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Elliott M. Abramson
DePaul University

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The Medical Malpractice Imbroglia: A Non-Adversarial Suggestion

BY ELLIOTT M. ABRAMSON*

I. THE CURRENT SYSTEM

The current tort system, as applied to medical malpractice, has two goals: a) to guarantee fair compensation to persons injured through the negligence of medical care providers; and b) to deter poor practice by imposing liability on parties who engage in negligent medical care.¹ The fair compensation goal focuses on compensating victims for the losses they suffer as a result of the negligent party's conduct.² This reflects the so-called "positive side" of tort law.³ On the other hand, the deterrence goal focuses on discouraging and stigmatizing the provider's substandard medical care.⁴ This embodies the so-called "negative side" of tort law.⁵ In fact, the current system has failed to achieve either of these goals due to the complexity and nature of medical malpractice litigation.⁶ This failure is evidenced by inconsistent awards⁷ resulting in undercompensation of victims in some cases⁸ and overcompensation in others,⁹ higher medical costs due to defensive medicine¹⁰

* Professor of Law, DePaul University. B.A., Columbia University, 1960; J.D., Harvard Law School, 1963.

¹ Tancredi, *Designing a No-Fault Alternative*, 49 LAW & CONTEMP. PROBS. 277, 277-78 (1976).

² Owen, *Deterrence and Desert in Tort: A Comment*, 73 CALIF. L. REV. 665, 666 (1985).

³ *Id.* at 667.

⁴ *Id.* at 669. The deterrence goal may be accomplished through direct deterrence, which forces the provider to pay damages, or indirect deterrence, which focuses on loss of market share. Indirect deterrence results in loss of market share by requiring the provider to pay damages, causing higher prices and, thus, loss of market share.

⁵ *Id.* at 667.

⁶ See *infra* notes 22-25 and accompanying text.

⁷ See *infra* notes 13-21 and accompanying text.

⁸ See *infra* notes 22-29 and accompanying text.

⁹ See *infra* notes 30-40 and accompanying text.

¹⁰ See *infra* notes 41-47 and accompanying text.

and medical malpractice insurance,¹¹ and higher administrative costs.¹²

One of the most vexing problems of the current system is the inconsistent, arbitrary awards that juries accord injured patients. Jury awards are affected by the ability of the opposing lawyers, the nature of the injury, and the whim of the particular jury.¹³ Because juries often base their verdicts on emotion or sympathy for the victim,¹⁴ they seem to award more for injuries that they can actually see.¹⁵ Thus, similarly situated victims receive widely disparate awards.¹⁶ For example, a federal judge in Texas simultaneously tried several asbestos cases before separate juries.¹⁷ Although the juries heard the same evidence, they granted widely varying awards.¹⁸

In addition to the jury process, geographical bias also causes inconsistent awards. A study by Professor Danzon found that "[u]rbanization is the single most powerful predictor of both frequency and severity" of claims.¹⁹ The result is that courts located in urban areas grant higher awards than those located in rural areas. Furthermore, these geographical differences are manifested in awards that vary among the states.²⁰ Thus, the amount of compensation that victims receive could depend on where they live.

Due to the inconsistencies in the current system, doctors are sometimes held liable where a patient's injuries are attributable to preexisting conditions rather than to negligence, while in some cases of actual negligence, no liability arises. In short, tort liability for medical malpractice resembles a lottery²¹ rather than a reliable remedy and a deterrent to negligent medical practice.

¹¹ See *infra* notes 48-53 and accompanying text.

¹² See *infra* notes 54-68 and accompanying text.

¹³ Sugarman, *Doing Away with Tort Law*, 73 CALIF. L. REV. 555, 594 (1985). See also R. KEETON & J. O'CONNELL, BASIC PROTECTION FOR THE TRAFFIC VICTIM 22-24, 29-30, 225 (1965).

¹⁴ O'Connell, *A "Neo No-Fault" Contract In Lieu of Tort: Preaccident Guarantees of Postaccident Settlement Offers*, 73 CALIF. L. REV. 898 (1985) "Jurors will award substantially less for a seriously injured back or other injury they cannot see, than for a more visually striking injury such as extensive scarring." *Id.* at 900.

¹⁵ *Id.*

¹⁶ Sugarman, *supra* note 13, at 594.

¹⁷ Sugarman, *Taking Advantage of the Tort Crisis*, 48 OHIO ST. L.J. 329, 336 n.40 (1987).

¹⁸ *Id.*

¹⁹ Sugarman, *supra* note 13, at 594 (quoting Danzon, *The Frequency and Severity of Medical Malpractice Claims*, 27 J.L. ECON. 115, 143 (1984)).

²⁰ *Id.*

²¹ O'Connell, *Neo No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS. 125, 127 (Spring 1986).

