claims are paid regardless of whether the health care provider can be proven negligent.

Such studies could be done either hypothetically or by actually paying certain numbers of claims on a no-fault basis. A hypothetical study could be done either retrospectively or prospectively. If done retrospectively, closed claim files of insureds and insurers should be examined to determine the effect that no-fault payment would have had on average claim cost and claim frequency. Medical data should be used to estimate what the effect of no-fault payment on claim frequency would have been. Since insurance payment has been based on common-law tort criteria, existing records will by no means reveal all the claims that would be eligible for payment once common-law tort liability criteria are abandoned. But medical data are often available to ascertain the number of adverse results from given medical procedures, regardless of whether the adverse results are negligently induced. A prospective study, on the other hand, would begin with study of claim files as they are closed to determine the relevant data and with similar supplementary use of medical data to determine the effect of no-fault payment on claim frequency. A possible disadvantage of a retrospective study is

that the available data may not have been collected in the most suitable form. Such a defect poses no problem for a prospective study since one can define at the outset what data to collect. But a corresponding disadvantage of a prospective study is the delay in waiting for claims to be closed. Of course, it might prove possible to combine these methods to supplement and cross-check each other.

As to hypothetical versus factual studies, hypothetical studies have, by definition, an unreal quality about them. Actual payments on a no-fault basis might be somewhat different from hypothetical predictions as to what payment of such claims might entail. But, of course, an experiment in actually paying claims on a no-fault basis is a much more ambitious undertaking than a hypothetical study. On the other hand, it is by no means unfeasible. Cooperating hospitals, for example, might well be willing to experiment with actually contracting to pay on a no-fault basis for certain adverse results of in-house surgery or other accidents. Whoever funds such no-fault research may need to provide an additional subsidy to cover unexpectedly large losses. But with or without a subsidy, a "stop loss" provision¹⁶² could ensure that only a committed amount was exposed in the experiment.

Whichever of these research methods is adopted, measures should begin immediately for expediting experimentation by simplifying the insured event for medical maloccurrences. Such simplification can best be achieved by implementing, wherever feasible, guaranteed but limited payment for predictably adverse results as a replacement for the present "roulette" system of medical malpractice compensation under which injured patients are forced to pursue the remote possibility of a relatively huge settlement or verdict.

VII. DISABILITY INSURANCE AS AN ALTERNATIVE TO INSURANCE FOR DEFINED COMPENSABLE EVENTS

It may turn out that the device of listing compensable events under elective no-fault insurance for medical injuries will prove too difficult to arrange (depending, as it does, on the intense cooperation and coordination of doctors, lawyers, insurers, and in-

162. A "stop loss" provision is designed to cut off exposure to losses at a certain point. In this case, once loss reserves of a given amount are committed, no further no-fault contracts would be offered.

sureds) or execute (in that adverse results may not be easily isolatable, e.g., cardiac arrest can lead to brain damage—would the latter be included under cardiac arrest as an adverse result?).

An alternative—and arguably simpler device—might be worth considering, especially (but not exclusively) for hospitals. Under this proposal, a health care provider would agree in advance of surgery to provide disability insurance covering further medical expense and wage loss (up to \$200 per week) once any other health insurance or sick leave applicable to the patient had been exhausted. Such insurance would cover *any* disability commencing within a certain number of hours or days after surgery (the precise time to be determined in the insurance policy). In return for every one dollar of disability coverage, the health care provider would contract with the patient for a corresponding exemption from medical malpractice liability. In other words, if the health care provider contracted with the patient to provide, say, \$10,000 of disability insurance, such provider might secure an exemption for medical malpractice liability up to \$20,000 of tort liability damages. The particular multiple would turn on how much disability insurance could be purchased from the savings that would result if malpractice insurance premiums were calculated on the basis of this tort exemption. It might turn out to be on a ratio of 1:1 or 1:2 or, on the other hand, even higher, because of the large number of claims that might have to be paid under such disability insurance. In light of the relatively remote chance that any given patient would ever be paid from medical malpractice insurance and the long delay in payment if made,¹⁶³ the exchange might appeal to most patients at almost any ratio.

That the new coverage is disability insurance—covering any disability leading to further medical expense or wage loss—would dispense with problems of exhaustively defining adverse results from particular medical procedures. Litigation over whether a particular adverse result was, in fact, within the scope of the definition would also be avoided. Note that payment under such disability insurance could be defined to commence only after the normal recuperative period—also defined in the policy—for the particular medical procedure.¹⁶⁴

If it turns out that providing coverage for wage loss as well as for the cost of further medical care is too expensive, the disa-

163. See text accompanying note 32 *supra*.

164. See generally note 118 *supra* and accompanying text.

bility insurance contract could be written to cover only medical care costs. And since medical care is furnished in kind by the health care provider, this coverage might be much less expensive. Here, too, because of the uncertainty and delays of payment under traditional medical malpractice insurance, most patients would probably readily agree to substitute certain payment for needed medical care for an uncertain claim for tort damages.

Furthermore, the advantages of greater assurance of payment are so undeniable that even if the costs of such disability insurance turn out to be so much greater than tort liability insurance that health care providers cannot offer it as a substitute (even without including wage loss), they might nonetheless offer it to patients for an additional charge. Such an arrangement might still be advantageous to the patient, since he would not bear the full cost of the coverage. The health care provider would pay the premium to the extent of his savings from the lower malpractice insurance rates attributable to the tort exemption feature of disability insurance.

As a further inducement to lower costs, the tort exemption could be based on a sliding scale. Thus when the health care provider offers disability benefits of a very substantial amount (such as \$200,000), a total tort exemption might be secured in return.¹⁶⁵ Moreover, a total exemption might be justified for even much lower disability benefits (\$50,000 or less), depending on comparative tort and disability insurance costs.

Note that health care providers would not be obliged to offer such disability insurance to all patients. Aged patients or others particularly susceptible to adverse surgical results might be excluded. Furthermore, no patient would be required to accept the substitution of disability insurance for medical malpractice liability. And such disability insurance need not cover death benefits.

Finally, as with the proposal for elective no-fault medical malpractice insurance, a stop loss device could be employed to ensure that only a predetermined amount of the insurers' resources were exposed in an experiment with disability insurance.

VIII. ELECTIVE NO-FAULT REFORM IN BROAD PERSPECTIVE

Recently, Daniel Patrick Moynihan, in urging favorable consideration of elective no-fault insurance, called no-fault auto insurance "the one incontestably successful reform [proposed in]

165. See O'Connell, *supra* note 76, at 281.

... the 1960's."¹⁶⁶ It is significant that the principal dispute as to no-fault auto insurance for personal injury concerns whether and how it is to be extended beyond the states where it has been enacted.¹⁶⁷ No state in which it has been enacted is seriously considering abandoning it, but every state that does not have it is debating whether to adopt it. Even more significantly perhaps, after more than 50 years of experience with no-

166. Moynihan, *Foreword* to J. O'CONNELL, *supra* note 17, at xi. See note 99 *supra* and accompanying text.

167. Auto no-fault laws that wipe out tort suits (so-called "true" no-fault laws as opposed to "spurious" ones; for a discussion of the distinction, see J. O'CONNELL, *supra* note 17, at 24 n.4) have meant genuine—and arguably dramatic—improvement in law and insurance applicable to personal injury resulting from auto accidents. For favorable reports on no-fault as applied to personal injury in New York, Connecticut, and New Jersey, see N.Y. Times, Oct. 5, 1975, § E (News of the Week), at 6, cols. 4-8. There may be a need to increase the tort threshold (below which claims based on fault cannot be pursued) because of rising costs for auto insurance in New York State. See N.Y. Times, Dec. 21, 1975, § E (News of the Week), at 5. See also *id.*, Jan. 24, 1976, at 1, cols. 1-3; *id.*, Jan. 25, 1976, at 1, cols. 5-7. As to Massachusetts, Benjamin Taylor of the Boston Globe staff writes: "It was hoped the law would root out phony claims and eliminate costly legal fees thereby halting the rapid rise of insurance rates for bodily injury coverage which occurred during the late 1960s. As John O'Connor, a spokesman for the insurance industry, said 'It worked beyond anyone's wildest dreams.'" Boston Sunday Globe, Oct. 12, 1975, at 37, col. 4. For favorable reports on no-fault in Minnesota, see St. Paul Dispatch, Sept. 25, 1975, at 33, cols. 3-6; and Minneapolis Star, Sept. 25, 1975, § B, at 8, col. 1. For a more documented appraisal of the success of no-fault as applied to personal injury, see *Hearings, supra* note 99, at 402-34 (testimony of Robert Keeton). For an appraisal of no-fault auto insurance as on the whole successful, though plagued by, among other things, inflation and the elimination of too few tort suits by low tort thresholds, see Wall St. J., Jan. 21, 1976, at 1, col. 6.

