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I. INTRODUCTION

Renewed disquietude over the inefficiencies of the current tort-based system of medical malpractice has resulted, once again, in public calls for reform. But whereas past reform efforts focused simply on refurbishing the tort-based system, the Utah Medical No-Fault Proposal, now under consideration by Utah legislators and professionals, seeks wholesale abandonment of the tort system.[1] This no-fault scheme, its drafters claim, would improve the delivery of insurance compensation payments to patients injured in the course of medical treatment at substantially the same cost as the current system without assessing the fault of individual health care providers. However, serious questions abound about the actual affordability of the plan, its shifting of liability from doctors to hospitals, its constitutionality, and several other key assumptions.

This Comment analyzes the no-fault plan proposed for Utah. Part II reviews the current tort-based system. Part III reviews plans already adopted in Sweden, Finland, New Zealand, Virginia, and Florida, and discusses a recent New York study which purportedly established the economic feasibility of a comprehensive no-fault plan in the United States. Part IV enumerates the component facets of the Utah plan, several of which Part V individually analyzes: the plan's affordability, enterprise liability, the system of appeals, proof of causation, the plan's constitutionality, and the legislative action necessary for complete adoption of the plan in Utah.

II. THE CURRENT SYSTEM

Our tort-based system of medical malpractice boasts a venerable common law heritage. It hails from ancient English

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1. Appendix A reproduces the Utah Medical No-Fault Proposal.

practices transplanted to America by the founding fathers and "preserved" in the United States and Utah Constitutions.[2] It also appeals to our sense of justice. As Walter Gellhorn observed, the tort-based system was traditionally thought to fulfill "the community's sense of right and wrong"; "[t]he development of liability for fault . . . reflected a moral sentiment, by no means now extinct, that *justice* . . . demands that the doer of an injurious act compensate an innocent person who has suffered as a direct consequence of that act."[3] The basic inquiry of the tort system is, thus, as one scholar wrote, "did the defendant's actions display an unreasonable preference for his own interests and insufficient regard to the risks his actions generated for the plaintiff's rights?"[4] If so, "the law judges it only fair to require the defendant to make the plaintiff whole for the injuries suffered."[5] The fault locating and damage imposing functions of the tort system make sense to public intuition. They echo our concepts of free enterprise and democracy, and are derived from Hebraic teachings first propagated by Moses.

In recent decades, however, critics of the tort-based system have vituperatively complained about its costliness and apparent inequities. Initially, this criticism sprang from reactions to a "medical malpractice insurance crisis." Skyrocketing malpractice insurance rates—purportedly precipitated by increased patient litigiousness and overly generous jury awards—provoked waves of legislative reform in

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2. U.S. CONST. amend. VII. (mandating that "the right of trial by jury shall be preserved" according to the rules of the common law); *see also* U.S. CONST. amend. XIV, § 1 (assuring that no one will be deprived of person or property without "due process of law"). The Utah Constitution has analogous provisions. *See* UTAH CONST. art. I, § 7 (due process); UTAH CONST. art. I, § 10 (trial by jury). Additionally, it has an open courts provision which guarantees patients access to any tribunal in the state. *See* UTAH CONST. art. I, § 11. For a discussion of the constitutional ramifications of the proposed No-Fault Medical Liability Plan, see part V.F.

Initially, claims for medical malpractice were based in contract theory. *See, e.g.*, Hawkins v. McGee, 146 A. 641 (N.H. 1929). During the mid-nineteenth century, however, claims began to be brought under negligence and related tort-based theories such as battery. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 28, at 160-61 (5th ed. 1984).

3. Walter Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.)* 73 CORNELL L. REV. 170, 176-77 (1988); *see also* GUIDO CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 301 (1970).

4. PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 44-45 (1991).

5. *Id.*

both the 1970s and 80s.[6] In Utah, these reforms resulted in caps on the amount of money juries can award successful claimants for noneconomic damages,[7] limits on what plaintiff attorneys can charge their clients,[8] and panels of experts who screen all medical malpractice cases in an attempt to prevent spurious claims from reaching court.[9] Other reforms disallowed collateral source compensation[10] and mandated that benefits for damages incurred in the future be paid as expenses accrue.[11]

More recently, though, bolder voices have surfaced which challenge the very premises of the tort-based system. These critics contend that the reforms previously proffered by legislators do not address the real problems of a fault-based

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6. *See* Peter H. White, Note, *Innovative No-Fault Tort Reform for an Endangered Specialty*, 74 VA. L. REV. 1487, 1497 & n.51 (1988).

> The Utah Legislature specifically found in that regard that the number of suits and claims for damages and the amount of judgments and settlements arising from health care has increased greatly in recent years. Because of these increases the insurance industry has substantially increased the cost of medical malpractice insurance. The effect of increased insurance premiums and increased claims is increased care cost, both through the health care providers passing the cost of premiums to the patient and through the provider's practicing defensive medicine because he views a patient as a potential adversary in a lawsuit. . . .
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> In view of these recent trends and with the intention of alleviating the adverse effects which these trends are producing in the public's health care system, it is necessary to protect the public interest by enacting measures designed to encourage private insurance companies to continue to provide health-related malpractice insurance while at the same time establishing a mechanism to ensure the availability of insurance in the event that it becomes unavailable from private companies.

UTAH CODE ANN. § 78-14-2 (Michie 1992).

The Utah Supreme Court, however, repudiated this finding in Lee v. Gaufin, 867 P.2d 572, 588 (Utah 1993), holding that the "crisis" referenced in this statute resulted instead from bad investment choices: Insurers incurred substantial losses through investments during this time of inflation. To recoup these losses, the insurers drastically increased their malpractice coverage rates for doctors nationwide. *Id.* In explaining their rate increases, however, they disingenuously asserted that their losses sprang, instead, from escalating malpractice litigation and increasingly generous jury awards. *Id.* at 584. For a more extended discussion of *Lee*, see *infra* notes 173-175 and accompanying text.

7. UTAH CODE ANN. § 78-14-7.1 (Michie 1992) (imposing cap of $250,000 on noneconomic damages).

8. *Id.* § 78-14-7.5 (limiting attorney fees to 33.33% of amount recovered).

9. *See id.* § 78-14-12.

10. *Id.* § 78-14-4.5.

11. *Id.* § 78-14-9.5 (1992) (mandating periodic payments of future damages that equal or exceed $100,000 in malpractice actions).

liability system, namely, the inefficiency inherent in bringing claims, the arbitrariness of awards, and the relatively small number of negligence-caused injuries that actually receive legal attention at all.[12] Thus, the critics contend that "the reality of personal injury tends to get lost from view in the legislative chamber" and that typical tort-reform packages are unfairly friendly to doctors.[13] More importantly, they assert, the current system's ability for "corrective justice" and its professed morality are no longer persuasive justifications for the system.[14]

Judge Guido Calabresi, former dean of the Yale University law faculty, affirms that the "rather undifferentiated notions of justice" which buttress the tort system result from "a simplistic bilateral view of the accident problem."[15] Indeed, as both Calabresi and Harvard law professor Paul Weiler maintain, the reality is "that in our present system the legally negligent doctor does not pay."[16] Instead, a vast insurance labyrinth has infused the tort-based system and has largely subsumed the doctor's role in litigation. There is no longer a simple moral arrangement between a patient and doctor: While the doctor, as a nominal defendant, may have a say as to whether to settle or fight the claim, "[t]he insurer selects and pays for the defense attorney . . . and pays the bill for the settlement or trial verdict if the doctor appears to have been negligent."[17]

In fact, even if the insurer is required to pay, the doctor rarely feels any individual financial impact. Premiums are commonly charged to a collectivity of doctors who are insured against malpractice claims according to their specialty and region.[18] These doctors, in turn, include the cost of their

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12. *See* WEILER, *supra* note 4, at 53-54; Gellhorn, *supra* note 3, at 172; Kenneth Jost, *Still Warring Over Medical Malpractice: Time for Something Better*, A.B.A. J., May 1993, at 68; Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908 (1993); White, *supra* note 6, at 1501.

13. Weiler, *supra* note 12, at 910.

14. *Id.* at 920; *see also* WEILER, *supra* note 4, at 45.

15. CALABRESI, *supra* note 3, at 301.

16. Weiler, *supra* note 12, at 920; *see also* CALABRESI, *supra* note 3, at 301-02; WEILER, *supra* note 4, at 45.

17. WEILER, *supra* note 4, at 46.

18. *See* UTAH OFFICE OF LEGISLATIVE AUDITOR GENERAL, A PERFORMANCE AUDIT OF THE MEDICAL MALPRACTICE PRELITIGATION PANELS app. at H2 (1994) (listing by specialty the current medical malpractice insurance rates of insurance companies that service Utah). Contrary to general practice, however, Utah Medical Insurance Association (UMIA) Vice President Art Glenn maintains that his company experience-rates premiums. According to Glenn, underwriters at UMIA look at

premiums in what they charge their patients. Moreover, most patient bills are paid by private or public health insurers. Hence, the cost of a malpractice award is borne, to a great extent, by prospective patients and their employers who purchase health insurance and by taxpayers supporting Medicaid and Medicare, not the "culpable actor" as was intended under the tort-based system of medical malpractice.[19] The threat to doctors of "financial ruin" is negated in this context, and the deterrent value of the tort system "is no longer likely to be wholly effective . . . in the real world today."[20]

Indeed, if one accepts this pragmatic view of the current system, "it becomes very hard to see how the fault system can be supported on grounds of justice."[21] As Judge Calabresi asserted, "the moral aims of our society . . . can be better met through systems that concentrate on the *deterrence* and *compensation* we want than an archaic system of liability."[22] Naturally, then, the impetus of modern tort reformers has been to construct a medical malpractice system which better compensates all victims of injury, prevents future medical mishaps, and disburses insurance benefits more efficiently and economically than the current system[23]—rather than focusing merely on retribution and fairness.[24]

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how long doctors have practiced, the number and frequency of claims against them, what additional training they have received, and whether their procedures are unduly risky in assigning individual malpractice insurance rates. Interview with Art Glenn, Vice President of Claims, in Salt Lake City, Utah (June 24, 1994).