As a result of the current system, many injured patients are undercompensated or go entirely without compensation for their injuries, while others win awards far in excess of the damage caused by their actual injuries. Some victims are undercompensated for their injuries due to the complexity of medical malpractice litigation. Personal injury cases arising from medical malpractice are among the most difficult to litigate because both medicine and the human body are extremely complex.²² Juries frequently cannot understand the technical, confusing, and often conflicting testimony of medical experts,²³ or the distinctions between injuries attributable to a physician's negligence and injuries that fall within normal statistical probabilities of occurrence.²⁴ In addition, it may be difficult to find another doctor to testify against the defendant because of the so-called "conspiracy of silence".²⁵

Victims are also undercompensated because of the high transaction costs involved in complex litigation. Indeed, after accounting for the time, effort, and cost of litigation, the victim usually receives less than fifty percent of the verdict award.²⁶ This hardly makes victims "whole" again; in fact it doesn't even make them "half".

Even more devastating than cases of undercompensation, perhaps, are cases that are not even litigated. Here, injured victims get *no* compensation. Because many lawyers accept only large claims (in hopes of "hitting it big"),²⁷ injured patients with relatively small claims are entirely uncompensated for their injuries.²⁸ Additionally, many victims never file an initial claim because of loyalty to their physician or ignorance of the tort litigation system.²⁹

²² J. O'CONNELL, ENDING INSULT TO INJURY: NO-FAULT INSURANCE FOR PRODUCTS AND SERVICES 29 (1975).

²³ O'Connell, *supra* note 21, at 125.

²⁴ B. KEENE, A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE, CALIFORNIA'S MEDICAL MALPRACTICE CRISIS 29 (1976).

²⁵ The medical profession resents malpractice lawsuits and, as a result, it is extremely difficult to find physicians to serve as expert witnesses on behalf of plaintiffs. See O'Connell, *Expanding No-Fault Beyond Auto Insurance: Some Proposals*, 59 VA. L. REV. 749 (1973) "In one particularly grim example, research conducted by the Boston University Law Medicine Institute indicated that 70 percent of doctors polled would refuse to testify on behalf of a patient in a suit against a surgeon who had mistakenly removed the wrong kidney, despite the clear merit of the claim." *Id.* at 756. See also J. O'CONNELL, *supra* note 22, at 30.

²⁶ M. SCHWARZ, MEDICAL MALPRACTICE—TORT REFORM, LIABILITY CRISIS: THE PHYSICIANS' VIEWPOINT 18 (1987).

²⁷ O'Connell, *supra* note 25, at 756.

²⁸ *Id.*

²⁹ Comment, *The Medical Malpractice Crisis: Will No-Fault Cure The Disease?*, 9 U. HAW. L. REV. 241, 243 (1987).

Paradoxically, many victims are overcompensated for their injuries. First, many injured patients receive extravagant pain and suffering awards. Because of the difficulties in placing a monetary amount on noneconomic injuries and the complexity of modern medical practice, juries often grant enormous verdicts to injured patients based on sympathy toward the victims.³⁰ Lawyers in subsequent cases base their claim for damages on the latest "benchmark" award, thus spiraling the size of claims upward.³¹

These extravagant pain and suffering awards have resulted in a dramatic increase in the size of recoveries. The average size of a medical malpractice verdict increased 363% from 1975 to 1985.³² Specifically, the average verdict rose from \$220,018 in 1975 to \$1,017,716 in 1985.³³ Do injured patients today incur more "pain and suffering" than injured patients in 1975?

A recent Rand study of jury cases in Cook County, Illinois concluded that jury awards vary widely among victims with the same injury.³⁴ In fact, the average victim of medical malpractice received five times the amount of an injury-on-property plaintiff and almost two times the amount of a victim injured at work or by a defective product.³⁵ The victims of medical malpractice, however, are presumably no more deserving than the victims of automobile accidents, defective products, or work-related injuries.³⁶ Moreover, other disabled people (including individuals who are genetically disabled, sick, elderly, veterans, or unemployed) have the same "need" for compensation as victims of medical malpractice, yet the programs that pay for their disabilities do not compensate for pain and suffering.³⁷ Thus, the large awards granted to medical malpractice victims seem disjunctive with the amounts given to other victims of injuries and disabilities.

Second, some medical malpractice plaintiffs are overcompensated because the high cost of litigation often induces providers to settle even unmeritorious claims. Because they find it cheaper to pay the claim than to litigate it, health care providers often don't

³⁰ O'Connell, *supra* note 21, at 125.

³¹ Winter, *Medical Malpractice: Will Jumbo Awards Spark Another Insurance Crisis?*, 68 A.B.A. J. 1545, 1547 (1982).

³² M. SCHWARZ, *supra* note 26, at 18.

³³ *Id.*

³⁴ *Id.* (citing Chin & Peterson, *Deep Pockets, Empty Pockets*, RAND CORP. INST. CIV. JUST. 54 (1985)).

³⁵ *Id.*

³⁶ Sugarman, *supra* note 13, at 595.

³⁷ *Id.*

resist small, nuisance-type claims.³⁸ Thus, some plaintiffs with unmerited or frivolous claims receive a higher award than they deserve.

