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I. INTRODUCTION

The recurring crises in medical malpractice litigation have been widely discussed and documented over the past two decades.[1] In response to these crises, a growing consensus has emerged among legislatures, government agencies, and scholars in favor of tort reform.[2] Indeed, virtually every state has passed some tort reform legislation.[3] Despite the reforms, several serious problems persist in medical malpractice. The current tort system does not compensate injured patients adequately or equitably, nor does it deter negligent practices sufficiently. These failings occur despite the increasingly high costs to soci-

1. *See, e.g.*, U.S. DEP'T OF HEALTH, EDUC. & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (1973); P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY (1985); *Medical Malpractice: Can the Private Sector Find Relief?*, 49 LAW & CONTEMP. PROBS. 1 (Spring 1986).

2. *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE 32-48 (1987) [hereinafter HHS REPORT]; U.S. DEP'T OF JUSTICE, REPORT OF THE TORT POLICY WORKING GROUP ON THE CAUSES, EXTENT AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY 60-75 (1986) [hereinafter DOJ REPORT]; *see also* Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 LAW & CONTEMP. PROBS. 201 (Spring 1986); O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS. 125 (Spring 1986).

3. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS 9 (1986) [hereinafter 1986 GAO STUDY]; *see, e.g.*, W. VA. CODE §§ 55-7B-1 to 55-7B-11 (Supp. 1988).

ety of the tort system. Particularly troublesome is the impact of these crises on the access to and quality of medical care.

In response to these persistent problems and the failure of conventional tort reform efforts, the American Medical Association, thirty-one national medical specialty societies, and the Council of Medical Specialty Societies have joined together as the AMA/Specialty Society Liability Project (Liability Project) to propose a new and comprehensive alternative to the existing tort system.[4] The proposal has three components and is designed for implementation on an experimental basis in one or more states.

The proposal first calls for an administrative hearing process to replace the civil jury system in deciding claims of medical malpractice. Second, while fault is retained as the basis for liability, the proposal modifies several of the other legal rules for determining liability. These first two elements of the proposal are designed to bring greater rationality, equity, and efficiency to the tort system's goal of compensation. The proposal also includes reforms of the processes for educating, credentialing, and disciplining physicians.[5] These changes will ensure that physicians are of a high quality which, ultimately, is the purpose of deterrence in the current malpractice system.

Part II of this Article discusses the problems with the current tort regime in medical malpractice. Part III describes the medical profession's proposed alternative, and Part IV explains why the proposed system is superior to the current tort system in dealing with medical injury. Part V concludes that the proposed administrative alternative is fair to patients, physicians, and the public and deserves implementation, at least on an experimental hasis.

II. Rationale for an Alternative System

A. *Failure of the Tort System to Serve the Goal of Compensation*

The current tort system precludes many patients with relatively small damage claims from receiving any compensation for injuries caused by medical negligence. This preclusion of small claims occurs because the potential recovery may not be large enough to yield an ade-

4. The full list of the members of the Liability Project is included in Appendix A at the end of the Article.

5. The educational, credentialing, and disciplinary reforms apply only to physicians. The education, credentialing, and disciplining of other health care providers will continue to be performed by their specific licensing boards. On the other hand, because many claims of negligence involve several different kinds of health care providers, the new system for resolving malpractice claims will apply to all health care providers in order to ensure efficient resolution of such claims.

The system will not have jurisdiction, however, over claims other than malpractice claims, such as products liability claims, even if those other claims arise out of the same incident.

quate contingent fee to permit the patient to enlist the services of an attorney, particularly if the complexity of the relevant medical issues requires a substantial investment of attorney time.[6] According to one estimate, most lawyers will not accept a medical malpractice case unless the expected recovery is at least 50,000 dollars.[7] Hence, the United States General Accounting Office has identified "the need for the injured party to obtain a lawyer to gain access to the system" as one of the primary limitations of the current compensation scheme.[8]

Significant evidence suggests that a substantial number of potential claims are never brought into the civil justice system. In his classic study of hospital records in California, Don Harper Mills found a surprisingly large number of injuries caused by negligent medical treatment.[9] The Harvard Medical Practice Study Group, in a more sophisticated analysis, found comparable results in its 1987 pilot study on the feasibility of a no-fault alternative.[10] Professor Patricia Danzon compared Mills's data on injuries with estimates of malpractice claims in California for the same period of time.[11] Professor Danzon concluded that "at most 1 in 10 incidents of malpractice resulted in a claim at the height of the malpractice crisis, and at most 1 in 25 received compensation."[12] Adjustment of the California data to reflect the increased filing of claims since the studies were conducted yields a similar result: only twenty percent of negligently inflicted injuries are likely to give rise to

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6. P. Weiler, Legal Policy for Medical Injuries 226 (Jan. 1988) (unpublished manuscript); Tobias, *Background Paper* to TREATING MALPRACTICE: REPORT OF THE TWENTIETH CENTURY FUND TASK FORCE ON MEDICAL MALPRACTICE INSURANCE 5 (1986) (concluding that "because of the staggering costs of trials, many legitimate claims are never brought simply because they are not financially rewarding enough to attract a lawyer"). *But see infra* note 14.

7. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION 23 (1987) [hereinafter GAO FRAMEWORK].

8. *Id.* at 30.

9. CAL. MEDICAL ASS'N, MEDICAL INSURANCE FEASIBILITY STUDY (1977). It is far from clear that all of the incidents Mills identified involved actual negligence by a healthcare provider because all he had available were hospital records.

10. *See* HARV. MEDICAL PRACTICE STUDY GROUP, MEDICAL CARE AND MEDICAL INJURIES IN THE STATE OF NEW YORK: A PILOT STUDY 59 (1987). Of course, given the increased frequency of claims since the 1970s, it is reasonable to expect that the number of incidents that are ignored has decreased.

11. P. DANZON, *supra* note 1, at 18-29.

12. *Id.* at 25. Other studies of malpractice frequency have reached similar conclusions. Records of patients discharged from two hospitals in 1972 suggested that only 7% of injuries resulting from negligence led to filing of claims. Moreover, the researchers felt that they had underestimated the frequency with which malpractice occurred. Schwartz & Komesar, *Doctors, Damages and Deterrence: An Economic View of Medical Malpractice*, 298 NEW ENG. J. MED. 1282, 1286 (1978). Data from the American Bar Association indicate that only about 17% of malpractice-related injuries result in claims. ABA Special Comm. on Medical Professional Liab., Report to the House of Delegates 31 (1986).

claims.[13] In short, convincing data show that the civil justice system fails to compensate a significant number of those injured by medical negligence.[14]

Even when the current tort system provides compensation, it does not treat similarly situated litigants equitably. The Rand Corporation found that juries have awarded plaintiffs significantly greater amounts—200 to 500 percent—in malpractice cases than in cases concerning identical injuries not involving physicians as defendants.[15] Similarly, in Miami, the average malpractice award was nearly 900,000 dollars during 1985 to 1987 compared with an average award of 265,000 dollars for all tort cases.[16]

The current tort system also does not treat similarly situated malpractice plaintiffs equitably. Because large portions of the awards depend upon subjective and emotional considerations,[17] some injured patients recover nothing, some receive less than fair compensation, and others recover amounts far in excess of their losses, both economic and noneconomic.[18] Among patients with grave and permanent total disabilities whose claims closed in 1984, for example, recoveries ranged from a low of 10,000 dollars to a high of 2,472,020 dollars.[19] Among malpractice plaintiffs generally, those with economic losses over 100,000 dollars are not fully compensated, while claimants with economic losses less

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13. P. DANZON, *supra* note 1, at 25. This phenomenon of low rates of suit is not confined to medical malpractice. Low rates of suit are widespread in tort law, generally. *See* Pierce, *Encouraging Safety: The Limits of Tort Law and Government Regulation*, 33 VAND. L. REV. 1281, 1295-96 (1980).

14. The infrequency of malpractice claims cannot he explained fully on the basis that most injuries carry a probable recovery too low to justify the litigation costs. Professor Danzon found that fewer than 15% of patients with major permanent disabilities due to malpractice filed claims. P. DANZON, *supra* note 1, at 25.

15. A. CHIN & M. PETERSON, DEEP POCKETS, EMPTY POCKETS: WHO WINS IN COOK COUNTY JURY TRIALS 55 (1985). The average medical malpractice award was five times the size of jury award to similarly situated personal injury plaintiff and almost twice the size of average award in product liability cases for similar injuries. *Id.*

16. *See* ACADEMIC TASK FORCE FOR THE REVIEW OF THE INS. & TORT SYS., PRELIMINARY FACT FINDING REPORT ON MEDICAL MALPRACTICE 155 (1987).

17. D. DOBBS, LAW OF REMEDIES 545 (1973). In particular, juries have virtually unbridled discretion in determining damages for pain and suffering. Although such injuries involve real loss to the plaintiff, there is no meaningful way for anyone to measure this loss in monetary terms. *Id.* Indeed, the unquantifiable nature of pain and suffering is one explanation for why people never purchase insurance for these damages. *See* Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1547 (1987).

18. Grad, *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, 36 CASE W. RES. L. REV. 1058, 1067-68 (1986); Moore & O'Connell, *Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss*, 44 LA. L. REV. 1267, 1269 (1984) (arguing that the result is akin to a lottery); O'Connell, *supra* note 2, at 899-900.

19. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984, at 43 (1987) [hereinafter 1984 GAO STUDY].

than 50,000 dollars are overcompensated.[20] In sum, an important limitation of the current civil justice system in the medical liability context is the "unpredictable nature of and lack of uniformity in loss compensation."[21]

Moreover, the use of juries is an inefficient way to resolve medical liability disputes. As Professor Jeffrey O'Connell has observed, deciding whether a physician is at fault requires "exhaustive offers of proof from both sides," resulting in practiced and confusing litigation.[22] The fact finder must make a determination of causation in the face of considerable medical uncertainty about why illnesses strike particular individuals at particular times. In addition, the fact finder must decide whether the patient was treated appropriately whenever experts cannot agree on that question. Lay juries in malpractice cases are ill-equipped to resolve the arcane issues involved.[23] Furthermore, juries cannot evaluate independently the expert testimony[24] almost always introduced in malpractice cases to explain the two major elements of liability: failure to meet the appropriate standard of care and causation.[25]

The nature of medical knowledge compounds the difficulties presented as a result of the jury's lack of expertise. Despite technological progress, the appropriate treatment for a particular case is often debated within the medical field because medical science remains an art. The legal system, however, does not accommodate the fact that science and medicine involve inherent uncertainty. Because of the complexity of the issues, judges allow juries to hear medical views that may not be scientifically credible.[26]

Moreover, the process of presenting issues to the jury through questioning of an expert by counsel is not always calculated to educate

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20. *Id.* at 44-45. One study of the fault system for automobile accidents found overcompensation in small cases, while plaintiffs with high economic damages often received less than 25% of their loss. Franklin, *Replacing the Negligence Lottery: Compensation and Selective Reimbursement*, 53 VA. L. REV. 774, 780 (1967).

21. GAO FRAMEWORK, *supra* note 7, at 30.

22. O'Connell, *supra* note 2, at 899.

23. DOJ REPORT, *supra* note 2, at 63 (concluding that "[l]ay juries are a very poor mechanism for second-guessing the judgment of established mainstream scientific and medical views"); *see also* Richardson, Rosoff & McMenamin, *Referral Practices and Health Care Costs*, 6 J. LEGAL MED. 427, 443 (1985); Tancredi, *Compensating for Medical Injuries*, 1986 N.Y. ST. J. MED. 370, 372 (reporting that an important defect in the tort system is the jury's inability to evaluate medical responsibility).

