August 2015

Congress Takes a Look at a No-Fault Proposal For Medical Malpractice: Some Observations

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CONGRESS TAKES A LOOK AT A NO-FAULT PROPOSAL FOR MEDICAL MALPRACTICE: SOME OBSERVATIONS

THE PROBLEM

EVEN A CURSORY GLANCE at the news media in the recent past indicates that problems in the area of medical malpractice are rising to turbulent heights. For example, newspapers are increasingly printing long and passionate letters-to-the-editor dispraising numerous circumstances and individual types, which are allegedly the cause of the problem.[1] The primary development, which caused the initiation of this storm, is the rising premium rate for medical malpractice insurance.[2] The pinch on the physician's pocketbook has resulted in outcries of frustration and anger from the medical community. Objects of these attacks have included the insurance industry, the legal profession, and the litigious nature of contemporary patients. Attorneys and members of the insurance industry have responded with counter allegations and justifications for the present state of affairs.

The main result of these interchanges has been the development of much myth and misconception as to the nature of the medical malpractice problem.[3] Nevertheless, a problem does exist. The premiums for medical malpractice insurance have increased dramatically. The reason for this rise has been attributed to a variety of causes, not the least being the growing number of suits filed.[4] The increase in litigation has incurred difficulty for insurance companies in the preparation of actuarial tables and in many instances has

[1] *See, e.g.*, Cleveland Plain Dealer, Feb. 23, 1975, at 3-AA, col. 1.

[2] Many news articles offer figures to represent the magnitude of these premiums. Geographical variations is one of the reasons for the disparity in the amount of premiums. The following indicates maximum premiums for high risk medical professionals across the continental United States. NEWSWEEK, Dec. 23, 1974, at 50 ($20,000); Cleveland Plain Dealer, Feb. 2, 1975, at 16-A, col. 2 ($47,000); N.Y. Times, Dec. 29, 1974 § 6 (Magazine), at 20, col. 2 ($14,000).

[3] At the direction of the President, the Secretary of Health, Education and Welfare, Elliot Richardson, established a Commission to study the medical malpractice situation. This Commission prepared a report with a corresponding appendix offering its findings and recommendations. HEW, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (1973) [hereinafter cited as SECRETARY'S REPORT]. The Commission arrived at a similar conclusion. SECRETARY'S REPORT, at 4.

> If we accomplish nothing else, we will have achieved some degree of success if this Report corrects some of the current misconceptions about the magnitude of the problem and the fundamental causes and consequences of malpractice claims and suits. The subject has spawned entirely too much rhetoric and speculation, most of which has impeded the search for viable solutions.

[4] *See* J. Brant, *Medical Malpractice Insurance: The Disease and How to Cure It*, 6 VALPARAISO UNIV. L. REV. 152 (1972); C. Havighurst & L. Tancredi, *Medical Adversity Insurance—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 1974 INS. L.J. 69; J. King, *Malpractice Prevention: A Bi-Professional Approach*, 1971 INS. L.J. 335; Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York: An Alternative to Litigation*, 2 HOFSTRA L. REV. 261 (1974).

made the providing of medical malpractice insurance unprofitable.[5] In addition, the tendency toward larger damage recoveries has aggravated the overall situation, including the inter-professional conflict between attorneys and physicians.[6]

So much controversy has emanated from this broad range of difficulties which make up the "problem," that professionals and lay people have met across the country in an attempt to isolate the issues and develop solutions.[7] A variety of plans have been proposed which range from minor adjustments of the present tort system to its complete abandonment.[8] Three general normative

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[5] C. Havighurst & L. Tancredi, *Medical Adversity Insurance—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 1974 INS. L.J. 69; Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York: An Alternative to Litigation*, 2 HOFSTRA L. REV. 262 n.7 (1974). *But see* J. Brant, *Medical Malpractice Insurance: The Disease and How to Cure It*, 6 VALPARAISO UNIV. L. REV. 152, at 161 (1972).

> Much of the blame for the rising rates must rest with the insurance companies. Although it is probably true that they were neither able to adequately anticipate the rising number of claims nor to cope with the delays inherent in malpractice litigation, they have been lax in developing new methods for risk selection, rate making or prevention of claims.

See also TIME, May 5, 1975, at 82 (state legislatures are being forced to pass so-called "band-aid" bills to provide emergency malpractice coverage where major insurers have announced their imminent withdrawal from providing this type of service).

[6] *See, e.g.*, Niles v. City of San Rafael, 42 Cal. App. 3d 230, 116 Cal. Rptr. 733 (1974) (total damages awarded: $4,025,000.00). J. WALTZ & F. INBAU, MEDICAL JURISPRUDENCE 299 (1971). "What bothers many, including physicians, is the inference that jurors will return hugely inflated money damage verdicts to ensure that the plaintiff has a sizeable sum left after his attorney has skimmed off his agreed percentage." *See* NEWSWEEK, Dec. 23, 1974, at 50.

