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## ARTICLES

### LITIGATION IN MEDICAL EDUCATION: RETROSPECT AND PROSPECT

*Lelia B. Helms,\* Charles M. Helms, M.D.,\*\*  
& Selden E. Biggs\*\*\**

#### I. INTRODUCTION

The final years of the Twentieth Century promise to be uncertain ones for the American health care system in general and for academic medicine in particular. After two decades of piecemeal reforms, local initiatives, and institutional diversification, public opinion has shifted in favor of simplification, standardization, and their inevitable counterpart, centralization. Though the momentum for national solutions to health care delivery problems has ebbed as Congress has attempted to legislate public concern, the trend is toward greater federal and state supervision over the financing and organization of medical education programs, training, and research. Academic medicine must respond and adapt to this external challenge if it is to preserve its mission and maintain its resources as it enters the Twenty-first Century.

The trend toward increased regulation was manifested in President Clinton's American Health Security Act of 1993. Despite public and media preoccupation with the patient care delivery aspects of health system reform, the Clinton plan envisioned a substantial restructuring of medical education institutions. Some of the proposed reforms directed at academic medicine included:

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- Creation of a national pool of funds drawn from Medicare payments and from a surcharge on private health insurance premiums in order to reimburse academic health centers and training programs for costs related to graduate medical education;
- Reduction of Indirect Medical Education payments and phasing out of Medicaid Disproportionate Share Hospital adjustments;
- Federal determination, allocation, and funding of approved residency positions;
- Joint federal, state, and health alliance identification of diseases, procedures, and treatments for which health plans are required to establish a contractual relationship with academic health centers;
- Federal incentives for training and retraining of primary care physicians;
- Reform of the dispute resolution system for medical malpractice, including changes in tort law, development of alternative dispute resolution mechanisms, and funding of demonstration projects to establish enterprise liability; and
- Antitrust reforms and guidelines to regulate hospital mergers, physician provider networks, and state grants of immunity to hospitals and other institutional health care providers.<sup>1</sup>

Whether any or all of these proposals ever will be legislated cannot be predicted. Similarly, the potential impact of these or other related reform measures is unknown. Based upon experience, however, one thing is certain: new government standards and programs will produce a wave of litigation in both federal and state courts. If the history of Medicare, Medicaid, and the health manpower legislation of the 1960s and 1970s is any guide, the effects of federal and state reforms in the 1990s will be litigated well into the Twenty-first Century. The role of the courts in overseeing and interpreting federal and state legislation is one of the few certainties which academic medicine can rely on in the uncertain years ahead.

This study undertakes a comprehensive review of the patterns of litigation involving medical education institutions over the past four decades. This paper identifies the major areas and trends in medical education litigation based on the results of a comprehensive survey of reported litigation involving medical schools, their students, residents, and faculty from

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1. See Working Group Draft, President's Health Reform Proposal (Sept. 7, 1993).

1950 to 1992.<sup>2</sup> The purpose is to provide a baseline description of the risks of litigation in order to assist policy makers in evaluating potential exposure to liability in all sectors of academic medicine.

Over the past two decades the costs of litigation to medical education institutions have grown rapidly. Future escalation of costs, based on new federal and state legislation will further burden academic institutions forced to cope with the new standards and competitive pricing that health care reform will surely introduce. Although details of federal and state reforms remain unclear, the experience of the past can provide valuable guidance with respect to the future. Many of the issues related to reforming academic medicine have already been litigated in the courts over the past four decades and this record remains the best—if incomplete—guide to the future.

The remainder of this article is divided into five sections:

- A brief survey of the setting of academic medicine;
- An explanation of the research methodology employed;
- An overview of the survey data set and the classification of cases by litigant and issue litigated;
- A detailed review of the litigation; and
- A concluding assessment of the implications of this study for medical education policymakers.

The ultimate objective of this study is to describe historical patterns of cause and effect linking federal and state policies with subsequent litigation involving institutions of academic medicine. Since the focus of this research is on the dependent variable—that is, litigation related to academic medicine—the goal is simply to identify those previous reforms that have the greatest impact in terms of volume of litigation. Thus, this research provides both a framework and a starting point for the system-

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2. This study integrates and analyzes research previously published by the authors. See generally Lelia B. Helms & Charles M. Helms, *Forty Years of Litigation Involving Medical Students and Their Education: I. General Educational Issues*, 66 ACAD. MED. 1 (1991) [hereinafter *Medical Students: General Educational Issues*]; Lelia B. Helms & Charles M. Helms, *Forty Years of Litigation Involving Medical Students and Their Education: II. Issues of Finance*, 66 ACAD. MED. 71 (1991) [hereinafter *Medical Students: Issues of Finance*]; Lelia B. Helms & Charles M. Helms, *Forty Years of Litigation Involving Residents and Their Training: I. General Programmatic Issues*, 66 ACAD. MED. 649 (1991) [hereinafter *Residents: General Programmatic Issues*]; Lelia B. Helms & Charles M. Helms, *Forty Years of Litigation Involving Residents and Their Training: II. Malpractice Issues*, 66 ACAD. MED. 718 (1991) [hereinafter *Residents: Malpractice Issues*]; Lelia B. Helms & Charles M. Helms, *Litigation Involving Medical Faculty and Academic Medical Centers, 1950-1991*, 68 ACAD. MED. 7 (1993) [hereinafter *Litigation Involving Medical Faculty*].

atic analysis of potential legal repercussions of proposed reforms in medical education.

## II. THE SETTING OF MEDICAL EDUCATION

Academic medicine is organized around three interrelated activities—medical education, research, and patient care. Medical schools and their faculties are directly involved in clinical practice, as well as medical education and research, to an extent unparalleled in other professions. The complex interdependence of medical education, research, and patient care activities is one of the hallmarks of academic medicine and the primary source of vulnerability to federally mandated reform of health care delivery services. Academic medicine has been likened to a three-legged stool and any changes to the leg of clinical service inevitably will destabilize the other two.

Academic medicine institutions experienced substantial and sustained growth in the latter half of the Twentieth Century. This expansion can be measured in both human and financial terms, and can be examined through the traditional two-part division of academic medicine: undergraduate institutions or medical schools, and graduate programs of medical education and training.

### A. *Medical Schools*

Since 1942, the number of accredited medical schools increased from 77 to 126, while the number of medical students nearly tripled. However, the growth rate for medical students peaked around 1975, and in recent years the total number actually declined. As FIGURE 1 illustrates, increases in the number of faculty represented the principal contributor to the growth of medical schools.<sup>3</sup> From 1960 to 1990, the number of basic science medical school faculty grew four-fold while the number of full-time clinical faculty grew eight-fold. Indeed, more than three-quarters of medical school faculty have full-time clinical appointments. At current

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3. This survey compiles data on the numbers of students, residents, and faculty from yearly issues of the *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (JAMA)*. *JAMA* devotes one issue per year, in September, to presenting information about undergraduate and graduate medical education. Of particular use in compiling the figures are the issues from September 1992 and 1993. In addition, this study employs data from ROBERT F. JONES, *ASSOCIATION OF AM. MEDICAL COLL., AMERICAN MEDICAL EDUCATION: INSTITUTIONS, PROGRAMS, AND ISSUES* (1992) and DAVIS G. JOHNSON, *PHYSICIANS IN THE MAKING: PERSONAL, ACADEMIC, AND SOCIOECONOMIC CHARACTERISTICS OF MEDICAL STUDENTS FROM 1950 TO 2000* (1983), in constructing the figures for this article.

rates of growth, clinical faculty will outnumber medical students by the turn of the century. (See FIGURE 2).

The increase in financial resources sustaining this expansion in human resources is equally impressive. As shown in FIGURE 3,<sup>4</sup> since 1960, medical school revenues increased eleven-fold in constant 1990 dollars.<sup>5</sup> This reflects a real annual growth rate of more than eight percent for the entire thirty-year period. Significantly, in the 1970s, the average annual growth rate in revenues actually declined while, during the same period, the growth in human resources was at its greatest. However, during the last decade, revenues increased, while the growth in numbers of students, residents, and faculty decreased. In recent years, per capita revenues—as measured against numbers of students, residents, and faculty—increased.

This expansion in medical school revenues is accompanied by a substantial realignment in the sources of revenues.<sup>6</sup> FIGURE 4 demonstrates the changing composition of medical school revenues. Since the mid-1960s, the share of federal, state, and local government support of medical schools has decreased from more than 57% to 36%. At the same time, the share of revenues from medical services income increased eight-fold from 5.6% to 44.8%. The largest component of medical services income is derived from revenues from physician practice plans which increased at an estimated average rate of 15% annually in recent years, and which currently constitutes over 31% of all medical school revenues. Therefore, medical schools have become increasingly dependent upon revenues derived from the patient care services that clinical faculty provided through physician practice plans, service contracts, and other arrangements with health care providers. The diversity of these arrangements and their rapidly increasing contribution to medical school revenues makes medical schools particularly vulnerable to federal and state regulation of the funding and organization of health care delivery systems.

### *B. Graduate Medical Education*

Currently there are about 7,000 accredited programs of graduate medi-

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4. As with other figures in this research, this survey compiles data on revenues supporting medical education from the annual September issues of JAMA devoted to medical education.

5. Leanne D. Jolin et al., *U.S. Medical School Finances*, 268 JAMA 1149, 1152 (1992).

6. *Id.* at 1152-53.

cal education<sup>7</sup> providing patient care training for more than 80,000 medical residents. These programs are located at more than 1,300 teaching hospitals and a wide variety of nonhospital institutions. The growth of graduate medical education in the past three decades paralleled that of undergraduate education. In the period from 1950 to 1990, the number of residents increased four-fold as training programs for medical specialties lengthened. (See FIGURE 1). Despite this, the number of residency positions has grown at a relatively faster rate (21% from 1981 to 1991), and the number of residency positions available currently exceeds the number of residents on duty by a ratio of 1 to 1.2.<sup>8</sup>

Due to the number of programs and the variety of institutional arrangements and organizational settings, the financial parameters of graduate medical education are more difficult to quantify. The Association of American Medical Colleges (AAMC) estimates that 29% (or \$1.5 billion) of the total direct spending for graduate medical education comes from Medicare direct payments alone. The federal-state Medicaid program, together with private third party payers, contributes 48% of the total direct costs of graduate medical education. The remainder is funded by the Department of Veterans Affairs, which contributes 11%, the Department of Defense, state and local support, and faculty practice plans.<sup>9</sup> However, AAMC figures do not include the indirect costs of graduate medical education resulting from the presence of educational programs in a patient care environment. Medicare indirect medical education payments in fiscal year 1992 totaled \$3.9 billion.<sup>10</sup> Reliable estimates for other indirect sources of funding are not available. Health care providers traditionally incorporated the indirect costs of graduate medical education in their patient care cost structure. This is a significant disadvantage for teaching hospitals and other institutions in a competitive health care delivery market.

### C. Conclusions

Academic medicine institutions experienced four decades of rapid growth and expansion. Although the primary increase in human resources came with the expansion of medical school enrollments during

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7. Carlos J.M. Martini, *Graduate Medical Education in the Changing Environment of Medicine*, 268 JAMA 1097, 1097 (1992).

8. *Id.*

9. ASSOCIATION OF AM. MEDICAL COLL., *ACADEMIC MEDICINE HEALTH CARE REFORM: GRADUATE MEDICAL EDUCATION* 3 (1993).

10. Working Group Draft, *supra* note 1, at 136.

the 1960s and 1970s, the growth in faculty and revenues continued and even accelerated in the latter half of the 1980s and the early years of the 1990s. This extended period of expansion helped cushion the impact of the explosion of medical education related litigation that followed in the wake of the Medicare, Medicaid, and health care manpower legislation of the 1960s and 1970s. Given the economic and political environment of the 1990s, the growth in resources available to academic medicine surely will decline and even may begin to shrink. In such a resource-constrained environment, the costs of litigation will loom ever larger as medical education is forced, for the first time, to cope with the twin challenges of increased regulation and reduced resources.

Of equal significance, however, has been the rapidly increasing dependence of academic medicine on revenues from medical services and from indirect fees embedded in the price structures of teaching hospitals and other health care providers. The relationships between academic medicine and patient care delivery service are multidimensional and difficult to disentangle. The diversity and complexity of these institutional arrangements and funding mechanisms makes them particularly vulnerable to the imposition of national standards and price competition, and therefore prime candidates for future litigation.

### III. METHODOLOGY

Legal scholarship traditionally has focused on the doctrinal analysis of cases and statutes. The audience for this approach consists primarily of lawyers and others participating in and administering the legal system. More recently, a segment of legal scholarship has applied the tools of social science to the analysis of legal issues. "Contemporary legal scholarship has increasingly engaged in empirical studies of the law."<sup>11</sup> While the utility of newer approaches remains a topic for debate among legal scholars, there is recognition among interdisciplinary and policy journals of the need to apply different tools to understand the role of law.

The debate over the utility of newer approaches has evolved primarily in the field of laws affecting elementary and secondary educational institutions.<sup>12</sup> This focus is motivated in part by the long history of federal

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11. Arthur Bonfield, *Some Major Issues in Contemporary Legal Scholarship*, 31(1) IOWA ADVOCATE 23 (1992).

12. For an overview of the methodology applied to education-related litigation, see Clifford P. Hooker, *Teachers and the Courts, 1965-1986*, 48 EDUC. L. REP. 7 (1988); Michael Imber & David Gayler, *A Statistical Analysis of Trends in Educational-Related Litigation Since 1960*, 24 EDUC. ADMIN. Q. 55 (1988); DAVID TYACK ET AL., *LAW AND THE*



court reliance on empirical research related to school desegregation and state financing of primary and secondary education. Additional impetus for this research came from taxpayer awareness of litigation against public primary and secondary school teachers, administrators, and local school boards. However, the field of higher education law, in general, and medical education, in particular, reflect less integration of empirically based scholarship. In the first instance, the target population of institutions is smaller in number, as well as more geographically and politically dispersed. Moreover, the issues litigated at this level are often too complex and too technical in nature to support either quantitative assessment or court reliance on empirical legal research. The norms and practices of graduate education and professional training may be fertile ground for litigation, but the issues typically defy easy classification or generalization. Finally, the costs of litigation to both private and public academic medicine institutions are largely hidden from public view. University and hospital administrators are not held directly accountable to the taxpayers as are their primary and secondary school counterparts. Therefore, empirical research methodologies have had only limited impact upon the study of litigation in higher education in general and academic medicine in particular.<sup>13</sup>

This situation is beginning to change. Public interest in the costs of both health care and medical education has increased. Medical malpractice reform was raised as a platform issue in the 1992 election campaign. Television, through the popular series, "Northern Exposure," introduced millions of viewers to the legal, ethical, and financial issues involved in state funding of medical education. At the same time, empirical research on the quality of health care delivery services, medical malpractice, and defaults on student loans has grown apace.<sup>14</sup> Although recent studies of

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SHAPING OF PUBLIC EDUCATION 1785-1954 (1987); Perry A. Zirkel, *Research in Education Law*, 29 EDUC. L. REP. 475 (1986); and Perry A. Zirkel & Sharon N. Richardson, *The "Explosion" in Education Litigation*, 53 EDUC. L. REP. 767 (1989).

13. The limited research in higher education includes: Lelia B. Helms, *Patterns of Litigation in Postsecondary Education: A Case Law Study*, 14 J.C. & U.L. 99 (1987); Lelia B. Helms, *Litigation Patterns: Higher Education and the Courts in 1988*, 57 EDUC. L. REP. 1 (1990); and MARGARET LAM, INSTITUTE FOR HIGHER EDUCATION LAW AND GOVERNANCE, PATTERNS OF LITIGATION AT INSTITUTIONS OF HIGHER EDUCATION IN TEXAS, 1978 TO 1988. (Monograph 88-9, 1989).

14. Research on a broad range of issues in health services may be found in multiple journals including, but not limited to, HEALTH SERVICES RESEARCH, HOSPITAL AND HEALTH ADMINISTRATION, QUALITY ASSURANCE AND UTILIZATION REVIEW, JOURNAL OF HEALTH SERVICES, QUALITY REVIEW BULLETIN. There is extensive literature on medical malpractice litigation. This research relies primarily on the recent empirical work of

litigation related to medical malpractice and medical education partially confirm the popular wisdom about increases in rates of litigation, there has been no published effort to characterize either the frequency or range of litigation related to academic medicine on a national scale. This paper seeks to fill that void and provide a frame of reference for future empirical research on the scope and costs of litigation in medical education.

Previous attempts to characterize the frequency and range of issues in litigation on a national scale generally relied upon the Westlaw data base and used roughly similar methods.<sup>15</sup> The on-line Westlaw data base reports information on federal court decisions at the Supreme Court, appellate, and selected district court levels in the federal system, as well as selected cases from all fifty state appellate court systems. By counting the number of reported cases included in a legal data base for a particular topic during a selected time period, rough estimates about rates of litigation may be drawn. When Imber and Gayler examined the statistical assumptions underlying this inference, they found that trends of growth or decline in litigation rates could be reliably inferred from rate changes in Westlaw reported opinions.<sup>16</sup> However, no study has argued that reported opinions reliably reflect the magnitude of litigation in a particular category.

This study utilized the Westlaw computerized legal research service to access decisions recorded in the state and federal reporting systems through a keyword identification system.<sup>17</sup> The study period included all cases reported from 1950 through 1992 which identified medical students, residents, or faculty, as a party to litigation. The limitations of this legal reporting system have previously been commented upon, and include a bias toward federal cases, failure to report outcomes or to follow-up when cases are remanded, and multiple reporting for cases reported at several levels.<sup>18</sup> In contrast to reported decisions, the actual number of suits related to students, residents, and faculty cannot be determined. No reliable methodology exists to identify or characterize the number of cases filed, dismissed, settled out of court, or decided but not yet re-

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PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993). Evidence on medical student defaults and related problems is found in *Medical Students: Issues of Finance*, *supra* note 2, at 71.

15. See generally *supra* note 12.

16. Michael Imber & David Gayler, *A Statistical Analysis of Trends in Education Related Litigation Since 1960*, 24 EDUC. ADMIN. Q. 75 (1988).

17. For further explanation of the survey method, see generally *supra* note 2.

18. *Id.*

ported, because judicial information systems do not yet collect such information either comprehensively or systematically by party or by issue.<sup>19</sup>

This study reviews cases for selected categories of information and eliminates cases reported multiple times so that only the latest data recorded are included. Pertinent data include the parties to the suit, date of decision, court system, factual problem giving rise to litigation, primary and legal issues, and outcomes, if known. Such data permit characterization as to general patterns of volume, court system, parties, issues litigated, and outcomes.

Finally, the format of judicial decisions further limits the number of cases actually included in the data set. This study retains only those decisions where the analysis of the facts or legal reasoning contained in the published opinion provided clear evidence that a faculty member, resident, or student was involved. Reported decisions generally focus on the few legal or factual questions being challenged and may or may not review the general context of the dispute. As a result, this study identifies but excludes cases that focused solely on narrow legal questions where a description of the factual setting was limited or nonexistent, and therefore a party's status as a student, resident, or faculty member could not be clearly established. Claims involving medical malpractice were the most problematic. Malpractice decisions often addressed narrow legal or procedural issues and did not provide sufficient contextual descriptions to ensure that the cases met established study criteria. Because this paper focuses on the potential impact of litigation—including malpractice claims—on medical education and not on medical malpractice *per se*, this study excludes cases from the data set where this relationship could not be established.

#### IV. LITIGATION DATA SET

Between 1950 and 1992, Westlaw reported 604 judicial decisions involving medical students, residents, or faculty. Viewing this data set as a whole, three overall trends in the litigation stand out. First, during the more than forty years this study covers, the volume of reported litigation increased dramatically. (See FIGURE 5). From an average of two to three cases a year in the decades of the 1950s and 1960s, the number of reported cases abruptly quadrupled in the mid-1970s and increased to an average of more than forty-three per year by the late 1980s. Although

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19. Imber & Gayler, *supra* note 16 (discussing efforts to address this methodological problem).

the decade of the 1990s so far has seen a slight decrease in reported cases, the numbers remain consistently high. Clearly, this increase in litigation reflects the expansion in the size of undergraduate and graduate medical institutions detailed in Section II above.

Second, the overall pattern of growth in litigation shown in FIGURE 5 reflects another trend not easily explained by the steady increase in numbers of medical students, residents, and faculty. The growth in litigation is neither gradual nor linear. The data set clearly divides two discrete periods: the first period, from 1950 through 1975 averaged slightly more than three reported cases per year; the second period, from 1976 to the present, averaged more than thirty cases annually. This sudden, ten-fold increase in the number of reported cases cannot be explained solely by incremental increases in the population of students, residents, and faculty. This explosion in litigation points to the impact of external events. Allowing for the "lag time" required to litigate cases through state and federal court systems, the external cause for the abrupt increase in reported litigation during the late 1960s and early 1970s appears to be the passage of federal legislation including Medicare, Medicaid, and financing for medical education. From an overall perspective, litigation involving medical education can be divided into pre- and post-Medicare/Medicaid eras, with the latter characterized by a ten-fold increase in litigation.

Finally, the data set also illustrates an ever-broadening range of legal issues arising in the context of medical education. While more than half of the reported cases in the period from 1950 to 1975 involved malpractice by residents, the share of malpractice cases is less than twenty percent in the period since 1975, as litigation involving other issues such as student financing, faculty clinical, and administrative matters expanded. The range of issues litigated expanded as the overall volume of litigation increased. This differentiation trend mirrors the growing size and complexity of academic medicine institutions. Nevertheless, many of the "new" issues litigated are products or byproducts of federal and state legislation related to Medicare, Medicaid, and the financing of medical education.

