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Medical Malpractice and the Crisis of Insurance Availability: The Waning Options

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MEDICAL MALPRACTICE AND THE CRISIS OF INSURANCE AVAILABILITY: THE WANING OPTIONS

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Professor Grad argues that the current "medical malpractice crisis," mirroring the crisis of 1975, is in reality a crisis of insurance availability. The crisis has its roots in the very foundation of the entrenched American medical malpractice system. He discusses in detail the social and economic costs of the established American method of dealing with medical injury, including the inability of the system to encourage increased physician competence, the costly practice of defensive medicine, the inherent waste involved in litigating or settling claims, and the inequitable distribution of compensation to victims of medical negligence. He examines the palliative, legislative measures enacted in response to the crisis, such as shortening statutes of limitations, providing caps on recovery, and establishing alternative dispute resolution mechanisms. In view of the ineffectiveness of this symptomatic approach, Professor Grad advocates completely replacing the current American system with a no-fault, compensation system in which all qualifying victims of untoward medical outcomes, whether or not due to negligence, would be compensated.

INTRODUCTION

THE SO-CALLED medical malpractice crisis, in reality a crisis of insurance availability, had its origins in the late 1960's, when the number of negligence actions arising out of automobile accidents was considerably reduced in many states by the advent of no-fault automobile compensation.[1]

The medical malpractice crisis received major attention in the early 1970's, and in 1973 was the subject of a major report by the Secretary of Health, Education and Welfare (HEW) (now Health

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1. It is interesting to speculate whether the decrease in the number of negligence actions for automobile accidents had any impact on the increase of medical malpractice liability actions. It has been observed that the number of elective surgeries increases with the number of surgeons practicing in the area. While no cause and effect relationship can be shown in either instance, both of them provide food for thought.

and Human Services). At the time, attention was focused on the increased number of medical malpractice actions. The problem of insurance availability had not yet become a major concern and was not even mentioned in the Secretary's report. But a mere two years later, in 1974-75, America had its first full-fledged medical insurance availability crisis.

The crisis of 1975 received a great deal of attention from professionals and authors in the field, as well as from federal and state governmental agencies and legislatures. A great deal of legislation has been enacted since 1975, intended to cure the medical malpractice insurance problem and to avoid the recurrence of the crisis.

The developments of the past ten years have shown that these purported solutions failed to address the root causes of the crisis and did little more than paper over the problem. Predictably, the legislation failed to stave off a further crisis in 1985. This second crisis, a carbon copy of the crisis of 1975, was, in reality, a continuation of the earlier one.

One option is to regard the problem as a chronic one, and to provide a temporary "fix" every ten years or so, hoping that somehow we will muddle through or that the problem will take care of itself. It is possible that some other problem might become the focus of our and the trial bar's attention. For instance, as more and more injuries resulting from exposure to hazardous waste are discovered, hazardous waste personal injury litigation might take the "heat" off medical malpractice. However, we cannot rely on this displacement.

This Article will review medical malpractice in the context of the tort law liability insurance configuration, and will analyze this configuration with particular reference to its cost as part of the general cost of the rendition of personal health services. It will also review the measures taken to remedy the health care system following the 1975 insurance availability crisis, and examine current legislative efforts to salvage the system in the light of past failures. Finally, since the 1975 to 1985 legislative efforts failed, as was inevitable in view of the nature of the problem, this Article proposes the substitution of a no-fault compensation system. This system would solve the problem of insurance availability, and provide the most cost-effective, least expensive, means of protecting persons injured by adverse medical outcomes.

I. THE GENERAL IMPLICATIONS OF MEDICAL MALPRACTICE ON THE RENDITION OF HEALTH CARE

Under the common law, a physician can be held liable for damage resulting from his failure to exercise the degree of reasonable and ordinary care, diligence, and skill in the diagnosis and treatment of his patient that physicians engaged in the same line of practice during the same period of time ordinarily possess and exercise.[2] Thus, malpractice liability, a subset of the law of tort, is imposed on the physician for failing to meet the usual, accepted standard of care in treating a patient.[3] Strictly speaking, it defines the duties arising out of a one-to-one, physician to patient, relationship. But this private relationship gives rise to issues of health care of national scope with attendant public cost.

Medical malpractice, while initially a failure of a private relationship, is indeed a major public problem. Although most physicians are competent and careful practitioners, there are a significant number of instances of medical malpractice and even more medical malpractice claims. Even assuming that the majority of medical malpractice claims are unfounded, the number of claims raises issues of physician competence, which is a substantial public issue.[4]

To protect themselves against medical malpractice claims, some physicians resort to the practice of "defensive medicine," i.e., subjecting patients to unnecessary diagnostic and therapeutic procedures in order to establish a litigation-proof "chart." Defensive medicine is practiced despite the fact that there is little agreement as to either what procedures and clinical tests are necessary for patient care or, conversely, the omission of which procedures and clinical tests constitute medical malpractice. To the extent that defensive

2. *See* Pike v. Honsinger, 155 N.Y. 201, 209, 49 N.E. 760, 762 (1898). For a collection of selected definitions of medical malpractice to the same effect, see REPORT OF THE SPECIAL ADVISORY PANEL ON MEDICAL MALPRACTICE, STATE OF NEW YORK 170-72 (1976) [hereinafter cited as N.Y. PANEL REPORT]; 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE § 8.03 (1985). *See generally* A. HOLDER, MEDICAL MALPRACTICE LAW (2d ed. 1978); D. HARNEY, MEDICAL MALPRACTICE (1973); MEDICAL MALPRACTICE—THE ATL SEMINAR 449-68 (L. Harolds & M. Block eds. 1966). There is some question whether the applicable standard is that of the practitioner in the particular locality, or whether a broader or national standard is applicable. Most states reject the locality rule. *See* DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE-APPENDIX 155 (1973) [hereinafter cited as HEW REPORT]; W. PROSSER & W. KEETON, THE LAW OF TORTS 185-89 (5th ed. 1984).

3. *See generally* D. HARNEY, *supra* note 2, at 88-193; A. HOLDER *supra* note 2, at 43-71; W. PROSSER & W. KEETON, *supra* note 2, at 185-93.

4. For a discussion of the relationship of medical malpractice to physician discipline, see *infra* notes 29-36 and accompanying text.

medicine is real, it is a public health concern because it results in a misuse or waste of scarce medical resources.[5]

This Article focuses on the major problems of public policy and cost in medical malpractice which result from the present system's reliance on medical malpractice liability insurance. Liability insurance serves two functions. It protects physicians against personal liability for damages for medical malpractice, and it provides an insurance pool to pay damages to victims of medical malpractice. During the early 1970's, the payouts on this liability insurance rose so astronomically—in some cases tenfold—that in 1974, several important insurers withdrew from the field. After a temporary respite, this scenario repeated itself in 1985.

Unable to obtain adequate insurance coverage in 1975 and 1985, physicians in several states threatened to stop rendering professional services unless properly protected. These threats triggered the much-discussed "medical malpractice crisis" of recent years. The ensuing critical review of medical malpractice insurance shows that the system is very expensive and absurdly ineffective—only one-fourth of the costs is used to compensate victims. Moreover, vast amounts of public funds are being misspent because the cost of health care includes the cost of medical malpractice coverage.[6]

This absurdly inefficient system has few justifications. It fails to discipline physicians or to advance their competence, fails to compensate victims fairly, and moreover, it is premised on an outmoded theory of liability. A more equitable and efficient system must be found.

II. MEDICAL MALPRACTICE AND PHYSICIAN COMPETENCE

In 1970, there were 18,000 new malpractice claims.[7] That same year, 16,000 existing claims were closed, fifty percent without recourse to a lawsuit.[8] The other 8,000 resulted in lawsuits, but eighty percent never went to trial.[9] The remaining 1,600 claims were resolved by jury trials, with physicians winning four out of five cases—i.e., only about 320 plaintiffs actually won their case after a

5. For a discussion of medical malpractice and defensive medicine, see *infra* notes 46-54 and accompanying text.

6. For a discussion of medical malpractice and the cost and effect of liability insurance, see *infra* notes 55-69 and accompanying text.

7. *See* HEW. REPORT, *supra* note 2, at 8.

8. *See id.* at 10.

9. *See id.* at 9.

jury trial.[10] Even assuming that only a small percentage are justified, the sheer number of medical malpractice claims raises the question of physician competence.[11] That issue vitally touches the public health, since most efforts to improve the public health ultimately rely on the professional efforts of physicians. Furthermore, the number of claims belies the argument that private medical malpractice claims are an important device to maintain professional discipline and competence.[12]

Medical malpractice, based on the theory of negligence, is part of the law of tort. The main purpose of tort law is to find fault for wrongdoing and to deter the wrongdoer by compelling him to pay damages to the victim.[13] Hence, in order to prevail in the medical malpractice situation, the claimant must show that the physician or other health care provider was negligent, i.e., that he failed to provide adequate medical care, and that this failure was responsible for a bad medical outcome. When the victim-plaintiff succeeds in showing such actionable negligence, the cost of the bad outcome is then shifted from the patient-victim to the physician-wrongdoer by way of damages. It is assumed that, if the physician is forced to bear the cost, he, as well as other providers, will be more careful. Thus, further bad outcomes will be avoided.[14]

The other aim of the system is to provide proper and just compensation to injured persons. The system was originally intended to provide damages to only those victims who were entitled to compensation as a result of a physician's negligence.[15] Over the years, the system has moved in the direction of compensating not only for the results of negligence, but also for a variety of bad medical out-

10. *See id.* at 10.

11. Especially when one considers that approximately 45% of all claims resulted in a payment to the claimant. *See id.*

12. *See* N.Y. PANEL REPORT, *supra* note 2, at 16: *"The number of malpractice claims continues to rise without any necessary relationship to negligent medical care.* Our best hospitals and specialists are sued for millions of dollars." The report notes that there are no reliable indications "how much medical injury, negligently induced or not, exists in the medical care system . . . ." *Id.*

13. *See* 2 F. HARPER & F. JAMES, THE LAW OF TORTS § 11.5 (1956); W. PROSSER & W. KEETON, *supra* note 2, § 1, at 5-7.

14. For a discussion of this generally accepted thesis, see Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, in MEDICAL MALPRACTICE: THE DUKE LAW JOURNAL SYMPOSIUM 1 (1977). For more recent critical commentary on the deterrence theory, see Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts about the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939, 949-93 (1984).

15. *See* N.Y. PANEL REPORT, *supra* note 2, at 169; Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 52-53 (1977).

comes in situations where negligence, although asserted, is far from clear.[16] This point will be discussed at greater length in another context.[17]

The presence of liability insurance in the system serves a dual purpose: it protects the assets of the physician or other provider, and it assures the victim a more certain recovery than would reliance on the provider's own personal resources.[18] In meeting these two purposes, however, liability insurance largely defeats the purposes of deterrence implicit in the law of medical malpractice, for it effectively insulates the physician against the consequences of his culpable mistakes. A physician who has been found negligent does not even pay more for his insurance because medical malpractice liability insurers do not "experience-rate" the individual physician in most states.[19] Moreover, the physician or other health care provider does not bear the financial burden of his insurance coverage, even though he writes the check for the premium.[20]

While the theory of tort law is to deter the negligent or incompetent practice of medicine, the practical effect of liability insurance is to protect physicians from the adverse financial consequences of such practice. Trial lawyers and patient advocates who argue that the current medical malpractice system is an instrument of medical

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16. The N.Y. PANEL REPORT states:

> Since the existence of injury rather than fault is often the basis of the initiation and termination of a malpractice action, the system, under the guise of negligence, no longer adequately differentiates between cases of negligent conduct and those of simply poor results.
>
> The effect of the development of the tort system for malpractice claims into one of injury compensation is that the finding of fault is no longer the principal goal in inquiry, but has become merely a hook upon which to hang the injured plaintiff's right to recover.

N.Y. PANEL REPORT, *supra* note 2, at 169. *See also* Helling v. Carey, 83 Wash. 2d 514, 520 P.2d 981, 984 (1974) (Utter, J., concurring) noting that in actuality the court had decided who "between an innocent plaintiff and doctor" should bear the risk of loss. *See also* Meisel, *supra* note 15, at 56-59 (the system is moving toward strict liability). The N.Y. PANEL REPORT notes in its findings the development of the notion that the "victim of adverse medical outcomes or injuries resulting from medical treatment ought to be compensated." N.Y. PANEL REPORT, *supra* note 2, at 14.

17. See *infra* text accompanying notes 27-28.

18. *See* N.Y. PANEL REPORT, *supra* note 2, at 13; Roddis & Stewart, *The Insurance of Medical Losses*, in MEDICAL MALPRACTICE: THE DUKE LAW JOURNAL SYMPOSIUM 107, 108-11 (1977).

19. Instead, practitioners have traditionally been rated by location and specialty. *See* N.Y. PANEL REPORT, *supra* note 2, at 223. The lowest rate was set for psychiatrists, the highest for neurosurgeons. Within particular specialties, rates are higher in urban centers, and are lower for nonurban practitioners. New York has since begun a system of experience rating. *See* Bell, *supra* note 14, at 955-57.