Admittedly, as Professor Keeton points out, "the possibilities for improvement of the [auto insurance] system [as applied to car damage] ... are very modest in comparison with the dramatic improvements affected by a real no-fault system for injuries to people." *Hearings, supra* note 99, at 676. This is largely because the savings of eliminating payment for pain and suffering and lawyers' fees are not applicable (since car damage cases are often arbitrated inexpensively and expeditiously between insurance companies). Indeed, most of the public dissatisfaction with the operation of no-fault insurance has stemmed from its application to property damage. See Boston Sunday Globe, Oct. 12, 1975, at 37, cols. 2-5. In Michigan, see note 37 *supra* and accompanying text, and in Florida, *Kluger v. White*, 281 So. 2d 1 (Fla. 1973), the property damage provisions of the no-fault laws have been ruled unconstitutional.

For two scholarly empirical studies reporting favorably on the experience under no-fault laws in Florida and Massachusetts, see Little, *No-Fault Auto Reparation in Florida: An Empirical Examination of Some of Its Effects*, 9 U. MICH. J.L. REFORM 1 (1975); Widiss, *Accident Victims Under No-Fault Automobile Insurance: A Massachusetts Survey*, 61 IOWA L. REV. 1 (1975).

fault workers' compensation, none of the 50 states that have adopted it has ever seriously considered voluntarily abandoning it.¹⁶⁸ Moynihan has attempted to place elective no-fault liability in a broad socio-political context. He cites the rise in distrust of business and professionals, as well as government, exemplified in the increasing aggressiveness—but concomitant futility—of the consumer movement.¹⁶⁹

There is an element . . . in the new consumerism which is not reassuring at all . . . I fear that American education is in-

168. According to the National Commission on State Workmen's Compensation Laws:

We have discussed the implications of abolishing workmen's compensation and reverting to . . . negligence suits, a remedy abandoned some fifty years ago. This option is still inferior to workmen's compensation. . . . [Tort] liability suits [are] a drawn-out, costly and uncertain process that was dismissed long ago as a means of dealing with occupational injuries and diseases.

NATIONAL COMM'N ON STATE WORKMEN'S COMPENSATION LAWS, REPORT 25, 45 (1972).

The ironic thing about criticism of auto no-fault is that, in large measure, it has stemmed from four associations—two insurance associations (the American Mutual Insurance Alliance and the National Association of Independent Insurers) and two lawyer associations (for the plaintiffs, the Association of Trial Lawyers of America, and for the defendants, the Defense Research Institute). See *Wall St. J.*, Jan. 21, 1976, at 1, col. 6. And it is precisely these groups that have labored energetically—and in large measure successfully—to see to it that any no-fault law is crippled by a low tort "threshold," with the result that relatively few claims based on fault are eliminated. Thus, insurers must stand ready in far too many cases to respond to both no-fault and fault-based claims. Having labored to see to it such no-fault laws are passed, these organizations and their members then point to such emasculated laws as proof that no-fault laws don't work as well as their *genuine* supporters promised. But those *genuine* supporters urged—and are urging—an elimination of all but the most serious claims based on fault (for example where damages for pain and suffering exceed \$5000 or where total disability exceeds 90 days), while the insurers and trial lawyers mentioned above have seen to it that tort thresholds, where enacted at all, allow claims based on fault to be brought whenever medical expenses exceed amounts as low as \$500. See J. O'CONNELL, *supra* note 17, at 24-25, nn. 4, 5, 6, 12. See also J. O'CONNELL, *THE INJURY INDUSTRY AND THE REMEDY OF NO-FAULT INSURANCE* 110-21 (1971). Indeed, these same insurers and trial lawyers advocate no-fault plans that mandate no elimination of tort claims whatsoever. But simply adding on no-fault coverage without ensuring the elimination of any claims based on fault would seem to raise inevitable risks of much higher costs. For discussion of this approach, see *Hearings, supra* note 99, at 691-712 (testimony of Robert Keeton and Craig Spangenberg); J. O'CONNELL & R. HENDERSON, *TORT LAW, NO-FAULT AND BEYOND: TEACHING MATERIALS ON COMPENSATION FOR ACCIDENTS AND AILMENTS IN MODERN SOCIETY* 306-07 (1975).

169. "It may be possible to make a strong case against either markets or [governmental] administration systems, but if we are against both we are in trouble." A. LINBECK, *POLITICAL ECONOMY OF THE NEW LEFT* 32 (1971).

creasingly turning out persons of socially active dispositions who do not understand or accept how the American economic system works and that this is going to have the most baleful consequences for that system. It is going to become overregulated and oversued, undercapitalized and underproductive.¹⁷⁰

Writes Moynihan:

Distrust grows—or is alleged to grow—practically in proportion to the measures taken to allay it. Hence, the latest news from Washington is that an enlightened Republican senator, in the course of the debate over the Consumer Protection Agency, has asked who is going to represent the consumer before the agency designed to represent the consumer before the agencies designed to represent the consumer. Literally, I quote:

OMBUDSMAN FOR CONSUMERS: Senator Taft has filed an amendment to the Consumer Protection Bill, now before the Senate, which would create an "ombudsman Agency" to oversee activities of a new Agency for Consumer Advocacy proposed by the Bill. Taft fears the ACA would become "an irresponsible and unrestrained super-agency, speaking only for a few, more vocal interest groups" while ignoring the real interest of the consuming public.

One recalls a pressing issue from the McCarthy days, formulated, as I recall, by Zero Mostel: "Who's going to investigate the man who investigates the man who investigates me?"¹⁷¹

"It is here," asserts Moynihan, "that [elective no-fault liability insurance] . . . assumes an almost unique importance, for while modest seeming, it addresses the largest of questions."¹⁷²

Since elective no-fault insurance for products and services is self-executing, without the need for a new and cumbersome bureaucracy, such as those ordained by PSROs, it is, for Moynihan, a prototype of the kind of innovative, pragmatic, cooperative, and mutually beneficial reform that is essential to our society. It is, he writes,

conservative . . . in the sense that Justice Frankfurter was conservative. [It] . . . values highly those things the legal system can do, and . . . is concerned that [the legal system] . . . not seek to overdo. An overextended system, dealing with ever more peripheral issues, eventually becomes incapable of dealing with those vital and central issues for which it was created. The image of empires collapsing on their marches comes to mind. [The proponents of elective no-fault liability do] . . . not want us litigating ourselves into a stalemated and paranoid society. We could do so. We could take all the fun out of it, all the pride out of it, and that would be such a waste, such a loss. [Not long ago] . . . a Congressional study on medical malpractice [was] subtitled 'The Patient Versus the Physician.'

170. Moynihan, *supra* note 166, at xviii-xix.

171. *Id.* at xvi.

172. *Id.* at xviii.

This is a relation [we do] . . . not want. It won't help doctors and it won't help patients. Similar confrontational, adversary relations are developing seemingly everywhere. They can't succeed. When everyone sues, no one gets satisfied. (Our experience with the automobile brought us after the fact to that realization.) . . . The legal system becomes ever more encumbered. . . . Justice . . . is not done. . . . Free systems come more and more to be seen as threatening; regulation ever more normal and necessary. Thereafter regulation of the regulators. And thence regulation of the regulators of the regulators. This is the way systems die.¹⁷³

Earlier, Moynihan, in discussing the advantages of no-fault auto insurance, had stated that the proponents of no-fault insurance "are right in the all-important perception as to what it is Americans are good at. We are good at maintaining business relationships once a basis of mutual self-interest is established. [No-fault insurance] . . . would establish one."¹⁷⁴ Elective no-fault insurance allows doctors and their patients and manufacturers and their customers to bypass both lawyers and bureaucrats, with all their self-serving cumbersomeness, in dealing with accidental injuries suffered in the course of medical treatment or from defective products. It too, then is an excellent example of establishing a relationship based on mutual self-interest. As such, writes Moynihan, it is not "merely . . . concerned with aspects of tort liability [; it is concerned with] . . . those particulars whereby a free society remains free."¹⁷⁵

Professor Luke Cooperrider also has discerned the essence of elective no-fault insurance. In identifying the practical consequences of adopting such a system, he, too, comments perceptively on the ramifications for American social policy:

The tort system is strongly condemned, not only because it treats accident victims badly, but also because in the process it dissipates the resources that could otherwise provide more adequately for their needs. It could be argued that it is arraigned for not doing what it was never designed to do. Tort law is a system of conflict resolution, by nature contentious. It is difficult to see how it could be otherwise, or how it could come to be thought of as a likely machine for the efficient treatment of massive social problems. However that argument would beg the question. If it makes sense, for either compassionate or economic reasons, for society to replace the economic losses of all those who become the fortuitous victims of a technological environment—and it can scarcely be denied that this reflects the trend of the times even in tort litigation—then it surely makes sense to seek a more efficient way of doing it than the tort sys-

173. *Id.* at xix-xx.