19. Weiler, *supra* note 12, at 914-15.

20. Gellhorn, *supra* note 6, at 177. The critics acknowledge, however, that a doctor's desire to avoid involvement in litigation—because of its emotional toll, professional stigma, etc.—may result in the doctor's practicing defensive medicine. Randall R. Bovbjerg et al., *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265 JAMA 2836, 2836-43 (1991).

21. CALABRESI, *supra* note 3, at 303.

22. *Id.* at 307 (emphasis added).

23. WEILER, *supra* note 4, at 47; *see also* Weiler, *supra* note 12, at 921.

24. This position is revolutionary, particularly in light of past legislative movements calculated to counter the perceived unfair, antidoctor biases of juries by making it more difficult for patient-plaintiffs to initiate medical malpractice claims and by restricting what successful claimants can eventually recover. *See supra* notes 7-11 and accompanying text. Indeed, reforms often arise out of public assumptions that juries are antidoctor and are swayed by their emotions in giving unfair "windfall" awards to undeserving patients. Two recent studies, however, largely contradict these assumptions. Duke University School of Law researchers found that juries ruled in favor of doctors in 18 of 19 cases insurers expected to win, in 13 of 17 cases they rated as tossups, and in 6 of 11 cases they expected to lose. Similarly, a New Jersey study shows that of 976 tried cases, doctors won

Professor Weiler and several of his colleagues from Harvard schools of public health, medicine, and government (the "Harvard Group") have been particularly zealous in this movement. In 1984, they orchestrated an extensive study in which they reviewed over 30,000 patient records in several New York hospitals to test the viability of a hypothetical no-fault medical liability scheme aimed at compensating victims of all iatrogenic injuries,[25] irrespective of provider fault.[26] Now, based on their positive findings in that study, they have proposed a five-year application of a similar no-fault plan in Utah.[27] This Comment will analyze the plan proposed for Utah.

III. NO-FAULT GENERALLY

A. Existing No-Fault Plans

The no-fault concept—compensating victims of unexpected, but avoidable medical injuries without regard to whether the injury resulted from provider negligence—did not originate with the Harvard Group. Comprehensive no-fault plans have been implemented in three other countries; in addition, Virginia and Florida enacted limited no-fault liability schemes during the 1980s.[28]

Both Sweden and Finland have adopted no-fault as part of their larger systems of social insurance, which already guarantee their citizens cost-free access to all medical care.[29] Thus, in these countries, no-fault simply augments the amount of compensation available to victims of medically related injuries, and neither country is much concerned with disciplining doctors or health care professionals who demonstrate potentially negligent behavior.[30] Similarly, in 1972, New Zealand em-

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76%. Jost, *supra* note 12, at 68, 70-71. Moreover, the "windfall" numbers frequently quoted in newspapers are often misleading because they do not reflect the vast majority of cases which settle for often nominal amounts out of court. *Id.* at 71.

25. Iatrogenic injuries are defined as unexpected, avoidable and disabling injuries arising out of medical treatment. App. A, ¶ 3.

26. For a discussion of the New York Study, see *infra* part III.B.

27. Appendix A reproduces the Utah Medical No-Fault Proposal.

28. No-Fault plans have also been proposed and rejected in the New York and Massachusetts legislatures. JAMES ROSENBLUM, MALPRACTICE SOLUTIONS: COMING TO DOCTORS' DEFENSE 54-58 (1993).

29. *See* Diana Brahams, *No-Fault Compensation Finnish Style*, 1988 THE LANCET 733, 733-34.

30. *See generally* MARILYNN M. ROSENTHAL, DEALING WITH MEDICAL MALPRAC-

braced a no-fault system designed to compensate those "who suffer personal injury by accident," which is defined as any medical "misadventure."[31] This expansive application of no-fault allows compensation when medical care merely results in any "worsening" of the treated malady.[32] Such a broad use of no-fault has effectively precluded the need to buy insurance from private insurance companies, making the no-fault fund a universal insurer.[33] Additionally, because health care providers are viewed as necessary pillars of the no-fault bureaucracy, they remain essentially beyond reproach.[34]

The schemes adopted by Virginia[35] and Florida[36] came in response to the malpractice insurance crisis of the 1980s which seemed to threaten the delivery of obstetrical services in both states.[37] As a result, both schemes were narrowly tailored to only compensate babies suffering from birth-related neurological injuries.[38] The effectiveness of these limited plans, however, is dubious—both in their ability to adequately compensate injured newborns and in restoring insurance coverage to obstetricians.[39] Both plans have been roundly criticized in recent years.[40]

B. The New York Study

Despite Virginia's and Florida's enactment of limited no-fault schemes during the malpractice insurance crisis, the idea of comprehensive no-fault in the United States has, until now,

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TICE: THE BRITISH AND SWEDISH EXPERIENCE (1988); Brahams, *supra* note 29, at 734.

31. Gellhorn, *supra* note 3, at 188. *See generally id.* at 188-210.

32. *Id.* at 190.

33. *Id.* at 189-93. A 1985 government survey showed 117,436 injuries were compensated in 1983, but only 91 of those were "explicitly characterized as medical misadventures." *Id.* at 193 n.64.

34. *Id.*

35. VA. CODE ANN. §§ 38.2-5000-5021 (Michie 1994 & Supp. 1995).

36. FLA. STAT. ch. 766.301-.316 (1993).

37. White, *supra* note 6, at 1495.

38. FLA. STAT. ch. 766.301(2), 766.302(2); VA. CODE ANN. § 38.2-5001.

39. William Bodiford admits that drops in malpractice insurance premiums may not be tied to Florida's no-fault plan—insurance rates have stabilized all over the country. Bodiford rates Florida's "social insurance program" as "O.K." but not deserving of any "rave reviews." Telephone Interview with William Bodiford, Florida Department of Insurance (June 14, 1994). There is no ampirical data regarding the financial impact of the plan on the state. Letter from Lynn B. Dickinson, Executive Director, Florida Birth-Related Neurological Injury Compensation Association (June 1, 1994) (on file with author).

40. Telephone Interview with William Bodiford, *supra* note 39.

been categorically dismissed as unrealistically expensive and unduly revolutionary.[41] Recent changes in the health care system and increased disquietude over the inefficiencies surrounding the tort-based system have reinvigorated interest in comprehensive proposals.[42] Significant in this trend toward no-fault acceptance was the Harvard Group's highly touted New York Study, which purportedly established the economic feasibility of comprehensive medical no-fault.

The Harvard Group examined the hospital records of 31,000 randomly selected patients treated in New York hospitals during 1984 and discovered that 1133 patients (about 4% of the total patients surveyed) suffered injuries resulting from their medical care.[43] From these findings, researchers deduced that 98,000 patients were injured in New York during 1984.[44] Interestingly, only 4000 malpractice claims stemming from 1984 treatment had been filed by the time of the Study,[45] and of these, researchers found "persuasive evidence of negligent injury" in only one sixth of the records.[46] Additionally, researchers found that there was "only one malpractice claim paid for every three serious, negligently inflicted, medical injuries that could be identified."[47] Thus, they concluded, the vast

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41. *See* Weiler, *supra* note 12, at 910-11. A 1974 study in California, showing that only a fraction of negligently injured patients ever initiated malpractice claims, demonstrated that the increased coverage and easier access of comprehensive no-fault would explode health care costs. CALIFORNIA MEDICAL ASSOCIATION, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY (1977); William G. Johnson et al., *The Economic Consequences of Medical Injuries: Implications for a No-Fault Insurance Plan*, 267 JAMA 2487, 2487 (1992).

42. Since the 1970s, the number of malpractice claims per doctor has skyrocketed, as has the overall cost of malpractice insurance for doctors. *See* Jost, *supra* note 12, at 69 (noting that even President Clinton "endorsed taking medical malpractice out of the courts" during his presidential campaign). *Compare* White, *supra* note 6, at 1487-89, *with* Gellhorn, *supra* note 3, at 171.

43. Johnson et al., *supra* note 41, at 2488 (members of the Harvard Group explaining the methodology and results of their Study). *See generally* HARVARD MEDICAL PRACTICE STUDY GROUP, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990); WEILER, *supra* note 4.

These findings corroborated earlier findings of the California study: "Almost 4% of hospital admissions involved an iatrogenic injury that prolonged the stay or persisted beyond it," and nearly one-quarter of these resulted from provider negligence. Paul C. Weiler et al., *Proposal for Medical Liability Reform*, 267 JAMA 2355, 2355 (1992).

44. Johnson et al., *supra* note 41, at 2487.

45. *Id.*

45. Weiler et al., *supra* note 43, at 2355.

47. Weiler, *supra* note 12, at 913.

majority of New York patients suffering iatrogenic injuries remained uncompensated or undercompensated by the tort system.[48]

After reaching this conclusion, the Harvard Group contrived a hypothetical no-fault medical liability scheme which would have provided compensation to injured patients for their financial losses if the effects of their injuries lasted more than six months (the "deductible period"[49]) and if their losses were not otherwise compensated. Hence, a collateral source offset was preserved, and subrogation rights of insurers—including those of Medicaid and Medicare—were revoked.[50] Financial losses were defined to include medical expenses, lost net income,[51] some lost fringe benefits, and lost household production, but not pain and suffering or other nonpecuniary losses.[52] Next, the Harvard Group contacted 794 injured patients and a corresponding number of noninjured patients to ask them questions "concerning the consequences of their 1984 hospitalizations in the years from 1984 to July 1988."[53] They then fit the data collected from these interviews into the no-fault plan they devised.