24. As a corollary, since advocates are required to educate juries on the complex medical issues, discovery and the ensuing trials are lengthy and costly processes. Abraham, *Medical Liability Reform: A Conceptual Framework*, 260 J. A.M.A. 68, 70-71 (1988).

25. W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS 188-89 (5th ed. 1984) [hereinafter PROSSER & KEETON]. Particularly important are failure to meet the standard of care and causation, because these elements involve technical and scientific issues.

26. DOJ REPORT, *supra* note 2, at 62-63.

jurors on the issues. If, for example, the attorney fails to clarify a point to a juror's satisfaction, that juror is not permitted to ask any questions of the witness which might help the juror to understand the basis for the testimony.[27]

Even under the best of circumstances, juries can never be as effective as specialized triers of fact at deciding malpractice cases because jurors are exposed to the medical issues only once; consequently, they cannot develop an institutional memory to aid them in deciding a specific dispute. This lack of exposure to medical issues not only impairs jurors' ability to decide each case, but also increases costs[28] and the likelihood of inconsistency across different cases. Furthermore, since juries are not required to articulate reasons for their findings and award determinations, their decisions cannot be scrutinized by insurers, lawyers, and claimants to establish reliable predictions for future claims.[29] The uncertainty produced by the system undermines the appearance of legitimacy and aggravates the problems of availability and affordability of insurance.[30]

These inefficiencies of the jury system lead to a very time consuming dispute resolution process. According to conservative estimates, it takes an average of over two years from the filing of a malpractice claim until its disposition.[31] Claims in which indemnity payments are made typically require more time. Cases involving substantial awards remain outstanding for the longest period of time: some cases are still open after ten years.[32]

B. Failure of the Tort System to Serve the Goal of Deterrence

Tort liability is an inadequate deterrent to negligent behavior in medical malpractice. Because negligent behavior is not closely related to the likelihood of paying an injured victim, the tort system does not communicate effective signals to physicians. As discussed above, most patients injured by malpractice never file a negligence claim.[33] Patients

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27. L. WEINREB, DENIAL OF JUSTICE 112-13 (1977).

28. Abraham, *supra* note 24, at 70.

29. M. Trebilcock, The Insurance-Deterrence Dilemma of Modern Tort Law, Presentation to the National Conference of State Legislatures National Seminar, Controlling Liability Costs: State Actions and Alternatives 405 (Dec. 14-16, 1986).

30. When tort liability and awards become unpredictable, insurers cannot effectively group insureds into risk pools. Thus, premiums increase as the range of potential liability expands, until at some level of uncertainty insurers are forced to withdraw coverage. Priest, *supra* note 17, at 1582-84.

31. 1984 GAO STUDY, *supra* note 19, at 33. Another report estimates that a malpractice claim takes an average of seven years to adjudicate. Moore & O'Connell, *supra* note 18, at 1270 n.9.

32. 1984 GAO STUDY, *supra* note 19, at 33.

33. *See supra* notes 6-14 and accompanying text.

often do not know whether a bad result is caused by medical malpractice, a pre-existing condition, or an inherent risk of the accepted medical treatment.[34]

Moreover, whether an injury becomes a claim depends to a great extent on factors other than whether the health care provider is culpable. The severity of a patient's injury and the personal relationship between the physician and patient are two often cited factors contributing to a patient's decision whether or not to file suit for an injury.[35] Some patients refrain from suing because they rely upon and trust their medical care providers and do not wish to disrupt a longstanding physician-patient relationship.[36] In particular, the tort system discourages Medicare patients from filing malpractice claims; these elderly patients file claims at only one-quarter of the filing rate for patients younger than sixty-five years old.[37] Medicare patients fear they will not find another physician if they sue their current one. Furthermore, contingency-fee lawyers lack incentives to represent elderly patients: the expected awards will be lower due to the decreased life expectancy and lower earning capacity of senior citizens.[38] The tort system thus fails to capture a sufficient number of malpractice claims to deter negligent medical treatment.[39]

Finally, claims that do enter the system and reach resolution may result in over deterrence. Liability may be imposed in cases where it is unwarranted. When the physician's practices are viewed in hindsight after they have caused a serious injury, it is easy to overestimate the risks and underestimate the benefits of those practices.[40] Hence, the effect of the threat of tort liability on the quality of each physician's practices is uncertain. This uncertainty increases the use of defensive medicine and undermines deterrence effects.[41]

The existence of liability insurance[42] further exacerbates the uncertainty surrounding the question of what influence the threat of tort liability has on the quality of each physician's practices. The availability of insurance distorts deterrence because insurers generally do not indi-

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34. *See* O'Connell, *supra* note 2, at 126.

35. P. Weiler, *supra* note 6, at 136; *see also* Book Note, 99 HARV. L. REV. 2001, 2002 n.12 (1986).

36. O'Connell, *supra* note 2, at 126.

37. Moore & O'Connell, *supra* note 18, at 1269-70.

38. *Id.* at 1270.

39. This problem is not unique to medical malpractice; it occurs widely among different kinds of torts. *See* Pierce, *supra* note 13, at 1295-96.

40. *Cf.* Easterbrook, *The Supreme Court 1983 Term, Forward: The Court and the Economic System*, 98 HARV. L. REV. 4, 29-30 (1984).

41. O'Connell, *supra* note 2, at 125-26.

42. Grad, *supra* note 18, at 1063.

vidualize premiums according to malpractice experience of physicians.[43] Thus, good physicians and bad ones pay the same premiums within a particular specialty.

An additional failure of the tort system highlights the need for regulatory deterrent mechanisms: only negligent behavior that results in an identifiable injury qualifies as a potential claim. This aspect of the tort system, known as the "defendants' lottery," treats similar negligent behavior differently by imposing liability only on the defendant whose unfortunate victim is injured and successfully establishes a compensable claim.[44] Therefore, it is important to complement the indirect deterrence of tort liability with direct efforts to identify and correct substandard medical practices.[45] The proposal's monitoring element is designed to fill the void in the compensation system where negligent activity occurs but escapes sanction.

C. Unjustifiably High Costs to Society of the Current Tort System

Society pays a heavy price for the current tort system's deficiencies. Over the past twenty years, for example, the frequency of malpractice claims has soared. While there was only one claim per thirty-seven physicians in 1968, by 1975 there was one claim for every eight physicians.[46] In some states, including California, Florida, and New York, there is now one claim filed for every three or four physicians.[47] Moreover, these increases have occurred despite the absence of any medical basis for their development. There also have been substantial increases in the severity of claims, measured by the size of damage awards, especially for noneconomic damages.[48] Between 1975 and 1985, the average medical malpractice jury award increased from 220,018 dollars to 1,017,716 dollars.[49]

As a consequence of the increases in the frequency and severity of

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43. *See* Brook, Brutoco & Williams, *The Relationship Between Medical Malpractice and Quality of Care*, 1975 DUKE L.J. 1197, 1206. By using deductibles together with experience ratings for liability insurance, deterrence could be maintained. P. Weiler, *supra* note 6, at 139. Experience rating, however, is not feasible in the context of insurance for medical malpractice. *Id.* at 139-48.

44. *See* Franklin, *supra* note 20, at 790-91.

45. P. Weiler, *supra* note 6, at 146 n.207; *see also* Shavell, *Theoretical Issues in Medical Malpractice*, in THE ECONOMICS OF MEDICAL MALPRACTICE 35, 49 (S. Rottenberg ed. 1978) (stating that nonmarket mechanisms, such as licensing and education, may be necessary to assure competent and quality health care).

46. P. DANZON, *supra* note 1, at 60.

47. 1986 GAO STUDY, *supra* note 3, at 17.

48. DOJ REPORT, *supra* note 2, at 35-42. On average, compensation for pain and suffering accounts for 80% of the total award when the recovery for pain and suffering exceeds $100,000. *Id.* at 67.

49. *Id.* at 35-36. Of the 363% increase, only 100% can be attributed to the decline in the value of the dollar. *Id.* at 36, 42 n.41.

malpractice claims, malpractice insurance premiums have skyrocketed. In the mid-1970s, insurers imposed increases in premiums of up to five hundred percent,[50] and the total costs for medical liability insurance rose from sixty million dollars in 1960 to nearly five billion dollars in 1985.[51]

The high costs of the system for resolving malpractice claims are exacerbated by the system's inefficiencies. According to the best evidence available, only sixteen to forty cents of each dollar paid in malpractice insurance premiums is paid as compensation for an injury caused by medical negligence.[52] In contrast, the administrative worker's compensation scheme delivers fifty-five to seventy percent of premium dollars to the injured claimant.[53] Moreover, the monies received by injured patients are substantially reduced by their litigation expenses, including attorneys' fees and additional sums for expert witnesses.[54]

The civil justice system also imposes high intangible costs. Both patients and physicians are subject to the anguish and lost productivity of the tort system's lengthy proceedings.[55] The increasing amount of time that physicians must expend to respond to malpractice claims compounds the problem of decreased access to medical care. For example, a recent physician survey revealed that fifty-five percent of malpractice claims took three or more years to close.[56] Moreover, the system's adversarial approach is fundamentally at odds with the cooperation between physicians and patients that is vital to the provision of quality medical care. Consequently, the civil justice system often compromises the integrity of the physician-patient relationship.[57]

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50. P. DANZON, *supra* note 1, at 97.

51. *Compare* U.S. DEP'T OF HEALTH, EDUC. & WELFARE, APPENDIX: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 509 (1973) *with* U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: INSURANCE COSTS INCREASED BUT VARIED AMONG PHYSICIANS AND HOSPITALS 25, 39 (1986).

52. *See* Grad, *supra* note 18, at 1072 & n.57; *see also* HHS REPORT, *supra* note 2, at 16 (reporting that other estimates show that 18 to 54 cents of each premium dollar compensates the plaintiff).

53. HHS REPORT, *supra* note 2, at 16.

54. Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.)*, 73 CORNELL L. REV. 170, 172 & n.6 (1988). Estimates show that less than half of total insurance premiums spent by health care providers is paid to the injured patients and only half of those dollars actually compensates the plaintiffs for their injuries. A significant portion of awards, usually a one-third contingent fee, goes to attorneys. *Id.*

55. *See* Moore & O'Connell, *supra* note 18, at 1268.

56. OPINION RESEARCH CORP., PROFESSIONAL LIABILITY AND ITS EFFECTS: REPORT OF A 1987 SURVEY OF ACOG'S MEMBERSHIP 13-21 (1988) (report prepared for the American College of Obstetricians and Gynecologists) [hereinafter ACOG REPORT].

57. HHS REPORT, *supra* note 2, at 17; NAT'L INST. FOR DISPUTE RESOLUTION, PATHS TO JUSTICE: MAJOR PUBLIC POLICY ISSUES OF DISPUTE RESOLUTION 10 (1983) (Report of the Ad Hoc Panel on Dispute Resolution and Public Policy).

The costs of the current tort system are threatening the availability and affordability of insurance coverage and health care in many geographic areas in the United States and in many medical specialties. Several of the major national insurance carriers, including Hartford, Fireman's Fund, and Travelers, have stopped writing malpractice insurance entirely.[58] In response to coverage limitations and enormous increases in insurance premiums for certain medical specialties, many physicians have curtailed their practices. For example, obstetrician-gynecologists increasingly are turning away from the practice of obstetrics. According to a recent survey of physicians conducted by the American College of Obstetricians and Gynecologists, almost one in eight obstetrician-gynecologists has stopped delivering babies because of concern over malpractice liability, with two-thirds of that group quitting obstetrics before the age of fifty-five.[59] Consequently, forty-four percent of the counties in Georgia,[60] forty-two percent of the counties in Alabama,[61] and thirty percent of the counties in Colorado[62] no longer have any physician providing obstetrical services. Even among obstetrician-gynecologists still practicing, there have been sharp reductions in the provision of health care, particularly with respect to high-risk obstetrical patients. For example, while only 1.6 percent of obstetrician-gynecologists in 1985 devoted less than 10 percent of their practice to high-risk care, 45.4 percent of obstetrician-gynecologists in 1987 so limited their high-risk practice.[63] The crisis in litigation also has led to cutbacks in emergency care. The high cost of malpractice insurance for surgeons forced five out of the six hospitals in Dade County, Florida's trauma network to close their trauma units,[64] and fifteen out of the nineteen hospitals in Broward County, Florida to close or restrict their emergency rooms.[65]

D. Inadequacies of Other Proposed Alternatives

Because the existing judicial tort system imposes high costs on society without serving adequately its goals of compensation and deter-

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58. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS. 5, 8-9 & n.23 (Spring 1986).

