DePaul Law Review

Volume 54
Issue 2 *Winter 2005: Symposium - Starting Over?: Redesigning the Medical Malpractice System*

Article 3

Reforming Medical Malpractice in a Radically Moderate - and Ethical - Fashion

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REFORMING MEDICAL MALPRACTICE IN A RADICALLY MODERATE—AND ETHICAL—FASHION

*Paul C. Weiler**

INTRODUCTION

The major focus of tort reform battles in both state and federal legislatures has long been medical malpractice. Thus, after the 2002 election put his Republican Party in charge of both branches of Congress, President George W. Bush presented their favorite brand of malpractice reform, a legal cap on pain and suffering damages to injured patients.[1] His stated rationale was that "what we all want is quality

* Henry J. Friendly Professor of Law, Harvard Law School. This Article will also be the first chapter in my ongoing book project, *Radically Moderate Law Reform*, with later chapters devoted to such other contemporary public policy issues as "Enhancing Worker Lives Through Fair Labor and Worklife Law," "Renovating Our Recreational Crimes" (about using marijuana and betting on sports), and "Constitutionalizing and/or Democratizing Our Lives" (about abortion, affirmative action, and gay marriage). This key part of that work is largely based on: (1) the major empirical research project that I engaged in with my partners in the Harvard Medical Practice Studies (HMPS) in New York, Colorado, and Utah, investigating the risks of both medical and legal mistakes being made here; and (2) the tort reform project that I did with my partners for the American Law Institute (ALI), devising the most efficient and also ethical reforms of all tort law, including medical malpractice. For two books that synopsized those reports in connection with the subject of this Article, see PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (2001); PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE (1991).

This Article also relies on a host of other scholarly analyses written over the last decade, especially by Dr. Troy Brennan, who was not only my partner in both projects, but was rendered especially expert in this field by having gone to both medical and law school. For an update of the key data about medical injuries and lawsuits, see VASANTHAKUMAR N. BHAT, MEDICAL MALPRACTICE: A COMPREHENSIVE ANALYSIS (2001). For a depiction of the key principles that should now govern all legislative tort reform, see CHARLES FRIED & DAVID ROSENBERG, MAKING TORT LAW: WHAT SHOULD BE DONE AND WHO SHOULD DO IT (2003). For the viewpoint of a prominent lawyer advocating serious tort reform for the "common good," rather than just the interests of lawyers or doctors, see PHILIP K. HOWARD, THE COLLAPSE OF THE COMMON GOOD: HOW AMERICA'S LAWSUIT CULTURE UNDERMINES OUR FREEDOM (2001). I want to thank Dr. Brennan, Dr. Howard Hiatt, my co-chair of the HMPS, and Professors Kip Viscusi and Ken Abraham, my other partners in the ALI tort reform scholarly effort, for their really helpful comments and suggestions for this Article.

1. *See* Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003).

health care, not rich trial lawyers,"[2] whom he labeled "the only winners" in the "giant [lawsuit] lottery."[3]

This specific measure was actually signed into law back in 1975 by Ronald Reagan in one of his earlier roles as Governor of California.[4] That pioneering law, the *Medical Injury Compensation Reform Act* (MICRA), placed a $250,000 ceiling on pain and suffering damages—the same number President Bush proposed in 2003.[5] As notable malpractice defense attorney, James Griffith, stated in celebrating that legislative measure, American juries too often "act like Santa Claus, handing out millions of dollars in cases involving comparably minor injuries."[6] Thus, several other states followed California's lead throughout the 1980s. However, the fact that Hillary Clinton, in her 1993 Report and recommendation to her Presidential husband,[7] was not prepared to follow Reagan's lead (and instead had another important change in malpractice law) played an important role in blocking any reforms in our broader health care system on behalf of present and future American patients.

This malpractice issue returned to the political arena at the beginning of this new millennium because our doctors—especially obstetricians and surgeons—received the rather distressing news that their malpractice premium costs were suddenly surging upwards.[8] In response, not only did numerous doctors announce that they were going to stop practicing (at least in these costly specialties), but also beginning in West Virginia on January 1, 2003, and then expanding to Jacksonville, Florida, Newark, New Jersey, Long Island, New York, and elsewhere, they mounted major work stoppages in protest.[9] One American Medical Association (AMA) member even proposed at its

2. Tanya Albert, *Bush Decries "Junk Lawsuits," Calls for Federal Tort Reform*, AM. MED. NEWS, Aug. 12, 2002, at 2.

3. President George W. Bush, Remarks on Access to Health Care (Jan. 28, 2004), *available at* http://www.whitehouse.gov/news/releases/2004/01/print/20040128-2.html.

4. Medical Injury Compensation Reform Act of 1975 (MICRA) (codified at CAL. BUS. & PROF. CODE § 6146 (West 2003), CAL. CIV. CODE § 3333 (West 1997), CAL. CIV. PROC. CODE §§ 340.5, 1295 (West 1982)).

5. H.R. 5 § 4.

6. James D. Griffith, *What Will It Take to Resolve the Malpractice Crisis?*, MED. ECON., Sept. 27, 1982, at 195.

7. DOMESTIC POLICY COUNCIL, THE WHITE HOUSE, HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE 78–79 (1993).

8. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES, Highlights Page (June 2003), *available at* http://www.gao.gov/new.items/d03702.pdf (providing very useful data about the movement in malpractice insurer premiums over the last decade).

9. *See, e.g.*, Tanya Albert, *N.J. Physicians Stop Work in Biggest Liability Protest Yet*, AM. MED. NEWS, Feb. 17, 2003, at 1.

2004 conference that doctors should *not* be providing medical services to malpractice plaintiffs' lawyers and their spouses.[10] As then-Senate Majority Leader Trent Lott put it, the source of this sudden drop in doctor earnings was trial lawyers, "a pack of wolves [who are] going to kill the goose that laid the golden egg."[11] Thus, his successor as Majority Leader, Dr. Bill Frist (the first practicing physician to reach the Senate since 1938), set out to rein in these lawyers and their lawsuits.[12]

Almost all the Democratic Senators opposed this specific measure because, as California Senator Dianne Feinstein pointed out, her surgeon husband (and AMA member) was protected in their home state by a $250,000 damages cap, which, if simply adjusted for overall price inflation (rather than health care or stock market inflation), would now be worth $780,000. Neither side was prepared to accept the Feinstein compromise proposal of a basic $500,000 pain and suffering cap without an important exception for the victims of truly "catastrophic" medical negligence.[13]

Thus, in stark contrast to President Bush's (unfortunately) successful effort to again reduce the taxes paid by those whom the AMA was labeling as "greedy lawyers,"[14] and the American Trial Lawyers Association (ATLA) was labeling "negligent doctors killing their patients,"[15] (as well as all other well-to-do Americans), this measure—which, ironically, was titled *Help Efficient, Accessible, Low-Cost, Timely Healthcare*,[16] to earn the nickname, HEALTH—was foiled in the 2003 Senate.[17] This proved to be an important issue in the Presidential 2004 election campaign—in which George W. Bush was challenged not only by lawyer John Kerry, but also by his tort-lawyer Vice Presidential running mate, John Edwards.[18] American voters deserve to learn the truth about what this medical and legal problem actually consists of, and then what is the truly fair and constructive way to

10. Tanya Albert, *AMA to Study Liability Surcharges*, AM. MED. NEWS, July 5, 2004, at 1.

11. Jim VandeHei, *GOP Plans New Caps on Court Awards*, WASH. POST, Dec. 29, 2002, at A5.

12. *See* Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003, S. 607, 108th Cong. (2003).