20. *See infra* notes 58-60 and accompanying text.

discipline[21] are quite misguided. They are correct, however, in citing the tort law remedy as the only instrument presently available to vindicate the rights of the patient who has been hurt by physician negligence.[22] If society were truly committed to the deterrence theory of tort law, medical malpractice liability insurance would be eliminated because it shields the physician against the consequences of his alleged wrongful and negligence acts. This would be analogous to the law of the nineteenth century when courts invalidated liability insurance contracts as contrary to public policy because they allowed a person to insure against his own wrongdoing.[23] It is unlikely that such a return to a supposedly more "responsible" view of tort law would be welcomed either by physicians (who would have to carry the cost themselves)[24] or by patients (who would have to forego a ready source of payment for their judgments).[25]

The present system suffers from inherent contradictions—it aims to compensate the victim and deter the wrongdoer while it protects the wrongdoer's assets.[26] It is also evident that knowledge of the availability of the malpractice insurance pool has had the effect of increasing the number and size of claims for damages.[27]

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21. *See* S. LAW & S. POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE 28-50 (1978); Weitz, *New York State Trial Lawyers Position Paper on Medical Malpractice Insurance*, 10 TRIAL LAW. Q. 1, 7 (1974): "One may rightly argue that the legal profession through the aegis of malpractice suits has in fact elevated the standards of medical care in this state."

22. While, in theory, a patient who has suffered an injury resulting from malpractice could complain to the state medical practice board or to the appropriate medical society, in practice, neither of these institutions is likely to prove effective in disciplining the physician. *See* R. DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES 87-89 (1967); F. GRAD & N. MARTI, PHYSICIANS' LICENSURE AND DISCIPLINE 23-25, 125-30 (1979). Even if the board or society were to find the physician at fault, such a finding would not produce any compensation to the patient.

23. *See* W. PROSSER & W. KEETON, *supra* note 2, at 585-86. *See also* McNeely, *Illegality as a Factor in Liability Insurance*, 41 COLUM. L. REV. 26, 31-33 (1941) (denial of recovery as a deterrent to antisocial conduct). For an early discussion of the distinction between insuring against the consequences of intentional misconduct and insuring against the consequences of negligence, see Waters v. The Merchants' Louisville Ins. Co., 26 U.S. (11 Pet.) 213 (1837).

24. The very threat of the unavailability of liability insurance created the medical malpractice crises in 1975 and 1985 in which some physicians indicated that they would not engage in practice unless protected by insurance.

25. Patient groups have generally favored laws that support insurance availability. *See, e.g., Malpractice! the Consumer View*, in CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. 2, 3 *Health Perspectives*, May-June 1975, at 7.

26. For comments on this inherent contradiction, see Bell, *supra* note 14, at 949-56; N.Y. PANEL REPORT, *supra* note 2, at 14.

27. It is difficult to demonstrate that the availability of an insurance pool has had the effect of increasing the number of claims and their severity, but the position accords with the insight of plaintiffs' attorneys who look for a responsible and solvent defendant. For claim experience, see *infra* notes 43, 58, 61, 79. *See also* Harley & Rheingold, *New Survey of Mal-*

Demands for damages continue to expand the boundaries of negligence. Consequently, the funds pooled by insurance carriers to pay damages for negligence are used as compensation for bad medical outcomes in situations where negligence is attenuated or only remotely demonstrable.[28]

One reason why malpractice litigation continues to be recognized as an instrument of medical discipline is the lack of other effective controls on physicians' performance. Although every state licenses physicians and entrusts a medical practice board with responsibility for maintaining high standards of practice, the system has not been effective. Some 325,000 physicians practice in the United States; of these, medical authorities have estimated that about 16,000 are substandard in their medical knowledge and medical techniques. Yet, fewer than 100 physicians have had their licenses revoked each year.[29] Likewise, medical societies are expected to exercise some control over the standards and professional conduct of their members, but this source of self-regulatory control has also been inadequate. The only sanction the medical societies have at their disposal is suspension or loss of membership in the society, which in the past had an impact on hospital privileges. These sanctions, like revocation, are rarely exercised and generally ineffective.[30] Since hospitals are now generally held responsible for

practice Litigation, N.Y.L.J., Apr. 28, 1976 (experienced malpractice specialists will not accept a case unless it is "worth" at least $40,000 of potential recovery).

28. *See supra* note 16; W. PROSSER & W. KEETON, *supra* note 2, at 590-91.

29. During the five-year period 1968-1972, only 1033 formal disciplinary proceedings occurred in the 47 states for which data were available. *See* Derbyshire, *Medical Ethics and Discipline*, 228 J. A.M.A. 59, 61 (1974). These proceedings resulted in 297 license revocations, 110 suspensions, 400 probations, 198 reprimands, and 28 voluntary surrenders of licenses. *See id.* In a ten-year survey, fewer than 0.66% of all physicians were found to have had charges brought against them. *See id.* A more recent survey of nine states (with eight states responding) found that, in 1977-1978, the picture had not changed. *See* F. GRAD & N. MARTI, *supra* note 22, at 414-15, app. B. New York had 1191 complaints (about two percent of the physician population), with only 17 dispositions by the medical boards and six by the Board of Regents. *See id.* Michigan recorded only 15 complaints with 14 dispositions (about 0.01% of the physician population). *See id.* California received 2494 complaints and Mississippi reported seven, but information was not available on dispositions. *See id.* Note that what is classified and recorded as a complaint varies from state to state. Gross incompetence is a basis for discipline in virtually all of the states, but very few cases based on this charge have been reported, largely because of the difficulty of finding other physicians willing to testify that a colleague is incompetent. *See id.* at 425-28. *See also* Grad, *The Antitrust Laws and Professional Discipline in Medicine*, 1978 DUKE L.J. 443, 456-57; N.Y. PANEL REPORT, *supra* note 2, at 148-50 (inadequacy of regulation of medical discipline recognized as a contributing cause for medical malpractice actions). The New York Times reported that there had been a 60% increase in license revocations between 1984 and 1985. New York Times, Nov. 9, 1986 at pt. 1, 26.

30. Current national figures on professional self-discipline by medical societies are virtu-

the performance of their physician staff,[31] discipline and physician performance within the hospital are now more likely to be supervised than they were a few years ago. All the same, there is little evidence that hospitals have been successful in weeding out incompetents.[32] Other efforts to control quality, such as through the specialty boards[33] or through Medicare and Medicaid,[34] have been similarly ineffective. Hence, absent effective controls on professional practice, undue reliance has been placed on the control allegedly exerted by the fear of private medical malpractice litigation.[35]

Despite the protection afforded by liability insurance, the threat of a malpractice suit is very real and does affect the physician's behavior. A medical malpractice suit may affect the physician's professional reputation and self-esteem. It is also very anxiety producing as well as time consuming, and is likely to divert the physician's attention from other professional concerns. The experience of testifying in court and of having his or her professional judgment questioned and subject to criticism in the course of cross-examination is not only upsetting but also demeaning for most physicians.[36]

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ally nonexistent. The most recent figures available are from 1968 when 33 state medical societies reported no disciplinary procedures at all. *See* Derbyshire, *supra* note 29, at 60. For several years, the American Medical Association (AMA) requested that medical societies report disciplinary actions to the AMA, but the practice was terminated in 1969 by the AMA Department of Medical Ethics, which considered it "a waste of time." *Id.*

31. *See, e.g.*, Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); Breck v. Tuscon Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972).

32. F. GRAD & N. MARTI, *supra* note 22, at 200-11.

33. The 22 specialty boards, which establish standards and control certification of their respective medical specialties, coordinate their activities through the American Board of Medical Specialties (ABMS). *See id.* at 88-96. The boards are private, nonprofit organizations without any governmental authority, and do not generally regard professional discipline as part of their task. *See id.* For a discussion of the certification process, see Wallace, *Occupational Licensing and Certification: Remedies for Denial*, 14 WM. & MARY L. REV. 46 (1972).

34. Medicare and Medicaid attempted to control quality by means of the Professional Standards Review Organization (PSRO). For comments on earlier PSRO effectiveness in assuring quality of medical care, see Brook, Brutco & Williams, *The Relationship Between Medical Malpractice and Quality of Care*, in MEDICAL MALPRACTICE: THE DUKE LAW JOURNAL SYMPOSIUM, 19, 27, 50-51 (1977); F. GRAD & N. MARTI, *supra* note 22, at 307-13; Grad, *supra* note 29, at 477-82; Havighurst & Blumstein, *Coping with Quality Cost Trade-Offs in Medical Care; the Role of PSROs*, 70 NW. U.L. REV. 6, 35-68 (1975); N.Y. PANEL REPORT, *supra* note 2, at 143-48.

35. *See, e.g.*, S. LAW & S. POLAN, *supra* note 21, at 28-50; Brook, Brutco & Williams, *supra* note 34, at 28-29, 44; L. LANDER, DEFECTIVE MEDICINE 126-27 (1978).

36. *See* L. LANDER, *supra* note 35, at 131-42. The physician's fear and resentment are also related to the practice of defensive medicine. *See id.*; Bell, *supra* note 14, at 975-90 (discussing the psychological impact of the threat of a medical malpractice action).

As a consequence, many physicians consent to out-of-court settlements rather than face a courtroom battle.

Moreover, just as the threat of litigation has not had a significant impact on physician discipline, the fear of litigation has not resulted in conduct that has produced fewer lawsuits.[37]

However, the increase in the number of medical malpractice claims does not necessarily bear any relationship to negligent medical care. This is not to deny the reality of medical malpractice. Indeed, a great deal of medical injury occurs, and a substantial part of it is caused by negligence. Yet only a small fraction of medical injuries give rise to malpractice claims.[38] Many of the claims and many of the lawsuits are against the best hospitals and most eminent practitioners.[39] While only a small fraction (some three or four percent) of reported incidents of medical error gives rise to malpractice claims, no accurate statistics are available to show what portion of the reported incidents are attributable to negligence.[40] Studies pre-

37. On November 4, 1974, the American Medical News reported that the number of malpractice claims filed had increased eight to nine percent per year. The Insurance Services Office, an independent rating organization, reported in 1966 that 1.7 physicians per 100 were sued, but by 1972, three physicians per 100 were sued. STAFF OF HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG., 1ST SESS., AN OVERVIEW OF MEDICAL MALPRACTICE 5 (Comm. Print 1974) [hereinafter cited as HOUSE OVERVIEW].

38. *See* HEW REPORT, *supra* note 2, at 24.

A study done for the HEW Committee on Medical Malpractice reported that in two community hospitals about 7.5% of hospital admissions resulted in medical injury and that 20% of these injuries were attributable to negligence. *See* N.Y. PANEL REPORT, *supra* note 2, at 16. Yet only 31 out of 500 potential malpractice claims were actually filed against the two hospitals. *See id.* at 141.

Extrapolating the foregoing percentages to New York hospital admissions "would yield a figure of over 200,000 medical injuries resulting from medical treatment of which over 40,000 would be said to be negligently caused. This is a staggering number when compared to the number of claims currently brought." *Id. See supra* note 37 (presenting data on actual claim levels).

In a study for the New York Medical Malpractice Panel, one major teaching hospital cited 3,100 incidents a year reported by its professional and administrative staff. However, only about 100 malpractice claims were filed against the institution. *See* N.Y. PANEL REPORT, *supra* note 2, at 16. The Report adds:

> Whether the tort system is an effective deterrent to negligent medical care by physicians and hospitals seems hardly susceptible of proof. *What is certain is that whatever its effect, it has not been sufficient to prevent the persistent rise in annual malpractice cases.* A relatively small number of cases, some 2,000 in 1974, was large enough to have occasioned the crisis in the tort law/liability insurance system.

Id. (emphasis in original.)

39. *See, e.g.*, Hirsch, *Malpractice Crisis: Facts or Fiction*, 80 CASE & COM. 3, 6 (1975) ("The 'best' and most competent physician, rather than the 'quack' is the subject of the malpractice suit.").

40. See *supra* note 38. Not only does the number of injuries and incidents exceed the number of claims, there is also some evidence that what the medically trained person or hospital observer perceives as an injury will not necessarily match the patient's perception.

pared for the HEW Secretary's Report in 1973 indicate that about twenty-nine percent of the reported injuries are caused by negligence.[41] Thus, it appears that about four out of five reported incidents are not likely to be related to negligence. There is also no hard evidence to show that medical care has become more negligent in recent years.[42] Nevertheless, the number of malpractice claims has continued to rise.[43] The scant evidence available leads to some negative conclusions: namely, that the rise in the number of malpractice claims may not be related to more negligent medical care and that the assertion that the tort law and lawsuits against physicians for medical malpractice exert a deterrent effect is not demonstrated by existing evidence, despite claims by the trial bar and patient advocates.[44] At the same time, the availability of insurance has resulted in subjecting more physicians to charges of malpractice in instances of adverse medical outcomes as opposed to clear negli-

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A risk management program at an unnamed hospital association generated about 700,000 reports of unusual incidents (such as equipment failures, anesthesia deaths, slips and falls) over a twenty-year period. During the same period only 15,000 malpractice claims were filed, and 85 percent of these involved incidents that were *not* reported.

L. LANDER, *supra* note 35, at 6. *See also* Bell, *supra* note 14, at 951 (suggesting a claim rate of one in four malpractice incidents).

41. *See* HEW REPORT, *supra* note 2, at 62. The Report's estimate is based on limited studies. "Data on the size of either the universe of medical injuries or the universe of medical negligence are so scattered and fragmentary as to be essentially useless." L. LANDER, *supra* note 35, at 5. *See also* CALIFORNIA CITIZENS' COMMISSION ON TORT REFORM, REPORT: RIGHTING THE LIABILITY BALANCE 102-04 (1977) (reporting more than three times as many medical occurrences that could have given rise to medical malpractice judgments than the number of claims filed each year). In an earlier California hospital survey, it is reported that of some 24,000 instances of malpractice in 1974, fewer than 4,000 victims filed claims. *See* Schwartz & Komesar, *Doctors, Damages and Deterrence*, 298 NEW ENG. J. MED. 1282, 1286 (1978).