59. ACOG REPORT, *supra* note 56, at 5.

60. GA. OBSTETRICAL & GYNECOLOGICAL SOC'Y, PHYSICIAN SURVEY (1987).

61. MEDICAL ASS'N OF THE STATE OF ALA., SURVEY ON OBSTETRICAL CARE (1985).

62. Calonge, *Colorado Obstetrical Care Malpractice Study Report*, COLO. MED., Feb. 15, 1988, at 63.

63. ACOG REPORT, *supra* note 56, at 6-7.

64. *See* Perspectives Insert, *Crisis in Trauma Care*, 42 MED. & HEALTH (K. Fackelman ed. Aug. 29, 1988).

65. *See* Sutton, *Patients Wait for Malpractice Solutions*, United Press Int'l (Sept. 20, 1987) (LEXIS, Nexis library, Current file).

rence, it is reasonable to consider whether a more fair and efficient alternative can be developed. While minor changes within the civil justice system may ameliorate some of the problems, these changes have been tried for over a decade in most states without resolving the crisis surrounding the availability and affordability of professional liability insurance.[66] The uneven success of these reforms within the current system justifies serious consideration of a proposal that represents a complete alternative for resolving medical liability disputes.

Indeed, some states already have begun to explore more dramatic departures from the traditional system. For example, both Virginia and Florida recently enacted legislation establishing a no-fault compensation fund for a limited category of infants suffering from birth-related neurological injuries.[67] Commentators have called for more extensive experiments with various alternatives to the present system, including no-fault compensation for medical injuries[68] and contractual approaches.[69]

After considering a wide range of alternative tort reform proposals, we are convinced that a state administrative agency, applying a negligence standard, would be best able to respond to the deficiencies in the current system while simultaneously preserving the goals of tort law. This administrative, fault-based system has several distinct advantages over the other proposed alternatives.

No-fault systems, such as those proposed by Professor O'Connell,[70] offend notions of justice and individual accountability by imposing liability on health care providers even when they have done everything humanly possible to treat a patient but were unable to prevent a bad outcome. Although technically a no-fault system would remove any stigma from the imposition of liability, health care providers and patients are likely to consider imposition of liability as a criticism of the health care provider's competence.

Moreover, no-fault proposals do nothing to address the goal of deterrence. No-fault, including its latest manifestation as the Designated Compensable Event,[71] also was rejected by the Liability Project out of

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66. *See* U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OR SOLUTIONS 3 (1986).

67. Florida Birth Related Neurological Injury Compensation Plan, FLA. STAT. ANN. §§ 766.301-.316 (West Supp. 1988); Virginia Birth-Related Neurological Injury Compensation Act, VA. CODE ANN. §§ 38.2-5000 to -5021 (Supp. 1989).

68. *See, e.g.*, O'Connell, *supra* note 2.

69. *See, e.g.*, Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87.

70. O'Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21 (1975).

71. Tancredi, *Designing a No-Fault Alternative*, 49 LAW & CONTEMP. PROBS. 277, 281 (Spring

concern that either the costs of such a system would be excessive[72] or it would be necessary to apply strictly scheduled benefits,[73] and that such guaranteed but limited benefits would be widely perceived as inadequate compensation.[74]

The private contract alternatives, such as the one discussed by Professor Epstein,[75] also were rejected, but for reasons different from those that led to rejection of a no-fault system. First, contract proposals are predicated on an assumption that patients and health care providers are in equal bargaining positions. This assumption is subject to serious question, particularly for poor patients who have little economic bargaining power.[76] Second, the contract proposal does nothing to ensure that medical malpractice claims are removed from the expensive and inefficient court system. Patients who believe they have been injured by medical negligence and who are displeased with the bargain they made *ex ante* are free, and likely, to seek nullification of their contract in court. The very fact that the court can examine tbe terms of the contract to determine whether it should be voided adds an element of uncertainty that the contract proposals were designed to eliminate.[77] Third, it is unclear how the patient and health care provider can draft an adequate contract *ex ante* that will cover all situations which might develop during treatment.[78] To the extent a situation develops that

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1986); A.B.A. COMM'N ON MEDICAL PROFESSIONAL LIAB., DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY 9-11 (1979).

72. P. DANZON, *supra* note 1, at 217-18; Calabresi, *The Problem of Malpractice—Trying to Round Out the Circle*, in THE ECONOMICS OF MEDICAL MALPRACTICE, *supra* note 45, at 233, 239; Epstein, *Medical Malpractice: Its Cause and Cure*, in THE ECONOMICS OF MEDICAL MALPRACTICE, *supra* note 45, at 245, 260-62; *see also* Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 614-15 (1973) (questioning advantage of no-fault system because it would require costly determinations of cause).

73. The concern was that sucb a system would have to function like the social security disability system or the New Zealand no-fault tort system. In 1974 New Zealand abolished medical malpractice litigation and provided a compensation system for personal injury accidents and medical misadventures. Gellhorn, *supra* note 54, at 188-202.

74. Based on the experience with workers' compensation systems, commentators have concluded that limited benefits inadequately compensate the injured for their full economic loss. Soble, *A Proposal for the Administrative Compensation of Victims of Toxic Substance Pollution: A Model Act*, 14 HARV. J. ON LEGIS. 683, 715-18 & n.111 (1977).

75. *See* Epstein, *supra* note 69.

76. Rohinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, 49 LAW & CONTEMP. PROBS. 173, 186-93 (Spring 1986); *see also* Zeckhauser & Nichols, *Lessons from the Economics of Safety*, in THE ECONOMICS OF MEDICAL MALPRACTICE, *supra* note 45, at 19, 22 & n.7 (stating that communication and interpretation of medical risk information is too limited and difficult to assure patients efficient and free contracts).

77. O'Connell, *supra* note 2, at 137; *cf.* Havighurst, *"Medical Adversity Insurance"—Has Its Time Come?*, 1975 DUKE L.J. 1233, 1253 & n.60 (stating that "[t]he vast amount of litigation spawned by the 'work-relatedness' of injuries under workmen's compensation serves as a warning against leaving too many factual issues open to dispute").

78. *See* O'Connell, *supra* note 2, at 137. Although it is likely that standard contracts will be

does not appear to have been contemplated by the terms of the contract, it is more likely that a court will be persuaded to examine the agreement's terms, find them unavailing, and resolve the dispute as a tort action.

Finally, both the no-fault and contract proposals were rejected because they fail to address the need to improve the disciplinary system. The contract proposals ignore the need to improve the skills of some practitioners as an integral part of any plan to ameliorate the malpractice crisis, relying instead on the market to persuade physicians that they should maintain an appropriate level of skill.[79] Although no-fault could be integrated into a comprehensive agency that also has enhanced disciplinary powers, the no-fault proposals to date have focused on compensation without making any provisions for improving physician skills as a way of decreasing the incidence of medical injury.

The medical profession's alternative advocates an administrative, fault-based system for resolving liability claims to be implemented at the state level. Through this system, which is to be administered by a new state agency (the Board),[80] patients, physicians, and the public-at-large can realize important advantages over the existing tort system. Under an administrative, fault-based system, patients will have greater access to compensation for their injuries, and decisions on liability can be made more predictably, quickly, and efficiently.

It is clear from every study done on the incidence of medical negligence that there are more instances of iatrogenic injury than there are claims of medical malpractice.[81] There also is evidence that the threat of liability is not a very effective deterrent to inadequate medical care.[82] This evidence suggests that no system of liability determination and compensation can, by itself, effectively identify, retrain, and discipline physicians who are providing substandard care. For these reasons, the Liability Project chose to integrate its proposal for an administrative fault-based claim process into a specialized medical practices agency. This specialized medical practices agency will have significantly strengthened educational, disciplinary, and licensing powers and increased resources to permit the Board to perform the expanded functions.

The proposed system also is designed to enhance deterrence of sub-

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developed over time, there always will be cases with unusual or unforeseen complications that were not anticipated by the terms of the agreement.

79. P. Weiler, *supra* note 6, at 207.

80. The Board is modelled loosely on the example of the National Labor Relations Board. 29 U.S.C. § 153 (1982).

81. *See supra* notes 9-14 and accompanying text.

82. *See supra* notes 33-45 and accompanying text.

standard practices. Under the proposal, the two types of state regulation of the quality of medical care—resolution of malpractice claims and direct oversight of physician practices—would be combined in the jurisdiction of the Board and thereby coordinated more effectively. In addition, the proposal imposes greater requirements upon physicians to continue their medical education and adopt risk management measures. Finally, the Board would be given greater authority than existing state agencies generally have to monitor physician performance and respond to substandard or unprofessional practices. The effectiveness of this enhanced authority will be ensured by the proposal's provisions for sufficient staff and resources to carry out this new authority.

III. THE PROPOSED ALTERNATIVE[83]

As indicated above, the proposed alternative has three primary components: a process for resolving medical malpractice claims, a codification and modification of the legal elements of medical liability, and education, credentialing, and disciplinary reforms.

A. Claims Resolution

Claims of medical malpractice no longer will be resolved by a court, but will be decided by the Board through an administrative adjudicatory process. In addition, strong incentives to facilitate settlement are incorporated into the claims' resolution system. For those claims that are not settled, plaintiffs will have to demonstrate the basic elements of a malpractice claim—duty, negligence, causation, and damages—and the adversarial approach will be maintained. However, claims will be tried by experienced and qualified hearing examiners instead of randomly selected juries.

The claims resolution function can be divided into four stages: the prehearing process, the hearing, review by the members of the Board, and judicial review. In addition, the Board will have rulemaking authority to facilitate its claims resolution function.

1. Prehearing

Patients who believe they have suffered injuries because of inadequate health care will be able to initiate administrative claims by filling out a simple form identifying the circumstances that serve as the basis for their claims. Claims forms will be readily available throughout the state and patients will be able to file the forms without the assistance of

83. A full description and a codification of the proposal can be obtained from the Office of the General Counsel, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610, or the *Vanderbilt Law Review*, Vanderhilt University, Nashville, Tenn., 37240.

an attorney. In the event patients do experience difficulties in completing the form, the state will provide a toll-free telephone number for patients to call for help. The claims generally must be filed within two years of the date on which the allegedly inadequate health care occurred.[84] The Board will employ claims reviewers to evaluate each claim on the basis of a review of the medical records and interviews with the patient, the health care provider(s)[85] named as respondent(s) to the claim, and other individuals with knowledge of the relevant facts.