13. Tanya Albert, *Tort Reform Clears House, Moves Forward in States*, AM. MED. NEWS, Apr. 7, 2003, at 1.

14. Tanya Albert, *Tax Break on Liability Insurance Proposed*, AM. MED. NEWS, June 2, 2003, at 7.

15. Berkeley Rice, *Do Doctors Kill 80,000 Patients A Year?*, MED. ECON., Nov. 21, 1994, at 53.

16. S. 607.

17. U.S. GEN. ACCOUNTING OFFICE, *supra* note 8, at 9.

18. Joel B. Finkelstein, *Edwards' Trial Lawyer Past Raises Red Flags for Doctors*, AM. MED. NEWS, Aug. 2, 2004, at 1.

reform this part of our legal regime and thence, hopefully, also our overall health care system.[19]

II. THE REAL MALPRACTICE INSURANCE "CRISIS"

Medical malpractice insurance premiums charged to doctors have certainly been rising over the last three years—especially for specialties and settings like the orthopedists in Jacksonville, Florida who saw their premiums surge by more than 50% in that period. However, there are several intellectual fallacies in the standard political rhetoric, including the claim that this is a problem created by malpractice litigation, and even more, the claim that this is the key reason why our health insurance costs have gone up at least 10% a year since 2000.[20]

First, we should all be aware of the fact that malpractice insurance and litigation costs have long represented just around 1% of our total health care costs—which have soared from $27 billion in 1960, or 5% of our gross domestic product (GDP), to $1.4 trillion, or 15% of our GDP.[21] And while total malpractice litigation costs of around $15 billion cannot possibly be significantly responsible for that surge in total health care expenditures, the latter has generated a sizable portion of these rising malpractice costs because a large share of the tort compensation for malpractice victims consists of the expensive medical treatments required by the medical injury.

Of course, from the perspective of doctors and their families, what they have been experiencing must seem as economically disabling as the physical disability experienced by a few of their patients—for example, the surgeons in Miami, Florida who were suddenly charged

19. Indeed, there is also a striking illustration of how this may be fitting with the much broader public policy challenges facing America in this new millennium. In late May 2004, after being part of one of the first fully legalized gay marriages in the United States, Cindy Kalish filed a medical malpractice suit against the clinic that had been treating her new lesbian spouse, Michelle Charron, alleging that "loss of consortium" had occurred as a result of the clinic's negligent failure to detect breast cancer in Charron early enough for effective treatment. *Newly Married Lesbians File Malpractice Lawsuit*, N.Y. TIMES, May 23, 2004, at 23. In *Feliciano v. Rosemar Silver Co.*, 514 N.E.2d 1095, 1096 (Mass. 1987), the Massachusetts Supreme Judicial Court ruled that unmarried partners cannot bring such loss of consortium lawsuits; consequently, this major constitutional debate is also going to have an impact on medical malpractice—and hopefully its truly ethical reform.

20. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 6 (Aug. 2003), *available at* http://www.iltla.com/Medical%20Malpractice/GAO_8_03_implications_risingpremiums.pdf.

21. *See* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 4 (1991) (stating that total health care expenditures in 1960 amounted to around $25 billion, or 5% of GDP). *See also* VASANTHAKUMAR N. BHAT, MEDICAL MALPRACTICE: A COMPREHENSIVE ANALYSIS 203 (2001) (stating that the United States spent about $1.149 trillion, or 13.5 % of GDP, on health care in 1998).

more than $200,000 a year for their personal malpractice insurance.[22] This certainly is a legitimate concern, and one for which I will eventually provide the most ethical as well as efficient solutions (and by "ethical," I mean serving the genuine public interest of everyone affected, not just the private interests of those closest to the government currently in power). Again, though, a little history and economic analysis is important to help us understand why we should not blame "greedy" tort lawyers for this physician plight.

Recall that over the last three decades we have experienced three different episodes of essentially the same malpractice insurance crisis. The first took place in the early 1970s, and inspired California's Governor Ronald Reagan to fashion that state's pioneering $250,000 cap on pain and suffering damages.[23] Then, in the mid-1980s the same crisis returned, so that numerous other states adopted that same measure[24] (though California decided it needed to add some constraints on insurance premium increases to match what it had done to jury damages awards). With that historic perspective, we should recognize that the common factor in each of these crises was not a sudden surge in malpractice suits and awards, but rather a dramatic drop in the financial markets. In each of those financial settings, the insurers felt compelled to sharply increase their malpractice premiums. In effect, they made their doctor-clients serve as the human shield for their stockholders against the unhappy consequences of having gambled in the stock market. Obviously, this was more disturbing to physicians in cities like Miami, Florida and Philadelphia, Pennsylvania where, because of historically more generous jury verdicts, the absolute premium size was already much higher than in fellow-state cities like Tampa Bay and Pittsburgh.

Much more than any other form of tort insurance (especially for automobile accidents), medical malpractice insurers find a large part of their revenues and the biggest source of their profits to be in the financial marketplace. This is because of the relatively lengthy period between the time when doctors pay their premiums while treating their patients and the time when the insurers are compelled by lawsuits to pay any substantial sums of damages to the few patients seriously injured in that insured year. The period of time averages over

22. *See* Tanya Albert, *Liability Premium Increases Slowing, Yet Rates Remain at Record High*, AM. MED. NEWS, Nov. 15, 2004, at 1.

23. MICRA (codified at CAL. BUS. & PROF. CODE § 6146 (West 2003), CAL. CIV. CODE § 3333 (West 1997), CAL. CIV. PROC. CODE §§ 340.5, 1295 (West 1982)).

24. *See* FRANK A. SLOAN ET AL., INSURING MEDICAL MALPRACTICE 10 (1991).

five years, and often amounts to an eight to ten year time lag.[25] That is why it has always been rational for malpractice insurers to take that money and invest it in a fashion that will provide substantial additional revenue for the litigation costs when they come due.

However, these insurers were induced to make the same investment mistakes in the mid to late 1990s that the general public made—sharply increasing the share of their revenues in the stock market to 20%, including in what were then hugely popular, high technology NASDAQ firms (though the bulk of their investments remained in bonds). The immediate result was that doctors received all of the benefit of higher interest rates and a surging stock market because of the serious price competition among their insurers. The average premiums remained remarkably stable even though malpractice payments continued to rise and even though there was a bigger growth in health care costs and physician income during that decade. But when the bond interest rates started to fall and the stock market bubble burst in 2000, a number of major insurers (e.g., the second largest, St. Paul Companies) went entirely out of this brand of liability insurance.[26] Those left in the market responded to those higher costs and lower competition by quickly raising their premiums to protect their own profits and shareholders.[27] For example, while the rate of malpractice insurance payments to patients in New Jersey actually declined by 21% from 2001 through 2003, the insurance premiums charged to doctors surged there in the same way as was occurring across the United States.

Thus, physicians who had grown accustomed to their artificially low premiums in the late 1990s suddenly felt distressed by that new charge because they could not make the same instant increase in their own fees, since it was then necessary to do so with public and private health care insurers, not their patients.[28] That is why so many obstetricians and surgeons in places like Miami, Florida and Philadelphia, Pennsylvania decided to retire, and their younger colleagues set off on a quest to secure their insurers' favorite law reforms—damages caps and the like.[29]

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25. *See generally* Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393 (2005) (discussing the length of the "tail" in malpractice insurance).