174. Moynihan, *Next: A New Auto Insurance Policy*, N.Y. Times, Aug. 27, 1967, § 6 (Magazine), at 26.

175. Moynihan, *supra* note 166, at xx.

tem provides. It makes sense to try to put it on an insurance basis rather than a litigation basis. If . . . a comprehensive social insurance system that would provide not only for medical care, but also for income maintenance, is not for us in the foreseeable future, then one must look to the private sector. There one finds that a significant part of the problem is already treated on a first party basis through medical insurance and service contracts, various employment related fringe benefits, and some public benefit systems. The problem is to provide a supplementary plan to replace economic losses not absorbed by these systems for those persons to whom they apply, and also to bring the less well connected members of society under the umbrella. The most immediate access to this part of the problem seems to lie through the liability system, as there is no other obvious way of bringing in from the cold those who do not presently enjoy the benefits provided by our conglomeration of private sector medical expense and income protection devices—which is what the automobile no-fault statutes, in their limited way, have accomplished in respect to the injuries to which they apply. The solution proposed here for other categories of accidental injury is by no means so neat as that which was possible in respect to automobile accidents, but that is due to the intractability of the subject matter . . .¹⁷⁶

In sum, elective no-fault insurance does provide the only practicable means of immediately "bringing in from the cold" many of those whose losses from accidents outstrip their collateral resources.

We should get on with that task.

176. Cooperrider, *Book Review*, 22 WAYNE L. REV. 189, 194-95 (1975) (reviewing J. O'CONNELL, *supra* note 17).

ROBERT L. FOGEL
ATTORNEY AT LAW

LAW OFFICES OF
HILFMAN & FOGEL, P.C.

SUITE 1700
33 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60602
(312) 236-5207

STRAIGHT TALK ON MEDICAL MALPRACTICE

Separating Fact from Fiction



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Barry J. Nace, President
Larry S. Stewart, President-Elect

STRAIGHT TALK ON MEDICAL MALPRACTICE
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STRAIGHT TALK ON MEDICAL MALPRACTICE

Separating Fact from Fiction

I. Introduction

Americans increasingly have focused their attention on a profound problem of national concern -- the escalating costs of our health care system. In 1990, the United States spent 12 percent of its gross domestic product (GDP) on health care.¹ This was more than twice as much as the country spent on national defense and nearly twice as much as it spent on education. If current trends go unchecked, the U.S. Congressional Budget Office estimates that health care spending will increase to 18 percent of GDP by the year 2000.²

In response to this grim forecast, federal and state policymakers have proposed solutions that would attempt to control spending and provide quality health care to all Americans. Too often, however, the resulting debate has diverged from the real issues and instead focused on America's medical liability laws.³ The medical and insurance industries contend that America's medical liability system drives up health care costs by promoting unnecessary litigation and "defensive medicine." Therefore, they claim, we need to "reform" our liability laws to contain costs.

These false arguments do not surprise attorneys who represent health care consumers. For more than a decade, the medical and insurance industries have waged a public relations and marketing campaign to foster the perception that America is awash in medical malpractice lawsuits and outrageous jury verdicts. Neither claim is true, but the motive underlying this campaign is obvious: to promote a reordered legal system that protects the interests of health care providers and insurers.

Under the benign banner of "tort reform," the medical and insurance industries seek to:

- make it harder for injured health care consumers to bring lawsuits,
- make it tougher for consumers to prevail when they do, and
- arbitrarily limit the amount an injured consumer may recover, even after a judge or jury decides that the consumer is entitled to compensation.

These proposals are a direct assault on the Seventh Amendment's guarantee that every American has the right to trial by jury.⁴ They also would interfere with the fundamental principle of federalism upon which our nation was founded.⁵ The framers of our Constitution never intended that a national tort compensation scheme be established. Under federalism, the states have developed their own tort compensation schemes, including medical liability systems, taking into account the culture and history of the individual state. Differences among the states are a source of pride and symbol of strength in our legal system.

¹ CBO, Economic Implications of Rising Health Care Costs 1 (Oct. 1992).

² *Id.*

³ See, e.g., James S. Todd, "Reform of the Health Care System and Professional Liability," 329 New Eng. J. Med. 1733 (Dec. 2, 1993); Jessica Lee, "Malpractice: Big-ticket battle," USA Today, June 9, 1993, at 8A.

⁴ The Seventh Amendment states: "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law."

⁵ The Tenth Amendment provides: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

The medical and insurance industries, however, have not been deterred from seeking special treatment.⁶ Predictably, these industries have glossed over the alarming frequency and often catastrophic results of medical malpractice. Their proposals fail to address methods of reducing or eliminating malpractice and would have no effect on cost control. As a result, the truth about medical malpractice has been distorted in the health care debate. It is essential, therefore, to examine what effect, if any, medical malpractice litigation has on health care costs. It is equally important to understand the effects that some proposals would have on the quality of care and, ultimately, health care consumers.

To that end, this paper separates fact from fiction by assessing the impact of medical liability on health care costs and the quality of care. Further, this paper illustrates how medical liability has a positive effect on the quality of health care. Finally, the paper offers proposals to improve the quality of care by reducing the incidence of malpractice and suggests methods to contain high insurance premiums experienced in some medical specialties.

II. Medical Liability Is NOT a Factor in Rising Health Care Costs

Neither the cost of medical malpractice litigation nor so-called "defensive medicine" play any appreciable role in health care costs. In fact, malpractice litigation accounts for less than 1 percent of total health costs. Instead, focusing on malpractice liability and defensive medicine simply diverts attention from an insidious cost driver in America's health care system: self-dealing by the medical industry.⁷

A. The Impact of Medical Liability on Health Care Costs

The impact of medical malpractice litigation on total health care costs is illustrated by considering the cost of medical liability insurance. In the event of malpractice, nearly all health care providers are protected from liability by insurance. Insurers obviously do not pay out all that they collect in malpractice premiums; in fact, the medical malpractice line is very profitable.⁸

In 1991, insurers collected about \$4.8 billion from health care providers for malpractice insurance.⁹ These premiums equaled about 0.64 of 1 percent of national health care expenditures of nearly \$752 billion in 1991.¹⁰ Thus, medical liability insurance contributed less than 1 percent to national health care costs. In everyday terms, that amounts to 26 cents out of a \$40 office visit.

Given these facts, it is not surprising that the U.S. Congressional Budget Office, an independent arm of Congress, concluded in 1992:

⁶ Ironically, American physicians and their families already are the recipients of special treatment that is not available to other citizens. "Professional courtesy," the delivery of health care at no charge or a reduced rate by physicians to other physicians and their families, is offered and supported by almost all physicians in the United States. Mark A. Levy et al., "Professional Courtesy--Current Practices and Attitudes," 329 New Eng. J. Med. 1627 (Nov. 25, 1993).

⁷ See discussion of physician self-referral *infra* p. 7.

⁸ The National Association of Insurance Commissioners reported in 1991 that medical malpractice as a line had the highest profit as a percentage of premiums. Losses paid by insurers in 1991 for medical negligence amounted to 0.31 percent (or 31 cents out of every \$100) of national health care costs, according to a specialty database prepared by A.M. Best Co. For a discussion of insurer profitability, see p. 15.

⁹ A.M. Best Co., Best's Aggregates and Averages 109 (1992 ed.). By comparison, Americans spent an estimated \$6.4 billion on dog and cat food in 1991, or nearly \$1.5 billion more than doctors spent on medical liability insurance that year. Pet Food Institute, Fact Sheet (1993).

¹⁰ Health Care Financing Administration of the U.S. Department of Health and Human Services (1992).

[R]estructuring malpractice liability alone would not generate large savings in U.S. health care costs.

[M]alpractice premiums amount to less than 1 percent of national health care expenditures. Thus, these premiums directly contribute little to the nation's overall health care costs.¹¹

Furthermore, restricting health care consumers' rights and access to courts will not eliminate the necessity of medical malpractice insurance. Since some level of malpractice insurance would be required under even the most Draconian proposals, savings achieved through such restrictions would amount to a small fraction of a demonstrably minuscule cost. Moreover, any savings achieved through lower malpractice premiums would be pocketed by the medical industry, not health care consumers.

B. State Experience with Medical Malpractice "Reform"

To understand the effect of medical liability changes on costs, policymakers should consider the states' experience with medical malpractice "reform." State efforts to control health care costs by "reforming" liability laws have failed miserably. Unfortunately, these efforts have simply cut back on health care consumers' rights and remedies.

In 1975, Indiana sought to control health care costs by enacting a total cap on damages. Injured consumers could recover no more than \$500,000 (subsequently amended to \$750,000) for noneconomic damages such as pain and suffering and economic damages such as medical expenses. However, this measure has done nothing to stem rising health care costs in Indiana. Between 1980 and 1990, Indiana's health care spending increased 139.4 percent -- which was even higher than the national average increase of 138.7 percent.¹² Instead, this measure has forced the most severely injured consumers to seek public assistance when their damages exceed the cap. The taxpayers of Indiana, rather than the wrongdoer, now ultimately bear responsibility for the continuing care of injured medical consumers.¹³

Likewise, California attempted to harness escalating health costs in 1975 by enacting MICRA (Medical Injury Compensation Reform Act). Among other "reforms," this law caps noneconomic damages at \$250,000, eliminates the collateral source rule, allows health care providers to require patients to waive their right to a jury trial in the event of malpractice, and imposes a short statute of limitations. As in Indiana, these changes have not contained California's health care costs, which rose 143.9 percent between 1980 and 1990.¹⁴ Again, this increase was higher than the national average. Moreover, malpractice premiums for doctors in southern California increased from 16 to 337 percent, depending upon physician specialty, between 1980 and 1986.¹⁵

The District of Columbia, in contrast to Indiana and California, has not enacted comprehensive changes to its medical liability laws. Nevertheless, the per capita increase in health care spending in the District between 1980 and 1990 was 108.4 percent, far below the national average of 138.7 percent.¹⁶ Given that malpractice litigation is such an insignificant part

¹¹ CBO, supra note 1, at 27.