Finally, some injured patients are compensated twice: in tort *and* by their health insurance.³⁹ Eighty-five percent of Americans have some type of insurance from a collateral source (i.e., group or individual health insurance, Medicare, Medicaid).⁴⁰ Those who do not are usually quite poor. Under the current tort system, allowing those covered by insurance to also sue in tort results in a double recovery.

In 1986, an American Medical Association ("AMA") survey found that seventy-eight percent of physicians thought they practiced "defensive medicine".⁴¹ Thus, they not only diagnose and treat patients on the basis of medical necessity,⁴² but also with an eye toward avoiding legal liability. For example, assume a patient complains of a headache.⁴³ This is an illness, like most others, that requires the physician to exercise medical judgment in prescribing a treatment. The patient is most likely (ninety-eight percent probability) suffering from a migraine or tension headache; however, the patient has a two percent chance of having a brain tumor.⁴⁴ The physician should use his or her judgment to determine if a CAT scan⁴⁵ should be performed. The CAT scan can detect the brain tumor, but it is costly and has a five percent chance of causing an adverse reaction. The threat of a malpractice suit may nudge the physician toward performing the test on *everyone* with a headache. Given the great number of patients with headaches, such a practice would be very costly.⁴⁶ In fact, the cost of defensive medicine has been estimated at \$15.1 billion, or four percent of health expenditures.⁴⁷

³⁸ WILLARD, MEDICAL MALPRACTICE—TORT REFORM, THE MEDICAL MALPRACTICE CRISIS AND THE NEED FOR TORT REFORM 6 (1987).

³⁹ O'Connell, *supra* note 21, at 125-26.

⁴⁰ Sugarman, *supra* note 13, at 647.

⁴¹ M. SCHWARZ, *supra* note 26, at 20 (citing L. HARVEY & S. SHUBAT, A.M.A. SURVEYS OF PHYSICIAN AND PUBLIC OPINION (1986)).

⁴² *Id.*

⁴³ This example was developed in Comment, *supra* note 29, at 246.

⁴⁴ *Id.* (citing R. RAKEL, CONN'S CURRENT THERAPY 732 (1985)).

⁴⁵ "CAT stands for computerized axial tomography, an advanced technique which reconstructs a three-dimensional view of the body's organs." Comment, *supra* note 29, at 245 n.33.

⁴⁶ *Id.*

⁴⁷ *Id.* at 242 (citing A.M.A., REPORT NO. 1 PROFESSIONAL LIABILITY IN THE 80'S 16 (1984)).

This raises another major problem of the current system: the enormous price physicians must pay for malpractice insurance. The total premiums paid by physicians doubled in two years: from \$1.7 billion in 1983 to \$3.4 billion in 1985.⁴⁸ The average premium for all physicians in 1985 was \$10,500 per year.⁴⁹ This figure is much higher (up to \$92,000 per year) for high risk specialties such as neurosurgery and obstetrics.⁵⁰ It is, therefore, not surprising that many physicians have abandoned these expensive specialties⁵¹ and some insurance companies have stopped providing coverage to such specialists.⁵² Physicians who continue to practice must pass these higher costs on to their patients. The result is that society bears the burden of the current medical malpractice system through higher medical costs and a reduced number of physicians.⁵³

The current system also carries high administrative costs. Since proving medical malpractice is very difficult, litigation requires great amounts of time and research into causal factors.⁵⁴ This results in substantial costs to the patient and the health care provider, and an increased burden on court dockets.⁵⁵ Administrative costs are also increased because the current system encourages injured patients to prolong their disabilities.⁵⁶ The collateral source rule permits a double recovery for injured patients by allowing them to recover damages for medical expenses already reimbursed through insurance.⁵⁷ Thus, injured patients can raise the amounts they can recover by simply incurring more medical expenses.⁵⁸ Furthermore, injured patients are also encouraged to run up their

⁴⁸ WILLARD, *supra* note 38, at 4.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ Comment, *supra* note 29, at 242.

⁵² *Id.*

⁵³ *Id.* at 243.

⁵⁴ B. KEENE, *supra* note 24, at 29.

⁵⁵ Medical malpractice cases are among the most difficult to litigate. They usually take two or three times longer than other personal injury cases because of the complexity of the requisite expert medical testimony. Thus, although few in total number, they contribute significantly to the congestion and overload of the court system. U.S. Department of Health, Education, and Welfare, Report of the Secretary's Commission on Malpractice 18 (1973). See also J. O'CONNELL, *supra* note 22, at 30.

⁵⁶ O'Connell, *supra* note 14, at 900.

⁵⁷ *Id.*; see, e.g., *Nation v. Bank of California*, 649 F.2d 691 (9th Cir. 1981) "Under the collateral source rule, benefits received by an injured party from a source wholly independent of the wrongdoer should not be deducted from the damages that the wrongdoer otherwise is compelled to pay the injured party." *Id.* at 699.