[7] The most notable of these efforts was the Secretary's Commission on Medical Malpractice (*see* note 3 *supra*). This group was composed of lay people, attorneys, physicians, and members of the insurance industry. They held hearings nationwide and authorized the preparation of numerous research projects to arrive at the conclusions contained in their report.

[8] A. Adler, *Malicious Prosecution Suits as Counterbalance to Medical Malpractice Suits*, 21 CLEV. ST. L. REV. 51 (1972) (within the context of the present tort system, this approach contemplates a reduction of nuisance malpractice suits by subjecting the unmeritorious claimant to possible civil liability for malicious prosecution); C. Havighurst & L. Trancredi, *Medical Adversity Insurance—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 1974 INS. L.J. 69 (a plan which would provide scheduled payment to patients by private insurers for certain compensable events without regard to the fault of the health service provider); Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York: An Alternative to Litigation*, 2 HOFSTRA L. REV. 261 (1974) (this plan utilizes screening panels under the auspices of the Court before suits are prosecuted in an effort to eliminate the cost of suits by unmeritorious claimants); Comment, *Private Physician Unions: Federal Antitrust and Labor Law Implications*, 21 U.C.L.A. L. REV. 983 (1973) (this comment discusses the possibility of physicians' unions in order to create greater bargaining power with respect to the establishment of malpractice rates). The alternatives suggested above are clearly not exhaustive. A more complete listing would require explanation of the oftentimes subtle distinctions capable of being drawn from the numerous different approaches. That task is beyond the scope of this work.

considerations, which guide the various proponents when they consider the alternatives, can be isolated from these different approaches. First, most agree that the high quality of medical care available in the United States today should be maintained and improved. Second, the high cost of medical malpractice insurance is not only a deterrent to some physicians in their practice,[9] but it also increases the cost of medical treatment to all since these costs are being passed on to the consumer-patient. Alternatives to the present system must consider keeping at a minimum costs to the consumer-patient for his medical care. Third, the common law tradition of providing civil redress for harm suffered due to the negligent acts of others indicates that an alternative plan must provide some form of recovery for the negligently injured patient. These three considerations should be applied when analyzing any proposed alternative to the present tort system.[10]

THE PROPOSED PLAN

In recognition of the medical malpractice controversy, and undoubtedly in response to complaints from numerous sectors of the American public, the United States Congress has before it several proposals offering alternatives to the current tort system.[11] For the purposes of this comment, only one of these recent proposals will be examined. The bill offered by Senators Inouye and Kennedy on January 17, 1975,[12] represents a preliminary legislative attempt to draft a no-fault medical insurance compensation plan.[13] This analysis will

[9] This deterrent effect takes several forms. Semi-retired physicians may find the malpractice insurance premiums prohibitive to the extent that full retirement is more economically justifiable. Young physicians may encounter financial difficulties in their attempts to establish solo practices in the sense of the traditional family physician, and be forced into institutional attachments. *See* NEWSWEEK, March 10, 1975, at 56. Also, the malpractice threat has been charged to varying degrees with the cost inflation from defensive medicine. *See Project, The Medical Malpractice Threat: A Study of Defensive Medicine,* 1971 DUKE L.J. 939.

[10] Clearly, there are a variety of sub-factors which must also be brought to bear in an appropriate analysis, *e.g.,* efficiency and justness of any revised system for legal redress to the injured patient.

[11] National Medical Malpractice Insurance and Arbitration Act of 1975, S. 482, 94th Cong., 1st Sess. (January 29, 1975); National Medical Injury Compensation Insurance Act of 1975, S. 215, 94th Cong., 1st Sess. (January 17, 1975); Federal Medical Malpractice Insurance Act, S. 188, 94th Cong., 1st Sess. (January 16, 1975).

[12] National Medical Injury Compensation Insurance Act of 1975, S. 215, 94th Cong., 1st Sess. (January 17, 1975) [hereinafter the bill will be cited as S. 215 with appropriate section numbers following when necessary for clarity. The text can be found in the Congressional Record for January 17, 1975].

[13] It should be noted that the authors of the bill had not, at the time of its presentation, entirely committed themselves to a preference for a no-fault approach. Senator Kennedy remarked, on behalf of himself and Senator Inouye, upon the presentation of their insurance and arbitration plan (*see* note 11 *supra*): "I have introduced two fundamentally different proposals to deal with the rapidly worsening medical malpractice problem because I wish to explore all sides of the issue and all possible solutions to the problem. . . ." 121 CONG. REC. S1142 (January 29, 1975).

use that proposal as a model for a discussion of the potential hazards which might accompany attempts to establish, on a federal level, a no-fault medical malpractice scheme. The mechanics of the bill will first be briefly explained.

