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## MEDICAL MALPRACTICE REFORM: A PRELIMINARY ANALYSIS

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### INTRODUCTION

In late November, 1975, the University of Maryland School of Law, in association with the Schools of Medicine of the University of Maryland and The Johns Hopkins University, held a two-day conference on "The Medical Malpractice Crisis: Managing the Costs." The conference was interdisciplinary — the participants were specialists in law, medicine, insurance, economics, and sociology. Papers on various topics were presented to the conference, followed by intensive discussion of the questions they raised. Several of those papers are published in this issue of the *Maryland Law Review*. No summary of two days of analysis can accurately reflect the thrust and flavor of all the views expressed. This essay attempts, however, to explore the wide range of issues that were analyzed at the conference.

During the last two years, almost every state legislature has enacted one or more measures dealing with medical malpractice.<sup>1</sup> The battle still rages in most of these legislatures and before state insurance commissioners over reform of law and practice in this area. Although the process of reform began with an indignant roar from the medical profession over the cost of medical malpractice insurance, other groups with varying interests have since entered the picture. Underlying all

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1. See S. GROSSMAN, THE MEDICAL MALPRACTICE CRISIS: STATE LEGISLATIVE ACTIVITIES IN 1975 (National Center For Health Services Research document, Oct. 1975); Medical Malpractice and the State Legislatures (Monthly newsletter of the National Conference of State Legislatures, Apr., May, June, July & Aug. 1976); Comment, *An Analysis of State Legislative Responses To The Medical Malpractice Crisis*, 1975 DUKE L.J. 1417 [hereinafter cited as *State Legislative Responses*].

suggestions for reform are differing assumptions about the defects that exist in the current system and about the proper objectives of reform. The pressure of debate has not always allowed clarification of these assumptions or dispassionate analysis of the possible impact of proposed changes. Because only some of the proposals for reform are fully developed, and because the effects of those that have been enacted into law are only beginning to surface, such an analysis must necessarily be incomplete. An assessment at this preliminary stage may nevertheless be useful.

### I. THE CONTEXT

The number of medical malpractice claims and the average amount paid in settlement or judgment of them<sup>2</sup> have increased dramatically during recent years.<sup>3</sup> Many factors are cited to explain this phenomenon: a weakening of physician-patient relationships caused by growing medical specialization;<sup>4</sup> a loss of trust and confidence in the medical profession by the consumers of health care;<sup>5</sup> the double-digit inflation which occurred during part of this period;<sup>6</sup> and court-created modifications of the law that have expanded the group of persons entitled to recovery.<sup>7</sup> The increase in the number and severity of claims has,

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2. The amount paid to a claimant in a settlement or by judgment is known as the "severity" of the claim.

3. For reference to the experience of the St. Paul Fire and Marine Insurance Company, one of the nation's major underwriters of medical malpractice insurance, see BUREAU OF INS., STATE CORP. COMM'N (Virginia), *MEDICAL MALPRACTICE INSURANCE IN VIRGINIA: THE SCOPE AND SEVERITY OF THE PROBLEM AND ALTERNATIVE SOLUTIONS* 20 (1975) [hereinafter cited as *VIRGINIA REPORT*]. The frequency of claims made against physicians insured by St. Paul rose 139 percent between 1968 and 1974; the average severity of claims rose 117 percent during the same period. These figures do not include claims in New York and California, where St. Paul does not write medical malpractice insurance.

4. See Peterson, *Consumers' Knowledge of and Attitudes Toward Medical Malpractice* in U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, *REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE* (Appendix) 658, 666-67 (1973) [hereinafter cited as *SECRETARY'S COMMISSION REPORT*]; Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 *DUKE L.J.* 1179, 1183.

5. See Mechanic, *supra* note 4, at 1186.

6. See R. Rosett, *The Medical Malpractice Insurance Crisis* [paper presented to a University of Maryland Law School Conference entitled *The Medical Malpractice Crisis: Managing the Costs* (hereinafter cited as *Maryland Conference*) November 21, 1975, on file with the *Maryland Law Review*].

7. See AMERICAN MEDICAL ASSOCIATION, *MALPRACTICE IN FOCUS* 27 (source document prepared by the editors of *PRISM*, Aug. 1975).

of course, led to a series of increases in medical malpractice liability insurance premiums.

Another factor complicates the problem. Increases in the number and severity of claims have been occurring at unpredicted (and probably unpredictable) rates.<sup>8</sup> It is therefore difficult for companies writing medical malpractice liability insurance to fix accurate prices for the future protection that they sell to physicians. One way to avoid the risk of inadequate pricing is to fix premium rates so high that they are certain to be adequate. Another is to withdraw from the market, possibly leaving physicians without access to insurance coverage. Both have occurred during recent years.

A further factor, which had always been present but was more clearly recognized as the insurance "crisis" materialized, is that medical malpractice claims are expensive to resolve. Often factually and technically complex, they require extensive pretrial discovery and considerable time on the part of counsel and expert witnesses in all stages of litigation. Consequently, a comparatively small portion of the malpractice premium dollar finds its way into the pocket of the successful claimant. The rest is consumed by the administrative and legal costs of resolving claims.<sup>9</sup>

Literally hundreds of proposals have been made for dealing with these problems. For convenience of analysis, they may be divided into four categories. First, some *insurance reforms* aim at rendering the risk of suffering a malpractice claim more easily insurable by adjusting the type of coverage that is sold to the insuring physician. Another goal of certain insurance reform proposals is to spread the cost of insuring against claims more uniformly among physicians either by altering premium classification structures or by compensating patients out of a public fund for damages above a specified ceiling. Second, *tort law modifications* are aimed at either reducing the number of persons entitled to bring malpractice actions or limiting the amount that is recoverable in these claims. A third focal point of proposals for reform is the *dispute resolution mechanism*. Medical

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8. See Roddis & Stewart, *The Insurance of Medical Losses*, 1975 DUKE L.J. 1281, 1292; SECRETARY'S COMMISSION REPORT, *supra* note 4, at 41-42.

9. For estimates of the portion of the premium dollar which is actually paid to patients, see PHYSICIANS CRISIS COMMITTEE [of Detroit], COURT DOCKET SURVEY 2 (1975); O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries*, 60 MINN. L. REV. 501, 506-09 (1976); Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141, 1155 (1975); SUBCOMM. ON EXECUTIVE REORGANIZATION OF THE SENATE COMM. ON GOVERNMENT OPERATIONS, 91ST CONG., 1ST SESS.; MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN 10 (Comm. Print 1969).

review boards, screening panels, and arbitration are all devices that might help to resolve medical malpractice claims in a more reliable, less costly, and less time-consuming manner than under the current system. Finally, *new compensation systems* have the potential of promoting a number of positive effects. Channelling liability through hospitals instead of through physicians, for example, might create new financial incentives on the part of hospitals to avoid malpractice within their walls. Another approach, no-fault compensation for medical injuries, would provide compensation to more people than are currently able to collect. In addition, a no-fault system might be structured to increase physicians' incentives to avoid certain adverse outcomes of medical treatment.

These reforms, of course, focus on different "defects" in the existing system, and are based on varying premises about the nature of the medical malpractice problem. The truth of some of these premises has not been convincingly demonstrated. Consequently, the following analysis will concentrate on both the underlying assumptions and the probable impact of each approach to reform.

## II. INSURABILITY

### A. *The Claims-Made Policy*

The longer the period covered by a particular insurance policy, the greater is the difficulty of predicting future claims and of fixing an accurate price for the coverage provided. This is especially true when, as in recent medical malpractice experience, current change appears to portend unpredictable change in the future. Until recently, medical malpractice liability insurance policies were written with relatively long periods of coverage. These policies protected the insured against claims arising from any treatment provided during the policy year, regardless of when the claim was made. Claims relating to treatment provided under this "occurrence" form of coverage can be made and paid years after issuance. This phenomenon is known as the "long-tail" effect; it is in part the result of certain exceptions to statutes of limitations<sup>10</sup> and the length of time between the filing of a claim and its resolution. Because of these uncertainties it is possible that the cost of all the claims attributable to a given treatment year may be unknown until years later. Thus, in order to set a price for occurrence coverage, insurance companies must predict the social and economic inflation in claims and recoveries that may occur between

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10. See text accompanying notes 35 to 39 *supra*.

the issuance of the policy and the last date when a claim covered by it may be resolved.

Recently, however, there has been a shift toward use of "claims-made" coverage, under which the policy holder is insured only against claims made during the policy year, regardless of when the treatment out of which the claim arises was provided. Claims-made coverage is designed to avoid some of the difficulties posed by the "long-tail" in medical malpractice insuring. By insuring only against claims made within a year from the date a policy is issued, insurance companies reduce the need to predict increases in claim frequency and severity. Although this pricing system may be more accurate, it is not without its drawbacks. In pricing occurrence coverage, insurance companies had the burden of planning for the long term. Under a claims-made system, however, much of the risk of planning for the uncertain future is shifted from the insurer to the insured.

For example, the physician maintaining occurrence coverage knows that once he retires or ceases to practice, the policies he purchased in the past will provide him with complete coverage against any future claims. In contrast, the retired physician who practiced with claims-made insurance must continue to purchase yearly policies after he ceases treating patients and earning money to pay for premiums. He will therefore be wise to invest funds during his active life to finance the purchase of insurance coverage after retirement. Yet he will have great difficulty predicting what the amount of this investment should be. This is exactly the problem that has caused insurance companies to shift from occurrence to claims-made coverage. Thus, the claims-made approach not only shifts the risk that future claims experience will differ from current predictions; it also shifts to the individual physician the burden of investing funds in anticipation of future premiums.