26. U.S. GEN. ACCOUNTING OFFICE, *supra* note 8, at 31.

27. *Id.*

28. *See, e.g.*, Tanya Albert, *No State Immune to Liability Stress*, AM. MED. NEWS, Aug. 23, 2004, at 1.

29. Tanya Albert, *Tort Reform Clears House, Moves Forward in States*, AM. MED. NEWS, Apr. 7, 2003, at 1.

III. Relations Between Malpractice and Health Care Costs

As we will see shortly, there are several major legal flaws in our current malpractice system that merit the kind of radically moderate reforms my scholarly partners and I have long been advocating. First, though, I should explain why the kinds of proposals now being made are unethical as well as irrational.

Ironically, the typically conservative advocates have long said that state autonomy should be protected from federal interference and constraints. Here, though, they not only want Washington to govern a truly local issue—the amount an injured patient can secure in a state court from her doctor, hospital, and their liability insurers—but also actually override the far more rational decisions made by several state legislatures who have adjusted their pain and suffering damages caps to inflation. Instead of President Bush ordaining former California Governor Reagan's $250,000 figure (which now should have reached nearly $800,000 if inflation were adjusted in the same fashion as that enjoyed by doctors, lawyers, and everyone else under our federal income tax law), he should at least rely on either Maryland's current $620,000 cap,[30] or the $750,000 figure currently sought in his home state of Texas.[31]

Next, we should be aware of the fallacy in blaming malpractice litigation for our rising health care costs. First, as we have already seen, malpractice insurance premiums account for just over 1% of total health care expenditures. If anything, it is our steadily rising treatment costs that explain a significant part of the price of malpractice insurance. Even if we solely focus on the relations between malpractice litigation law and its own liability insurance costs (whose current $15 billion figure is certainly quite sizable), we reach the same result.[32] From 1991 through 2002, in the thirty-two states (including the District of Columbia) without damages caps, medical malpractice payments made to patient-litigants rose by 38% and the premiums charged to doctors rose by 36%, but in the nineteen states with those caps, the same financial figures were much higher—71% and 48% respectively.

The one exception to that latter trend, California, is the only damages cap state that eventually chose to give its physicians the benefit of lower malpractice premiums by constraining what their insurers

30. Md. Code Ann., Cts. & Jud. Proc. § 11-108(b)(2) (2002).

31. Tex. Civ. Prac. & Rem. Code Ann. § 74.301 (Vernon 1986).

32. I learned this from a recent Weiss Ratings Group report.

could charge, and not just what their juries could award.[33] Ironically, though, the California Supreme Court felt compelled to read into that 1988 Referendum, Proposition 38, a special exception to guarantee that the insurers were earning, not losing, money from this serious business risk[34]—something that court has never done for the impact that a three-decades old, non-inflation adjusted damages cap may be having on the insured patients' lives. Thus, if our legislators (and judges) are going to be truly principled here, they should stop passing laws that in fact are principally protecting the profits of insurers, rather than the prices of their doctor-clients. Even more importantly, they should give priority to the needs of the patients who are ultimately paying them both.

With respect to doctors, for example, while the net incomes of some have slumped in the last couple of years, over the last several decades they have surged more than any other profession in any other country. Not only does the average American doctor earn roughly twice what the average American lawyer earns (though top lawyers, especially a few tort lawyers, make far more than our top doctors), but also the median physician earnings are twice as high as all worker earnings in France, and four times as high in Canada, while the United States labor market now has doctors earning six times the amount of their worker-patients.

Indeed, this relative earnings increase has taken place at the same time the number of American doctors has also surged. Over the last three decades, the supply of physicians has grown by approximately 125%,[35] and relative to the increasing population, by 75%.[36] This includes the supposedly endangered specialties of surgeons and obstetricians.

Understandably, these latter groups feel especially troubled by what has happened to their net incomes recently, though again if they have a broader historical perspective they should be aware that during the Nixon Administration, their top tax rates were 72%[37] whereas President Bush has dropped them to 35%.[38] That is why we should be troubled by our current popular, not just political, culture giving priority in medical malpractice "reform" efforts to the cause of healthy doctors (even more, to their profitable insurers), rather than to their

33. CAL. INS. CODE §§ 1861.01, 1861.05 (West 1993).

34. Calfarm Ins. Co. v. Deukmejian, 771 P.2d 1247, 1270 (Cal. 1989).

35. *See* BHAT, *supra* note 21, at 155–56.

36. *Id.* at 156.

37. *See* Tax Policy Center, Historical Top Tax Rate, *at* http://www.taxpolicycenter.org/TaxFacts/TFDB/TFTemplate.cfm?Docid=213 (last visited Mar. 18, 2005).

38. 26 U.S.C. § 1(i)(2) (2000).

largely working class patients. Indeed, we have been imposing a cap on damages to the most seriously injured patients, and thus the ones most in need of fair *legal* treatment.

It is not just these injured patients who have been the victims of our relatively unfair versions of malpractice "reform," but also the potential patients who have suffered from the absence of another kind of federal reform needed in our overall health care insurance system. Especially in the early years of the Clinton Administration, one of the major obstacles to obtaining malpractice reform was the constant battle between lawyers and doctors about whether and how to change our malpractice litigation rules.[39] It is important, then, that the general public be taught what a sensible brand of tort reform is, so we can start to transform our entire health care regime.

To gain some perspective on the latter issue, our total health care costs (in current dollars) have risen from around $125 billion in 1960 to over $1 trillion today.[40] Thus, not only do we have the world's biggest tort (not just medical malpractice) system in the world—now amounting to about 2.5% of our GDP—but also by far the world's most expensive health care system. While the British, German, and Japanese people spend between 7% and 8.5% of their respective GDP's on their publicly provided health care, Americans spend approximately 15% of our GDP on largely private health care and its insurance.[41]

Some relative virtues of the private marketplace exist, even for as crucial a matter of public interest as caring for everyone's health. But perhaps the single most troubling feature of becoming the world's most economically unequal major democracy is the disparity in health insurance coverage, and thus the immediate access to helpful (not just negligent) care.[42] This is not much of a problem if one is elderly and covered by Medicare, or even truly poor and covered by Medicaid, or a well-to-do or unionized worker covered by private insurance. But at any one time there are now 43 million Americans who do not have employers or anyone else offering them health insurance as part of their compensation package for working (or studying),[43] and annually many more experience that same fate. Not only is there a major racial disparity in this health care coverage—ranging from 11% of white

39. *See* David Rogers, *Initial Clinton Medical Malpractice Reform Plan Pulled After Resistance by Entrenched Interests*, WALL ST. J., June 15, 1993, at A20.

40. BHAT, *supra* note 21, at 3.

41. *Id.* at 205.

42. *Id.* at 203.

43. *Id.*

families to 18% of African-Americans and 35% of Hispanic-Americans[44]—but also there is disparity by state, with Minnesota residents insured at only half the national average of 14% and Texas residents almost doubling it at 27%.

Thus, if a family member becomes really sick, either he or she does not get the necessary helpful and expensive treatment—and an estimated 18,000 unnecessary American deaths occur every year because of lack of access to health care[45]—or he or she does get the necessary treatment by imposing on the family a major financial burden for the rest of their lives. The only way we can treat this most troubling feature of American health care is by reaching a political settlement in favor of taking the truly fair route to reforming the legal treatment of medical malpractice litigation.