42. *See* N.Y. PANEL REPORT, *supra* note 2, at 16-17. The increase in claims and lawsuits also has been attributed to a variety of factors that cause patient anger, as opposed to greater negligence in medical practice. *See* L. LANDER, *supra* note 35, at 3-15.

43. *See* N.Y. PANEL REPORT, *supra* note 2, at 248. New York State Medical Society figures showed that between 1969 and 1974, the number of lawsuits annually increased from 355 to 970. In the first half alone of 1975, 620 lawsuits were brought. *See id.* The Report found a 20% annual trend factor, i.e., an annual increase of the combined frequency and severity rates for the future. *See id.* at 19. This factor appears to have continued to 1984. See *infra* text accompanying note 113.

44. *See supra* note 21; NEW YORK STATE TRIAL LAWYERS ASS'N, *Malpractice Suits, Patients' Only Protection Should Not Be Outlawed*, in ASSOCIATION OF TRIAL LAWYERS OF AMERICA, QUALITY HEALTH CARE—A CITIZEN'S RIGHT 294-307 (1975); Weitz, *supra* note 21, at 3, 9; Lanzone, *No-Fault Medical Malpractice: Is This Really the Solution?*, 11 TRIAL LAW. Q. 46-48 (1975); ABA, 1977 REPORT OF THE COMMISSION ON MEDICAL PROFESSIONAL LIABILITY 91-92 (expressing some support for the retention of tort law deterrence).

gence.[45] Thus, the present system has produced great social costs as well as severe injuries to the self-esteem of competent professionals.

III. FEAR OF MALPRACTICE LITIGATION AND THE DEFENSIVE PRACTICE OF MEDICINE

It has been asserted repeatedly that fear of medical malpractice litigation leads physicians to practice defensive medicine, that is, to subject patients to unnecessary diagnostic procedures, and sometimes to unnecessary therapeutic ones, in order to establish a set of records that cannot be faulted in the event of litigation.[46]

There is no agreement as to what constitutes defensive medicine. A clinical test or procedure that one practitioner undertakes defensively may be regarded by another as essential for the protection of the patient.[47] Moreover, the practice of defensive medicine may not provide the desired protection to the practitioner, because there is rarely, if ever, a perfect paper record or a wholly unassailable patient chart.[48]

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45. *See* Roddis & Stewart, *supra* note 18, at 125-26.

46. Defensive medicine has been defined as "the alteration of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted." HEW REPORT, *supra* note 2, at 14. *See generally Project: The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939. The study has been criticized for excluding general surgeons and anesthesiologists from the survey. *See, e.g.*, L. LANDER, *supra* note 35, at 225 n.18.

47. *See* Hershey, *The Defensive Practice of Medicine—Myth or Reality?*, 50 MILBANK MEMORIAL FUND Q. 69, 71-73 (1972). Defensive medicine may also involve the physician's refusal to undertake certain procedures. Alternately, he or she may refer patients who require such procedures to specialists or may insist on performing certain procedures only in a hospital rather than in the office.

Recent reports indicate that resort to defensive medicine, however defined, is the most usual reaction to the perceived threat of malpractice litigation. *See* Bell, *supra* note 14, at 966 n.120 (*citing* Hartnett, *An Analysis of the Impact of Wrongful Birth and Wrongful Life on Obstetricians and Gynecologists in New York* (Jan. 1984) (unpublished study)); Wiley, *The Impact of Judicial Decisions on Professional Conduct; An Empirical Study*, 55 S. CAL. L. REV. 345 (1981). The defensive practice of medicine is confirmed by numerous physicians' surveys. *See* L. LANDER, *supra* note 35, at 135-39. These include a 1977 poll conducted by the AMA Center for Health Services Research and Development, which showed that 76% of 111 physicians who responded to a questionnaire sent to 500 doctors were practicing defensive medicine by ordering more diagnostic tests and other additional procedures. *See id.* at 135. A similar result was reported by a 1976 Medical Society of Virginia questionnaire as well as by a 1974 *Medical Economics* questionnaire. *See id.* at 136. The latter questionnaire was sent to a random national sample of physicians and showed that 80% had changed their practice in response to concerns over legal liability; 48% indicated that the change consisted of ordering more diagnostic tests. *See id.*

48. For a somewhat different view, namely that the concept of defensive medicine is subjective and that "[o]ne doctor's defensive medicine may be another's prudent medical practice," see S. LAW & S. POLAN, *supra* note 21, at 114-15. The authors opine that, in part,

There is agreement, however, that defensive medicine is costly and wastes scarce medical resources. The precise cost of defensive medicine is a matter of considerable disagreement, even though the AMA Center for Health Policy Research has recently put a $15 billion price tag on it.[49] A major cause of the disagreement is that it is difficult to distinguish between practices that protect patients and those that are thought to protect practitioners.

There is some agreement that there is more surgery—"elective surgery"—in the United States than is warranted; it is undisputed that the majority of medical malpractice claims result from surgical interventions.[50] It has also been asserted that thousands of deaths occur each year as a result of unnecessary surgery.[51] To obtain a "second opinion" before surgery may seem a matter of good sense to patients, but it may also be regarded as an aspect of defensive medicine. If it is used to create advance alibis, it is costly and wasteful. If it is used, as Blue Cross-Blue Shield has suggested, to reduce the number of unnecessary surgical interventions, then it is a useful device to control surgical costs and should be recognized as a reimbursable item of medical care.[52] Despite our inability to deter-

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defensive medicine is simply an indication that tort law is effective in changing human behavior in order to avoid risks. *See id.* at 115.

49. *See* AMA SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE, RESPONSE OF THE AMERICAN MEDICAL ASSOCIATION TO THE ASS'N OF TRIAL LAWYERS OF AMERICA STATEMENTS REGARDING THE PROFESSIONAL LIABILITY CRISIS 13 n.48 (1985).

The practice of defensive medicine adds substantially to health care costs. *See* HEW REPORT, *supra* note 2, at 15. The utilization of radiology and pathology services has risen much more rapidly than the utilization of health services generally; this suggests a correlation with the increase in malpractice cases. *See* N.Y. PANEL REPORT, *supra* note 2, at 110. Caspar Weinberger, former secretary of Health, Education and Welfare, asserted that $3 to 7 billion annually was spent on defensive medicine. Weinberger, *Malpractice—A National View*, 32 ARIZ. MED. 117, 117 (Feb. 1975). The cost of unnecessary X-rays alone has been estimated at $1 billion annually. *See* HOUSE OVERVIEW, *supra* note 37, at 9.

50. In 1949, when the United States population was 148 million, 9 million surgical operations were performed, while in 1975, 20 million operations were performed on a population of 211 million. This translates into a 122% increase in surgery for a 43% rise in population. *See* L. LANDER, *supra* note 35, at 50-51. Studies of the National Association of Insurance Commissioners and the Insurance Services Office show that about 60% of all claims that close with payment to the claimant involve surgery. *See id.* at 205 n.65.

51. *See* SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94th Cong., 2d Sess., *Cost and Quality of Health Care: Unnecessary Surgery* (1976) (concluding that 11,900 persons died from unnecessary surgery in 1975). The AMA strongly disputed the figure. The Subcommittee also asserted that the rate of surgery for patients eligible for Medicaid was more than double the rate for the population as a whole. *See* S. LAW & S. POLAN, *supra* note 21, at 18-19.

52. See Recommendation No. 4 of the N.Y. PANEL REPORT: "Require by statute second opinions or other measures to verify the need for elective surgery, if the surgery is to be compensated by third party reimbursement. Whenever such verification is required, both the

mine the extent of and the costs of defensive medicine, it is clear that a system that tends to encourage such costly and wasteful practices is undesirable.

A new development and counterpoise to defensive medicine can be found in current cost-cutting efforts under Medicare and Medicaid. Recent Medicare amendments, particularly efforts to impose cost restraints prospectively through rates determined using "diagnosis-related groups" (DRGs), may severely limit the physician in making treatment choices and in determining the time of the patient's discharge from the hospital. The issue is no longer excessive defensive treatment, but rather the tension between the physician's desire to provide full treatment and the law's requirement to cut costs.[53] A similar tension has arisen in the states under cost containment legislation designed to limit the cost of Medicaid.[54]

IV. MEDICAL MALPRACTICE AND THE COST AND EFFECT OF LIABILITY INSURANCE

Medical malpractice liability insurance has had a major economic impact on the cost of rendering medical and hospital services. Because of increases in the number and severity of malpractice claims (plus adverse economic conditions and a falling stock market which prevented insurance companies from realizing their expected income on premium reserves invested against future claims), insurance premiums for medical malpractice policies increased tenfold—1,000%—from 1964 to 1974. Then, in 1974, several major insurers withdrew from the medical malpractice business, thereby creating the so-called medical malpractice crisis of that year. It is now generally agreed that it was a crisis not of medical malpractice but of insurance availability. The crisis drew attention to what had theretofore been less than obvious—that the existing system was very costly and expended substantial sums of money that could be used to better advantage in other efforts to protect public health. The

initial opinion and the verification should be subject to third party reimbursement." N.Y. PANEL REPORT, *supra* note 2, at 64 (emphasis omitted). A study by Blue Cross-Blue Shield of Greater New York found the second opinion failed to confirm the need for elective surgery in one out of four cases. N.Y. Times, Feb. 27, 1978, at A12, col. 2 & 3. *See also* N.Y. INS. L. § 250 (McKinney 1985).

53. *See* Deficit Reduction Act of 1984, Pub. L. No. 98-369, div. B, tit. III, 98 Stat. 494, 1061. For comment, see Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004 (1985).

54. *See* Note, *California Negotiated Health Care: Implications for Malpractice Liability*, 21 SAN DIEGO L. REV. 455 (1984) (analyzing the implications of a California program of direct, fixed-fee contracts for the rendition of care).

cost of malpractice insurance premiums is very high: in 1976 it was estimated at $2 billion per year.[55] The 1985 estimate by an AMA research group is $4 billion per year.[56] This very substantial amount, however, is significantly higher than the compensation received by the victims of medical malpractice. Such compensation amounts to less than one-fourth of the cost of insurance.[57] Thus, it costs society about four dollars to pay the victim one dollar.

The major part of the cost of the system is borne neither by physicians nor by hospitals. Since medical malpractice insurance is regarded as a regular expense in the practice of medicine, the cost of insurance is part of the costs figured in third-party reimbursement rates by Medicare and Medicaid, Blue Cross-Blue Shield, and other payors who pay nearly ninety percent of all medical and hospital costs.[58] To the extent that the cost of insurance is not reimbursed, it is part of the physician's necessary professional expenditures and is therefore a tax-deductible item on his income tax. Thus, the public at large, the taxpayer, bears a percentage of the nonreimbursed cost of insurance while the physician is reimbursed for the remainder through a system of elaborate pass-throughs or simply by increasing patient fees.[59] While physicians and hospitals have

55. *See* AMERICAN SURGICAL ASSOCIATION, *Statement of Professional Liability*, 295 NEW ENG. J. MED. 1292 (1976). The total figure for medical liability insurance in New York in 1975 was $244 million. *See* N.Y. PANEL REPORT, *supra* note 2, at 22. New York health costs are about 11% of total national health costs. Thus, the full national cost in 1975 may be extrapolated to about $2.2 billion. Since the cost of insurance has increased by about 15 to 20% annually since the "crisis," the $2 billion estimate is probably a very low and conservative one.

56. *See* AMA SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE, *supra* note 49, at 5. The $4 billion figure was provided in retort to the $1.5 billion figure issued by the Association of Trial Lawyers of America (ATLA). It should be noted, here and throughout this Article, that all figures must be viewed skeptically in light of their source. Moreover, all of the figures are somewhat misleading because they are raw figures, which have never been adjusted for inflation.

57. Estimates range from 16 to 40%. *See, e.g.*, Shapiro, *Medical Malpractice: History, Diagnosis and Prognosis*, 22 ST. LOUIS U.L.J. 471 (1978) (18 to 20%); HOUSE OVERVIEW, *supra* note 37, at 5 (16 to 38 cents on the dollar); N.Y. PANEL REPORT, *supra* note 2, at 20 (25 to 40%). For other forms of insurance and social insurance, such as health insurance and worker's compensation, the effective payment ranges from 54 to well above 90%. *See id.* at 20.

58. *See* N.Y. PANEL REPORT, *supra* note 2, at 107. In 1975-1976, only 38.8% of medical fees were direct patient payments. *See id.* at 109.

59. The issue of the pass through of medical malpractice insurance premiums is frequently ignored in the literature. The substantial increase in premiums is emphasized without noting that the physician who pays the premium does not ultimately carry the burden, because he is largely reimbursed by third-party payors. For a detailed analysis of this pass through, see N.Y. PANEL REPORT, *supra* note 2, at 105-09. The Report notes:

Until the present time, more than 95% of the cost of hospital malpractice insurance

vociferously resisted premium increases, they pay, at most, a very minor portion of the premium. The ultimate burden falls on the public.[60]

The present malpractice system has met the objective of protecting physician's and hospital's assets at a very great cost to society and potentially to the health care providers themselves. The cost of the system has risen so astronomically that even its capacity to protect the assets of the health care providers over the foreseeable future is doubtful. This pessimism as to the system's capacity to respond finds historical support in the crisis of 1975. There, even though the 1973 report of the HEW Secretary indicated (in what must surely be a prime example of the clouded crystal ball) that insurance availability was not a problem,[61] a mere two years later several major liability insurance companies withdrew from the medical malpractice field.

The 1975 "crisis" developed as follows. Insurance companies, who had raised premiums as much as tenfold in some instances,[62]

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was passed through directly to third party payers, with the remainder being absorbed by the hospital because of bad debts or cost ceiling rules. However, it is now uncertain to what extent the Medicaid, Medicare, and Blue Cross programs will reimburse hospitals for the unusually large recent increases in malpractice premiums.