If a respondent makes a settlement offer while the claim is being reviewed, the patient will be offered the services of an attorney employed by the Board to provide assistance in evaluating the offer.[86] In the absence of a settlement, the claims reviewer will complete the review within sixty days of the date on which the claim was filed. If the claim is found to have apparent merit, the reviewer will recommend that the claim be pursued.[87] Should the reviewer find the claim without merit, a recommendation to dismiss the claim will be issued, accompanied by a short statement explaining the recommendation.[88]

Patients may appeal the claims reviewer's recommendation to dismiss to a single member of the Board who will then undertake a de novo review of each claim in deciding whether to uphold the reviewer's recommendation or to issue a recommendation that a claim be pursued. If dismissal is upheld, patients still may pursue a claim with private counsel by submitting an affidavit from an expert health care provider attesting that an injury was caused by inadequate health care.[89]

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84. An extension of time for filing may be granted if the claim is based upon a foreign object left in the patient's body and the patient reasonably could not have discovered the foreign object earlier. In such a case, the extension is for one year after the date on which the foreign object is discovered but in no case for more than four years beyond the date at which the foreign object was left inside the patient's body. In the case of a child, claims based upon injuries tbat occurred before the child's eighth birthday may be filed at any time through the child's tenth birthday. Finally, if the health care provider fraudulently conceals the basis of a claim, the patient may file at any time within two years after discovering the basis of the claim.

85. A health care provider is defined as any person, organization, or other legal entity that provides medical or other health care services.

86. Alternatively, the patient may choose private representation. Health care providers will continue to be represented privately just as they are today.

87. If the reviewer finds that the patient may have a valid claim against a health care provider not named as a respondent, the reviewer shall so notify the patient who will then have 20 days in which to add the unnamed health care provider as a respondent.

88. The claims reviewer may also find it appropriate to dismiss one or more parts of a claim. For example, when patients are injured, they often name everyone who provided care even though some of the health care providers were not involved in the specific incident that caused their injuries. In such cases, the claims reviewer could dismiss the uninvolved health care providers from the claims.

89. Very likely, there will not be many experts who will support claims or attorneys who will pursue claims after they bave been dismissed by a claims reviewer. Consequently, it is not expected that many claims will be pursued in this fashion.

When the claims reviewer recommends that a claim be pursued, the Board will enlist the services of a private physician to serve as a peer reviewer, that is, a qualified expert in the health care provider's field of practice. This reviewer will provide a second level of scrutiny to claims similar to that currently employed by private liability insurers. The peer reviewer will consider the documentation collected by the claims reviewer and will be authorized to interview the patient, the defendant health care provider(s), and any other relevant individuals. If the peer reviewer also concludes that a claim has apparent merit, the Board will assign the claim to an administrative law judge (ALJ) and appoint a staff attorney to represent the patient in the subsequent settlement negotiations or litigation.[90] If the peer reviewer does not find merit, the Board will hire a second, independent peer reviewer to review the claim. If the second expert finds merit, the claim will be assigned to an ALJ, and a staff attorney will be appointed.

In the absence of a recommendation to pursue by a peer reviewer, claims will be dismissed by the Board, again accompanied by a short explanation for the dismissal.[91] At this stage there is no provision for appealing a dismissal to the members of the Board. However, patients again are provided the option to pursue their claims with private counsel by submitting an affidavit from an expert health care provider attesting that an injury was caused by inadequate health care.[92]

2. Hearing Stage

An ALJ will preside over the subsequent proceedings. An ALJ will be a full-time employee of the Board who hears medical negligence claims and disciplinary charges against physicians.[93] The Board may not employ as an ALJ any health care provider who has been in active practice during the previous five years or any person who serves as an officer, director, or employee of a health care provider or who has a substantial financial interest in a health care provider.[94] The ALJ will supervise cases as they develop and decide any claims that do not settle

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90. The patient may reject the Board-appointed attorney and employ a private attorney to provide representation. The private attorney is prohibited from charging unreasonable fees, including a contingency fee arrangement that exceeds specific limits: 40% of the first $50,000 recovered, 33 ⅓% of the next $50,000 recovered, 25% of the next $100,000 recovered, and 10% of any amount over $200,000 recovered.

91. The explanation will include a summary of the peer reviewers' reports.

92. After two peers have recommended a dismissal, it is very unlikely that a patient will find an expert to support the claim or an attorney to pursue the claim. Consequently, it is anticipated that this avenue almost never will be used.

93. An ALJ will not need to be an attorney or to have judicial experience.

94. ALJs cannot undertake the provision of health care services or assume a professional or financial interest in a health care provider during their service.

before the scheduled hearing.

In order to encourage reasonable and timely settlements, the proposal requires blind settlement offers by the parties at an initial prehearing conference,[95] scheduled within sixty days after a claim is assigned to an ALJ. A second round of blind offers will be required at the final prehearing conference. A party will be subject to sanctions if the outcome of the case is not a significant improvement over a settlement offer that the party had rejected at the final prehearing conference.[96] Thus, the potential sanction is imposed when each side has access to the greatest amount of information and therefore when unrealistic settlement positions are least defensible.[97]

In the absence of a settlement, the parties will proceed to a hearing. At least twenty-one days before the hearing date, each party will provide the ALJ and each other party with the following: a list of the witnesses expected to testify on that party's behalf accompanied by a brief summary of each witness's testimony, the affidavit or deposition testimony of each expert witness whom the party intends to call, a copy of each document that the party expects to submit at the hearing, and a short and plain statement of the factual and legal bases for the party's position. In response, each party has the option of submitting a statement that may include a description of testimony or evidence to be offered in rebuttal, a list of objections to any testimony or evidence to be offered by another party, or a short and plain reply to another party's factual or legal argument. An oral hearing will be held if either party requests a hearing or if the ALJ believes that an oral hearing will aid significantly in resolving any disputed issues of law or fact. The ALJ will have the authority to limit the subject matter of an oral hearing to material issues genuinely in dispute.

The hearing will function like an informal trial: evidence will be introduced under standards less exacting than in court, witnesses will be examined and cross-examined, and attorneys will represent the parties. The ALJ will have broader authority than a civil judge to conduct the proceedings. For example, the ALJ will be able to question witnesses at the hearing. Moreover, if after the conclusion of the hearing, the ALJ is unable to resolve any specific issue because of a medical or

95. If the health care provider's offer equals or exceeds the patient's offer, the ALJ will award the average of the two offers. If the offers do not overlap, the hearing examiner will attempt to mediate a settlement.

96. The offeror of the rejected offer will receive compensation for the costs, expenses, and attorneys' fees incurred after the final prehearing conference.

97. The ALJ also will oversee expedited discovery and ensure that the parties will support their positions with valid expert evidence. Each party would be limited to 30 interrogatories and 3 depositions per opposing party unless a party could show good cause for enlargement of these limits.

legal matter in controversy, the ALJ may call an independent expert in medicine or law to answer questions concerning the case. The parties also will be able to question the expert.

The ALJ will be required to render a written decision with findings of fact and conclusions of law within ninety days of the hearing. In the decision, the ALJ will determine, based on a preponderance of the evidence, whether the health care provider is liable for the claimant's injury and how much should be paid in damages if a health care provider is liable.

3. Board Review

The losing party will have thirty days within which to file a notice of appeal. If no appeal is taken, the members of the Board will review the ALJ's opinion. If the opinion contains a satisfactory statement of the law and facts of the case, the Board will issue an order designating the opinion as representing its views. In this way, the ALJ's opinion will become binding precedent in future cases. If the Board does not designate the opinion as representing its views, the ALJ's opinion has no precedential value, but it will bind the parties because no appeal was taken by the losing party.

If an appeal is taken, the ALJ's decision will be subject to review by the Board's governing members. The Board ordinarily will reconsider the ALJ's decision as an appellate body in a panel of three members, one of whom will be a health care provider. The panel will subject all legal issues to de novo review[98] but must accept those findings of fact that are supported by substantial evidence. Thus, for example, the panel would accept an ALJ's findings that certain monitoring techniques were employed by an anesthesiologist during an operation, but would decide for itself whether the technique failed to satisfy the proper standard of care and thereby caused injury.

After considering an appeal, the panel will issue an opinion adopting, modifying, or rejecting the recommended judgment of the ALJ. The opinion will include a statement of the panel's reasoning. If the panel finds a physician liable, the Board will report that fact to its clearinghouse described in section C below.[99] The liable health care provider will have to pay the damages within thirty days of the award.[100]

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98. The Board also will develop the legal rules for malpractice claims through its rulemaking authority.

99. *See infra* notes 115-23 and accompanying text. If another kind of health care provider is found liable, for example a nurse, a report will be made to the appropriate licensing board.

100. The intermediate appellate court of the state may stay the judgment upon petition of the health care provider if the provider is likely to succeed on the merits on appeal. *See infra* note 123 and accompanying text.

This requirement is based on the need to get money to injured claimants as soon as possible and on the assumption that few, if any, cases will be appealed successfully to the courts. In addition, by requiring payment before a judicial appeal, the Board will eliminate any incentive the losing party may have to appeal as a means of delaying the obligation to satisfy the judgment.

4. Judicial Review

Appeal from the Board's decision will be to the intermediate appellate court of the state. The review will be limited to whether the Board acted arbitrarily or capriciously or otherwise abused its discretion.[101] The court will have no authority to establish medical standards or to determine whether there was malpractice. If the court concludes that an error has been committed by the Board, the court will remand the case to the Board.[102] The procedures for judicial review thereby ensure that all ultimate decisions about liability and damages are made by the Board.

5. Rulemaking

Similar to other administrative agencies, the Board should be given rulemaking authority to implement statutory standards and requirements. The Board will exercise its authority in the manner prescribed by the state's administrative procedures act. In addition, when public notice of proposed rulemaking is required, the Board will notify the state bar association, state medical association, state hospital association, and any other relevant associations. These organizations will have a direct interest in the administrative action and therefore will be able best to provide useful insights.

In general, the Board's rulemaking authority will exist immediately upon implementation of the proposal. However, the proposal creates a five-year moratorium on rules that purport to define a standard of care for health care providers. This limitation is designed to ensure that the Board allows itself time to implement its other functions and an opportunity to develop experience and expertise in deciding liability issues before undertaking such a difficult and sensitive task. The validity of any rule promulgated by the Board will be reviewable by the courts on the ground that it is arbitrary, capricious, or in excess of the Board's statutory authority.

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101. The standard of review is modelled on the standard applied by courts to decisions by administrative agencies. 5 U.S.C. § 706 (1982).

102. Appeal to the state's highest court will be governed by the state's existing procedures for discretionary appeal to that court.

B. Substantive Reforms of the Bases of Medical Liability

In addition to restructuring the procedures for resolving malpractice claims, the proposal includes modifications of the substantive rules for determining whether there is medical liability. Set forth below is a description of the significant changes in the legal rules.

1. Standard of Care

The appropriate standard of care no longer will be based simply upon the customary practices in the community, a standard by which proper practices are determined on the basis of what similar health care providers customarily do in similar situations.[103] Instead, the standard will focus on whether the challenged actions fall within a range of reasonableness, to be determined by reference to the standards of a prudent and competent practitioner in the same or similar circumstances, using available resources and contemporary principles, and which is commensurate with the care and skill of others of similar training, experience, and/or certification. The Board will be required to consider a variety of factors in determining the range of reasonableness, including the expertise of the health care provider, the state of medical knowledge, the availability of health care facilities,[104] and whether the patient's medical problems limit the options available for treatment. Similar to current law, this new formulation permits health care providers to employ a course of treatment that is recognized as appropriate by a respectable minority of health care providers.[105]

As is currently the case, expert witnesses will be required to testify regarding the standard of care,[106] unless the negligence would be obvious to a lay person.[107] However, as recommended by the Physician Insurers Association of America,[108] the proposal requires expert witnesses to have occupational experience in the field about whose standards they

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103. 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 8.04 (1988). A typical statement of the standard is as follows:

> A medical practitioner has the duty to apply to diagnosis and treatment of his patient the ordinary skills, means and methods that are recognized as necessary and which are customarily followed in the particular case, according to the standard of those who are qualified by training and experience to perform similar services in the community.

Campbell v. United States, 325 F. Supp. 207, 210 (M.D. Fla. 1971).