Under the Inouye and Kennedy bill, the Secretary of Health, Education and Welfare will be authorized to establish an insurance program for health care providers.[14] Participation in the program by the providers will be entirely voluntary, but subject to minimal requirements established in the bill.[15] In the state where the provider practices, participation will be denied unless: (1) the state licenses health professionals in accordance with the minimum standards established in Part D of the bill;[16] (2) the state licenses health care institutions in accordance with regulations established by the Secretary; and, (3) Professional Standards Review Organizations have been designated pursuant to the Social Security Act.[17] Participant providers must obviously comply with these licensure requirements. In addition, physicians must meet several other requirements to participate. They must submit to review by the Professional Standards Review Organizations[18] and they must accept payment from Social Security recipients in accordance with the federal pay schedule. Also, with respect to those surgical procedures designated by the Secretary, the physician must consult with specialists in the area and obtain recommendation for the surgery[19] before proceeding.

After these requirements for the state and individual are met, then the provider has the option of participating in the national insurance program. Established in the Treasury of the United States will be a Medical Injury Compensation Insurance Fund.[20] The balance of the fund shall be entirely credited from premiums paid by participating providers. The fund shall be used to make all necessary payments required under the insurance

[14] This group would include physicians, other health professionals, and health care institutions. S. 215 § 1701.

[15] S. 215 § 1704.

[16] S. 215 §§ 1731-33. Some of the major provisions include the following. All new professionals must pass to the satisfaction of the Secretary an examination prepared by the Secretary. All new professionals must demonstrate written and spoken proficiency in the English language and any other requirements necessary to evaluate competence. All professionals must be relicensed at least every six years in accordance with procedures deemed appropriate by the Secretary. There will be no durational residency requirement necessary for state licensure. The Secretary will periodically review the state procedures to assure that they meet minimum federal requirements. Failure to meet these standards will subject the state to termination of participation in the insurance program.

[17] 42 U.S.C.A. § 1320c-1 (1974). The draft of the bill contains reference here to § 1152 of Title 42, but this is not where the authorization for the Professional Standards Review Organizations is to be found in the United States Code.

[18] *See* note 17 *supra.*

[19] This particular procedure will be controlled in more detail by regulations which the Secretary will establish.

[20] S. 215 § 1702.

contracts and to pay the necessary administrative expenses of carrying out the insurance program.[21]

The type of incident which will be insured under this plan will be both justifiable no-fault and tort claims. When a patient of an insured is injured, he will have an option to proceed under the no-fault scheme or the traditional tort route.[22] In any event, if the provider knows of an injury to a patient which would be compensable under the no-fault side, he must so notify the patient within a given time.[23] Failure to notify the patient so that he does not file his no-fault claim within the required time[24] will result in the insured's loss of his insurance benefits. In other words, the provider will then be personally liable for the amount the patient would have been entitled to recover had he filed a timely claim.[25] The amounts of these no-fault recoveries will be determined according to the guidelines established in the bill.[26] As stated before, the patient will also have available to him the traditional tort route, but this approach is precluded if a no-fault claim is filed.[27]

Other characteristics which do not fall within the above explanation are included in the bill, and it is necessary to elucidate them in order to understand fully the impact of the proposal, if it becomes law. The role of the Advisory Council on Medical Injury Compensation will be to advise the

[21] What will be included in these administrative costs is not entirely clear from the bill. Initially it will require at least payments to the Advisory Council on Medical Injury Compensation (*see* S. 215 § 1724). In addition, the Secretary is required to make findings of fact and decisions on the claim of any individual under the no-fault plan (S. 215 § 1715). This task will probably require the establishment of boards across the nation as a matter of administrative necessity in order to handle the determination of all claims in a somewhat efficient manner. Payment will be required for this nationwide system. These are two obvious administrative expenses but they are probably not exhaustive of all that will be necessary in light of the nationwide nature of this program and the mammoth task which will confront the administrative agents.

[22] There are two significant aspects to the no-fault side. First, the injured patient must bring his claim within a given period of time (S. 215 § 1716). Secondly, the provider must also furnish the Secretary with information necessary to determine whether payment is due on the claim S. 215 § 1705.

[23] The provider must notify the patient of the compensable event within 30 days after he knew or reasonably should have known of the injury S. 215 § 1705(c)(2).

[24] The patient must file his initial no-fault claim no later than 18 months after he knew or should have known of the injury S. 215 § 1716.

[25] S. 215 § 1705(c)(2).

[26] S. 215 §§ 1711-14. These recoveries will be limited to a specified strata of economic losses in addition to traditional noneconomic losses recoverable under tort law (but not including punitive or exemplary damages). An interesting change to most existing legal measures is a required reduction for collateral sources of recovery stemming from the injury (but not to be reduced by life insurance or Social Security benefits).

[27] S. 215 § 1717. No claim for no-fault benefits will be accepted without a written waiver of rights to tort recovery. Once this waiver is signed, and if the patient subsequently does bring a tort action, the Secretary will then be authorized to bring suit for breach. The amount of liquidated damages will be any recovery from the tort action.