Another result of the move to claims-made coverage may be a fundamental change in the group of persons ultimately bearing the cost of insuring. Assuming that a sizeable portion of a physician's premiums are ultimately paid by his patients, then under an occurrence policy those treated shortly before and during the year for which the policy covers the physician, will finance that policy.<sup>11</sup> Thus, the

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11. Whether the patients treated in the years before or in the year during which coverage is in effect actually bear this cost will depend on the physician's ability to save funds during the previous year for payment of the next year's premium and on his ability to predict what that premium will be. To the extent that the physician does not increase his charges as malpractice premiums increase, then he and his patients from years past finance the insurance.

cost of insuring patients against malpractice will be paid largely by those patients themselves. In contrast, under the claims-made approach, unless a physician is able to set aside funds sufficient to pay future premiums, each year's patients will pay for insurance against malpractice committed in years past. This change represents a subtle shift from a near full-cost imposition on those purchasing the service to a "pay as you go" approach resembling the financing of social security insurance. The effect of this shift is to transfer part of the incentive to confront the system's current problems from the present to the future, when the cost of dealing with the problems of predicting claims experience may have greatly increased and our ability to deal with them may have diminished.

### B. *Patient Compensation Funds*

Medical malpractice liability insurance premiums are set with reference to several risk categories. These categories are based on the medical specialties. Normally there are five or six classes within each state, varying from the lowest risk class (the general practitioner who performs no surgery), to the highest risk class (the neurosurgeon or orthopedic surgeon). The difference between the premiums paid by the two classes can be enormous.<sup>12</sup> Several states have dealt with this disparity by imposing ceilings on the liability of health care providers for malpractice while establishing Patient Compensation Funds to pay claimants the excess of awards or settlements beyond the ceiling.<sup>13</sup> Depending on the manner in which the fund is financed, a number of objectives can be achieved by this device. If the fund were financed out of general state revenues, then the ceiling would relieve health care providers of the risk of unpredictable increases in claims severity. A difficulty with this approach, however, is that the fund would operate much like an insurance company writing claims-made insurance since it would assess taxes based on each year's expected pay-outs. Taxpayers would then be subjected to a burden similar to that of the physician covered by a claims-made policy. If the fund is maintained by assessments paid by health care providers (as are the funds created

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12. St. Paul's rates as of January 1, 1975 for basic minimum coverage (\$100,000/\$300,000) in Maryland, Virginia and the District of Columbia were as follows: Maryland — class 1 (low risk), \$360, class 5 (high risk), \$2273; Virginia — class 1, \$433, class 5, \$2728; District of Columbia — class 1, \$599, class 5, \$3790. See VIRGINIA REPORT, *supra* note 3, at 14.

13. See, e.g., FLA. STAT. ANN. § 627.353 (West Supp. 1976-1977); ch. 796, § 14 1975 Ore. Laws Spec. Sess. 2315.

thus far), the method of assessing becomes critical. A uniform assessment against all providers would adjust the differential premiums now paid by providers in high risk classes; differentials would exist only in connection with below-ceiling liability insurance. But where assessments are levied on the basis of risk criteria similar to those now used by the commercial insurers,<sup>14</sup> there is no levelling of premium differentials. In such cases the apparent function of the fund is to assure the health care profession that insurance against high recoveries will be available.

### III. TORT LAW MODIFICATIONS

Changes in forms of insurance coverage would alter the manner in which the risk of suffering a medical malpractice claim is insured against. In contrast, modification of doctrines in the law of torts would reduce the scope of that risk. Attempts at reducing claim exposure have taken two forms: first, rules of law have been modified so that the number of persons entitled to make a claim is reduced; second, the amount that may be recovered has been limited.

Evaluation of proposed and enacted modifications of the law on an individual basis is especially difficult in this area. Most of the controversial doctrines arose in response to what were considered serious inequities in the tort system. In many cases, these inequities will arise again if the doctrines are eliminated. Although critics often refer to abuses in specific cases, the arguments for extensive alteration of any particular doctrine are not convincing. Hence, the impression that emerges after a survey of the arguments for change in this area is that dissatisfaction with the legal system lies not with any particular doctrine, but with the overall balance of advantage between potential plaintiffs and defendants. It may be useful, therefore, to evaluate briefly the proposals for change of some of the more prominent doctrines that arise in medical malpractice cases. Following this evaluation, by focusing on the relationship between judge and jury in medical malpractice cases, I will attempt to illuminate some of the criticisms of the medical malpractice liability system's overall operation that seem to be implicit in these attacks on individual doctrines.

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14. See, e.g., FLA. STAT. ANN. § 627.353(2)(c) (West Supp. 1976-1977), which provides, *inter alia*, for a uniform assessment in the first year of the fund's operation, followed by an assessment after the first year based on:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;
2. The prior claims experience of persons or hospitals covered under the fund . . . ."



A. *Reducing the Number of Persons Entitled to Recover*

1) *Expert Witnesses and Locality Rule*

One of the critical features of almost all medical malpractice cases is the presentation of expert testimony on behalf of the plaintiff.<sup>15</sup> The defendant's conduct is measured by a standard that is normally inaccessible to the jury in the absence of expert testimony: the skill and learning commonly possessed by members of the profession in good standing.<sup>16</sup> For many years the standard of skill and learning was established by reference to those physicians who practiced in the geographical locality of the defendant.<sup>17</sup> Only a physician practicing in that locality could qualify as an expert on the standard. The understandable reluctance of physicians to testify against a colleague — the "conspiracy of silence" — was thought by many to be a major obstacle to making a successful claim. Reacting to this phenomenon, some courts held that physicians who had familiarized themselves with the standards of the relevant locality could qualify as experts even though they did not themselves practice there.<sup>18</sup> In addition, the growing nationalization in the character of standards of medical care caused courts to enlarge the relevant locality. It often became statewide and, in some cases and specialties, nationwide.<sup>19</sup> The number of physicians capable of testifying concerning the appropriate standard of care therefore increased, as did the number of cases that could be won despite a "conspiracy of silence" by a defendant's local colleagues.

Dissatisfaction with abolition of the locality rule seems to be twofold. First, many physicians are genuinely outraged by the existence of what they term "hired guns" — physicians who devote a large portion of their careers to testifying in malpractice cases. This represents dissatisfaction with the fact of such a person testifying as to the standard of care, rather than with the standard itself. That a physician spends much of his time as a witness does not itself seem suffi-

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15. For a discussion of the doctrine of *res ipsa loquitur*, which enables the presentation of certain cases without the support of expert testimony, see text accompanying notes 29 to 34 *infra*.

16. See 2 F. HARPER AND F. JAMES, *THE LAW OF TORTS* 969 (1956); W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 162 (4th ed. 1971) [hereinafter cited as W. PROSSER, *TORTS*].

17. See W. PROSSER, *TORTS*, *supra* note 16, at 164.

18. See, e.g., *Teig v. St. John's Hosp.*, 63 Wash. 2d 369, 387 P.2d 527 (1953). See generally Comment, *Medical Malpractice — Expert Testimony*, 60 Nw. U.L. REV. 834 (1966).

19. See, e.g., *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 349 A.2d 245 (1975) (holding that Maryland does not apply the locality rule).

cient reason for his disqualification as an expert. So long as he possesses expertise in the relevant field, his testimony should be admissible. Normally, of course, that expertise should be demonstrated by the maintenance of a substantial (though not necessarily full-time) practice in the field. There is no evidence available as to the extent of testimony by "hired guns," or, for that matter, as to the qualifications of all the physicians who testify in malpractice cases. If physicians who are not sufficiently familiar with the standards of practice are frequently being qualified as experts, then a statutory standard requiring potential experts to devote a minimum portion of their time to actual practice might be appropriate. In the absence of proof that there is widespread use of unqualified experts, the trial judge's discretion to bar testimony by a potential witness whose qualifications are not demonstrated should suffice to control attempted abuses.<sup>20</sup>

The second argument for restoring the locality rule is more basic. The movement to state or national standards of care may require that certain physicians conform their practices to higher standards. This may necessitate not only change in patterns of physician conduct, but also increases in the resources that must be made available to physicians and hospitals.<sup>21</sup> This might create hardships in certain situations, but the general availability of medical literature, post-graduate education, and of national accreditation of hospitals would seem to justify holding physicians and hospitals to minimum national standards. The alternative would be to deprive some communities of the quality of care that the rest of the nation's physicians consider to be the acceptable minimum.<sup>22</sup>

## 2) *Informed Consent*

In a growing number of cases a claimant has been allowed recovery on the ground that the defendant physician failed to obtain the plaintiff's "informed" consent to undergo a procedure involving a risk of a harm which the patient in fact later suffered.<sup>23</sup> The issue in most

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20. For a discussion of the discretion of the trial court in determining the qualifications of proposed experts see 2 J. WIGMORE, EVIDENCE § 561 (3d ed. 1940).

21. The extent to which the resources available to physicians and hospitals may be taken into account in evaluating their conduct varies. Compare *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 349 A.2d 245 (1975), with *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968).

22. For a discussion of the sense in which quality standards may result in the provision of "excess" care, see Havighurst & Blumstein, *Coping With Quality/Cost Trade-Offs In Medical Care: The Role of PSROs*, 70 Nw. U.L. REV. 6, 25-30 (1975).

23. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). See also discussions in Epstein, *Medical Malpractice: The Case for Con-*

of these cases is the reasonableness of the physician's failure to disclose the risk in question. The trend seems to be to test the reasonableness of the decision not to disclose by asking whether a reasonable patient would have desired to know the undisclosed information prior to his deciding whether to consent to treatment.<sup>24</sup> Critics of the doctrine point out that there are both theoretical and practical difficulties in applying it. Because a retrospective determination that the patient would have consented to the procedure had the risk been disclosed is of questionable accuracy, the causal connection between failure to disclose and subsequent injury is suspect.<sup>25</sup> There is also a strong argument that the claimant's damages should be offset against the loss or injury he would have suffered by refusing treatment. Professor Richard Epstein has recently argued that the physician's liability should be limited to those situations in which he has failed to make disclosures that the standards of the profession require.<sup>26</sup> Despite the troublesome problems posed by the doctrine as it now stands, such a limitation on the doctrine would be unwise. The effect of the limitation would be to vest in the medical profession total discretion to determine what a patient needs to know in order to undergo treatment. Although the custom of the profession may be strong evidence of what

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*tract*, 1976 AM. BAR FOUN. RES. J. 87, 119-28; Shartsis, *Informed Consent: Some Problems Revisited*, 51 NEB. L. REV. 527 (1972); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970). Although reliance on the doctrine may be increasing, the nature of the available data makes comparison between past and current experience difficult. One study analyzed 3699 appellate malpractice cases decided between 1950 and 1971. Over that period, informed consent was the most significant issue in only 72 of these cases. Dietz, Baird & Berul, *The Medical Malpractice Legal System*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 147. A survey of claims closed in 1974, however, found that failure to obtain informed consent was alleged or was the basis of a claim's disposition in 13 percent of the claims surveyed. INSURANCE SERVICES OFFICE, SPECIAL MALPRACTICE REVIEW: 1974 CLOSED CLAIM SURVEY, PRELIMINARY ANALYSIS OF SURVEY RESULTS 31 (Dec. 1, 1975) [hereinafter cited as ISO SURVEY]. Because the former survey deals with the most significant issue in appellate cases, and the latter with allegations in all closed claims, definitive comparison cannot be made.