¹² Lewin/ICF estimates as published by Families USA Foundation (Oct. 1990). Lewin/ICF is now known as Lewin/VHI.

¹³ Frank Cornelius, "Malpractice Damage Caps Won't Help," Wall St. J., Oct. 13, 1993, at A23.

¹⁴ Supra note 12.

¹⁵ GAO, Medical Malpractice: Case Study on California 11 (Dec. 1986).

¹⁶ Supra note 12.

of overall health care costs, it should surprise no one that states that have changed their liability laws have not succeeded in containing health costs.

C. "Defensive Medicine"

Another key element in the campaign to change America's medical liability system is the elusive concept of defensive medicine. While defensive medicine is nearly impossible to define or quantify, the medical and insurance industries assert that health care providers, fearing potential liability, order unnecessary medical tests that drive up costs.

However, defensive medicine may simply be careful medicine: using the newest testing to eliminate errors or rule out particular diagnoses; obtaining more consultations, second opinions and referrals; taking better histories, keeping better records and scheduling more follow-up visits. One study by two doctors notes:

Standards in most specialties of medicine have not been clearly described, so that what might appear to be defensive medical practice to one clinician may, to another, be quality medical care.¹⁷

The American Medical Association itself concluded in 1975 that defensive medicine is good medicine.

Generally, it is recognized that "defensive driving" is a good practice for motorists to follow. Similarly, it appears that "defensive medicine" is essentially beneficial for patients.¹⁸

However, after surveying the political terrain, the AMA more recently has concluded that it would be better served by decrying the costs of so-called defensive medicine.

Other members of the medical establishment remain skeptical about the very existence of defensive medicine. Dr. William Ira Bennett, former editor of the Harvard Medical School Health Letter, has written:

A common complaint is that the costs of "defensive medicine" are also raised by the current fear of malpractice. This is hard to prove. Thanks to the abundance of health insurance, neither doctors nor patients are much deterred from spending money on excessive testing. In reality, though, failure to order a questionable test is the basis for only a small minority of malpractice judgments; most (other than slips and falls in the hospital) involve clearly wrong procedures or diagnoses.¹⁹ (Emphasis added.)

¹⁷ Laurence R. Tancredi and Jeremiah A. Barondess, "The Problem of Defensive Medicine," 200 Science 879 (May 26, 1978).

¹⁸ R.P. Bergen, "Defensive Medicine Is Good Medicine," 228 JAMA 1188 (May 27, 1974).

¹⁹ William Ira Bennett, "The Pluses of Malpractice Suits," N.Y. Times, July 24, 1988, at 31 (Magazine). See also Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York 10 (Executive Summary) (1990). On the issue of defensive medicine, the Harvard researchers concluded:

Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as a result of a specific suit. Thus, it was unclear whether defensive medicine resulted from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO), state and hospital requirements, or a combination of factors.

Nevertheless, the medical and insurance industries continually assert that defensive medicine is driving up health costs. After polling physicians, the AMA Committee on Professional Liability estimated that the cost of defensive medicine in 1983 was between \$15 billion and \$40 billion.²⁰ More recently, researchers for the AMA's Center for Health Policy Research used the physician survey to arrive at two estimates of the cost of defensive medicine in 1984: \$13.7 billion and \$12.1 billion.²¹ It is noteworthy that these latter figures include physicians' insurance premiums, in addition to defensive medical practices. By 1991, the AMA estimated that defensive medicine cost \$25 billion.²²

Other studies, however, have concluded that the cost of defensive medicine is less than compelling. In a report released by a group advocating malpractice reform,²³ the consulting firm Lewin/VHI estimated in January 1993 that changing medical liability laws could save \$35.8 billion over five years in insurance premiums and defensive medical practices.²⁴ Assuming the accuracy of these figures for the sake of argument, these reforms purportedly would save \$7 billion a year in premiums and practice changes. Again, this is less than 1 percent of total health care costs of almost \$752 billion in 1991.

The facts, when separated from fiction, led the Congressional Budget Office to conclude in 1992:

[M]uch of the care that is commonly dubbed "defensive medicine" would probably still be provided for reasons other than concerns about malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this "defensive care" helps to reduce the uncertainty of medical diagnoses, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform.²⁵

D. The Real Culprit of High Costs: Self-Referral

As long as the health care debate focuses on medical liability and defensive medicine, the medical industry can continue to deflect attention from self-referral practices that drive up health costs. As Dr. Arnold S. Relman, editor-in-chief emeritus of the New England Journal of Medicine, has observed:

Self-referral is a prime example of the current and growing encroachment of commercialism on medical practice. . . . [T]his

²⁰ American Medical Association, Report of the Board of Trustees, "Study of Professional Liability Costs" 93-102 (Dec. 1983).

²¹ Roger A. Reynolds et al., "The Cost of Medical Professional Liability," 257 JAMA 2776-81 (May 22, 1989).

²² Medical Malpractice in Health Care Reform, Nov. 10, 1993: Hearings Before the Subcomms. on Health and the Environment and Commerce, Consumer Protection and Competitiveness of the House Comm. on Energy and Commerce, 103d Cong., 1st Sess. (statement of Dr. Joseph T. Painter, President, American Medical Association).

²³ National Medical Liability Reform Coalition. In addition to the AMA and other medical associations, listed supporters of this coalition include Dow Chemical Company, the Health Insurance Association of America, the National Association of Manufacturers, the Pharmaceutical Manufacturers Association, and the U.S. Chamber of Commerce.

²⁴ Lewin/VHI, Inc., Estimating the Costs of Defensive Medicine (Jan. 27, 1993).

²⁵ CBO, supra note 1, at 27.

issue reflects the increasing tension between professional and business values.²⁶

A growing body of evidence shows that a substantial purpose of "unnecessary" tests is to increase the income of physicians. The Consumer Federation of America (CFA) reported in 1991 that the most significant change in physicians' practices during the 1980s was the dramatic increase in self-dealing for ancillary medical services, including clinical laboratory tests, PAP smears, X-rays and other imaging services.²⁷ The CFA report found that doctors with a financial interest in a lab ordered 34 to 96 percent more tests and, as a result, their prices were 2 to 38 percent higher and total bills were 26 to 125 percent more than those of independent labs.²⁸

Not surprisingly, the profit motive plays a major role in self-dealing. At least five recent studies of this practice show that self-referring doctors order testing up to eight times more often than referring doctors, and self-referring doctors' costs were up to seven and a half times higher than when outside services were used.²⁹

Compounding the problem of self-referral is the fact that medical consumers lack the expertise to evaluate the necessity for testing. As a result, consumers have essentially no voice in the decision to use doctor-owned services. Moreover, it is unrealistic to expect a medical consumer, whose health is at stake, to vigorously question his or her doctor about the utility of a medical test.

Doctors, not patients, are the consumers of medical testing services. When they self-deal, doctors have interests on both sides of the same transaction, eliminating any market supply/demand check on the process. Yet, the medical industry vehemently opposes measures that would eliminate or regulate self-referral.³⁰ Thus, it has fallen on state legislatures to enact statutes requiring physicians to disclose their financial interest in lab facilities to patients before referral,³¹ or statutes that prohibit doctors from having financial interests in testing facilities.³² In addition, Congress has prohibited certain financial arrangements between referring physicians

²⁶ Arnold S. Relman, "'Self-Referral' -- What's at Stake?" 327 New Eng. J. Med. 1522-24 (Nov. 19, 1992).

²⁷ Consumer Federation of America, Physician Self-dealing for Diagnostic Tests in the 1980s: Defensive Medicine v. Offensive Profits 3 (Oct. 1991).

²⁸ *Id.* at 8-9.

²⁹ Jean M. Mitchell and Jonathan H. Sunshine, "Consequences of Physicians' Ownership of Health Care Facilities -- Joint Ventures in Radiation Therapy," 327 New Eng. J. Med. 1497-501 (Nov. 19, 1992) (joint ventures appear to have an adverse effect on patients' access to care and increase the use of services and costs substantially); Alex Swedlow et al., "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," 327 New Eng. J. Med. 1502-06 (Nov. 19, 1992) (physical therapy initiated 2.3 times more often by self-referring physicians, while 38 percent of magnetic resonance imaging (MRIs) by self-referring doctors was found inappropriate); Bruce J. Hillman et al., "Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population," 268 JAMA 2050-54 (Oct. 21, 1992) (self-referring physicians ordered imaging examinations 1.7 to 7.7 times as often, and their charges were 1.6 to 6.2 times higher than doctors who did not self-refer); Jean M. Mitchell and Elton Scott, "Physician Ownership of Physical Therapy Services," 268 JAMA 2055-59 (Oct. 21, 1992) (visits per patient were 39 to 45 percent higher in joint venture facilities, while gross and net revenues were 30 to 40 percent higher in facilities owned by self-referring doctors); Bruce J. Hillman et al., "Frequency and Costs of Diagnostic Imaging in Office Practice -- A Comparison of Self-Referring and Radiologist Referring Physicians," 323 New Eng. J. Med. 1604-08 (Dec. 16, 1990) (self-referring doctors ordered imaging exams 4.0 to 4.5 more frequently and their average charges were 4.4 to 7.5 times higher).