IV. The True Flaws in Both Rooms

To make the fully intelligent judgment on that latter score, however, we should know what our prospects are in the hospital operating room as well as in the courtroom. Thus, I shall briefly synopsize the key findings made by my great physician-scholar partners Dr. Howard Hiatt and Dr. Troy Brennan as part of the Harvard Medical Practice Studies (HMPS) made in the 1980s in New York and then in the 1990s in Colorado and Utah.[46]

First, around one quarter of the times a patient seeks medical treatment, he or she suffers an "adverse" outcome, such as an injury. Of the 85% of these medical injuries which we could realistically judge on this second question, about 35% were due to negligent treatment. Among all of the adverse events, around 3% produced permanent disabilities, and another 14% generated deaths. Thus, applying these New York figures (which we essentially corroborated in Colorado and Utah) to the 35 million annual hospitalizations across the country, these produce 350,000 medical injuries, of which around 10,000 are serious and permanent disabilities, and of which 75,000 are fatal.

How does our legal regime function in relation to our health care system? By comparison with the annual 115,000 negligent medical in-

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44. *Id.* at 235.

45. Dianne M. Wolman & Wilhelmine Miller, *Understanding the Magnitude of the Problem: The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. Med. & Ethics 397, 400 (2004).

46. For a detailed discussion of these findings, see Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990) [hereinafter HMPS]. *See also* Weiler, *supra* note 21; Paul C. Weiler et al., A Measure of Malpractice (1993).

juries or deaths, there are about 55,000 lawsuits, of which just 15,000 produce any payments at all (whether through settlements or jury awards). In other words, there is just one paid malpractice claim for every twenty-one negligent medical injuries, and just one for every eight serious or fatal injuries.

Why is there only one malpractice suit filed for every two negligently injured patients? And why do only a minority share of these suits win any money at all? The first reason is that while scientists are able to detect these adverse events, the lay patient usually cannot distinguish the consequences of her treatment from her original illness, let alone tell whether the professional treatment was actually negligent. Next, while the bulk of the negligent injuries are relatively minor, it is always costly for the plaintiff's lawyer (working for just a percentage of the recovery) to mount such a tort suit in this complex health care setting (in comparison to the setting for litigation involving auto accidents, for example). Even if the injury is a serious one, if it has happened to a poor patient who was unemployed and is covered by Medicaid, then there are no significant financial losses (as opposed to emotional pain and suffering) to sue for. Finally, those who are over sixty-five are about twice as likely to suffer serious and negligent injuries as those aged between fifteen and sixty-five (because they are even more likely to be going to the hospital for treatment) and are far less likely to sue because Medicare is covering these additional health care costs. Those over sixty-five are mostly retired and thus not losing any income, and do not have much expected time to live in pain and suffering with their disability.

Trial lawyers regularly cite those HMPS findings as supporting their case for legislation expanding rather than contracting malpractice litigation.[47] I should note here what I will elaborate later on in justifying my radically moderate tort reform proposals. My expert HMPS colleagues discovered that the majority of malpractice payments (whether by way of settlement or jury verdict) did not involve any negligent treatment at all, and a substantial minority share did not even have a medical injury (as opposed to the original illness getting worse). Of all the malpractice claims we studied, 42% of those with no adverse events secured an average $29,000 payment; of those with medical injuries but no negligence, 46% collected an average of $98,000; and of those with both an adverse injury and medical negligence, 56% received an average of $201,000 through our legal system.

47. *See* Rice, *supra* note 15, at 46.

In sum, while our tort law obviously does to some extent recognize the presence or absence of both adverse medical injuries and doctor or other health care provider negligence, such recognition is far more likely to be expressed in the amount, rather than the likelihood of individual tort recovery. We do need some important malpractice law reforms, but only those that focus on the actual needs of patients, rather than just on the interests of doctors, hospitals, their insurers, and the lawyers on both sides of the courtroom.

But in reforming our malpractice law to produce a far more level legal field, we must also remember that we have or will be playing three different roles as patients. First, if we are one of those patients who was injured in the hospital—especially seriously injured when we were supposed to be working—we need and deserve fair compensation to be provided quickly, rather than facing a damages cap following long struggles and delays in the courtroom (while the insurers are perhaps gambling again in the financial market). Next, if we are one of those patients who is about to be treated and wants to avoid adverse effects from that care, we need our legal system to provide strong incentives for our doctors and other health care staff to be truly careful, not just economical and/or profitable. Finally, if we are one of the vast array of future patients who now are actually bearing the costs of our sizeable $15 billion malpractice insurance budget (though a relatively tiny portion of the health care expenditures we are all funding), we must have this malpractice money spent in the most efficient and economical manner possible.

V. Rational as Well as Ethical Damage Reform

We begin with damages awards, which are the main focus of legislative intervention in the malpractice field, especially now that the average jury award has risen from $360,000 in 1994 to slightly over $1 million today. For example, the New York legislators felt compelled to immediately reform that state's law after its Court of Appeals, in *Desiderio v. Ochs*,[48] actually increased the jury award from $40 million to $140 million (paid out over fifty-five years) in favor of infant Samuel Desiderio for the permanent brain disability inflicted by his delivery.[49] As we shall see, besides pain and suffering, which has always attracted the bulk of the popular as well as political attention, there have regularly been legislative debates and actions regarding what to do when some part of the injured patient's financial damages

48. 791 N.E.2d 941 (N.Y. 2003).
49. *Id.* at 948.

have already been paid by such "collateral" sources as health care or salary insurance. Indeed, President Bush also wants to follow the lead of numerous states and place a statutory cap on how much the patient's lawyer can charge his or her client for winning the lawsuit.[50]

Starting with pain and suffering, this certainly is the most inherently subjective feature of damages awards, unlike the more objective calculation of how much money the injured patients need to replace their lost earnings. What actually comes before the juries ranges from the physiological pain suffered from the injury, treatment, and recuperation to an enduring loss of enjoyment of life when a permanent disability blocks the victim from enjoying the pleasures of normal personal and social activities. Even if the patient died quickly, the family-member plaintiffs have experienced the anguish of seeing their spouse or child in pain and of watching them pass away, and then experienced the further emotional distress of forever losing them. The legal policy problem is that a once and for all lay jury is basically asked to judge what the approximate *financial* translation of this purely *psychological* loss is.

Another important body of empirical research has discovered first that, while juries are only half as likely to find in favor of plaintiff-patients in medical malpractice cases as they are in automobile accident cases, the average awards (or settlements) for the medical malpractice cases are three times as high for the same kind of injury and disability.[51] Even within these malpractice cases themselves, the average awards in the top quartile are approximately ten times higher than those in the bottom quartile for what scientists have appraised as essentially the same severity of injury.[52]

A further consequence of this disparity and unpredictability surrounding the ultimate jury verdict is that even the clear medical negligence cases are far harder to settle.[53] This both deprives the victims of the immediate relief needed for their basic financial losses, and imposes on the general public (i.e., future patients) the far greater financial costs of administering malpractice litigation which we pay for through both health insurance premiums and taxes.

The ideal (and ethical) solution to this definite legal problem is *not* to have our lawmakers simply impose a cap on how much the jury can award for patient pain and suffering. If we want to be truly fair, we

50. HEALTH Act of 2003, S. 607, 108th Cong. § 6(a)(2)(B) (2003).

51. Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 Nw. U. L. REV. 908, 908 (1989).