24. See, e.g., *Wilkinson v. Vesey*, 110 R.I. 606, 627, 295 A.2d 676, 689 (1972) ("Materiality may be said to be the significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or treatment."); cf. W. PROSSER, *TORTS*, *supra* note 16, at 165-66 (standards of professional conduct).

25. One suggestion for dealing with this problem of proof is to avoid putting the physician "at the mercy of his patient's hindsight" by posing the issue in terms of the effect that disclosure would have had on the "reasonable" person in the plaintiff's position. See Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628, 646-47 (1970).

26. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. BAR FOUN. RES. J. 87, 120.

disclosures are appropriate, there will be occasions when it should not be conclusive.

The existence of the doctrine of informed consent not only seems to have encouraged physicians to procure consent, but has also improved communication between physician and patient. Publicity in medical journals and word of mouth have familiarized many physicians with leading cases. Physicians admit to spending more time and effort than they did in the past in explaining to patients the risks of treatment and in helping patients understand the alternatives.<sup>27</sup> Perhaps as important as the securing of informed consent are the collateral benefits of this increased communication between physicians and patients. For example, the sharing of information may create a positive relationship with the patient that discourages the bringing of a malpractice action on other grounds.<sup>28</sup> In short, despite its weaknesses, the doctrine advances two important ends: it encourages the physician to keep the patient informed and it protects the patient's control over the treatment he receives.

### 3) *Res Ipsa Loquitur*

The doctrine of *res ipsa loquitur* has been used in medical cases where 1) it is unlikely that the injury in question would have occurred in the absence of negligence and 2) the injury has been caused by an agency or instrumentality within the exclusive control of the defendant.<sup>29</sup> When applicable, *res ipsa loquitur* eliminates the need for the plaintiff to prove a specific act of malpractice. This is an important function; it enables a claimant's case to reach the jury when it is likely that malpractice has occurred, although direct evidence of malpractice is unavailable. It is important to stress that *res ipsa loquitur* may be applied in only a narrow class of cases: those in which, among other things, the patient's injury would not ordinarily have occurred in the absence of negligence.<sup>30</sup> Further, most states

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27. This conclusion is based in part on my discussions with physicians and observation of their behavior in the course of the study described in K. Abraham, *Life In A Hospital and The Feasibility of No-Fault*, (paper presented to the Maryland Conference, *supra* note 6, on file with the *Maryland Law Review*).

28. For speculation concerning the effect of the physician-patient relationship on the incidence of malpractice claims, see Peterson, *Consumers' Knowledge of and Attitudes Toward Medical Malpractice*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 667.

29. 2 F. HARPER & F. JAMES, *THE LAW OF TORTS* 1085 (1956); W. PROSSER, *TORTS*, *supra* note 16, at 214. See generally Comment, *The Application of Res Ipsa Loquitur in Medical Malpractice Cases*, 60 NW. U.L. REV. 852 (1966).

30. See *Brown v. Keaveny*, 117 U.S. App. D.C. 117, 326 F.2d 660 (1963).

apply the doctrine only where the presumed causal connection between the claimant's injury and an act of malpractice is a matter of common knowledge.<sup>31</sup> Only a few jurisdictions admit testimony by an expert that the injury in question does not ordinarily occur in the absence of malpractice.<sup>32</sup> Thus, the number of cases in which the doctrine may be applied is limited.<sup>33</sup>

Suggestions for reform of the use of *res ipsa loquitur* have focused on specifying the situations in which the doctrine would apply.<sup>34</sup> Criticism of the doctrine is thus implicitly directed at the exercise of discretion by the judiciary in applying it, rather than at the theory of the doctrine itself. The problem with the specification approach is obvious: it limits judicial discretion to apply the doctrine to claims that do not fall within a specified category. Any doctrine, of course, can be misused, but a limitation on the use of *res ipsa loquitur* in medical cases that is more exacting than the current requirements could be especially harsh. In medical cases the claimant is likely to be peculiarly unable to reconstruct the chain of events leading to his injury — he is often unconscious, and impartial witnesses are not easily obtained. Moreover, the complexity of medical conditions and incompleteness of medical knowledge, the same factors that militate

31. See D. LOUISELL & H. WILLIAMS, TRIAL OF MEDICAL MALPRACTICE CASES 206-07 (Supp. 1975); W. PROSSER, TORTS, *supra* note 16, at 227; Comment, *The Application of Res Ipsa Loquitur in Medical Malpractice Cases*, 60 NW. U.L. REV. 852 (1966).

32. See, e.g., *Raza v. Sullivan*, 432 F.2d 617 (D.C. Cir. 1970); *Tomei v. Henning*, 67 Cal. 2d 319, 62 Cal. Rptr. 9, 431 P.2d 633 (1967); *Fehrman v. Smirl*, 20 Wis. 2d 1, 121 N.W.2d 255 (1963).

33. Applicability of *res ipsa loquitur* was the most significant issue in 189 of the 3717 appellate cases decided between 1950 and 1971 surveyed in Dietz, Baird & Berul, *The Medical Malpractice Legal System*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 142. At the trial level, the doctrine formed the basis of allegations in only 8 percent of the 1974 closed claims surveyed in another study. ISO SURVEY, *supra* note 23, at 31.

34. See, e.g., NEV. REV. STAT. § 41A.100 (1975), creating a "rebuttable presumption" of negligence where one or more of the following has occurred:

- 1) A foreign substance other than medication or a prosthetic device was unintentionally left within the body of a patient following surgery;
- 2) An explosion or fire originating in a substance used in treatment occurred in the course of treatment;
- 3) An unintended burn caused by heat, radiation or chemicals was suffered in the course of medical care;
- 4) An injury was suffered during the course of treatment to a part of the body not directly involved in such treatment or proximate thereto; or
- 5) A surgical procedure was performed on the wrong patient or the wrong organ, limb or part of a patient's body.

See also Epstein, *Medical Malpractice: The Case for Contract*; 1976 AM. BAR FOUN. RES. J. 87, 138-41.

against application of the doctrine in cases where it is impossible to identify the cause of a patient's injury, suggest that specifying situations in which *res ipsa loquitur* can be applied may exclude many claims in which application of the doctrine would be appropriate. This is a high price to pay to ensure that an uncertain (but probably small) number of cases in which *res ipsa* should not apply are eliminated.

#### 4) *Statutes of Limitations*

Another feature of the tort system that has been criticized during the recent controversy is related to statutes of limitations on the bringing of malpractice actions. These statutes limit the period during which a claimant may initiate suit. Shortening this period may accomplish some objectives, but it is important to recognize that the overall impact of this reform will be limited.

As pointed out above,<sup>35</sup> medical malpractice liability is complicated by a phenomenon known as the "long-tail" effect, *i.e.*, there may be a long period between medical treatment and the final resolution of all claims made in connection with that treatment. The length of the tail is determined by several factors. Medical malpractice claims may be more complex than the average tort claim, requiring more time for all aspects of litigation,<sup>36</sup> and thus the length of time from filing of a suit to final resolution is likely to be greater. Altering statutes of limitations would have no effect on these factors because they affect only the time from filing to resolution.

Nevertheless, changes in the statutes of limitations might shorten the portion of the long tail that corresponds to the period between the occurrence of the incident in question and the filing of suit. This interval occasionally exceeds the period of the statute of limitations because of two exceptions. The first exception pertains to the patient's discovery of malpractice. Courts in many jurisdictions have held that the statutory period for bringing a claim does not begin to run until the claimant discovers (or in the exercise of reasonable care should have discovered) the alleged malpractice.<sup>37</sup> In the typical personal

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35. See text accompanying note 10 *supra*; SECRETARY'S COMMISSION REPORT, *supra* note 4, at 42.

36. SECRETARY'S COMMISSION REPORT, *supra* note 4, at 42.

37. See, *e.g.*, *Lipsey v. Michael Reese Hosp.*, 46 Ill. 2d 32, 262 N.E.2d 450 (1970); *Ruth v. Dight*, 75 Wash. 2d 660, 453 P.2d 631 (1969). The statute may also be tolled where there has been fraudulent concealment of error by the physician or where the physician continues to provide treatment after the injury but fails to discover his error. See *State Legislative Responses*, *supra* note 1, at 1430-32.

injury claim the fact of the injury often quite painfully gives a potential plaintiff notice that he may have a claim. In contrast, since even properly performed medical procedures may entail physical discomfort, the period between injury and discovery may be lengthy. A number of states have recently enacted legislation repealing the discovery exception in whole or in part.<sup>38</sup>

A second exception to statutes of limitations applies to minors and other persons under a legal disability. In most states the statute of limitations does not begin to run until the injured party reaches the age of majority or the disability is removed. In some instances, the "tail" on claims relating to treatment provided in a particular year may exceed twenty years. The procedural explanation for this exception is the incapacity of such persons to bring suit in their own name. A more substantive justification that might be offered, however, is that the effects of medical injuries to minors may take a number of years to emerge, either because of maturational phenomena or because of a child's inability to articulate his complaints. Several recent amendments to state statutes of limitations appear to have taken account of this possibility.<sup>39</sup>

Whether these limitations on the exception for minors and persons under a disability are justifiable is unclear. There is greater justification for restricting this exception than for restricting the exception for undiscovered injuries. This is because there is normally someone on whom responsibility could be placed for bringing an action on behalf of a minor or disabled person within the limitation period, whereas no one can be blamed for failing to bring an action for an undiscovered injury. Alteration of the minority and disability exceptions might, therefore, penalize a small group: those whose parents or legal guardians through negligence or inadvertence fail to initiate claims within the allotted time. On the other hand, such an alteration could cause the earlier initiation of cases that are currently delayed because of a strategic decision to postpone filing in order to take advantage of possible social and economic inflation. It would be interesting to learn what portion of the "late" claims filed by minors are the result of strategic delay. If most of these claims are late because of a deliberate decision to postpone filing rather than because of parental carelessness, it might be worthwhile to sacrifice the occasional claim by a minor whose

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38. See, e.g., MD. CTS. & JUD. PROC. CODE ANN. § 5-109 (Cum. Supp. 1976).