Based on this data, the Harvard Group concluded that if the hypothetical plan had actually been implemented in New York during 1984, its compensation costs would have totaled $878 million ($161 million in medical care, $276 million for lost wages and benefits, and $441 million for lost household production in 1989 dollars)—$222 million less than the roughly $1 billion New York physicians annually pay for malpractice insurance.[54] Although including administrative costs would inflate the plan's price 25% to 30%,[55] the Study concluded that

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48. *Id.* at 912-13.

49. The deductible period is a time during which patients receive no compensation for their injuries. Johnson et al., *supra* note 41, at 2489. "The use of deductible periods eliminates the large number of claims with small losses and the proportionately larger administrative costs associated with them and consequently provides more funds to those victims who suffer[] the largest losses and who are least likely to be compensated by other forms of insurance . . . ." *Id.* at 2491.

50. Johnson et al., *supra* note 41, at 2489-92; Weiler et al., *supra* note 43, at 2357.

51. The Group defined net income as gross income less taxes payable and, in the case of deceased persons, an allowance for personal consumption. Johnson et al., *supra* note 41, at 2488.

52. *Id.* at 2491.

53. *Id.* at 2488-89.

54. *Id.* at 2487, 2491 tbl. 4.

55. *Id.* at 2492.

"a no-fault program would not [have been] notably costlier" than the present system and would have compensated a substantially greater number of negligently injured patients.[56]

IV. THE UTAH PROPOSAL

Based on its New York Study, the Harvard Group has proposed a five-year trial of a similar no-fault plan in Utah[57]—one year of analyzing Utah's medical and legal environments, and four years of actually implementing the plan in a few volunteer hospitals.[58] Like the hypothetical New York plan, the Utah plan would compensate financial losses stemming from injuries lasting longer than a prescribed "deductible period."[59] The parameters of this plan, however, are somewhat different. The Utah plan would reimburse only 80% of lost net earnings up to a cap of twice the state's average wage.[60] It would make no adjustment for lost fringe benefits, nor would there be compensation for lost household production.[61] Significantly, though, the plan would add compensation for the patient's pain and suffering and relax the deductible period from six to two months.[62] The plan would also preserve a ban against collateral source payments and curtail the subrogation rights of other payors. It would remove liability from individual doctors and assign it to the hospitals with which they associate.[63]

These alterations appear motivated by a goal to make compensable a greater number of claims while conserving funds sufficient to compensate the most severe medical injuries. Compensation to individual patients would follow a schedule of Designated Compensable Events (DCEs) compiled at each participating hospital by panels of physicians and hospital staff.[64] Iatrogenic injuries judged by a panel to be DCEs would automatically be compensated according to the plan's parame-

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56. *Id.* at 2487, 2492.
57. See Appendix A for a copy of the Utah Medical No-Fault Proposal.
58. App. A, ¶¶ 1, 6, 9.
59. *Id.* ¶¶ 4-5, 17.
60. *Id.* ¶ 18.
61. *Cf. supra* note 51.
62. App. A, ¶ 4.
63. *Id.* ¶ 2.
64. *Id.* ¶¶ 15-16. DCEs "are the unexpected or avoidable injury/outcomes covered under the no-fault plan." *Id.* ¶ 15.

ters (medical costs, lost wages, pain and suffering, etc.).[65] DCE lists would be regularly updated and revised to reflect technological advances and the experience of medical panels in administering the plan.[66] The Department of Commerce would oversee the hospital panels and coordinate their lists of DCEs.[67] The proposal also provides an appeals process through which patients could combat rejected claims.[68]

V. ANALYSIS OF THE PROPOSAL

A private group of interested Utahns, headed by attorney Elliott Williams and funded by the Robert Wood Johnson Foundation, have collaborated with the Harvard Group in conducting the one-year study of Utah called for by the proposal. According to Williams, his group is now half finished with that study, which has employed the same methodology as the New York Study.[69] Researchers have reviewed the records of 5000 Utah patients treated in 1992 to determine the extent and magnitude of treatment-related injuries. They have not, however, published results from this initial survey.[70] Their next step will be to project the economic costs of their proposed no-fault plan based on the data they have gathered.[71]

No matter the results of this cost study, however, serious consideration should be given to several of the plan's key components and assumptions, which, a review of recent no-fault literature reveals,[72] have been all but smothered in rhetoric regarding the plan's predicted cost-effectiveness. The next few sections will analyze several specific aspects of the plan that inform against its adoption in Utah.

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65. *Id.* ¶¶ 15, 27-28.

66. *Id.* ¶ 15.

67. *Id.*

68. *Id.* ¶¶ 29-30.

69. Telephone Interview with Elliott J. Williams, General Counsel, Utah Medical Association (Dec. 6, 1995); *see supra* part III.B.

70. *Id.*

71. *Id.*

72. Based on the apparent success of their New York Study, the Harvard Group, including Paul Weiler, William Johnson, and Troyen Brennan, have written copiously about no-fault. *See e.g.*, HARVARD MEDICAL PRACTICE STUDY GROUP, *supra* note 43; WEILER, *supra* note 4; Johnson et al., *supra* note 41; Weiler, *supra* note 12; Weiler et al., *supra* note 43.

A. Affordability—Time and Money

The plan's main selling point is its purported economic feasibility. The Harvard Group maintains, based on its New York Study, that a no-fault system could compensate the iatrogenic injuries of many more patients than the current system, at substantially the same price.[73] Furthermore, the Group claims, no-fault could significantly decrease the amount of time it takes injured patients to recover money for their injuries.[74]

A General Accounting Office (GAO) survey shows that in 1984 it took patients a median of thirteen months after their injury to file a claim and another twenty-three months for those claims to be closed, while more serious cases frequently took much longer.[75] By contrast, the Utah plan mandates that claims for no-fault compensation be evaluated within sixty days from filing.[76] Recovery may thus occur more quickly as well. In workers' compensation—the oft-cited model for no-fault medical liability—"benefits are paid in a median time of only three weeks for uncontested claims and four months if the claim is contested."[77] Although proving causation in medical no-fault would likely take longer, plan supporters assert that recovery under the Utah plan would be similarly expeditious.[78]

Supporters also assert that, under the current system, administrative costs devour most of the money recovered by injured patients in settlements or jury verdicts and paid out by health care providers in malpractice premiums: Successful claimants pocket only 40% to 45% of the money awarded them.[79] In contrast, the Harvard Group estimated administrative costs for its hypothetical New York plan at 25% to 30% of the total cost by comparing the costs incurred in administering workers' compensation and the Swedish no-fault program, both

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73. Johnson et al., *supra* note 41, at 2487, 2492; Weiler, *supra* note 12, at 926.

74. WEILER, *supra* note 4, at 52-53; App. A, ¶ 5.

75. U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 32,33 (1987); *see also* WEILER, *supra* note 4, at 53.

76. App. A, ¶ 26.

77. WEILER, *supra* note 4, at 53 (footnote omitted); *see* Gellhorn, *supra* note 3, at 173.

78. *See* WEILER, *supra* note 4, at 52-53; Johnson et al., *supra* note 41, at 2492.

79. WEILER, *supra* note 12, at 53; Gellhorn, *supra* note 3, at 172 ("[L]ess than half of the total amount of the liability insurance premiums that health care providers pay reaches the pockets of claimants."); Weiler, *supra* note 12, at 926.

of which spend "approximately 20¢ of the claims dollar on administration,"[80] and by adding costs that necessarily would be incurred in proving causation.[81]

Furthermore, the Harvard Group asserts, based on its New York Study, that the compensation costs of no-fault would not significantly out-run those of the tort system.[82] In the New York Study, the Group concluded that its plan could compensate the financial losses of all patients receiving treatment in 1984 whose otherwise uncompensated iatrogenic injuries lasted longer than six months for approximately $878 million, far less than the amount paid for malpractice insurance.[83] However, it may be impossible to extrapolate much from these findings that would apply to Utah.

First, the hypothetical New York plan varies markedly from the Utah plan. The New York plan omitted compensation for pain and suffering which the Utah plan contemplates.[84] Under the plan, awards would be fixed by prearranged DCE schedules and could reach as much as $250,000 per claimant.[85] Additionally, the New York plan would compensate lost

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80. Johnson et al., *supra* note 41, at 2492; *see* Weiler, *supra* note 12, at 926.
81. *See* Johnson et al., *supra* note 41, at 2492.
82. *Id.* at 2487, 2492; *see supra* text accompanying note 56.
83. *Id.* at 2490; *see supra* note 53 and accompanying text.
84. App. A, ¶¶ 4-5, 18.
85. App. A, ¶ 15.

> Awards for pain and suffering would contemplate:
> [1] The physiological pain felt by the victim at the time of the injury and during recuperation . . . .
> [2] The anguish and terror the victim felt in the face of impending injury or death . . . .
> [3] The immediate emotional distress and long-term loss of love and companionship that is the result of an injury to or death of a close family member.
> [4] Most important is the accident victim's enduring loss of enjoyment of life when a permanent physical impairment precludes the pleasures of normal personal and social activities.

WEILER, *supra* note 4, at 54-55 (footnotes omitted). Medical expenses, a portion of lost wages, and other pecuniary costs of injury are covered by different facets of the plan. *See supra* part III.