Secretary of Health, Education and Welfare on the establishment and operation of the program.[28] This 15-member Council, composed of no less than seven health professionals, will undoubtedly have a profound effect on the exact nature of the plan in operation. From a legal perspective, this Council's effect will initially be most notable in the area of establishing rules of evidence and standards of proof for the no-fault hearings which will determine whether compensation is justified. The bill authorizes[29] whatever evidentiary standards are deemed appropriate in order to present the no-fault claimant a fair opportunity to prove his case for compensation. The proposal also establishes guidelines for the payment of reasonable attorney's fees based on time expended, regardless of whether the claim is no-fault or tort.[30] The Council will again be instrumental in establishing the specific rates under these guidelines. Finally, the bill includes an anti-fraud provision,[31] which makes a misdemeanor[32] the misrepresentation of any material fact by claimant or insured with respect to compensation or insurance recovery.[33]

OBSERVATIONS ON THE PROPOSED PLAN

Before any discussion of specific problems, it must first be explained that this "no-fault" approach is not a system premised on a total disregard of fault before compensation is afforded. It therefore will not be no-fault in the pure sense. Since participation in the plan is voluntary, there will undoubtedly be instances where fault will have to be determined in order to ascertain whether no-fault benefits are available. The situation is certain to arise where a patient is injured in a large non-federally insured (no-fault) medical institution and at the approximate time of injury he was treated by several health care professionals, only some of whom were covered by the national no-fault insurance. In order to determine whether the injured patient merits

[28] S. 215 §§ 1703, 1724. In addition to advice on all necessary regulations, this Council will specifically play an important role in establishing (a) premium rates, (b) loss-deductible for tort liability, (c) limitations of coverage and (d) general terms of insurability.

[29] S. 215 § 1723.

[30] S. 215 § 1726(b). "No part of such no-fault benefits or tort damages may be applied in any manner as attorney's fees in connection with such claim or action to recover such damages." A violation of this provision by an attorney will subject the lawyer to misdemeanor charges (a fine not more than $10,000 or imprisonment for not more than one year, or both).

[31] S. 215 § 1727.

[32] The penalty upon conviction will be a fine of not more than $10,000 or imprisonment for not more than one year, or both.

[33] Participating providers will also be subject to another type of criminal liability. S. 215 § 1727(4).

> Whoever—(4) in the case of a health professional or health care institution, knowingly and willfully makes or causes to be made any false statement or representation respecting the participation of such professional or institution in the insurance program established under this title, shall be guilty of a misdemeanor. . . .

no-fault benefits the administrators of the no-fault program will again be back in the business of determining fault in order to ascertain whether the injury suffered was the result of health care services provided by an insured.

Variations of the above fact pattern, which would not be unusual, will expose more of the same problem. At least to this extent, the no-fault system will be a fault system not unlike the present system. In addition, the development of parameters within which compensable events will be situated may require a resort to fault concepts in order to place some limitations on the types of injuries for which payment will be made. Since the system provides for hearings to decide whether no-fault claims merit recovery,[34] the proposal implicitly recognizes that some injuries related to health care are not compensable. Some standards will be necessary in order to make this determination, and common law fault concepts will be readily available to provide guidelines for what should be compensable.[35] This factor may also tend to make the system less no-fault and provide it with a more fault-oriented conceptual framework.

Now an attempt will be made to isolate some of the major potential problems with a plan of this nature.[36] There is no convenient order for the presentation of these observations, but the nature of this forum indicates the propriety of an initial focus on possible legal entanglements.

The requirement that the provider notify the patient within 30 days of a compensable event offers a time-bomb of problems.[37] To begin, the definitions of compensable events in the area of medical injuries will not be easily developed.[38] Notwithstanding this difficulty, during the bill's initial operation,

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[34] S. 215 § 1715(1)(a).

[35] The following cases illustrate what a compensable event has been at common law. Jefferson v. United States, 77 F. Supp. 706 (D. Md. 1948) (2½' by 1½' towel left in stomach after abdominal surgery); Voss v. Bridwell, 188 Kan. 643, 364 P.2d 955 (1961) (administration of anesthesia which totally incapacitated a previously able-bodied man); Wolfsmith v. Marsh, 51 Cal. 2d 832, 337 P.2d 70 (1959) (improper hypodermic injection of sodium pentathol which caused phlebitis in the knee area); Wooten v. Curry, 50 Tenn. App. 549, 362 S.W.2d 820 (Ct. App. 1962) (vagina closing after hysterectomy is prima facie negligence—the court also permitted joinder of suit by husband with this action); Sheffield v. Runner, 163 Cal. App. 2d 48, 328 P.2d 828 (1958) (failure to hospitalize patient suffering simultaneously from bronchial pneumonia and chicken pox).

[36] Dependent upon one's point of view, the "major" problems may appear to be quite different. This discussion will attempt to be as objective as possible with respect to the plan's workability in light of the present legal structure and serious nature of the present malpractice problem.

[37] *See* text accompanying notes 23 and 24 *supra*.