39. See, e.g., IND. CODE ANN. § 16-9.5-3-1 (Burns Supp. 1976); OHIO REV. CODE ANN. § 2305.11(B) (Page Supp. 1975), which toll the statutes in these states only until minors reach the age of six and ten respectively.

parents had carelessly failed to initiate suit during the statutory period.<sup>40</sup>

Even if the only effect of modification of statutes of limitations is to change the pattern of claim reporting so that all claims are known earlier, prediction of total claim exposure may be somewhat facilitated. In assessing the wisdom of further curtailing these traditional exceptions, however, it should be noted that untimely claims have contributed only slightly to the unpredictability that has troubled the industry. One recent study found that 98.1 percent of all incidents, involving 98.3 percent of all award dollars, are reported within five years of their occurrence.<sup>41</sup> In short, although the tail is long, it may not be very wide.<sup>42</sup>

### B. *Reducing the Severity of Claims*

Rather than reducing burgeoning costs by limiting the number of persons entitled to recover, a second approach would focus on limiting the average amount recovered by all claimants. Like the limitations on the numbers of persons entitled to recover, however, these devices are based upon certain assumptions about defects in the system that require scrutiny.

#### 1) *Ceilings on the Amount of Recovery*

An obvious way to limit the cost of medical malpractice insurance and to make more reliable the predictions necessary for accurate pricing is to place a ceiling on the amount recoverable. A ceiling can be fashioned in several ways. A statutory maximum can be set on the

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40. Elimination or narrowing of the discovery, minority, and legal disability exceptions may also ameliorate a problem related to increases in award levels between the time of the incident and final claim resolution. Where this period is lengthy, the value of a claim may exceed the limits of the standard occurrence policy that was issued during the treatment year in question. Since most medical malpractice liability insurance until 1975 was occurrence coverage, this problem could exist for years to come. If claims-made coverage becomes standard, the problem will begin to recede, since the policy limits will be set to take account of recent award levels. In the interim, "prior-acts" coverage insuring physicians against judgments above past occurrence policy limits could provide protection. The industry apparently does not offer such coverage at present.

41. See ISO SURVEY, *supra* note 23, at 25-26.

42. Some claims recently made by persons injured when they were minors may have been delayed because of pessimism about the possibility of recovery at the time of injury. See R. Rosett, *The Medical Malpractice Insurance Crisis*, *supra* note 6. Perceived expansion in the right to recover (*e.g.*, because of dissipation of the "conspiracy of silence") may therefore account for a portion of the current "late" claims. To the extent that this is the case, the tail may be expected to narrow even further in the future.



amount recoverable by a claimant either from an individual defendant<sup>43</sup> or from all defendants in a particular claim.<sup>44</sup> Other variations might limit the amount of general or special damages recoverable.

Ceilings impose the full cost of limiting malpractice awards on those who would otherwise recover damages in excess of the ceiling. A ceiling might be justified if it could be demonstrated that high awards have exceeded the amount of damages suffered by their recipients, but there does not seem to be any conclusive evidence regarding this proposition. Since a significant portion of large awards constitutes general damages for "pain and suffering" — a rather subjective item — evaluation of the accuracy of such awards is difficult. Nor is there evidence that smaller awards are more accurate than larger ones. Until there is such evidence, the purported inaccuracy of large awards cannot justify the imposition of ceilings.

Another argument occasionally made in support of ceilings is simply that society cannot afford the payment of damages above a specified sum. Assuming that the claimant has actually suffered above-ceiling losses, this argument is unpersuasive. Failing to compensate a victim for a portion of his losses does not eliminate their cost — it simply imposes the cost on the victim. Moreover, if it is appropriate for the victims of medical malpractice to bear a portion of their losses, it is difficult to discern why it is not equally appropriate for the victims of other professional negligence — or negligence in general — to bear a portion of their losses. In short, a convincing case for differential treatment of medical malpractice awards has not been made.

## 2) *The Collateral Source Rule*

According to a traditional rule of tort law, the damages recoverable by the plaintiff for personal injuries may not be reduced by the amount of payments received from collateral sources such as insurance benefits.<sup>45</sup> Several arguments have been advanced in support of the rule.<sup>46</sup> First, it is said that the plaintiff is in effect penalized for having pur-

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43. See IDAHO CODE §§ 39-4204 to 4205 (Supp. 1975).

44. See ILL. ANN. STAT. ch. 70, § 101 (Smith-Hurd Supp. 1976-1977) (setting the maximum recovery for a plaintiff in a medical malpractice action at \$500,000); IND. CODE ANN. § 16-9.5-2.2 (Burns Supp. 1976) (\$100,000 limitation; excess up to \$500,000 recoverable from Patient Compensation Fund).

45. The earliest cases to apply the rule seem to be *The Propeller Monticello v. Mollison*, 58 U.S. (17 How.) 152 (1854) and *Althorpe v. Wolfe*, 22 N.Y. 355 (1840). See Mocerri & Messina, *The Collateral Source Rule In Personal Injury Litigation*, 7 GONZAGA L. REV. 310 (1972); Note, *Unreason In The Law of Damages: The Collateral Source Rule*, 77 HARV. L. REV. 741 (1964).

46. For a more detailed summary, see *State Legislative Responses*, *supra* note 1, at 1447-50.

chased insurance. Second, it is predicted that applying insurance proceeds against damage awards will discourage the purchase of insurance coverage. Third, proponents of the rule fear that reduction in defendants' liability will diminish the deterrent effect of liability. Under close analysis, none of these traditional arguments is persuasive. The plaintiff is not truly penalized for having purchased insurance; rather, he gets just what he bargained for — certainty of payment. Nor is the purchase of insurance likely to be discouraged. Most first party insurance coverage that compensates for medical malpractice injuries covers a much wider range of events than those for which recovery could be obtained in a tort action (*e.g.*, health, life, and disability insurance). Therefore, such insurance will probably be purchased regardless of the status of the collateral source rule. In addition, the elimination of the rule will probably have little effect on the deterrence of medical negligence. Since in many instances payments from collateral sources will constitute much less than half the damages suffered by a plaintiff, a financial threat will still exist.<sup>47</sup> Furthermore, the other forces that encourage physicians to exercise care and skill, such as the adverse publicity accompanying litigation and the possibility of peer group disciplinary action, will continue to be at work even if the rule is eliminated.<sup>48</sup>

The rule could be modified in several ways. By simply abolishing it, evidence of collateral source payments would be admissible and jurors could decide for themselves by what amount, if any, to reduce damages. A better method would be to require the reduction of damages pro tanto so that all parties receive uniform treatment with respect to collateral sources. Once the "double recovery" for the plaintiff is denied, the benefit could be passed on either to defendant (or his insurance carrier) in the form of a reduced judgment or to the plaintiff's collateral sources. If the judgment that the defendant's insurer must pay is reduced by the amount of collateral source payments, physicians and their patients will benefit through reduced (or less drastically increased) medical malpractice insurance premiums. If, on the other hand, a portion of the judgment equal to the collateral source payments received or receivable by plaintiff is reimbursed to those sources, then the ultimate beneficiaries are those who purchase this type of insurance. Nevertheless, the cost of transferring these funds to collateral sources hardly

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47. See James, *Social Insurance and Tort Liability: The Problem of Alternative Remedies* 27 N.Y.U.L. REV. 537, 548-50 (1952); O'Connell, *An Alternative To Abandoning Tort Liability: Elective No-Fault Insurance For Many Kinds of Injuries*, 60 MINN. L. REV. 501, 505 n.11 (1976).

48. See *State Legislative Responses*, *supra* note 1, at 1448.

seems worth what might be gained by doing so. As discussed above, the reduction of deterrence will be negligible even if physicians benefit from the reduction in damages paid. Further, the ultimate beneficiaries are broad classes — in one case all patients, in the other, all those possessing insurance coverage — which are probably composed mainly of the same persons.<sup>49</sup>

There is a final question which has been raised earlier in connection with ceilings on the amount of recovery. Is there a justification for confining the modification (in this case elimination of the collateral source rule) to medical malpractice claims? It has been noted that elimination of the rule is unlikely to affect the behavior of physicians because there are other factors (*e.g.*, genuine desire to provide quality care, fear of adverse publicity, and the possibility of peer disciplinary action) that would maintain their incentive to act with care. Similar factors are clearly present in other areas of professional liability. It could conceivably be argued that in cases where these factors are not present, elimination of the rule would reduce deterrence of unsafe conduct. Although their absence might have minor effects, it seems unreasonable to expect any serious loss of deterrence. There is therefore little justification for confining modifications of the collateral source rule to medical malpractice cases. Uniform treatment in all cases is warranted.

### 3) *Periodic Payments*

The possibility that a claimant might either die or fully recover from his injuries shortly after receipt of a large award has prompted proposals that damage awards be paid periodically instead of in a lump sum.<sup>50</sup> The concept of periodic damage payments for personal

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49. No modification of the collateral source rule has shifted the benefit to the collateral source. Rather, defendant's obligation has in each case been reduced. A version of the former approach is, however, suggested in Havighurst & Tancredi, "Medical Adversity Insurance" — *A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK MEMORIAL FUND Q. 125, 129 (1973), reprinted in 1974 INS. L.J. 69, 72 [hereinafter cited as Havighurst & Tancredi, citations to INS. L.J.]. Medical Adversity Insurance (MAI) is a no-fault medical accident compensation system under which large numbers of persons would receive compensation for their injuries (probably at a reduced rate). MAI is expressly designed to improve upon the quality assurance aspect of the tort system. Since under MAI the number of incidents respecting which health care providers would be required to pay compensation would be much larger than at present, the quality incentive that might be produced by requiring the reimbursement of claimants' collateral sources could be significantly greater than those produced by such a requirement within the existing compensation system.