Plan drafters highly tout their inclusion of pain and suffering compensation in the plan when talking about its patient orientation. WEILER, *supra* note 4, at 57-58. Indeed, by some accounts, such inclusion is "extremely liberal." Interview with Carl Hawkins, Emeritus Guy Anderson Professor of Law, Brigham Young University, in Provo, Utah (June 15, 1994); *see* Jost, *supra* note 12, at 72. Because no-fault derives from efforts to facilitate distribution of insurance benefits and rejects the archaic system of justice which retributivaly assesses the moral culpability of doctors, *any* compensation for pain and suffering is generous in that the "infliction of a painful injury does not increase the need for and valuation of money." WEILER,

household production, while the Utah plan would not.[86] The Utah plan would also place limits on compensation for lost earnings.[87] Adjusting for such differences and adding in administrative costs, therefore, would bring the hypothetical New York plan's total cost to approximately $930 million, even with a six-month deductible period.[88] Art Glenn, Vice President of Claims at the Utah Medical insurance Association (UMIA), maintains that the New York Study ignores in its calculations injuries resulting from the doctor's failure to properly diagnose a patient's condition, which failure accounts for 85% of current cases.[89] In short, it is hard to say from what was done in New York whether Utah's plan would prove cost effective.

Second, the medical and legal environments in New York differ substantially from those in Utah. Even the Harvard Group has admitted that "New York is one of the nation's leaders in malpractice litigation and insurance costs," and only "in that state," or one so costly, can citizens purchase no-fault insurance at a price comparable to their malpractice insurance bill.[90] In Utah, on the other hand,

> medical malpractice suits are almost as rare as a New York-style deli. There were only 100 or so medical suits filed in state courts in all of 1991.[91] New Yorkers filed 3,400 malpractice suits . . . in state courts during the same period.
>
> Utah doctors pay among the lowest insurance premiums in the country: about $7,600 annually for basic coverage for physicians and surgeons. General practice physicians pay more than $20,000 for comparable insurance in the New York City area, and premiums in several specialties surpass $100,000.[92]

Art Glenn estimates that under no-fault the number of claims filed in Utah would increase seven to ten times their

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supra note 4, at 56-57. Neither Virginia nor Florida includes pain and suffering compensation in its no-fault scheme.

86. Johnson et al., *supra* note 41, at 2490.

87. App. A, ¶ 18 (limiting compensation for lost earnings to 80% of wage up to twice the state's average wage).

88. Johnson et al., *supra* note 41, at 2490.

89. Interview with Art Glenn, *supra* note 18.

90. Weiler, *supra* note 12, at 925.

91. Between July 1, 1994 and June 30, 1995 only 110 claims were filed. UTAH OFFICE OF STATE COURT ADMINISTRATOR: UTAH STATE COURTS: 1996 ANNUAL REPORT 32 (1996).

92. Kenneth Jost, *Fault-Free Malpractice*, A.B.A. J., Jan. 1994, at 46 (footnote added).

current levels.[93] This is remarkable, he avers, especially considering that 68% of malpractice claims in Utah are settled without payment.[94] It is not unreasonable, therefore, to conclude that the tab for no-fault in Utah could far exceed what local physicians currently pay in malpractice insurance premiums.

B. Enterprise Liability

The Utah plan absolves physicians of liability and assigns legal and financial responsibility for all patient injuries to the hospitals (or enterprises) in which these doctors are employed or hold admitting privileges.[95] It is in this aspect that the plan aligns itself most closely with workers' compensation (which makes employers legally responsible when their employees suffer injuries "by accident arising out of and in the course of employment"[96]) and distinguishes itself from foreign and limited no-fault plans which do not assign legal responsibility.[97]

Some consider inclusion of enterprise liability in the Utah plan a highly innovative way to address problems of abuse, prevention, deterrence, quality assurance, and discipline, be-

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93. Interview with Art Glenn, *supra* note 18.

The Harvard Group estimates that about 400 patients would file claims for medical injury in Utah, resulting in a compensation bill of around $20 million plus at least $5 million in administrative costs. Memorandum from Troyen A. Brennan, Professor of Law and Public Health, Harvard School of Public Health, to Elliott J. Williams, General Counsel, Utah Medical Association (Sept. 28, 1993) (on file with author).

94. Interview with Art Glenn, *supra* note 18; *cf.* UTAH OFFICE OF LEGISLATIVE AUDITOR GENERAL, supra note 18, app. at B2, figure B1 (finding that of 1208 cases between July 1, 1985 and June 30, 1990 for which prelitigation hearings were requested 59% were dismissed or otherwise disposed of, 34% settled or went to trial, 3% achieved nuisance settlements, and 4% were unresolved).

95. App. A, ¶¶ 2, 16-17.

96. UTAH CODE ANN. § 35-1-45 (Michie 1994).

97. Swedish and Finnish programs simply promote the purposes of their parent systems of social insurance, long-armed governmental caretaking regimes that abrogate liability entirely. Efforts at preventing medical mishaps are hand-slapping at best. New Zealand's program is similarly centered on compensation, and its safety officers slink from programs of discipline and deterrence. All three schemes rely "solely on ethical, market, or regulatory incentives to ensure the necessary levels of safety and quality." Weiler, *supra* note 12, at 937. All finance their no-fault regimes with public moneys. *Id.* Likewise, the limited no-fault plans of Virginia and Florida diffuse "responsibility for compensating medical injuries among all [doctors and participating hospitals, which are] required to contribute to the insurance fund." *Id.*

cause they believe it prods the enterprise to develop procedures and technologies that "minimize the ever-present risk of occasional human failure, rather than simply to single out for blame those individuals whose mistakes happen to inflict [injuries serious enough] to surface in the courtroom."[98] It also aims to prevent doctors from colluding with their marginally injured patients to collect unwarranted compensation under the plan.[99] In truth, under the plan, hospitals would have heavy financial incentives to assure the general quality of treatment given by care providers, and to discipline individual providers whose records reveal a tendency toward "erratic behavior."[100]

While noble, enterprise liability's goals of preventing abuses of no-fault and of assuring the quality of medical care present severe complications, which the plan's advocates largely overlook. First, the Utah proposal specifies that its "plan would . . . cover injuries resulting from the diagnosis or treatment at the non-employee doctor's office."[101] If the enterprise is given legal responsibility for injuries occurring in the doctor's private office, it must also be able (and is required by the plan[102]) to assert quality control and monitoring power over what happens in that office.[103] This requirement places a significant burden on hospitals and other health care organizations, which would likely result in a decrease in the number of doctors to whom they give admitting privileges. Hospitals would also discourage doctors from practicing in private clinics.

Second, doctors, who would otherwise cheer at being relieved of fault, balk at the idea that hospitals would be policing them—not only inside the hospitals, but in their clinics as well.[104] Traditionally, hospitals have existed to serve patients admitted by affiliated, but independent, physicians, and the

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98. *Id.* at 942. Professor Weiler maintains that workers' compensation, which has a similar system of enterprise liability, deserves credit for significantly reducing the occurrence of worker deaths by between 25% and 45%, and implies that a similarly structured medical no-fault scheme would have analogous results in decreasing medically related injuries and deaths, *Id.* at 938.

99. In order to recover compensation under the New Zealand no-fault regime, patients must obtain a certification as to the extent and duration of their injuries from their doctors. Doctors, however, face virtually no disciplinary threat if they exhibit propensities to "erratic" behavior, leading to situations conducive for such collusion. Gellhorn, *supra* note 3, at 197-98; *see* Weiler, *supra* note 12, at 941.

100. Weiler, *supra* note 12, at 941; App. A, ¶¶ 2, 19.

101. App. A, ¶ 17.

102. *Id.* ¶ 19.

103. *Id.* ¶ 2.

104. *See id.* ¶ 17.

relationship between these hospitals and doctors has been founded in mutual reliance. But no-fault seeks to change this, subjecting physicians in private practice to management scrutiny. No-fault would treat non-employee doctors as if they were contracted employees, as in a health maintenance organization. Understandably, doctors worry that enterprise liability would allow accountants to restrict their options for treatment, forcing them to use less expensive methods of care that may not adequately address the needs of their patients.

Third, the Harvard Group's modeling of the Utah plan on workers' compensation assumes that that system is worthy of emulation. Many commentators, however, consider workers' compensation "the major failure in insurance": drastically rising costs, a broadening idea of what is compensable, low benefits, widespread abuse, and fraud.[105] While it may adequately compensate the many minor claims presented it, workers' compensation can be deplorable in treating claims for major inju-

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105. Interview with Art Glenn, *supra* note 18; *see also* Paul E. Jones, *House Bill 928: Solution or Band-Aid for Kentucky Workers Compensation?*, 22 N. KY. L. REV. 357, 357-58 (1995) ("Relatively high and rising costs for medical, hospital, rehabilitation, and legal services have contributed to the financial troubles affecting the workers' compensation program . . . . [T]he big increase in injury claims has not been due to an increasing frequency of accidents but rather a broadening of what is considered a compensable injury. The workers' compensation program in Kentucky appears to have become more and more a social welfare or entitlements program.'") (quoting *William Baldwin et al., Workers' Compensation in Kentucky: A System in Distress, A Report by the Center for Business and Economic Research* 32 (1994); Angela Mickelson et al., *Managed Care Potpourri: Medi-Cal, Workers' Compensation & Beyond*, 16 WHITTIER L. REV. 87, 91 (1995) ("For years the worker's [sic] compensation system in California has been notorious for being high in premiums, low in benefits, riddled with abuses, and a great source of frustration for anyone even remotely associated with it."); Vernelia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 81 (1994) ("In any system where compensation is made not on the basis of conduct but on the basis of status, the problems of fraud, abuse, and malingering are intensified. . . . Thus, curing [these problems] will be a problem with a medical injury compensation scheme just as it has been a problem with workers' compensation." (footnotes omitted)); Gary T. Schwartz, *Waste, Fraud, and Abuse in Workers' Compensation: The Recent California Experience*, 52 MD. L. REV. 983, 983-994 (1993) (noting that national compensation costs have risen from $21 billion in 1980 to $62 billion in 1992 and chronicling fraud and abuse of workers' compensation in California); Emily A. Spieler, *Perpetuating Risk? Workers' Compensation and the Persistence of Occupational Injuries*, 31 HOUS. L. REV. 119, 123 (1994) ("American workers and enterprises are . . . paying a price for both the persistent levels of injury and disease and the growing costs of workers' compensation.").

ries.[106] A medical no-fault system may be similar, leaving the most severely injured patients undercompensated.