[38] The Secretary's Commission on Medical Malpractice recognized this problem when they indicated "the enormous difficulty of determining the threshold of compensability that all too often is overlooked, particularly by those who facilely suggest a no-fault compensation system for medically injured persons comparable to some of the automobile no-fault plans which have been proposed or adopted." SECRETARY'S REPORT at

the only definitional guideline established will be "any injury suffered as a result of health care services provided by an insured."[39] Even assuming that valid definitions of compensable events can be developed, there will be an uncomfortable period of time where all involved will not know where they stand until a wide spectrum of decisions is rendered.[40] The physician particularly will be cornered and confused since his very insurance coverage is dependent upon timely notification.

Another aspect of this notification requirement is the development of evidentiary problems.[41] Although this notification may never acquire the technical status of an admission of liability, its probative value cannot be underestimated. Given the context of this plan, the notification will have ramifications two-fold. On the no-fault side, the notification's ("admission's") probative value, tending to indicate the possibility of some negligent activity, may easily result in a greater number of no-fault recoveries.[42] On the tort side, this notification takes on greater proportions. First, it must be remembered that the provider is encouraged to notify in order to maintain his no-fault coverage. It is conceivable that even questionable cases will result in notification due to this systemic pressure. Yet its probative value remains unchanged. If this notification were admitted into evidence at trial, the question of fair adjudication, particularly by jury, comes into issue. Undoubtedly, the rules of evidence will develop to exclude this notification[43] as unfairly prejudicial, but the battle to keep it out of court will be never-ending, particularly since the plaintiff is the party who was notified.[44]

One of the probable reasons that the notification provision was included in the bill arises from the discontent, particularly by defendant physicians, with the ever-broadening application of *res ipsa loquitur* in medical malpractice

101. *Contra,* C. Havighurst & L. Tancredi, *Medical Adversity Insurance—A No-Fault Approach to Medical Malpractice and Quality Assurance,* 1974 INS. L.J. 69.

[39] S. 215 § 1711.

[40] The number of decisions necessary to provide some degree of certainty will be numerous due to the complex nature of medical treatment. Many debatable and fine lines will have to be drawn. Doctors agree on the subtle necessities of their art no more than lawyers.

[41] As a matter of discovery under the tort system, evidence of physician negligence has been almost impossible to acquire since the physician is oftentimes the only party who has the requisite knowledge concerning the negligence issue, and his liability is on the line. The tort system has responded to this difficulty with an expansion of the doctrine of *res ipsa loquitur. See* J. WALTZ & F. INBAU, MEDICAL JURISPRUDENCE 88 (1971). Developers of no-fault plans have responded to this problem with the notification requirement. C. Havighurst & L. Tancredi, *Medical Adversity Insurance—A No-Fault Approach to Medical Malpractice and Quality Assurance,* 1974 INS. L.J. 69.

[42] This point goes to the cost issue. *See* text accompanying note 70 *infra.*

[43] S. 215 § 1705(C)(3)(B) (notification section) "Nothing in this subsection shall be construed to affect the tort liability of any insured."

[44] This factor may also go to the cost issue. *See* text accompanying note 70 *infra.*

cases.[45] In these types of cases, the factual patterns often develop where the defendant health care provider is the only party in a position to know what actually occurred. In these situations, *res ipsa loquitur* is invoked creating a presumption of negligence and thus shifting the burden of going forward to the defendant in order to provide the missing factual information.[46] The complaints about the use of this doctrine arise from those situations where the procedure has been so loosely applied that not only the burden of going forward has shifted to the defendant but also the burden of persuasion. The defendant health care provider is then placed in the position of proving to the jury that there was no negligence. Critics of the present system claim that this result creates an unfair advantage for plaintiffs thus permitting more judgments against defendant health care providers.[47]

However, assuming *arguendo* the validity of this complaint against *res ipsa loquitur,* the notification requirement contained in the proposed bill does not appear to be a viable solution.[48] As indicated above, this provision may create more prejudicial problems than it solves. A judicious application of *res ipsa loquitur*[49] may be more useful in determining liability, or even whether the no-fault provider was the party who administered the treatment in question. This traditional tort approach leaves more discretion to the jury, but it may be more desirable than establishing a procedure where a notification motivated by a desire to preserve one's insurance coverage creates an even stronger probative inference of some degree of culpability.[50]

Other evidentiary problems are raised in the bill by the section[51] which authorizes the Secretary, upon the recommendations of the Advisory Council on Medical Injury Compensation, to establish rules of evidence and proofs appropriate to determine the rights of beneficiaries under the no-fault side. However, since this type of authorization is granted to many administrative

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[45] *See* note 41 *supra.*

[46] The classic example is surgery. Here the injured patient is unconscious when the alleged negligent activity occurs. Only the health care providers are available to provide information as to what happened at that time.

[47] "[A]pplication of the principle is limited, theoretically, to those cases where a jury does not need the assistance of an expert witness to discern negligence." J. WALTZ & F. INBAU, MEDICAL JURISPRUDENCE, at 90 (1971).

[48] Another attempt to formulate a no-fault plan considered and rejected a notification requirement as "not operable." E. Roth & P. Rosenthal, *Non-Fault Based Medical Injury Compensation Systems,* SECRETARY'S REPORT (Appendix), at 464.