50. See, *e.g.*, MALPRACTICE IN FOCUS, *supra* note 7, at 27; American Medical Association, "Discussion Draft" — Testimony for Remedial Legislation 16 (1975);

injuries is not new.<sup>51</sup> Two approaches may be taken. First, upon entry of a judgment, the defendant might be ordered to purchase an annuity or to deposit sufficient funds in trust to pay plaintiff his estimated annual damages during each year of his life expectancy.<sup>52</sup> A second method of providing periodic payment would be to provide for periodic adjustable payments dependent upon plaintiff's current damages.

Neither method of periodic payment is likely to reduce overall costs. The annuity method of periodic payment would reduce costs only if jury decisions concerning damages have been generally inaccurate in one or more respects. The annuity approach would of course eliminate windfalls to the heirs of plaintiffs who die prior to the life expectancy upon which the jury has based its award, but it would also require payments to plaintiffs who outlive their life expectancies. These parties would receive larger awards than are paid to them under the "lump sum" award system. If juries, on the whole, have been overestimating plaintiffs' life expectancies this annuity method might result in costs savings. If, on the other hand, such estimates have been randomly inaccurate, the method should result in no savings. Another jury miscalculation that might be remedied by this approach is the estimation of plaintiffs' investment abilities. To the extent that juries inflate awards to ensure that the proper sum will be available despite plaintiffs' poor investment of the award, the use of an annuity for payment might produce net savings.

There are several additional reasons why the second approach, the payment of periodic but adjustable damages, might result in cost savings, but that approach also entails greater danger of increasing overall costs. First, if overestimation of life expectancies and underestimation of plaintiffs' investment capacities have been occurring, savings might accrue in the same manner as under the annuity approach. In addition, in the event that the inflation during plaintiff's

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Maryland Hospital Association, Inc., Malpractice Insurance Position Paper 8 (Sept. 1975); Medical and Chirurgical Faculty of the State of Maryland, Statement to the Medical Malpractice Insurance Study Committee of Maryland 4 (1975) [all the above are on file with the *Maryland Law Review*].

51. Periodic payment is one of the basic elements of most workmen's compensation systems. See 1 A. LARSEN, *THE LAW OF WORKMEN'S COMPENSATION* § 2.60 (1972); 8 W. SCHNEIDER, *WORKMEN'S COMPENSATION* § 1790 (3d ed. 1951).

52. A variation might involve the periodic payment of only special damages, such as medical expenses and lost wages, with general damages being paid "up front." See, e.g., Ala. H.B. 300 § 13 (1975), reproduced in *State Legislative Responses, supra* note 1, at 1454 n.184. That Alabama bill as finally passed provided for periodic payment of all damages (less out-of-pocket expenses and attorney's fees). See No. 513, § 10, 1975 Ala. Acts 1159.

lifetime is lower than was predicted at trial, periodic adjustment of the award may be less expensive than payment of a lump sum. The opposite, of course, is just as likely to occur. Finally, the periodic adjustment approach may be less expensive if juries have generally overestimated the permanence or severity of plaintiffs' injuries.

The factor that must be considered in weighing the advantages of periodic adjustment of awards is the inevitable administrative and legal costs. Even if savings might be captured by sharpening the damage estimation process through periodic rehearings, these savings could be easily depleted by the costs of counsel and experts at the additional proceedings. Any benefits accruing from periodic payment would lie instead in the system's increased capacity to make finely-tuned damage awards. Some defendants would pay more, some less; some claimants, in the long run, would receive more, and some would receive less than they would under the current system, but it is difficult to conclude that changes in the method of payment could produce overall savings.

### C. *Adjustment of the Roles of Judge and Jury*

Modern tort law often delegates broad authority to juries.<sup>53</sup> This delegation occurs in both formal and informal ways. First, Holmes was probably too optimistic in his prediction that a fund of experience with similar cases would increasingly enable trial judges to establish required standards of care without jury assistance.<sup>54</sup> Tort law continues to rely upon juries for judgments concerning the reasonableness of defendants' conduct. Further, courts are generally reluctant to provide juries with written statements of the rules of law that they are charged with applying. Inevitably, the jury's decision reflects common sense, conscience, or prejudice.

That there is wisdom in allowing the trier of fact some latitude is indisputable. Juries should have freedom to counterbalance the rigidities of legal doctrine with their own notions of fairness. The wisdom of this notion in general, however, does not mean that judges should abdicate their responsibility to impose the obligations of the

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53. See 2 F. HARPER & F. JAMES, *THE LAW OF TORTS* 883-95 (1956); Nixon, *Changing Rules of Liability in Automobile Accident Litigation*, 3 *LAW & CONTEMP. PROB.* 476, 479 (1936).

54. See O. HOLMES, *THE COMMON LAW* 98-103 (M. Howe ed. 1963). See also MORRIS, *Custom and Negligence*, 42 *COLUM. L. REV.* 1147, 1156 (1942): "Modern courts are curiously prone to dodge the responsibility of deciding the negligence issue — it sometimes goes to the jury even when the defendant's conduct is not in dispute, and even though a verdict of negligence would be outrageous."

law on juries as best they can. To refrain from doing so would be to discard the desirable tension between legal formality and community conscience in favor of unregulated jury discretion.

Increased assertion of decision-making authority by trial judges might provide a more equitable and precise means of redressing improper imbalances between plaintiffs and defendants in medical malpractice cases than would the substantial reformulations of the legal doctrines discussed earlier. For example, the exercise of judicial authority to exclude the testimony of those who do not qualify as experts in the specialty of the defendant, to direct a verdict for defendants in situations where plaintiffs' reliance on *res ipsa loquitur* is misplaced, and to reduce excessive verdicts might remedy inequities without resort to harsh solutions that will unfairly hamper meritorious claims.

Application of the law regarding the standard of care is another area in which increased assertion of judicial authority might achieve justice in particular cases more effectively than wholesale substantive law reform. A physician is obliged to exercise that degree of skill and care possessed by other members of his profession or specialty. This is a standard based on custom, but not all physicians would choose the same form of treatment or provide it in the same manner — differing schools of thought exist with respect to the treatment of many conditions. Thus a rule has developed that if the physician follows a standard that is acceptable to a "respectable minority" of the profession, then "he is within the bounds of permissible conduct."<sup>55</sup> Yet allowing juries relatively unguided discretion to make the required findings of fact and to apply the standard of care to those facts may inadvertently encourage a shift away from this "respectable minority" rule.<sup>56</sup>

Consider the following trial situation. Plaintiff's case consists in part of expert testimony concerning the standard of care that defendant should have met and his failure to conform to it. Defendant's case also consists in part of expert testimony, but defendant's expert testifies that he (and a respectable minority of others) would choose a different course of treatment than plaintiff's expert. Defendant's expert concludes that defendant conformed to the standard of the minority view.

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55. See D. LOUISELL & H. WILLIAMS, TRIAL OF MEDICAL MALPRACTICE CASES § 8.04 (1973); W. PROSSER, TORTS, *supra* note 16, at 163.

56. I am indebted to Professors Oscar S. Gray and Jon T. Hirschhoff for having suggested that an "under the table" shift away from this standard may be occurring at the trial level. The American Bar Association Commission on Medical Professional Liability is currently analyzing a sample of case records in order to determine, among other things, if this is the case. See American Bar Association Commission on Medical Professional Liability, Information Report 7 (Jan. 5, 1976).

If this expert's testimony is accurate, then the defendant should prevail. The jury's function in such a situation should be quite limited: to assess the credibility of defendant's expert. Unless plaintiff has introduced evidence tending to prove that the standard of conduct to which the defendant conformed is not acceptable to a "respectable minority" of physicians, the jury should be directed to find for the defendant.

Admittedly, although such cases are perhaps common, the evidence in a typical case is probably more complicated. First, the circumstances that existed at the time of the alleged malpractice may be in dispute. Second, features of the defendant's conduct — what action he took and when he took it, for example — may be the subject of disagreement. Finally, the proper standard of care and its application to the facts, whatever they are, will also be at issue. In this more complex setting a simple charge to the jury based on the credibility of defendant's expert normally will not suffice. If, however, defendant's expert has testified that the defendant followed a standard accepted by a respectable minority, even accepting the plaintiff's factual contentions, then the issue for the jury should be that expert's credibility. Even in cases in which there is no such testimony, the trial judge may use his charge to guide the jury by asking it first to determine what conditions existed at the time of the incident, next to determine what actions the defendant took and when he took them, and only then to apply the proper standard of care. A special verdict procedure in which the jury is required to make these individual findings might be useful under such circumstances. Undoubtedly a jury determined to find for one party might do so despite its belief in the truth of his adversary's factual contentions. Nevertheless there are surely fewer jurors who would do this than those who at present, out of frustration or confusion in sorting out the legal and factual issues in the case, find for the party with whom they sympathize.

The ability of the jury to ignore the court's charge and the difficulty which even sincere jurors may experience in attempting to faithfully execute that charge are phenomena that are characteristic not only of medical malpractice claims, but of many other personal injury cases as well. Yet the justification for allowing these phenomena to operate is less compelling in malpractice cases than in most others. Counterbalancing the rigidity of the law by introducing the conscience of jurors familiar with the behavior of ordinary people may be proper in the standard negligence case because the ultimate issue in such cases is in fact the kind of behavior required of the ordinary person. The standards of behavior required of defendants in medical malpractice cases, however, are not set by the community-at-large. Juries in most cases are totally unfamiliar with and unable to evaluate the

professional quality of the defendant except by reference to the testimony of experts. Therefore, juries in medical malpractice and other professional liability cases should be allowed considerably less latitude in applying the standard of care than in other negligence cases.