52. *Id.* at 938.

53. *Id.* at 917.

must, instead, develop and provide to the juries a set of damages guidelines, based not just on the severity of the injury, but also on the age of the victim. In other words, our legislators, not just our juries, should finally recognize that there is a qualitative—and thence a quantitative—difference in the pain felt by an eighty-year-old patient with a limp and a twenty-year-old patient rendered blind, both incurred as a result of mistakes made by their respective health care givers.

Congress' ideal role, then, should be to pass a law requiring all states to establish such a guidelines system to replace both their at-large jury verdicts and their inequitable, non-inflated damages cap regime. Each state should create its own body—consisting not just of doctors, lawyers, and insurers, but also of past and future patients—to appraise an array of injuries (i.e., being crippled, scarred, or losing a toe), the duration of the pain (i.e., to a baby or to her grandfather), and the like. Once the combination of these various factors have been graded together (ranging from one to one hundred, not just A to F), then financial numbers should be attached to each. Those figures must be based on the total amount that people in the state want to spend on compensating all of their annual patient-victims' pain and suffering, divided by both the seriousness of the various injuries and the percentage of occurrences that each type represents of all injuries.

After that legislative and administrative initiative has been completed, these guidelines (i.e., damages scales) can then be given to the jury to enable it to rationally appraise the appropriate financial compensation for what regularly are rather idiosyncratic cases. As we gain more experience with more cases across the country, these guidelines bodies can be recalled to expand or even to revise its figures.

Such a regime is obviously much fairer to all patients (in the three patient-roles mentioned earlier) than our two current legal schemes—either unguided jury discretion or a one-sided legislative cap with no damages floor. It is also much more efficient in two respects. First, both trial judges and appeals courts will have sounder footing on which to make their judgments about whether the jury numbers were unreasonably high (or low). Second, both sides to the case will have a bigger incentive and assurance in having their lawyers reach a pre-trial settlement rather than putting themselves through the trauma and expense of a protracted trial (where malpractice suits dwarf automobile accidents in both the percentage of claims that go to court and the length of time to receive a jury verdict).[54]

54. *See id.* at 926.

While pain and suffering is obviously the most visible law reform issue here, and the one most in need of a fairer stance, another feature of malpractice damages regularly constrained by state legislatures and debated in Congress relates to the victim's financial losses. More specifically, even more states than those that have restrained pain and suffering awards have enacted some version of "collateral source offsets."[55]

This phrase means that the part of the patient-victim's financial losses which are covered by other forms of compensation—such as health care insurance or the employer making up for the lost pay—is to be deducted from the tort award.[56] In my previous writings and testimony I have always supported this brand of general tort reform, but only if another key financial item is added to the award.[57]

The standard rationale offered by its political proponents is that this offset will eliminate what is labeled a "windfall" double payment to the victim from two different insurers.[58] The opponent's response is that if we feel committed to a "free" market economy, the principled way to eliminate such double payments is to have the first party insurers simply include in their contracts with potential victims this additional term. Any health care expenses or lost wages recovered by the victim from a "guilty" third party and its liability insurer are to be returned to the first party insurer. More important, though, from the point of view of those of us who ultimately bear the cost burdens of all of these brands of insurance, is the necessity of making our first party insurers bear these costs. First party insurers spend less than 10% of their revenues on administrative and litigation expenses, whereas medical liability insurers spend 55% to 60% of their revenues that way, which we eventually pay for as part of our health care expenses.

These are the key reasons why my ALI partners and I have long advocated both a collateral source offset for financial damages and guidelines for pain and suffering damages—not just for medical malpractice cases, but also for all personal injury tort litigation.[59] Neither of these changes would be justifiable, or even ethical, unless accompanied by a key reform regarding the way the law treats the victorious plaintiffs' major use of these two damages items—paying their lawyers' fees.

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55. *See* WEILER, *supra* note 21, at 32.

56. *Id.* at 51 (stating that "the prospect of a tort windfall for losses already compensated would aggravate rather than reduce the overall risk of medical injuries").

57. *See id.* at 31–32.

58. *See* Paul C. Weiler, *Fixing the Tail: The Place of Malpractice in Health Care Reform*, 47 RUTGERS L. REV. 1157, 1177 (1995).

59. *See* WEILER, *supra* note 21, at 61–69.

The standard practice developed by our free market in legal services for tort suits is that while the defendant's attorney is paid on an hourly basis (with the fee rate dependent on the lawyer's relative talent and reputation), the plaintiff's attorney is paid only if he or she wins the case.[60] That "contingent" fee is always made a percentage of the award amount, typically one-third of it (but sometimes rising as the award figure gets higher). That kind of lawyer reward has always seemed justifiable in our tort law market not just because it pays for the attorney's work in cases that do not succeed in the courtroom, but also because it gives the lawyers a strong personal incentive to carefully assess the merits of each case before deciding to take it on, or even to continue pursuing it after assessing the host of pre-trial witnesses.

As always, though, reacting to the relative unpopularity of tort lawyers, the standard legislative response has been just to impose a ceiling on permissible plaintiff fees. The typical statutory measure (again begun in California back in 1975) is to cap the percentage at 40% for the first relatively small award or settlement amount, and then to reduce the lawyer's share down to as low as 10% as the damages figure rises.[61] Actually, it was Florida that made the more rational judgment of basing that sliding fee ceiling on when the case was resolved—such as by pre-trial settlement, by jury verdict, or on appeal.[62] That system is better for the public, not just private, interests because it encourages more voluntary resolutions of these cases by both sides. The defendant doctor can pay less while the injured patient ends up with a higher amount by settling the case earlier, without the lawyers having to do more work and thus getting paid more.

However, the rather immoral as well as irrational feature of either of these brands of legislative policy is that they only seek to restrain the fees, and thus influence the judgments of the injured patient's lawyer, and not the judgments of the lawyers representing the doctors, hospitals, and their liability insurers. Contrary to the standard myth that plaintiffs' lawyers are much better paid than their defense-side counterparts (fueled by the huge publicity given to such record-setting cases as the $250 billion tobacco suit settlement),[63] the average plaintiffs' lawyers earnings are roughly the same as those on the defense side (as must be the case in this free market setting).

60. PROSSER ET AL., CASES AND MATERIALS ON TORTS 524 (9th ed. 1994).

61. CAL. BUS. & PROF. CODE § 6146 (West 2003).

62. FLA. BAR REG. R. 4-1.5(f)(4)(B) (2003).

63. *Big Tobacco Strikes Deal with States*, WASH. POST, Nov. 15, 1998, at A20.

Thus, if we feel we really need to regulate this one branch of the legal market, the only rational as well as ethical brand of regulation is to impose such restraints on both sides of these cases. After all, we have to preserve a reasonably level legal field by ensuring that all of the highly skilled tort lawyers do not feel financially motivated to move over to the defense side where there are no caps on how much higher they can be paid than their opponents. And remember, it is not the doctors, hospitals, and their insurers, but the past, present, and future patients (some of whom are even plaintiffs) who are actually financing those fees as part of their overall health insurance costs.