³⁰ Relman, *supra* note 26, at 1523 (noting that six months after advising physicians to avoid self-referral, the AMA declared self-referral to be ethical as long as the patient is informed of the physician's financial interest in the facility).

³¹ States that have enacted such statutes include: California, Kansas, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New York, Pennsylvania, Tennessee and Virginia.

³² Georgia, Florida and Michigan have prohibited the ownership of financial interests in testing facilities.

and clinical laboratories in response to the abuse of the Medicare system and physician reimbursements.³³

Again, when the facts are separated from fiction, it is clear that:

- malpractice litigation is not a factor in rising health care costs;
- medical liability "reforms" enacted in the states have failed to control costs;
- defensive medicine is impossible to quantify and, in any event, contributes little to overall costs; and
- self-referral adds significant costs to health care.

III. The Incidence of Medical Malpractice

For all their concern about medical liability, the medical and insurance industries have failed to address the underlying cause of malpractice lawsuits: negligent medical care. Rather than promote improvements in quality of care or root out incompetent doctors, health care providers and insurers have diverted public attention to medical liability laws and defensive medicine.

Meanwhile, medical malpractice injures and kills consumers each day, often with little chance of being brought to public attention. Understandably, consumer groups have lined up against proposals that would cut back on citizens' rights rather than eliminate malpractice. The consumer group Public Citizen observed in November 1993:

[M]ost attempts to address the problem of medical malpractice have been embodied in attacks on victims and their right to recover damages from negligent providers, not on solving the problem at the source -- ensuring quality care and eliminating medical negligence.³⁴ (Emphasis in original.)

A. The Dimensions of Malpractice

Although most health care providers are competent and well-meaning, medical malpractice in America occurs far too frequently. The Harvard Medical Practice Study found that in New York state hospitals in 1984 there were more than 27,000 negligent adverse events, including nearly 7,000 deaths and almost 900 cases of permanent disability of more than 50 percent.³⁵ Extrapolating these figures to the nation as a whole, medical researchers have estimated that malpractice kills more than 80,000 Americans a year and injures hundreds of thousands more.³⁶

As appalling as these figures are, they actually undercount the incidence of malpractice because they are based only on in-hospital negligence. The Harvard researchers, for

³³ 42 U.S.C. § 1395nn (1992).

³⁴ Medical Malpractice in Health Care Reform, Nov. 10, 1993: Hearings Before the Subcomms. on Health and the Environment and Commerce, Consumer Protection and Competitiveness of the House Comm. on Energy and Commerce, 103d Cong., 1st Sess. (statement of Pamela Gilbert, Director, Public Citizen's Congress Watch). Other consumer groups that have stated their belief that malpractice reform might further harm injured consumers, while doing nothing to rein in costs, include the American Association of Retired Persons, Citizen Action, Coalition for Consumer Rights and Center for Patients' Rights.

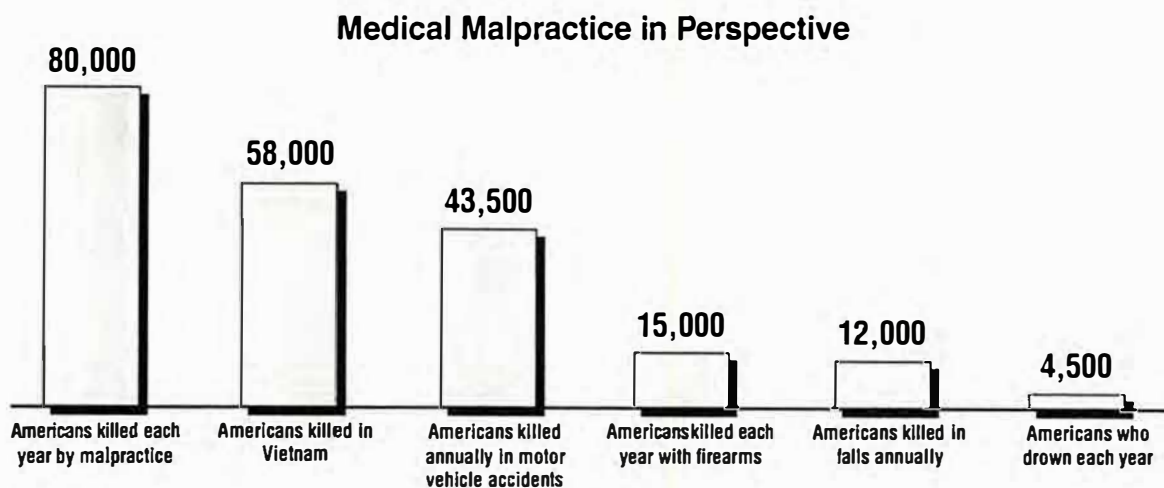
³⁵ Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York 11-1 (1990).

³⁶ Patricia Danzon, an economist and expert on malpractice in the United States, estimates that only about 10 percent of medical malpractice incidents result in a claim. Patricia Danzon, *Medical Malpractice: Theory, Evidence and Public Policy* (Harvard University Press, 1985). Thus, if the AMA is correct in estimating that 42,000 malpractice claims were filed in 1983, there would have been 420,000 malpractice incidents that year under Danzon's estimate.

example, did not attempt to quantify the extent of malpractice in clinics or private practice. Considering the number of negligence-related injuries and lawsuits actually filed, the Harvard researchers estimated that only one in eight negligently injured consumers ever brings a claim.

The 80,000 deaths annually from medical malpractice are even more chilling when put into perspective. Consider that --

- nearly 58,000 Americans were killed in the Vietnam War³⁷;
- about 43,500 Americans die annually in motor vehicle accidents³⁸;
- more than 15,000 citizens are murdered each year with a firearm³⁹;
- more than 12,000 Americans perish each year from falls⁴⁰; and
- about 4,500 citizens drown annually.⁴¹



Unfortunately, the medical industry's only response to the incidence of medical malpractice has been to seek limits on injured consumers' remedies and access to courts. Reducing the risk of malpractice and disciplining negligent providers are not the medical industry's top priorities.

B. Hidden Malpractice

A great deal of information now exists about the quality of medical care, the competence of doctors, and mortality and morbidity rates. Yet, the institutional bias inherent in the medical industry shields most malpractice from public view. As a result, health care consumers have little basis to make informed choices about health care.

Malpractice is hidden at two levels. First, the medical culture protects its own, enforcing an informal conspiracy of silence. Early on, new health care providers learn the economic value of silence and the high price they will pay if they deviate from the norm.

Second, legislative and administrative actions shield much malpractice from ever coming to public attention. Most peer review records are not open to the public, and accreditation

³⁷ Eric Schmitt, "Female Vietnam Veterans Welcomed Home," N.Y. Times, Nov. 12, 1993, at A1.

³⁸ National Safety Council, Accident Facts 4 (1992).

³⁹ FBI, Uniform Crime Reports (1992).

⁴⁰ Supra note 38.

⁴¹ Id.

reports rarely see the light of day. The one major database that collects information on practitioner quality of care, the National Practitioner Data Bank, is off limits to health care consumers. Even doctors who want to make referrals are barred from obtaining information from the data bank.

Thus, pervasive secrecy and an almost total absence of professional discipline create an atmosphere that permits and fosters medical malpractice. Health care providers know there is little chance they will be held accountable for negligent treatment.

The rare state medical board that does act against an incompetent physician often finds that all it has done is encourage the physician to set up shop in another state. Incompetent physicians can evade disciplinary proceedings in one state by simply packing their bags and moving to another state.⁴²

No one knows how many times medical boards have foisted bad doctors onto health care consumers in other states in return for a physician's promise to leave the original state. Unfortunately, if an incompetent doctor agrees to leave a state, the board often will agree to drop a complaint and the doctor's record remains unblemished.

Consumers and their families must blindly trust the medical industry as they are thrust into this information vacuum. In some instances, information about a health care provider's expertise may be obtained, but it is hard to get. More often, the competency of a doctor or hospital is not questioned until after a patient has been negligently injured.

The medical industry essentially defends secrecy on the ground that health care consumers would be misled by (i.e., are not smart enough to understand) quality-of-care data.⁴³ However, Americans have proved time and again that, given adequate information, they are quite capable of making extremely difficult choices. Patients who can choose between alternative courses of treatment, which they clearly have a legal right to do, can surely make more effective decisions when given access to quality-of-care information. Today, health care consumers are never given that choice.