Id. at 105-06.

The size of the pass through depends on third-party payor reimbursement rules. In the past, physicians "have been able to pass through 80-90% of the cost of malpractice insurance." *Id.* at 108. *See also* Bell, *supra* note 14, at 958-60.

60. *See* N.Y. PANEL REPORT, *supra* note 2, at 107. The Report calculated that of the $116.4 million hospital malpractice costs in New York State, 90%, or $104.8 million, was paid by public (tax funds) and private third-party payors. The Report indicated that in the future, if reimbursement rates change, hospitals may have to absorb more of these costs. *See id.* at 106.

Based on a 38.8% self-pay rate for physicians' services, it appears that $75.6 million out of a total $123.5 million of physician medical malpractice payments are reimbursed by third-party payors. *See id.* at 109. These figures do not reflect the additional public cost resulting from the deduction of the cost of medical malpractice insurance as a business expense on physicians' federal income tax returns.

61. *See* HEW REPORT, *supra* note 2, at 38.

62. In 1960 the cost of medical malpractice insurance was estimated at $65 million nationally. *See* HEW REPORT, *supra* note 2, at 494 app. Estimates for 1975 were a billion dollars. *See* HOUSE OVERVIEW, *supra* note 37, at 4. Nationally, between 1960 and 1970, malpractice insurance for dentists rose 115%, for hospitals 262.7%, for physicians other than surgeons, 540.80%. *See* HEW REPORT, *supra* note 2, at 13. From 1960 to 1972, malpractice insurance for the second lowest risk category for physicians nationally, on a 1966 index of 100, rose from 71.9 to 498.3, and for surgeons, from 52.3 to 526.2. *See id.* For hospitals, the rise in the index for the period from 1960 to 1972 was from 86.5 to 461.3. *See id.* For physicians in New York State, the average malpractice insurance premium for the lowest limits of liability currently available ($100,000/$300,000) rose from $275 in metropolitan New York in 1965 to $3,150 in 1974. *See* N.Y. PANEL REPORT, *supra* note 2, at 243.

withdrew from the field for a combination of reasons.[63] First, there was the "severity" factor—that is, the substantial increase in recent years in the size of claims, and perhaps even more significant, the increase in the number of large claims.[64] The National Association of Insurance Commissioners noted at the time that only three percent of the claims involved recoveries of $50,000 or more, but these three percent accounted for more than sixty-three percent of the total damages paid out.[65]

The second factor precipitating insurer withdrawal was the general decline in the economy, particularly in the stock market. Insurers set aside reserves for claims pending as well as reserves for inchoate claims not as yet asserted based on their prior loss experiences. These reserves were invested, and in good times the yield on these reserves was more than adequate to pay the claims as they were settled. However, as a result of adverse stock market experience during the economic downturn, insurance companies failed to realize expected income from and, additionally, suffered losses on the reserves. These factors continued to convince them to withdraw from the business of insuring physicians' and hospitals' liability.[66]

While the crisis was really one of insurance availability, it had

63. In New York, the state which consumed 11% of the nation's health services, Employees of Wausau, a Wisconsin company that had been the principal insurer of physicians, withdrew on July 1, 1974. *See* N.Y. PANEL REPORT, *supra* note 2, at 10. The company was replaced by Argonaut, a California company, at a rate increase of 93.5%. *See id.* Argonaut then announced a further increase of 196.8%, effective a mere six months later, in January 1975. *See id.* Argonaut then reversed itself and announced its withdrawal from the New York market for medical malpractice insurance effective July 1, 1975. *See id.* The combination of events that prompted the decision to withdraw from the market included both the increase in the number and severity of claims as well as the occurrence of substantial investment losses resulting from the decline of the stock market. *See id.*

64. In New York, for instance, the number of incidents for which payment was made rose from 326 in 1966 to 620 in 1974, and the average payment per incident rose from $10,722.17 to $35,151.70 during the same period. *See* N.Y. PANEL REPORT, *supra* note 2, at 246; *see also* American Surgical Association, *Statement on Professional Liability*, 295 NEW ENG. J. MED. 1292 (1976) (number of lawsuits filed doubled between 1970 and 1975).

65. *See* T. LOMBARDI, MEDICAL MALPRACTICE INSURANCE: A LEGISLATOR'S VIEW 148 app. B (1978) (fewer than 10% of the claim payments were over $100,000 but produced 66% of total claim payment dollars).

66. For a detailed analysis of the economics of the insurance industry, particularly the impact of market reserves on the decision of insurers to withdraw from the malpractice liability market, see S. LAW & S. POLAN, *supra* note 21, at 167-86. *See also* L. LANDER, *supra* note 36, at 116-17. The opportunity to gain from the investment of reserves against future claims made it possible, if not desirable, for insurers to live with the "long tail"—i.e., the period from the occurrence of the accident to the eventual claim and its disposition, which is a common feature of the business of medical malpractice insurance. The "long tail" makes it difficult for the actuary to predict the frequency and magnitude of awards up to fifteen years in the future. *See* N.Y. PANEL REPORT, *supra* note 2, at 18, 219-20.

immediate repercussions on medical practice and public health when physicians in many parts of the country threatened to "strike"—i.e., to stop rendering medical care—unless they were protected against liability claims.[67] Though the reality of the threat was never very clear, the legislatures of several states, particularly those states with substantial numbers of physicians, enacted a variety of laws that purported to deal with the situation.[68] These laws were palliative and gave spurious assurances that the "crisis" had passed. It soon became readily apparent that the problem had been merely papered over, to reappear all too soon.[69]

67. There is no evidence that any strikes occurred, although such ad hoc groups as the Physicians Crisis Committee, a group of Detroit surgeons and anesthesiologists, made threats of "strikes" (i.e., of withholding medical services) explicitly or implicitly in their public pronouncements. *See* L. LANDER, *supra* note 36, at 122-23. Physicians were outraged at the insurers' unwillingness to carry an unprofitable line of business, yet they were unwilling themselves to carry the risk of financial losses in professional practice that might occur without adequate insurance coverage. See also Lombardi, *New York: Medical Malpractice Crisis*, in A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE 44-48 (D. Warren & R. Merritt eds. 1976) [hereinafter cited as A LEGISLATOR'S GUIDE] in which the chairman of the New York State Senate Health Committee describes, from a state legislator's point of view, the physician slowdown in certain hospitals and the "strike" that was threatened.

68. For a general review and summary of this crisis-averting legislation, see A LEGISLATOR'S GUIDE, *supra* note 67; *see also* AMERICAN BAR ASSOCIATION, FUND FOR PUBLIC EDUCATION, REPORT CONCERNING LEGAL TOPICS RELATING TO MEDICAL MALPRACTICE, submitted to HEW under Contract No. 282-76-5231GS, by T.S. Chittenden, staff director (January 1977), at iii-viii, 1-15; Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, in MEDICAL MALPRACTICE: THE DUKE LAW JOURNAL SYMPOSIUM 241, 292 (1977), which concludes rather rapidly: "It can be said with confidence, however, that the experimentation now being conducted in fifty state laboratories will surely serve as guideposts along the road toward the fairest and most efficient resolution of the malpractice crisis."

For comments closer to the 1985 crisis, see, e.g., Bell, *Legislative Intrusion Into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939 (1984); Danzon, *The Frequency and Severity of Medical Malpractice Claims*, 27 J. L. & ECONOMICS 115 (1984); Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981); Neubauer & Henke, *Medical Malpractice Legislation: Laws Based on a False Premise*, TRIAL 64 (Jan. 1985); Note, *Medical Malpractice Damage Awards: The Need for a Dual Approach*, 11 FORDHAM URB. L.J. 973 (1983); Note, *Medical Malpractice: A Sojourn Through the Jurisprudence Addressing Limitation of Liability*, 30 LOY. L. REV. 119 (1984); *see also Survey, Torts, Medical Malpractice*, 16 IND. L. REV. 401 (1983).

69. A number of commentators share this view. *See, e.g.*, L. LANDER, *supra* note 36, at 143-68, especially 166-67; S. LAW & S. POLAN, *supra* note 21, at 195-205; see also ABA, *supra* note 44, at 9-10, commenting on the 1977 situation:

> When the Commission was established in February 1975, a crisis in the delivery of medical care seemed imminent because of the unavailability of liability insurance at a cost which was acceptable to high-risk providers. Now, a little more than two years later, the medical malpractice crisis seems to have abated, and much of the

V. LEGISLATION TO RESOLVE THE INSURANCE AVAILABILITY CRISIS

The laws passed in 1975 or thereabouts fall into two general categories. First, laws were passed restructuring the kind of companies that would offer medical malpractice insurance, and the kind of policies they would offer. Second, laws were passed reducing the risk of judgments, especially large judgments, for physicians, and, consequently, for insurance companies. These legislative efforts share two characteristics—they hurt claimants who were forced to shoulder more of the burden for adverse medical outcomes, and they did not benefit physicians and insurers. The 1975 crisis returned in 1985 in a strikingly similar scenario—premium increases, threats of physician strikes, followed by another round of legislative activity which mimicked the discredited 1975 efforts.

A. *Legislation to Restructure the Medical Malpractice Insurance Market*

The majority of states passed legislation which provided for the availability of medical malpractice insurance by establishing joint underwriting agencies, i.e., insurance pools that were to carry the obligation of malpractice insurance,[70] or by authorizing the estab-

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attention to such problems has shifted to product liability, legal malpractice and municipal liability . . . .

Joint underwriting associations, patients' compensation funds, and provider-owned insurance companies have been established in many states, thus creating additional sources of insurance. Also, many larger hospitals have developed self-insurance plans to obviate the need to transfer some or all of their risks to insurance companies. The health care industry has generally found it possible to adjust to large premium increases by passing them on to patients or third party health insurers in the form of higher charges. In this way the impact of these increases has been diffused throughout the nation's health care system.

The publicity accompanying the medical malpractice crisis, protests by provider groups and a continuing advertising campaign by liability and health insurers appear to have contributed to a leveling off of the number of law suits and the size of verdicts.

The many changes in tort law and procedure adopted by state legislatures in 1975 and 1976 may have had some downward impact in some states on the frequency and severity of claims and therefore may have lessened the escalation of insurance rates, but most of the enacted tort law changes do not reach the underlying problems.

70. ALASKA STAT. § 27-26-20; CAL. BUS. & PROF. CODE § 2508; COLO. REV. STAT. § 12-4-80; DEL. CODE ANN. tit. 18, § 6830; FLA. STAT. ANN. § 1065.25; IND. CODE § 16.-9.5-08.2 (Residual Malpractice Insurance Authority); IOWA CODE ANN. § 519a.3; K. REV. STAT. § 304.40-400; LA. REV. STAT. ANN. § 40:1299.46 (Residual Malpractice Authority); KAN. STAT. ANN. § 40-3413; ME. REV. STAT. ANN. § 24-2401; MD. INS. CODE ANN. 48A, § 550; MASS. GEN. LAWS. ANN. § 175A-5A; MICH. COMP. LAWS § 500-25000; MINN. STAT. § 60F.02; MISS. CODE ANN. § 80-30-1; MO. REV. STAT. § 383.150; MONT. CODE ANN. § 40-6003; NEV. REV. STAT. § 686.180 (enacting legislation if no other coverage avail-

lishment of mutual insurance companies by physician organizations or medical societies.[71] In a number of states, these new insurance arrangements were incorporated in temporary legislation. The legislation was to expire in a few years, when it was expected that more conventional insurance would be available.[72] Several states went beyond the joint underwriter or mutual company schemes by establishing a state stabilization reserve fund to pick up excess risks or exceptional recoveries.[73] Other states established patient compensation funds to provide a secondary source for patient recovery.[74] These insurance devices were clearly unobjectionable: they made insurance available, thus keeping physicians in practice, and they also assured patients a fund for the payment of damages. However, these makeshift insurance arrangements did not solve the basic problem. They did not attack the issue of the excessive cost of the system; they merely provided a way to carry these costs for the next few years. The joint underwriters and mutual companies had to

able); N.J. STAT. ANN. § 17.30; N.M. STAT. ANN. § 58-34.1; N.Y. INS. LAW § 681; OHIO REV. CODE ANN. § 3929.73; P.R. LAWS ANN. tit. 26, § 4104; S.C. CODE § 38-19-40; S.D. COMP. LAWS ANN. § 58-23-17-1; TENN. CODE ANN. § 56-33-101; UTAH CODE ANN. § 78-34.1; VT. STAT. ANN. tit. 8, § 4961; VA. CODE § 38.1-775; WIS. STAT. ANN. § 619.04.

71. E.g., ARK. STAT. ANN. § 66-5318; N.Y. INS. LAW § 681; N.D. CENT. CODE § 26-40-01.

72. E.g., California, to Mar. 1, 1978; Colorado, to Feb. 1, 1978; Delaware, two years; Idaho, to Jan. 1, 1978; Illinois, to 1981; Iowa, two years; Maine, to July 1, 1979; Mississippi, to May 1, 1979; New Jersey, to Jan. 1, 1982; New Mexico, one year after effective date; New York, to July 1, 1981; Ohio, to Dec. 31, 1980; Puerto Rico, not to exceed eight years; South Dakota, two years; Vermont, to Dec. 31, 1981; Virginia, to July 1, 1980. The first expiration date has been given; for citations, see *supra* note 70. Note that many of the laws have since been extended.