#### *A. Parties To Litigation*

This study categorizes the reported case law according to the status of the litigants: medical students, residents, and medical faculty. This study utilizes a key word identification system to identify cases involving the

three categories of participants in litigation. It reviews the case, then identifies the role of the student, resident or faculty member in the dispute and assigns the parties to the appropriate category. Where the dispute involves two or more categories of participants, the study classifies the case according to the party initiating suit. The cases are further subclassified with respect to the issue that generated the dispute. A chronological summary of reported litigation involving these parties is presented in FIGURE 5.

Students were involved in 147 of the reported cases (24%), resident physicians, in 204 (34%), and faculty, in 253 (42%). Sixty-five percent of all student, 40% of all resident and 60% of all faculty cases were reported since 1985. Litigation involving medical students initially tracked, with some "lag time," expanding enrollments during the 1965 to 1980 period. (See FIGURE 1). Before 1975, less than one case per year was reported on average. Volume sharply increased between 1975 to 1979 when the number of reported cases increased seven-fold. Since then, growth in volume appears to have consolidated at a slower rate. Nonetheless, the number of decisions doubled between 1979 and 1992. An increase in litigation continued despite a decline in enrollments and competitiveness in admissions in the late 1980s.

Between 1950 and 1975 reported litigation primarily involved issues arising from residency training and the actions of residents. Of the total number of cases (83) decided in those years, 51 cases (61%) identified residents as a party or as responsible for the act giving rise to the dispute. The data point to continued growth in cases involving residents, with some parallels in timing to cases involving medical students. Proportionately, however, the growth in litigation involving residents does not appear similar to that for students when comparing the numbers of medical students and residents. (See FIGURE 1). Throughout the period, the number of residency positions exceeded the availability of residents.

Faculty exposure to litigation increased consistently: before 1965, there were only five reported cases. After 1965, litigation involving faculty doubled in each successive five-year period. Despite this, this study substantially underreports faculty litigation because a major subset of faculty cases—those involving medical malpractice—was excluded. Many malpractice cases were initially identified, but eventually excluded, as a group, because of the lack of any systematic means of clarifying the faculty status in the written opinion. Because of the saliency of the issue of public/private sector relationships, however, this study retains those cases in which the faculty status of a litigant was clear, and issues arising

from the doctrine of sovereign immunity were decided. Therefore, this restriction limits the number of faculty cases included in this survey.

The fastest growing category of the three examined comprises faculty litigants. Since 1985, there have been more reported decisions involving faculty than either students or residents. Not unexpectedly, this finding may reflect the redistribution of participants in medical education which has occurred. Over the study period, the ratio of faculty to residents and students doubled from approximately 1.5 to 10, to 3 to 10. (See FIGURE 2). Although litigation involving faculty increased as the growth rate in numbers of faculty decreased after 1970, it grew most rapidly during the 1980s, a period of expanding revenues. (See FIGURE 3).

### *B. Litigation In State And Federal Courts*

Of the 604 cases this survey categorizes, federal courts decided 281 cases (47%) and state courts decided 323 cases (53%). Federal courts decided student cases at a proportionately higher rate (67%) than either faculty (51%) or resident (26%) cases. These proportions reflect the underreporting of state court decisions generally. In 1990, the number of lawsuits filed in state courts (31 million) was over 100 times greater than the number filed in federal courts (280,000).<sup>20</sup> Although state court reporter systems include appellate-level decisions, state district court decisions are generally excluded. This results in a bias toward federal and appellate level cases in this survey's data set.

Within this reporting bias, there have been some changes in the pattern of courts from which litigants seek recourse over the study period. Of the 53 decisions reported during the first 20 years this study covers, 43 (81%) were decided in state courts. During the past 13 years (1980-1992), 215 (49%) of the 442 cases were decided in state courts. This change, in part, reflects the underreporting of malpractice cases in the survey. Malpractice cases appear throughout the study period as a continuing and consistent source of litigation. These cases are found predominantly in state courts; and of those cases included in this study, they primarily involve residents. Despite this, litigation in federal courts increased disproportionately. This reflects, in part, the impact of a growing number of federal policies which affect medical education across a broad range of programs.

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20. Henry J. Reske, *Record State Caseloads in 1990*, 78 A.B.A. J. 23, 23 (1992).

### C. *Issues Litigated*

Once the survey established the status of the litigants as students, residents, or faculty, it examined the cases to identify general issue areas giving rise to litigation. Because both the volume of litigation and range of issues litigated increased rapidly over the four decades of reported cases, this survey adopts new categories when necessary and reevaluates older cases to fit the evolving classification scheme. Some categories and subcategories are based upon standard legal concepts—e.g., medical malpractice—but most are defined and redefined based upon a comprehensive review of the reported cases. Refinement of this classification permits analysis based on the specific findings as to frequency, characteristics, and setting of litigation involving programs of medical education. Again, limits arise primarily in the area of malpractice litigation where methodological concerns shaped reporting of results.

TABLE 1 identifies seven general categories: educational and financial issues affecting students and programs of undergraduate medical education; educational and malpractice issues affecting residents and programs of graduate medical education; and issues of general, clinical, and research administration affecting the faculty of both. This survey further subdivides these seven general categories into specific programmatic or problem areas. Although this typology of litigation experience is only preliminary, it provides a starting point for assessment of trends in litigation in medical education.

#### 1. *Students: Education and Finance*

Litigation involving medical students identifies two general issues: education and finance. In the former, seventy-four cases involve primarily educational issues arising from a range of problems medical students encounter. The case law data point to a sharp growth in volume between 1975 to 1979, with some consolidation during the 1980s. These cases further subcategorize into seven specific problem areas affecting medical students: dismissal, academic dishonesty, retaking work, admission, readmission, negligence, and miscellaneous.

Seventy-three cases involve disputes over students financing their medical educations and, occasionally, financial aid programs themselves. Almost all of this medical student financial litigation was reported since 1975, with a sharp increase in volume occurring after 1985. This study subdivides these cases into five specific areas: National Health Service Corps and other scholarship programs, Chapter 7 Bankruptcy, Chapter

13 Bankruptcy, statutory aid, and tuition/fees. Much of this litigation occurred long after students graduated from medical school and involved repayment of debts or service obligations after graduation. Nonetheless, because the litigation arose from disputes over the terms, conditions, or administration of financial aid programs designed to assist students in obtaining a medical education, this survey classifies these cases as student-generated.

## *2. Residents: Education and Malpractice*

This survey divides litigation involving residents and programs of graduate medical education into two general issue areas: educational programs and malpractice. Fifty-eight cases addressed problems arising from educational programs for residents. Again, while growth in litigation occurred consistently since 1965, reported cases doubled since 1985. This study further subdivides the litigation into four specific problem areas for analysis: academic administration (including dismissal, government regulation, admissions, safety and accreditation); tax and program reimbursement; collective bargaining; and, other. More than two-thirds of the cases involving residents reported by Westlaw involve academic administration, and almost all of these date from the mid-1980s.

Malpractice suits (146 cases), arising from the clinical practice of medicine by residents, constitute the largest group of reported cases involving residents. Because of the volume of malpractice litigation, this survey classifies and discusses these cases separately. However, malpractice is first and foremost an educational concern, because the purpose of graduate medical education is to train clinically competent physicians, thereby reducing the probability of malpractice. Exposure to malpractice litigation increased over the study period but, in contrast with other areas of litigation, the increase is somewhat more continuous and proportionate to the growth in numbers of residents. The growing complexity of the practice environment in which graduate medical programs operate, the increasing severity of illness of patients cared for by residents, and the passage of state tort reform legislation may also have contributed to this increase.

Because all malpractice cases involving residents arise from a similar problem, an adverse incident arising from allegedly substandard clinical care, this survey subdivides these cases according to the legal issue, rather than the alleged clinical mistake in dispute. For purposes of analysis, this study identifies eight subcategories: duty of care; standard of care; judi-



cial procedures; sovereign immunity; failure to supervise; breach/causation; informed consent; and, other. Nearly half of the reported cases involved either duty of care or standard of care, while the remainder are divided among the remaining six categories.

### *3. Faculty: Administration, Clinical Affairs, and Research*

This study divides litigation involving faculty into three categories: general administration, clinical affairs, and research. Ninety-two cases are characterized as arising from disputes about administrative issues facing colleges of medicine in their dealings with faculty generally. Litigation sharply increased in the 1976 to 1979 period and again in 1984 to 1989, both periods when the rate of expansion in number of faculty was slowing. Reported litigation related to general administration most often concerned the area of hiring, promotion and/or tenure, and discharge of faculty, in which nearly half of the cases alleged discriminatory practices. Other administrative disputes arose over allocation of departmental resources and responsibilities, faculty conduct, relationships with the Veterans Administration, employee benefits, system-wide discrimination, collective bargaining, and other reasons.

The most numerous group of 112 faculty cases involved issues arising out of the organization and practice of medicine by faculty responsible for the clinical education of students and residents. This survey separately categorizes these cases as they illustrate the range of complex legal issues academic medical institutions encounter as participants in the health care delivery system. As revenue from medical services provided by clinical practice increased, so has the volume of litigation. (See FIGURE 4). More than eighty percent of the cases have been reported since 1980. This increased frequency occurred across all issues identified by this study and appears to respond, in part, to the regulatory environment in which the health care industry functions, regardless of the intent of such measures as protection for the provider or for the consumer.

This survey subdivides the 112 cases involving faculty and clinical issues into eight areas. Most numerous are twenty-eight cases arising from disputes over liability for malpractice by publicly-owned or affiliated entities under the doctrine of sovereign immunity. As previously discussed, except for this subset of cases, this survey generally excludes suits against faculty for malpractice. The remaining seven areas include: organization and administration of practice plans; staff privileges; teaching hospital re-

relationships; indemnification disputes; peer review/confidentiality of records; conduct of clinical practice; and, other.

A third group of forty-nine cases decided issues arising from faculty-conducted research. Litigation relating to biomedical research often involved complex questions, and this survey divides these cases into seven areas: grants and/or personnel administration; conduct of research; commercialization of academic research; ethical questions; treatment of animals used in research; funding disputes; and, other. The distribution of cases among the first six substantive areas is relatively even. The apparent increase in frequency and scope of litigation over biomedical research appears to be a result of changes in the legal and cultural environment of medical research. Public interest in, and state/federal regulation of, biomedical research increased significantly in the past decade, accounting for the recent surge in reported litigation. In addition, federal policy initiatives introduced to stimulate collaboration between academic and commercial research programs began to affect the state appellate and federal dockets.

## V. DETAILED FINDINGS

### A. *Students: Educational Issues*

The evolution of reported litigation in the seven programmatic or problem areas involving educational issues is presented in TABLE 2. Dismissal of personnel, an endemic problem, is the most frequently litigated. While these cases are reported throughout the study period, the number of these cases increased rapidly in the late 1970s and again in the early 1990s.

In the 1970s, as courts defined issues of students' rights, students prevailed in almost half of the cases challenging a dismissal.<sup>21</sup> However, since the Supreme Court's 1978 decision in *Board of Curators v. Horowitz*,<sup>22</sup> which distinguished the due process procedures required for academic and disciplinary dismissal decisions, academic medical institutions have prevailed more regularly in litigation, indicating institutional adaptation to legal expectations. The case law supports the conclusion that courts defer to academic judgments made by faculty if academic medical institutions provide appropriate procedural protection for students.

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21. This discussion draws on and updates research originally reported in Helms & Helms, *Medical Students: General Educational Issues*, *supra* note 2, at 1.

22. 435 U.S. 78 (1978).

Nevertheless, the frequency of reported litigation challenging academic dismissals continues to increase. The reasons for this continued growth are not clear. Several factors may contribute to the recent spate of academic dismissal cases. A nadir in the ratio of applicants to admissions in 1989 may reflect some reduction in the quality of students. The growing costs of medical education, and resulting burden of debt, may enhance economic incentives to challenge dismissals. Moreover, civil rights legislation, including the Americans with Disabilities Act (ADA),<sup>23</sup> may be more readily available as a cause of action after the clarifying litigation and legislation of the 1980s.<sup>24</sup>

Despite judicial deference to substantive academic judgments about dismissal, due to the fact that institutions successfully adapted to procedural prerequisites, the case law identifies an expanding role for courts in scrutinizing procedures and decisions made prior to dismissal. This survey identifies eleven cases, separately identified as disputes over academic dishonesty (7) and retaking work (4) which address a variety of problems antecedent, but related to, a final dismissal decision. (See TABLE 2). Cases involving academic dishonesty are both persistent and troublesome. Academic dishonesty was the issue in one of the earliest decisions reported. Courts viewed cheating primarily as an academic offense and permitted dismissal under academic, rather than disciplinary, procedural standards. As a result, these cases focused primarily on what process is due to students by applying principles of contract law to private institutions or due process to public institutions. Courts also found problematic the speed with which institutions acted to dismiss students for cheating, and courts have recently been willing to issue preliminary injunctions to forestall immediate consequences.<sup>25</sup>

Four cases examined medical school practices permitting or denying students the right to repeat courses or examinations.<sup>26</sup> Illustrative of the

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23. 42 U.S.C. §§ 12101-12213 (West Supp. 1991).

24. Remedies for violations of civil rights statutes by programs "receiving federal assistance" were problematic after the Supreme Court restricted termination of funding only to programs actually receiving federal funds. *Grove City College v. Bell*, 465 U.S. 555, 572 (1984). The Civil Rights Restoration Act of 1987, Pub. L. 100-259, 102 Stat. 28 (1988), rejected the *Grove City* interpretation.

25. *University of Tex. Medical Sch. v. Than*, 834 S.W.2d 422 (Tex. Ct. App. 1992); *James v. Wall*, 783 S.W.2d 615 (Tex. Ct. App. 1989); *Beilis v. Albany Medical Coll. of Union Univ.*, 525 N.Y.S.2d 932 (App. Div. 1988); *Corso v. Creighton Univ.*, 731 F.2d 529 (8th Cir. 1984); *Hall v. Medical Coll. of Ohio*, 742 F.2d 299 (6th Cir. 1984), *cert. denied*, 469 U.S. 1113 (1985); *Pride v. Howard Univ.*, 384 A.2d 31 (D.C. 1978); *People v. Board of Trustees of Univ. of Ill.*, 134 N.E.2d 635 (Ill. App. Ct. 1956).

26. *Lewis v. Russe*, 713 F. Supp. 1227 (N.D. Ill. 1989); *Bergstrom v. Buettner*, 697 F.

degree to which a court may scrutinize institutional practice is the decision in *Bergstrom v. Buettner*.<sup>27</sup> There, the court reversed a summary judgment which had sustained the dismissal of a student for failing a course based on a professor's failure to issue written, rather than oral, grading criteria for the course as school policy required.

The second largest subcategory of educational issues in the survey comprises cases involving admission to medical school. Of the ten admissions cases, six were reported between 1970 to 1979, three between 1980 to 1989, and one since 1990. Temporal trends in the frequency of litigation over admission may track, in part, changes in the competitiveness and selectivity of medical school admissions. The ratio of the number of applicants to acceptances over the study period ranged from a high of 2.8 to 1 between 1973 and 1975 to a low of 1.6 to 1 between 1988 and 1989.<sup>28</sup> Between 1970 and 1979, medical schools lost almost half of the challenges to their admissions decisions. Since 1980, however, schools successfully weathered admissions litigation.<sup>29</sup> The most recent litigation in this area reflects more generalized policy concerns over testing. For example, a New York law challenged the required disclosure of the test provisions of the Medical College Aptitude Test (MCAT).<sup>30</sup>

A related subcategory of admissions cases involves the readmittance of previously enrolled students. Four cases challenged decisions denying re-admission after illness or prior to dismissal. In three of these cases, illness necessitated requests for formal leaves of absence, and the issues in these cases focused on what type of conditions could be imposed on reinstatement. A fourth case challenged a denial of reinstatement which was based on the student's prior dismissal for academic reasons.<sup>31</sup>

Within litigation over dismissals and admissions, students alleged discrimination based on race, gender, or disability in twenty of the cases. Many of these litigation disputes are recent. Five admissions cases in-

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Supp. 1098 (D.N.D. 1987); *Moire v. Temple Univ. Sch. of Medicine*, 613 F. Supp. 1360 (E.D. Pa. 1985), *aff'd per curiam*, 800 F.2d 1136 (3d Cir. 1986); *In re Levy*, 450 N.Y.S.2d 574 (App. Div.), *aff'd*, 442 N.E.2d 1276 (N.Y. 1982).

27. 697 F. Supp. at 1098.

28. Information compiled from DAVIS G. JOHNSON, *PHYSICIANS IN THE MAKING: COMPANION FACT BOOK* (1983) and Harry S. Jonas et al., *Educational Programs in US Medical Schools*, 268 JAMA 1083, 1086 (1992).

29. *Medical Students: General Educational Issues*, *supra* note 2, at 3.

30. *Association of Am. Medical Coll. v. Cuomo*, 928 F.2d 519 (2d Cir.), *cert. denied*, 112 S. Ct. 184 (1991).

31. *North v. State*, 400 N.W.2d 566 (Iowa 1987); *Doe v. New York University*, 666 F.2d 161 (2d Cir. 1981); *Evans v. West Va. Bd.*, 271 S.E.2d 778 (W.Va. 1980); *Williams v. Howard*, 528 F.2d 658 (D.C. Cir. 1976).

volved discrimination,<sup>32</sup> including three challenges to affirmative action programs based on claims of reverse discrimination. Two cases decided issues of discrimination against minorities in retaking course work.<sup>33</sup> One addressed readmission after a period of mental illness.<sup>34</sup> The remainder involved claims of discrimination in dismissal. Since 1990, five cases, including an important interpretation of the requirements for accommodating learning disabled students under Section 504 of the Rehabilitation Act of 1973,<sup>35</sup> addressed issues of discrimination based on disability.<sup>36</sup>

Progress toward diversification of medical students is uneven. Although the percentage of first year minority students rose from 16.1% between 1981 and 1982 to 29.8% between 1991 and 1992, that change primarily reflects a three-fold increase in students of Asian and Pacific Island origins. All other minority groups experienced a slight growth in enrollment over the same period. For example, enrollment of African-Americans and Hispanics increased only 7.6% and 5.8%, respectively.<sup>37</sup> Moreover, African-American students are enrolled in relatively few medical schools, with 40% of all first year students attending only fourteen schools.<sup>38</sup> As medical schools continue to contend with demands for access, more litigation may reinforce demands for the diversification of the medical profession. Recent amendments to basic civil rights legislation, as well as implementation of the ADA, may enhance reliance on the courts as a forum for pursuing claims of discrimination.

Five cases illustrate the range of issues exposing medical schools to tort liability. Three cases involved malpractice arising from student-provided medical care. In one of the earliest reported cases a patient successfully

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32. *Baker v. Board of Regents*, 721 F. Supp. 270 (D. Kan. 1989); *McDonald v. Hogness*, 598 P.2d 707 (Wash. 1979), *cert. denied*, 445 U.S. 962 (1980); *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978); *Cannon v. University of Chicago*, 559 F.2d 1063 (6th Cir. 1976), *rev'd*, 441 U.S. 677 (1979); *Alevy v. Downstate Medical Ctr.*, 348 N.E.2d 537 (N.Y. 1976).

33. *Lewis v. Russe*, 713 F. Supp. 1227 (N.D. Ill. 1989); *Moire v. Temple Univ. Sch. of Medicine*, 613 F. Supp. 1360 (E.D. Pa. 1985), *aff'd per curiam*, 800 F.2d 1136 (3d Cir. 1986).

34. *Doe v. New York Univ.*, 666 F.2d 761 (2d Cir. 1981).

35. *Wynne v. Tufts Univ. Sch. of Medicine*, 976 F.2d 791 (1st Cir. 1992), *cert. denied*, 113 S. Ct. 1845 (1993).

36. *Lowinger v. State Univ. of N.Y. Health Science Ctr.*, 580 N.Y.S.2d 316 (App. Div. 1992); *Wolsky v. East Va. Medical Auth.*, 795 F. Supp. 171 (E.D. Va. 1992), *rev'd*, 1 F.3d 222 (4th Cir. 1993), *cert. denied*, 114 S. Ct. 881 (1994); *Nathanson v. Medical Coll. of Pa.*, 926 F.2d 1368 (3d Cir. 1991); *Chusid v. Albany Medical Coll. of Union Univ.*, 550 N.Y.S.2d 507 (App. Div. 1990).

37. *Jonas et al.*, *supra* note 28, at 1088.

38. *Id.* at 1085-86.

sued a student for malpractice.<sup>39</sup> In 1992, two decisions spoke to the requirements for informed consent when medical students participate in patient care.<sup>40</sup> Both cases held that by virtue of the students' presence in an established teaching hospital, the hospital provided patients sufficient notice of the students' role in the patient care and therefore specific provisions in the patients' consent forms were unnecessary. The remaining two cases decided the responsibility of medical schools for injuries students sustained in school-sponsored or required activities.<sup>41</sup>

Two miscellaneous cases dealt with issues of fraudulent student misrepresentation. One involved a student who quit eleven days after entering medical school, and the other involved false imprisonment when university security detained a medical student whom they found living in the storeroom of a university building.<sup>42</sup>

This study identifies a learning curve in terms of institutional success in litigation brought by its own medical students. The relative early successes in litigation of medical students from 1975 to 1979 reflected a re-framing of basic student rights that occurred in all sectors of education during that period. By 1980, however, medical schools adapted to legal expectations by adopting appropriate procedural standards. These decisions "sustain the idea that faculty have little reason to fear judicial intervention in academic standards" provided that appropriate procedures are employed.<sup>43</sup> However, litigation may not decrease because incentives for litigation in this area have not abated. Instead, the data indicate that courts are now being asked to extend the scope of their review, particularly as to questions of fairness and procedure, by resolving a variety of problems related, but antecedent, to dismissal.