⁵⁸ O'Connell, *supra* note 14, at 900.

medical expenses because juries generally grant higher pain and suffering amounts to victims with higher economic losses.⁵⁹

The disincentive for insurance companies, plaintiffs' attorneys, and patients to settle out of court further burdens the court system and increases administrative costs. An insurance company is diversified and, therefore, can bear the risk of losing the case better than the individual victim.⁶⁰ Because an insurance company earns interest by holding on to its money while the victim might become desperate enough to settle for a modest amount, the company benefits from the delays of litigation.⁶¹ Plaintiffs' lawyers are also diversified, as they have many cases among which to spread their risk of loss.⁶² Rather than settle out of court for the patients' economic losses, the lawyer may bring all cases to trial in the hope that one case will "hit it big".⁶³ While the lawyer may indeed strike gold by winning one of those cases, he or she might forego a reasonable settlement for other clients.⁶⁴

The injured patient might also discourage early settlement. If the patient's medical expenses are already being reimbursed by insurance, the patient might be willing to take a chance at a sizable verdict. Since most offers to settle out of court will be below the actual economic loss,⁶⁵ an early offer equal to the economic loss might be seen by the plaintiff as a sign of weakness on the part of the health care provider.⁶⁶ This might encourage the plaintiff *not* to settle in hopes of receiving more through litigation.⁶⁷ Some plaintiffs, however, may be forced to accept this low settlement because of desperation, urgent financial need, or lack of proof.⁶⁸

Beyond these quantitative problems, many qualitative problems also corrode the current system. Injured patients who are entitled to a recovery might not receive their awards until many years have passed.⁶⁹ The doctor/patient relationship is contaminated⁷⁰ because

⁵⁹ *Id.*

⁶⁰ *Id.* at 901.

⁶¹ *Id.*

⁶² *Id.* at 902.

⁶³ *Id.* at 903.

⁶⁴ *Id.*

⁶⁵ *Id.* at 902.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ Sugarman, *supra* note 13, at 594.

⁶⁹ See O'Connell, *supra* note 14, at 914 (for example, a teenager in Seattle, Washington, who was paralyzed by a football injury, waited over seven years to obtain a jury verdict).

⁷⁰ M. SCHWARZ, *supra* note 26, at 21.

doctors, who feel that their role is to support and aid their patients, are uncomfortable in the paradoxical role of potential adversary. The trust and confidence between doctor and patient, which is critical to proper health care, is therefore poisoned.⁷¹ Moreover, in many cases, providers and employing institutions such as hospitals are also pitted against one another as each tries to defend against charges of malpractice by shifting responsibility to the other.⁷² Some physicians incur great emotional distress and injuries defending malpractice suits, leading to losses of time, confidence, and morale.⁷³ Physicians may also be reluctant to use new procedures and to treat high risk patients because of the fear of liability.⁷⁴

The malpractice crisis has generated a cumulative effect of jeopardizing necessary medical services, increasing costs, and creating mistrust and poor morale on the part of both doctor and patient. Yet, notwithstanding this cost, the twin goals of the tort system (compensation and deterrence) are not achieved because of the poor correlation between injury and liability. However, merely complaining about the evils of the current system serves no purpose unless an alternate system of compensation and deterrence exists. The most promising such alternative seems to lie in a more non-adversarial, no-fault approach.

II. HISTORY OF NO-FAULT REMEDIES FOR INJURY

The earliest no-fault remedy for injury was embodied in workers' compensation laws in late nineteenth century Germany.⁷⁵ Similar laws were adopted in the United States shortly after the turn of the century.⁷⁶ Prior to the enactment of these laws, workers and employers faced many problems similar to those facing patients and doctors today: high costs of pursuing claims in tort, the potential bar of contributory negligence, development of ill will between parties where cooperation is desirable, if not necessary, and many uncompensated losses.⁷⁷ After workers' compensation

⁷¹ Moore & O'Connell, *Foreclosing Medical Malpractice Claims By Prompt Tender of Economic Loss*, 44 LA. L. REV. 1267, 1269 (1984).

⁷² *Id.*

⁷³ O'Connell, *supra* note 21, at 126 n.4.

⁷⁴ M. SCHWARZ, *supra* note 26, at 21.

⁷⁵ O'Connell, *supra* note 21, at 128.