Fourth, it may be impossible for insurance companies to underwrite the enterprise liability scheme. Paul Weiler suggests that hospitals under such a system self-insure or purchase insurance that "can be experience-rated in an actuarially credible way to maintain a potent incentive for the enterprise to prevent injuries."[107] But Glenn reports that actuaries everywhere are opposed to no-fault; there is no "credible" way to determine rates and underwrite it accurately.[108] Even with the one-year study period preceding implementation of the Utah plan, which the Harvard Group claims would solve this problem, Glenn maintains that from his experience "it is impossible."[109] There will simply be no reliable experience or data available by which to assign rates.[110]

Fifth, in freeing doctors of individual fault, the Utah plan also attempts to free them from having to report paid claims to the National Practitioner Data Bank since only hospitals would be named in claims.[111] However, a $10,000 fine is imposed on doctors who report paid claims under clinic or professional corporation names—it is illegal.[112] Granted, negligence-based claims are different than no-fault claims which are based in "adverse events," but the Department of Health and Human Services may still require that no-fault claims be reported in the doctor's name.[113] Allowing no-fault claims to go unreported would make moot the Data Bank's purpose of preventing high-risk doctors in one state from simply setting up shop in another state.[114] Yet, requiring that all claims be reported

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106. Interview with Ralph L. Dewsnup, Past President, Utah Trial Lawyers Association, in Salt Lake City, Utah (June 14, 1994); *see also* Mickelson et al., *supra* note 105, at 91.

107. Weiler, *supra* note 12, at 937; *see also* Weiler et al., *supra* note 43, at 2357; App. A, ¶ 19.

108. Interview with Art Glenn, *supra* note 18.

109. *Id.*

110. *Id.*

111. Memorandum from Troyen A. Brennan to Elliott J. Williams, *supra* note 93, at 4. When payments are made on behalf of insured physicians or health care practitioners, malpractice insurance companies are required to report the practitioner's name, the amount of payment, a description of the claim, and other information required by statute to the National Practitioner Data Bank which is administered by the Secretary of Health and Human Resources. 42 U.S.C. § 11131 (1994).

112. 42 U.S.C. § 11131; Interview with Art Glenn, *supra* note 18.

113. 42 U.S.C. § 11131.

114. *See* 42 U.S.C. § 11101(2) (1994) ("There is a national need to restrict the

could unfairly jeopardize nonnegligent doctors practicing under no-fault who move to areas where no-fault has not been introduced, because these doctors, though never guilty of negligence, may still have been subjected to no-fault claims.[115]

Sixth, hospitals would have to devise a way to raise the money they would be obligated to pay in compensation to injured patients. An American Law Institute study directed by Professor Weiler reported that the cost of malpractice liability for medical treatment could be built into the fees charged by health care providers for their work.[116] However, the study found, "[i]f liability were shifted to the hospital, [doctors'] fees would have to be sharply reduced, while hospital charges for [patients] would have to be increased to cover the new institutional expense."[117] The problem is that doctors and hospitals have little control over what they are paid. Their fees are firmly fixed by the reimbursement schedules of public and private health insurers.[118]

C. Appeals

The Utah proposal envisions an administrative compensation scheme run by the Department of Commerce, which, except for the question of fault,[119] resembles that sponsored by the American Medical Association.[120] Each hospital's medical panel would evaluate patient claims to determine their validity and would then assign appropriate awards.[121] Patients wishing to pursue rejected claims would be entitled to the assistance of "patient advocate[s],"[122] and appeals would advance through the following sequence: (1) an informal hearing before

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ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.").

115. If a doctor under no-fault incurs several reported "claims," although the claims may not have resulted from negligence, he may well be prevented from securing admitting privileges in hospitals or health care institutions not within the no-fault regime.

116. 2 AMERICAN LAW INSTITUTE, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY: REPORTERS' STUDY 120 (1991) [hereinafter 2 ALI STUDY].

117. *Id.*

118. While these fee schedules can, with difficulty, be changed, their widespread use and complexity would significantly obfuscate the ability of plan proponents to effect the switch to enterprise liability.

119. The tort liability of participating hospitals and physicians would be waived. App. A, ¶ 13.

120. *See* Jost, *supra* note 12, at 70.

121. App. A., ¶¶ 27-28.

122. *Id.* ¶ 27.

an administrative law judge; (2) a formal hearing before an administrative law judge; and (3) an appeal before the Utah Court of Appeals.[123] According to the proposal, however, the appeals court would only be able to determine "whether the administrative law judge followed" appropriate rules "and whether the decision was arbitrary or capricious."[124]

While arguably more efficient than the current system, the plan's administrative appeals system appears to contravene existing Utah law which would prove exceptionally difficult to change.[125] The Utah Administrative Procedures Act[126] delineates procedures for informal and formal hearings and mandates that all administrative remedies be exhausted before judicial review be granted.[127] Likewise, the Act allows the appellate court to grant relief only if the appellant has been "substantially prejudiced" by agency action that is unconstitutional, contrary to the prescribed procedure or precedence of the agency, or "otherwise arbitrary or capricious"—just as specified by the proposal.[128] However, the Act also permits the appeals court to grant relief when agency action is "based upon a determination of fact, made or implied by the agency, that is not supported by substantial evidence."[129] This provision grants the court "greater latitude in reviewing the record" than would be allowed under the Utah proposal.[130]

Brigham Young University law professor Carl Hawkins, who aided in drafting the Act, maintains that efforts at lobbying for an exemption to this provision would be near futile because of the Act's tight language.[131] Furthermore, trial attorneys would zealously fight to maintain the court's broadened scope of review. Changing the Utah plan to expand appellate review would undoubtedly increase the costs of administering the plan, both in terms of time and money, but would also

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123. *Id.* ¶¶ 29-30.

124. *Id.* ¶ 30.

125. *See infra* part V.F.

126. UTAH CODE ANN. §§ 63-46b-0.5 to -22 (Michie 1993).

127. *Id.* § 63-46b-5 (informal proceedings); *Id.* §§ 63-46b-6 to -10 (formal proceedings); *Id.* § 63-46b-14 (exhaustion of administrative remedies).

128. *Id.* § 63-46b-16(4).

129. *Id.* § 63-46b-16(4)(g).

130. Interview with Carl Hawkins, *supra* note 85; *see* Grace Drilling Co. v. Board of Review, 776 P.2d 63, 68 (Utah App. 1989) (holding that appellate courts in applying the "substantial evidence test" review the "whole record" before them) (citations omitted).

131. Interview with Carl Hawkins, *supra* note 85.

increase the ability of patients to receive fair treatment in seeking compensation for alleged injuries. Workers' compensation in Utah has been required to adhere to the more expansive form of review for decades. In fact, members of the Industrial Commission coauthored the Administrative Procedures Act with Professor Hawkins, and are supportive of its provision.[132] No-fault should be required to adhere to the Act as well.

D. Proof of Causation

The Utah plan requires that compensable injuries be iatrogenic in nature—unexpected, preventable, and arising out of and in the course of treatment.[133] This requirement has interesting implications. Most patients entering the hospital already suffer from illnesses, which may carry their own unwanted outcomes: lost time, pain, sometimes even lasting disability. But only damages related to iatrogenic injuries would be compensable under no-fault. Medical panels and judges, charged with assigning compensation, must disentangle the unfortunate consequences of illness from those of injury. They must also determine whether such consequences could be reasonably anticipated by the inherent risks of required treatment or whether they were unexpected.[134]

The Harvard Group admits that the plan they propose for Utah would cost *more* than the current system if proving *cause* is as difficult as proving *fault*.[135] But the results of the New York Study, it asserts, demonstrate that proving cause is not so difficult. The Group classified only 5% of the cases it reviewed as "close calls,"[136] and, "given an identifiable . . . injury," the Group "could readily attribute subsequent spells of disability to either the injury or the illness."[137] The Group further asserts that the plan's deductible period[138] would decrease the burden on the panels and administrative judges of adjudicating causation by decreasing the number of complicated claims.[139]

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132. *Id.*
133. App. A, ¶ 3.
134. *See* Johnson et al., *supra* note 41, at 2487-88; Weiler, *supra* note 12, at 928-29.
135. 2 ALI STUDY, *supra* note 116, at 495.
136. Weiler, *supra* note 12, at 932.
137. Johnson et al., *supra* note 41, at 2490-91.
138. *See supra* note 49.
139. 2 ALI STUDY, *supra* note 116, at 500.

Also, the use of designated compensable events would greatly simplify the adjudication process.[140]

Others disagree. As one commentator lamented, "[i]t's going to cost a fortune to prove [causation]. That's what costs a fortune now."[141] Certainly, hearings to determine causation would remain adversarial, with panels acting more as judges than as experts in evaluating the claims presented them—like the screening panels established by previous tort reforms.[142] In fact, the Utah plan explicitly provides for advocates to represent injured patients who appeal their claims.[143] Who are these advocates, and who will pay for them? Although the language of the proposal is vague, the natural answer is that attorneys will assume the advocate's role. But will the agency appoint them or will patients be required to hire their own counsel? How will they be paid?[144] Regardless, costs will likely rise above plan predictions.[145] Moreover, costs are likely to exceed predictions due to the difficulty, if not impossibility, of ascertaining exactly which treatment expenses should be attributed to the underlying illness and which to the iatrogenic injury, particularly if the patient asserts failure to diagnose or other instances of omission.[146]

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140. Weiler, *supra* note 12, at 933; *see supra* note 63.