### B. Students: Financial Issues

TABLE 3 documents the reported case law involving disputes over student and program financing of medical school. Most cases involving finance reflect disputes by former medical students over the terms and

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39. *Christensen v. Des Moines Still Coll. of Osteopathy & Surgery*, 82 N.W.2d 741 (Iowa 1957).

40. *Bowlin v. Duke Univ.*, 423 S.E.2d 320 (N.C. Ct. App. 1992); *Wilson v. Board of Regents*, 419 S.E.2d 916 (Ga. 1992).

41. *Gehling v. St. George's Univ. Sch. of Medicine*, 705 F. Supp. 761 (E.D.N.Y.), *aff'd per curiam*, 891 F.2d 277 (2d Cir. 1989); *Turner v. Rush Medical Coll.*, 537 N.E.2d 890 (Ill. App. Ct. 1989).

42. *Parker v. Downing*, 547 So. 2d 1180 (Ala. Civ. App.), *cert. denied*, 547 So. 2d 1185 (Ala. 1988); *Reimer v. Tien*, 514 A.2d 566 (Pa. Super. Ct. 1986).

43. *Medical Students: General Educational Issues*, *supra* note 2, at 5.

conditions for repayment of loans obtained during medical school. Over the study period, a combination of increasing medical school tuition, growing reliance on student loans to finance medical education, and burgeoning student indebtedness may have contributed to the recent burst of litigation. Whereas in the 1960s and early 1970s academic medicine institutions limited tuition increases, tuition costs consistently increased and even accelerated in 1980 after the demise of federal capitation payments.<sup>44</sup>

In response, students turned to loans and service exchange programs to finance their educations, resulting both in accelerated indebtedness and in disputes over the terms of service exchanged. The mean debt of medical school graduates increased from \$14,622 in 1979<sup>45</sup> to \$50,384 in 1991.<sup>46</sup> The slightly decreasing proportion of medical students with indebtedness, from 85% in 1984 to 78% in 1991, suggests a shift toward enrolling more affluent students. Level of debt varies by type of medical school, public or private, although in both sectors the mean level of debt has increased 133% and 185%, respectively, since 1980.

Medical students rely primarily on loans to finance their educations. Currently, the Stafford Student Loan program allows students to borrow \$8,500 in subsidized student loans and \$18,500 in unsubsidized student loans annually with maximum limits of \$65,500 and \$138,500, respectively. Both types of loans provide students with favorable interest rates and extensive grace periods after graduation. The Health Education Assistance Loan Program (HEAL), with less favorable interest provisions, permits students to borrow \$20,000 yearly, up to \$80,000. In 1990 to 1991, these programs accounted for 82.5% of all loans disbursed to medical students.<sup>47</sup>

Scholarship support for medical students underwent several changes over this study period. The National Health Service Corps (NHSC), a program designed to supply primary care physicians to underserved areas, and the Armed Service Health Professions Scholarships, a program exchanging service for scholarships, accounted for 62% of the scholarship funds available to medical students in 1977 to 1978.<sup>48</sup> This proportion

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44. See generally Robert G. Petersdorf, *Financing Medical Education*, 66 *ACAD. MED.* 61 (1991) (discussing medical students' financial data in the 1960s, 1970s, and 1980s).

45. *Id.* at 63.

46. Jolin et al., *supra* note 5, at 1155 (discussing more recent medical student financial data).

47. *Id.*

48. ASSOCIATION OF AM. MEDICAL COLL., *AMERICAN MEDICAL EDUCATION: INSTITUTIONS, PROGRAMS AND ISSUES* 16 (1989) [hereinafter AAMC].

drastically decreased and accounted for only 38% of the available scholarship funds in 1987 to 1988,<sup>49</sup> and only 5.7% of the total financial aid disbursed in 1990 to 1991.<sup>50</sup> School-based scholarship programs, despite their limited resources, increased funding for students.

Over the past decade, the academic medicine community expressed concern over the problems of financing medical education. In 1986, the AAMC implemented MEDLOAN, a program which guarantees all medical students in good standing access to \$30,000 annually to finance their medical educations. Estimates of the impact of a burgeoning student debt load on capacity for repayment, as well as on choice patterns in selecting medical specialization, are receiving greater attention. AAMC data indicates that the mean student indebtedness of \$50,000 in 1991, requires a five-year post graduate income level of \$79,000 in order to repay school loans at a rate of 8% of gross income (termed "comfortable"), whereas indebtedness of \$75,000, a level of debt 11% of graduates carry, requires a comparable income of \$145,000.<sup>51</sup> Such levels of debt may influence the student's choice of specialization toward more lucrative career options.<sup>52</sup>

TABLE 3 identifies five categories of litigation involving the financing of medical education. More than one-half (39) of these cases addressed problems with the interpretation or application of laws setting up federal or state programs to pay the cost of medical education, many of which exchange funding of medical school loans for a period of service the physician performs in a designated area of need. Most of these cases (34 of 39) arose over the terms of the NHSC requirements of service. The remaining cases in this group addressed similar issues arising out of state scholarship-for-service programs.

The NHSC program, established in 1976 to address shortages in health care personnel in certain regions of the nation, provides for scholarships and living expenses to medical students in exchange for a period of service after graduation equal to the number of years of scholarship support. Service takes several forms: (1) as a commissioned officer in the Public Health Service or civilian employee in the NHSC, (2) in private practice in a designated, underserved area (private practice option), or (3) as an employee of a nonfederal entity such as a state-run community clinic (pri-

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49. *Id.*

50. Jolin et al., *supra* note 5, at 1155.

51. Petersdorf, *supra* note 44, at 63.

52. *Id.*



vate practice assignment).<sup>53</sup> NHSC assigns students to underserved areas after completion of their undergraduate and some portion of their graduate medical education. The penalty for default is stipulated by law and amounts to three times the scholarship amount, plus interest. Approximately 17% of the 13,800 NHSC recipients failed to honor their service commitments.<sup>54</sup>

NHSC's process and criteria for placing graduates were the subject of 34 of the 39 cases this survey classifies as NHSC or other service program cases. To date, the courts supported all decisions and actions. At present, litigation on this topic does not permit former medical students any common law defenses in resisting claims upon default,<sup>55</sup> although the potentially harsh effects of the treble damage provisions may enhance incentives to litigate. For example, in *United States v. Conway*,<sup>56</sup> the court calculated the default repayment obligation to be \$520,993, consisting of \$238,701 owed on principal and \$282,292 owed on interest with additional interest assessed at 17.4% from the date of judgment. In another case, *United States v. Roper*,<sup>57</sup> the court sustained the NHSC's denial of a hardship waiver requested by a physician close to completing her term of NHSC service. The case involved a physician whose husband committed suicide. The resulting psychological trauma to her three children led one of them to attempt suicide. The physician proposed that during her six remaining months of service she be permitted to move to a more affluent practice in the vicinity of the underserved area so as to provide the necessary income to support the costs of psychiatric care for her children, while continuing to practice in the rural community where she was assigned to serve during the weekends.

This study identifies twenty-five cases (35%) involving bankruptcy proceedings in which debt acquired to finance medical education was the issue. (See TABLE 3). Two forms of relief in bankruptcy are available: Chapter 7 and Chapter 13. Chapter 7 permits discharge of a debtor's obligations if undue hardship can be demonstrated while protecting the rights of creditors against abuses. In 1976, Congress amended the Bankruptcy Code to make student loans, including those for medical education, non-dischargeable for any reason until five years after the first

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53. 42 U.S.C. §§ 254c-254r (1990).

54. *Scholarship Swindles*, L.A. DAILY J., Mar. 3, 1992, at 6.

55. Donald Lohman, Comment, *The Final Frustration of Defaulting NHSC Scholars?: United States v. Hatcher*, 19 J.C. & U.L. 385, 400 (1993).

56. 686 F. Supp. 571 (E.D. La. 1988), *aff'd per curiam*, 868 F.2d 1269 (5th Cir. 1989).

57. 681 F. Supp. 77 (D. Me. 1988), *vacated per curiam*, 873 F.2d 1432 (1st Cir. 1989).

payment becomes due.<sup>58</sup> Chapter 13 provides for a proportionate reduction in a debtor's obligations and is available only to individuals with regular, but insufficient, income and unsecured debts of less than \$100,000.<sup>59</sup> There were eighteen bankruptcy cases under the provisions of Chapter 7, and seven bankruptcy cases under Chapter 13.

Of the eighteen Chapter 7 cases, eleven involved attempts to discharge debts and penalties incurred under the NHSC program, four under the HEAL program, and three under various state loan programs. Generally, courts were unwilling to discharge debts incurred for medical education under the undue hardship standard. Even when students who did not complete their medical education incurred debts, courts were reluctant to grant a waiver for undue hardship.<sup>60</sup>

However, recent decisions may point to very limited judicial willingness to mitigate the harsh impact of the case law and the economics of medical education. Since 1987, four cases allowed former medical students a partial discharge of their debts. These cases all dealt with the problems of tracing the various sources of the debt and discharging specific portions of the total amounts due. Specifically, the courts allowed limited discharge of amounts attributable to the interest or penalty portion of the debts which accrued on the original amount after the student failed to meet their obligation or of funds provided for living expenses. Loans for tuition expenses were not dischargeable.<sup>61</sup> One of these decisions, later overruled, allowed partial forgiveness and debt restructuring when the student failed to complete medical school and became a nursing home administrator.<sup>62</sup> Another recent case, subsequently overruled, permitted discharge of half the defaulted NHSC debt, originally amounting to \$46,726, but totaling \$379,486 in 1990, where the physician earned \$85,000 annually but could demonstrate no prospects of full repayment within the circumstances of her practice.<sup>63</sup>

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58. See Paula Aiello & Eric K. Behrens, *Chapter 13 of the Bankruptcy Code and the 1984 Bankruptcy Amendments*, 13 J.C. & U.L. 1 (1986) (discussing the Bankruptcy Amendments and its effects).

59. *Id.* at 3 n.13.

60. *In re Brown*, 18 B.R. 219 (Bankr. Kan. 1982); *In re Pierre*, 12 B.R. 693 (Bankr. S.D. Fla. 1981); *In re De Simone*, 6 B.R. 89 (Bankr. S.D.N.Y. 1980).

61. *In re Malloy*, 144 B.R. 38 (Bankr. E.D. Va. 1992), *rev'd*, 155 B.R. 940 (E.D. Va. 1993), *aff'd*, 23 F.3d 402 (4th Cir. 1994); *In re Matthews*, 150 B.R. 11 (Bankr. W.D. Pa. 1992) *rev'd sub nom.*, *Matthews v. Pineo* 19 F.3d 121 (3d Cir. 1994), *cert. denied*, 1994 U.S. LEXIS 5590 (1994); *In re Brown*, 79 B.R. 789 (Bankr. N.D. Ill. 1987); *In re Lipps*, 79 B.R. 67 (Bankr. M.D. Fla. 1987).

62. *In re Malloy*, 144 B.R. at 38.

63. *In re Matthews*, 150 B.R. at 11.

Of the remaining two categories of cases in TABLE 3, statutory aid and tuition/fees, five involved issues of medical school eligibility for financial aid for academic programs or students. Two cases decided questions of state law arising from public funding for private institutions and accreditation.<sup>64</sup> Two cases involved challenges to federal programs administering financial assistance to American students enrolled in foreign medical schools.<sup>65</sup> One resolved an unsuccessful claim for loan forgiveness under an existing state program by a foreign medical school graduate practicing, but not educated, in that state.<sup>66</sup> Three cases resolved challenges by students in favor of the institution over assessment of tuition or fees.<sup>67</sup> One case decided a dispute in a divorce decree over payment of expenses for medical education.<sup>68</sup>

The group of student cases addressing financial issues increased dramatically since 1985. Traditionally, medical school graduates have had lower default rates than other health care professionals. This study suggests that this may be changing.<sup>69</sup> As NHSC funding for medical education increased, then decreased, and dependence on non-service based loan programs continues to increase, litigation may shift from questions of service obligations to petitions for bankruptcy. The reported litigation in this area draws attention to underlying structural issues with long-term spillover effects. Sharp increases in the investment required to become a physician, plus the availability of financial aid through programs designed to remedy the problem of supplying physicians to underserved areas in exchange for educational funding, may enhance students' incentives to litigate. Students who incur a heavy burden of debt, and have difficulty in completing their medical educations, have substantial economic stake in challenging academic decisions. The low probability of being able to reduce or discharge such debt only reinforces incentives to litigate at the time of dismissal.

### C. Residents: Educational Issues

TABLE 4 reviews the evolution of litigation affecting residents and pro-

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64. *Board of Trustees v. Cory*, 145 Cal. Rptr. 136 (Ct. App. 1978); *Overman v. State Bd. of Control*, 62 So. 2d 696 (Fla. 1952).

65. *St. George's Univ. Sch. of Medicine v. Bell*, 514 F. Supp. 205 (D.D.C. 1981); *Ross Univ. Sch. of Medicine v. Cavazos*, 716 F. Supp. 638 (D.D.C. 1989).

66. *Van Bellingham v. Department of Educ.*, 555 N.Y.S.2d 571 (Sup. Ct. 1990).

67. *Petty v. Utah State Bd. of Regents*, 595 P.2d 1299 (Utah 1979); *Eisele v. Ayers*, 381 N.E.2d 21 (Ill. App. Ct. 1978); *Basch v. George Wash. Univ.*, 370 A.2d 1364 (D.C. 1977).

68. *Shriver v. Kobald*, 553 N.E.2d 867 (Ind. Ct. App. 1990).

69. AAMC, *supra* note 48, at 17.

grams of graduate medical education in four basic areas. The largest group of cases (41) deals with issues arising in administering an educational program for residents. Within this area, there are several, smaller clusters of cases: dismissals (22); regulations by external agencies (11); admissions (3); safety (3); and accreditation (2).

Dismissal of personnel was most problematic. Courts have decided the great majority (14) of the dismissal cases since 1985. In part, this may be associated with the changing dynamics of the economics of medical education. Residents with substantial indebtedness, threatened by the loss or reduction in present and future income, increasingly may be willing to challenge dismissals by graduate training programs. Limited data reported on the issue of dismissals of residents suggest that residents who are dismissed or who withdraw due to their substandard performance comprise only a small portion of those not completing residency programs. Indeed, in 1991, there were only 307 residents (12%) in this category.<sup>70</sup>

Before 1983, due process was the only issue litigated in dismissal cases. The issue was often whether to classify residents as employees or as students with minimal rights to due process.<sup>71</sup> Since then, courts addressed sovereign immunity, defamation, the interpretation of contractual provisions in collective bargaining agreements, and discrimination within the context of dismissal. In only four cases did residents succeed in challenging a program's decision,<sup>72</sup> while the outcome was unclear or mixed in two cases.<sup>73</sup> Five of the dismissal cases alleged discrimination, with four of these reported since 1985.<sup>74</sup>

While these findings may point to patterns similar to those reported for undergraduate medical education, some evidence of future directions of litigation is found in recent research documenting the nature and extent

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70. Martini, *supra* note 7, at 1105.

71. See generally *Residents: General Programmatic Issues*, *supra* note 2, at 649.

72. *Lipsett v. University of P.R.*, 864 F.2d 881 (1st Cir. 1988); *Navato v. Sletten*, 560 F.2d 340 (8th Cir. 1977); *Ezekial v. Winkley*, 572 P.2d 32 (Cal. 1977); *Walker v. State Personnel Bd.*, 94 Cal. Rptr. 132 (Ct. App. 1971).

73. *Dillingham v. University of Colo. Bd. of Regents*, 790 P.2d 851 (Colo. Ct. App. 1989), *cert. denied*, 1990 Colo. LEXIS 294 (Colo. 1990); *Banerjee v. Roberts*, 641 F. Supp. 1093 (D. Conn. 1986).

74. *Assaad-Faltas v. University of Ark. for Medical Sciences*, 708 F. Supp. 1026 (E.D. Ark. 1989); *Lipsett v. University of P.R.*, 864 F.2d at 881; *Samper v. University of Rochester, Strong Memorial Hosp.*, 528 N.Y.S.2d 958 (Sup. Ct. 1987), *modified*, 535 N.Y.S.2d 281 (Sup. Ct. 1988); *Hankins v. Temple Univ. Health Sciences Ctr.*, 829 F.2d 437 (3d Cir. 1987); *Van Nostrand v. University of Minn.*, 656 F.2d 315 (8th Cir. 1981).

of sexual harassment in medical training.<sup>75</sup> Initial research found that more than two-thirds of female and one in five male residents reported incidents of alleged harassment, primarily by attending physicians or other physicians during the residents' medical training. These sexual harassment episodes reportedly were distributed almost equally between medical school and residency training.

Eleven cases involving academic administration dealt primarily with the role of government in monitoring or regulating programs of graduate medical education. Programs of graduate medical education are often characterized by complex institutional relationships for governance. Eligibility for institutional accreditation to offer residency programs is established by the American Council of Graduate Medical Education (ACGME) and is open to any institution. Of the 7,065 programs of graduate medical education, 35% (2,489) are either sponsored by, or participate with, hospitals controlled by medical schools.<sup>76</sup> Nonprofit institutions sponsor the largest proportion (62%) of residency programs, with public entities responsible for 32%. However, this appears to have minimal influence on the educational characteristics of residency programs.<sup>77</sup>

Litigation reflects the growing complexity of the environment in which graduate medical education is delivered. Three cases challenged the Veteran's Administration; two involved program terminations, and one involved a program's authority to prohibit moonlighting.<sup>78</sup> There were several challenges to state regulatory decisions, including the powers of state medical boards to set requirements for the supervision of residents, to set salary rates, and to establish licensing requirements.<sup>79</sup> Residents sought to rescind a long-standing contract between the County of Los Angeles, California, that provided for the employment of residents in a

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75. Miriam Komaromy et al., *Sexual Harassment in Medical Training*, 328 NEW ENG. J. MED. 322 (1993).

76. Carlos J.M. Martini & Gary Grenholm, *Institutional Responsibility in Graduate Medical Education and Highlights of Historical Data*, 270 JAMA 1053, 1057 (1993).

77. *Id.*

78. *Chu v. Schweiker*, 690 F.2d 330 (2d Cir. 1982); *Jones v. Schweiker*, 554 F. Supp. 1195 (E.D. La. 1983); *Mulry v. Driver*, 366 F.2d 544 (9th Cir. 1966).

79. *De Salle v. Wright* 762 F. Supp. 229 (N.D. Ill. 1991), *aff'd*, 969 F.2d 273 (7th Cir. 1992); *Saint Barnabas Medical Ctr. v. New Jersey Hosp. Rate Setting Comm'n*, 520 A.2d 805 (N.J. Super. Ct. App. Div. 1987); *Gonzales-Blanco v. Clayton*, 441 N.E.2d 1308 (Ill. App. Ct. 1982); *Garden State Comm. Hosp. v. State Bd. of Medical Examiners*, 371 A.2d 794 (N.J. Super. Ct. App. Div.), *cert. denied*, 377 A.2d 794 (1977); *Snyder v. Burns* 214 So. 2d 636 (Fla. Dist. Ct. App. 1968), *cert. denied*, 222 So. 2d 751 (Fla. 1969).

county health care facility.<sup>80</sup> A suit brought by a union representing house staff challenged state regulations limiting the number of hours and establishing minimum operating standards for hospitals.<sup>81</sup>

The substantial expansion in both numbers of residency positions and programs limited disputes over admissions. This is due in part to the advent of the National Residency Matching Program (NRMP) in 1952, which standardized policies and procedures for matching prospective residents with available positions. A subset of only three academic cases was related to admissions into residency programs. One case resolved an issue of disability discrimination in favor of a resident with multiple sclerosis.<sup>82</sup> Another challenged limits on admission of osteopathic physicians to an allopathic cardiovascular fellowship program.<sup>83</sup> In the last case, the NRMP was sued for damages after a resident was matched to a program that was subsequently terminated.<sup>84</sup>

Current proposals for health care reform may have a dramatic impact on admissions. One strategy for increasing the proportion of primary care physicians to those in subspecialty fields involves controlling admissions to residency programs providing specialty training.<sup>85</sup> The financial support provided to training programs through Medicare funding, \$1.5 billion in direct medical education payments and \$3.33 billion in indirect adjustments in 1991 alone, creates leverage.<sup>86</sup> Prospectively, disputes over admissions may be subject to increased litigation as the number of positions available in the more desirable and lucrative specialty training programs are regulated under health care reform.

Three cases decided questions related to safety. Two arose from the issue of responsibility for residents' safety on the job.<sup>87</sup> A recent decision addressed the complex issue of patient and physician safety when a resident was HIV positive. There, the court confirmed a plan whereby the

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80. *Joint Council of Interns and Residents v. Board of Superv.*, 258 Cal. Rptr. 762 (Ct. App. 1989).

81. *Hospital Ass'n of New York v. Axelrod*, 546 N.Y.S.2d 531 (App. Div. 1989).

82. *Pushkin v. Regents of Univ. of Colo.*, 658 F.2d 1372 (10th Cir. 1981).