The relationship between damages and causation is a final area in which increased assertion of judicial authority may be desirable. Medical malpractice claims present a practical problem that rarely arises in other tort cases. In the typical tort claim there is relatively little difficulty in proving that the defendant's act was the cause-in-fact of plaintiff's injuries. The physical condition of the plaintiff at the time of the accident is usually easily demonstrable. Unless the plaintiff had already been injured or diseased, he probably would have remained in healthy condition but for the defendant's act. The matter of causation is seldom so simple in medical malpractice claims. People who enter physicians' offices and hospitals are injured or diseased. Even if the defendant has committed an act constituting malpractice, there will not always be a demonstrable connection between this act and the plaintiff's subsequent injuries. There are two other possible explanations. First, these injuries may be the result of the plaintiff's underlying condition — a natural progression of the injury or disease for which he sought treatment from the defendant. Second, these injuries may be the result of some feature of the medical intervention undertaken by the defendant, but not the result of that feature which the plaintiff has characterized as malpractice. Unless the jury is convinced that the defendant's malpractice, rather than the plaintiff's underlying condition or some legally neutral medical intervention, is the cause of the plaintiff's injuries, the defendant should prevail. This is merely an application of the rule that the plaintiff has the burden of proving each element of his cause of action.

The plaintiff's problem is that much of the operation of the human body remains a medical mystery. Moreover, much of what has been learned about the body is not a matter of common knowledge. Expert testimony is therefore often required not only concerning the standard of care, but concerning the causal relationship between defendant's alleged failure to conform to that standard and plaintiff's injuries. Often this testimony must be based on a reconstruction of the plaintiff's probable condition at various points during treatment. The primary responsibility for contesting the factual basis of such a reconstruction and of the expert's opinion concerning the causal relationship between the treatment and the subsequent disability must of course rest on defense counsel. But when the state of medical knowledge does not support an informed conclusion concerning the condi-



tion of the patient at critical points or concerning the causal connection between the alleged act of malpractice and the plaintiff's injuries, trial judges should exercise their authority to keep cases from the jury by granting directed verdicts. It is impossible to determine how many cases are sent to the jury with inadequately formulated or misunderstood guidelines: a detailed study of the evidence and jury charges in many cases would be necessary before even an educated guess could be hazarded. Moreover, it cannot be demonstrated objectively that criticisms, which on the surface appear to be directed at particular doctrines, are really indicative of less focused dissatisfaction with the entire system. But the suspicion is strong that the same level of concern would reverberate even in a jurisdiction that has enacted the entire catalogue of tort law reforms canvassed here. Those concerns would continue not merely out of a desire to further reduce insurance premiums (assuming the reforms could have any serious effect on these), but because there would still persist a sense that there had been a weakening of the control necessary to ensure that the law on the books and the law in action largely coincide. This is a much more difficult problem to deal with than evaluation of legal doctrines, but this relationship between the theory of the system and its operation may well be at the heart of the current controversy.

#### IV. ALTERNATIVE METHODS OF CLAIM RESOLUTION

##### A. *The Medical Review Board*

Another method of managing the cost of medical malpractice is to encourage resolution of claims before non-judicial forums. Normally, parties in litigation do not obtain a definitive determination of the strength of their respective cases until a final decision is delivered. One way to encourage the settlement of claims is to provide one or both the parties with such a determination, albeit nonbinding, at an earlier stage in the dispute.<sup>57</sup>

This concept was first applied in the "medical review board" — a body of physicians convened to hear the facts of a claim in informal fashion and to render a decision as to the possible commission of malpractice by the defendant.<sup>58</sup> In some instances this nonstatutory

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57. See *Documentary Supplement, Medical-Legal Screening Panels as an Alternative Approach to Medical Malpractice Claims*, 13 WM. & MARY L. REV. 695, 709-10 (1972); *State Legislative Responses*, *supra* note 1, at 1456. See generally Baird, Munsterman & Stevens, *Alternatives to Litigation, I: Technical Analysis*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 214.

58. See Baird, Munsterman & Stevens, *Alternatives to Litigation, I: Technical Analysis*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 224-25.

review is available only to physicians; the board's decision is in essence "advice" to the physician about whether to settle or to litigate the dispute. Other boards, however, also allow claimants to make a presentation. If the physician's insurance policy grants him the right to decide whether to settle a case, the review procedure provides a method for avoiding the investment of resources in defense litigation doomed to failure. An impartial recommendation by a physician's colleagues that the case be settled may encourage a settlement in those instances in which a stubborn defendant would otherwise refuse to accept the advice of his insurer or where the insurer's estimate of the chances of a successful defense of the claim is too optimistic.

The success of any nonbinding review procedure in encouraging settlement of claims depends at least in part upon its capacity to predict what will occur at trial. When review procedures accurately reflect the nature of trial presentation, the parties must afford great weight to the recommendation of the board because its prediction is likely to be accurate. If only physicians sit on the board, if the plaintiff does not present his side of the case, or if damages are not in issue, it is less likely that the board's recommendations will be followed than if the procedure provides a more reliable and complete picture of the strength of the parties' positions. The medical review board provides an incomplete picture.

### B. *The Screening Panel*

Legislative action in at least nineteen states<sup>59</sup> over the last two years has created screening panels, a procedure designed to achieve the objectives of the medical review board in more effective fashion. The

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59. See ch. 1, 1976 Ariz. Leg. Serv. No. 1, at 15-18 (codified at ARIZ. REV. STAT. § 12-567); ARK. STAT. ANN. § 34-2602 (Supp. 1975); FLA. STAT. ANN. § 768.133 (Supp. 1976-1977); ch. 278, 1976 Idaho Sess. Laws 953; ILL. ANN. STAT. ch. 110, §§ 58.2-10 (Smith-Hurd Supp. 1976-1977); IND. CODE ANN. § 16-9.5-9 (Burns Supp. 1976); ch. 249, 1976, Kans. Sess. Laws 970; LA. REV. STAT. ANN. § 40:1299.47 (West Supp. 1976); MD. CTS. & JUD. PROC. CODE ANN. § 3-2A01 to 2A09 (Cum. Supp. 1976); MASS. ANN. LAWS ch. 231, § 60B (Supp. 1975); Leg. Bill 434, §§ 40-47, 1976 Neb. Laws 151; NEV. REV. STAT. § 41A.020 (1975); N.M. STAT. ANN. §§ 58-33-14 to 24 (Supp. 1976); N.Y. JUDICIARY LAW § 148-a (McKinney Supp. 1975); OHIO REV. CODE ANN. § 2711.21 (Page Supp. 1975); PA. STAT. ANN. tit. 40, § 1301.301-606 (Supp. 1976-1977); TENN. CODE ANN. § 23-3401 to 21 (Supp. 1975); VA. CODE ANN. §§ 8-911 to 22 (Supp. 1976); WIS. STAT. ANN. §§ 655.02-21 (1976). Joint Medical-Legal Screening Panels had been in existence in parts of Arizona, Florida, Iowa, Idaho, Maine, Nevada, New York, Ohio, Pennsylvania, Washington and Wisconsin for some years even without statutory authorization. See Baird, Munsterman & Stevens, *Alternatives To Litigation, I: Technical Analysis*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 228.

screening panel is intended to encourage early settlement of meritorious claims and voluntary dismissal of nonmeritorious claims. By "screening out" some claims that would otherwise proceed to trial, the cost of litigating those claims is avoided. Although the use of screening panels varies somewhat from state to state, a general pattern is emerging.

1) *Composition of the panel.* In contrast to the medical review board, the screening panel is not composed solely of physicians. Typically, an attorney, a physician, and a layperson serve. The presence of an attorney on the panel means that the law of professional liability can be more accurately applied. The physician provides technical expertise, and the layperson serves as the panel's conscience — more or less the jury "representative." The decision of a mixed panel is more likely to be accepted by plaintiffs because its credibility for him is greater than that of a medical board.

2) *Scope of Authority.* Submission of claims to the panel is generally mandatory,<sup>60</sup> but the panel's decision is not binding because the right to a jury trial *de novo* (though termed an "appeal" in some statutes) is preserved. Some states have given the panel authority to make a decision as to liability only;<sup>61</sup> in others, decisional authority extends also to damages.<sup>62</sup> There is a major weakness in screening panel designs of the former type. If the panel's decision covers liability only, then damages, a major feature of the case, is left undecided. Because the parties will not have a complete picture of the strength of this aspect of their cases, fewer claims will be screened out. On the other hand, the unique capabilities of the panel — those that might be said to justify creating the procedure itself — lie in the combined expertise of the physician and attorney on the question of liability. Whether the panel will have abilities superior to those of the typical jury in the area of damages is doubtful. Authority to make findings regarding damages may nevertheless be necessary to the successful functioning of

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60. *But see* VA. CODE ANN. § 8-912 (Supp. 1976).

61. *See, e.g.*, LA. REV. STAT. ANN. § 40:1299.47(G) (West Supp. 1976); NEV. STAT. ANN. § 41A.060 (1975) (board to render a decision whether there is a "reasonable probability that the acts complained of constitute professional negligence").

62. *See, e.g.*, ARK. STAT. ANN. § 34.2605 (Supp. 1975); ILL. ANN. STAT. ch. 110, § 58.7 (Smith-Hurd Supp. 1976-1977); PA. STAT. ANN. tit. 40, § 1301.508(9) (Supp. 1976-1977). In some states the finding does not include a specific sum. *See, e.g.*, FLA. STAT. ANN. § 768.133(8) (Supp. 1976-1977) (after a finding of liability, the panel may, upon agreement of the parties, make a recommendation as to the "reasonable range of damages"); IND. CODE ANN. § 16-9.5-9-7(d) (Burns Supp. 1976 (panel to find the "extent and duration of disability" and "any permanent impairment and the percentage of the impairment")).

the procedure. A comparison of the claim settlement experience in states with these different procedures should eventually provide guidance.