More importantly, though, if we want to embark on a productive and principled reform of medical malpractice damages, we should combine that collateral source offset and pain and suffering guidelines reform by *adding* another feature to those damages awards—the winning plaintiff's reasonable attorney fees. That "reasonability" judgment again should rest on some sensible guidelines proposed by neutral litigation experts, and based on the nature and complexity of the case and the time at which the complaint was resolved (and thus the amount of work the lawyer had to do). Just as we already do in litigation, those legal fees are realistically judged to be just as much a part of the victim's damages as the additional doctor fees.[64] We should not, then, feel compelled to have a losing plaintiff pay the defendant's fees because: first, the plaintiff was not being negligent in filing the suit (unlike the losing defendant); and second, the doctors and hospitals are already fully insulated (via malpractice insurance) against these legal costs—something that the past and future patients have already paid for as part of their health insurance or medical fees.

VI. WHO SHOULD BE LEGALLY RESPONSIBLE?

This packaging together of all the legitimate changes in damages awards in our medical malpractice system—ideally in all tort suits—is a morally moderate reform because it is designed to serve general public needs rather than just specific private interests. We must recognize, though, that there is an important and legitimate group whose needs would not be fully served by any brand of damages reform: the individual physicians who are being sued.

One aspect of this is the major difference between insurance premiums experienced by obstetricians and surgeons and those experienced

64. WEILER, *supra* note 21, at 66.

by doctors in specialties.[65] Neither the typically unfair damages caps nor the very fair damages guidelines can do much for the former group who are far more likely than the latter to be producing both patient injuries and lawsuits from their brands of treatment. This is why, for example, numerous obstetricians now feel compelled to stop delivering babies and just concentrate on things like birth control and other gynecology roles.[66] However, even though it would reduce their premium costs to around one quarter of their annual costs, their counterpart gynecologists, psychiatrists, general practitioners, and all other physicians still experience or face the risk of the personal burden and emotional distress of being personally sued. Not only must they devote a considerable part of their time and effort to defending the suit, but also they must bear the cost to their reputation and personal lives of being publicly found negligent (which my HMPS partners often found to be due to incorrect judgments by our lay juries).[67]

Since my HMPS partners often found these negligence (or not) verdicts to be based on incorrect judgments made by our lay juries, we need to repair that branch of the law even more than the damages awards. As scholar Philip Howard elegantly displayed in his recent book, *The Collapse of the Common Good*, the best way to effect this repair is not by once and for all giving jury members better guidance about whether or not the doctor was negligent, but by replacing the jury system with what I would label a Medical Liability Tribunal.[68] A pioneering pilot program to demonstrate the effects of such a system has been developed for obstetrics cases in Massachusetts by my HMPS and ALI partner, Dr. Troy Brennan, and whether to authorize such a legal experiment is now being debated in our state legislature.[69]

I have long supported this effort because such a full-time administrative body (analogous to every state's workers' compensation boards for workplace injuries) would be comprised of people with real medical, as well as legal, expertise in deciding whether negligent treatment actually caused the current disability of the patient-plaintiff.

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65. *See* BHAT, *supra* note 21, at 33; U.S. GEN. ACCOUNTING OFFICE, *supra* note 8, at 13; Tanya Albert, *Liability Premium Increases Slowing, Yet Rates Remain at Record Highs*, AM. MED. NEWS, Nov. 15, 2004, at 1.

66. *See, e.g.*, Tanya Albert, *No State Immune to Liability Stress*, AM. MED. NEWS, Aug. 23, 2004, at 1 (describing physicians in several states who have given up high-risk parts of their practices due to liability insurance premiums).

67. *See* WEILER, *supra* note 21, at 1 (discussing the "personal, emotional cast to a lawsuit between patient and doctor that gives medical claims an edge that is not present" in other suits).

68. PHILIP K. HOWARD, THE COLLAPSE OF THE COMMON GOOD: HOW AMERICA'S LAWSUIT CULTURE UNDERMINES OUR FREEDOM 58–62 (2001).

69. For the statute governing our state's existing malpractice tribunal, see MASS. GEN. LAWS ch. 231, § 60B (2000).

Another important benefit of such expert accuracy replacing regular law errors is the reduction of the extensive delays experienced in reaching a malpractice verdict. Not only is the administrative process much faster than the tort system, but also both sides would have a much greater incentive to settle the case without a trial, rather than gamble on a future jury making a mistake in their favor.

The next big step, a substantive change, is one that my ALI colleagues and I fashioned for responding to legitimate doctor concerns about our current legal (not just jury) regime. We should replace the traditional *personal* liability of individual physicians by a new full-blown *enterprise* liability of health care organizations. As we will see, this change will actually serve the interests of patients as well as doctors. Thus, we were pleased to learn that in her earlier role, Hillary Clinton was persuaded to make this proposal the key malpractice recommendation to her husband's administration as part of their broader health care reform.[70] We were all saddened, though, to hear the doctors' representatives (both the AMA and the Physician Insurers Association of America (PIAA)) saying to Congress, "please don't take our liability away from us." Instead, they advocated various caps on the amount that the injured patients and their lawyers can secure in the courtroom.

Of course, this truly moderate reform would apparently make a radical change in our historic "corrective justice" theory of tort law,[71] making the culpable actor pay for all the damages he has inflicted on the innocent victim. However, especially in medical malpractice, that tort principle has long been transformed by our free market creation of liability insurance. Almost always it is not the negligent physician but his insurer who pays all of the costs of these suits, with present and future patients ultimately paying for that malpractice insurance through the fees charged for their medical services. In sum, tort law is no longer "correcting" an "injustice" done by a "guilty" doctor to an "innocent" patient—which the law has not been doing anyway because of the regular mistakes made by our legal system in judging whether a negligent injury actually took place in our medical system. From an economic perspective especially, it is the insured public in general who collectively bears the cost of these injuries and this part of our legal system.

The law itself has already made some significant moves away from pure individual physician liability. Under general tort theory, the hos-

70. *See* Health Security Act, H.R. 3600, 103d Cong. § 5311 (proposing creation of the Enterprise Liability Demonstration Project).

71. *See* WEILER, *supra* note 21, at 44–46.

pital has always been vicariously liable for the negligence of the physicians it is employing, just like it has been for the nurses and other staff members who are involved in a substantial number of these cases. The hospital has occasionally been found liable under the "agency" concept, based on the apparent authority it is exercising over non-employed doctors dealing with patients in the hospital's emergency, radiology, and anesthetic rooms.[72] Yet another legal doctrine used here is "corporate" liability, for failing to check the original credentials and ongoing performance of the independent doctors whom it permits to come in and deliver babies and perform operations inside its facility.[73] Hence, even if it is the patients who have personally picked their doctors, the hospitals can be sued for negligently failing to maintain qualifications and performance of their doctors.

Having analyzed these judicial starting points, my ALI partners and I fashioned our proposal arguing that legislators go all the way and make hospitals and other health care organizations bear liability for all physician negligence, as they have long had to do for all nursing mistakes. Not only would this largely relieve obstetricians and surgeons of the emotional as well as financial burdens of litigation and liability insurance, but also it would leave patients much better off as the supposed beneficiary of the three functions that modern tort law is supposed to be performing for them.

First, enterprise liability is much better than individual doctor liability in ensuring that patients who have already been negligently injured are going to be fully compensated, because the regular surges in insurance premiums for high-risk specialties have led many obstetricians and surgeons to reduce ceilings on their own malpractice insurance.[74] That step has actually imposed de facto caps on how much the most seriously injured patients can recover for their financial losses as well as for their pain and suffering because faced with a multi-million dollar and largely uninsured jury verdict, some doctor-defendants now use another branch of our law—bankruptcy—to relieve themselves of that liability.