83. *Reiswig v. St. Joseph's Hosp. and Medical Ctr.*, 634 P.2d 976 (Ariz. Ct. App. 1981).

84. *Unger v. National Residents Matching Program*, 928 F.2d 1392 (3d Cir. 1991).

85. David Kindig et al., *The Elusive Generalist Physician: Can We Reach a 50% Goal*, 270 JAMA 1070 (1993).

86. Anne Schwartz et al., *Reforming Graduate Medical Education: Summary Report of the Physician Payment Review Commission*, 270 JAMA 1079, 1079 (1993).

87. *Beck v. Kansas Adult Auth.*, 735 P.2d 222 (Kan. 1987); *Beck v. Calvillo*, 671 F. Supp. 1555 (D. Kan. 1987).

HIV status of an infected resident was revealed to his patients.<sup>88</sup>

The last two cases involving problems related to academic administration challenged withdrawal of accreditation by the American Council on Graduate Medical Education (ACGME). In one, a New York court upheld a determination that a medical center had failed to comply with the general academic requirements established by the ACGME for a residency program in surgery. The review committee of the ACGME was found to have acted reasonably and with sufficient due process in its evaluation and appeals procedures.<sup>89</sup> A second decision sustained the ACGME's withdrawal of accreditation from a residency program in obstetrics and gynecology. The court found that the ACGME's refusal to exempt a Catholic hospital from the requirement of teaching family planning procedures did not violate the free exercise of religion clause<sup>90</sup> even though the court found the withdrawal of accreditation to be state action.

A group of ten reported decisions addressed a variety of questions related to financial issues. First, whether stipends awarded residents were income or scholarships provoked litigation over a period of years; stipends were eventually determined to be income.<sup>91</sup> Recently, there have been several challenges to the Health Care Finance Administration's denials of reimbursement for training programs' proportionate share of pass-through funding under Medicare and Medicaid. To date, all have been decided in favor of the hospitals' interpretation.<sup>92</sup> Medicare funding is critical to the financial underpinnings of graduate medical education. This source of funding may be expected to provide leverage vis-à-vis programs of graduate medical education as health care reform efforts seek to reconfigure the supply of primary care physicians. Restructuring may be expected to generate litigation as legislation is clarified and issues redefined.

A group of five cases resolved issues of collective bargaining.<sup>93</sup> The

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88. *In re M.S. Hershey Medical Ctr.*, 595 A.2d 1290 (Pa. Super. Ct. 1991), *aff'd*, 634 A.2d 159 (Pa. 1993).

89. *Interfaith Medical Ctr. v. Sabiston*, 527 N.Y.S.2d 48 (App. Div. 1988).

90. *St. Agnes Hosp. of the City of Baltimore, Inc. v. Riddick*, 748 F. Supp. 319 (D. Md. 1990).

91. *Krupin v. United States*, 439 F. Supp. 440 (E.D. Mo. 1977); *Leathers v. United States*, 471 F.2d 856 (8th Cir. 1972); *Coggins v. United States*, 1970 WL 382 (W.D. Tex. 1970); *Quast v. United States*, 293 F. Supp. 56 (D. Minn. 1968).

92. *Administrators of Tulane v. Sullivan*, 799 F. Supp. 1210 (D.D.C. 1992); *Temple v. White*, 941 F.2d 201 (3d Cir. 1991); *Ohio State Univ. v. Sullivan*, 777 F. Supp. 582 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir. 1993); *University of N.C. v. Sullivan*, 887 F.2d 1082 (4th Cir. 1989); *University of Cincinnati v. Bowen*, 875 F.2d 1207 (6th Cir. 1989).

93. *University Hosp. v. State Employ. Relations Bd.*, 587 N.E.2d 835 (Ohio 1992);

rights of residents to organize and bargain collectively in public hospitals were sustained under state law in California and Ohio, but denied in Michigan. Residents working in private hospitals, covered by federal rather than state law, failed in a claim that the National Labor Relations Board should permit bargaining. While the court reasoned that residents were to be classified as employees rather than students, the National Labor Relations Act specifically excluded residents from its provisions.<sup>94</sup>

One case, which could not readily be classified, arose when a supervising physician personally sued a resident for wrongful interference with contractual relations.<sup>95</sup> The physician argued that testimony provided by the resident to the hospital's peer review committee caused the eventual removal of the physician's staff privileges. In a case with important implications for physician-house staff relations, the court ordered a retrial to determine whether the resident had any motivation to "get even." If such motive was established, then the privilege accorded testimony given to hospital peer review committees in exercising their quality control functions would be revoked.

Growth in litigation over programs of graduate medical education may derive from forces similar to those propelling litigation by medical students. Dismissal has been an early and persistent theme in litigation. Whether the resident should be classified as an employee or a student has been troublesome. Economic incentives created by the burden of growing student debt may also motivate residents to litigate when dismissal either forecloses or delays opportunities for debt repayment. Again, as with medical students, this growth in litigation has occurred despite the fact that the courts most frequently sustain actions by training programs as meeting judicial standards.

The cases also illustrate the exposure of residency programs to litigation from multiple sources. These include issues of collective bargaining, peer review, state regulatory requirements for licensing and working conditions, accreditation, tax, and funding, especially under Medicare and Medicaid, which reimburse training programs in hospitals as a cost of providing general health care. In most instances, these cases primarily

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Mihalakis v. Cabrini Medical Ctr., 542 N.Y.S.2d 988 (App. Div. 1989); Regents of the Univ. of Cal. v. Public Employ. Relations Bd., 224 Cal. Rptr. 631 (1986); Physicians Nat'l House Staff Ass'n v. Murphy, 443 F. Supp. 806 (D.D.C. 1978), *aff'd*, 642 F.2d 492 (D.C. Cir. 1979), *cert. denied*, 450 U.S. 917 (1981); Regents of the Univ. of Mich. v. Michigan Employ. Relations Comm'n, 195 N.W.2d 875 (Mich. App. 1972).

94. See Physicians Nat'l House Staff Ass'n, 443 F. Supp. at 806.

95. Straube v. Larson, 600 P.2d 371 (Or. 1979).



interpreted policies made by non-educational participants, most frequently governments, making decisions affecting the basic fiscal structure of graduate medical education.

#### D. Residents: Malpractice Issues

Medical malpractice commands the attention of both the legal and medical communities, as well as the popular press. Research characterizing the scope and dynamics of the problem of malpractice is, however, slowly providing evidence to frame objective discussion in the heated debate over appropriate policy responses.<sup>96</sup>

Knowledge about malpractice issues in the setting of academic medicine is virtually nonexistent.<sup>97</sup> There is, however, limited, indirect research on the involvement of resident physicians in malpractice litigation. In studying interhospital variation in the rates of adverse events (injuries to patients caused by medical intervention as distinct from the disease process) and negligence (substandard care), there were differences between teaching and non-teaching hospitals.<sup>98</sup> University teaching hospitals, those owned by or closely tied to medical schools, had substantially higher rates of adverse events, but significantly lower rates of negligence, than other affiliated teaching hospitals and non-teaching hospitals.<sup>99</sup> These findings may be explained by the severity of illness of patients served by university teaching hospitals. University hospital patients often are acutely ill and undergo more numerous invasive procedures. As a result, although more can go wrong, there is less substandard care.<sup>100</sup>

In addition, there is evidence that socioeconomic status affects propensity to sue for malpractice. Poor, as well as uninsured, patients are less likely to file malpractice claims, whether on the basis of appropriate or inappropriate claims.<sup>101</sup> Similar findings also apply to the elderly.<sup>102</sup>

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96. There is extensive literature on this topic. This study relies primarily on research by Paul Weiler. See generally WEILER ET AL., *supra* note 14; PAUL WEILER, *MEDICAL MALPRACTICE ON TRIAL* (1991). See also Paul Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 4 *LAW & CONTEMP. PROBS.* 57 (1986).

97. Ben A. Rich, *Malpractice Issues in the Academic Medical Center*, 13 *J.C. & U.L.* 149, 149-50 (1986).

98. Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 *NEW ENG. J. MED.* 3265 (1991).

99. *Id.* at 3266.

100. *Id.* at 3267.

101. Helen R. Burstin et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 *JAMA* 1700 (1993).

These results suggest that hospitals, especially university teaching hospitals serving primarily poor and elderly patients, may enjoy a decreased incidence of malpractice claims.

The number of malpractice claims does not correspond to the number of patients who suffer an identifiably negligent injury. The chances that a claim was filed by a patient with such an injury were one in fifty in one study.<sup>103</sup> On the other hand, a substantial majority of malpractice claims filed are not based on substandard care or adverse events.<sup>104</sup> Medical malpractice is both underreported in terms of valid claims filed due to actual negligence and overreported in terms of the number of groundless claims filed.<sup>105</sup> The litigation process, however, is "reasonably efficient in filtering out spurious claims."<sup>106</sup>

TABLE 5 categorizes reported malpractice cases by the primary issue addressed by the courts in the decision. The question of who owed a duty of care to the plaintiff was litigated consistently over the study period and accounted for 44 (30%) of the 146 cases. This time period saw a broadening in the allocation of responsibility between physicians and hospitals. Previously, under the "captain of the ship" doctrine, supervising physicians had been held personally responsible for the acts of all members of the medical team caring for a patient. Since *Darling v. Charleston Community Memorial Hospital*,<sup>107</sup> in the mid-1960s, the hospital as employer and health care provider has been more frequently found jointly liable with the supervising physician. Most of the cases resolving questions of duty of care turned on the doctrine of vicarious liability in which responsibility for the actions of the resident was assigned to the hospital as well as the supervising physician. Theoretically, imposition of vicarious liability broadens the incentives for those in positions of authority, both hospitals and supervising physicians, to act with diligence and to coordinate care. Practically, a finding of vicarious liability deepens the pockets from which the claimant may recover.

Residents defending malpractice claims are often ancillary parties caught in a legal battle to allocate responsibility. As a result, the outcomes of these cases may frequently have less direct impact on residents

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102. Mark Sager et al., *Do the Elderly Sue Physicians?* 150 ARCH. INT. MED. 1091, 1092-93 (1990).

103. WEILER ET AL., *supra* note 14, at 52, 73.

104. *Id.* at 140.

105. *Id.* at 71.

106. *Id.* at 140.

107. 211 N.E.2d 253 (Ill.), *cert. denied*, 383 U.S. 946 (1965).

themselves. This sorting and distribution of responsibility is further complicated when residency programs utilize different hospitals for training and rely on contractual arrangements to address complex issues of supervision, staffing, reimbursement, and indemnification.<sup>108</sup>

Twenty-eight cases focused on the standard of care provided to the patient. Of these, nineteen dealt with defining an overall standard and reflected the general trend during the study period of moving toward a national rather than a community based standard to evaluate physician performance.<sup>109</sup> Nine cases traced the evolution of the question whether a separate standard applies to residents as physicians in training. Courts now appear to impose the same standard of care on residents as that imposed on physician-specialists because attending physicians are expected to provide a high level of direct supervision.<sup>110</sup>

The third most frequent group of reported cases (20) arose from statutes or rules governing plaintiffs' right to be in court or compliance with judicial procedures. Of these, 13 were decided since 1985, with all but one tried in state court. Recent state efforts to enact limited malpractice reform may have contributed to the recent flurry of reported decisions. Seven recent cases have decided compliance with changes in statutes of limitations and service and notice requirements at varying stages of filing a claim.<sup>111</sup> Two cases addressed the allowable scope of discovery by the courts.<sup>112</sup> The outcomes of these decisions have few implications for risk management practices for graduate medical school administrations. However, one case did resolve a question of whether a resident's statement, given to a hospital insurer and impugning the responsible physician, should be allowed as evidence in court.<sup>113</sup> Changes in the legal protection afforded the physician peer review process may provoke future litigation over issues of discovery.

Immunity from liability was litigated in a group of 16 cases, eight of

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108. *See generally Residents: Malpractice Issues, supra* note 2.

109. Rich, *supra* note 97, at 150.

110. *Id.* at 153.

111. Rizk v. Cohen, 538 N.Y.S.2d 229 (1989); *Nolph v. Scott*, 725 S.W.2d 860 (Ky. 1987); *Lackey v. Bressler*, 358 S.E.2d 560 (N.C. Ct. App. 1987); *Heilprin v. Ohio State Univ. Hosp.*, 508 N.E.2d 178 (Ohio Ct. App. 1986); *McSwain v. Dussia*, 499 So. 2d 868 (Fla. Dist. Ct. App. 1986); *Public Admin. of Kings County v. University Hosp.*, 507 N.Y.S.2d 47 (App. Div. 1986); *Clothier v. Lopez*, 711 P.2d 870 (N.M. 1985).

112. *Maher v. State*, 500 N.Y.S.2d 943 (Ct. Cl. 1986); *Vythoulkas v. Vanderbilt Univ. Hosp.*, 693 S.W.2d 350 (Tenn. Ct. App. 1985).

113. *Myles v. Women and Infants Hosp. of R.I.*, 504 A.2d 452 (R.I. 1986).

which were reported since 1985. Depending on state law, residents may be entitled to sovereign immunity if acting as agents of the state as an employee of a public hospital or to charitable immunity if employed by private, not-for-profit organizations. Most commonly, courts were asked to determine the extent to which sovereign immunity covered administrators, department chairs, and faculty as supervising physicians and as employees with discretionary decision making authority. The outcomes in these cases again reflect interpretations of varying state laws in this area rather than specific management practices. Additionally, cases in several states have identified changes in the application of the doctrine of sovereign immunity to public hospitals and residents.<sup>114</sup> Another troubling problem involved affiliation agreements between varying combinations of public and private medical and educational institutions involved in residency training programs. These pose complex questions of immunity when malpractice is alleged.<sup>115</sup>

Fifteen cases addressed the question of failure to supervise. (See TABLE 5). Although these cases form a subset of the general issue of standard of care, they are categorized separately because all focus specifically on whether the responsible physician or hospital failed to exercise appropriate supervision over the resident. In one case, the plaintiff successfully argued that the department chair failed to develop both appropriate programs to educate residents and procedures to monitor their performance.<sup>116</sup> In another, plaintiffs unsuccessfully argued that this responsibility should be assigned to a state board of regents.<sup>117</sup> Finally, a failure to exercise appropriate supervision by those responsible for residents at one institution or level often led to complex counterclaims identifying other potential defendants to the litigation. In some cases, affiliated hospitals sued the training program or the employing hospital, or both, depending on the nature of the contract, for breach of the duty to supervise. In another, a resident sued a program for failing in its duty to educate. Such cases sometimes arose when residents were found to be personally liable or when insurers challenged claims for indemnification

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114. *Shands Teaching Hosp. and Clinics v. Pendley*, 577 So. 2d 632 (Fla. Dist. Ct. App. 1991); *Gould v. O'Bannon*, 770 S.W.2d 220 (Ky. 1989); *Roberts v. City of Pontiac*, 440 N.W.2d 55 (Mich. App. 1989); *Jaar v. University of Miami*, 474 So. 2d 239 (Fla. Dist. Ct. App. 1988); *DeRosa v. Shands Teaching Hosp. and Clinics*, 504 So. 2d 1313 (Fla. Dist. Ct. App. 1987); *Hyde v. University of Mich. Bd. of Regents*, 393 N.W.2d 847 (Mich. 1986).

115. *Kelley v. Rossi*, 481 N.E.2d 1340 (Mass. 1985).

116. *Maxwell v. Cole*, 482 N.Y.S.2d 1000 (App. Div. 1984).

117. *Sibley v. Board of Supervisors of La. State Univ.*, 490 So. 2d 307 (La. Ct. App. 1986).

on malpractice policies after a hospital or physician was found not to have met the standard of care.<sup>118</sup>

Twelve cases resolved factual disputes as to whether a resident's act constituted a breach of duty or caused the injury. These cases appeared throughout the study period and litigated a range of factual issues common in malpractice litigation.

Interestingly, only six cases decided issues of informed consent. All have been reported since 1975.<sup>119</sup> Despite the extensive literature in health law addressing this question, treatment performed without a valid consent was not a commonly reported claim against residents, and residents frequently prevailed in these cases. The cases focused primarily on the problem of whether the patient knew that the resident, and not the supervising physician, would be providing care. The trend in litigation holding residents to the same standard of care as that of attending physicians may have served to undermine the reasoning in this line of cases.

Five cases could not be specifically categorized.<sup>120</sup> These included a range of problems: assumption of risk, contract when insurance carriers disputed a hospital's right to indemnification, state limits on recovery for malpractice enacted as a reform, and a claim that a residency program failed to provide an education adequate to ensure competency in practice.

Malpractice suits constitute the largest group of reported cases involving residents and are an important legal issue facing training programs today. Exposure to malpractice litigation has increased for several reasons: an expansion in numbers of residents; some limited evidence that malpractice claims against physicians occur more frequently earlier in

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118. *Solomon v. Presbyterian Univ. Hosp.*, 530 A.2d 95 (Pa. Super. 1987), *appeal denied*, 583 A.2d 500 (Pa. 1988); *Riverside County v. Loma Linda Univ.*, 173 Cal. Rptr. 371 (Ct. App. 1981); *Themins v. Emmanuel Lutheran Charity Bd.*, 637 P.2d 155 (Or. Ct. App. 1981), *review denied*, 644 P.2d 1129 (Or. 1982).

119. *Wachter v. United States*, 877 F.2d 257 (4th Cir. 1989); *Young v. United States*, 648 F. Supp. 146 (E.D. Va. 1986); *Zimmerman v. New York City Health and Hosp. Corp.*, 458 N.Y.S.2d 552 (App. Div. 1983); *Hill v. Seward*, 470 N.Y.S.2d 971 (App. Div. 1983); *Prooth v. Walsh*, 432 N.Y.2d 663 (App. Div. 1980); *German v. Nichopoulos*, 577 S.W.2d 197 (Tenn. Ct. App. 1978).

120. *AETNA Casualty & Surety Co. v. Oregon Health Sciences Univ.*, 773 P.2d 1320 (Or. Ct. App. 1989), *aff'd*, 793 P.2d 320 (Or. 1990); *Condemarin v. University Hosp.*, 775 P.2d 348 (Utah 1989); *Swidryk v. Saint Michael's Medical Ctr.*, 493 A.2d 641 (N.J. Super. Ct. Law Div. 1985); *United States Fidelity and Guaranty Co. v. Doctor's Hosp.*, 265 A.2d 774 (D.C. App. 1970); *Bruce v. United States*, 167 F. Supp. 579 (S.D. Cal. 1958).

their careers;<sup>121</sup> the growing complexity of the practice environment in which graduate medical programs operate; the increasingly severe degree of patient illness cared for by residents; and, the passage of state tort reform legislation. However, proportionately, malpractice claims involving residents do not appear to have increased as rapidly as those against practicing physicians.<sup>122</sup>

Three important areas of negligence in graduate medical education were identified: negligence in educational training programs, negligence in supervision, and vicarious liability where the actionable conduct is attributed to the supervising physician or employing institution.<sup>123</sup> The last two of these three areas together constituted forty percent of the reported litigation. This finding emphasizes the importance of setting policies that clearly delineate for faculty levels of supervision as well as clearer standards of responsibility. Problems often arise because of cooperative arrangements between affiliated hospitals and programs, both public and private, as plaintiffs search for indemnification from multiple defendants and "deep pockets."

#### *E. Faculty: Administrative Issues*

The growth of litigation involving specific areas of academic administration is presented in TABLE 6.<sup>124</sup> The most numerous group of cases (34) involved personnel decisions. Within this group, 6 decisions involved hiring; 13 involved promotion and tenure; and, 15 involved discharge. Universities prevailed in nineteen of these cases. Recently, however, decisions unfavorable to the institution, or with unclear outcomes, have grown, with ten reported since 1985. These cases addressed a range of common problems: reduction in work force necessitated by financial exigency as well as subsequent rights to be rehired when economic conditions improved; whether an unpaid visiting lecturer had status as an employee; the appropriate procedures for decision making on promotion, tenure, and discharge; and, whether commitments about promotion, ten-

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121. E. Kathleen Adams & Stephen Zuckerman, *Variation in the Growth and Incidence of Medical Malpractice Claims*, 9 J. HEALTH POL., POL'Y. & LAW 475 (1984).

122. WEILER ET AL., *supra* note 14, at 62.

123. The areas identified in this survey of litigation generally conform to problems identified by academic physicians. See AMERICAN MEDICAL ASSOCIATION CONFERENCE PROCEEDINGS, ON THE HORIZON: REGULATION OF PHYSICIAN TRAINING PROGRAMS (1989).

124. See generally *Litigation Involving Medical Faculty*, *supra* note 2, at 7.

ure, and discharge could be inferred from administrative actions or from institutional policies.