104. The availability of health care facilities includes consideration of the accessibility of transportation and communication facilities. Accordingly, health care providers are not at fault when they fail to employ medical equipment or procedures that are not available in the local community and which cannot reasonably he procured elsewhere under the circumstances. However, geographic location does not by itself affect the standard of care expected.

105. *See* Sprowl v. Ward, 441 So. 2d 898, 900 (Ala. 1983).

106. PROSSER & KEETON, *supra* note 25, at 188.

107. *See, e.g.*, Toppino v. Herhahn, 100 N.M. 564, 567, 673 P.2d 1297, 1300 (1983).

108. Report of PIAA Alternative Committee, § IA2, at 2 (1987).

testify.

2. Causation

The causation standard for determining liability will be modified significantly. Traditionally, when there was more than one possible cause for the patient's injury, recovery has been denied unless the health care provider was more than fifty percent responsible for the patient's loss.[109] Under the proposed causation standard, recovery will be permitted if the provider's negligence is a "contributing factor" in causing the injury. A health care provider's conduct is deemed a significant contributing factor if it substantially increased the risk of an injury and such injury occurred.

Damages under this standard will be apportioned according to the provider's degree of fault under a pure comparative responsibility standard. Thus, if the patient's pre-existing condition is responsible for sixty percent of the patient's posttreatment condition and the provider's negligence is forty percent responsible, the provider is liable for forty percent of the damages. As a corollary, the rule of joint and several liability will be abolished so that health care providers become liable for damages only in proportion to their actual responsibility for injuries.

3. Informed Consent

As is currently the law,[110] health care providers will be obligated to obtain informed consent before providing any health care services. Patients also will retain the right to refuse treatment.[111] The only significant modification of existing law involves the standard for disclosure of information in obtaining consent. The proposal adopts what is currently the minority rule. The adequacy of the health care provider's disclosure will be measured from the perspective of the reasonable patient and not from the perspective of the reasonable provider.[112]

4. Damages

Patients injured by malpractice will recover economic damages according to current legal rules. Economic damages therefore will restore injured patients to the position that they would have occupied "but

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109. *See, e.g.*, Fitzgerald v. Manning, 679 F.2d 341, 348 (4th Cir. 1982).

110. *See* 2 D. LOUISELL & H. WILLIAMS, *supra* note 103, ¶ 22.01.

111. Bouvier v. Superior Court, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 300 (1986); John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921, 923-24 (Fla. 1984); *In re* Conroy, 98 N.J. 321, 347-48, 486 A.2d 1209, 1222 (1985).

112. 2 D. LOUISELL & H. WILLIAMS, *supra* note 103, ¶ 22.10.

for" their injuries. These damages will be measured by the sum of lost income plus the expenses actually incurred as a result of the injury.[113] Specific guidelines will be developed through rulemaking for the different components of economic damages, including interest rates, work- and life-expectancy, and the costs of medical, rehabilitative, custodial, housekeeping, and childcare services.

Noneconomic damages will be capped at an amount that is tied to a percentage of the average annual wage in the state. The cap will range from about 150,000 dollars to 700,000 dollars, depending upon the life expectancy of the patient before the injury. In addition, any award of future damages will be made in accordance with a periodic payment schedule if the present value of these damages exceeds 250,000 dollars. Finally, damages generally will be reduced by collateral source payments.[114]

C. *Physician Monitoring*

In conjunction with its new authority to handle medical liability claims, the Board will assume a greater role in tbe education, credentialing, and disciplining of physicians. To enhance the quality of medical practice, the proposal requires all physicians to complete at least fifty credit hours of continuing medical education per year. At least thirty of these hours must be directly relevant to the physician's clinical practice. All physicians also will be required to participate in a quality assurance-risk management program.[115]

To ensure more comprehensive review of physician practices, the proposal includes several kinds of reporting requirements concerning the practices of physicians. First, hospitals periodically will be required to review the performance of their physicians and to report any finding that a physician's performance has been substandard. Second, insurers will be required to report denials of coverage for reasons that are not class based.[116] Third, courts in the state will be required to report any criminal convictions of physicians. Finally, all physicians will be required to report suspected incompetence, impairment, and drug or alco-

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113. *See id.* ¶ 18.01.

114. Collateral source payments refer to compensation from health insurance, disability insurance, and other similar benefits. Under the proposal, the patient could not receive double recovery for an injury.

115. This program would include the implementation of measures to reduce the risk of injury to patients, automatic review of patient charts to detect problems in care, required reporting of adverse incidents with immediate investigation of those incidents, educational programs, and periodic inspections of health care facilities to detect problem areas.

116. Physicians will be required to have adequate insurance coverage or, alternatively, they will bave to document the availability of assets that could be used to satisfy an adverse medical liability judgment.

hol dependence among their colleagues.

The Board will create and maintain a clearinghouse for the reports from hospitals, insurers, courts, and physicians. The clearinghouse also will receive reports of any settlements or awards made in the claims resolution process and any notifications that disciplinary actions have been taken by other states.[117] The Board will review a physician's complete file whenever one of these required reports is submitted.

When review of a physician's clearinghouse file suggests substandard or unprofessional performance, the Board will commence an investigation of the physician's performance. Investigations also will be initiated when complaints about physician performance are filed by any member of the public,[118] including Board members or ALJs who review malpractice claims. Investigations will be conducted by committees on professional conduct, which will have three Board members, one of whom will be a physician. If there is reason to believe that the physician whose practices are under investigation poses a threat to patient health, the committee will have authority to conduct an on-site review of the physician's practices. Moreover, if it appears that a physician's practices constitute an imminent threat to the health of any individual, the committee may order the physician to cease those practices immediately.

When appropriate, the committee will recommend that action be taken by the Board's general counsel.[119] If there is evidence of alcoholism, alcohol abuse, drug abuse, or mental illness, the committee will recommend referral to an Impaired Physician Program,[120] whether or not it has recommended action by the general counsel. If action by the general counsel is recommended, the general counsel then will decide whether to initiate a disciplinary charge. Once a disciplinary charge is initiated, the general counsel will prosecute the charge before an ALJ who will decide what action is indicated. The ALJ's decision will be rendered after a full due process proceeding. The Board's policy is to rehabilitate or reeducate a physician whose practices have become sub-

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117. Much of the information that will be collected under this proposal overlaps with the reporting already provided for under current federal law. *See* 42 U.S.C. §§ 11,101-11,152 (Supp. IV 1986).

118. A formal investigation will not be launched on the basis of a lay person's complaint until a claims reviewer has screened the complaint.

119. There are numerous grounds for disciplinary action, including the practice of medicine without authorization, the fraudulent practice of medicine, gross incompetence or repeated negligence, practice while physically or mentally impaired, drug addiction, commitment of an act of sexual misconduct that reasonably calls into question the physician's ability to provide health care services, or conviction of a felony.

120. An Impaired Physician Program is a medically directed treatment program for physicians impaired by alcoholism, alcohol abuse, drug abuse, or mental illness.

standard. If such efforts do not succeed, however, punitive measures will be imposed.[121] The examiner's action is subject to review by the Board[122] and the intermediate appellate court of the state.[123] After a final decision to discipline a physician, the Board is required to provide notice of the disciplinary action to the physician's hospital(s) and insurer(s) and to the agencies that regulate the practice of medicine in other states.

D. Board Structure

The Board will be governed by seven full-time members, of which at least two but not more than three members will be physicians. Four of the Board members may not be health care providers, and at least one member may not have a professional or financial interest in any health care provider. Members will be selected by the governor who will choose from a list of nominees selected by a distinguished nominating committee. Following selection, the members are subject to approval by the legislature. The nominating committee will have ten members and will be composed of physicians, other health care providers, attorneys, and three individuals who are neither attorneys nor health care providers.

The Board's members will have authority to hire the Board's employees.[124] All the Board's employees will be selected and retained on the basis of their ability and commitment to resolving efficiently and fairly claims of negligence and complaints of substandard performance. The Board's members also will have subpoena power to compel cooperation with investigations conducted by the hearing examiners, claims reviewers, or committees on professional conduct. Finally, the Board will be given rulemaking authority in order to implement the provisions of the proposed system.

IV. JUSTIFICATION FOR THE PROPOSED ALTERNATIVE

A. Claims Resolution

A persuasive case can be made for employing a fault-based administrative alternative to the tort system. The proposed alternative re-

121. Punishments range from fines to permanent revocation of the physician's license to practice medicine.

122. The Board will accept the hearing examiner's findings of fact if they are supported by substantial evidence on the record as a whole.

123. The court will uphold the Board's judgment unless the Board acted arbitrarily, in excess of statutory authority, unsupported by substantial evidence, or in violation of its procedural requirements.

124. The general counsel will be appointed by the Governor, and will be responsible for supervising attorneys employed by the Board and for representing the Board in court.

sponds directly to the flaws in the current system described in Part II of this Article. Most important, the proposed system will permit more injured parties to be compensated than does the current system. Medical liability disputes will be resolved more quickly and equitably than they currently are. Claims resolution will be conducted more efficiently and with greater certainty, thereby enhancing the predictability of compensation for medical liability.

Under the proposed system, injured patients will enjoy far greater access to the legal process than they traditionally have had. As previously discussed,[125] a patient can initiate the administrative process without enlisting the services of an attorney, and the state will bear the costs involved in developing the claim. Once a claim form is filed, the Board's staff will launch an investigation, including a review of the medical records, interviews with the people involved, and consultations with medical experts. This preliminary investigation will be done at no cost to the claimant. If the staff deems the claim meritorious, the Board also will offer free legal representation to the patient, who will be free to accept the offer or to retain a private attorney.[126] In short, compensation will not be limited to the small percentage of patients whose potential damage award is large enough to attract private attorneys.

The broader access to the legal system initially should result in a larger number of meritorious claims. On the other hand, claims in which negligence or causation is not established will be dismissed quickly. Moreover, claims without any out-of-pocket losses by the patient will not require adjudication,[127] although they may indicate instances where a physician's medical practices warrant attention by the Board.

The proposed system also will generate more reliable judgments. The ALJs, selected on the basis of their qualifications and aptitude, will replace randomly chosen jurors as decision makers. Furthermore, these individuals will develop experience and special expertise in dealing with malpractice claims. Expertise also will be made available by the provisions for independent experts. The proposal's emphasis on medical expertise parallels tort law's traditional deference to the medical community in setting the standard of care in malpractice cases.[128] In both instances, the approach recognizes that juries often are ill-

125. *See supra* Part IIIA.

126. Patients whose claims were not viewed as meritorious also could pursue their actions before the Board but only with the assistance of a privately retained attorney.

127. In other words, when collateral sources cover damages, the patient has no interest in suing the health care provider since the collateral source rule is abolished under the proposed system. *See supra* note 114 and accompanying text.

128. 1 D. LOUISELL & H. WILLIAMS, *supra* note 103, ¶ 8.04.

equipped to make judgments concerning the adequacy of a physician's practices in a specific case. In contrast to the current situation in which jurors frequently are swayed by purely emotional appeal, the proposal should moderate award levels for two reasons. Damages will be decided by dispassionate, experienced decision makers. In addition, the triers of fact must explain in writing the precise basis for the amount awarded.

The proposal's procedural requirements also should lead to more reliable and respected judgments. By employing a permanent staff of decision makers who issue detailed, written explanations for their verdicts and damage awards, the proposed system should ensure a higher degree of consistency among judgments and, as a corollary, clearer guidance to physicians and attorneys regarding the legal rules of medical malpractice.[129] Moreover, the explanations should ensure that the decisions are more acceptable to the parties involved as well as to the public generally.[130]

The third flaw in the current system addressed by the proposal is the lengthy and costly judicial process involved in resolving disputes. It is clear that it takes much longer for a dispute to be resolved by a jury than by other, more specialized, triers of fact. It has been estimated that jury trials consume sixty-seven percent more time than bench trials.[131] Similarly, workers' compensation hearing officers decide claims more quickly than juries because they are more familiar with the medical terminology and the law.[132] The potential time savings in having medical liability disputes resolved in administrative proceedings instead of by juries should be significant. These time savings are built explicitly into the Liability Project's system with specific deadlines at various steps in the process. Thus, the system can be designed so that no more than one year should elapse from the filing of the claim to a final judgment. This will be a significant advantage to patients and to providers.