Second, enterprise liability reduces the administrative and legal costs of overall malpractice insurance, which is about double the percentage of our automobile liability insurance.[75] We would no longer have multiple defendants (who now make up around one quarter of

72. WEILER, *supra* note 21, at 125 (stating that, by the 1960s, courts had "largely cleared away [the] initial legal obstacles to a hospital's liability for the negligence of its own employees").

73. *See id.* (discussing the concept of "ostensible authority").

74. *See id.* at 125–26.

75. Bovbjerg et al., *supra* note 51, at 929.

all malpractice suits),[76] each of which has to have both separate legal counsel and liability insurers.[77] This also makes it more likely that the parties will (as my Harvard colleague Roger Fisher once put it) "get to yes"[78] in negotiating a peaceful settlement to the suit because only one defendant has to agree with the plaintiff-patient on the appropriate terms. There is also no longer a group of defendants having to determine how to divide these damages among themselves.

Third, tort law's most important role, injury prevention, is also the one most likely to be enhanced by the move from individual physician to organizational liability.[79] In contrast with the doctors who typically are fully insured against damages payments, hospitals and other health care bodies have always had either experience-rated or pure self insurance against malpractice suits and awards.[80] Thus, they have the real financial incentive to take the steps necessary to provide better and more effective patient care.

True, even fully insured doctors have a strong incentive to reduce the emotional and reputational burden of lawsuits that assert they were negligent in treating their patients. However, they would face somewhat the same burden and incentive (like the nurse-employees) even if we moved from individual to enterprise liability. But as we have already learned from the product liability setting, the best tort way to reduce injuries is to add to our traditional concentration on momentary and inadvertent errors by an individual a new organizational incentive to find a common pattern in all the individual mistakes, one that can then effectively be dealt with through a safer mode of treatment.[81]

One of those common patterns may well be doctors who are most prone to make these mistakes in treating their patients. The responsible organization thus has this legal incentive to create an internal peer review committee as one of its quality assurance programs. This committee should consist of a few top physicians who regularly review the performance and patient results of their colleagues, whether or not these have produced lawsuits upheld by juries. They then make expert judgments as to whether any detectable individual problems are the result of their skills or their work settings, and what must be done to remove either source. The fact that we have always made the air-

76. WEILER, *supra* note 21, at 127.

77. *Id.*

78. *See generally* ROGER FISHER ET AL., GETTING TO YES: NEGOTIATING AGREEMENT WITHOUT GIVING IN (1991).

79. WEILER, *supra* note 21, at 129.

80. *Id.* at 130.

81. *See id.* at 130–31.

lines, not the pilots, bear the legal responsibility for any plane crashes[82] should be the role model to reduce what our HMPS found to be a far greater aggregate risk in the hospital than up in the air.

In contrast with what I stated earlier about malpractice damages, I am not advocating that Congress enact a law mandating a national move from individual to organizational medical liability. Instead, as my ALI partner Ken Abraham and I proposed a decade ago, the more sensible step is for various states to conduct their own experiments about the appropriate design of this more radical (but equally ethical) reform of our existing judge-made law.[83] We were pleased by the more ethical brand of federal reform introduced by Wyoming Senator Mike Enzi in July 2003. His proposed *Reliable Medical Justice Act* aimed to provide federal funding for such state experiments, as long as the states also conducted detailed analyses and made reports about how they were working.[84]

One key issue is which is the appropriate enterprise to bear such responsibility—for example, the hospital or the HMO? In more and more situations, we do not need to make that choice because the two bodies are legally related. Where they are totally separate, though, the hospital is likely the better candidate to be the presumptively liable organization because it has a better intellectual and administrative capacity than an insurer to make our health care safer, not just cheaper.

Any such organizational liability must then be imposed not only for negligent treatment that takes place inside the hospital, or outside to patients who have been treated before or after that mistake, but also ideally with respect to patients who never came into the hospital because their conditions were misdiagnosed in the doctors' offices. If, as regularly happens, the careless doctor is affiliated with more than one hospital, then the one where he or she does most of his or her work (which should be designated for all doctors in the state) would bear the legal responsibility for that latter case. But within that broader statutory framework, the various hospitals and HMOs should still be free to negotiate and agree to any contractual reallocations about the financial costs, the design, and the administration of safety procedures. The costs of this enterprise liability regime, like the current one, would be paid for by the patients and their health care insurers.

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82. *See, e.g.*, Cox v. Northwest Airlines, Inc., 379 F.2d 893 (7th Cir. 1967).

83. *See* Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 421–36 (1994).

84. Reliable Medical Justice Act, S. 1518, 108th Cong. (2003).

VII. FAULT VS. NO-FAULT LIABILITY

While the legal move from individual to enterprise medical liability should be made on the state level, federal law must make it clear that state legislatures are free to make this move if they so choose. State governments should also give the same freedom to their health care bodies to begin experimenting with what I have long advocated as an even more radical reform—moving from fault-based to no-fault medical liability. This is an ethical step because it will treat the patient who is injured in the hospital in essentially the same legal fashion as a nurse injured there.

To understand why it is also a very productive move, we should compare no-fault liability with current medical malpractice in terms of the three basic tort policy standards. The most obvious gain from no-fault liability is that it will provide compensation to everyone who was injured by their medical treatment, not just to those patients who were able to detect and prove to a jury that some identifiable negligence caused their injury. This approach is also financially feasible because reimbursing the costs of those injuries would add just a tiny fraction to our constantly surging $1.4 trillion health care budget[85] (some part of which is already spent to give the additional care needed by medically injured patients). More importantly, if we do follow the workers' compensation model, we would actually be stabilizing the costs of reimbursing injured patients and reducing the number of injured patients.

This legally required medical injury compensation should be provided only for relatively serious injuries—such as those that last for at least two months. While the more slightly injured patients would thus be formally deprived of their current legal rights if their injuries were due to negligence, the fact is that they typically are insured against those short-term health care costs and lost pay, and would rarely be suing for such pain and suffering. Even for the lengthier medical injuries, this no-fault compensation regime should be reimbursing patients for just their *net*, not their *gross*, losses, leaving first party insurance to play the same primary reimbursement role that I have also endorsed under the collateral source offset principle, even for fault-based liability.

Next, following the same principle of workers' compensation for injured nurses, the net wage losses to be reimbursed by no-fault patient compensation should be based on a scale ranging from 100% of the

85. For one account of the rising cost of our health care system, see Katharine Levit et al., *Health Spending Rebound Continues in 2002*, HEALTH AFF., Jan.–Feb. 2004, at 147, 148.

pay lost by low-paid workers, to 80% of the average worker earnings, and down to 50% or less of the lost earnings of those at or above three times that average (though ideally these ceilings should also be adjusted by the number of family members being supported by the now-disabled patient). This is actually a much more equitable form of legal redress because it is the working class majority of this country who will bear the bulk of the costs of this regime (as they now do for malpractice litigation) as a portion of their public and private health care premiums. The more well-to-do families, who have always been far more likely to be fully insured for all their health care treatments, can also make sure they have invested in private disability insurance to cover their additional lost pay (as we already do above our basic Social Security plan). Following these principles, our HMPS research found that the costs of this far broader and fairer brand of medical injury insurance are fully affordable when compared to the present expenditures on malpractice litigation and insurance.