3) *Effect and Reviewability of Decision.* In some states the decision of the panel has no effect in a subsequent trial de novo.<sup>63</sup> In others, the decision of the panel is admissible in evidence.<sup>64</sup> In most instances the scope of the judicial review to which these decisions may be subjected prior to their admission in evidence is unclear. In the absence of an express statutory provision,<sup>65</sup> the panel decision should not be admissible upon proof that there was a material failure of the panel to perform its statutory duties. The most important of these statutory duties, either express or implied, is to apply existing law.<sup>66</sup> Nevertheless, counsel may encounter difficulty in proving error, because most statutes do not require the panel to render an opinion detailing the legal bases of its decision. The absence of explanatory opinions may allow panels broad discretion to determine questions of liability and damages without reference to the rules of law governing these matters. There is no reason to believe that the various panels would exercise this power to ignore the law in similar fashion. Some might enlarge the scope of liability, while others might narrow it. Since the panel's decision is likely to be a strong influence on a jury in any later trial, decisions concerning admissibility should be made with a view toward encouraging responsible application of the law and a semblance of uniformity in future panel determinations. Whenever the basis of the panel's decision can be ascertained and does not conform to existing law (or when it is clearly arbitrary), the decision should be excluded from evidence. Otherwise, the use of screening panels may produce a random enlargement or contraction of the right to recover in medical malpractice cases.<sup>67</sup>

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63. There is no reference to admissibility, for example, in the Nevada statute. See note 59 *supra*. The Arkansas statute states expressly that the panel's findings may not be used in other proceedings. See ARK. STAT. ANN. § 34-2609 (Supp. 1975).

64. See, e.g., FLA. STAT. ANN. § 768.134(2) (Supp. 1976-1977); IND. CODE ANN. § 16-9.5-9-9 (Burns Supp. 1976); LA. REV. STAT. ANN. § 40:1299.47(I) (Supp. 1976); MD. CTS. & JUD. PRO. CODE ANN. § 3-2A06(d) (Supp. 1976); PA. STAT. ANN. tit. 40 § 1301.510 (Supp. 1976-1977) (finding regarding liability is admissible, finding regarding damages is not); TENN. CODE ANN. § 23.3409 (Supp. 1975).

65. Ohio is one of the few states that does make comparatively express provision for review. See OHIO REV. CODE ANN. § 2711.21(c) (Page Supp. 1975).

66. See, e.g., N.M. STAT. ANN. § 58-33-20 (Supp. 1976) (providing that the panel "shall decide . . . (1) whether there is substantial evidence that the acts complained of occurred and that they constitute malpractice").

67. For analysis of the same issue in connection with binding arbitration, see pp. 519-20 *infra*.

4) *Prehearing and Hearing Procedure.* In most states, parties before a screening panel are allowed prehearing discovery rights paralleling those provided litigants prior to a trial.<sup>68</sup> Evidence considered at the hearing may consist entirely of written submissions<sup>69</sup> or may include both written submissions and oral testimony.<sup>70</sup> The hearings are usually informal and do not involve strict adherence to the rules of evidence.<sup>71</sup> This flexible structure permits the panel's decision to be informed yet avoids the equivalent of a full-scale trial — the expensive procedure that screening panel legislation seeks to avoid. There is a real possibility, however, that the added costs of screening panels will exceed the savings from their use. First, extra costs will be incurred in every case that is not settled after a panel hearing, because another layer of procedure will have been added. Second, extensive discovery, preparation, and participation by counsel in a hearing will occur even in those cases that are settled after a hearing. This is especially true in jurisdictions where the decisions of the panel are admissible at trial. The counsels' preparation for their presentations to the panel will be extensive because the panel's decision may be very influential evidence before a jury. Moreover, some of these cases might have been settled prior to trial under the current system, perhaps without as much investment in their resolution. Finally, the availability of the informal and initially less expensive screening panel procedure may encourage the filing of claims that would not otherwise be made, thus adding to the total cost of resolving claims.

One way to limit costs is to curtail both discovery and the length of the hearing before the panel. None of the existing schemes limit either the amount of time or the number of witnesses the parties may call. Admitting a panel's decision into evidence when prehearing discovery and the hearing itself have been severely limited may be unfair,

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68. See FLA. STAT. ANN. § 768.133(5) (Supp. 1976-1977); ILL. ANN. STAT. ch. 110, § 58.6(3) (Smith-Hurd Supp. 1976-1977); IND. CODE ANN. § 16-9.5-9-4 (Burns Supp. 1976) (such discovery as the panel allows); LA. REV. STAT. ANN. § 1299.47(D) (Supp. 1976); MD. CTS. & JUD. PRO. CODE ANN. § 3-2A05(b) (Supp. 1976); OHIO REV. CODE ANN. § 2711.07 (Page 1954); PA. STAT. ANN. tit. 40, § 1301.508(3) (Supp. 1976-1977) (the panel itself may take depositions). In states in which a civil action is first filed and then referred to the panel, litigants probably have the right to discovery pursuant to existing rules of civil procedure. See, e.g., MASS. ANN. LAWS ch. 231, § 60B (Supp. 1975).

69. See IND. CODE ANN. § 16-9.5-9-4 (Burns Supp. 1976); LA. REV. STAT. ANN. § 1299.47(D) (Supp. 1976).

70. See, e.g., FLA. STAT. ANN. § 768.133(6) (Supp. 1976-1977); ILL. STAT. ANN. ch. 110, § 58.6(3) (Smith-Hurd Supp. 1976-1977).

71. See, e.g., ARK. STAT. ANN. § 34-2604 (Supp. 1975); TENN. CODE ANN. § 23-3409 (Supp. 1975).

however, because the panel may not have had sufficient facts before it to reach a proper decision. The choice, then, is between a comparatively complete and costly procedure which possesses the deterrent of admissibility, and a streamlined, less expensive procedure, which will probably screen out fewer cases because its panel decision will be inadmissible. A compromise approach, in which the panel's decision remains admissible might be fashioned. A permanent hearing administrator might limit discovery on an ad hoc basis, and the panel itself might "encourage" the parties to be brief during the hearing. No state has adopted this compromise approach; experience in the next few years may reveal whether it will be necessary.

### C. *Binding Arbitration*

The most important difference between binding arbitration and screening panels is that a trial de novo is not available after binding arbitration, because the decision of an arbitration board is final. Although binding arbitration may be either compulsory or voluntary, no state has mandated arbitration of medical malpractice claims. Several states, however, have enacted legislation expressly authorizing or regulating voluntary binding arbitration of such cases.<sup>72</sup> In addition, many states have enacted versions of the Uniform Arbitration Act,<sup>73</sup> pursuant to which voluntary binding arbitration of medical malpractice claims becomes valid.<sup>74</sup> In avoiding a trial in a court of law, arbitration may reduce the costs of adjudication by resolving disputes in a less formal setting and before persons who are more familiar with the complexities of medical treatment and the law than a jury. Some proponents also claim that arbitration will stabilize the amounts awarded by removing the emotionalism that characterizes jury trials.<sup>75</sup>

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72. See No. 513, § 8, 1975 Ala. Acts 1158; CAL. CIV. PRO. CODE § 1295 (West Supp. 1976); LA. REV. STAT. ANN. §§ 9:4230-36 (West 1975); MICH. COMP. LAWS ANN. §§ 600.5040-5065 (Supp. 1976-1977) (certain health care providers required to offer patients the arbitration option); OHIO REV. CODE ANN. §§ 2711.01, 2711.21-24 (Page Supp. 1975); S.D. COMPILED LAWS ANN. §§ 21-25A to 25B, 58-41-58 (Supp. 1976); VT. STAT. ANN. tit. 12, §§ 7001-08 (Supp. 1976); VA. CODE ANN. § 8-922 (Supp. 1976).

73. See D. DOBBS, HANDBOOK ON THE LAW OF REMEDIES 937-38 (1973).

74. For a comprehensive analysis of the applicability of arbitration law in each state to medical malpractice disputes, see Wadlington, *Alternatives to Litigation, IV: The Law of Arbitration In The U.S.*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 346.

75. See Bergen, *Arbitration of Medical Liability*, 211 J.A.M.A. 175, 176 (1970); Schnepfle, *Arbitration: Solution to Malpractice Dilemma?*, 48 HOSPITALS 41, 43 (Dec. 1, 1974).

Voluntary binding arbitration must overcome several substantial problems in order to succeed. First, arbitrators may compromise more claims than juries. The result of such a tendency would be a higher percentage of decisions for claimants, albeit with lower average awards.<sup>76</sup> In addition, since the presentation of a case to a board of arbitration may prove simpler and less technical than presentation in a trial by jury, the filing of claims that are currently foreclosed because of their low potential recovery may be encouraged. The only serious statistical study of arbitration currently available does not provide definitive conclusions regarding these questions.<sup>77</sup> Of course, the absence of major cost savings from voluntary binding arbitration of medical malpractice claims will not necessarily undermine the approach if the parties to arbitration are generally more satisfied with the results than parties to adjudication. For the physician, arbitration allows his conduct to be evaluated both without adverse publicity and by a board which often includes his peers; for the claimant, the informality of arbitration may be more agreeable than a formal jury trial which follows strict rules of evidence.

Two purely legal problems will have to be resolved as the incidence of voluntary binding arbitration increases. The first involves the validity of agreements to arbitrate. When the agreement is made at the time the patient needs treatment (and therefore prior to the existence of a claim), the patient's physical condition as well as his dependence on the health care provider for necessary medical care may affect his ability to understand and evaluate the wisdom of entering into the agreement. Therefore, if the health care provider were to seek a court order to compel compliance with the agreement to arbitrate, the patient might raise defenses of incompetency or unconscionability.<sup>78</sup> Several statutes address this problem by granting the patient a right to rescind the agreement within a specified period after execution or termination of treatment.<sup>79</sup> In other states the courts will inevitably be forced to make case-by-case determinations of the validity of arbitration agreements executed in varying circumstances. Until general rules are

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76. For example, four out of five medical malpractice cases actually tried to a verdict in 1970 resulted in a finding in favor of the defendant. See SECRETARY'S COMMISSION REPORT, *supra* note 4, at 10.

77. See Heintz, *Arbitration of Medical Malpractice Claims: Is It Cost Effective?*, 36 MD. L. REV. 533 (1977).

78. See generally Henderson, *Alternatives to Litigation, III: Contractual Problems In the Enforcement of Agreements To Arbitrate Medical Malpractice*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 321.