Finally, the current tort system fails to provide reasonable compensation because it frequently does not encourage settlements effectively. Indeed, there are incentives for the health care provider to delay early disposition of a claim. In particular, time favors providers because they will have the use of the money until a judgment is satisfied.[133] Plaintiffs' attorneys also are encouraged to forgo early settlement. By going

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129. This procedure is in contrast to the current jury system in which juries are not required to articulate reasons for their awards. *See supra* note 29 and accompanying text.

130. Traditionally, the reasons for requiring a written opinion from administrative decision makers include guidance for future conduct and the promotion of the parties' satisfaction with the result. S. Doc. No. 8, 77th Cong., 1st Sess. 30 (1941).

131. H. Zeisel, H. Kalven & B. Buchholz, Delay in the Court 71-81 (1959).

132. Martin Urling Co., Prototype of an Administrative Workers' Compensation System 44 (1982).

133. Moore & O'Connell, *supra* note 18, at 1285.

to trial, they preserve the opportunity for a big award. Even though these attorneys may receive nothing on the contingency-fee basis if they lose, they may be willing to risk losing at trial because they can spread this risk among all their clients. In contrast, the injured patient has only one case and bears the risk of not receiving any compensation.[134]

The current system can be needlessly expensive, because it is not designed to encourage settlements. By contrast, the proposed administrative system has been developed to promote early settlement of the vast majority of cases and to limit the period within which all cases must be resolved. For example, blind settlement offers[135] must be presented at the initial and final prehearing conferences, and sanctions will be imposed for unreasonable failures to settle. The judicial process, which has a wide range of cases demanding the court's attention and resources, is not readily adaptable to such changes.[136] Accordingly, an alternative system that clearly holds out the promise of resolving claims in a more efficient and timely manner should reduce significantly the costs per case to the parties.[137] In sum, the proposed administrative model enhances the likelihood that injured patients will be compensated in a fair, cost-effective, and expeditious fashion.

B. Physician Monitoring

The proposed system also is designed to enhance the quality of medical care by strengthening the process for credentialing and disciplining physicians. As previously discussed, tort liability does not adequately deter negligent behavior and therefore does not promote quality health care.[138] Thus, it is important to complement the indirect deterrence of tort liability, which is retained in this proposal, with direct efforts to identify and correct substandard medical practices.[139]

The proposal's mandatory continuing education and risk management programs will encourage physicians to maintain and enhance their professional skills. A risk management program at Harvard Medical School, for example, resulted in the development of standards and procedures for monitoring anesthetized patients that has been endorsed for all anesthesiologists by the American Society of Anesthesiologists.[140] As

134. *Id.*

135. *See supra* note 95 and accompanying text.

136. The costs of delay are considerable. As mentioned above, only 16 to 40 cents of each dollar paid in premiums are paid as compensation for an injury caused by medical negligence. *See supra* note 52 and accompanying text.

137. GAO FRAMEWORK, *supra* note 7, at 30.

138. *See supra* notes 33-45 and accompanying text.

139. *See supra* notes 115-23 and accompanying text.

140. Eichhorn, Cooper, Cullen, Maier, Philip & Seeman, *Standards for Patient Monitoring During Anesthesia at Harvard Medical School*, 256 J. A.M.A. 1017 (1986).

a result of these efforts, malpractice should occur less frequently and with less severity. Indeed, there is indirect evidence that these predictions are correct. The anesthesia standards have stabilized, and even decreased, malpractice premiums for some anesthesiologists.[141]

The proposal's required collection of information regarding physician performance from multiple sources, including hospitals, insurers, courts, physicians, and other members of the public, and the immediate reviews of that information will enable the Board to detect many substandard practices before they result in injuries to patients. Moreover, because all physicians will be monitored, identification of negligent behavior will be far more effective.

Performance reviews triggered automatically by malpractice verdicts and settlements; sanctions by hospitals, insurers or other states; and complaints by members of the public also will ensure that substandard practices are brought quickly to the attention of the Board. Once improper practices are identified, the Board will respond with thorough investigations, including on-site reviews of the physicians' practices. The Board also will provide appropriate corrective measures, primarily retraining and rehabilitation and, if necessary, discipline.

The drafters of the proposed system recognize a strong public perception that existing state boards have not exercised adequately their disciplinary functions.[142] Consequently, several measures have been adopted to ameliorate this problem. First, the close coordination between the claims resolution function and the credentialing and disciplining process ensures that judgments of negligence will not escape the notice of officials responsible for licensing physicians. Similarly, the close coordination among state licensing boards will prevent disciplined physicians from relocating their substandard practices to other areas. In addition, the Board will be given a large, full-time staff. Hence, unlike the situation in many states, where disciplinary efforts have been hampered by limited budgets and part-time employees,[143] there will be sufficient resources available for the Board to fulfill its responsibilities. Finally, by joining health care providers with a diverse majority of individuals from other occupations on the Board, the proposal permits the Board to be guided by professional expertise while avoiding the risk of a Board dominated by any one interest group.

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141. *Anesthesiologists O.K. New Standards*, Am. Med. News, Oct. 21, 1988, at 10, col. 1.

142. H.R. REP. No. 903, 99th Cong., 2d Sess. 2, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385.

143. *Health Care Quality Improvement Act of 1986: Hearings on H.R. 5540 Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary*, 99th Cong., 2d Sess. 36-37 (1986) (prepared statement of Richard P. Kusserow, Inspector General, HHS).

C. Substantive Reforms of the Bases of Medical Liability

As will be explained,[144] the proposed system will not pass constitutional muster unless it is a reasonably just substitute for the current jury system. Changes in the legal rules for malpractice will provide part of the quid pro quo for the elimination of the jury trial. The overall design in formulating the revised rules has been to serve the fundamental goals of professional liability reform: fair compensation to injured patients, deterrence of substandard medical care, and an efficient allocation of scarce resources. In some instances, choices have been made overtly to benefit patients. On the other hand, the system is not one-sided. The current insurance availability problems are attributable to weaknesses in the current legal rules,[145] especially those used to award damages. Thus, modifications in those rules that benefit physicians and insurers clearly are warranted to limit the pressure of insurance rate increases.

1. Standard of Care

The primary motivation behind the change in the standard of care is to ensure that the broad range of acceptable medical care is recognized in law as nonnegligent. The proposed formulation, which is based on the standards of a "prudent and competent practitioner," specifically will direct the decision maker to consider the full spectrum of factors that legitimately affect a health care provider's medical judgments. These factors include the availability of medical facilities and the health of the patient.

The traditional standard of care, which is based on "customary practices,"[146] often has led physicians to be judged by unrealistically high standards of care. Rather than permitting physicians to rely upon the general good practices of the medical community, the customary standard has permitted plaintiffs to present expert witnesses that focus on perfect care.[147] In an era of rapid progress in medical knowledge and techniques, it usually is possible to find an expert who will say that the defendant failed to employ the latest and most advanced diagnostic or therapeutic techniques, regardless of their practical availability or cost-effectiveness.

Use of the current customary standard of care also serves to per-

144. *See infra* notes 174-81 and accompanying text.

145. *See generally* DOJ REPORT, *supra* note 2, at 8-13; N.Y. ADVISORY COMM'N ON LIAB. INS., INSURING OUR FUTURE: REPORT OF THE NEW YORK ADVISORY COMMISSION ON LIABILITY INSURANCE 6-15 (1986); Priest, *supra* note 17.

146. *See, e.g.*, Campbell v. United States, 325 F. Supp. 207, 210 (M.D. Fla. 1971). *See generally* 1 D. LOUISELL & H. WILLIAMS, *supra* note 103, ¶ 8.04.

147. Epstein, *supra* note 72, at 52-53; Tobias, *supra* note 6, at 37-39.

petuate the practice of defensive medicine. Defensive medicine is defined as medical care that is provided solely to avoid possible litigation. Once physicians begin to practice defensive medicine, the customary standard necessarily tends to make defensive practices virtually mandatory to avoid liability.[148]

The vast majority of analysts who have examined the problems with the customary standard have concluded that, despite its flaws, it properly relies upon the medical profession to define its content.[149] Accordingly, the "prudent and competent practitioner" standard is designed to preserve the basic principle that decisions about liability must be based on standards developed by the medical profession itself while minimizing the flaws in the application of the customary standard.

2. Causation

Redefining the rules of causation also eliminates a number of inadequacies in current law, in particular its inability to deal with a pre-existing condition, such as a disease that predates the physician's contact with the patient. Some courts have required patients to show that the physician's negligence, as opposed to the pre-existing condition, more likely than not caused the injury. Thus, unless the plaintiff can show that negligence contributed more than fifty percent to the injury for which compensation is sought, the plaintiff receives no compensation.[150] Other courts have allowed a finding of causation based on some diminution in the chance of recovery or an increase in the risk of harm, even if the physician's negligence was not shown to be more than fifty percent of the cause of the harm.[151] Such inconsistency in legal result demonstrates both the failure of the current rules to give meaningful guidance on causation and the manifest unfairness of a legal rule that leads to recovery in one court and to a denial of damages in another court, even though the facts are essentially the same.

In contrast to the current all-or-nothing standard, the proposed "contributing factor" standard for causation is inherently fair; all health care provider negligence that is causally linked to a patient's injury will give rise to recovery. Thus, the "contributing factor" rule permits an injured patient to obtain compensation from a negligent physician to the extent that the physician's negligence actually added

148. *See* Zuckerman, *Medical Malpractice: Claims, Legal Costs, and the Practice of Defensive Medicine*, 3 HEALTH AFF. 128, 131-33 (Fall 1984).

149. *See, e.g.*, P. DANZON, *supra* note 1, at 149.

150. King, *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353, 1365 & n.38 (1981).

151. *See id.* at 1380 & n.96.

to the injury.

The proposed rule also more accurately reflects the probabilistic nature of medicine and medical injuries. It succinctly states and reflects the uncertainty inherent in the practice of medicine today and avoids the arbitrariness of cutting off all recovery at a fixed percentage of causation. Finally, the proposed rule discourages the inefficient allocation of resources: currently parties spend disproportionate time and resources litigating the issue of causation because the outcome of that issue has all-or-nothing consequences.[152] The "contributing factor" rule should increase the likelihood of settlement.

3. Informed Consent

The informed consent doctrine is an important vehicle for dealing with the uncertainties inherent in the practice of medicine. Informed consent brings the patient into partnership with the physician in determining the appropriate course of treatment. This partnership protects the patient's right of self-determination and better prepares the patient for the possibility that a proposed treatment will lead to unavoidable injury.[153]

Consistent with these general principles, the proposed adoption of the current minority rule for the adequacy of disclosure of information places greater emphasis on the patient's needs and desires for information than does the current majority rule. The majority rule properly has been criticized as underappreciative of patients' rights.[154] Therefore, the law should be modified to favor patients.

The proposed rule, by focusing on the patient's concerns, also holds out the prospect of improving care by giving patients a greater role in the process for making treatment decisions. Recent studies have found that active participation by patients in their medical treatments has therapeutic value. For example, patients may recover more quickly and with fewer complications from their surgery when they are better informed about the procedure and its potential effects, particularly if they are given suggestions on coping with any difficulties that might arise.[155] The proposed rule also holds out the promise of improving care by directing physicians to articulate benefits, risks, costs, and alternatives more clearly, which in turn should improve the physician's ability

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152. *See supra* text accompanying note 22.