⁷⁶ *Id.*

⁷⁷ *Id.*

laws were enacted, workers were compensated more quickly, consistently, and uniformly for economic losses.⁷⁸

Recently, no-fault automobile insurance has replaced tort claims with regard to automobile accidents in the United States. Because each party's insurance company pays its client's economic loss regardless of fault, the large transaction costs associated with the adversarial system have been eliminated. Again, it has resulted in quicker, more reliable compensation to plaintiffs at a lower cost than was possible under tort litigation.⁷⁹ Moreover, there is no evidence that the absence of tort liability has increased occurrences of reckless driving.⁸⁰

A no-fault remedy was first adopted in the medical area with the advent of the National Childhood Vaccine Injury Act of 1986⁸¹ ("Vaccine Act"). An increase in tort litigation involving vaccine-related injuries was causing vaccine manufacturers to withdraw from the market⁸² and many injured children were not receiving compensation for their vaccine-related injuries.⁸³ Congress took action to avoid the possibility of a national health care problem by enacting the Vaccine Act.⁸⁴

Under this legislation, a claimant must first file a claim with the U.S. District Court.⁸⁵ A master⁸⁶ obtains evidence and conducts hearings to determine whether the child's injuries were in fact caused by the vaccine.⁸⁷ The master's findings are then forwarded to the district court for a formal ruling.⁸⁸ If an award is granted, it is generally confined to economic losses and limited pain and suffering damages.⁸⁹ The claimant then has the option of accepting the judgment or suing the manufacturer in tort.⁹⁰ Funding to pay

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ 42 U.S.C.A. § 300aa-1 (West Supp. 1989).

⁸² Schwartz & Mahshigian, *National Childhood Vaccine Injury Act of 1986: An Ad Hoc Remedy or a Window for the Future?*, 48 *OHIO ST. L.J.* 387, 388-89 (1987).

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.* at 390.

⁸⁶ The district court designates "a special master to assist in obtaining evidence, information, and testimony, and to conduct hearings and prepare proposed findings of fact and conclusions of law and submit these findings to the district court." Schwartz & Mahshigian, *supra* note 82, at 390.

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.* at 390-91.

⁹⁰ *Id.* at 392-93.

damages awarded under the Vaccine Act comes from a trust fund financed by an excise tax on the sale of the vaccines covered by the Act.⁹¹

In 1987, Virginia adopted legislation under which infants who incur severe neurological injuries during the birth process may be compensated.⁹² Florida passed a similar statute, which took effect in 1988.⁹³ Both statutes provide automatic scheduled compensation for the injured infants without regard to the physician's fault.

Under the mechanics of these statutes, the claimant files a petition with a commission, which also hears workers' compensation claims.⁹⁴ A medical advisory board, comprised of physicians, then evaluates the claim's merits⁹⁵ and files a response within thirty days.⁹⁶ The commission then must hold a hearing within 120 days after the claimant files the petition.⁹⁷

The commission determines whether the injury is a birth-related neurological injury.⁹⁸ A rebuttable presumption arises that the injury is a birth-related neurological injury if the infant sustained a brain or spinal cord injury caused by oxygen deprivation or a mechanical injury, and the infant is physically or mentally impaired.⁹⁹ If the commission determines that the injury falls within the statute, it then awards compensation to the infant for his or her economic losses, less any amount received from collateral sources.¹⁰⁰ The commission's determination is conclusive and its remedies are exclusive.¹⁰¹

As a separate matter, the medical advisory board determines whether the injury resulted from, or was aggravated by, the physician or the hospital.¹⁰² The board has the authority to take appropriate disciplinary action against the physician or the hospital.¹⁰³

⁹¹ *Id.* at 389.

⁹² VA. CODE ANN. § 38.2-5000 to 5021 (1988).

⁹³ FLA. STAT. ANN. § 766.301-.316 (West 1988).

⁹⁴ *Supra* note 92, at § 38.2-5004(A)(1); *supra* note 93, at § 766.305(1).

⁹⁵ *Supra* note 92, at § 38.2-5004(B); *supra* note 93, at § 766.308(1).

⁹⁶ *Supra* note 92, at § 38.2-5004(D); *supra* note 93, at § 766.308(1).

⁹⁷ *Supra* note 92, at § 38.2-5006; *supra* note 93, at § 766.307(1).

⁹⁸ *Supra* note 92, at § 38.2-5008(A); *supra* note 93, at § 766.309(1)(a).

⁹⁹ *Supra* note 92, at § 38.2-5008(A)(1); *supra* note 93, at § 766.309(1)(a)1.

¹⁰⁰ *Supra* note 92, at § 38.2-5009; *supra* note 93, at § 766.310(1).

¹⁰¹ *Supra* note 92, at §§ 38.2-5011, 38.2-5002(B); *supra* note 93, at §§ 766.311, 766.303.

¹⁰² *Supra* note 92, at § 38.2-5004(B)-(C); *supra* note 93, at § 766.305(4)-(5).

¹⁰³ *Supra* note 92, at §§ 38.2-5004(B), 38.2-5004(C); *supra* note 93, at § 766.305(4)-(5).

The program is financed through a compensation fund.¹⁰⁴ Participating physicians and hospitals contribute an initial assessment fee to join the program.¹⁰⁵ Insurance carriers contribute an annual assessment in proportion to the premiums they write for all medical activity.¹⁰⁶ Early indications are that the statute has been successful in terms of increased access and reduced rates of insurance.¹⁰⁷

Traditionally, no-fault mechanisms have developed in areas where tort systems have failed to adequately compensate injured plaintiffs, and where the costs of the system became so burdensome as to outweigh its benefits. In areas where no-fault approaches have been applied, such as workers' compensation, automobile insurance, and the Vaccine Act, costs have been reduced while the speed and reliability of compensation has improved. Because the problems facing the medical profession are substantially similar, a no-fault methodology that is properly tailored to medical malpractice should vastly improve compensation and deterrence while reducing costs.