IV. Medical Malpractice Claims Are NOT Exploding

Even though it is estimated that negligent medical treatment kills and injures hundreds of thousands of Americans each year, claims and jury awards actually are declining. In addition, studies show that juries are not biased toward plaintiffs nor do they render unjustified awards.

A. The Number of Medical Malpractice Claims

Over time, medical malpractice claims should increase as more Americans have access to health care. This is because:

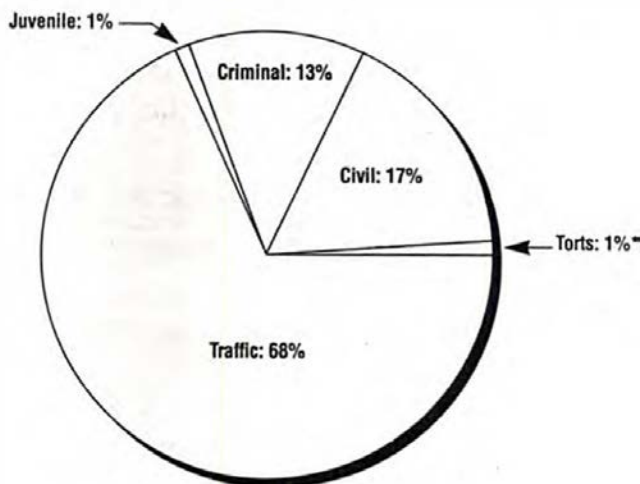
- the delivery of care becomes more efficient and doctors can treat more patients daily;
- medical learning and technology advance so that doctors are held to a higher standard of care (i.e., doing nothing or too little breaches the applicable standard of care); and
- the population ages, resulting in an increased need for care.

⁴² See, e.g., Sandra G. Boodman, "What You Can't Know About Your Doctor," Wash. Post, Sept. 14, 1993, at 11 (Health Section); Charlotte L. Rosenberg, "How Bad Doctors Dodge Discipline," 62 Med. Econ. 240 (Mar. 18, 1985).

⁴³ Boodman, *supra* note 42. (This report notes that the AMA's House of Delegates has voted to seek the abolition of the National Practitioner Data Bank.)

Nevertheless, independent studies show that medical consumers do not bring dubious claims and, in general, are reluctant to file lawsuits against health care providers. The Harvard Medical Practice Study estimated that only one in eight negligently injured patients ever brings a claim.⁴⁴ The number of claims each year barely amounts to half of the deaths attributable to medical negligence and constitutes a very small percentage of the total injuries.⁴⁵ Thus, concluded the Harvard researchers: "[W]e do not now have a problem of too many claims; if anything, there are too few."⁴⁶

1989 Trial Court Filings



* Tort filings accounted for about 950,000 cases or less than 1% of total filings of 98,464,561.
Sources: National Center for State Courts, 1989; Deborah R. Hensler the RAND Institute for Civil Justice

Rather than increase, the number of malpractice claims has dropped at an average annual rate of 8.9 percent since 1985.⁴⁷ The AMA reported in 1992:

Claim frequency for all physicians was 7.7 claims per 100 physicians in 1990, as compared with 7.4 per 100 in 1989. While the claims rate did increase between 1989 and 1990, that increase was not statistically significant. In general, the results indicate a leveling off in the claims rate in contrast to the increases of the early- and mid-1980s.⁴⁸ (Emphasis added.)

Likewise, the Minnesota Department of Commerce, in a comprehensive analysis of all closed claims filed in Minnesota, North Dakota and South Dakota, found that the frequency of claims had decreased between 1982 and 1987. That study concluded:

It would appear . . . that the data does not substantiate the litigation explosion asserted. Claim frequency has not changed measurably

⁴⁴ See also Stephen Daniels, *The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases* 7 (American Bar Foundation Working Paper No. 8806, 1989) (estimates that only one in 25 negligently injured patients ever brings a claim); Deborah Hensler, *Compensation for Accidental Injuries in the United States* 55 (RAND Institute for Civil Justice, 1991) (estimates that one in 10 injured consumers seeks compensation from the tort liability system).

⁴⁵ The AMA estimated that there were 42,000 malpractice claims in 1983, compared to the estimated 80,000 deaths each year that are attributable in part to medical negligence.

⁴⁶ Harvard Medical Practice Study, *supra* note 35, at 11-4.

⁴⁷ *Socioeconomic Characteristics of Medical Practice, Medical Professional Liability Claims and Premiums, 1985-1990*, 23 (American Medical Association, 1992). In addition, the National Center for State Courts reported a drop in malpractice suits in the 1980s.

⁴⁸ *Id.*

in the last six years. The 1987 frequency rate is actually less than the 1983 rate. . . . Average payments actually appeared to be decreasing over the period of study.⁴⁹

Despite a decrease in claims frequency, the Minnesota study noted, physicians paid about three times more for malpractice insurance in 1987 than in 1982.⁵⁰

Another myth that evaporates under even minimal scrutiny is that indigent patients are more likely to sue for medical malpractice than patients with greater economic resources. The General Accounting Office (GAO) found in 1993 that poor patients actually bring fewer claims than the general population and that awards to indigents "account for a relatively small share of total hospital malpractice losses."⁵¹

A more recent study corroborates the GAO finding. It concluded that poor and uninsured patients are "significantly less likely to sue for malpractice. . . ."⁵² The authors noted that their results suggest that proposed legislation shielding physicians who serve the poor from malpractice suits should be reconsidered.

B. Jury Awards

Contrary to the assertions of the medical and insurance industries, malpractice claims seldom result in jury trials. In fact, most studies conclude that 10 percent of claims or less are tried.⁵³ Injured consumers receive compensation through negotiated settlements agreed to by both sides in about 50 percent of the remaining cases. No compensation is received by plaintiffs in 40 percent of cases.⁵⁴ Of the 10 percent of cases that go to trial, the evidence shows that (1) juries are not biased against doctors and (2) awards are not unjustified or out of control.⁵⁵

Plaintiffs often must overcome several hurdles, not the least of which is jurors' generally favorable view of health care providers. If anything, plaintiffs bear an extra burden in malpractice cases because jurors are suspicious of plaintiffs' motives for suing and scrutinize their actions more closely than those of defendants. Further, plaintiffs generally begin from a weaker position since health care providers and insurers have vast resources. At least one court has observed that medical malpractice litigation is "galaxies apart" from typical cases and

⁴⁹ Minnesota Department of Commerce, Medical Malpractice Claim Study, 1982-1987, 17 (1989).

⁵⁰ *Id.* at 31.

⁵¹ GAO, Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses 2 (Aug. 1993).

⁵² Helen R. Burstin et al., "Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status," 270 JAMA 1697 (Oct. 13, 1993).

⁵³ See, e.g., Mark I. Taragin, "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," 117 Annals Internal Med. 780 (Nov. 1, 1992) (about 12 percent of claims studied went to jury trial); Neil Vidmar, "The Unfair Criticism of Medical Malpractice Juries," 76 Judicature 118 (Oct.-Nov. 1992) (about 10 percent of claims were eventually tried by a jury); Michael J. Saks, "Do We Really Know Anything About the Behavior of the Tort Litigation System -- and Why Not?" 140 U. Pa. L. Rev. 1147, 1212-13, 1226 (Apr. 1992) (fewer than 10 percent of medical malpractice cases are tried); Brian Ostrom et al., "What Are Tort Awards Really Like? The Untold Story from the State Courts," 14 Law & Pol'y 77 (1992) (authors conclude that only 9.8 percent of all medical malpractice claims go to trial); Minnesota Department of Commerce, Medical Malpractice Claim Study, 1982-1987, 31 (1989) (less than half of 1 percent (0.5) of all claimants were awarded damages by a jury, while the likelihood of receiving any compensation was about 25 percent).

⁵⁴ Vidmar, *supra* note 53, at 118.

⁵⁵ Neil Vidmar, "Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases," 43 Duke L. J. 217 (Nov. 1993) (the reputation of juries for reaching into the perceived deep pockets of health care providers and giving excessive awards for pain and suffering is not warranted).

attorneys who represent medical consumers shoulder a heavy burden.⁵⁶ It is not surprising, then, that defendants win the majority of the malpractice cases.⁵⁷

In addition, health care consumers do not benefit from large, unwarranted jury awards. The facts, when separated from the fiction, show that the median award -- which accurately reflects system-wide results -- is far less than the anecdotal claims of the medical and insurance industries. Moreover, awards are generally consistent with severity of injury. A New Jersey study showed that the defensibility of the case and not the severity of the injury was the predominant factor in whether any payment was made.⁵⁸ The authors concluded: "Our findings suggest that unjustified payments are probably uncommon."⁵⁹

V. Medical Liability: A Force for Quality Health Care

By neglecting to police health care providers, the medical industry has failed to ensure quality health care. State medical boards, which are underfunded and understaffed, have not protected the public from negligent providers. Thus, without appropriate oversight, it has fallen on America's medical liability system to deter negligence.⁶⁰ Medical liability, through the civil justice system, has held bad doctors accountable for their mistakes and forced the medical industry to recall or improve the safety of dangerous products and bad drugs. Nevertheless, the medical industry continually pushes for liability "reforms" that would reduce the only effective deterrent to negligence.