The most common complaint in this group of cases was discrimination (15 cases) with bias based on sex claimed in 7;<sup>125</sup> race in 4;<sup>126</sup> national origin in 2;<sup>127</sup> and, age in 2.<sup>128</sup> Eight of the discrimination cases have been decided since 1985. Two of the most recent cases addressed contentious disputes about sexual harassment, one in terms of a hostile work environment and failure to promote;<sup>129</sup> the other in terms of the discharge of a tenured professor who lied about past charges of sexual harassment at the time he was hired.<sup>130</sup>

These findings may point to continuing litigation over issues of discrimination. The demographics of medical faculties have changed very slowly over the study period. The proportion of female faculty members rose from 13% in 1967-1968 to 20% in 1988-1989. Only three percent of medical faculty belonged to minority groups.<sup>131</sup> A large cohort of faculty, appointed in the 1950-1970 era to staff new medical schools, is now nearing traditional retirement age. However, statutory provisions requiring mandatory retirement are prohibited. Furthermore, the number of available positions is expected to stabilize or shrink.<sup>132</sup> Recent publicity about harassment and the demeaning of female faculty provides preliminary evidence of the growing scrutiny of discriminatory practices, especially "insensitivity, intolerance, and a validated legacy of sexism" by faculty.<sup>133</sup>

A second group of twenty-two cases dealt with disputes over the alloca-

125. *Duello v. Board of Regents of Wis. System*, 487 N.W.2d 56 (Wis. Ct. App. 1992); *Jew v. University of Iowa*, 749 F. Supp. 946 (S.D. Iowa 1990); *Garner v. Michigan State Univ.*, 462 N.W.2d 832 (Mich. Ct. App. 1990); *Cohen v. Board of Trustees of the Univ. of Medicine and Dentistry of N.J.*, 867 F.2d 1455 (3d Cir. 1989); *Soble v. University of Md.*, 778 F.2d 164 (4th Cir. 1985); *Johnson v. University of Pittsburgh*, 435 F. Supp. 1328 (D. Pa. 1977); *Flanders v. William Paterson Coll. of N.J.*, 394 A.2d 855 (N.J. Super. Ct. App. Div. 1976).

126. *Johnson v. Michigan State Univ.*, 547 F. Supp. 429 (W.D. Mich. 1982), *aff'd*, 723 F.2d 909 (6th Cir. 1983); *Henry v. Texas Tech. Univ.*, 466 F. Supp. 141 (N.D. Tex. 1979); *Hunter v. Ward*, 476 F. Supp. 913 (D. Ark. 1979); *State Div. of Human Rights v. University of Rochester Sch. of Medicine and Dentistry*, 422 N.Y.S.2d 224 (App. Div. 1979).

127. *Tadros v. Coleman*, 717 F. Supp. 996 (S.D.N.Y. 1989); *Pande v. Johns Hopkins Univ.*, 598 F. Supp. 1084 (D. Md. 1984).

128. *Ovadia v. Michael Reese Hosp. and Medical Ctr.*, No. 90-C-0806, 1991 WL 61041 (N.D. Ill. 1991); *Nobler v. Beth Israel Medical Ctr.*, 702 F. Supp. 1023 (S.D.N.Y. 1988).

129. *Jew v. University of Iowa*, 749 F. Supp. 946 (S.D. Iowa 1990).

130. *Garner v. Michigan State Univ.*, 462 N.W.2d 832 (Mich. Ct. App. 1990).

131. AAMC, *supra* note 48, at 11.

132. *Id.*

133. *Sexism Is Far From Dead in Medicine*, AMA NEWS, June 24, 1991, at 5.

tion of departmental resources and responsibilities, an area likely to generate increasing conflict with heightened competition for scarce resources. Generally, the courts sustained institutional actions.<sup>134</sup> Most cases (14) challenged whether decisions about reassignment of duties or reallocation of resources required procedural due process. Six arose over removals of department chairpersons.<sup>135</sup> Four dealt with allegations by faculty members that they were being "frozen out" of their positions through the allocation of various employment benefits, including salary and laboratory space.<sup>136</sup> Three cases questioned a department's authority to transfer faculty to different departments and to alter responsibilities.<sup>137</sup> Two challenged the authority of a chairperson to remove practice privileges, as distinguished from faculty status, from department members.<sup>138</sup>

The third group of twelve cases illustrates a range of common problems associated with the personal conduct and behavior of faculty. Four decisions addressed questions of an injury to the reputation of a faculty member or a former student: three cases involved letters of recommendation and one case involved student evaluations.<sup>139</sup> Two cases litigated allegations of sexual harassment by faculty against a graduate student and a secretary.<sup>140</sup> Patients who served as subjects for teaching in grand rounds charged invasion of privacy and malpractice in two cases.<sup>141</sup> A faculty member sued faculty colleagues who had negatively evaluated his performance during a hearing on license revocation.<sup>142</sup> A former protégé

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134. *Litigation Involving Medical Faculty*, *supra* note 2, at 14.

135. *Hindo v. University of Health Sciences*, 604 N.E.2d 463 (Ill. App. Ct. 1992); *Kapp v. Naughton*, No. 90-591E, 1900 WL 181179 (W.D.N.Y. 1990); *Spiegel v. University of S. Fla.*, 555 So. 2d 428 (Fla. Dist. Ct. App. 1989); *Vargas-Figueroa v. Saldana*, 826 F.2d 160 (1st Cir. 1987); *McLaurin v. Fischer*, 768 F.2d 98 (6th Cir. 1985); *Peacock v. Duval*, 694 F.2d 644 (9th Cir. 1982).

136. *Williams v. Northwestern Univ.*, 523 N.E.2d 1045 (Ill. App. Ct. 1988); *Williams v. Northwestern Univ.*, 497 N.E.2d 1226 (Ill. App. Ct. 1986); *Gertler v. Goodgold*, 487 N.Y.S.2d 565 (App. Div. 1985); *Sanders v. Duke Univ.*, 538 F. Supp. 1143 (D.N.C. 1982).

137. *Farkas v. Ross Lee*, 727 F. Supp. 1098 (W.D. Mich. 1989); *Gottlieb v. Tulane Univ.*, 809 F.2d 278 (5th Cir. 1987); *Stitzer v. University of P.R.*, 617 F. Supp. 1246 (D.P.R. 1985).

138. *McLaren v. Emory Univ.*, 705 F. Supp. 563 (N.D. Ga. 1988); *Dillard v. Rowland*, 520 S.W.2d 81 (Mo. Ct. App. 1974).

139. *Sophianopoulos v. McCormick*, 385 S.E.2d 682 (Ga. Ct. App. 1989); *Guntheroth v. Rodaway*, 727 P.2d 982 (Wash. 1986); *McDonald v. St. Joseph's Hosp., Inc.*, 574 F. Supp. 123 (N.D. Ga. 1983); *Scarpelli v. Jones*, 626 P.2d 785 (Kan. 1981).

140. *Leadbetter v. Rose*, 467 N.W.2d 431 (N.D. 1991); *Fuchilla v. Layman*, 537 A.2d 652 (N.J. 1988).

141. *Adams v. St. Elizabeth Hosp. Medical Ctr.*, No. 87-CA-180, 1989 WL 25561 (Ohio Ct. App. 1989); *Rainer v. Grossman*, 107 Cal. Rptr. 469 (Ct. App. 1973).

142. *Commission on Medical Discipline v. McDonnell*, 467 A.2d 1072 (Md. 1983).



sued to have her name removed from authorship of a course syllabus.<sup>143</sup> Faculty attempted to collect a fee for testimony given as an expert witness in a medical malpractice action.<sup>144</sup> Faculty also sought to force a medical school to comply with a state open meetings law in decisions on admissions.<sup>145</sup>

Nine cases distributed throughout the study period decided problems between medical faculty and the Veterans Administration (VA). The issues addressed primarily were related to the fairness of appointment, transfer, and retention practices.<sup>146</sup> Closer scrutiny of relationships between VA Medical Centers and affiliated medical schools appears to be on the policy agenda. Recent federal concern has focused on potential conflicts of interest where senior medical staff employed by the VA are also appointed and salaried on a part-time basis by affiliated medical schools that provide contract medical services to VA centers. In 1993, the General Accounting Office recommended enforcement of federal ethics requirements, which generally prohibit managers with dual appointments at both the VA and an affiliated medical school, to participate in the award or administration of VA contracts with that affiliated entity.<sup>147</sup>

A fifth group of eight cases decided disputes over employee benefits, and involved questions of employment law frequently litigated in state court. Four cases involved problems of disability or workmen's compensation and included two dealing with faculty injuries sustained at social events.<sup>148</sup> One resolved a dispute over TIAA benefits<sup>149</sup> and another,

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143. *Weissmann v. Freeman*, 868 F.2d 1313 (2d Cir. 1989).

144. *Epstein v. Wilder*, 596 F. Supp. 793 (N.D. Ill. 1984).

145. *Carl v. Board of Regents of Univ. of Okla.*, 577 P.2d 912 (Okla. 1978).

146. *National Ass'n of Veterans Admin. Physicians v. Derwinski*, No. 87-2302 1991 WL 120105 (D.D.C. 1991); *Woods v. Milner*, 760 F. Supp. 623 (E.D. Mich. 1991); *Lee v. Walters*, No. 85-5383, 1988 WL 105887 (E.D. Pa. 1988); *Balderman v. United States Veterans Admin.*, 666 F. Supp. 461 (W.D.N.Y. 1987); *Gilbert v. United States*, 10 Cl. Ct. 501 (1986); *Franks v. Nimmo*, 683 F.2d 1290 (10th Cir. 1982); *Claus v. Gyorkey*, 674 F.2d 427 (5th Cir. 1982); *Gilbert v. Johnson*, 601 F.2d 761 (5th Cir. 1979); *Kletschka v. Driver*, 411 F.2d 436 (2d Cir. 1969).

147. UNITED STATES GENERAL ACCOUNTING OFFICE, VA HEALTH CARE: INADEQUATE ENFORCEMENT OF FEDERAL ETHICS REQUIREMENTS AT VA MEDICAL CENTERS, SUPPLEMENT TO REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, COMMITTEE ON VETERANS' AFFAIRS, HOUSE OF REPRESENTATIVES (1993).

148. *Ginsberg v. Hontas*, 545 So. 2d 1154 (La. Ct. App. 1989); *Langer v. Monarch Life Ins. Co.*, 879 F.2d 75 (3d Cir. 1989); *Taterka v. Nationwide Mut. Ins. Co.*, 457 N.Y.S.2d 53 (App. Div. 1982); *Chilton v. Bowman Gray Sch. of Medicine*, 262 S.E.2d 347 (N.C. Ct. App. 1980).

149. *Frank v. Teachers Ins. & Annuity Ass'n*, 365 N.E.2d 28 (Ill. App. Ct. 1977).

sick leave provisions.<sup>150</sup> Two cases addressed benefit eligibility problems where faculty were employed by two systems: whether a faculty member could draw retirement benefits in one system while continuing to work in another,<sup>151</sup> and, how to reconcile dual eligibility for VA and university benefits.<sup>152</sup> The environment of employee benefits legislation, including enactment of ERISA and family leave legislation, has been dynamic and points to ongoing exposure to litigation in this area.

The remaining three categories of cases identified litigation of system-wide discrimination, collective bargaining, and a final case challenging a proposed reformulation of authority relationships in a foundation trust providing supplemental funds for medical education.<sup>153</sup> Three cases involved class action suits where a named plaintiff, representing medical faculty, alleged discrimination against all female faculty in a college, university, or university system. These cases are classified separately because each alleged a pattern and practice of system-wide discrimination in employment or pay, not a specific instance of individual discrimination.<sup>154</sup> The three collective bargaining cases included disputes over a non-physician faculty member in a college of medicine assigned to a bargaining unit composed of nonmedical rather than medical faculty,<sup>155</sup> disputes over whether establishment of a mandatory retirement age for faculty was subject to mandatory bargaining in contract negotiations,<sup>156</sup> and disputes over provisions for discovery of information relating to negotiations.<sup>157</sup>

While courts generally supported the exercise of administrative discretion and institutional decision making, procedures were closely examined. The complexity of administering a decentralized and loosely-coupled professional organization, characteristic of a university, limits the ability of administrators to coordinate procedures which are reliant on faculty for

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150. *Koffler v. Hahneman Univ.*, 1986 WL 7841 (E.D. Pa. 1986).

151. *Robinson v. New York State Employee's Retirement Sys.*, 386 N.E.2d 253 (N.Y. 1978).

152. *Weisman v. Blue Shield*, 209 Cal. Rptr. 169 (Ct. App. 1984).

153. *Foye v. New York Univ.*, 269 A.2d 63 (Del. 1970).

154. *Sobel v. Yeshiva Univ.*, 839 F.2d 18 (2d Cir. 1988); *Penk v. Oregon St. Bd. of Higher Educ.*, No. Civ. A. 80-436 FR, 1985 WL 25631 (D. Or. Feb. 13, 1985); *Mothan v. Temple Univ. of the Commonwealth System of Higher Educ.*, 83 F.R.D. 368 (D. Pa. 1979).

155. *Leapley v. Board of Regents, Fla. State Univ. Sys.*, 463 So. 2d 431 (Fla. Dist. Ct. App. 1982).

156. *University of Medicine and Dentistry of N.J. v. American Ass'n of Univ. Professors*, 538 A.2d 840 (N.J. Super. Ct. App. Div. 1988).

157. *University of S. Fla. Coll. of Medicine Faculty Ass'n v. Public Employ. Relations Comm'n.* 338 So. 2d 1286 (Fla. Dist. Ct. App. 1976).

implementation and challenges their ability to ensure administrative and procedural consistency. The nature of most faculty work, independent, specialized, and protected from day-to-day administrative concerns, renders achievement of a degree of organizational consensus, cohesion, and cooperation difficult. Risks of litigation in such environments may be increased where faculty have authority to recommend advancement and retention for colleagues.

#### *F. Faculty: Clinical Affairs*

The clinical faculty of medical schools have traditionally has combined patient care with the teaching of undergraduate and graduate medical students. In recent years this task has been carried out in an increasingly complex environment characterized by escalating costs, competition, state and federal regulation, malpractice litigation, greater dependence on practice revenues, and changing practice arrangements and reimbursement mechanisms. During this period, income from medical services provided by clinical faculty grew from 6% to 46.6% of the budget for medical schools.<sup>158</sup> TABLE 7 reflects a categorization of issues precipitating reported litigation over the study period.

Malpractice cases were generally not included in this study because of the difficulty of systematically identifying the faculty status of physicians within the facts of reported decisions. However, a quantitatively and legally important subgroup of this body of tort litigation relating only to issues of individual or institutional liability under the legal doctrines of sovereign or governmental immunity was included. These cases dealt with whether a public institution, as an arm of the state, can be sued and how the state's cloak of immunity extends to faculty members practicing medicine at state owned academic medicine centers.

Although many states have restricted the liability of state institutions and/or their employees for negligence in many instances during the last twenty years,<sup>159</sup> litigation on this topic has not been deterred. An example is Michigan's experience in generating four reported cases since 1986.<sup>160</sup> In overruling a 1979 decision that the operation of a state-supported general hospital was not a governmental function within the state

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158. Jack Krakower, *U.S. Medical School Finances*, 270 JAMA 1087 (1993).

159. Rich, *supra* note 97, at 166.

160. *Joplin v. University of Mich. Bd. of Regents*, 459 N.W.2d 70 (Mich. Ct. App. 1990). *Stein v. Southeastern Mich. Family Planning Project*, 438 N.W.2d 76 (Mich. 1989); *In re Ritter v. University of Mich. Bd. of Regents*, 851 F.2d 846 (6th Cir. 1988); *Hyde v. University of Mich. Bd. of Regents*, 393 N.W.2d 847 (Mich. 1986).

tort claims statute,<sup>161</sup> the Michigan Supreme Court first extended the shield of state sovereign immunity to state supported hospitals, then fine tuned its applicability and tested its effect. Oklahoma, Kentucky, and Virginia provide examples of other states moving toward limiting immunity.<sup>162</sup>

Other aspects of the doctrine of sovereign immunity which were litigated included: whether municipally-owned teaching hospitals affiliated with medical schools were immune under distinctions arising in the law between institutions operated by state and by local governmental entities;<sup>163</sup> whether the purchase of malpractice insurance by state institutions constituted evidence of an intent to waive immunity;<sup>164</sup> whether federal or state immunity statutes applied to the VA and cooperating medical schools;<sup>165</sup> whether sovereign immunity was limited to the institution or extended to its employees;<sup>166</sup> whether medical faculty exercised discretionary authority in its practice and was thus covered under immunity protective of state officials in policy-making functions, as opposed to being classified as employee/agents in their relationships to patients;<sup>167</sup> and, whether medical faculty members were employees or independent contractors under the practice plan operating within the institution.<sup>168</sup> These opinions begin to illustrate the tangled web of relationships which structure the setting for the delivery of patient care in publicly supported academic medicine settings.

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161. *Parker v. City of Highland Park*, 273 N.W.2d 413 (Mich. 1978).

162. *Klein v. Boyle*, 776 F. Supp. 285 (W.D. Va. 1991); *Nickell v. Westervelt*, 354 F. Supp. 111 (W.D. Va. 1973); *University of Louisville v. O'Bannon*, 770 S.W.2d 215 (Ky. 1989); *Gould v. O'Bannon*, 770 S.W.2d 220 (Ky. 1989); *Blue v. Pursell*, 793 S.W.2d 823 (Ky. Ct. App. 1990); *Fox v. Oklahoma Memorial Hosp.*, 774 P.2d 459 (Okla. 1989); *Hershel v. University Hosp. Found.*, 610 P.2d 237 (Okla. 1980); *James v. Jane*, 282 S.E.2d 864 (Va. 1980).

163. *Hyde v. City of Lakewood*, 207 N.E.2d 547 (Ohio 1965); *Holt v. City of Cincinnati*, 212 N.E.2d 630 (Ohio Ct. App. 1964), *appealed in*, *Hyde v. City of Lakewood*, 207 N.E.2d 547 (Ohio 1965).

164. *Curtis v. Board of Regents of the Univ. Sys. of Ga.*, 416 S.E.2d 510 (Ga. 1992); *Board of Regents v. Tyson*, 404 S.E.2d 557 (Ga. 1991); *McGaha v. Board of Regents of Univ. of Okla.*, 691 P.2d 895 (Okla. 1984).

165. *Lurch v. United States*, 719 F.2d 333 (7th Cir. 1983), *cert. denied*, 466 U.S. 927 (1984); *Quilico v. Kaplan*, 749 F.2d 480 (7th Cir. 1984).

166. *Nickell v. Westervelt*, 354 F. Supp. 111 (W.D. Va. 1973); *Stein v. Regents of the Univ. of Minn.*, 282 N.W.2d 552 (Minn. 1979).

167. *Martin v. Drylie*, 560 So. 2d 1285 (Fla. Dist. Ct. App. 1990); *Jaar v. University of Miami*, 474 So. 2d 239 (Fla. Dist. Ct. App. 1985), *reh'g denied*, 484 So. 2d 10 (Fla. 1986); *Smith v. Steinberg*, 481 N.E.2d 1344 (Mass. 1985).

168. *Rivera v. Hospital Universitario*, 762 F. Supp. 15 (D.P.R. 1991); *James v. Jane*, 282 S.E.2d 864 (Va. 1980); *Carroll v. Kittle*, 457 P.2d 21 (Kan. 1969).

A second group of twenty seven cases, twenty of which were reported since 1980, reflect the complexities of organizing practice plans for clinical faculty in the current health care environment. Most cases involved finances. In suits involving plans, faculty members failed in challenging limits or constraints imposed on their income from practice.<sup>169</sup> Eight cases involved objections by practice plans to third-party reimbursement formulas for services provided by clinical faculty.<sup>170</sup> Most grew out of amendments to the statutory provisions relating to Medicare payment for services rendered by provider-based physicians in the Tax Equity and Fiscal Responsibility Act of 1982, which required distinctions between charges personally rendered to patients under Part B of Medicare and those which benefit patients generally and are reimbursed on a reasonable cost basis under Part A.<sup>171</sup>

Tax questions, including property tax exemptions for buildings provided to faculty for clinical practice and assessment of local income taxes, constituted another cluster of practice plan cases.<sup>172</sup> These cases illustrate a growing range of tax related issues. For example, in a decision since challenged by the Internal Revenue Service, the not-for-profit exemption a university derived from procedures performed on patients used in teaching was extended to income generated by diagnostic procedures performed on the private patients of faculty members operating

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169. *Zitelli v. Dermatology Educ. and Research Found.*, 597 A.2d 1173 (Pa. Super. Ct. 1991), *aff'd in part, vacated in part*, 633 A.2d 134 (Pa. 1993); *Albany Medical College v. McShane*, 499 N.Y.S.2d 376 (1985); *Adamsons v. Wharton*, 771 F.2d 41 (2d Cir. 1985); *Kountz v. State Univ. of N.Y.*, 437 N.Y.S.2d 868 (Sup. Ct. 1981), *aff'd*, 450 N.Y.S.2d 416 (App. Div. 1983); *Gross v. University of Tenn.*, 620 F.2d 109 (6th Cir. 1980); *Kovachevich v. University of Louisville*, 597 S.W. 2d 621 (Ky. Ct. App. 1980).

170. *Ohio State Univ. v. Sullivan*, 777 F. Supp. 582 (S.D. Ohio 1991), *aff'd*, 966 F.2d 112 (6th Cir. 1983), *vacated by*, *Shalala v. Ohio State*, 114 S. Ct. 2731 (1994); *Loyola Univ. of Chicago v. Bowen*, 905 F.2d 1061 (7th Cir. 1990); *Louisiana Dep't of Health and Human Resources v. Bowen*, Civ. A. No. 87-1330, 1988 WL 93430 (D.D.C. Aug. 22, 1988); *Oregon on Behalf of the Oregon Health Sciences Univ. v. Bowen*, 854 F.2d 346 (9th Cir. 1988); *Temple Univ. v. Commonwealth of Pa., Dep't of Public Welfare*, 521 A.2d 986 (Pa. Commw. Ct. 1987); *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976); *Shapira v. United Medical Serv., Inc.*, 257 N.Y.S.2d 150 (1965); *Scheinberg v. United Medical Serv., Inc.*, 246 N.Y.S.2d 512 (Sup. Ct. 1964), *aff'd*, *Shapira v. United Medical Serv., Inc.*, 257 N.Y.S.2d 150 (1965).