73. The following states have established state stabilization reserve funds: Alabama (ALA. CODE § 27-26-27 (1977)), Colorado (COLO. REV. STAT. § 10-4-907 (Supp. 1985)), Delaware (DEL. CODE ANN. tit. 18 § 6833 (Supp. 1984)), Idaho (IDAHO CODE § 6-1001 (1979)), Illinois (ILL. ANN. STAT. ch. 73, § 1065.212 (Smith-Hurd Supp. 1985)), Kansas (KAN. STAT. ANN. § 40-3414 (1981)), Maryland (MD. ANN. CODE art. 48A § 553 (1979)), Michigan (MICH. COMP. LAWS ANN. § 500.2508 (West 1983) (board to submit plan for fund)), Minnesota (MINN. STAT. ANN. § 62F.09 (West Supp. 1986)), Mississippi (MISS. CODE ANN. § 83-36-13 (Supp. 1985)), New Jersey (N.J. STAT. ANN. § 17.30D-9 (West 1985)), Ohio (OHIO REV. CODE ANN. § 3929.74 (Page Supp. 1984)), Tennessee (TENN. CODE ANN. § 56-33-106 (1980)), and Virginia (VA. CODE § 38.1-781 (1981)).

74. The following states have established patient compensation funds: Florida (FLA. STAT. ANN. § 768.54 (West Supp. 1985)), Illinois (ILL. ANN. STAT. ch. 73, § 1065.300 (Smith-Hurd Supp. 1985)), Indiana (IND. CODE ANN. § 16-9.5-4-1 (West 1984)), Kentucky (KY. REV. STAT. ANN, § 304.50-330 (Baldwin 1981)), Louisiana (LA. REV. STAT. ANN. § 1299.44 (West 1977 & Supp. 1986)), New Mexico (N.M. STAT. ANN. § 41-5-25 (1984)), North Carolina (N.C. GEN. STAT. § 58-254.21 (1982)), North Dakota (N.D. CENT. CODE § 26-40.1-15 (1983)), Puerto Rico (P.R. LAWS ANN. tit. 26, § 4105 (Supp. 1983)), South Carolina (S.C. CODE ANN. § 38-59-120 (Law. Co-op. 1985)), and Wisconsin (WIS. STAT. ANN. § 655.27 (West 1980 & Supp. 1985)).

raise their premiums substantially each year,[75] so that within three to four years of their creation, their premiums, too, doubled. Thus, the public cost of medical malpractice liability insurance continues to grow.

B. *Legislation to Shorten Statutes of Limitation*

Many states shortened the time period within which a plaintiff may bring a lawsuit for medical malpractice.[76] In New York, not only was the statute of limitations reduced from three to two and one-half years, but in the case of minors, the law was changed to require the commencement of any lawsuit no later than ten years after the occurrence of the injury.[77] This changed the prior law that allowed minors to reach majority before bringing suit.[78] Commentators generally agree that reducing the statute of limitations will neither reduce the number of malpractice actions brought, nor improve insurance availability, because it will have no impact on ultimate recovery.[79] However, it may unfairly disadvantage some

75. Following the "crisis" in New York, the joint underwriter, Medical Malpractice Insurance Association, filed a 90% rate increase. However, the superintendent of insurance allowed only a 20% rate increase. J. LEWIS & S. CLUMNA, HOSPITAL MALPRACTICE INSURANCE IN NEW YORK STATE 7-8 (1977). The mutual company, Medical Liability Mutual Insurance Company, was granted a 20.6% rate increase. *See id.* Their report showed a combined increase in cost per bed of hospital insurance fee for commercially and self-insured hospitals of 332% in the two years 1974-1975 to 1976-1977. *See id.* at 33; *see also* A. MURRAY, THE MEDICAL MALPRACTICE SITUATION IN CALIFORNIA 2 (Health Policy Program 1976) (predicting that "premium levels can only continue to rise over the next few years").

76. For instance, Alabama's time limit is now two years from injury or six months from discovery provided that filing occurs within four years of the alleged malpractice. Neither limit applies to minors under four who may only file suit upon their eighth birthday. *See* ALA. CODE § 6-5-482 (1977). In California, the time limit is three years from injury or one year from discovery. These limits do not apply if there is proof of fraud, intentional concealment or a foreign body in the injured person. *See* CAL. CIV. PROC. § 340.5 (West 1982).

77. *See* N.Y. CIV. PRAC. LAW § 208 (McKinney Supp. 1986).

78. Under prior law, a minor could bring a medical malpractice claim within three years of reaching the age of eighteen. *See* N.Y. CIV. PRAC. LAW § 208 (McKinney 1972). The new two and one-half year statute of limitations commences on the date of the treatment or surgery complained of or on the date of the last treatment in the case of a continuous course of treatment. *See* N.Y. CIV. PRAC. LAW § 214-a (McKinney Supp. 1986). In actions based on discovery of a foreign object in the patient's body, once the two and one-half year statute has run, suit must be brought within one year of discovery, or within one year from the time when such discovery should reasonably have been made. *See id.*

79. Although trial lawyers and patients' rights groups initially opposed the New York reduction of the statute of limitations, their opposition was not very vigorous, thus indicating that the change is not likely to reduce the number or the severity of claims. *See* N.Y. PANEL REPORT, *supra* note 2, at 176. The ABA 1977 *Report of the Commission on Medical Professional Liability* concluded (at 55): "Even as important a change as shortening the statute of limitations may have a small impact on costs." The report noted that 98% of injuries are known within two years. However, it added that the limitation on the time for suit on behalf

claimants.

C. *Legislation to Limit Actions Based on Failure to Obtain Informed Consent*

A physician's failure to fully inform his patient and to obtain the patient's consent prior to a surgical or diagnostic procedure constitutes grounds for a "battery" action, i.e., for an unlicensed touching of the person.[80] In recent malpractice actions, failure to obtain informed consent has been included as an allegation of malpractice. Some of the new legislation seeks to limit this development by statutorily defining what constitutes informed consent or by creating a presumption that the patient has given his informed consent unless fraud on the part of the physician is proved.[81] Since very few mal-

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of minors, etc., would have a stabilizing effect on actuarial calculations. *See id.* at 56. An Insurance Services Office Closed Claims Survey found that 98.1% of all incidents, involving 98.3% of all awards in total dollar amount, are reported within five years of occurrence, prompting the comment that "although the tail is long, it may not be very wide." Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489, 503 (1977).

80. *See, e.g.*, Fogal v. Genesee Hosp., 41 A.D.2d 468, 473, 344 N.Y.S.2d 552, 559 (1973). The underlying rationale for the doctrine of informed consent is that every person has a right to determine what should be done to his body and that he cannot exercise that right unless he is told what the physician proposes to do and what the likely consequences will be. *See* N.Y. PANEL REPORT, *supra* note 2, at 37. Some commentators contend that the doctrine of informed consent, while having originated in battery, has now developed into a tort of negligence. *See, e.g.*, Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1636 (1974); W. PROSSER & W. KEETON, *supra* note 2, at 165. Others acknowledge that the doctrine can be identified with either negligence or battery, without expressing a preference. *See, e.g.*, Comment, *A New Standard for Informed Consent in Medical Malpractice Cases—The Role of the Expert Witness*, 18 ST. LOUIS U.L.J. 256 (1973); D. HARNEY, *supra* note 2, at § 2.5; A. HOLDER, *supra* note 2, at 260.

The Secretary's Commission found it an "abuse" that liability could attach under the doctrine without proof that the physician was negligent. *See* HEW REPORT, *supra* note 2, at 29. On the other hand, the Committee on Medicine and Law of the Association of the Bar of the City of New York found that the doctrine is "salutary and probably restate[s] a requirement of medical ethics." *Committee Reports the Medical Malpractice Insurance Crisis*, 30 REC. A.B. CITY N.Y. 336, 349 (1975) [hereinafter cited as *NYC Bar Association Report*].

81. The following states have enacted informed consent statutes: Alaska (ALASKA STAT. § 9.55.556 (1985)); California (CAL. BUS. & PROF. CODE § 4211.5 (West Supp. 1986)); Delaware (DEL. CODE ANN. tit. 18, § 6852 (Supp. 1984)); Florida (FLA. STAT. ANN. § 768.46 (West Supp. 1985)); Georgia (GA. CODE ANN. § 88-2901 to -2907 (1979)); Hawaii (HAWAII REV. STAT. § 671-3 (1976 & Supp. 1984)); Iowa (IOWA CODE ANN. § 147.137 (West Supp. 1985)); Kentucky (KY. REV. STAT. ANN. § 404.40-320 (Baldwin Supp. 1981)); Louisiana (LA. REV. STAT. ANN. § 40.1229.40 (West 1977)); Maine (ME. REV. STAT. ANN. tit. 24, § 2905 (Supp. 1985)); Nebraska (NEB. REV. STAT. § 44-2816 (1984)); Nevada (NEV. REV. STAT. § 41A-110 (1979)); New Hampshire (N.H. REV. STAT. ANN. § 507-C2 (1983)); New York (N.Y. PUB. HEALTH LAW § 2805-d (Consol. 1985)); North Carolina (N.C. GEN. STAT. § 90-21.13 (1985)); North Dakota (N.D. CENT. CODE § 26-40.1-05 (1978)); Ohio (OHIO REV. CODE ANN. § 2317.54 (Page 1981)); Oregon (OR. REV. STAT. § 677.097 (1985)); Rhode Island (R.I. GEN. LAWS § 9-19-32 (1985)); Tennessee (TENN. CODE ANN.

practice actions rely solely on the failure of informed consent, this legislation does not make any real difference to claims experience or to total damages paid out.[82]

D. *Legislation to Limit* Res Ipsa Loquitur

Some states responded to physicians' demands that the doctrine of res ipsa loquitur be abolished in medical malpractice cases. Physicians and medical societies have mistakenly asserted that the doctrine required the physician to prove that he was not negligent rather than compelling the plaintiff to prove negligence affirmatively.[83] The doctrine, which literally translated means "circumstances speak for themselves,"[84] is an evidentiary device that allows the plaintiff to make out a prima facie case, i.e., a case legally adequate to go to the jury, on the basis of certain well-defined circumstantial evidence.[85] Classic situations in which the doctrine has been applied include a clamp left inside a patient during surgery or

§ 29-26-118 (1980)); Texas (TEX. HEALTH & SAFETY CODE ANN. § 6.01-.07 (Vernon Supp. 1986)); Utah (UTAH CODE ANN. § 78-14-5 (1977)); Vermont (VT. STAT. ANN. tit. 12, § 1909 (Supp. 1984)); Washington (WASH. REV. CODE ANN. § 7.70.050 (Supp. 1986)). *See also* A LEGISLATOR'S GUIDE, *supra* note 67, at 10.

82. *See* N.Y. PANEL REPORT, *supra* note 2, at 38, 180; *see also* ABA FUND FOR PUBLIC EDUCATION, REPORT CONCERNING LEGAL TOPICS RELATING TO MEDICAL MALPRACTICE 73-74 (1977) (submitted to HEW) (recently enacted tort law changes, including changes relating to informed consent, are likely to have only a small impact on premiums); Glazer, *Medical Malpractice: Informed Consent*, 16 TRIAL L.Q., Fall 1984, at 52 (discussing how the trial bar copes with the new requirements).

83. *See* N.Y. PANEL REPORT, *supra* note 2, at 172.

84. BLACK'S LAW DICTIONARY 1173 (5th ed. 1979). *See generally* W. PROSSER & W. KEETON, *supra* note 2, at 257-58; HEW REPORT, *supra* note 2, at 28-29.

85. *See* Griffen v. Manice, 166 N.Y. 188 (1901); Fogal v. Genessee Hosp., 41 A.D.2d 468, 474-77, 344 N.Y.S.2d 552, 561-63 (1973). The procedural effect of *res ipsa loquitur* varies in different jurisdictions. The general view is that it is only a permissible inference. As such, it enables the plaintiff to escape a directed verdict against him and instead allows the case to go to the jury. *See* W. PROSSER & W. KEETON, *supra* note 2, at 258. But in some jurisdictions, *res ipsa loquitur* shifts the burden of proof, i.e., risk of nonpersuasion, to the defendant. *See* Weiss v. Axler, 137 Colo. 544, 551, 328 P.2d 88, 92 (1958); Johnson v. Coca-Cola Bottling Co., 239 Miss. 759, 765, 125 So. 2d 537, 539 (1960). Probably the better view is that the procedural effect of *res ipsa loquitur* should depend on the strength of the inference to be drawn. If the inference is strong enough that a properly functioning jury could come out only in the plaintiff's favor in the absence of explanation, the risk of nonpersuasion necessarily shifts to the defendant; otherwise, there is only a permissible inference, and liability remains a factual question to be decided by the jury. *See* W. PROSSER & W. KEETON, *supra* note 2, at 257-59. In some jurisdictions, the plaintiff may be entitled to a directed verdict against the defendant unless the defendant introduces evidence counteracting the effect of the inference created by the doctrine of *res ipsa loquitur*. *See* Moore v. Atchison, Topeka & Santa Fe Ry., 28 Ill. App. 2d 340, 352-53, 171 N.E.2d 393, 398-99 (1961); Whitley v. Hix, 207 Tenn. 683, 693, 343 S.W.2d 851, 856 (1961).

an operation on the wrong part of the body.[86] In such situations, the injury caused to the plaintiff is of a kind not normally caused without negligence, and the instrumentality that caused the injury was under the exclusive control of the physician. Thus, he is the only person who can, and should, explain what happened.

Asserting, mistakenly, that the doctrine means that the physician is presumed negligent until he proves otherwise, physicians have called for its abolition. There is general agreement that abolishing the doctrine would not result in outcomes more favorable to physicians, although it would require that plaintiffs provide more expert testimony and would thus raise trial costs.[87] Some of the states that have legislated on the matter have merely codified the common law rule,[88] while others have limited the application of the doctrine to foreign body cases.[89] While these amendments may make the plaintiff's case somewhat more difficult to prove, these changes in the law neither improve insurance availability nor reduce insurance costs.