141. Jost, *supra* note 92, at 49.

142. *See supra* note 9.

143. App. A, ¶ 27.

144. Will there be contingency fee arrangements, as now in medical malpractice suits, or will advocates charge an hourly fee for the services they render? Professor Weiler suggested that "patients who need an attorney to successfully establish a contested claim would be reimbursed for this legal cost of their injury. Ideally, such costs would be reimbursed through a modest percentage formula that provides reasonable returns for lawyers operating in this less formal, less complex administrative process." Weiler, *supra* note 12, at 923.

145. Interview with Ralph L. Dewsnup, *supra* note 106.

146. Paul Weiler concedes that such instances "would require the use of a 'reasonable care' standard [rather than 'optimal care'] to distinguish between problems the doctor should have prevented and those that should go uncompensated because a doctor would not be expected to prevent them." Jost, *supra* note 92, at 49. Such a standard is critical if we do not wish to slide, like New Zealand, "down the slippery slope [of social insurance,] compensating illness or death every time" the patient's "bodily condition is worsened rather than bettered by medical treatment." Gellhorn, *supra* note 3, at 190, 191; *see also* Weiler, *supra* note 12, at 930-31 (noting that the "particularly difficult cases in the medical setting are instances of omission, in which the harmful consequence is attributable to a failure to properly diagnose and treat the patient's condition in the first place," and encouraging development of "*policy* causation"—"what *should* have happened"—versus merely "*factual* causation"—"what did or might have happened").

Finally, because the system compensates only iatrogenic injuries, patients bear the burden of proving that the damages they suffer in fact result from such injuries, and, as Pamela Gilbert of the consumer group Congress Watch says, "[a]s soon as you put a proof requirement on the injured victim, you remove the benefit of trading off for lower compensation."[147]

E. Constitutionality

The Utah plan and many of its chief components arguably infringe rights guaranteed by both federal and state constitutions. The U.S. Constitution preserves "the right of trial by jury"[148] and enjoins states from depriving anyone of property "without due process of law."[149] The Utah Constitution echoes these guarantees.[150] Additionally, the Utah Constitution allows individuals to defend or prosecute "any civil cause" before "any tribunal in the State"[151] and mandates that "[a]ll laws of a general nature" shall [have] uniform operation."[152]

Plan proponents cite the Supreme Court's handling of workers' compensation to support their plan's constitutionality. Indeed, in 1917 the Court in *Mountain Timber Co. v. Washington*[153] held that workers' compensation did not improperly exclude the claimant's right of trial by jury because "[a]s between employee and employer, the act abolishes all right of recovery in ordinary cases, and therefore leaves nothing to be tried by jury."[154] That same term, the Court in *New York Central R.R. v. White*[155] found that "[t]he denial of a trial by jury is not inconsistent with 'due process,'" and that rules defining legal duty may be altered as long as a state provides some "reasonably just substitute."[156] The Supreme Court of Utah has ruled similarly on these constitutional issues.[157]

The New York Study did not account for such "instances of omission" as injuries in its data. *See supra* note 96 and accompanying text.

147. Jost, *supra* note 92, at 47.

148. U.S. CONST. amend. VII.

149. U.S. CONST. amend. XIV.

150. UTAH CONST. art. I, §§ 7, 10.

151. UTAH CONST. art. I, § 11.

152. UTAH CONST. art. I, § 24.

153. 243 U.S. 219 (1917).

154. *Id.* at 235.

155. 243 U.S. 188 (1917).

156. *Id.* at 201, 208 (citations omitted); *see also* White, *supra* note 6, at 1506-07.

157. *See generally* Cudahy Packing Co. v. Industrial Comm'n, 207 P. 148

Since then, however, the U.S. Supreme Court increasingly has found in favor of plaintiffs' right to trial by jury under the Seventh Amendment.[158] Significantly, in *Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry*,[159] the Court stated that the right to trial by jury is preserved for all "Suits at common law," defined as those cases requiring resolution of "*legal* rights" rather than equitable rights.[160] Whether an action requires resolution of "legal rights" is determined by comparing the action to common law suits available in 1791 (when the Seventh Amendment was passed) and by examining the nature of the remedy requested.[161] Tort-based actions for malpractice and their remedies, certainly, are legal in nature.[162]

However, even if the Court could find that malpractice actions do not involve legal rights or are not legal in nature, removing them from juries is improper. In *Atlas Roofing Co., Inc. v. Occupational Safety & Health Review Commission*,[163] which challenged the administrative law system established for OSHA actions, the Court found that juries are not required in historically nonlegal actions when *both* (1) the action involves a public right and (2) all fact finding takes place exclusively within the administrative law system (the executive

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(1922).

158. *See* 9 CHARLES A. WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE, *Civil*, § 2302.1 (describing a "series of Supreme Court cases decided since 1959 in which the Court adopted a 'dynamic concept' of the jury trial right" recognizing "a strong federal policy favoring trial by jury").

159. 494 U.S. 558 (1990).

160. *Id.* at 564 (plurality opinion) (quoting Parsons v. Bedford, 28 U.S. (3 Pet.) 433, 447 (1830)).

161. *Id.* at 565 (plurality opinion).

162. *See* part II. In addition to the historical nature of negligence-based malpractice actions, the damages sought invariably involve money awards rather than equitable relief. This aspect of the malpractice claim is likely dispositive: "The second inquiry [into the nature of the remedy] is more important in our analysis." *Terry*, 494 U.S. at 570 (citing Granfinanciera, S.A. v. Nordberg, 491 U.S. 33, 42 (1989)). The remedy inquiry is the only part of the *Terry* test on which a majority of the Court clearly agreed. *See id.* at 574 (Brennan, J., concurring); *cf.* Ross v. Bernhard, 396 U.S. 531, 538-542 (1970) (holding that whether an action is legal "depends on the nature of the issue to be tried rather than the character of the overall action" and that, while the action at bar was historically equitable, the underlying issue was legal—money damages were sought for negligence, breach of contract, and breach of fiduciary duty—and was, therefore, entitled to trial by jury); Orenstein v. United States, 191 F.2d 184 (1st Cir. 1951) (stating that actions which at common law would fall within well-recognized forms of action are jury actions).

163. 430 U.S. 442 (1977).

branch).[164] While fact finding in the Utah plan would occur solely within the system administered by the Department of Commerce,[165] an injured patient's claim would *not* involve a public right—which the Court has defined as involving the government suing on behalf of the public[166]—but the purely private right against personal injury.[167] Thus, a jury trial is constitutionally required for malpractice actions.

Also troubling for the Utah plan is the Utah Constitution's "open courts" provision.[168] In 1985, the Utah Supreme Court held that, under this clause, access to courts may be denied only if (1) the substitute legislation provides the injured person with a "reasonable alternative remedy [that is] substantially equal in value . . . to the remedy abrogated, for vindication of his constitutional interest," or (2) "if there is a clear social or economic evil to be eliminated and . . . elimination of [the] existing legal remedy" is reasonable.[169] Eight years later, in *Lee v. Gaufin*,[170] the court refined this second prong to prohibit legislation that "discriminates against a person's constitutionally protected right to a remedy for personal injury" unless the legislation "(1) is reasonable, (2) has more than a speculative tendency to further the legislative objective and, in fact, actually and substantially furthers a valid legislative purpose, and (3) is reasonably necessary to further a legitimate legislative goal."[171]

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164. *Id.* at 450.

165. *But see supra* part V.D. Disallowing appellate review of the factual record when a finding is not supported by "substantial evidence" conflicts with the Utah Administrative Procedures Act of 1987. UTAH CODE ANN. § 63-46b-16 (4)(g) (Michie 1992).

166. *Atlas Roofing*, 430 U.S. at 450.

167. *Cf. id.* at 450 n.7. There is no public benefit in a personal injury claim for medical injury. Conversely, OSHA, the administrative scheme challenged in *Atlas Roofing*, was created with the express purpose to ensure public safety. 29 U.S.C. § 651(b) (1994).

The constitutionality of workers' compensation's administrative system was affirmatively established in Mountain Timber v. Washington, 243 U.S. 219 (1917). That decision has not been successfully challenged under *Atlas Roofing*. *Cf.* Walthal v. Fletcher & Sons, Inc., 861 F.2d 715, 1988 WL 109265 (4th Cir. 1988) (unpublished opinion) (confirming *Mountain Timber*).

168. UTAH CONST. art. I, § 11.

169. Berry v. Beech Aircraft Corp., 717 P.2d 670, 680 (Utah 1985) (citations omitted); *see also* Sun Valley Water Beds, Inc. v. Hughes and Son, Inc., 782 P.2d 188, 191-92 (Utah 1989).

170. 867 P.2d 572 (Utah 1993).

171. *Id.* at 582-83 (citations omitted).

The Harvard Group justifies its no-fault proposal under the "clear social or economic evil" prong of *Berry*.[172] It is highly unlikely, however, that the court would accept the Group's justification for the medical no-fault proposal, particularly under the heightened requirements of *Lee*. Indeed, in *Lee*, the court went out of its way to reject a similar contention made by proponents of previously enacted tort reforms.[173] In a lengthy opinion by Justice Stewart, the court voided statutes of limitation and repose for malpractice claims of minors despite arguments that the reforms were necessary to counter the effects of the medical malpractice insurance crisis.[174] The court's disposition in *Lee* suggests an inhospitable attitude toward malpractice tort reform and even seems to invite suits to challenge reforms.[175]

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172. *Berry*, 717 P.2d at 680. Telephone interview with Elliott J. Williams, General Counsel, Utah Medical Association (Dec. 6, 1995); *see supra* text accompanying notes 12 and 23.

173. *See supra* notes 7-9 and accompanying text for a list of tort reforms adopted by Utah legislators in response to the alleged "malpractice insurance crisis."