171. See Carl Hitchner, *Medicare and Medicaid Reimbursement of Teaching Hospitals and Faculty Physicians*, 10 J.C. & U.L. 85 (1983).

172. *Laird v. Board of Trustees of Inst. of Higher Learning*, 721 F.2d 529 (5th Cir. 1983); *Barnes Hosp. v. Leggett*, 589 S.W.2d 241 (Mo. 1979); *Medical Ctr. Hosp. of Vt., Inc. v. City of Burlington*, 303 A.2d 468 (Vt. 1973).

under the same practice plan.<sup>173</sup>

Antitrust litigation has not historically been an area of concern for academic medicine because of its focus on regulating commercial activities. Nonprofit status alone, however, does not confer immunity from antitrust law on a practice plan.<sup>174</sup> Restraints on professional activities and on public service are now viewed as violations of the antitrust laws. Practice plans were sustained in antitrust actions seeking to add optometrists to an ophthalmological group,<sup>175</sup> and seeking to compel Blue Cross to rescind an action removing preferred provider status.<sup>176</sup> However, a challenge to a plan that regulated fees charged to patients by physician members who conducted their own private practice in campus facilities was permitted to proceed after a court found a sufficient nexus with interstate commerce.<sup>177</sup>

Faculty members involved in individual disputes arising from their roles as members of practice plans were generally less successful. Faculty lost in individual efforts to recoup fees from third parties.<sup>178</sup> Faculty also lost in failing to report outside practice income as opposed to salary earned through teaching.<sup>179</sup> Faculty prevailed when a city imposed an income-based licensing fee on faculty salary derived from clinical practice.<sup>180</sup> The outcome was unclear in one case where a faculty member sued a department chairperson when there was an appearance of bribery in awarding privileges and facilities to faculty.<sup>181</sup>

Twenty-two cases involved disputes over denial or removal of staff privileges permitting clinical faculty the right to care for patients. All but one of these cases have been reported since 1980. Institutional decisions were sustained in all but three. Under federal law, these claims centered

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173. *St. Luke's Hosp. of Kansas City v. United States*, 494 F. Supp. 85, 92-93 (W.D. Mo. 1980); *Internal Revenue Service*, 1985-2 C.B. 85-110.

174. Wendy Kirby, *Federal Antitrust Issues Affecting Institutions of Higher Education: An Overview*, 11 J.C. & U.L. 345 (1984).

175. *Southern College of Optometry v. Tennessee Acad. of Ophthalmology, Inc.*, 1989 WL 105635 (Tenn. Ct. App. 1989).

176. *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 663 F. Supp. 1360 (D. Kan. 1987).

177. *Tarleton v. Meharry Medical Coll.*, 717 F.2d 1523 (6th Cir. 1983).

178. *Parsa v. State*, 485 N.Y.S.2d 27 (1984); *Shapira v. United Medical Serv., Inc.*, 257 N.Y.S.2d 150 (1965); *Scheinberg v. United Medical Serv., Inc.*, 246 N.Y.S.2d 512 (App. Div. 1964).

179. *United States v. Lillehei*, 357 F. Supp. 718 (D. Minn. 1973).

180. *City of Richmond v. Boshier*, 89 S.E.2d 36 (Va. 1955).

181. *Cooperman v. University Surgical Ass'n, Inc.*, 513 N.E.2d 288 (Ohio 1987).

on allegations of antitrust violations,<sup>182</sup> discrimination based on race,<sup>183</sup> sex<sup>184</sup> and age,<sup>185</sup> and restrictions on rights of due process<sup>186</sup> and speech.<sup>187</sup> State decisions addressed more complex issues: interpreting contracts containing a noncompetition clause limiting any subsequent practice of medicine in the region;<sup>188</sup> granting faculty status to clinical physicians;<sup>189</sup> and, terminating the services of a pathologist and any income from the practice plan while preserving his faculty status.<sup>190</sup> Two cases decided whether the duty of a physician to provide the best possible care for patients overrode denial of access to hospital facilities and privileges.<sup>191</sup>

Of the remaining categories in TABLE 7, eleven cases involved teaching hospitals. These cases reflect only a small portion of the litigation involving teaching hospitals, but were included because the decisions discussed medical faculty in some way. The decisions addressed problems encountered in reorganization,<sup>192</sup> merger,<sup>193</sup> transfer of ownership,<sup>194</sup> and in complying with certificate of need regulations governing the purchase of advanced technology,<sup>195</sup> compliance with state and local tax laws,<sup>196</sup> and

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182. *Nurse Midwifery Assoc. v. Hibbett*, 918 F.2d 829 (6th Cir. 1990), *cert. denied*, 112 S. Ct. 406 (1991); *Malini v. Singleton and Assoc.* No. Civ. A. H-78-1870, 1988 WL 126562 (S.D. Tex. Sept. 9, 1988); *Humana of Ill. v. Board of Trustees of S. Ill. Univ.*, 1986 WL 962 (C.D. Ill. 1986); *Feldman v. Jackson Memorial Hosp.*, 571 F. Supp. 1000 (D. Fla. 1983); *Tarleton v. Meharry Medical College*, 717 F.2d 1523 (6th Cir. 1983).

183. *Alcena v. Raine*, 692 F. Supp. 261 (S.D.N.Y. 1988); *Beverly v. Douglas*, 591 F. Supp. 1321 (S.D.N.Y. 1984).

184. *Joshi v. Florida State Univ. Health Ctr.*, 763 F.2d 1227 (11th Cir. 1985).

185. *Manoharan v. Columbia Univ. College of Phys. & Surgeons*, 842 F.2d 590 (2d Cir. 1988).

186. *Darlak v. Bobear*, 814 F.2d 1055 (5th Cir. 1987); *Yashon v. Hunt*, 825 F.2d 1016 (6th Cir. 1987), *cert. denied*, 496 U.S. 1032 (1988); *Elbaor v. Grand Prairie Hosp. Auth.*, 599 F. Supp. 1111 (D. Tex. 1984), *vacated*, 788 F.2d 1563 (5th Cir. 1986).

187. *Daly v. Sprague*, 742 F.2d 896 (5th Cir. 1984).

188. *St. Louis Univ. v. Cantor*, 720 S.W.2d 382 (Mo. Ct. App. 1986).

189. *Gleicher, Friberg & Associates v. University of Health Sciences, The Chicago Medical School*, 586 N.E.2d 418 (Ill. App. Ct. 1991); *Press v. Howard Univ.*, 540 A.2d 733 (D.C. 1988); *Susmano v. Associated Internists of Chicago, Ltd.*, 422 N.E.2d 879 (Ill. App. Ct. 1981).

190. *Sisters of St. Mary v. Blair*, 766 S.W.2d 773 (Mo. Ct. App. 1989).

191. *Brindisi v. Univ. Hosp.*, 516 N.Y.S.2d 745 (App. Div. 1987); *Maltz v. New York Univ. Medical Ctr.*, 503 N.Y.S.2d 570 (App. Div. 1986).

192. *In re Hitchcock Clinic, Inc.*, 499 A.2d 974 (N.H. 1985).

193. *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D. Va.), *aff'd*, 892 F.2d 1042 (4th Cir. 1989); *Jackson v. Conway*, 476 F. Supp. 896 (E.D. Mo. 1979), *aff'd*, 620 F.2d 680 (8th Cir. 1980).

194. *Kromko v. Arizona Bd. of Regents*, 718 P.2d 478 (Ariz. 1986).

195. *Harrisburg Hosp. v. Thornburg*, 616 F. Supp. 699 (M.D. Pa. 1985), *aff'd*, 791 F.2d 918 (3d Cir. 1986); *University of Ala. Hospitals v. Alabama Renal Stone Inst.*, 518 So. 2d

compliance with zoning and rent control laws.<sup>197</sup>

A group of nine cases reported disputes over indemnification or responsibility for payment once liability had been determined. The complexity of existing practices for managing liability is revealed in decisions which focus primarily on reviewing very specific contractual provisions for apportioning fiscal responsibility for liability. For example, insurers were responsible for expenses incurred by a dean in defending an anti-trust action arising in a denial of privileges case,<sup>198</sup> and for settlement in a case where a faculty member had inadvertently practiced medicine with a lapsed license.<sup>199</sup> However, in two cases, states, rather than insurers, were responsible for legal expenses incurred by faculty determined to be state employees, rather than independent contractors, practicing medicine.<sup>200</sup> Finally, it was not clear whether a state, as employer, would be required to indemnify a faculty member who lost his claim that sexual relations with patients was a legitimate form of therapy.<sup>201</sup>

In 1986, Congress enacted legislation, the Health Care Quality Improvement Act (HCQIA)<sup>202</sup> which went into effect in 1990 and responded to a spate of litigation by immunizing good faith peer review activities from liability under certain conditions. Seven cases, all reported in the 1980s before the effective date of HCQIA, reflect the volatile nature of determining access to peer review or other records maintained by hospitals, practice plans, or universities.<sup>203</sup> These cases focused on the

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721 (Ala. Civ. App. 1987); *Condell Hosp. v. Illinois Health Facilities Planning Bd.*, 530 N.E.2d 217 (Ill. 1988).

196. *Pennsylvania Ass'n of St. Mental Hosp. Physicians v. Commonwealth*, 437 A.2d 1297 (Pa. Commw. Ct. 1981); *English v. Alameda County*, 138 Cal. Rptr. 634 (Ct. App. 1977).

197. *Draude v. District of Columbia Bd. of Zoning Adjustment*, 582 A.2d 949 (D.C. App. 1990); *Mount Sinai Hosp. v. Loutsch*, 462 N.Y.S.2d 1004 (Civ. Ct. 1983).

198. *Board of Trustees of Univ. of Ill. v. Insurance Corp.*, 969 F.2d 329 (7th Cir. 1992); *Insurance Corp. of Ireland v. Board of Trustees of S. Ill.*, 937 F.2d 331 (7th Cir. 1991).

199. *Blue Cross of Ga./Atlanta, Inc. v. Grenwald*, 251 S.E.2d 585 (Ga. Ct. App. 1978).

200. *Frontier Ins. Co. v. State*, 576 N.Y.S.2d 622 (App. Div. 1991); *Utterback v. United States*, 668 F. Supp. 602 (N.D. Ky. 1987).

201. *Olson v. Connerly*, 457 N.W.2d 479 (Wis. 1990).

202. 42 U.S.C. §§ 11101-11152 (1988). For a detailed overview of the law framing passage of this act, see Janet Miller Rowland, *Enforcing Hospital Responsibility Through Self-Evaluation and Review Committee Confidentiality*, 9 J. LEGAL MED. 377 (1988).

203. *Stone v. University of Md. Medical System Corp.*, 948 F.2d 128 (4th Cir. 1991); *Hurst v. Creasman*, No. C-88-345-D, 1989 WL 151660 (M.D.N.C. 1989); *Emory Clinic v. Houston*, 369 S.E.2d 913 (Ga. 1988); *Dennie v. University of Pittsburgh Sch. of Medicine*, 638 F. Supp. 1005 (W.D. Pa. 1986); *University of Tex. Health Science Ctr. at San Antonio v. Jordan*, 686 S.W.2d 652 (Tex. Ct. App. 1985); *Jenkins v. Wu*, 468 N.E.2d 1162 (Ill. 1984); *Mason v. Robinson*, 340 N.W.2d 236 (Iowa 1983).



legal issues of access to materials to be employed in litigation dealing primarily with malpractice. Institutions had some success in protecting peer review and quality assurance records from discovery,<sup>204</sup> but not once these materials are held by a court.<sup>205</sup> A medical school was denied access to a faculty member's peer review records held by the faculty practice plan when the legal relationship between the two entities was at issue.<sup>206</sup> However, in another case, the promotion and tenure records of clinical faculty members were discoverable in a malpractice action.<sup>207</sup> HCQIA provisions mandating reporting of state licensure actions, malpractice payments, and professional review actions to a National Practitioner Data Bank may further accelerate litigation in this contentious area.

Seven cases arose out of faculty member conduct in clinical roles. Institutions successfully defended challenges to policies restricting abortions performed by the university medical center<sup>208</sup> and providing services to patients with disabilities,<sup>209</sup> as well as to a claim that faculty members were not referring patients to plaintiff's home health care agency.<sup>210</sup> However, a university lost a suit by a faculty member challenging a prohibition on moonlighting by staff.<sup>211</sup> Faculty members were involved in personal suits for defamation brought by staff nurses claiming injury for adverse performance evaluations.<sup>212</sup> In one case, a faculty member psychiatrist prevented a state licensing board from obtaining records of his prescriptions of controlled substances to patients.<sup>213</sup> In a final case, separately categorized, university faculty members succeeded in disqualifying a plaintiff's attorney in a malpractice action where the attorney was previously employed by the hospital.<sup>214</sup>

Litigation related to clinical affairs, and to the growing importance of medical services plans in sustaining medical education, increased most

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204. *University of Tex. Health Science Ctr. at San Antonio*, 686 S.W.2d at 652; *Jenkins*, 468 N.E.2d at 1162.

205. *Stone*, 948 F.2d at 128.

206. *Emory Clinic*, 369 S.E.2d at 913.

207. *Hurst*, 1989 WL at 151660.

208. *Orr v. Koefoot*, 377 F. Supp. 673 (D. Neb. 1974).

209. *United States v. Baylor Univ. Medical Ctr.*, 711 F.2d 38 (5th Cir. 1983), *cert. denied*, 469 U.S. 1189 (1985).

210. *Home Health Care Servs., Inc. v. Currie*, 706 F.2d 497 (4th Cir. 1983).

211. *Graf v. West Virginia Univ.*, 429 S.E.2d 496 (W. Va. 1992).

212. *Watson v. McClelland*, 563 N.Y.S.2d 400 (App. Div. 1990); *Woods v. Helmi*, 758 S.W.2d 219 (Tenn. Ct. App. 1988).

213. *Lieb v. Department of Health Servs.*, 542 A.2d 741 (Conn. App. Ct. 1988).

214. *Graf v. Frane*, 352 S.E.2d 31 (W. Va. 1986).

dramatically in recent years. These cases may reflect the complexity of the existing academic health care system and environment. Exposure to litigation would appear to respond, in large part, to two factors: the growth and redistribution of the fiscal base of medical education, and the regulatory environment in which the health care industry functions. The fact that decisions made by academic program administrators are widely sustained when litigated must be tempered by the observation that such results have little deterrent in decreasing litigation.

### *G. Faculty: Research Issues*

Although only a small portion of the total number of cases involve medical school faculty, litigation associated with biomedical research is growing. This observation belies a recent statement that “[a]lthough the conduct of research has been the subject of attention by regulatory and research bodies throughout North America, there are very few reported legal judgments dealing with these questions.”<sup>215</sup> Chronological data point to recent growth in litigation associated with research in medical schools. Such litigation may be associated with the changing regulatory and economic environment which saw national expenditures for biomedical and behavioral research increase more than eight-fold since 1965, although total health care expenditures increased twelve-fold over the same period.<sup>216</sup> The result has been a net decline from 4.8% in 1965 to 3.1% in 1987 in the proportion of total health care expenditures devoted to research.<sup>217</sup> This may be misleading, however, in that spending for health care has risen dramatically, both in total and as a proportion of the national budget. Federal expenditures, primarily for research conducted by academic institutions, have grown at an average annual rate of 5.4% since 1981-1982 when factoring in funding both for grants and contracts and indirect cost recovery.<sup>218</sup> In 1991-1992, federal funding for medical school research accounted for 19.3% of total revenues compared with 21.4% in 1981-1982.<sup>219</sup>

Seven general categories of disputes are identified in TABLE 8. Three of these accounted for more than half the reported cases: grants, person-

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215. Benjamin Freedman & Kathleen Cranley Glass, *Weiss v. Soloman: A Case Study in Institutional Responsibility for Clinical Research*, 18 L. MED. & HEALTH CARE 395 (Winter 1990).

216. AAMC, *supra* note 48, at 25.

217. *Id.*

218. Krakower, *supra* note 158, at 1089.

219. *Id.*

nel management, and the risks encountered first in conducting research and then later in its translation to commercial form. Among the disputes over the management of research grants and personnel, there appears to be substantial leeway accorded to grant administrators in defining the terms of employment and performance standards. Three cases addressed the issue of the employment status of personnel responsible for, or salaried by, research grants;<sup>220</sup> one case concerned alleged sex discrimination during a reduction in staff at the termination of funding.<sup>221</sup> The remaining cases illustrate a range of potential problems. A faculty member successfully challenged the Drug Enforcement Agency's action of placing a drug employed in an ongoing research project on its controlled substance list;<sup>222</sup> while a university prevailed in an indemnification dispute over liability for defamation between two researchers.<sup>223</sup> Further fact finding was required in cases dealing with a Ph.D.'s role in treating patients,<sup>224</sup> and with a claim that a faculty member's actions in committing a research technician for mental illness prior to firing him constituted false imprisonment.<sup>225</sup>

Issues associated with research were the focus of litigation in a second group of nine cases. These included issues addressing the application of a statute of limitations when prisoners in a research study claimed injuries;<sup>226</sup> the rights of a study participant to continued treatment for AIDS with a drug proven unsuccessful in a research trial;<sup>227</sup> mishaps during the actual research project;<sup>228</sup> and, failure to provide informed consent to participate in a research study when quinidine, a drug approved only for the treatment of arrhythmia, was given as a substitute to two children

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220. *Chiriboga v. Saldana*, 660 F. Supp. 618 (D.P.R. 1987); *Ghosh v. New York Univ. Medical Ctr.*, 576 F. Supp. 86 (S.D.N.Y. 1983); *Wahba v. New York Univ.*, 371 F. Supp. 567 (S.D.N.Y. 1973), *aff'd*, 492 F.2d 96 (2d Cir.), *cert. denied*, 419 U.S. 874 (1974).

221. *Faro v. New York Univ.*, No. 73 Civ. 3769, 1973 WL 238 (S.D.N.Y. Nov. 9, 1973), *aff'd*, 502 F.2d 1229 (2d Cir. 1974).

222. *Grinspoon v. Drug Enforcement Admin.*, 828 F.2d 881 (1st Cir. 1987).

223. *St. Paul Mercury Ins. Co. v. Duke Univ.*, 670 F. Supp. 630 (M.D.N.C. 1987), *aff'd in part, rev'd in part*, 849 F.2d 133 (4th Cir. 1988).

224. *Boone v. Sidney Schulman and New York Medical College*, No. 83 Civ. 4960 (E.W.), 1984 WL 911 (S.D.N.Y. Sept. 28, 1984).

225. *Kwan-Sa You v. Roe*, 387 S.E.2d 188 (N.C. Ct. App. 1990).

226. *Scott v. Casey*, 562 F. Supp. 475 (N.D. Ga. 1983).

227. *DeVito v. HEM, Inc.*, 705 F. Supp. 1076 (M.D. Pa. 1988).

228. *University of Miami Medical School v. Singleton*, 582 So. 2d 1182 (Fla. Dist. Ct. App. 1990); *Rabelo v. Board of Trustees of Temple Univ.*, Civ. A. No. 86-5476, 1988 WL 76127 (E.D. Pa. July 18, 1988); *Kelman v. University of Chicago*, 519 N.E.2d 708 (Ill. App. Ct. 1988).

seriously ill with malaria when no quinine was available.<sup>229</sup> Universities lost claims seeking discovery of a university's registry of cancer patients previously exposed to diethylstilbestrol (DES),<sup>230</sup> and requiring a university to provide an environmental impact statement for a proposed biological research facility.<sup>231</sup> Another case involving DES was remanded for evaluation of the adequacy of informed consent obtained from participants in drug trials.<sup>232</sup>

In 1981, two federal statutes, the Uniform Federal Patent Policy Act and the Economic Recovery Tax Act were enacted and contained provisions designed to encourage the transfer of technologies and research from universities to the commercial sector, as well as to enhance cooperation between these two sectors.<sup>233</sup> Universities were given ownership rights in patents arising from federal research funding. Reform of the tax code added other incentives, such as liberal contribution rules for scientific equipment and a tax credit to industry for expenditures to carry out university research.

The restructuring of incentives connected with research conducted in universities may increase the likelihood of litigation. Eight of the nine cases in the research commercialization category have been reported since 1985, and reflect the complexity of these evolving relationships between researchers, institutions, and vendors. In one case, a university faculty member successfully withstood a claim for fraud and conversion in developing a patented cell line to produce lymphokines from a leukemia patient's T-lymphocytes.<sup>234</sup> However, the faculty member was found to have potentially breached the doctor-patient privilege. Issues raised in other cases included the tracing of patent rights licensed by a university to a commercial vendor serving as a broker to multiple markets;<sup>235</sup> rights to require specific performance by a private vendor to develop and mar-

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229. *Osei-Afriyie v. Medical Coll. of Pa.*, 937 F.2d 876 (3d Cir. 1991).

230. *Deitchman v. E.R. Squibb & Sons, Inc.*, 740 F.2d 556 (7th Cir. 1984).

231. *Laurel Heights Imp. Ass'n of San Francisco, Inc. v. Regents of Univ. of Cal.*, 238 Cal. Rptr. 451 (Ct. App. 1987); *superseding* 742 P.2d 780 (Cal. 1987); *aff'd in part, rev'd in part*, 764 P.2d 278 (Cal. 1988).

232. *Wetherill v. University of Chicago*, 565 F. Supp. 1553 (D.C. Ill. 1983).