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86. The conditions usually required before *res ipsa loquitur* may be applied are stated as follows: (1) the event must be a kind that ordinarily does not occur in the absence of someone's negligence; (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant; (3) it must not be the result of any voluntary action or contribution on the part of the plaintiff; and (4) evidence as to the true explanation of the event must be more readily accessible to the defendant than to the plaintiff. *See* Fogal v. Genessee Hosp., 41 A.D.2d 468, 474, 344 N.Y.S.2d 552, 560 (1973); *see also* W. PROSSER & W. KEETON, *supra* note 2, at 244; 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, at 14-1 to 14-60. See *AMA Model Res Ipsa Loquitur Law*, which enumerates a number of situations in which a permissible inference of negligence may be drawn, including foreign objects unintentionally left in the patient's body after surgery; an explosion or fire originating in a substance used in treatment; an unintended burn caused by heat, radiation, or chemicals suffered in the course of medical care; an injury to a part of the body not directly involved in treatment; or surgery performed on the wrong patient, or the wrong part of the body. *See also* Abraham, *supra* note 79, at 499-500 (general discussion of use of *res ipsa loquitur* in medical malpractice cases).

87. "The abolition of the doctrine here [in New York] would not produce more outcomes favorable to the health care provider. It would only require additional expert testimony, in situations where they are not really needed, thus increasing trial costs." N.Y. PANEL REPORT, *supra* note 2, at 35. The conclusion appears to be accurate in those states where few cases have been decided on the issue. In a few states, however, notably California, the doctrine has been stretched to support outcomes generally more adverse to physicians. *See* HEW REPORT, *supra* note 2, at 29; Rubsamen, *Res Ipsa Loquitur in California Medical Malpractice Law—Expansion of a Doctrine to the Bursting Point*, 14 STAN. L. REV. 251 (1962).

88. *See, e.g.*, Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); IND. CODE ANN. § 16-9.5-9.1 to 16-9.5-9.9; LA. REV. STAT. ANN. 40; 1299.47; KAN. STAT. ANN. § 65-4901.

89. *See, e.g.*, FLA. STAT. ANN. § 768.45(4) (West 1985); LA. REV. STAT. ANN. 9-2794; N.D. CENT. CODE § 26-40.1-07.

E. *Legislation to Require Submission of Cases to Review Panels*

A number of states enacted legislation providing for submission, mandatory in some states and voluntary in others, of malpractice claims to a medical liability review panel first, generally composed of both physicians and lawyers.[90] While initially viewed as a device to aid the early settlement of cases, the use of such panels has raised further issues, such as the admissibility into evidence of the panel's conclusions and findings in the event that the case goes to trial. In many states, the panel's findings are admissible though not conclusive.[91] In some states panel members may be called as witnesses.[92] Although such panels have been applauded as a device to weed out frivolous cases, they seem to lengthen the process by requiring the basic issues to be tried before two separate tribunals. Moreover, there is no evidence that the use of panels reduces the number of claims or the size of the judgements.[93]

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90. *See* ALASKA STAT. § 09.55.536 (1985); DEL. CODE ANN. tit. 18 §§ 6803-6814 (1984); HAWAII REV. STAT. §§ 671-11 (1976) (amended 1984); IND. CODE ANN. §§ 16-9.5 to 9-1 (West 1984); KAN. STAT. ANN. § 65-4901 (1986); LA. REV. STAT. ANN. § 1299.47 (West 1973) (amended 1984); ME. REV. STAT. ANN. tit. 24 § 2811; MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-01 to -09 (1984); MASS. GEN. LAWS ANN. ch. 231 § 60B (West 1985); MONT. CODE ANN. §§ 27-6-101 to -704 (1985); N.H. REV. STAT. ANN. §§ 519-A:1 to :10 (1976); N.M. STAT. ANN. §§ 41-5-14 to -28 (1978); N.Y. JUD. LAW § 148-a (Consol. 1983) (amended 1984, 1985); OHIO REV. CODE ANN. §§ 2711.21 - .24 (Page 1981); PA. STAT. ANN. tit. 40, §§ 1301.501-514 (Purdon 1985); P.R. LAWS ANN. tit. 26, §§ 4110-4113 (1985); WIS. STAT. ANN. §§ 655.02-.21 (West 1980) (amended 1984).

91. *E.g.*, Indiana, Louisiana, Massachusetts, New Hampshire, New York (if panel members concur), Ohio, Pennsylvania (as to liability, not damages).

In Maine where the panel's findings are not admissible, the panel is obligated to supply an expert witness for the claimant if the panel has found in his favor. New Mexico will also supply an expert witness for the winning complainant, though the panel's findings are admissible in evidence. *See* citations, *supra* note 90.

92. *E.g.*, Indiana, Louisiana, Kansas, and New York (but only as to panel's recommendations). *See* citations, *supra* note 90.

93. Review panels, or mediation panels, were first used in New York in 1971 in the First Judicial Department of the state, when Harold A. Stevens, then presiding justice of the Appellate Division of the First Department, introduced them by judicial rule. *See* N.Y. PANEL REPORT, *supra* note 2, at 210. In 1974, the system was adopted statewide by legislation. *See id.* Because of the long experience with such panels in New York, the comment of the New York Special Advisory Panel of Medical Malpractice is especially salient:

> The evidence suggests that the screening panels do not affect the severity factor in settling malpractice claims. The increase in settlement figures coming out of the panels has been as great as the general rise in claims costs and sometimes even greater. The average award following mediation panel settlements in Kings County through June 1974 was almost $40,000, and for Queens County in 1975, is close to $58,000. The evidence indicates that where the Panel recommends a finding of liability, a settlement almost always occurs. Where the recommendation is against the finding of liability, or where the settlement figure which the panel finds reasonable is unsatisfactory, the plaintiff invariably decided to go to trial. Thus, it is fair to conclude that the mediation panel procedure reflects the general thrust of the system.

F. *Legislation to Limit Recoveries Generally for Certain Categories of Damages*

Some states have attacked the "severity problem"[94] of large verdicts by limiting medical malpractice recoveries. A few states have placed a flat limit or "cap" on medical malpractice damages, set variously at $200,000, $500,000, or $750,000. Other states limit noneconomic damages—generally, damages for pain and suffering.[95] The limits are generally rather high, and it is doubtful whether they will make a significant impact on the total damages paid out. However, they may severely penalize a particular plaintiff who has suffered very serious injury. Legislatures face a very difficult policy decision—unless these limits are severely reduced, there will be little or no impact on insurance premiums or availability. But the lower the limit set, the larger the number of claimants who will be adversely affected.

G. *Other Legislative Remedies*

Other legislative remedies include limitations on lawyers' contingent fees in medical malpractice cases; the abolition of the so-called collateral source rule; the requirement that jury verdicts be

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Id. at 48-49 (emphasis deleted). The report concluded that the panel device should be continued because it encouraged settlement of many worthwhile cases and thus was useful in that limited way. *See id.* at 49. The ABA 1977 *Report of the Commission on Medical Malpractice Liability*, at 41-48, reviewed the panel device at length, comparing states where resort to panels is voluntary with states where it is mandatory; states where the panel procedure has to be resorted to before formal legal action is brought and states where more formal post-suit requirements for panel review have been imposed; as well as the different consequences provided by state law for panel reports. After reviewing arguments for and against the use of panels, the ABA Commission concluded that it was unable to recommend a model panel procedure, indicating that more experience with the device should be collected. The ABA Commission staff had strongly supported review panels, largely on the grounds that they screened out worthless cases. *See id.* at 49-61. Note that neither the ABA nor its staff found that review panels had any impact on the cost of the system. *See also* S. LAW & S. POLAN, *supra* note 21, at 124-28.

94. "Severity" is used as a technical term in liability insurance. In setting rates for liability insurance, including medical malpractice insurance, the most significant factors are frequency, i.e., the number of claims made each year, and severity, i.e., the size of the payment per claim, the length of the claims period and the percentage of the number of all claims which such large claims constitute. *See* N.Y. PANEL REPORT, *supra* note 2, at 9, 216-21; Roddis & Stewart, *supra* note 18, at 1299-1300.

95. *E.g.*, IND. CODE ANN. § 16-9.5-2.2 (West 1978) (general limit $500,000); LA. REV. STAT. ANN. § 40:1299.42 (West 1977) (general limit $500,000); N.H. REV. STAT. ANN. § 507-c:7 (1955) ($250,000 "non-economic losses"); N.M. STAT. ANN. § 58-33-6 (1978) ($500,000, except for punitive damages and medical care and similar benefits); OHIO REV. CODE ANN. § 2307.43 (Page 1953) ($200,000 limit on "general" damages; special damages cover economic damages); S.D. CODIFIED LAWS ANN. § 21-3-11 (1969) ($500,000 limit in "general" damages); VA. CODE § 8.01-581.15 (1950) ($1,000,000 general limit).

itemized (this is useful in limiting recoveries for pain and suffering, because otherwise a jury could exceed the statutory limit by placing such damages under another category); and the substitution of arbitration for litigation in the courts.

Under the collateral source rule, if a plaintiff receives compensation for his injuries from a source wholly independent of the tortfeasor—e.g., workers' compensation, private health insurance—the fact of such payment is inadmissible in evidence and the payment cannot be deducted from the damages which he would otherwise collect from the tortfeasor. This rule has been modified in most states. A majority of states now provide that payments from other sources be offset, or otherwise taken into account, so as to avoid double recovery. Although very extensive cost savings were claimed for these modifications the full amount of savings has not as yet been documented.[96]

The contingent fee system is another feature of the present malpractice system that has come under fire and that has been affected by legislative limitations.[97] Although a number of jurisdictions have limited contingent fees by court rule, the 1975 and 1985 legislative efforts in several states limited contingent fees by statute[98]—generally to levels below the traditional one-third of the judgment or settlement. The contingent fee is defended by trial lawyers as the client's key to the courthouse door, although it happens to be a gold-plated key. In 1975, seasoned negligence lawyers would not accept a case that was not "worth" a judgment or settlement minimum of about $40,000.[99] Today that minimum is about three times as much.

The contingency fee issue is probably the most divisive issue be-

96. The collateral source rule prevents the defendant from introducing evidence of payment of any part of the plaintiff's damages from other "collateral sources," such as the plaintiff's own insurance or other third-party payors, thus resulting in double payment. Amendments to the rule either permit the jury to be told of such collateral sources or require that the defendant be credited for such collateral source payments, so as to avoid double recovery. *See, e.g.*, IOWA CODE § 147.136 (1972). This has resulted in some cost savings. *See, e.g.*, N.Y. PANEL REPORT, *supra* note 2, at 38-40, 183-86; Comment, *supra* note 68, at 271-74.

97. The issue of lawyers' contingent fees is essentially one of the high cost of all specialized professional services. After all, the cost of defending lawsuits on a straight-line, noncontingent basis is as high as that of bringing them. For a discussion of the issue, see N.Y. PANEL REPORT, *supra* note 2, at 42-43, 193-98; Comment, *supra* note 68, at 266-71.

98. *E.g.*, N.H. REV. STAT. ANN. § 507-6.8 (1983); N.Y. JUD. LAW § 474(a) (McKinney 1983); WIS. STAT. ANN. § 655.013 (West 1980).

99. *See* N.Y. PANEL REPORT, *supra* note 2, at 198 n.4 (surveys report "floors" ranging from $25,000 to $75,000 depending on the nature of the law firm).

tween physicians and lawyers. Since the plaintiff's attorney's fee comes out of the plaintiff's recovery, it is difficult to show how much it adds to the cost of the system. In addition, the literature pays little attention to fees paid to the defendant's lawyers who are paid on a time basis—win, draw or lose. We have no national income policy based on social worth—some baseball players make more than some lawyers or physicians. Absent an official measure of social worth, lawyers resent physicians' assertions that lawyers fees are too high; they interpret these assertions to mean that lawyers make too much money. The only aspects of this rather nasty fight between certain, limited groups of each of the two professions which have any relevance to cost containment of medical malpractice insurance are the suspicions that the contingent fee encourages more lawsuits, and that it encourages plaintiffs' attorneys to hold out for larger settlements or to try for larger judgments, because of the attorney's special interest in the maximum recovery. Conversely, trial lawyers assert that the risk of working without a guaranteed fee under the contingency fee arrangment serves to screen out cases without merit.[100] There is no clear indication how much of a reduction in premiums can be produced by severe cutbacks of contingency fees.

VI. CONSTITUTIONALITY OF STATUTORY LIMITATIONS OF COMMON LAW REMEDIES

Limitations on recoveries in medical malpractice suits, as well as procedural limitations—particularly the requirement of submission to medical malpractice screening panels—have been challenged repeatedly. Since it is agreed that victims of medical malpractice are not a specially protected class for equal protection purposes under the fourteenth amendment, these statutory limitations of common law remedies have only had to pass rational basis review.[101]

The only time the rational basis test came close to upsetting one of these statutory limitations was in *American Bank & Trust Co. v. Community Hospital of Los Gatos Saratoga, Inc.*[102] Initially, the California Supreme Court determined that the purpose of the stat-

100. For an overview of the entire debate, see AMA SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE, *supra* note 49, at 21-22.