174. In *Lee*, the court recounted how Utah legislators rushed to respond to an insurance "crisis" in the 1970s, which they presumed was caused by an increasing number of malpractice suits and higher verdicts. *Lee*, 867 P.2d at 583-89; *see* UTAH CODE ANN. § 78-14-2 (Michie 1992). The court held that "[a]lthough it was well-established that malpractice insurance premiums had substantially increased, the evidence for the asserted causes was largely anecdotal." *Lee*, 867 P.2d at 584. More significantly, "there was no evidence of increased malpractice lawsuits or of greater verdicts in Utah." *Id.* at 585. Indeed, the court noted that the number of malpractice claims in Utah actually decreased the year before the Malpractice Act was passed. *Id.* Hence, reforms in Utah were precipitated by fears grounded in national statistics: "we are involved . . . in paying the price for some bad experience in one particular state, the State of California," and "Utah is being penalized as the result of being subject to the national experience." *Id.* at 585-86 (quoting Statement of Rep. Franklin B. Matheson, Utah House of Representatives) (emphasis omitted).

The court also noted that much of the increase in insurance rates arose out of "the cyclical pricing and investment practices of insurance companies," not from an increased number of suits. Even California's "crisis" may have stemmed from the dubious pricing strategies of Argonaut Insurance Company. *Id.* at 588. In fact, the national "crisis" subsided when interest rates went up, making investments more profitable for insurance companies and decreasing their reliance on doctor premiums for earning money. The court extensively listed cases that challenged the "presumed causes" of the "crisis" and the efficacy of legislative responses. *Id.* Finally, the court concluded

> that the nonuniform application of the limitations provisions in the Malpractice Act to minors' malpractice claims does not actually and substantially further the policy of curbing and reducing malpractice premiums and of ensuring reasonably priced health-care services to the people of Utah and is not necessary to accomplish those ends.

Id.

175. The *Lee* opinion undercuts "the legislative purposes and objectives stated

Even if the Utah proposal could, on the whole, pass *Lee*'s heightened scrutiny standard by providing a "reasonably just substitute," many of its major components may not. The affordability of the plan depends on the $250,000 cap on noneconomic damages and other held-over reforms, as well as on the two-month deductible period, all of which are of dubious constitutionality. Revoking these facets of the plan would mean huge increases in cost.

F. Legislative Action

The Utah plan's success tenuously depends on key legislative action at both state and federal levels. While one member of the Harvard Group worked closely with Senator Hatch's office to redraft a U.S. Senate bill authorizing no-fault medical liability systems,[176] nothing tangible came from his efforts.[177] That same member wrote in a memo to Elliott Williams that "it will be necessary to gain Medicare and Medicaid and ERISA waivers" so as to assure the Utah plan's second position[178] for insurance purposes.[179] Curtailing the

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in [Utah Code] § 78-14-2" on which previous tort reform initiatives rest. *Lee*, 867 P.2d at 583; *see supra* notes 7-9.

176. *See* Memorandum from Elliott J. Williams, General Counsel, Utah Medical Association, to Troyen A. Brennan, Professor of Law and Public Health, Harvard School of Public Health (May 12, 1994) (on file with author).

177. Troyen Brennan and Senator Hatch's staff worked together to redraft a bill originally drafted by Florida's Senator Graham. However, Shawn Bentley, counsel to Senator Hatch on the Judiciary Committee, reported that the Senator did not introduce the new bill, but added portions of it into both Labor and Finance Committee health care reform bills. These portions provided generally for no-fault "demonstration projects" in a few states, with details and "politically tough" issues to be arranged or approved by the Secretary of Health and Human Services. Neither bill contained specifics; the no-fault addition to the finance bill was only one sentence long. Both bills provided for enterprise liability (a concession by Hatch to Senator Kennedy), and the Labor bill included Brennan's language on the types of disclosure that would be necessary under no-fault.

Elliott Williams reports that as of December 6, 1995, Senator Hatch continued to work with members of the Harvard Group to introduce the necessary enabling legislation. Telephone Interview with Elliott J. Williams, *supra* note 69. Williams also reports that one provision regarding no-fault already passed a voice vote of the U.S. Senate, but the bill has since died. *Id.*; *see* 141 CONG. REC. H5941 (daily ed. May 2, 1995) (roll call vote No. 144 Leg.).

Obviously, congressional authorization for no-fault in an era of fomenting opinions about health care reform—and particularly Medicaid and Medicare—is beyond prediction. Williams reports that even if the current Congress refuses to allow the Medicare, Medicaid, and ERISA waivers the Harvard Group seeks, that refusal will not be a death knell for the no-fault program—the financial impact will not be too great. Telephone Interview with Elliott J. Williams, *supra* note 69.

178. Medicare, Medicaid, and ERISA each have subrogation rights which enti-

subrogation rights of public and private insurers, he continued, "is the only way that the compensation plan can be fiscally viable."[180] It is highly unlikely, however, that Congress would authorize such waivers considering the current push by Republicans to cut Medicaid and Medicare spending and the fact that the programs' right to subrogation is a significant source of their incomes. As Art Glenn opined: "They're not going to give that up."[181]

It may be unrealistic to presume that Utah's legislature will sweep the whole proposal into law either. The legislative process (including committees, amendments, and compromise between the houses) strips many bills of their intended potency, and bill sponsors often win no more than minor concessions for their causes. UMIA's Art Glenn posits that a *limited* system of no-fault would be much worse for Utah than the current system ever has been; it would be the "worst of both worlds."[182] A system imposing no-fault compensation for damages less than $100,000 and leaving more expensive damages to tort, for example, would take all money-making ability from insurance companies—"they would fold because 85% of money they spend goes to fight claims of over $100,000."[183] Even Paul Weiler agrees: "If you're going to have no-fault, you should move to a general no-fault, [and] not simply single out some of the most prominent cases that now go into the fault system . . . ."[184] Partial adoption of no-fault would be worse than the status quo.

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tle them to reimbursement from collateral sources of compensation (e.g. private insurance companies) if the collateral sources give compensation to patients whom the federal programs have already compensated. The Harvard Group seeks to waive these subrogation rights as to the no-fault plan, making Medicare, Medicaid, and ERISA the primary payors.

179. Memorandum from Troyenn A. Brennan to Elliott J. Williams, *supra* note 93, at 2-3.

180. *Id.* at 3. The Harvard Group also recognized that the cost of their New York hypothetical plan would have increased $250 million absent these waivers. Johnson et al., *supra* note 41, at 2491. Brennan's redrafted bill provided for the necessary waivers, but Labor and Finance Committee mark-ups "do not address tho specific issue at all," thus leaving the waivers to Secretary Shalala's approval, although Bentley was not certain that she could take such action without congressional sanction. Bentley admitted "it's a tough issue." Telephone Interview with Shawn Bentley, Counsel to Senator Orrin G. Hatch on the Senate Judiciary Committee (June 14, 1994).

181. Interview with Art Glenn, *supra* note 18.

182. *Id.*

183. *Id.*

184. Jost, *supra* nots 92, at 49.

VI. CONCLUSION

The Utah plan rejects outright the tort-based notion of justice in favor of a system which, purportedly, would improve the delivery of compensation to injured patients. Its supporters allege, based on observations of the New York health-care environment and existing plans in Scandinavia, New Zealand, Florida, and Virginia, that such a scheme would compensate the serious injuries of many more patients at substantially the same price as the current system. Moreover, they say, the Utah scheme is more generous than other plans because it compensates victims for their pain and suffering,[185] as well as for the financial losses associated with their injuries, while implementing an enterprise liability system geared to ensure the good quality of medical treatment.

These assertions are unconvincing, however, given the considerations discussed in this Comment. First, while claimants under the plan may more quickly recover compensation for their injuries, the plan's purported financial affordability derives from statistics which do not accurately reflect Utah's medical or legal environments. Second, the enterprise liability scheme espoused by the plan engenders difficult questions regarding physician autonomy, institutional policing of doctors' private offices, the ability of insurance companies to underwrite liable hospitals, National Practitioner Data Bank reporting requirements, and hospital's ability to fund the system. Third, the plan's restrictions on what is appealable from the administrative determination of a claim conflicts with established Utah law. Fourth, requiring injured patients to prove that their injuries in fact resulted from their medical treatment adds great expense to the no-fault plan, in part because such proof likely will be offered through attorneys in an adversarial procedure. Fifth, the plan as a whole impinges constitutional rights of trial by jury and access to court, among others. And sixth, the viability of the plan depends upon the unlikely enactment of federal and state enabling legislation, including the granting of Medicare, Medicaid, and ERISA waivers.

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185. See *supra* note 85.

In short, the plan's purported benefits do not outweigh its practical, legal, and economic costs. Utah should reject adoption of the Harvard Group's plan for medical no-fault compensation.

Matthew K. Richards

APPENDIX A
UTAH MEDICAL NO-FAULT PROPOSAL

I. INTRODUCTION

¶1)[186] The basic premise for a no-fault medical injury compensation plan is simple: Patients who suffer a disabling injury resulting from medical treatment are entitled to compensation, regardless of whether or not the treatment was negligent. A voluntary five-year trial of the no-fault concept would allow Utah lawmakers to determine if such a plan would reduce the amount of defensive medicine (and thus lower health care costs), reduce the number of patients who are medically injured (further reducing costs), and increase the percentage of the medical liability dollar which goes to injured patients.

¶2) Although the plan would dispense with the determination of fault, it would not dispense with liability. It would, however, shift liability to the hospitals and health care organizations (project sites) where the patient was treated, rather than to individual health care providers. These project sites would thus have strong incentives [to] improve the quality of care rendered to patients and to prevent future injuries through more aggressive quality assurance measures.