This far broader, no-fault medical compensation costs no more than our much more limited fault-based liability system because the administrative expenditures for the former regime will be substantially lower than for the latter. In contrast with the 60% of medical malpractice administrative costs that is largely spent on determining whether an injured patient is entitled to any redress under tort law, just a 20% share is spent administering workers' compensation, providing for faster, fairer, and broader benefits for injured nurses and other care workers.

It is true, however, that the costs of administering a no-fault medical liability regime would be somewhat higher than for workers' compensation. The key reason is that some of the former cases would require a judgment about whether the doctor had *failed* to make the correct diagnosis or treatment that would have cured the original patient's illness, but instead allowed it to develop into a permanent disability or death. However, our Harvard Studies found these "close calls" to be just a small share (around 5%) of the total number of medically produced injuries. This is just a fraction of the far more difficult judgments that are now made about medical negligence—which include not just discovering whether someone was at fault, but also whether it was this particular mistake that actually gave rise to the current disability.

Yet another benefit from this no-fault system is that eventually doctors would feel little personal need to contest such claims. Indeed, just like supervisors now do for their injured workers, they would be far more likely to help rather than hinder their injured patients' at-

tempts to secure this crucial and fair compensation for their additional health care costs and lost earnings. Patient groups should also embrace rather than resist this idea of moving from our current slow and expensive process of trying to get in front of a one-time lay jury to decide whether the doctor was at fault, to the streamlined process of a full-time expert tribunal (made up of both expert doctors and lawyers) judging whether previous health care was one of the causes of the patient's current disability (or death).

As we have already witnessed with my earlier reform proposals, this now brings us to an even more important legal policy dimension than providing more equitable compensation through more economical administration for past injuries—securing more effective prevention of future injuries. This last feature is the key reason why we should not be tempted to adopt for medical injuries the even more equitable and inexpensive Medicare and Social Security models, which require proof only of the current disability and its financial losses without regard to causation.[86]

Our lengthy experience with having limited no-fault workers' compensation for those employees injured on the job (rather than at home, for example) provides legally and financially responsible employers with a major incentive to invest in and undertake serious efforts to make their workplaces safer, and thus not only prevent future injuries to their staff, but also reduce this brand of their productive costs.[87] The most revealing research appraisal of this feature of workers' compensation was done by my Harvard colleague and ALI partner Kip Viscusi. He discovered that, by comparison with government regulation of employer actions under the Occupational Safety and Health Act (OSHA),[88] which reduced workplace deaths by around 2% to 3%, the experience-rated workers' compensation laws are annually preventing 25% to 30% of what otherwise would be fatal accidents or diseases inflicted on employees by their jobs.[89]

An even bigger gain might well be achieved under no-fault medical injury law. Even though our HMPS research in New York, Colorado, and Utah found that the majority of medical injuries are covered by what were then judged to be blameless forms of medical treatment, the fact that even these patients' damages would have to be paid for

86. *See, e.g.*, Carpentier v. Sullivan, 755 F. Supp. 816, 820 (C.D. Ill. 1990) (summarizing the two-step process by which a plaintiff may establish disability under the Social Security Act).

87. *See, e.g.*, 80 ILL. COMP. STAT. 305/11 (2001) (providing compensation only for "injuries sustained by [an] employee arising out of and in the course of the employment").

88. 29 U.S.C. §§ 651–678 (2000).

89. *See generally* W. Kip Viscusi, *The Impact of Occupational Safety and Health Regulation, 1973–1983*, 17 RAND J. ECON. 567 (1986).

by an experience-rated or even self-insured hospital or other health care body would give them all a major legal and financial incentive to make this form of medical treatment safer as well as more productive.

Numerous hospitals, HMOs, and physician firms could poll their files about all patient injuries they needed to compensate and how exactly they were covered. Using this raw material (and aspiring for a future Nobel Prize), medical school and other scientific scholars would be able to devote some serious research efforts to devising the procedures and inventing the technologies that would help prevent future health care injuries, not just cure the original patient diseases.

Both my ALI and HMPS scholarly partners have long been committed to the value of this truly radical tort reform. However, I should make clear that we have not been advocating, at least at this stage, that our legislators (even at the state, let alone federal level) should be *mandating* the immediate replacement of our long-term, fault-based malpractice law by this brand of no-fault medical injury compensation. Instead, we need some serious experiments of this type to be engaged in by such bodies as the Harvard Health Care System. All we need from the legislatures are statutes that explicitly permit this to be done (and ideally offer some financial aid, as Senator Enzi has been calling for), as long as these plans meet the kind of truly fair standards synopsized here and elaborated in my book *Medical Malpractice on Trial.*

Indeed, as I discovered while working on the new edition of my *Sports and the Law* text,[90] there has been a surge in lawsuits against the team physicians in professional sports, especially in the more dangerous sports, football and hockey.[91] These suits are filed by players who were injured on the field or the ice, who then found their injuries and professional careers aggravated rather than alleviated by the doctor care provided by their teams.[92] These sports malpractice cases tend to produce far larger awards and settlements because of the way the average player salary has surged under major league unionization. On the other side, though, a considerable number of both doctors and insurers have recently decided to opt out of this specific branch of their professional lives.

Thus, what I have proposed as an insightful (and also popular) experiment here would be for the National Football League (NFL) and/or the National Hockey League (NHL) and their players' unions, the

90. PAUL C. WEILER & GARY R. ROBERTS, SPORTS AND THE LAW: TEXT, CASES, PROBLEMS (3d ed. 2004).

91. *Id.* at 1130.

92. *Id.* at 1130–31.

National Football League Players Association (NFLPA) and the National Hockey League Players' Association (NHLPA), to design and put into operation the specifics of this no-fault regime. The doctors should be made part-time employees—ideally, of the league, not individual teams, in order to avoid the tension between the wishes of the injured player's family and those of his coach that produced many of these cases. Then, both the actual losses of the injured players would be fully compensated and the leagues would have the incentive to make their games somewhat safer. The players as a whole, as well as the team doctors, would find this to be a much more productive as well as amicable instrument for shaping game care than sending a few (usually retired) players off to court.

VIII. Conclusion

I trust we have all now seen what I meant by advocating "radically moderate" as well as ethical law reform. This approach has us looking for a host of legal changes, ranging from the most obvious issues on the surface, to those that address the fundamental problems generated by the interplay of medical, legal, and even financial regimes. But to be truly ethical, we must only endorse reforms that, rather than designed to serve the special interests of any one (or even all) of these groups, focus instead on the truly public good—protecting the needs of past, present, and future patients in all three of these important citizen roles.

That is why my HMPS and ALI colleagues fashioned the three brands of malpractice law reform I have presented here. The first, damages guidelines, seeks to ensure that already injured patients secure all, but no more than they actually deserve to redress their losses. The second, moving from personal to enterprise liability, not only gives our doctors some insulation from the special emotional and financial burden that this litigation regularly generates for them (far more than any other profession's experience, including lawyers, judges, and law professors), but also gives patients much better protection, both in realizing their legal claims and enhancing their initial medical treatment.

Our most radical malpractice reform—moving from fault to no-fault liability and thus treating injured patients in the same fashion as injured nurses—is potentially the most productive on all of these patient dimensions. We should hope, then, that we will have both a legislative reform that makes such an experiment legally permissible, and a truly ethical enterprise like the NFL or NHL that can then give us all the benefits of their experience in that new legal venture.