101. *See, e.g.*, Jones v. State Bd. of Med., 97 Idaho 859, 555 P.2d 399 (1976); Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977); Everett v. Goldman, 359 So. 2d 1256 (La. 1978); Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

102. 33 Cal. 3d 674, 660 P.2d 829, 190 Cal. Rptr. 371 (1983), *vacated* 36 Cal. 3d 359, 688

ute was to lower malpractice premiums, thereby reducing or containing the cost of medical care to the public.[103] The court concluded that the statute did not meet the rational-relationship test because the premise that there was a connection between a reduction in malpractice premiums and containment of medical costs was erroneous.[104] Health care costs had risen at a rate of more than twenty percent per year since the enactment of the provision, while malpractice premiums had declined by twenty-five percent over the comparable five-year period.[105] However, on rehearing, the California Supreme Court vacated the prior decision, stating "the provision is obviously not irrational."[106]

In spite of some of the constitutional qualms that have been expressed,[107] in this author's view, the question of statutory limitations on medical malpractice remedies is less a matter of constitutional validity than a matter of sound policy, particularly in the light of experience. It is clear that statutorily created pre-trial medical malpractice screening panels and legislative caps on recovery severely limit a medical malpractice victim's access to the courts, and impose a severe restriction on the most seriously injured victims without any significant, compensating social benefits.

VII. THE MAKING OF THE 1985 INSURANCE AVAILABILITY CRISIS

The AMA Special Task Force on Professional Liability and Insurance reported in 1985 that during the mid-seventies, premiums in some specialities rose almost 500%, despite significant earlier increases. For all physicians, premiums increased 44.8% in the two years 1983-1984, and 236% in the last decade,[108] in spite of the 1974-75 legislative effort. Average premiums for physicians in New York, for instance, have risen 312% *since* 1975, a year that saw the greatest premiums increase ever.[109] According to AMA estimates,

P.2d 670, 204 Cal. Rptr. 671 (1984). *See* Note, *Medical Malpractice: A Sojourn through the Jurisprudence Addressing Limitation of Liability*, 30 LOY. L. REV. 136-38 (1984).

103. 33 Cal. 3d at 684, 660 P.2d at 839, 190 Cal. Rptr. at 381.

104. *See* 33 Cal. 3d at 685, 660 P.2d at 840, 190 Cal. Rptr. at 382.

105. *Id.* at 685, 660 P.2d at 840, 190 Cal. Rptr. at 378.

106. 36 Cal. 3d at 365, 683 P.2d at 676, 204 Cal. Rptr. at 677.

107. *See* Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981).

108. *See* AMA SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE, *supra* note 47, at 3.

109. *See id.*

medical costs related to professional liability, including defensive medicine, accounted for 20 to 25% of the $69 billion spent on physicians' services in 1983, from $13.8 to $17.3 billion.[110] These figures, to be sure, are challenged by the Association of American Trial Lawyers, and they are unadjusted—as are all other figures in this field—for inflation.

Even if different sets of figures are used, however, the cost of the medical malpractice system is staggering. It has been reported that from 1966 to 1982, personal health expenditures in the United States grew from $39.3 to $282.8 billion a year, an average rate of 13.1%.[111] From 1976 to 1981, the value of the average medical malpractice claim in New York (reproduced in the table below) rose at a rate of 18% per year, resulting in corresponding increases in the cost of liability insurance. The following data for New York, but of broader applicability, tell the devastating story:

	Amount of Payout Per Year
1971	$ 7.1 million
1972	11.2 "
1973	17.4 "
1974	21.7 "
1975	27.6 "
1976	23.5 "
1977	31.2 "
1978	47.3 "
1979	64.2 "
1980	81.9 "
1981	91.7 "
	Value of Average Claim
1976	$39,858
1977	44,209
1978	54,033
1979	62,963
1980	76,469
1981	89,351

If this exponential rate of growth continues, the 1989 average claim will be $700,000![112]

Note that the 1975 legislation had the arguable effect of reduc-

110. *See id.* at 4.

111. *See* Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, 7 HEALTH CARE FINANCING REV. 1 (1985).

112. *See* Note, *Medical Malpractice Damage Awards: The Need for a Dual Approach*, 11 FORDHAM URB. L.J. 973, 973 n.2 (1983) (The chart summarizes data from two insurers and the New York State Insurance Department.).

ing the 1976 payout, but even that is questionable because there was a similar reduction in payouts for those tort recoveries which were not the subject of the 1975 malpractice legislation, probably caused by a general change to "claims made" policies. Overall, the legislation to limit recoveries has not slowed the rate at which the value of the average claim has increased. Furthermore, it appears that even if the legislation resulted in the reduction of the severity factor, the effects were minimized by the increase in the frequency of claims.

VIII. THE VANISHING OPTIONS FOR THE FUTURE

The present system of dealing with medical malpractice by means of the law of negligence backed by liability insurance fails to meet a number of needs. It is outrageously expensive and absurdly inefficient—it cost four dollars for every dollar paid out to the injured plaintiff. The inefficiency is demonstrated not only by the excessive costs it imposes on health care, but also by the capricious way in which recipients of compensation are selected. The system overcompensates some and fails to compensate many others.[113] Legislative attempts to solve the insurance availability crisis have met with little, if any, success and there is no reason to believe that the chosen remedies will be more effective the second time.

A. *Option One—Muddling Through*

The most comfortable option, and perhaps the most likely to be followed, is to sit tight and wait out the effects of the most recent round of legislation. Because the limits on recovery were more ferocious this time than ten years ago, and because any new initiative is likely to provide a sense of positive development, as it did the last time, some observers will note improvements in insurance availability and announce the end of the crisis. But although caps may limit the severity of judgments, any resulting savings will be offset by the increase in the frequency of judgments.

In addition, improved insurance availability does not resolve the problem of the excessive cost of the system, nor the basic inequity of its operation. As the "crisis" renews itself, the gladiatorial contest between lawyers and physicians, a now recurring spectacle described and reported in the daily press, may provide the only source of comfort to the general public who is bearing the cost.

113. *See supra* notes 37-39 and accompanying text.

B. *Option Two—Tort Law Changes to Assure Actuarial Soundness and Insurance Availability*

Another choice is to try to "reform" the present tort law-liability insurance system of medical malpractice in order to ensure actuarial soundness and insurance availability. The goal of any reform must be to ensure a sound basis for actuarial projections. This will enable insurance companies to reenter the field and provide medical malpractice insurance at stable and reasonable rates. In this more stable insurance environment, innovations could result in further premium reductions. Measures to achieve injury prevention might be worked out between physicians and insurance companies. The more successful insurance companies are in reducing the number of injuries, the lower their premiums with a resulting increase in competition.[114] However, the unpredictable character of malpractice claims raises doubts whether this is a promising area for risk management. Alternatively, injury prevention might be fostered by offering lower premiums to physicians through experience rating.

To achieve the goals of insurance availability and assure continuity of physicians' and other providers' services, a substantial price would have to be paid in terms of the other social ends of the system. In order to reduce the cost of insurance, it would be necessary to make it more difficult for patients to recover from physicians. It might be necessary, for instance, to require that a patient prove not only that the physician was negligent, but also that his negligence amounted to gross negligence, before the patient could recover damages. Under such a standard, fewer patients would sue, and even fewer could recover.

In addition, it would probably be necessary to cut back statutes of limitations far beyond the slight cutbacks already legislated. This would mean shortening the time during which lawsuits for medical malpractice could be brought, even though later discovery of an injury was a reasonable expectation. It would also be necessary to impose even more rigid limitations on the dollar amount of damages that could be recovered. To enforce these limits—and not to have them nullified by sympathetic juries—it would probably be necessary to give the judge a greater role in the determination of liability and of damages.

Limiting a physician's liability by these means would assure insurance availability and would also relieve us of the threat—whether real or not—of physician strikes. This option, however, is

114. Such risk management efforts are encouraged by the California statute.

not likely to be acceptable to the public because the required changes would shift a major part of the cost from the system to the injured patient. This shift does not necessarily relieve society of the cost, because if the injured patient cannot carry the burden— which will often be the case—he will become a public charge or place burdens on other systems of social insurance, such as unemployment insurance, public assistance, and Medicaid. Thus, what appears to be a reduction is in reality a redistribution. This is undesirable because the cost of medical malpractice is properly a cost of the medical care system, and to shift the cost elsewhere misrepresents the full cost of medical care and confuses proper cost allocations. Accordingly, after considering the possibility of a redefined tort system, the New York State Advisory Panel on Medical Malpractice concluded in 1975 that "the stringent tort law approach is neither a desirable nor an attractive option."[115]

C. *Option Three—A Compensation Remedy*

The compensation remedy abandons the proof of negligence as a prerequisite to the collection of compensation, and generally uses an administrative tribunal rather than the courts. This type of remedy has found increasing acceptance, starting with workers' compensation, and its application to injuries resulting from medical malpractice has been proposed for some time,[116] although it has not been adopted by any jurisdiction. However, it deserves a close look at this time—not only because other options are running out, but because it is the only option which holds out the hope of a long-term resolution of the problem. Moreover, the compensation remedy is equitable, both in the social and economic sense, is affordable, and

115. N.Y. PANEL REPORT, *supra* note 2, at 56. The panel believed that "it could create actuarial certainty only by an erosion of the right to recover damages except in the most glaring of cases, and would shift the costs to the injured patient or to sources outside of the health care system." *Id.*

116. *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); Havighurst & Tancredi, *"Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 HEALTH & SOC. (MILBANK MEMORIAL FUND Q.) 125 (1973); J. O'CONNELL, ENDING INSULT TO INJURY (1975); O'Connell, *Elective No-Fault Liability by Contract—With or Without an Enabling Statute*, 1975 U. ILL. L.F. 59; O'Connell, *An Elective No-Fault Liability Statute*, 1975 INS. L.J. 261; O'Connell, *No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others*, 1977 INS. L.J. 531; O'Connell, *Expanding No-Fault Beyond Auto Insurance: Some Proposals*, 59 VA. L. REV. 749 (1973); A. HOLDER, *supra* note 2, at 431-33 (1975); Dornette, *Medical Injury Insurance—A Possible Remedy for the Malpractice Problem*, in MEDICINE, LAW & PUBLIC POLICY 26 (1975).

can provide decent compensation to all of the persons injured in medical accidents, rather than outsized recoveries to a few.

1. *Compensation Plan*

The compensation remedy discards the most costly and troublesome aspect of the present tort law-liability insurance system— the proof of negligence. A compensation system avoids the great uncertainty and actuarial instability of the present system, where a small but unpredictable number of verdicts or settlements give some claimants such large recoveries that they distort the entire claims experience.[117] It also eliminates anxiety and professional insecurity for the physician. The new approach would accept the fact that the risk of medical injury is inherent in the contemporary practice of medicine. It would provide compensation for medical injury as a proper charge on the health care system.

Accepting medical injury as one of the inevitable consequences of the rendition of health care would require recognition that a compensation system for medical injuries is different in purpose from a system that pays damages for the consequences of negligence. It would require giving up the notion that fear of medical malpractice litigation is a deterrent to careless practice or that it is an effective instrument of physician discipline. Instead, the primary objective of a compensation system would be to make payments to as many injured persons as possible in as substantial amounts as available, by saving the "transaction" or "friction" costs incurred to prove negligence in the present tort law-liability insurance system.

By abandoning the requirement of proof of negligence, the new system would probably have to respond to a greater number of claimants.[118] The present medical malpractice system pays only a small fraction of the premium dollar to the injured victim, using the substantially greater part of the premium dollar for legal, claims management, and insurance costs ("transaction costs").[119] With

117. *See* N.Y. PANEL REPORT, *supra* note 2, at 186-87; HEW REPORT, *supra* note 2, at 5-12; *NYC Bar Association Report, supra* note 80, at 336, 338-39.

118. Many claims that involve negligence presently go uncompensated. *See* HEW REPORT, *supra* note 2, at 10. It is likely that these previously uncompensated claims—which cast costs on society through welfare and other care-taking instrumentalities which did not appear as costs of the health care system—will be compensated under such a plan. Proponents of medical injury compensation schemes acknowledge the likelihood that more of the patients who suffered adverse medical outcomes would make claims under such a system. *See* Havighurst & Tancredi, *supra* note 116, at 130; O'Connell, *supra* note 116, 1975 U. ILL. L.F. at 62.

119. *See* N.Y. PANEL REPORT, *supra* note 2, at 249-50.

the reduction of legal and claims management expenses, an increased number of claimants could be compensated out of transaction cost savings. Thus, it has been suggested that a well-managed compensation system may well compensate many more persons for medical injuries than are being presently compensated without any additional public or provider costs.[120]

To be sure, the development and substitution of a new, workable compensation system in place of the old, inadequate medical malpractice system will require considerable study and planning. It will also require a number of decisions as to the precise nature of the compensation system.

Since the purpose of the new compensation system is to make the injured person whole, the negligence of the provider of medical care is no longer an issue. However, in return for the certainty of recovery, the person who has suffered a medical injury must give up the possibility of outsized or spectacular recovery.[121] Although the

120. *See* J. O'CONNELL, *supra* note 116; Havighurst & Tancredi, *supra* note 116, at 152-53; Dornette, *supra* note 116, at 30; MEDICAL MALPRACTICE 5 (McDonald ed. 1971). The New York State Special Advisory Panel on Medical Malpractice came to the following conclusion on the subject:

> In view of the fact that a compensation system for medical injuries is likely to incur lower friction costs, the quarter billion dollars that are presently spent in New York State for liability insurance could well compensate a far larger number of claimants than is possible under the present system. Even assuming that the compensation system would have a payout of only 75%, this would still make available over $180 million for actual payment to injured persons, a sum far in excess of any amount paid out today.

N.Y. PANEL REPORT, *supra* note 2, at 56. Under the tort system, only 25 to 40% of the total premium cost goes to the claimant and much of the payout goes to claimants with claims larger than $25,000 to $40,000. *See id.* at 98.