[49] Notwithstanding the fact that this doctrine has come under severe attack by the medical community, it appears to be a more appropriate approach.

[50] This discussion does not even handle the issue of failure to notify for what the provider deems adequate reason. This unknowing, or possibly unknowable, culpable omission may also create strong probative inferences of liability in fact, *i.e.,* the provider may be viewed as a participant in a cover-up attempt.

[51] S. 215 § 1723.

agencies for the operation of their hearings, the broad discretion granted and its incumbent problems have been handled previously.[52] This approach does not offer new evidentiary problems, although it is not certain that the old problems have been resolved to the satisfaction of all.

The availability of the Administrative Procedure Act[53] provides a credible guideline as to how evidence questions will be handled, particularly when courts review the Secretary's decisions as to whether an event is compensable on the no-fault side.[54] If this no-fault plan were to become law, the operation of other agencies with respect to the admission of evidence would indicate that the standards for admission at a no-fault hearing would not be stringent.

> The movement continues to be toward relaxing the rigidity of the jury-trial rules, toward admitting evidence in administrative proceedings without considering such rules, and toward basing findings on the kind of evidence on which responsible persons are accustomed to rely in serious affairs even if it would be inadmissible in a jury case.[55]

This procedure, which approaches a "let-everything-in" standard, may have ramifications in the medical malpractice area not analogous to the purpose for which other agencies were established.

In terms of a solution to the medical malpractice problem, this broad evidentiary latitude may offer difficulties with respect to the very purpose for which the plan is offered. This grant of discretion will have to be guided down a very narrow path in order to preserve two mandates necessary to maintain the viability of this national insurance alternative as preferential over the tort system. On one side, a criticism of the tort approach is that meritorious but small claims do not receive their day in court because of the contingent fee system.[56] No-fault is intended to alleviate this problem. Therefore, restrictive evidentiary rules for the no-fault hearings could work a great disservice to the

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[52] *See* MCCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE 836 (2d ed. 1972).

[53] 5 U.S.C.A. § 500 (1967).

[54] The bill clearly provides for review of the Secretary's decisions. S. 215 § 1715(a)(2). This position is in accord with the tenor of the Administrative Procedure Act. 5 U.S.C.A. § 702 (1967). "A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof." *Accord,* Comment, *Judicial Review of Administrative Decisions in Ohio,* 34 OHIO ST. L.J. 853 (1973).

[55] K. DAVIS, ADMINISTRATIVE LAW TREATISE, § 14.01, at 840 (Supplement 1970). *See also* K. DAVIS, DISCRETIONARY JUSTICE, A PRELIMINARY INQUIRY (1969).

[56] SECRETARY'S REPORT at 33. "Our study data showed that the contingent fee system tends to discourage the acceptance of legally meritorious malpractice cases involving minor injury and relatively small potential recovery, and we view this as a wholly undesirable and unfair result of the system."

purpose of the plan by denying meritorious claims adequate access to no-fault benefits.

On the other hand, the present tort system is severely condemned for its costs, particularly by way of insurance premiums for providers. Evidentiary standards for the no-fault hearings which "let everything in" could possibly create unnecessary prejudice against the provider's activity and spur no-fault compensation in questionable cases. This effect will merely increase the costs by way of premiums for the entire national insurance system, a result which the present dilemma indicates should be discouraged. In these respects, the standards of evidence developed for the operation of the no-fault hearing could have substantive ramifications in contradiction to the goals of no-fault as an alternative to the present system.

Beyond such potential evidentiary problems,[57] there exist broader issues which arise from provisions based on policy decisions. These are, (1) the abolition of the contingent fee system for all medical injury suits, and (2) the mandatory extensive licensure procedures for health care providers. The contingent fee system has been under attack from several directions. It has been charged, particularly by the medical community, with the promotion of unnecessary suits against providers with unconscionably high prayers for damages.[58] It has been condemned for not providing small but meritorious claims with adequate legal counsel, if any is provided at all.[59] The contingent fee is the primary alleged culprit for wiping out a substantial proportion of the recovery that an injured person does receive.[60] These criticisms, although their validity remains suspect, probably were instrumental in providing the impetus for its abolition in the proposed bill.[61]

Again, the success of this alteration will depend upon the nature of the regulations expounded by the Secretary for the payment of attorneys who

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[57] As indicated above (*see* text accompanying note 51 *supra*) evidentiary problems with respect to administrative agencies have already been confronted. However, it should be noted that the bill's provision for appeal to United States district courts again presents problems as to exactly what the courts can review by the way of facts presented in evidence. The substantial evidence rule may run into rough waters upon the review of technical medical disputes upon which there may be little agreement in the medical community. *See* MCCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE 846 (2d ed. 1972).

[58] This allegation, except perhaps in a few unusual circumstances, has been rejected by the authorities who have studied the situation in relation to the medical malpractice problem. SECRETARY'S REPORT at 33-34; G. Annos, *Medical Malpractice: Are the Doctors Right?* 10 TRIAL July-Aug. 59 (1974); *see* J. Brant, *Medical Malpractice Insurance: The Disease and How to Cure It*, 6 VALPARAISO UNIV. L. REV. 152, 162 (1972).