III. PROPOSAL FOR A MALPRACTICE TRIBUNAL

In the long-term, a non-adversarial system, similar to a no-fault approach, is the best alternative available to the existing tort system for compensating victims of medical malpractice. Because most cases of injury are truly accidental, involving neither malice nor gross negligence on the part of a physician, the most just, non-adversarial system would function most efficiently by using a malpractice tribunal. The tribunal, which would include at least one medical representative, one attorney, and one lay person, would investigate complaints of medical malpractice. The tribunal would then make a finding as to provider liability and determine compensation for the victim. The decisions of such a tribunal would be final. The tribunal would also have the power to recommend sanctions against a health care provider to appropriate licensing and disciplinary agencies. The system would increase the fairness and speed with which injuries are redressed and allegations

¹⁰⁴ *Supra* note 92, at § 38.2-5015; *supra* note 93, at § 766.314(1).

¹⁰⁵ *Supra* note 92, at § 38.2-5019 (repealed 1989) (§ 38.2-5020 now provides for an annual assessment); *supra* note 93, at § 766.314(4)(b)1.

¹⁰⁶ *Supra* note 92, at § 38.2-5020; *supra* note 93, at § 766.314(5)(c)1.

¹⁰⁷ Note, *Innovative No-Fault Tort Reform for an Endangered Specialty*, 74 VA. L. REV. 1487, 1499-1500 (1988).

of malpractice are investigated, while minimizing transaction and emotional costs.

This malpractice tribunal would be empowered to investigate claims of medical malpractice by gathering evidence and by obtaining testimony from the parties, third persons, and experts. In this respect, the role of the tribunal would be substantially similar to that of the master under the Vaccine Act.¹⁰⁸ This type of approach should substantially reduce the costs associated with the current system, where costly legal and other professional talent is directed toward persuading a jury as to whether someone's "fault" "caused" a patient's injury.

This scheme, however, must limit the spectrum of events under which a victim could be compensated in medical malpractice cases. In its broadest application, a no-fault compensation system would encompass all deteriorations in health that medical treatment fails to cure or inhibit.¹⁰⁹ Such a system would be enormously costly and for that reason infeasible.¹¹⁰ By retaining the general relationship between deterrence and compensation while not requiring costly case-by-case determinations of negligence, the tribunal offers a "middle ground" between compensating all those who are medically injured and the current tort system of determining negligence on a case-by-case basis.

Because the tribunal's objective is to replace the tort system in medical malpractice cases, its authority should be limited to compensating claimants whose injuries actually stem from substandard medical practice. For instance, persons whose injuries resulted from a preexisting condition would not be compensated because they are not compensated presently under typical tort principles.

Pursuant to the Vaccine Act, a Vaccine Injury Table¹¹¹ was compiled. When a condition listed in the table occurred, a rebuttable presumption arose that the injury was caused by the vac-

¹⁰⁸ Under the Vaccine Act, a master obtains evidence and conducts hearings in an inquisitorial, non-adversary fashion. The sole issue that the master determines is whether or not the injury was vaccine-related. If the claimant's injury is one of those listed and it occurred within the applicable time frame, there is a rebuttable presumption that the injury was caused by the vaccine. No showing of fault is necessary for compensation to be awarded. See Schwartz & Mahshigian, *supra* note 82, at 390.

¹⁰⁹ Moore & O'Connell, *supra* note 71, at 1269.

¹¹⁰ See Tancredi, *supra* note 1, at 280; see also, O'Connell, *supra* note 21.

¹¹¹ 42 U.S.C.A. § 300aa-14 (West Supp. 1989). The Vaccine Injury Table lists the various injuries, disabilities, illnesses, conditions, and death that can arise from the various vaccines. It also lists the time period in which the first symptom or manifestation of injury must occur in order for the injured party to be entitled to compensation under the program.

cine.¹¹² Because there are myriad forms of medical malpractice and because a finding of negligence is necessary, a much more general table of injuries would have to be developed for medical malpractice cases. Such a table would define the scope of the tribunal's jurisdiction and would yield useful statistical information that would likely encourage avoidance of those outcomes. Deterrence against future malpractice would, thereby, be engendered without the blunt threat of expensive lawsuits that currently exists.¹¹³

In 1980, the American Bar Association conducted a study of such a scheme and outlined the Designated Compensable Event System ("DCE").¹¹⁴ Lists of treatment-related injuries, which have a strong presumption of occurring due to malpractice, would be developed. The tribunal would refer to such lists in deciding whether or not to compensate the victim. Such lists would improve the predictability of outcomes by setting forth detailed outcomes that would give rise to compensation. This predictability should also reduce transaction costs because claims would be processed more quickly than under the present tort system.