121. See Montgomery v. Daniels, 38 N.Y.2d 41, 340 N.E.2d 444, 378 N.Y.S.2d 1 (1975), in which the New York Court of Appeals upheld the no-fault automobile accident compensation law:

> [W]e reject plaintiff's argument that there is no reasonable basis between reform as undertaken in article 18 and the objective of remedying the defects perceived by the Legislature to inhere in the fault-based tort system for compensating automobile accident personal injury claimants. On the contrary we conclude that, by eliminating recovery for pain and suffering in relatively minor cases and by simultaneously guaranteeing prompt and full compensation for economic losses up to $50,000 without the necessity of recourse to the courts, the Legislature acted reasonably to eliminate much of the wasted expenditures of premium dollars on expenses extraneous to treatment of injury (e.g., legal and investigative costs involved in determining fault and in establishing the value of alleged pain and suffering). Such action may further be viewed as reasonably related to guaranteeing full and fair recovery to all victims by reducing pressure on a seriously injured person to compromise down his claims in order to obtain funds for treatment while at the same time eliminating pressure on insurers to compromise up claims by persons suffering minor injuries in order to avoid the expense of investigating and defending against such minor claims. . . .

Id. at 55, 340 N.E.2d at 452, 378 N.Y.S.2d at 12. See also New York Cent. R.R. v. White, 243 U.S. 188 (1917), in which the New York Workmen's Compensation Law was upheld:

injured person would be assured of recovery, the injured person would be compensated under a system of strictly limited recoveries. Such limited recoveries could be awarded according to a schedule of recoveries graduated by the seriousness of the injury much like workers' compensation,[122] though the recoveries should be higher than the workers' compensation schedules in most states, which are currently inadequate. A system of compensation for medical injuries could also follow the general pattern of the New York automobile "no-fault" law.[123] This law limits recoveries to a fixed "basic economic loss," so as to cover purely economic damages, including medical costs and past and future loss of earnings up to $1,000 per month for not more than three years.[124]

Under either approach, the compensation system would not provide separate damages for pain and suffering, which in the past have contributed significantly to high verdicts and settlements.[125] If a compensation schedule approach is used, the compensation schedule for injuries could, and properly should, reflect some elements of pain and suffering in the amount of compensation set for particular injuries.

On the other hand, all systems that compensate on a schedule or limited recovery basis present certain problems to persons with special needs or in special situations. For example, these systems may not adequately compensate the artist or musician who suffers an injury to his hands. By the same token, a system of scheduled or limited recoveries is unlikely to compensate for an executive's loss of a very high income. However, it is precisely such specialized awards that have given rise to very large verdicts and that have

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> The Statute under consideration sets aside one body of rules only to establish another system in its place. If the employee is no longer able to recover as much as before in the case of being injured through the employer's negligence, he is entitled to moderate compensation in all cases of injury, and has a certain and speedy remedy without the difficulty and expense of establishing negligence or proving the amount of the damages . . . .

Id. at 201.

122. For example, New York law provides for payment of medical expenses and for scheduled compensation for specified disabilities. N.Y. WORK. COMP. LAW §§ 13f, 13g, 15 (McKinney 1985). The adequacy of compensation under workmen's compensation nationwide has long been criticized. *See* REPORT OF THE NATIONAL COMMISSION ON STATE WORKMEN'S COMPENSATION LAWS 117-19 (1972) and WHITE PAPER ON WORKER'S COMPENSATION (U.S. Departments of Labor, Commerce, HEW and HUD, 1974).

123. N.Y. INS. LAW (McKinney 1985).

124. The definition of "basic economic loss" excludes elements of pain and suffering, except insofar as they may be implicitly included in other damages. *See id.* at § 5102.

125. *See* N.Y. PANEL REPORT, *supra* note 2, at 188; *see also NYC Bar Association Report*, *supra* note 80, at 336, 355 (proponents of ceilings on awards urged a $100,000 limitation on damages of pain and suffering "to avoid large verdicts in New York in the future.").

increased the severity of claims and the expense of the present system. Under a compensation plan, persons in these unique situations may have to carry their own accident or health insurance to protect themselves adequately against all accidents. The adoption of a non-negligence-based compensation scheme would embrace the view that broader public protection is necessary and more equitable than the continuation of a system that grants recoveries of a very substantial nature to a very few persons without providing any recovery to a significant number of persons who suffer medical injury.[126]

If negligence is abandoned as a determinant of recovery, medical injury cases will be taken out of the courts. Under a medical injury compensation plan, just as in workers' compensation and other similar plans, the injured party would prove his or her claim to the health care provider's insurers. The insurers would be obligated to pay the claim unless the compensable nature of the injury or the scheduled elements of the recovery was disputed.[127] These disputes would be decided by an administrative agency, subject to judicial review of the agency's determination.

All of the proposed medical injury compensation plans assume that the system will not need the active intervention of an administrative agency in most instances and that the system will only require judicial intervention in unusual cases. Some cases might still have to go to court to determine whether they involve compensable medical injuries or come under some other legal theory. Once it is established that the injury for which the claim is made is compensable, the only remaining issue would be the amount of recovery.

Just as in other new systems of compensation, there may be many disputed issues when the compensation system first becomes operational. With experience, the number of disputed issues may be expected to stabilize.

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126. *See supra* note 121. *But see NYC Bar Association Report, supra* note 80, at 345.

127. In like manner, under automobile no-fault:

> "First party benefits" become due and payable "as the loss is incurred" and "are overdue if not paid within thirty days after the claimant supplies proof of the fact and the amount of loss sustained." . . . Any dispute with the insurer as to benefits may be resolved expeditiously by submission to binding arbitration at the option of the claimant.

Montgomery v. Daniels, 38 N.Y.2d 41, 47, 340 N.E.2d 444, 447, 378 N.Y.S.2d 1 (1975).

Worker's compensation operates in a similar fashion, except that disputes relating to claims for scheduled compensation are referred to a hearing board. *See, e.g.*, N.Y. WORK. COMP. LAW § 20.

2. *Definition of Compensable Event—"Medical Injury"*

Plans to compensate medical injuries without reference to negligence have been opposed because of the asserted difficulty of defining the compensable event. Even proponents of these plans have sometimes found it difficult to adequately define medical injury—the iatrogenic, treatment-related injury. Work accidents or automobile accidents are reasonably specific events to which injuries may be causally connected. In the case of medical injuries, there is the recurring issue of whether the injury is caused by the underlying disease or condition for which the treatment was sought.[128]

This problem needs to be studied and worked on; physicians, lawyers, and other specialists may well play a part in its resolution. Considerable progress has already been made in developing illustrative lists of compensable events. A general definition of medical injury or a broad definition of compensable event may be unnecessary. The solution may be found in specifying finite lists of compensable injuries, much in the manner of the list of covered surgical and medical procedures currently found in health insurance policies. There is a growing view that the number of adverse medical outcomes or medical injuries is finite and is capable of specification. Such a listing of injuries will, of course, be subject to correction and updating from time to time.[129]

Another approach, reflected in federal medical injury compensation legislation proposed in 1975,[130] is to define the compensable injury very generally, leaving the question of whether it is indeed treatment-connected to the preliminary determination of a hearing officer. A number of other optional approaches have also been proposed.[131]

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128. *See* HEW REPORT, *supra* note 2, at 102; Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 614-15 (1973); O'Connell, *supra* note 116, 59 VA. L. REV. at 790-93; Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141 (1975).

129. *See* Havighurst & Tancredi, *supra* note 116, at 132-50; Dornette, *supra* note 116, at 33-35.

130. S. 215, 94th Cong., 1st Sess. (1975), the "Inouye-Kennedy No-Fault Proposal." In case of contest, the compensability of the injury would be determined by the Secretary of HEW, i.e., by an appropriately designated hearing officer.

131. *See* J. O'CONNELL, *supra* note 116, at 97-138. O'Connell proposes that a compensation system be instituted on an elective, voluntary basis either by contract or by statute. This option would enable a health care provider and a patient to agree at the time treatment is commenced that, in the event of an adverse medical outcome, the patient would rely on the health care provider's compensation policy, regardless of provider negligence. In return for a right to recovery for any adverse medical outcome, the patient would waive any rights to proceed under the negligence malpractice law. For an interim period, a provider would have

3. *Method of Payment for Medical Injury Compensation Coverage*

Who will pay for medical injury compensation raises a number of policy issues. Most of the proposals would leave the burden of coverage on the provider, who would purchase compensation insurance just as he purchases liability insurance at the present time.[132] The provider would retain the option to self-insure. It has also been suggested that the patient or consumer could pay for coverage directly as part of his medical costs. This would be analogous to "trip insurance" in that a patient would be required to insure himself against medical injury before embarking on medical treatment or before undergoing a surgical procedure. Of course, such insurance might be sold for an extended term rather than on a "trip" basis.[133]

It is possible, although unlikely in light of current efforts to reduce the budget, that existing state and federal government subsidies of medical care could be increased to cover the cost of a compensation system. This would provide a better measure of the public cost of medical injuries because these additional subsidies for medical injury compensation would have to be specially and separately budgeted. Under the present system, the public cost of providing medical malpractice liability insurance is hidden in the general reimbursement of medical expense by the federal and state governments and third-party payors. Because the present cost of medical malpractice insurance is ultimately borne by public sources, it is possible that the direct takeover of such costs by the federal and state governments would not increase public costs very substantially. Along these lines, it is worth noting that a number of states have already taken on excess insurance coverage under patient compensation fund legislation.[134]

Whatever method of payment is chosen, the general public, either as taxpayers or as consumers, shoulders the ultimate cost of a

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to carry negligence liability coverage as well as compensation coverage. However, the provider could be given reduced premium treatment under his or her liability policy if more than a certain percentage of his or her patients elected to participate under his or her compensation policy. Such a plan would obviously be aided by appropriate provisions in enabling legislation.

See also O'Connell, *supra* note 116, 1975 INS. L.J. at 267-93. O'Connell's proposal is analogous to workmen's compensation statutes in that it authorizes compensation insurance and contains provisions which protect the agreement between the health care provider and patient from being invalidated as an adhesion contract.

132. *See* Havighurst & Tancredi, *supra* note 116, at 139; J. O'CONNELL, *supra* note 116.

133. *See* Dornette, *supra* note 116, at 29.

134. *See supra* note 73 and accompanying text.

medical injury compensation system.[135] The choice of method of payment is then largely a choice of how best to reduce transaction costs and how to reflect the cost of medical injuries as part of the general cost of health care delivery, of which it is an integral part.

4. *Constitutional Issues*

The adoption of a medical injury compensation plan raises a number of federal and state constitutional issues. These issues have been virtually put to rest by the New York Court of Appeals' 1975 decision in *Montgomery v. Daniels*[136] which upheld the constitutionality of the New York no-fault automobile accident compensation law. The law was challenged on the basis of the due process and equal protection clauses of the federal and state constitutions, and the alleged denial of the right to trial by jury. In upholding the automobile no-fault compensation law, the court stated "that to a very large extent the methodology of [the plaintiff's] assault would be equally applicable (or as we hold inapplicable) to any no-fault plan whatever its specifics."[137] The court addressed the issues in the context of a provision that permitted negligence actions once a certain threshold for "serious injuries" had been exceeded. Nonetheless, it is clear that the court's holding would have been the same if the legislature had abolished the common law remedy altogether. The decision accords with analogous decisions of the United States Supreme Court.[138]

IX. CONCLUSION

Even assuming the medical malpractice crises of 1974-75 and 1984-85 were merely crises of insurance availability, their occurrence is symptomatic of deep underlying problems of public health policy. Adverse medical outcomes are an inevitable consequence of the delivery of health care, but not all adverse outcomes are the results of inadequate or negligent health care delivery. The present system of negligence law and liability insurance has borne the cost of adverse outcomes badly: it has been wasteful and expensive, compensating some victims of adverse outcomes quite generously and others not at all, and it has done so at great expense in "trans-

135. *See* N.Y. PANEL REPORT, *supra* note 2, at 101-18.

136. 38 N.Y.2d 41, 340 N.E.2d 444, 378 N.Y.S.2d 1 (1975).

137. *Id.* at 49, 340 N.E.2d at 448, 378 N.Y.S.2d at 7.

138. E.g., Duke Power v. Carolina Environmental Study Group, 438 U.S. 59 (1977) (limiting amount of liability for nuclear accidents violates due process because it forces the victim to bear the cost of the accident while society as a whole benefits from nuclear power).

action" or "friction" cost, so that most of the millions of premium dollars do not find their way to the victim.

While the present medical malpractice system causes some physicians great anxiety and insecurity, there is little or no evidence that is has raised professional standards or has improved the quality of health care. In spite of the constant threat of medical malpractice litigation, the number of claims based on negligence rises every year.

Many theories have been advanced to explain the increase in medical malpractice claims. These include greater utilization of health services; greater risks associated with more advanced medical technology; changes in the traditional doctor-patient relationship; greater depersonalization of health services (which deals in "providers" and "consumers" of such services, thus giving rise to aggressive consumer attitudes); exaggerated expectations of the capabilities of modern medicine; and the inherent problems of a health care system that suffers from technical over-specialization and dehumanization. Each of these theories explains only a part of the phenomenon of increasing numbers and severity of claims. Despite these divergent theories, there is general agreement that adverse outcomes are part of the system and must be dealt with.

They cannot be dealt with by piecemeal adjustments to the law of medical malpractice, or by making more insurance available at ever-increasing cost to the general public. A system of sound social insurance is needed, a system of compensation that will compensate the victim of the adverse outcome rather than rely on "fault" or "negligence" to determine liability. A medical injury compensation plan meets that need.