[59] *See* note 55 *supra.*

[60] SECRETARY'S REPORT at 34; *see* J. Brant, *Medical Malpractice Insurance: The Disease and How to Cure It*, 6 VALPARAISO UNIV. L. REV. 152, 162 (1972).

[61] S. 215 § 1726.

handle medical injuries cases. There can be little doubt that the prospect of a large fee for a medical malpractice case is indeed an incentive for readily available legal counsel. At the same time, it appears to be generally accepted that small meritorious claims are not receiving adequate legal attention.[62] If these are the only effects that the contingent fee system has on medical malpractice litigation, then its abolishment and replacement with fee regulation would not be so difficult. The Secretary will have to find a fee schedule for hourly work which will attract sufficient numbers of attorneys to handle the claims but not provide them windfalls as the tort system is accused of doing.

The above fee payment system seems appropriate if the premises accepted are exclusive, but the contingency fee system serves another function. That system provides attorneys with an incentive to turn down unmeritorious cases regardless of how high an alleged recovery might be.[63] This screening function is valuable, in terms of the entire system, through its effect in keeping systemic costs down (*e.g.*, defense costs which create inflationary pressures on insurance premiums). This cost-saving device has not been replaced in the no-fault system. Any marginally potential claim can be filed, thus forcing the expense of administrative costs just to reject it.[64] This cost will eventually reach the consumer-patient. Instead of the patient paying his attorney to be told that he has an unmeritorious claim, all patients will pay their health care providers. The increased administrative expenses necessary to turn down the unmeritorious claims will raise the provider's insurance, a cost which he will pass on to his patients. This system does not have the merit of isolating these administrative costs to the unmeritorious claimant as does the contingency fee tort system. Consequently, the overall effect of the contingency fee abolition may not be a reduction in systematic health care costs, but rather another impetus to increase these costs to all.[65]

The licensure of health care providers presents difficulties of an entirely different nature and will only be handled briefly. In order for health care providers to participate in the national insurance they must be licensed subject

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[62] *See* note 55 *supra.*

[63] G. Annos, *Medical Malpractice: Are the Doctors Right?* 10 TRIAL July-Aug. 59 (1974). "The simple fact that 30% of nothing is nothing usually means that the contingency fee system actually serves to protect the physician by making the lawyer's office a place where weak or unfounded cases are screened out."

[64] Actual fraudulent claims will be deterred by the bill due to criminal sanctions contained therein. S. 215 § 1727. However, as any hypochondriac knows, proof of fraud with respect to claimed physical ailments is difficult.

[65] Nevertheless, it does appear from this analysis that the problem of the meritorious small claimant and his struggle to find legal representation does seem to be solved, provided that the Secretary's fee schedule is sufficient to attract attorneys for any medical malpractice case.

to minimum national requirements which will be established by the Secretary.[66] All new professionals will be required to pass a written examination, in addition to other necessary criteria to evaluate competency. Notwithstanding the ambiguity of this mandate, the entrance of the federal government into possible detailed control of the medical profession is ripe with potential for abuse. Undoubtedly, the reason for the proposal of this broad grant of regulatory power is premised upon an envisioned new necessity, once civil liability is effectively reduced, to control the irresponsible members of the medical profession. This new need under no-fault may indeed be a valid perception. The question then becomes one of means rather than ends. Passing examinations seems to be a poor substitute for testing the competency and responsibility of practicing health care professionals.[67] Perhaps the solution is to require local peer review with actual power to effectively police the profession, and the requirement to use this power under government auspices.[68] The bill does evidence aspects of such an approach, but its emphasis is improperly placed on licensure.

The last problem which will be discussed is perhaps already apparent. It appears the proposal will be costly.[69] Initially, it must be reiterated that the primary aggravant of the present medical malpractice situation is the high level of malpractice insurance premiums.[70] Whether one believes that the premiums, whatever they might be, are proportionately too high with respect to an individual provider's income, is really not the issue. The question, when one is attempting to revise an entire system, is whether the systemic costs can be reduced or at least maintained at the same level.[71] As the previous discussion of other potential problems illustrates, they almost all aggravate the costs of the national insurance program.[72] For example, the provider notice requirement has a potential to create more claims for no-fault benefits and the possibility of more recoveries in tort. Also, the abolition of the contingency fees eliminates an individually paid screening device for unmeritorious claims and replaces it with a systemically paid screening device.

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[66] *See* text accompanying note 16 *supra*.

[67] *Cf.* Defunis v. Odegaard, 416 U.S. 312 (1974) (Douglas, J., dissenting).

[68] The courts should always be available for review of these decisions so the peer review committees do not turn into anything but peer review committees, in a professional sense. The problem with giving peer review committees more power is simply that they will have more power. Abuse of this power for personal or political reasons should be discouraged and controlled.