¶3) Each project site would have a medical panel that would determine which injuries are compensable and allocate appropriate payments based on explicit criteria. The medical panel would not consider negligence, or even gross negligence, of the particular health care provider in deciding whether to award compensation. Their sole concerns would be to determine if an "iatrogenic" injury (an unexpected yet preventable injury resulting from medical treatment) occurred and the amount of compensation due to a patient with an iatrogenic injury. If the patient does not agree with the panel finding, he/she will have open access to a state agency (and a patient advocate attorney), which will make the determinations of injury and payment.

¶4) Payments would cover expenses incurred for treatment or rehabilitation of any iatrogenic injury lasting for two months or longer. The plan would also provide compensation for lost wages, loss of enjoyment of life and pain and suffering. Minor

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186. Paragraph numbers were added for citation convenience. Original on file with author.

injuries of duration less that two months would not be eligible for compensation under this system, since such injuries would normally be paid for through the patient's health insurance, disability policy or employment.

¶5) The payments for eligible injuries are not open ended. Unlike the traditional tort compensation, which covers large financial losses of only a few injured patients, the no-fault plan would address the more modest losses suffered by a larger number of patients who either can't or won't navigate the hazards of the current legal system. Payments would be limited to out-of-pocket expenses not covered by collateral sources of insurance. Additionally, there would be caps on the amounts available for various forms of compensation, such as pain and suffering. However, payments would be available to the injured patient much sooner than through the traditional tort system. There would no more be years of waiting as is often the case in today's system.

II. Five-Year Study Plan

¶6) During the first year, organizers would select the project sites—the hospitals and health care organizations that would be the system's basic units and insurers. Organizers would gather demographic and financial data and set up administrative mechanisms. A percentage of liability premiums paid by health care providers would go to establish a fund to pay administrative costs. Additionally, there would be a study (financed by private sources) to evaluate the incidence of patient injury and provide an ongoing study of plan operation. In other words, this is a no-risk experiment for the taxpayers of the state. No state funds would be needed to initiate the study or operate the project over its five-year course.

¶7) The importance of this study cannot be overstated. Utah will become the focus of national attention as the test site for the first real alternative to the tort system for cases of medical malpractice. If, as expected, the study shows that patients are being compensated fairly and speedily for iatrogenic injuries, that the number of injuries is being reduced, and/or that more of the money paid to cover malpractice claims is actually going to the injured patients, this project could become a model for reform across the country.

¶8) Once a project site is selected, the hospital or health care organization is free to withdraw from the no-fault plan upon the vote of its corporate or medical staff. After withdraw-

al, however, the project site will remain liable for any injuries occurring during the period beginning with the establishment of the project site until the date of withdrawal governed by the statute of limitations specified in the plan.

¶9) During the next four years, the project sites will make periodic reports to the Legislature, the governor, specified executive departments, such as the Departments of Health or Commerce and other interested organizations, such as the Utah Medical Association, the Utah Hospital Association and the Utah Bar Association. To protect privacy, any portion of the reports identifying individual patients will be exempt from disclosure requirements of the Government Records Access Management Act (GRAMA).

¶10) If legislative changes are necessary, amendments could be presented and acted on during a regular session of the Legislature or at an interim session called to consider the changes. Any amendment must be approved by a two-thirds vote. Alternatively, changes could be made through administrative regulations. Such changes must be approved by all executive agencies involved.

¶11) In the fifth year, the entire plan would be evaluated under the sunset provision, and necessary changes would be recommended to the Legislature. Lawmakers would then be given the option of continuing the plan for another 10 years and expanding it throughout the state.

III. Plan Implementation

¶12) The plan will be implemented voluntarily by each project site after approval by corporate officials, medical staff and other health care professionals. The designated lead state agency will develop the commitment forms. Once the officials and staff at the project site have signed on, they will be expected to develop a loss-injury prevention program geared to meet their particular needs. Patient participation at each project sites will be regulated by administrative process.

IV. Plan Administration

¶13) The Utah Department of Commerce will be the chief state agency in charge of administering the No-Fault Plan. The department will oversee the project sites to ensure project requirements are met. The department will also develop an administrative compensation scheme based on a waiver of tradi-

tional tort/fault liability for the project sites and their affiliated providers. The claims administration must be accessible, neutral and meet due process requirements.

¶14) The director of the Commerce Department will be the plan's head administrator and will coordinate other state agencies that are involved, such as the Departments of Health and Insurance. The Commerce Department will also create programs involving patient advocates and administrative law judges. It will also employ an ombudsman, who will be responsible for overseeing the program.

¶15) The Commerce Department will also oversee the medical panel that will be responsible for developing the list of Designated Compensable Events, or DCEs, which are the unexpected or avoidable injury/outcomes covered under the no-fault plan. These outcomes would be automatically compensated to the extent that they produce a disabling loss covered under the plan. The DCE list will be constantly modified in light of medical research and claim experience.

¶16) Further, each project site will have its own medical panel composed of representatives of medical services available at that site. The panel will develop DCEs specific to its area of medical practice. Those DCEs must be reported to the Commerce Department. The individual medical panels at each project site will assess each DCE, and each project site may settle any iatrogenic injury claim without administrative approval, provided the claim and settlement are reported to the Commerce Department.

¶17) The plan would cover all iatrogenic injuries of two months or longer duration suffered by patients at the project site, even those injuries resulting from treatment by non-employee doctors with admitting privileges. The plan would also cover injuries resulting from the diagnosis or treatment at the non-employee doctor's office.

¶18) The plan would compensate patients for out-of-pocket medical expenses not covered by medical insurance. The plan would cover 80 percent of net lost earnings, although there would be a ceiling of 200 percent of the state's average wage. Additionally, there will be a $250,000 cap on claims for pain, suffering and loss of enjoyment of life.

¶19) The project site will be required to operate quality assurance programs, including institutional measures that would hold providers accountable for an undue number of iatrogenic injuries arising in their areas of practice or responsibility.

The project site may establish a program of self-insurance, if it includes coverage for anyone with staff privileges. Otherwise, the site must have an experience-rated liability insurance. The Utah Insurance Department will oversee the financial viability of any insurance coverage obtained by the project site.

¶20) The project site will work with its medical staff and other health care professionals to develop an equitable distribution of the savings on insurance premiums. No collateral medical insurance provider will be entitled to recover the amounts of such benefits from any patients, health care provider or the project site participating in the no-fault plan.

V. PATIENT PARTICIPATION

¶21) Throughout the course of this project, patients will be free to participate or to refuse participation, based on their choice of hospital/health care facility. If they choose to go to a project site for their care, they also choose to participate in the no-fault plan. If they choose a non-project site, they cannot participate in the no-fault plan.

¶22) A patient admitted to a project site must consent to participate in the no-fault plan in one of three ways: (1) by signing a consent form prior to any medical procedure at the project site; (2) as a contractual obligation of the patient's medical insurance coverage; or (3) as a term of the patient's employment, if employment includes health insurance.

¶23) Consent could be obtained either by the patient's physician before treatment or by the project site before the patient is admitted. The consent forms will contain an explicit abrogation of all subrogation rights.

¶24) In an emergency situation where the patient cannot consent, consent will be implied for the treatment of the emergency condition. Parents, guardians, siblings or other authorized adults who are present at the time of admission may also provide written consent for the incapacitated patient.

¶25) A patient may transfer out of the project site for any of four reasons. First, the patient may transfer if complications from the iatrogenic injury require treatment beyond the capacity of resources of the project site. Second, the patient may transfer if he or she has other medical requirements as the result of disease of [sic] preexisting conditions that cannot be met by the project site. Third, a patient may transfer out upon his or her demand or that of a family member. Finally, a patient may transfer out when admission was based on an emer-

gency and that patient subsequently refuses to consent to participate in the no-fault plan.

VI. THE CLAIMS PROCESS

¶26) A patient claiming an iatrogenic injury must file the claim with the project site medical panel, which will evaluate the claim within a reasonable time, not to exceed 60 days. All claims must be made within one year after the patient or the patient's guardian discovers or, through the use or reasonable diligence, should have discovered, the injury.

¶27) Once a claim is made, the reviewing medical panel has essentially two options. First, it can reject the claim, which would entitle the patient to the assistance of a patient advocate for any additional proceedings. Second, it can propose an award to the claimant. Finally, the panel could certify the iatrogenic injury as being caused by wilful and wanton conduct, in which case the panel would report the health care professional who treated the patient to the Division of Occupational and Professional Licensing.

¶28) If the claim is granted, benefits would be available immediately. An administrative law judge from the state administrative agency will determine whether the disability is permanent. If the judge finds the injury is not permanent, or that it may fluctuate over time, the judge may grant a temporary award that may be renewed upon reevaluation of the patient's disability. Future losses exceeding $100,000 will be paid in installments.

¶29) If the claim is rejected or if the patient does not accept the award, the patient may appeal to an administrative law judge, who will hold an informal hearing with the patient, his/her advocate, and representatives of the project site where the alleged iatrogenic injury occurred. The judge will then make a preliminary decision, after which either party is entitled to request a formal hearing with a reviewable record. The judge may also certify the injury as resulting from wilful conduct and report it to the Licensing Division.

¶30) After the administrative law judge rules, either party may appeal to the Utah Court of Appeals. However, the appeals court is limited to a determination of whether the administrative law judge followed the rules of the state administrative agency and whether the decision was arbitrary or capricious.

VII. CONCLUSION

¶31) The plan is designed to increase the number of patients compensated for iatrogenic injuries, reduce undeserved windfall damage awards, reduce the total number of medically injured patients, and reduce the amount of defensive medicine without disturbing the incentives to provide high quality health care.

¶32) Although some members of the legal profession are likely to cry foul, this proposal is a pro-consumer approach to dealing with the problem of malpractice. It removes the barriers to appropriate compensation for medical injuries, while bolstering the doctor-patient relationship. The five-year study of the plan should be initiated as soon as possible.