153. Stuart, *A Natural History of Health Behavior Decision-Making*, in ADHERENCE, COMPLIANCE AND GENERALIZATION IN BEHAVIORAL MEDICINE 9 (1982).

154. Canterbury v. Spence, 464 F.2d 772, 783-85 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

155. Wallace, *Informed Consent to Elective Surgery: The "Therapeutic Value?"*, 22 SOC. SCI. & MED. 29, 32-33 (1986).

to make informed recommendations that are appropriate for a particular patient.

4. Damages

The reforms proposed for damages[156] address two overriding problems with the existing system in regard to the size of damage awards: inaccuracy and inconsistency, and therefore uncertainty and unpredictability.

Damage awards are inaccurate and inconsistent for several reasons. Current damages doctrine provides little guidance in establishing the appropriate size of an award of noneconomic damages.[157] The lack of standards, coupled with the requirement of deference to the jury's verdict, are the most significant factors in increasing the size and unpredictability of damage awards. In particular, noneconomic damages, unlike economic damages, are not subject to definite maximum limits. Consequently, multimillion dollar judgments are awarded that are unjustified by the purposes of tort law.[158] Moreover, because all damages are awarded in a lump sum payment with no subsequent modifications to account for unexpected changes in circumstance, awards for future damages are likely either to underestimate or overestimate the damages that eventually are incurred.

The principles for compensation of noneconomic damages have been criticized for resulting in overcompensation also because they are decided after the injury has occurred. From an *ex ante* view, the amounts awarded are clearly not justified.[159]

An increase in accuracy in measuring damages and a concomitant increase in the ability to predict accurately and insure against damage awards is a change in the law that should be neutral in its effects on patients and physicians. Full and fair compensation is an equitable goal, and the achievement of that goal is in the best interests of all parties involved in determining appropriate compensation for medical

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156. *See supra* note 113 and accompanying text.

157. 3 E. DEVITT, C. BLACKMAR & M. WOLFF, FEDERAL JURY PRACTICE AND INSTRUCTIONS: CIVIL § 85.02 (1987).

158. *See* Sugarman, *Doing Away with Tort Law*, 73 CALIF. L. REV. 555, 595-96 & n.180 (1985).

159. *Cf.* P. DANZON, *supra* note 1, at 152-56 (noting that compensating for nonpecuniary losses often results in payments heing made without regard to the individual's willingness to pay for prevention); Priest, *supra* note 17, at 1547-48 (discussing "*ex ante* moral hazard," the theory that because of insurance, the insured takes fewer precautions to avoid the loss). Not surprisingly, the current approach for awarding noneconomic damages has been subject to forceful criticism. *See* Fein v. Permanente Medical Group, 38 Cal. 3d 137, 159 & n.16, 695 P.2d 665, 680-81 & n.16, 211 Cal. Rptr. 368, 383-84 & n.16 (citing additional authorities that criticize the current approach), *appeal dismissed*, 474 U.S. 892 (1985).

liability injuries. Moreover, increasing the accuracy of awards serves the purposes of deterring malpractice and making the system economically efficient.

Accuracy in calculating damages will be increased generally because the ALJ will approach the calculation as an expert, with a large body of knowledge and experience to draw upon. More particularly, the specific guidelines for determining economic damages will lead to greater reliability and uniformity while reducing the transaction costs normally involved when injured parties are required to develop extensive evidentiary support for their claims of damages.

The limits placed on the maximum award of noneconomic damages will ensure that those damages do not become excessive. However, the proposal recognizes that flat monetary limits or limits tied to the amount of economic damages, in some cases, may appear unfair to the injured party. For example, in the case of a severely disfigured individual, a rule that limited noneconomic damages to the economic recovery could be inadequate because actual economic damages might be relatively small while pain and suffering and loss of enjoyment of life might be substantial. Therefore, the cap on noneconomic damages is defined by an amount equal to one-half of the average annual wage in the state multiplied by the injured party's life expectancy. This community-based standard of compensation provides a flexible approach to measuring what is otherwise an unquantifiable measure of damages. This limit is sufficiently large to allow full and fair compensation. Moreover, providing an upper boundary on noneconomic damage awards will bring needed certainty and predictability to the calculation of noneconomic damages. Greater certainty and predictability are critical to promoting the goal of available and affordable insurance.[160]

A limitation on damages also eliminates the "lottery mentality" created by enormous, unjustifiable awards. Multimillion dollar verdicts encourage patients to bring marginal claims, insurers to settle for unjustified amounts, and physicians to practice costly and medically unnecessary defensive medicine.[161]

The capping of noneconomic damages can have important effects on the quality of health care in addition to the restraint on increasing insurance costs. Physicians are less likely to curtail their practices in higher risk specialties like obstetrics or to avoid using new and innovative procedures in their practices because of the fear of unmanageable

160. The sharp increases in the magnitude of noneconomic damages, *see supra* note 9, have been particularly responsible for the uncertainty and volatility in rate-setting for malpractice insurance. *See supra* note 52 and accompanying text.

161. *The $65 Million Malpractice Question*, N.Y. Times, July 24, 1986, at A24, col. 1.

liability exposure. Similarly, physicians are less likely to employ expensive but unnecessary tests and procedures to confirm their medical judgment when such measures are motivated by the fear of exaggerated liability exposure.[162]

A limit on noneconomic damages is appropriate also because of the provision of free legal representation for meritorious claims. Traditionally, noneconomic damages have been justified in part to cover the plaintiff's attorneys' fees.[163]

All of the recommendations on damages are designed to further the goal of ensuring that damages do not overcompensate or undercompensate for the injury in question, without unduly increasing the transaction costs incurred in measuring damages. Providing for more accurate measures of compensation also should reduce social costs and increase the predictability of damage awards, thereby making insurance coverage and medical care less costly and more widely available.[164]

D. Constitutionality

A key question about the proposed system is its constitutionality. The system of trial by jury has strong historical roots in this country, and there are significant constitutional and political limitations on the range of alternatives to the civil justice system that can be implemented on even a limited basis. As a constitutional requirement at both the federal and the state level, the jury creates political legitimacy and satisfies the community's need for vindication and civil justice.[165] Consequently, legislation that encroaches on matters "peculiarly within the province of the jury" are suspect.[166]

While legislatures are substantially restricted from modifying the

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162. Some courts have suggested that a limitation on damages is counterproductive because it impairs the deterrence of tort law. *See, e.g.*, Hoem v. State, 756 P.2d 780, 783 (Wyo. 1988). However, as discussed, tort liability is not the primary mechanism for deterring inappropriate medical practices. Stato medical boards monitor physicians through licensing, relicensing, and investigations of suspicious practices. *See, e.g.*, LA. REV. STAT. ANN. §§ 37:1261-:1292 (West 1988 & Supp. 1989). Moreover, hospitals maintain high professional standards through peer review, risk management programs, and continuing education offerings. JOINT COMM'N ON ACCREDITATION OF HOSPS., AMH/88: ACCREDITATION MANUAL FOR HOSPITALS 111-30 (1987).

Even assuming the centrality of tort law in deterrence, it is reasonable to assume that the high amounts of damages still recoverable adequately will deter malpractice. In addition, the harm to a physician's reputation from a finding of malpractice is a powerful incentive to practice nonnegligently. *Cf.* Duke Power Co. v. Carolina Envtl. Study Group, Inc., 438 U.S. 59, 87 (1978) (finding that the risk of financial loss to a nuclear power plant is a great incentive to avoid irresponsible conduct).

163. Moore & O'Connell, *supra* note 18, at 1280.

164. *See generally* Priest, *supra* note 17.

165. Abraham, *supra* note 24, at 71.

166. *See* Boyd v. Bulala (Boyd II), 672 F. Supp. 915, 920-21 (W.D. Va. 1987).

jury's role in personal injury claims, there is considerably more discretion to eliminate causes of action entirely. It has long been the case that "the Constitution does not forbid the creation of new rights, or the abolition of old ones recognized by the common law, to attain a permissible legislative object."[167] What is unclear is whether and to what extent an alternative—a quid pro quo—is required by due process as a substitute for the abolished cause of action.

In analyzing the constitutionality of the proposed system, a number of federal and state constitutional provisions are relevant. The proposal will have to satisfy due process, equal protection, and jury trial requirements under the federal constitution. The proposal also will be subject to due process and equal protection scrutiny under the constitution of any state in which it is enacted. In addition to some states employing stricter tests than required by the federal constitution,[168] some states have other relevant constitutional provisions, such as open courts clauses,[169] that must be satisfied by the proposal.

1. Federal Constitution

a. Due Process

In analyzing the validity of this proposal under the fourteenth amendment's guarantee of substantive due process, courts almost certainly will adopt the traditional presumption of constitutionality and require only a showing that there be a rational relationship between the enacting legislation and a legitimate objective of government.[170] The United States Supreme Court and the lower federal courts consistently have viewed modifications of common-law tort actions as akin to economic or social welfare legislation and, therefore, not subject to the elevated standard of review applied when fundamental rights of a citizen are infringed.[171]

Legislation enacting this proposal would satisfy the due process standard of review for economic or social welfare legislation. Preserving a patient's access to quality health care is not only a legitimate government interest but indeed a compelling one.[172] Similarly, the legislative purposes of improving the compensation of malpractice victims and de-

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167. Silver v. Silver, 280 U.S. 117, 122 (1929), *quoted in Duke Power*, 438 U.S. at 88 n.32.

168. *See, e.g.*, Smith v. Department of Ins., 507 So. 2d 1080, 1087-88 (Fla. 1987).

169. *See* LA. CONST. art. I, § 22; TEX. CONST. art. I, § 13.

170. For a general discussion of substantive due process, see J. NOWAK, R. ROTUNDA & J. YOUNG, CONSTITUTIONAL LAW 443-51 (2d ed. 1983).

171. *See, e.g., Duke Power*, 438 U.S. at 82-84; Boyd v. Bulala (Boyd III), 877 F.2d 1191, 1197 (4th Cir. 1989); Lucas v. United States, 807 F.2d 414, 421-22 (5th Cir. 1986).

172. *See* Jacobson v. Massachusetts, 197 U.S. 11, 25-27 (1905); Prendergast v. Nelson, 199 Neb. 97, 112-13, 256 N.W.2d 657, 667-68 (1977).

terring negligent medical practices are clearly legitimate. There also is a rational relationship between these legislative purposes and the proposal. As explained above,[173] the proposal was designed to achieve more equitable, efficient, and reliable compensation for victims of negligence and more effective deterrence of negligent medical practices. Moreover, by controlling the costs of malpractice litigation, the proposed system will promote patient access to quality health care.

Some commentators have argued that the due process clause requires a "reasonably just substitute," a quid pro quo,[174] when a tort cause of action is abrogated by statute and replaced by an administrative alternative.[175] The Supreme Court expressly has declined to impose a quid pro quo requirement upon legislative limitations on tort recoveries,[176] but has reserved the issue for a later date.[177] Nonetheless, this proposal does provide a satisfactory quid pro quo in exchange for the loss of the common-law tort action. Most important, the implementation of an administrative model with free legal representation will mean that more patients who are injured by malpractice will be compensated for their losses. Many of those patients are excluded from potential recoveries under the current system. Common sense dictates that it is collecting a judgment, not merely having a cause of action, that is of value to a plaintiff.[178] The liberalization of the substantive rules for causation and informed consent also will ensure that more patients are compensated for the harms suffered.[179] Moreover, all injured parties will be compensated more quickly, equitably, and efficiently. The investigations of claims by claims reviewers and the peer review of meritorious claims will offer patients the benefit of discovery and an expert opinion at no cost.[180] The use of expert triers of fact in an administrative system ensures that claims are resolved in a shorter time period and with

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173. *See supra* Part III.