233. For a discussion of the impact of these provisions on postsecondary institutions, see Consuelo L. Kertz & James K. Hasson, *Universities and Development Activities: The Federal Income Tax Consequences of Research Contracts, Research Subsidies, and Joint Ventures*, 13 J.C. & U.L. 109 (1986).

234. *Moore v. Regents of the Univ. of Cal.*, 271 Cal. Rptr. 146 (1990), *cert. denied*, 499 U.S. 936 (1991).

235. *Millipore Corp. v. University Patents, Inc.*, 682 F. Supp. 227 (D. Del. 1987).

ket a university product;<sup>236</sup> rights to organize markets for university products in light of the antitrust laws;<sup>237</sup> ownership of rights to research produced by a faculty member over a career spent in several universities;<sup>238</sup> and, preservation of rights from interference by international competitors.<sup>239</sup> In addition to institutional interests in deriving commercial benefit from research performed by faculty, individual researchers have segregable personal interests in the applications of their work. In one case, a faculty member negotiated directly with a products development agent and prevailed in a contractual dispute over his rights to disseminate independently information about his invention.<sup>240</sup>

Issues of ethics and the use of animals in research comprise the next two most frequently litigated categories of cases. Both respond in part to recent policy and regulatory initiatives as well as to media attention. In 1989, the Association of Medical Colleges drafted a statement on misconduct in medical research.<sup>241</sup> In 1988, the Association of American Universities had issued a similar framework focusing on research fraud in general.<sup>242</sup> Since 1987, the federal government also has required universities to have procedures for investigating scientific misconduct.<sup>243</sup>

The federal government has exercised greater scrutiny through enhanced administrative oversight. This activity is reflected in a recent decision allowing discovery in a fraud case involving the National Institutes of Health (NIH) grants to the University of Texas,<sup>244</sup> as well as invalidation of NIH rulemaking procedures for investigating scientific fraud.<sup>245</sup> Other litigation dealt primarily with challenges to an institution's internal handling of allegations of misconduct, including charges of misconduct by one faculty member against a former faculty member.<sup>246</sup> Another case

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236. *Regents of the Univ. of Minn. v. Medical, Inc.*, 405 N.W.2d 474 (Minn. Ct. App. 1987).

237. *Pharmaceutical Diagnostic Services, Inc. v. University of Utah*, 801 F. Supp. 508 (D. Utah 1990).

238. *University Patents, Inc. v. Kligman*, 1991 WL 64652 (E.D. Pa. 1991).

239. *Griffith v. Kanamaru*, 816 F.2d 624 (D.C. Cir. 1987).

240. *Crainich v. Feinstein*, No. 91-C 4045, 1991 WL 259448 (N.D. Ill., Dec. 3, 1991).

241. ASSOCIATION OF AM. MEDICAL COLLEGES, *FRAMEWORK FOR INSTITUTIONAL POLICIES AND PROCEDURES TO DEAL WITH MISCONDUCT IN RESEARCH* (1989).

242. ASSOCIATION OF AM. UNIV., *FRAMEWORK FOR INSTITUTIONAL POLICIES TO DEAL WITH FRAUD IN RESEARCH* (1988).

243. *Misconduct in Science and Engineering Research*, 52 Fed. Reg. 24,466 (1987) (codified as amended at 45 C.F.R. § 689 (1993)).

244. *United States ex. rel. v. University of Tex. M.D. Anderson Cancer Ctr.*, 961 F.2d 46 (4th Cir. 1992).

245. *Abbs v. Sullivan*, 963 F.2d 918 (7th Cir. 1992).

246. *Dong v. Board of Trustees of Leland Stanford Junior Univ.*, 236 Cal. Rptr. 912

concerned institutional liability for a faculty member's violation of the patient-physician privilege.<sup>247</sup> Violations of ethical requirements may also provide a cause of action in libel for faculty in claims against third parties.<sup>248</sup>

Litigation arising out of the treatment of animals used in research forms another group of seven cases, responding to specific statutory requirements as well as to constituencies with a defined political agenda. Six of the cases have been reported since 1990. Federal legislation enacted in 1966, and since amended, provides guidelines for the care of animals used in research by institutions with federal funding.<sup>249</sup> In addition, state public records and open meetings laws provide access to information about the use and care of animals in research. Together, these mandates provide the legal basis for recent decisions in this area. Most litigation has been brought by student or public interest groups organized around the issue of animal rights. All ask either for discovery of institutional records or for participation in institutional meetings where issues of animal use and care are discussed.<sup>250</sup> Results are mixed and depend on state law provisions.

Six cases decided disputes over the funding of research. Three cases involved institutions and three involved faculty as plaintiffs. Five cases challenged actions of the federal government in awarding or administering grants including the rights of a faculty member to obtain information

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(1987), *cert. denied*, 484 U.S. 1019 (1988); Board of Trustees of Leland Stanford Junior Univ. v. Superior Court of Santa Clara County, 174 Cal. Rptr. 160 (1981).

247. *Anderson v. Strong Memorial Hosp.*, 531 N.Y.S.2d 735 (Sup. Ct. 1988), *aff'd*, 542 N.Y.S.2d 96 (App. Div. 1989).

248. *Immuno A.G. v. Moor-Jankowski*, 566 N.Y.S.2d 906 (App. Div.), *cert. denied*, 500 U.S. 954 (1991); *Rinsley v. Brandt*, 446 F. Supp. 850 (D. Kan. 1977).

249. Initial legislation was first passed in 1966, Pub. L. No. 89-544, 80 Stat. 350 (1966), and was amended in 1970, Pub. L. No. 91-579, 84 Stat. 1560 (1970); in 1976, Pub. L. No. 94-279, 90 Stat. 417 (1976), and in 1985, Pub. L. No. 99-158, 495, 99 Stat. 875 (1985); Pub. L. No. 99-198, §§1751-1759, 99 Stat. 1645 (1985). For an overview of these laws as applied to the setting of medical research see B.T. BENNETT ET. AL., *ESSENTIALS FOR ANIMAL RESEARCH, A PRIMER FOR RESEARCH PERSONNEL* (1990); *INSTITUTE OF MEDICINE, USE OF LABORATORY ANIMALS IN BIOMEDICAL AND BEHAVIORAL RESEARCH* (1988).

250. *Students for the Ethical Treatment of Animals v. Institutional Animal Care and Use Comm.*, 833 P.2d 337 (Or. App. 1992); *Students for the Ethical Treatment of Animals, Univ. of N.C. at Chapel Hill v. Huffness*, 420 S.E.2d 674 (N.C. Ct. App. 1992); *Medlock v. Board of Trustees of Univ. of Mass.*, 580 N.E.2d 387 (Mass. App. Ct. 1991); *American Soc'y for the Prevention of Cruelty to Animals v. Board of Trustees of the State Univ. of N.Y. at Stony Brook*, 556 N.Y.S.2d 447 (App. Div. 1990); *People for Ethical Treatment of Animals v. Institutional Animal Care and Use Comm.*, 794 P.2d 1224 (Or. Ct. App. 1990); *Progressive Animal Welfare Soc'y v. University of Wash.*, 790 P.2d 609 (Wash. 1990); *Central Westchester Humane Soc'y v. Hilleboe*, 115 N.Y.S.2d 769 (Sup. Ct. 1952).

about the reasons for being denied a grant,<sup>251</sup> the rights to obtain a list of unsuccessful grant applicants,<sup>252</sup> the portability of grants between institutions;<sup>253</sup> the right of the federal granting agency to control dissemination of results;<sup>254</sup> and, the antitrust liability of a federal agency funding the operation of a research center.<sup>255</sup> In one case, a private medical school challenged state statutes that funded research primarily in public institutions.<sup>256</sup>

Two cases could not be categorized. In one, the court found that data generated by faculty research and reported in peer-reviewed, scientific journals could not be protected from discovery and use in litigation.<sup>257</sup> In a second, a medical school engaged in infertility research was deemed to be in a bailor-bailee relationship and required to transfer a cryopreserved human pre-zygote to the parents.<sup>258</sup>

Litigation related to medical research involved complex issues of grants and/or personnel administration, research risks, commercialization, research funding, ethics and research animals. The apparent increase in frequency and scope of litigation appears to be a consequence, rather than a cause, of changes in the environment of medical research. Litigation appears to parallel federal policy initiatives to stimulate collaboration between industry and academia and to regulate more effectively policy areas affecting research. Relatively few cases were reported when federal research support was expanding. However, after 1965, as a result of the decline in the federal proportion of total research budget, competition among investigators and institutions for increasingly scarce research dollars and public scrutiny of the biomedical research enterprise enhanced the risks of litigation. Litigation before 1980, while typical of ongoing problems, dealt primarily with issues of grant administration, whether in areas of personnel or acquisition. Since 1981 and passage of two federal statutes, the Uniform Federal Patent Policy Act and the Economic Recovery Tax Act, designed to stimulate transfer of technology and research from universities to the commercial sector,<sup>259</sup> the frequency and scope of

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251. *Apter v. Richardson*, 510 F.2d 351 (7th Cir. 1975).

252. *Kurzon v. Department of Health & Human Servs.*, 649 F.2d 65 (1st Cir. 1981).

253. *Rubinstein v. Mayor & City Council of Baltimore*, 295 F. Supp. 108 (D. Md. 1969).

254. *Board of Trustees of Leland Stanford Junior Univ. v. Sullivan*, 1991 WL 192697 (D.D.C. 1991).

255. *Vest v. Waring*, 565 F. Supp. 674 (D. Ga. 1983).

256. *State ex rel. Creighton Univ. v. Smith*, 353 N.W.2d 267 (Neb. 1984).

257. *In re Am. Tobacco Co.*, 880 F.2d 1520 (2d Cir. 1989).

258. *York v. Jones*, 717 F. Supp. 421 (E.D. Va. 1989).

259. *Kertz & Hasson*, *supra* note 233, at 114.

exposure to litigation has increased with results indicating that not-for-profit academic institutions are only beginning to unravel the complexities of this altered environment.

## VI. CONCLUSIONS

Medical education may not be the target of health care reform, but it could become one of its principal casualties. Public support for medical education and the medical profession remains strong, as the record number of recent applicants to medical schools attests. Nevertheless, the movement to control costs, broaden access, and regulate the quality of health care service threatens to undermine the main source of funding for academic medicine. Decades of increasing reliance on clinical services for revenues have woven the three strands of education, research, and service into a Gordian knot that defies simple, statutory solutions. Although the Clinton Plan promised direct federal subsidies to university medical centers facing losses in revenues, current medical school funding mechanisms are too complicated, too diverse, and too variable to support standardized calculation and equitable allocation of federal funds. No matter what the final shape of Congressional legislation addressing health care reform, the future of medical education is bound to grow ever more uncertain.

The stakes of health care reform go beyond medical education and extend to the whole enterprise of higher education. At many of the nation's universities, medical schools absorb a large share of the expenditures and medical centers generate a major share of the total revenues. For example, expenditures for medical education make up forty-two percent of the Yale University budget and nearly one-half of the Johns Hopkins University budget.<sup>260</sup> Patient care services not only subsidize institutions of academic medicine, they also support the broader university community in many cases. Consequently, cost containment measures and market-based reforms of the health care delivery system could also impact higher education as a whole. Both graduate and undergraduate educational institutions may find themselves innocent victims of health care reform.

Health care reform will inevitably bring an increase in the volume and scope of litigation. The case law identified by this study tracks the broadening exposure of academic medicine to litigation as both a product and a byproduct of legislative, administrative, and judicial initiatives. During

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<sup>260</sup> Mary Jordan, *Health Overhaul Has Medical Schools Worried*, WASH. POST, Feb. 27, 1994, at A6.



the last two decades, Medicare, Medicaid, and declining direct federal support of medical education have pushed academic medicine toward localized integration of educational, research, and training activities, as well as toward greater dependency on revenues derived from clinical practice and patient care services. Though sustained by public support for social investments in medical technology and extraordinary lifesaving measures, the rapid growth in clinical faculty and residency positions also reflects economic incentives created by federal and state legislation. The current maze of institutional alliances and financial arrangements characterizing academic medicine is the product of two decades of government policymaking, not of government neglect. From the perspective of medical education, the national health care reform movement is more a reversal of course than an expansion of federal intervention. Throughout the four decades documented in this study, medical education has been adapting to the changing priorities and mandates of Congress and the federal bureaucracy. The Gordian knot of medical education financing is the joint product of both government and private sector efforts.

What does the analysis of forty years of past litigation tell us about the prospects for the future? Or, to be precise, how do federal legislation and other environmental factors impact the risks of litigation faced by the institutions of academic medicine?

The case law described in Section V reveals several distinct patterns of environmental challenge and institutional response. The most conspicuous, but by no means the most common, pattern is the sudden explosion of litigation based on new legislation or administrative rulemaking. Academic medicine may be the target of new policy or merely an innocent bystander, but in either case the net effect is the same — a wave of litigation over entirely new issues or in areas of the law not previously litigated. Examples of such cycles of litigation are found in the clusters of cases dealing with taxation of residents' salaries, challenges to the interpretation and administration of rules by the VA, or by other clinical and research funding agencies, and with interpretation of various judicial reforms controlling access to the courts. This initial wave gradually subsides as the case law becomes more and more settled or when the volume of litigation generates corrective action in the legislative or administrative arenas. Institutions must cope with the uncertainties of judicial interpretation, but can look forward to some light at the end of the tunnel.

In the second scenario, a wave of new cases never really subsides and the increased volume of litigation remains relatively stable over time. There is little or no learning curve and the legislation seemingly opens a

Pandora's Box of endless litigation. Examples of problem areas where little relief may be expected include litigation arising from the delivery of patient care services by clinical faculty, personnel decisions alleging violations of civil rights, the commercialization of medical research, the institutionalization of peer review practices, and student dismissals. As a case in point, while litigation over dismissals may initially have been viewed as conforming to the "tidal wave" scenario, the economics of medical education, driven by increasing levels of student indebtedness, have altered the incentive structures of litigation. Although, in this second scenario, institutions may learn to minimize their risk profiles and manage their liabilities, they cannot change underlying incentives to litigate. Clearly, the first or "tidal wave" scenario—however costly—is preferable to Pandora's Box. Health care reform will inevitably bring about the former but it is in the interest of all to craft policies and legislation that forestall the latter.

A third pattern displayed by the case law is that of "adaptive response" to such environmental variables as increased competition for medical school admissions, changing reward patterns for medical specialization, changes in institutional reimbursement formulas, or cultural attitudes toward medical practices and practitioners. Unlike the first two scenarios, the problem is not discontinuous change or legislative innovation but rather mandated changes in the values of enduring environmental parameters. The game remains the same, but the rules are altered and the payoffs recalculated. Litigation over admissions both for undergraduate and graduate programs, as well as over student indebtedness with consequent litigation initially at default and subsequently at bankruptcy, is illustrative. In such cases, the volume of litigation surges and ebbs in response to the environment. Legislation can exacerbate or inhibit the impact of these factors, but the risks are relatively predictable and manageable.

The fourth, and last, pattern of challenge and response may be labeled the "null scenario." In some cases, legislative or administrative initiatives have little lasting impact on the volume of litigation or issues litigated. Caseloads in certain areas may experience brief spikes, but issue areas remain relatively well defined and external. For example, in the legislative area, perturbations are quickly localized and resolved. Here, malpractice provides an example of a constant, relatively intractable issue. Others may include problems such as personnel disputes generally; and, employee benefits, faculty conduct, and collective bargaining specifically. The average volume of cases may grow as the number of participants

increases, but the issues litigated change little. The “null scenario” is generally invoked when legislatures and administrators attempt to change social and legal institutions equally, or even more deeply, rooted in the American psyche. Whether or not the health care reform movement can avoid the “null scenario” and fundamentally change the cultural and institutional foundations of American health care is a question that may take generations to answer. In any case, some areas of the law remain relatively immune to legislative intervention.

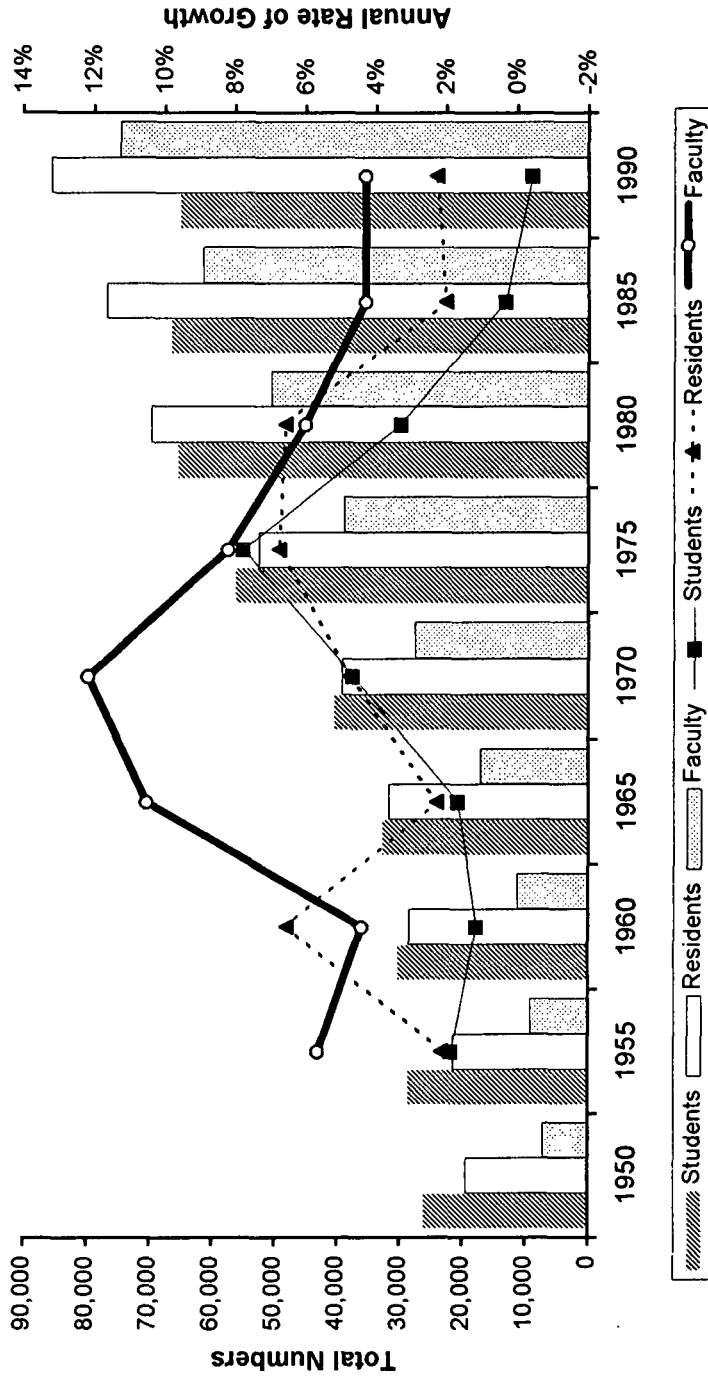
Finally, even without the uncertainties of health care reform, academic medicine confronts an environmental challenge unprecedented in the forty years of litigation examined in this paper. Since World War II, institutions of medical education have experienced an uninterrupted period of sustained rapid growth. Although the burden of funding this expansion has largely shifted from the federal government to the medical bills of individual patients, the real engine of expansion has been enduring public support for the values of academic medicine. Generations of Americans have been willing to pay a significant premium for leading-edge medical training, research, and services and have exempted the medical community from the discipline of the market and the norms of equity. Even in the midst of the health care reform debate, this wellspring of support is still tapped by politicians who blame lawyers and absolve doctors for the escalating costs of health care services. For five decades the values of academic medicine flourished virtually unchallenged.

In the final decade of the Twentieth Century, however, the cultural and financial environment of medical education has changed, perhaps forever. The economic values of competition, cost-effectiveness, and equal access have begun to compete with the notion of medical excellence at any cost. The values of the marketplace are beginning to penetrate the classrooms, laboratories, and operating rooms of academic medicine. As a result, the era of sustained rapid growth is coming to an end. This is the real message behind the rhetoric of health care reform.