State medical boards have failed to discipline negligent doctors. While over the years disciplinary actions -- license revocation, suspension and probation -- have increased, they actually have decreased proportionally due to the increase in number of doctors. In 1991, about 2,000 of the nation's 615,000 licensed physicians -- less than half of 1 percent -- were sanctioned by state medical boards.⁶¹ While the Harvard Medical Practice Study found 27,000 negligent adverse events in one year in New York hospitals, that state's Office of Professional Medical Conduct averaged only 236 disciplinary actions a year between 1986 and 1990.⁶² Many of the doctors who were disciplined were not even sanctioned for negligence, but for insurance fraud or falsifying records.

In addition, the AMA acknowledges that 30,000 to 40,000 physicians are impaired by alcohol or drugs.⁶³ Yet, only about 200 doctors lose their licenses a year and that includes those

⁵⁶ Baker v. Varela, 416 So. 2d 1190 (Fla. Dist. Ct. App. 1982).

⁵⁷ See, e.g., Vidmar, supra note 53, at 118 (in cases that were tried, juries ruled in favor of plaintiffs 20 percent of the time); Taragin, supra note 53, at 782 (for the small number of cases in which there was a jury verdict, only 24 percent resulted in payment to the plaintiff).

⁵⁸ Taragin, supra note 53, at 783.

⁵⁹ Id. at 784.

⁶⁰ On the deterrent effect of medical liability, economist and researcher Patricia M. Danzon has stated: "The advantage of the tort system is that it provides a continual, ongoing system of 'regulation by incentives.' And it does not rely on enforcement by the medical profession which, like any other profession, is notoriously reluctant to police its own members," Testimony of Patricia M. Danzon, presented to the Committee on Labor and Human Resources, U.S. Senate, July 10, 1984.

⁶¹ Boodman, supra note 42. See also Sidney Wolfe et al., 10,289 Questionable Doctors 8 (Public Citizen Health Research Group Report, Sept. 1993) (only 1,974 doctors out of 623,000 nationwide were disciplined in 1992).

⁶² Kevin Sack, "More Malpractice Than Lawsuits, New York Medical Study Suggests," N.Y. Times, Jan. 29, 1990, at A1.

⁶³ Harvey F. Wachsman, "Doctors Who Maim and Kill and Get Away with a Wink and a Smile," N.Y. Times, Aug. 25, 1989. According to Dr. Arnold S. Relman, editor-in-chief emeritus of the New England Journal of Medicine: "20,000 physicians . . . for one reason or another probably ought not to be practicing medicine. They are either alcoholics, drug addicts, senile, criminals, or simply incompetent physicians." Richard Greene, "Quackus tyrannus," Forbes, Oct. 5, 1987, at 67.

who commit fraud or felonies.⁶⁴ On average, only 3.44 serious disciplinary actions are taken for every 1,000 doctors.⁶⁵

When state medical boards do act, their investigations take years to complete. All the while, negligent doctors continue to treat patients. The actions of state boards also can have the unintended effect of spreading medical incompetence to other states by encouraging doctors to flee to avoid discipline.⁶⁶ A General Accounting Office study of 181 doctors whose licenses were to be revoked in Michigan, Ohio and Pennsylvania between 1977 and 1982 found that 33 simply set up shop in another state.⁶⁷ Some state boards have even agreed to dismiss a complaint in return for the doctor's promise to leave or quit practicing.

In this void of effective regulation, America's medical liability system stands alone as a check on the quality of care. As noted by one commentator in Hospital Practice:

It is sad but true that many physicians practice more carefully than they did in the past because they have one eye on the potential litigant. . . . If the courts and insurance companies and the fear of malpractice become the most important disciplinary weapon in medicine -- distasteful as the idea may be to physicians -- so be it.⁶⁸

Even the AMA has acknowledged the beneficial effect of medical liability on improving the quality of care.

For all of its ills, the tort system's fault-based standard of care has prompted hospitals, medical societies and, most notably, physician-owned insurance companies to become very active in a variety of endeavors to reduce the risk of patient injuries.⁶⁹

VI. The Need for Malpractice Insurance Reform

The root of the medical industry's push for liability "reform" is the cost of medical malpractice insurance. Premiums for high-risk specialties such as obstetrics and neurosurgery are frequently cited as examples.

Without question, some specialties pay very high premiums. However, this insurance issue is unrelated to malpractice claims. Even though some high-risk specialties have been hit with large premium increases, the cost of malpractice insurance has remained fairly constant at less than 1 percent of total health care costs. In the last few years, the cost of malpractice insurance actually has dropped. For example, malpractice premiums declined 3.4 percent (or \$4.8 million) in 1991, and dropped 7.6 percent between 1989 and 1991.⁷⁰ It is noteworthy that this decline has occurred in states that have not changed their medical liability laws as well as in states that have.

⁶⁴ Wachsmann, *supra* note 63.

⁶⁵ Public Citizen Health Research Group, Comparing State Medical Boards (Jan. 1993).

⁶⁶ Rosenberg, *supra* note 42.

⁶⁷ *Id.*

⁶⁸ Robert S. Derbyshire, "Malpractice, Medical Discipline and the Public," 19 Hosp. Prac. 209, 216 (Jan. 1984). See also William B. Schwartz and Neil K. Komisar, "Doctors, Damages and Deterrence: An Economic View of Medical Malpractice," 298 New Eng. J. Med. 1282 (June 8, 1978) ("By finding fault and assessing damages against the negligent provider, the [civil justice] system sends all providers a signal that discourages future carelessness and reduces further damages.").

⁶⁹ Liability Wk., Mar. 5, 1990 (statement of Dr. James Todd, executive vice president of the American Medical Association).

⁷⁰ Best's Review, "Medical Malpractice," 30 (Dec. 1992).

Even with this decline in premiums, insurers' profits have soared. The National Association of Insurance Commissioners (NAIC) recently examined profitability by looking at premiums earned, losses incurred and return on insurers' net worth. For the medical malpractice line, the most recent NAIC figures show \$4.86 billion in direct premiums earned in 1991, resulting in a total profit equal to 29.2 percent of the direct premiums earned (or \$1.4 billion), and a 15.9 percent return on net worth (or \$773 million). According to NAIC, the total investment gain in 1991 was \$1.88 billion. Indeed, medical malpractice as a line has the highest profit as a percentage of premiums at 29.2 percent of direct premiums earned, with the next highest percentage being 15.6 percent realized by other liability lines.⁷¹

Some high-risk medical specialists continue to experience outrageous premiums. Nevertheless, the answer to this problem is not to restrict the rights of injured consumers, but to address the following problems in the insurance industry:

A. Skimming of Risk. Even though competing insurers may have nearly equal shares of the market, they have different percentages of associated risk. Doctor-owned companies set up during the insurance "crisis" in the 1970s were insurers of last resort. They insured doctors who could not obtain insurance from for-profit carriers. Consequently, doctor-owned carriers may have, for example, 50 percent of the market in premiums, but a much higher share of risk. Meanwhile, the for-profit carrier may have 50 percent of the market, but a much smaller percentage of risk. This tactic, known as "skimming," results when for-profit carriers keep the least risky groups or individual doctors for their own client base.

A way to solve this problem is to put all doctors into a unified pool from which all malpractice insurers could write insurance based on their willingness to accept a proportional share of risk. If doctors in this unified pool were risk-rated by a neutral agency (i.e., the state insurance department), insurers could be required as a condition of licensure to take a percentage of higher-risk doctors in the pool roughly equivalent to their share of the entire medical malpractice market.

Under the "two-tiered" system now in place, for-profit carriers earn a substantial income and saddle the doctor-owned companies with too much risk for their share of premiums.

B. Proliferation of Risk Categories. A related problem that boosts malpractice premiums is insurers' practice of dividing doctors into too many risk categories. This has resulted in some specialties (e.g., obstetrics and neurosurgery) paying huge malpractice premiums, while other providers pay very low premiums.

Malpractice underwriters have so fine-tuned the risk by the type of medicine a doctor practices that they may have unwittingly destroyed the cardinal rule of insurance -- spreading the risk. In many states, underwriters have subdivided the medical community into as many as 12 to 19 different specialties. Because of this proliferation of risk categories, there are too few doctors in many of the specialty pools, such as neurosurgery. This is particularly true in states where there is not a large physician population. Since negligence associated with neurosurgery or obstetrics often results in a lifetime of continuing care, the cost of such injuries is extremely high but is spread among only a small pool of doctors in the specialty pool.

The solution is to return risk categories to the way they were originally set up. When there were only three or four categories, underwriters could put a doctor in high, medium

⁷¹ National Association of Insurance Commissioners, Report on Profitability by Line, by State (Dec. 1992).

or low risk. By dividing the pool of doctors into a few groups, each pool has sufficient numbers to allow the concept of insurance -- spreading the risk among many insureds to permit affordable premiums -- to work. This will not increase the total premium dollars collected, but it will reallocate what certain classes of doctors pay.