[69] The particular cost aggravants which were discussed previously are of a different nature than the systemic costs which will be discussed. The latter are costs which are inherent in the very proposal itself, viewed from a perspective of the entire system.

[70] *See* note 2 *supra* and accompanying text.

[71] If costs are to remain at the same level, the necessity for alternative plans only makes sense if other crucial areas are being improved.

[72] *See* text accompanying notes 42, 55, & 64 *supra*.

Besides these individual cost aggravants, the entire system by its nature is destined to be costly. The Secretary's Commission concluded with respect to no-fault that:

> . . . such system is bound to be more costly than the present one to the extent that it compensates injured persons whom the present system excludes either because their injuries were not due to negligence or because they are unable to prove negligence. The amount of the additional costs cannot be measured, but it is certain to be considerable.[73]

The very theory of no-fault indicates greater cost and, notwithstanding the reluctance of the Secretary's Commission, others have been willing to say how much. These estimates range from eight times[74] to several hundred times[75] as expensive as the present system for the patient-consumer. It would seem that the no-fault approach will not be able to keep costs at their present level.

CONCLUSION

The beginning of this comment indicated three primary considerations necessary to evaluate alternative medical compensation systems. The first of these was maintenance and improvement of the present high standard of medical care. The discussion of the proposed bill indicated that the licensure techniques were of questionable validity for this purpose.[76] The issue remains as to whether this bill will at least maintain present medical standards. One authority indicates doubt: "[S]uch a system . . . would not only eliminate all quality control mechanisms, but could even tend to encourage sloppiness."[77] However, this bill has made attempts to maintain some degree of quality by requiring physicians, against whom numerous benefits have been recovered, to come under review and be subject to discipline.[78] That this approach would be efficacious in maintaining present standards is true to the extent that the present system has similar provisions on the local level. Yet it is doubtful that the present standard of medical care is dependent solely upon disciplinary review. Numerous factors, beyond the scope of this work, significantly affect the present standard of health care (*e.g.*, educational standards, professional self-image, and research funds). No conclusion will be drawn here as to what

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[73] SECRETARY'S REPORT at 101.

[74] G. Annos, *Medical Malpractice: Are the Doctors Right?* 10 TRIAL July-Aug. 59, 62 (1974).

[75] SECRETARY'S REPORT at 133 (Separate Statement of Richard M. Markus, LL.B.).

[76] *See* text accompanying note 66 *supra.*

[77] G. Annos, *Medical Malpractice: Are the Doctors Right?* 10 TRIAL July-Aug. 59, 62 (1974). This conclusion concerning sloppiness is based on the notion that no-fault would effectively remove civil liability. Without other controls, it is argued, that providers would then have no incentive to avoid negligence beyond their own professional dedication.

[78] S. 215 § 1704.

effect a bill of this type would have on standards of health care, but the issue merits further research before any laws are passed.

The second consideration for evaluation of an alternative plan is whether redress will be provided for the negligently injured patient. It goes without further comment that this bill will offer this aspect. The final consideration is whether the costs to the consumer-patient will be kept to a minimum. The previous discussion[79] indicates that this criterion will not be met, at least in relationship to the costs of the present tort system. The only conclusion that can be drawn from the application of these considerations and the above discussion of detailed problems, is that the no-fault plan offered by Senators Inouye and Kennedy is not a preferable alternative system. The cost issue alone mandates the rejection of this plan.[80]

The Congress should direct its search for solutions elsewhere or make major revisions in the proposed no-fault approach.[81] Particularly, since this potentially costly plan also provides for voluntary participation by health care providers, a passed law of this nature may be a dinosaur at its birth because its high costs and marginal benefits will reduce its participants to a minimum. Other proposed alternatives are available, such as arbitration and medical screening panels, and those who seek solutions to the present difficulty might be wise to focus their energies on these.[82]

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[79] *See* text accompanying note 70 *supra.*

[80] 121 CONG. REC. S420 (January 17, 1975). Senator Kennedy stated: "The bill proposes that this program be entirely self-supporting through premium income at no additional cost to the taxpayer." This may be true for the average person when he wears his taxpayer hat, but when he wears his patient hat the costs will definitely increase.

[81] This author has not found a no-fault plan which does not increase the costs in the final analysis to the recipients of health care treatment. E. Roth & P. Rosenthal, *Non Fault Based Medical Injury Compensation Systems,* SECRETARY'S REPORT (Appendix), at 450; C. Havighurst & L. Tancredi, *Medical Adversity Insurance—A No-Fault Approach to Medical Malpractice and Quality Assurance,* 1974 INS. L.J. 69.

[82] SECRETARY'S REPORT at 87.

> In the final analysis it is the human interaction between all categories of health-care providers and patients that will determine the measure of success in the treatment process. We believe that increasing the degree of mutual understanding, courtesy, and respect between patients and health care providers will greatly reduce the antagonisms, misunderstandings, and dissatisfactions which all too often prompt patients to turn to malpractice litigation.