174. *See Duke Power*, 438 U.S. at 87-88.

175. *See, e.g.*, Note, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143, 200-01 (1981).

176. *Duke Power*, 438 U.S. at 87-88; Boyd v. Bulala (Boyd I), 647 F. Supp. 781, 786 (W.D. Va. 1986).

177. *See Duke Power*, 438 U.S. at 88.

178. *Cf. id.* at 89-90; *Prendergast*, 199 Neb. at 120-21, 256 N.W.2d at 671.

179. This proposal, then, stands in contrast to traditional tort reform measures. In those situations, the rights of malpractice victims are diminished so that society as a whole might benefit. *See* Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 328, 347 N.E.2d 736, 742 (1976) (stating that loss of recovery to some victims is offset by lower insurance premiums and lower medical costs for all recipients of medical care). Here, the quid pro quo directly redounds to the benefit of the injured patients.

180. *Cf. Prendergast*, 199 Neb. at 120-21, 256 N.W.2d at 671 (noting that in return for minor restrictions on the remedy, the patient receives assurance of collectibility of a judgment and the benefit of the opinion of a panel of experts).

greater reliability.

The proposal also meets the quid pro quo requirement by preserving the availability of medical services through stabilization of the costs of liability insurance.[181] Finally, the strengthened mechanisms for educating, accrediting, and disciplining physicians will complement the liability system in maintaining and enhancing the quality of medical care.

b. Equal Protection

Of the three standards of review developed by the Supreme Court under the equal protection clause—strict scrutiny, rational basis, and intermediate scrutiny[182]—the rational basis standard consistently has been applied by the federal courts to judge the validity of tort reforms.[183] Of course, medical malpractice reforms treat victims of malpractice differently than victims of other torts and, within the class of malpractice victims, treat those with injuries whose losses exceed damages caps differently than those whose losses do not. These distinctions, however, do not create a suspect or quasi-suspect classification,[184] nor do they infringe upon a fundamental right.[185] In short, the rational ba-

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181. *See* Fein v. Permanente Medical Group, 38 Cal. 3d 137, 160 n.18, 695 P.2d 665, 681 n.18, 211 Cal. Rptr. 368, 385 n.18, *appeal dismissed*, 474 U.S. 892 (1985).

182. J. NOWAK, R. ROTUNDA & J. YOUNG, *supra* note 170, at 590-99.

183. *E.g.*, *Duke Power*, 438 U.S. at 93-94 (finding the rationality of the Price-Anderson Act ample justification for the different treatment accorded persons injured in nuclear accidents); Lucas v. United States, 807 F.2d 414, 422 (5th Cir. 1986) (holding that the Texas legislature had a rational basis, and legitimate purpose, for enacting legislation that limited the extent to which a patient could recover nonmedical damages); *Boyd I*, 647 F. Supp. at 786-88 (stating that the Virginia medical malpractice cap legislation is clearly a rational means to achieve the legitimate goal of securing the provision of health care services).

184. *See Boyd I*, 647 F. Supp. at 786 & n.4.

185. Fundamental rights are those that are guaranteed by the federal constitution, either explicitly or implicitly. San Antonio Indep. School Dist. v. Rodriguez, 411 U.S. 1, 33-34 (1973); *Boyd I*, 647 F. Supp. at 787. The right to a recovery for a personal injury is provided by the common law and, therefore, as established by the Supreme Court over a century ago, "[a] person has no property, no vested interest" in the rules of tort law. Munn v. Illinois, 94 U.S. 113, 134 (1877), *quoted in Duke Power*, 438 U.S. at 88 n.32; *Boyd I*, 647 F. Supp. at 787.

The right to a jury trial may prevent a legislature from modifying common-law actions. Sophie v. Fibreboard Corp., 112 Wash. 2d 636, 771 P.2d 711 (1989). It does not preclude, however, a state from abolishing a cause of action and replacing it with an administrative claim. *See* Silver v. Silver, 280 U.S. 117, 122 (1929); *Boyd II*, 672 F. Supp. at 921.

States are split as to whether state constitutional guarantees to a jury trial may prevent a legislature from modifying common-law actions. While courts in Florida, Kansas, Texas, and Washington have determined that damage caps intrude on the jury's fact-finding function, most recently the Virginia Supreme Court held that this fact-finding function is completed once the extent of damages is ascertained and does not extend to the award of damages or other remedies. *Compare* Smith v. Department of Ins., 507 So. 2d 1080 (Fla. 1987); Kansas Malpractice Victims Coalition v. Bell, 243 Kan. 333, 757 P.2d 251 (1988); Lucas v. United States, 757 S.W.2d 687 (Tex. 1988) *and Sophie*, 112 Wash. 2d at 636, 771 P.2d at 711 *with* Etheridge v. Medical Center Hosps., 237 Va. 87, 376 S.E.2d 525 (1989). Notwithstanding this division as to modifying common-law

sis test would apply, and, as under the due process clause, the proposal would survive scrutiny.[186]

2. State Constitutions

The validity of the proposed system under state constitutions is more complicated because of the different constructions of state due process and equal protection requirements and the relevance of other constitutional provisions, particularly access to court and state right to jury trial guarantees. In some states, the analysis simply follows the analysis under the federal constitution.[187] In other states, tort reform legislation is subjected to heightened levels of scrutiny. For example, the equal protection or due process clause often dictates an intermediate level of review analogous to the federal equal protection clause's middle-tier of scrutiny.[188] Alternatively, a quid pro quo is clearly required by either the state due process clause[189] or other constitutional provisions, including a right of access to the courts[190] or prohibitions against special legislation.[191] The proposed system should satisfy the requirements of middle-tier scrutiny because, as discussed, the proposed system's administrative claim offers a reasonably just substitute, a quid pro quo, for the loss of the tort cause of action.[192]

Middle-tier scrutiny requires that the legislation be substantially related to a legitimate or important government objective.[193] Decisions under this standard have indicated three factors that are particularly relevant to the analysis: the importance of the state interest, the extent to which the legislative classification promotes the state interest, and the magnitude of the burden imposed upon the disadvantaged class by

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causes of action, the right to a jury trial does not preclude a state from abolishing a cause of action altegether. *See Boyd III*, 877 F.2d at 1196.

186. Arguably, the proposed system offers an improvement over the current tort system for victims of malpractice by providing patients with countervailing benefits when abrogating the common-law tort action for medical malpractice. Even though victims of other torts would not enjoy the same benefits, there would be no equal protection problem. Legislatures clearly are entitled to enact reforms on a step-by-step basis rather than all at once. City of New Orleans v. Dukes, 427 U.S. 297, 305 (1976).

187. *See, e.g.*, Bernier v. Burris, 113 Ill. 2d 219, 497 N.E. 2d 763 (1986).

188. *See, e.g., Bell*, 243 Kan. at 342, 757 P.2d at 258-59; Sibley v. Board of Supervisors, 477 So. 2d 1094, 1109 (La. 1985); Carson v. Maurer, 120 N.H. 925, 931-32, 424 A.2d 825, 830-31 (1980); Arneson v. Olson, 270 N.W.2d 125, 132-33 (N.D. 1978); Hoem v. Wyoming, 756 P.2d 780, 782 (Wyo. 1988).

189. *Bell*, 243 Kan. at 342, 757 P.2d at 258-59.

190. *Smith*, 507 So. 2d at 1087-88; *Lucas*, 757 S.W.2d at 690-91.

191. Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 324-29, 347 N.E.2d 736, 741-43 (1976).

192. *See supra* notes 174-81 and accompanying text.

193. *See* Craig v. Boren, 429 U.S. 190, 197 (1976); *Sibley*, 477 So. 2d at 1109; *Carson*, 120 N.H. at 932, 424 A.2d at 831.

the legislative classification.[194]

In addition, even though the legislature's classification is not entitled to a full presumption of validity, reviewing courts still must respect the essential judgments of the legislature and uphold them once their proponents demonstrate that the means and ends employed by the legislature were considered carefully and that the method selected will further the public interest. A state legislature is not obligated to employ an optimal solution to a problem, merely one that is designed to correct the evil at which it is aimed and which does not unduly impair the rights of those affected by the classification.

According to these considerations, the proposed system is well conceived and therefore should survive constitutional scrutiny. The government's interest in improving the access of the public to quality health care has long been recognized as a compelling government interest.[195] Similarly, legislative efforts to improve the compensation of malpractice victims and deter negligent medical practices clearly are legitimate.

There is also a close relationship between these goals and the design of the proposed system. As outlined above,[196] the current tort system has not served its objectives well. At the same time, it has imposed heavy costs on the quality and availability of health care. The proposed system addresses each of the failings of the current tort regime and does so in a narrowly tailored fashion. Consequently, a key question for the constitutionality of the proposal in a particular state is whether that state has suffered the kinds of problems in malpractice litigation that have occurred generally. Indeed, courts that have invalidated tort reform legislation often have observed that no showing was made of a serious problem in malpractice litigation in that state.[197]

As to the final consideration, the burden of the legislation on the disadvantaged class, the satisfaction of the quid pro quo requirement perforce meets any concerns here. The burden is fairly balanced with benefits that justify upholding the constitutionality of the proposal.

IV. CONCLUSION

Scholars and other commentators agree that the current tort system is seriously flawed.[198] The Medical Liability Project has developed an administrative alternative designed expressly to respond to the most

194. *See* Plyler v. Doe, 457 U.S. 202, 216-30 (1982); *Carson*, 120 N.H. at 932, 424 A.2d at 830-31.

195. *See* Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905); Prendergast v. Nelson, 199 Neb. 97, 114, 256 N.W.2d 657, 668 (1977).

196. *See supra* Part II.

197. *See Arneson*, 270 N.W.2d at 136; Reynolds v. Porter, 760 P.2d 816, 824-25 (Okla. 1988).

198. *E.g.*, P. DANZON, *supra* note 1, at 221. *See generally* Sugarman, *supra* note 158.

serious defects in the current method of resolving medical liability disputes. The proposed alternative is both comprehensive in its sweep and consciously balanced in its treatment of the rights and interests of all parties affected by the medical malpractice problem.

In designing its system for resolving medical malpractice claims, the AMA/Specialty Society Medical Liability Project has aimed for fairness: fairness to the patient, fairness to the physician, and fairness to the public. The system should be more equitable than the civil justice system because it will provide compensation to more patients who are injured by medical negligence, will result in more reliable determinations of fault and more appropriate awards of damages, and will limit expenditures for meritless claims and unnecessary transaction costs. Consequently, the alternative system deserves implementation at least on an experimental basis in one or more states to permit a fair evaluation of its relative merits as against the current tort system.

APPENDIX A

Steering Committee Members
- American Academy of Family Physicians
- American Academy of Orthopaedic Surgeons
- American College of Cardiology
- American College of Obstetricians & Gynecologists
- American College of Physicians
- American College of Radiology
- American College of Surgeons
- American Medical Association
- American Society of Anesthesiologists
- American Society of Internal Medicine
- American Society of Plastic & Reconstructive Surgeons
- Council of Medical Specialty Societies
- Society of Thoracic Surgeons

Other Project Participants
- American Academy of Dermatology
- American Academy of Facial Plastic & Reconstructive Surgery
- American Academy of Neurology
- American Academy of Ophthalmology
- American Academy of Otolaryngology—Head & Neck Surgery
- American Academy of Pediatrics
- American Association for Thoracic Surgery
- American Association of Neurological Surgeons
- American Association of Plastic Surgeons
- American College of Emergency Physicians
- American College of Gastroenterology

American Psychiatric Association
American Society of Clinical Pathologists
American Society of Cytology
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
International Society for Cardiovascular Surgery
Society of Nuclear Medicine
Society for Vascular Surgery