If risk categories are reduced, specialists will see their premiums drop dramatically, while general and family practitioners will experience a modest increase. However, this will reflect the changing pattern of medicine over the past 20 years. Today, the general or family practitioner accepts little or no risk in his or her practice. He or she refers risky patients to a medical specialist who has little in-depth contact with patients. So long as the support system of specialists exists to take on the higher-risk procedures, the general practitioner ought to be willing to subsidize a slight change in malpractice premium allocation. Such a change permits the general practitioner to continue to access a specialized medical opinion in the high-risk case.

Medical associations do not like the idea of reallocating malpractice premiums because it is a potentially divisive issue within the medical community. Nevertheless, such a plan offers the best chance to alleviate the high premiums that certain medical specialists are now forced to pay.

C. Lack of Experience Rating. When an insurer writes malpractice insurance, it does not consider the claims experience of the individual doctor. By comparison, a poor automobile driver will pay a higher rate, which takes into account his or her accident and driving record. Bad doctors are not charged higher rates, and good doctors receive no insurance break because of their competence. Lack of experience rating of malpractice premiums is unfair to good doctors and untenable.

Since a few doctors often are responsible for a large share of malpractice claims paid,⁷² insurers could deter malpractice by charging higher premiums to those most responsible for losses.

This proposal not only makes sense, but also is good public policy. It is long overdue. Basing premiums on claims experience will benefit medical consumers by deterring malpractice and encouraging good medicine.

D. Overreserving. Because medical malpractice claims generally take a long time to resolve, insurers establish reserves to cover their estimated future losses. Insurers label reserves as liabilities, but reserves are held and invested until claims and claim expenses are paid.

Insurers primarily base estimated future losses on historical loss patterns. Each year, estimates are adjusted when actual losses are compared to the estimated loss. If the income from the investment of reserves is included in calculating the annual change in the industry's medical malpractice reserve estimates, insurers overreserved by \$1.4 billion between 1982 and 1991.⁷³

This is not surprising when you consider how little insurers pay out in claims compared to the amount they receive in premiums. When annual premiums collected are

⁷² See, e.g., Testimony of Blaine F. Nye from public meeting entitled "Academic Task Force for the Review of the Insurance and Tort Systems" 169 (June 11, 1987) (less than 4 percent of doctors practicing in Florida in 1986 were responsible for approximately 45 percent of paid claims to injured consumers); Miller et al., Medical Malpractice: Crisis of Litigation or Crisis of Negligence? (Health Resources, Inc., March 18, 1987) (less than 2 percent of all physicians practicing in Cook County, Illinois, were defendants in 36 percent of malpractice claims filed between 1972 and 1986).

⁷³ A.M. Best Co., Casualty Loss Reserve Development Series -- Medical Malpractice (1992).

compared to actual annual losses paid, medical malpractice insurers paid out an average of only \$45.88 for every \$100 in premiums collected between 1979 and 1991.⁷⁴

VII. Restricting Patients' Rights Is No Solution

In the current debate over health care, the medical and insurance industries are once again pushing for changes to medical liability under the banner of "tort reform." But when fact is separated from fiction, these "reforms" would: (1) make it harder for injured medical consumers to bring lawsuits, (2) make it tougher for consumers to prevail when they do, and (3) arbitrarily limit the amount an injured consumer may recover, even after a judge or jury decides that the consumer is entitled to compensation.

The medical and insurance industries' "reforms" are not intended to help consumers or improve the system, but rather to shield health care providers from responsibility for their negligent acts. As one commentator has noted, most of the empirical data on the medical liability system

suggest[s] that the reforms that have generally been proposed would advance none of the goals of the malpractice tort system and would, in fact, exaggerate the system's most fundamental shortcomings (less compensation, larger gaps between losses and compensation) and weaken the one thing it may get right (deterrence).⁷⁵

Proposals that would do nothing to contain costs or improve the quality of care but which would restrict injured consumers' rights are:

A. Federalization of Medical Malpractice. America has always celebrated its great diversity. Our forebears recognized that the norm in one area may be perceived as unusual in another. As a result, they balanced state and federal power, and secured states' rights in the Tenth Amendment to our federal Constitution. Tort law, of which medical liability is a part, has always been a state issue and should remain so. The federal government should not become the arbitrator of what historically has been a matter of state right.

B. Caps on Damages. Arbitrarily capping damages is unjust and further injures those who have had the misfortune of being severely injured since their damages are most likely to exceed the cap. As this paper has shown, damage caps have done nothing to control health care spending in California and Indiana. Meanwhile, a jurisdiction that has not enacted caps -- the District of Columbia -- has seen its health care costs increase at a rate below the national average. Further, damage caps permit a negligent wrongdoer to evade accountability for his or her acts. Ultimately, taxpayers must make up the difference when an injured consumer's damages exceed the cap.

C. Alternative Dispute Resolution (ADR). In its simplest form, ADR can expedite litigation by providing a process for earlier settlements while still allowing a case to proceed unfettered in court if a party is dissatisfied with the result. In that sense, increased use of ADR can be beneficial, and ATLA supports programs such as court-controlled mediation and voluntary

⁷⁴ A.M. Best Co., *Experience by State (by Line)* (1992).

⁷⁵ Michael J. Saks, "Malpractice Misconceptions and Other Lessons About the Litigation System," 16 *Just. Sys. J.* 7 (1993).

arbitration. But many ADR proposals are promoted as substitutes for trial by jury, contain coercive penalties designed to force settlements or postpone the right to proceed in court until ADR has been completed. These forms of ADR are unfair, costly and interfere with the right of every American to have access to courts.

D. Mandatory Periodic Payments. Defendants who have been adjudicated as negligent should not be permitted to keep the plaintiff's compensation and dictate periodic payments. This only results in a windfall for defendants, since they are able to invest and earn income on the unpaid balance of an award. The injured consumer should receive this benefit. Moreover, there should never be any delayed payment without full posting of security to ensure future payments.

E. Abolition of the Collateral Source Rule. Permitting defendants and insurers to receive a windfall by requiring an injured patient to offset separately purchased benefits against an award turns the justice system on its head. The medical and insurance industries charge that plaintiffs "game the system" by receiving compensation in the form of an award and privately purchased insurance, i.e., a "double recovery." However, very few plaintiffs receive double recoveries. Further, there is no reason to benefit a wrongdoer simply because an injured consumer had the foresight to secure benefits from a collateral source.

F. Caps on Plaintiffs' Attorney Fees. Limiting plaintiffs' attorney fees is a Trojan horse intended to prevent injured medical consumers from retaining an attorney in the first place. Moreover, limiting plaintiffs' attorney fees while permitting defendants to spend unlimited sums on legal representation is patently unfair to health care consumers. This proposal attempts to stack the deck in favor of defendants.

VIII. Proposals to Improve the System

The Association of Trial Lawyers of America has never opposed change that will protect patients' rights. Thus, we advocate:

A. Improved Quality and Safety of Medical Care. The cause of medical malpractice is malpractice. Lawsuits would be greatly reduced if doctors would clean up the profession and drug companies would stop putting profits ahead of patient safety. State medical boards need to be strengthened. Performance audits and recertification for doctors, together with stronger regulation of hospitals, should be required.

The walls of secrecy should be torn down so that consumers will have meaningful access to reliable information concerning the quality of care -- particularly the National Practitioner Data Bank and peer review results. In this way, traditional market forces can weed out incompetent and dangerous health care providers.

Arbitrary limits on the liability system should be opposed or, where already enacted, repealed. The system should be allowed to work.

B. Elimination of Physician Self-Dealing. Taken alone, this will have an immediate and major impact on containing health care costs. As discussed in this paper, the medical establishment has opposed elimination or regulation of physician self-referral and, therefore, it generally has fallen on the individual states to try to limit or prohibit this costly practice.

C. Streamlining the Medical Liability System. At present, medical defendants obtain a decided advantage by delaying case resolution. Two changes at the state level would expedite case resolution:

1. Apply prejudgment interest in all medical liability cases. This would provide an incentive for liability insurers to seek early resolution as opposed to dragging cases out.

2. Develop a simplified system for handling small cases at the state level. Many cases currently are not filed because, given the medical and insurance industries' resources, litigation is simply too expensive. A simplified system for small cases would fill that void. It should, at a minimum, have strict time limits to ensure speedy resolution of claims, and simplified rules of proof and processes such as limits on experts and bans on costly discovery.

D. Reforming Malpractice Insurance. Necessary insurance reforms include compressed rate classifications and mandated experience ratings. Insurers also should not be allowed to either "skim" the risk or overreserve.

IX. Conclusion

Medical liability is a subject that has been driven largely by anecdotes and a public relations campaign supported by enormous budgets. It is too important to the quality of health care and the access to justice for millions of Americans to allow fiction to go unchallenged by fact.

We hope this paper helps separate fact from fiction and, ultimately, that the public and policymakers will realize that medical liability is not a factor in rising health care costs. Medical liability contributes to the overall quality of health care of our nation. Further, we hope that the health care debate will instigate reform -- not regressive measures of self-protection, but true reform that will secure equal justice for all.

ATLA
February 1994