A DCE system is attractive because of its flexibility. Since it is sometimes difficult to determine whether an outcome was triggered by malpractice or was a natural result of injury, the tribunal can go beyond the list, using it as a guideline to determine the amount of the award. Additionally, if there is no listing of adverse outcomes for a particular event, for example, when a patient complains of various vague symptoms that a doctor misdiagnoses due to the rarity of the patient's illness, the tribunal would have the power to base the award on its collective experience. In cases involving an event that is not listed as compensable, the victim may be eligible for compensation if he or she proves fault to the satisfaction of the tribunal.

¹¹² Schwartz & Mahshigian, *supra* note 82, at 390.

¹¹³ If a higher percentage of malpractice victims come forward and receive appropriate remedies under a no-fault plan than they do today, the information available to providers of health care would likewise become more complete and accurate than it is currently. See Tancredi, *supra* note 1, at 280-82.

¹¹⁴ The Commission on Medical Professional Liability explored a number of innovative alternatives, including a plan to compensate patients for all medically-caused injuries that occur in a hospital, a workers' compensation type of mechanism providing scheduled benefits to patients injured as the result of negligence, and two proposals that would define specifically the circumstances under which compensation would be paid. The Commission concluded that the most promising alternative was the DCE system, which would pre-define compensable outcomes according to established criteria. AMERICAN BAR ASSOCIATION DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY (1979).

Furthermore, such a DCE system would likely increase malpractice prevention while decreasing costs associated with defensive medicine. The lists created under DCE would identify those outcomes that the medical community believes are preventable through standard medical care. Doctors would then be able to concentrate their efforts on eschewing those outcomes, instead of taking costly precautions against all theoretically possible malpractice claims.

Once the tribunal investigates and determines whether there has been an injury caused by substandard care, it has the power to compensate victims for their losses. The funds for compensation could come from a trust fund, much as it does under the Vaccine Act. Financing could come from general tax revenues, an excise tax on medical goods and services, an "insurance tax" on physicians, or some combination of the above.¹¹⁵ Statistical information arising from the tribunal's cases may be used to formulate a tax rating system. For example, if the tribunal finds that a physician has committed malpractice, the physician would be required to contribute subsidies to the fund. Additionally, physicians who offer treatment to high-risk patients might be required to make additional contributions.

Since the purpose of the tribunal system is to compensate victims without having to expose them to a lottery system of either a massive recovery or nothing at all, the tribunal might limit compensation to actual economic losses. Such a limit would decrease the overall size of awards, but would increase the consistency of awards for similar injuries. However, exceptions could be made if associated pain and suffering were egregious, e.g., when non-wage earners are permanently injured due to malpractice and are unable to perform many functions that they were able to do previously. Because restitution of pure economic loss might not adequately compensate victims in these exceptional cases, the tribunal could take pain and suffering into account in awarding compensation.¹¹⁶ In most cases, however, compensation would be limited to actual costs such as medical expenses, rehabilitation, funeral expenses, lost earnings, and diminished capacity.

Under the tribunal system, intangible mental and emotional items, including pain and suffering, would not be compensated.

¹¹⁵ See Schwartz & Mahshigian, *supra* note 82.

¹¹⁶ A non-wage earner would receive an extremely small award for serious injury when compensation is based exclusively on economic loss. Hence, courts may be permitted, in such situations, to allow recovery for pain and suffering. See Moore & O'Connell, *supra* note 71, at 1282.

Although, initially, such a limitation may sound unduly restrictive, this method might result in appropriate compensation to a greater number of deserving victims without a substantial increase in the overall cost to society. Finally, punitive damages, meant to punish the physician and to deter future wrongdoers, would be eliminated. Such considerations would be left to the conscientious exercise of sanctions that licensing boards can impose.

Due to the reduced expense and the higher probability of compensation under the proposed system, more victims should be willing to file claims. The proposed system could limit the number of frivolous claims by excluding "small" claims that fall below a specified amount (e.g., \$5,000). In such cases, the loss might be left where it fell since it is relatively inconsequential.

However, the inconsequentiality of the loss varies with the assets and resources of the injured. Therefore, a preferred approach might be to cast the threshold for bringing a claim in terms of a percentage of the patient's total assets or resources. For example, when a claim is asserted that would amount to less than a certain percentage of total net worth or annual income, as verified by documents such as federal tax returns, no payment would be forthcoming. However, even in cases where a claim would be disqualified on these quantitative grounds, the tribunal could refer the incident to the licensing authority for discipline, if appropriate. Thus, an injured patient with a claim too small to merit compensation still might have an incentive, of a psychological nature, to report such an incident so that the offending physician might be subjected to discipline.

The decisions of the tribunal should be final. Conversely, some proponents of no-fault approaches have suggested a system where a patient could bring a traditional tort suit if the victim disagreed with the finding of the tribunal. However, such a system would not rectify the deficiencies of the current system and would add to overall costs because doctors would still perform excessive testing on patients in fear of possible lawsuits and, also, would need some type of insurance to cover these contingencies.