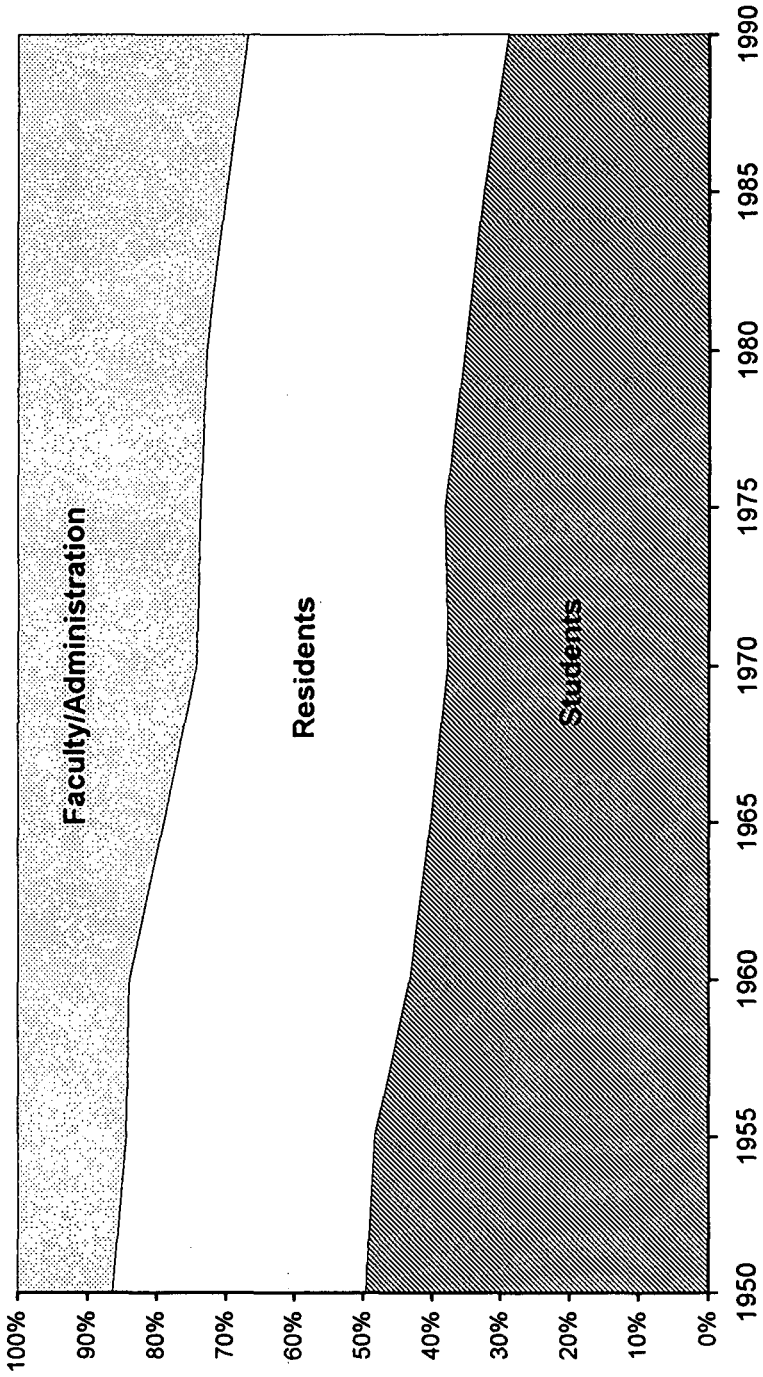
Unfortunately, in a competitive, market-oriented environment, the costs of excess litigation can no longer be absorbed by expanding budgets or indirectly subsidized by government entitlement programs. If the past is prologue to the future, health care reform—whether comprehensive or piecemeal—will trigger new waves of litigation for academic medicine during a period of maximum uncertainty and financial stringency. For the first time, litigation will really hurt. Therefore, the institutions of academic medicine need to monitor the progress of state and federal health care legislation carefully if they are to avoid the compound scourge of

diminishing resources and escalating litigation. The review of the case law detailed above represents the first step in an effort to identify the types of issues and patterns of litigation that may well plague academic medicine as it enters the Twenty-first Century.

Figure 1. Growth of Medical Students, Residents and Faculty



**Figure 2. Participants in Medical Education: Percent of Total (1950-1992)**



**Figure 3. Growth of Medical School Revenues**

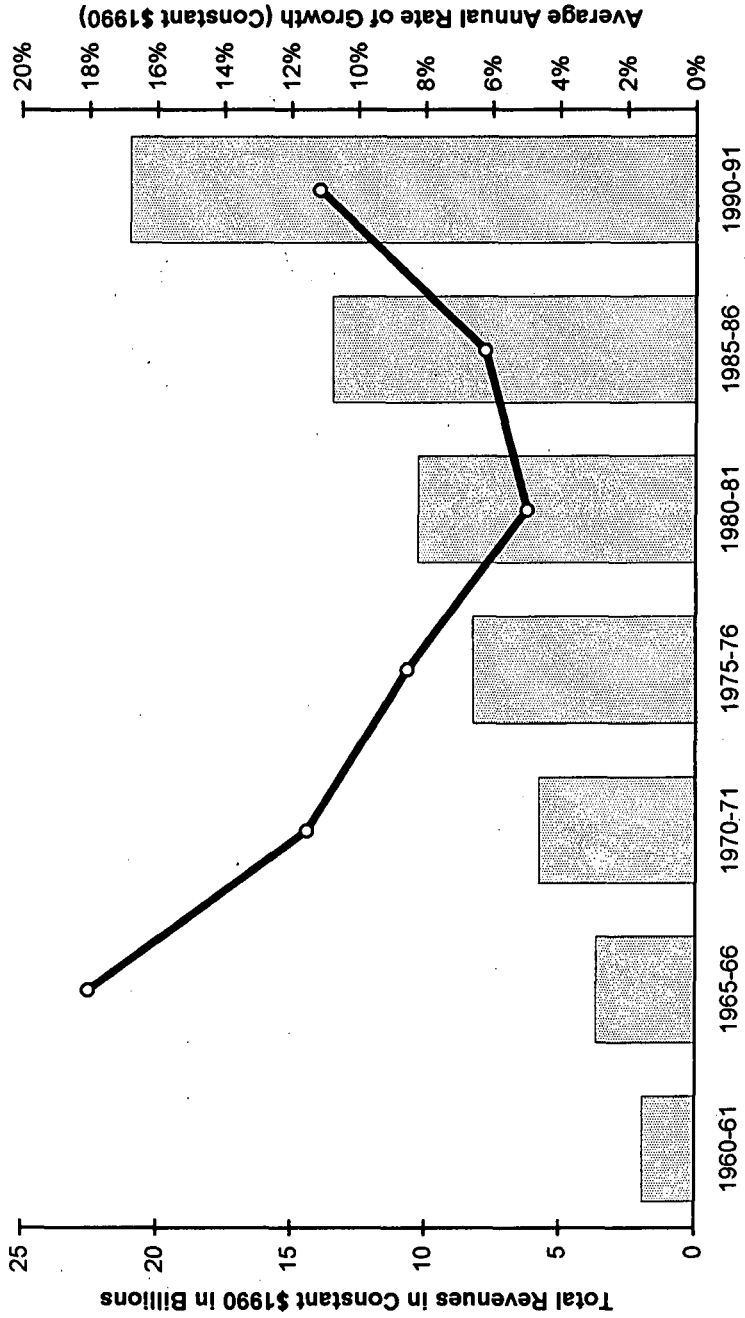
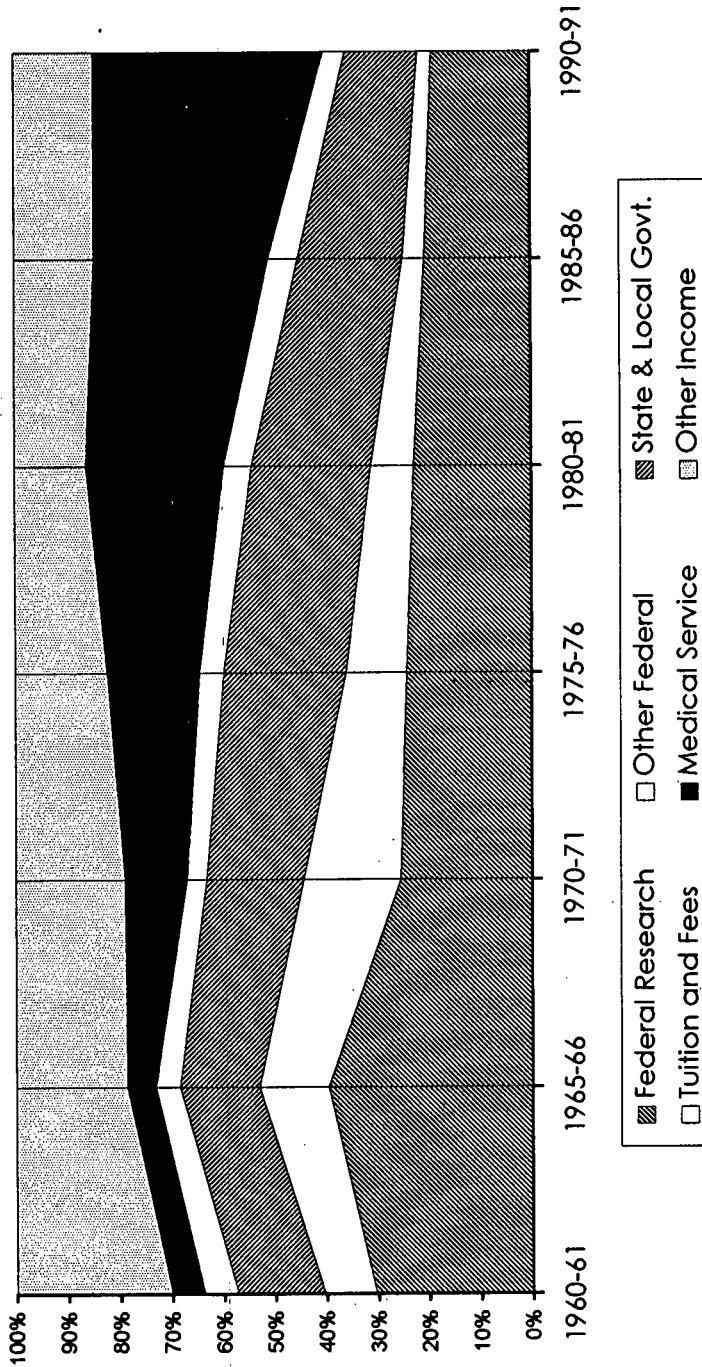


Figure 4. Sources of Medical School Revenues 1960-1990





**Figure 5. Cases Reported by Westlaw: Annual Totals by Party**

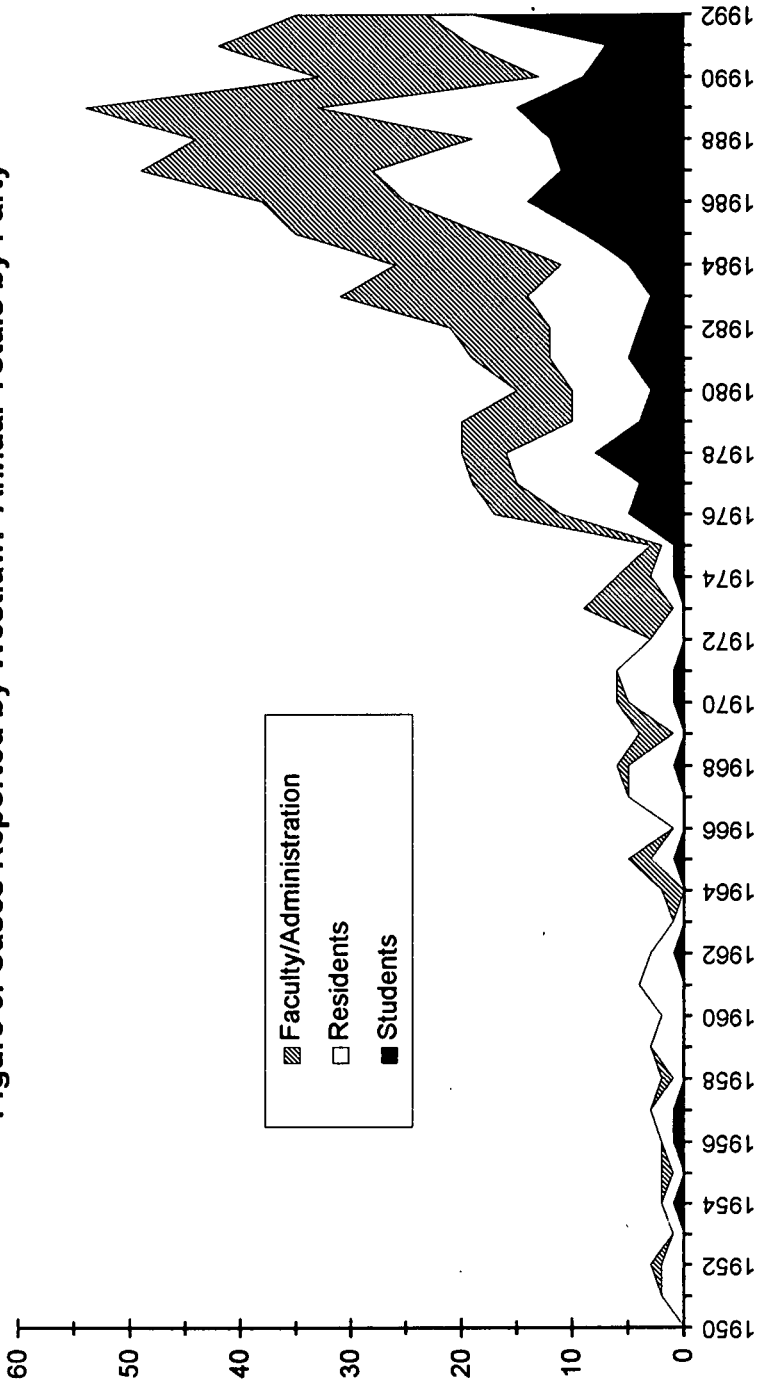


Figure 6. Reported Cases: Cumulative Display by Party and Issue (1970-92)

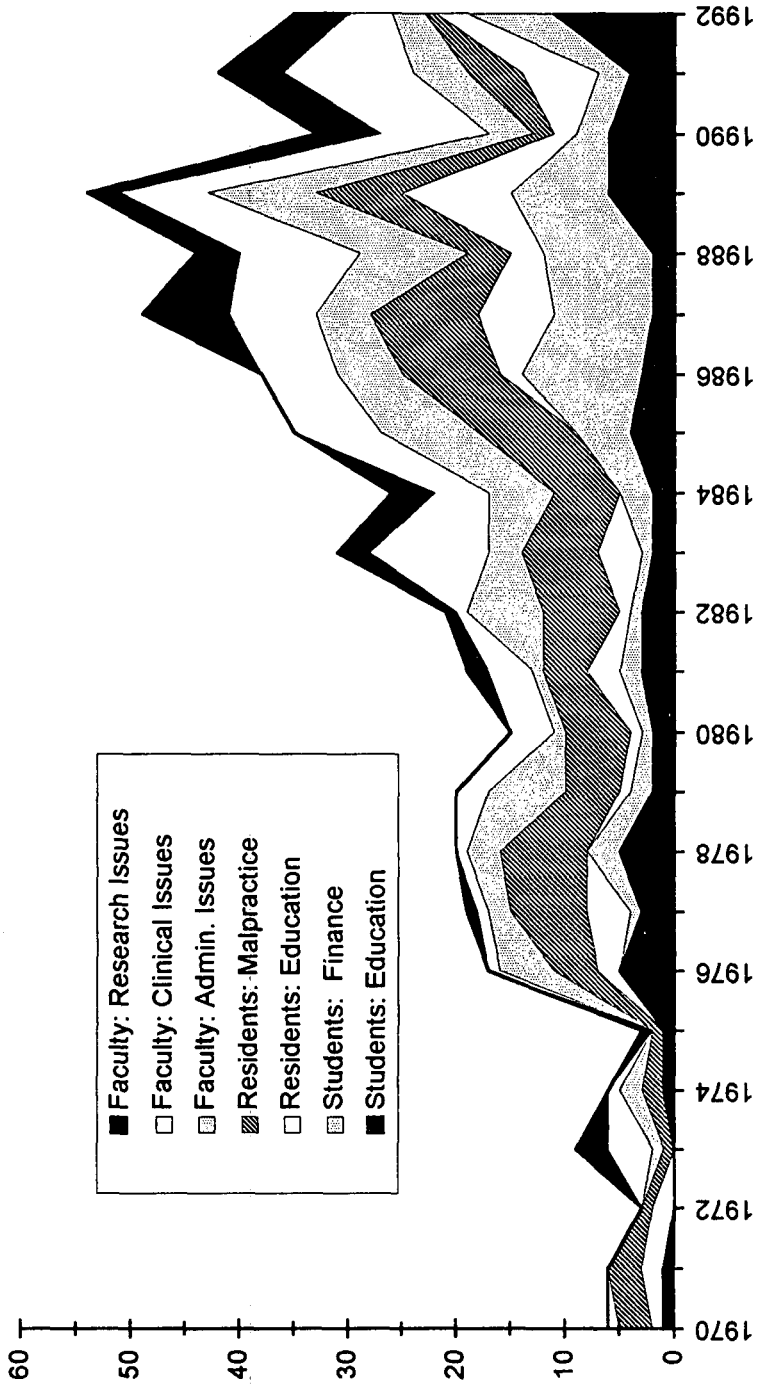


Table 1. Reported Cases by Party and Problem Area

PARTY	ISSUE	1950-54	1955-59	1960-64	1965-69	1970-74	1975-79	1980-84	1985-89	1990-92	TOTALS
STUDENTS	Education	0	2	1	2	3	16	12	17	21	74
	Finance	1	0	0	0	0	6	8	44	14	73
	Subtotal	1	2	1	2	3	22	20	61	35	147
RESIDENTS	Education	0	0	0	3	5	7	9	22	12	58
	Malpractice	5	9	9	10	10	25	30	40	8	146
	Subtotal	5	9	9	13	15	32	39	62	20	204
FACULTY AND ADMINISTRATORS	General Admin.	0	0	0	1	4	17	18	40	12	92
	Clinical Affairs	0	2	2	4	5	6	25	42	26	112
	Research	1	0	0	1	3	2	10	15	17	49
	Subtotal	1	2	2	6	12	25	53	97	55	253
	TOTALS	7	13	12	21	30	79	112	220	110	604

**Table 2. Students: Litigation Involving Educational Issues**

ISSUES	1950-69	1970-79	1980-89	1990-92	TOTALS
Dismissal	3	11	12	15	41
Academic Dishonesty	1	1	4	1	7
Retaking Work	0	0	3	1	4
Admission	0	6	3	1	10
Readmission	0	1	3	1	5
Negligence	1	0	2	2	5
Other	0	0	2	0	2
<b>TOTALS</b>	<b>5</b>	<b>19</b>	<b>29</b>	<b>21</b>	<b>74</b>

**Table 3. Students: Litigation Involving Financial Issues**

ISSUES	1950-69	1970-79	1980-89	1990-92	TOTALS
NHSC or Other Service Program	0	0	30	9	39
Chapter 7 Bankruptcy	0	1	13	4	18
Chapter 13 Bankruptcy	0	0	7	0	7
Statutory Aid	1	2	2	0	5
Tuition / Fees	0	3	0	1	4
<b>TOTALS</b>	<b>1</b>	<b>6</b>	<b>52</b>	<b>14</b>	<b>73</b>

**Table 4. Residents: Educational Cases**

ISSUES	1950-54	1955-59	1960-64	1965-69	1970-74	1975-79	1980-84	1985-90	1990-92	TOTALS
Academic Admin.	0	0	0	2	1	4	9	19	6	41
Tax/Reimbursement	0	0	0	1	3	1	0	2	3	10
Collective Bargaining	0	0	0	0	1	1	0	1	2	5
Other	0	0	0	0	0	1	0	0	1	2
TOTALS	0	0	0	3	5	7	9	22	12	58

Table 5. Residents: Malpractice Cases

ISSUES	1950-54	1955-59	1960-64	1965-69	1970-74	1975-79	1980-84	1985-90	1990-92	TOTALS
Duty of Care	3	5	6	2	4	11	3	6	4	44
Standard of Care	1	2	1	3	3	6	10	2	0	28
Failure to Supervise	0	0	0	2	1	2	6	4	0	15
Judicial Procedures	0	0	1	1	0	1	4	13	0	20
Sovereign Immunity	0	0	0	0	2	1	4	7	2	16
Breach/Causation	2	0	1	1	0	3	0	3	2	12
Informed Consent	0	0	0	0	0	1	3	2	0	6
Other	0	1	0	1	0	0	0	3	0	5
<b>TOTALS</b>	<b>6</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>10</b>	<b>25</b>	<b>30</b>	<b>40</b>	<b>8</b>	<b>146</b>

**Table 6. Faculty: General Administration Cases**

ISSUES	1950-74	1975-79	1980-84	1985-89	1990-92	TOTALS
Faculty Personnel Decisions	1	8	5	14	6	34
Department Resources and Responsibilities	1	3	3	12	3	22
Faculty Conduct	1	2	3	5	1	12
VA Relationships	1	1	2	3	2	9
Employee Benefits	0	2	3	3	0	8
System-wide Discrimination	0	0	1	2	0	3
Collective Bargaining	0	1	1	1	0	3
Other Issues	1	0	0	0	0	1
<b>TOTALS</b>	<b>5</b>	<b>17</b>	<b>18</b>	<b>40</b>	<b>12</b>	<b>92</b>

Table 7. Faculty: Clinical Cases

ISSUES	1950-74	1975-79	1980-84	1985-89	1990-92	TOTALS
Sovereign Immunity and Malpractice	5	1	6	9	7	28
Practice Plan	6	2	7	8	4	27
Staff Privileges	1	0	6	11	4	22
Teaching Hospitals	0	2	2	6	1	11
Indemnification	0	1	0	1	7	9
Peer Review / Records	0	0	2	4	1	7
Conduct of Practice	1	0	2	2	2	7
Other	0	0	0	1	0	1
TOTALS	13	6	25	42	26	112



**Table 8. Faculty: Research Cases**

ISSUES	1950-74	1975-79	1980-84	1985-89	1990-92	TOTALS
Grants and Personnel Management	2	0	3	3	1	9
Research Risks	0	0	3	4	2	9
Commercial Risks	1	0	0	3	5	9
Ethics	0	1	1	2	3	7
Research Animals	1	0	0	1	5	7
Research Funding	1	1	3	0	1	6
Other	0	0	0	2	0	2
<b>TOTALS</b>	<b>5</b>	<b>2</b>	<b>10</b>	<b>15</b>	<b>17</b>	<b>49</b>