A compulsory tribunal system would alter the substantive rights and duties among health care providers and patients and, therefore, might be challenged as unconstitutional. A review of the relevant issues, however, indicates that such concerns should not be material. For example, because the non-adversarial tribunal system will only apply to adverse medical outcomes, the system may be challenged under the equal protection clause on the ground that it

discriminates between persons injured in medical accidents and those injured in other kinds of accidents. Under the equal protection clause, the Supreme Court has held that, unless the classification affects a suspect class such as race or national origin, only a rational basis test will be used.¹¹⁷ Under the relaxed, minimum rationality standard of review, the unequal treatment of classes of injured parties is clearly justifiable, since rationality could be demonstrated empirically on the basis of the data used to compile the lists of compensable events.¹¹⁸

A stronger attack might be made under substantive due process. The fifth and fourteenth amendments to the U.S. Constitution prohibit the government from depriving any person of "life, liberty or property without due process of law."¹¹⁹ A change from the current tort system to the proposed tribunal system should survive this due process attack because only a rational basis test is used when no fundamental right is involved. Under such a test, laws such as workers' compensation statutes have previously been upheld.¹²⁰ The Supreme Court, in evaluating a New York workers' compensation statute, found no violation when the state replaced the tort system with the compulsory compensation scheme because the statute merely set aside one body of rules to establish another.¹²¹ Accordingly, the Court would likely find the tribunal system constitutional because the non-adversarial system is a reasonable substitute for the current tort system. Thus, against both equal protection and substantive due process challenges, the no-fault tribunal system should pass constitutional muster.

The tribunal might also be in a position to objectively identify those health providers who exercise substandard care. In part, this might occur due to the relative convenience and reduced expense of bringing claims. Thus, although providers of health care would not be personally liable for damages under the proposed scheme, the deterrence element could actually be greater than under the existing system. Doctors identified as habitual substandard providers would be subject to peer review and discipline by hospital

¹¹⁷ See, e.g., *Olsen v. Nebraska*, 313 U.S. 236, 245 (1941). See also AMERICAN BAR ASSOCIATION, *supra* note 114, at 88.

¹¹⁸ *Id.* at 83.

¹¹⁹ U.S. CONST. art. V; U.S. CONST. amend. XIV § 1.

¹²⁰ AMERICAN BAR ASSOCIATION, *supra* note 114, at 88.

¹²¹ *New York Cent. R.R. v. White*, 243 U.S. 188 (1917).

boards or licensing panels.¹²² In appropriate cases, the tribunal itself could recommend discipline to the relevant bodies.

The information generated by the tribunal could be used to make ratings of health care providers publicly available. This would improve the public's overall knowledge of available medical care and would allow the public to control the quality and cost of its health care. Providers would have a direct incentive to engage in skilled and careful, but not defensive, medicine.¹²³

CONCLUSION

The advantages of a malpractice tribunal over the existing tort system would be substantial. The malpractice tribunal would greatly reduce the economic costs of bringing a claim for malpractice by eliminating much of the adversarial character of the present system. The non-adversarial system would reduce the burden on patients and provide compensation more quickly.¹²⁴

By removing medical malpractice from the realm of private insurance and direct provider liability, much of the burden of determining actual liability would be reduced. Without the fear of personal financial impact, providers might be inclined to cooperate with the tribunal in many cases. Also, diluting the fear of malpractice liability should result in improved doctor-patient trust. Doctors might fully disclose medical risks without fear that such information would be used against them in court. The patient would also have more faith in the doctor's actions, knowing that tests were not being performed solely as a hedge against possible future lawsuits.¹²⁵

Provider cooperation would also reduce the overall transaction costs of claims by speeding the process of determining liability. Conversely, plaintiffs would not be encouraged to seek the "big hit" of extravagant awards, since the awards could be more closely tailored to actual injuries sustained. Thus, the difficulty of determining actual loss would be reduced.¹²⁶

The proposed non-adversarial malpractice tribunal would succeed in the two areas where tort has failed: fairly and consistently

¹²² See generally Tancredi, *supra* note 1.

¹²³ Tancredi, *supra* note 1, at 279-80.

¹²⁴ See Schwartz & Mahshigian, *supra* note 82, at 389-90; see also Tancredi, *supra* note 1, at 279.

¹²⁵ See generally J. O'CONNELL, *supra* note 22, at 30-43; see also Tancredi, *supra* note 1, at 279.

¹²⁶ O'Connell, *supra* note 21, at 125-26.

compensating persons injured through medical malpractice, and deterring substandard medical practice through positive incentive. The malpractice tribunal would cost less than medical malpractice litigation today, would assist the medical profession by improving available information and heightening awareness, and would discourage a litigation "lottery" while not inhibiting legitimate claims. Like workers' compensation, no-fault auto insurance, and the Vaccine Act of 1986, the malpractice tribunal could be a viable solution in another area where the costs of tort litigation have long outweighed the benefits.