79. See, e.g., CAL. CIV. PRO. CODE § 1295(c) (West Supp. 1976); MICH. COMP. LAWS ANN. § 600.5041(3) (Supp. 1976-1977); VA. CODE ANN. § 8-922 (Supp. 1976).

established, the overall cost of arbitration will be unnaturally inflated because of the cost of testing the validity of agreements executed under these varying conditions.<sup>80</sup>

A second problem involves the availability of judicial review of the arbitration decision. The more systematic statutes prescribe, either expressly or by reference to other standards, the standard of care to be applied by the arbitrators.<sup>81</sup> Failure of the arbitrators to follow this prescription should be grounds for setting aside the decision. In jurisdictions where the applicable statute does not prescribe a standard of care to be applied by the arbitrators but merely authorizes the submission of a "dispute" or "controversy" to arbitration, the availability of judicial review is less clear.<sup>82</sup> For example, the grounds for review of arbitration decisions in the typical general arbitration statute do not include the commission of legal error by the arbitrators.<sup>83</sup> Thus, unless the arbitration agreement itself prescribes the standard of care to be applied by the arbitrators,<sup>84</sup> they may have the discretion to make an independent determination of the appropriate standard by which to evaluate the defendant's conduct.

It is too early to discern the effect of this apparent discretion, although there are a number of possibilities. First, despite the absence of express obligation, arbitrators may feel inclined or obliged to follow existing law, at least as a general guideline in making decisions. Second, the combination of individual arbitration decisions could result in a subtle change toward strict liability of the health care provider, perhaps for less than "full" damages. Third, a change in the opposite direction might occur whereby health care providers would be liable only for actions taken in bad faith or in reckless disregard of the appropriate course of conduct. Finally, each of the above effects might

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80. For a discussion of the effect of this cost on the Southern California Arbitration Project, see Heintz, *Arbitration of Medical Malpractice Claims: Is It Cost Effective?*, 36 MD. L. REV. 533 (1977).

81. See CAL. CIV. PRO. CODE § 1295(a) (West Supp. 1976) (test is whether treatment was "negligently" provided); MICH. COMP. LAWS ANN. § 600.5043(b) (Supp. 1976-1977) (test is the standard of care prevailing in civil cases).

82. See, e.g., No. 513, § 8, 1975 Ala. Acts 1158 (medical malpractice claim arbitration); MD. CTS. & JUD. PRO. CODE ANN. §§ 3-201 to 3-234 (1974) (general arbitration statute).

83. For a survey of the grounds for modifying and vacating arbitration awards in each jurisdiction, see Wadlington, *Alternatives to Litigation, IV: The Law of Arbitration in the U.S.*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 346.

84. Since some statutes provide that the award may be vacated if the arbitrators have "exceeded their powers," refusal to apply the standard prescribed by the arbitration agreement is probably sufficient ground. See, e.g., MD. CTS. & JUD. PRO. CODE ANN. § 3-224(b)(3) (1974).



occur at different times, depending on the nature of the dispute and the composition of the arbitration panels. As the scope of this discretion becomes recognized, arbitration could be easily transformed into the battle of emotions and contrast of personalities that some currently attribute to trials by jury. The predictability and stability that might be achieved through a system of arbitration may turn out, then, to be illusory goals.

## V. NEW COMPENSATION SYSTEMS

### A. *Channelling*

One of the many reasons that the increases in medical malpractice claim frequency and severity have been perceived as a "crisis" is that a relatively small group of private parties, practicing physicians, have suffered the immediate effects of that increase. Although physicians may eventually pass on the costs of increased liability insurance premiums to patients, physicians initially pay this cost. Some of the adverse effects of this phenomenon could be avoided if liability were shifted to a group of individuals or institutions who could serve as a conduit for assessing the cost of insurance more easily. There are a number of ways in which this shift could be accomplished. First, physicians could be completely relieved of liability for malpractice. Patients might then purchase their own insurance against the commission of medical malpractice by a treating physician. This insurance might even be purchased in the same way an airline passenger purchases flight insurance. The cost of insuring against medical malpractice would thus be spread immediately to a much larger group of persons — all patients, as opposed to all physicians. Another method would likewise relieve physicians of medical malpractice liability but simultaneously would require employers to insure their employees against the commission of malpractice. Finally, compensation could be provided by government and financed through broad-based taxation. The main weakness of each of these approaches is that the elimination of physician liability also eradicates the incentive toward care and safety produced by the threat of liability.<sup>85</sup>

An alternative that might avoid this diminution in deterrence of unsafe behavior is to "channel" liability through hospitals.<sup>86</sup> Although

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85. For a detailed theoretical analysis of the relationship between the various goals of accident law, see G. CALABRESI, *THE COSTS OF ACCIDENTS* (1970).

86. The two leading proposals for this form of channelling are contained in VIRGINIA REPORT, *supra* note 3, at 79-93 and Steves, *A Proposal to Improve the Cost*

the number of hospitals is smaller than the number of physicians, the ability of hospitals to spread the cost of insuring against liability to a large number of persons could ameliorate the financial burdens of channelling liability through physicians. The system might be structured along the following lines. Physicians would be relieved of liability for any act of malpractice occurring within a hospital. Since approximately seventy-five percent of all malpractice actions concern treatment provided within hospitals,<sup>87</sup> this immunity should quickly reduce physicians' premiums for out-of-hospital treatment liability insurance. Concurrently, each hospital would become liable for all acts of malpractice occurring within its walls, regardless of whether they are caused by the acts of the hospital's employees. The cost of additional insurance that each hospital would have to procure would be passed on to patients in the form of increased charges. Premiums would be based in part on each hospital's claims experience so there would be an incentive to reduce the incidence of claims by monitoring or auditing treatment provided within the hospital.

Although channelling liability through hospitals would increase their incentive to reduce the incidence of malpractice occurring within their walls, the physicians relieved of liability would thereafter have less financial incentive to avoid malpractice. Thus, this form of channelling might result in increased malpractice. Enabling legislation might mitigate this effect in several ways. Hospitals might be given more authority to control or supervise the practices of physicians granted the privilege of providing treatment to admitted patients. Such legislation might also impose on physicians an obligation to indemnify the hospital for a portion of its liability resulting from their negligent treatment. For example, physicians might be liable to hospitals for fifty percent of the first \$5,000 (or any other sum, up to a maximum per year) paid on any claim. Such an approach would retain a measure of financial incentive for physicians to exercise care in treatment. Even without such legislation, similar relationships might be produced through the bargaining of physicians and hospitals after the inception of channelling.

Although the channelling proposal is intriguing, it is nevertheless doubtful that the prevailing public mood would support the abolition of direct physician liability for the consequences of their malpractice.

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*to Benefit Relationships in the Medical Professional Liability Insurance System, 1975*  
DUKE L.J. 1305.

87. Rudov, Myers & Mirabella, *Medical Malpractice Insurance Claims Files Closed in 1970*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 10; I.S.O. SURVEY, *supra* note 23, at 33.

Until more effective control and review of physician behavior is developed,<sup>88</sup> channelling is likely to remain on the sidelines of reform.

### B. *No-Fault Compensation*

No-fault compensation is the most fundamental of the reforms surveyed in this essay. Not only would this reform alter the system of insuring against medical liability and the method by which compensation for injury is paid, but it would also effectively revise the legal standard of care required of physicians. Not surprisingly, proposals for instituting no-fault systems raise fascinating but troublesome questions.

The proponents of no-fault systems (notably Professors Clark Havighurst<sup>89</sup> and Jeffrey O'Connell<sup>90</sup>) have fashioned their recommendations in response to defects in the existing liability/compensation system: it is extraordinarily expensive to administer; its effectiveness in deterring substandard conduct is doubtful; the incidence of claims is haphazard; and physicians are subjected to stigma for marginal errors and forced to undergo prolonged review of the treatment involving these debatable errors.

The alternative advocated seeks to avoid these defects through an abolition of tort liability and the substitution of a no-fault compensation system. Within the sphere of the system's operation, the existence of fault by medical personnel would be irrelevant to a patient's right to compensation. Instead, health care providers would procure insurance covering their patients in the event of certain injuries, regardless of whether they are caused by malpractice. Any patient suffering a covered injury — a "compensable event" — would be compensated. Ideally, such a system would reduce the expense of compensating the patient because: the high cost of determining whether malpractice has occurred would

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88. For a discussion of Professional Standards Review Organizations (PSROs), the most prominent device for such control and review, see Ball, *PSRO: An Alternative to the Medical Malpractice System as a Quality Assurance Mechanism*, 36 MD. L. REV. 566 (1977).

89. See Havighurst, "Medical Adversity Insurance" — *Has Its Time Come?*, 1975 DUKE L.J. 1233 [hereinafter cited as Havighurst]; Havighurst & Tancredi, *supra* note 49.

90. See J. O'CONNELL, ENDING INSULT TO INJURY: NO-FAULT INSURANCE FOR PRODUCTS AND SERVICES (1975); O'Connell, *No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others*, 1975 INS. L.J. 531; O'Connell, *Elective No-Fault Liability by Contract — With or Without An Enabling Statute*, 1975 U. ILL. L.F. 59; O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-Fault For Many Kinds of Injuries*, 60 MINN. L. REV. 501 (1976); O'Connell, *Contracting for No-Fault Liability Insurance Covering Doctors and Hospital*, 36 MD. L. REV. 533 (1977).

be eliminated; systematic feedback concerning the incidence of compensable events coupled with the financial incentive to avoid them would promote safety; and the stigma of a malpractice claim would be replaced by the neutral fact that a patient had submitted a claim for compensation. Nevertheless, a no-fault system would have to overcome a raft of theoretical and practical difficulties before it could be instituted.

1) *Defining the Compensable Event.* The occurrence of an injury caused by the malpractice of a health care provider currently affords the patient a right to compensation. With this fault standard eliminated, compensation criteria must focus solely on the patient and his injury. In other fields where either no-fault or strict liability have been instituted, the task of devising criteria that can identify compensable injuries has been relatively simple.<sup>91</sup> Injuries "arising out of maintenance or use of a motor vehicle"<sup>92</sup> are easy to isolate: if a person enters an automobile healthy and leaves it injured, he has probably suffered an injury satisfying the above criterion. The same is true for the injuries "arising out of and in the course of employment" for which workmen's compensation is paid.<sup>93</sup> But many if not most people who enter hospitals and physicians' offices have diseases or injuries. Consequently, many may still be suffering from diseases or injuries after treatment. If compensation is to be paid only for injuries caused by medical treatment rather than for the disabilities for which treatment was sought, a method of separating the two must be created, and that method must be one that does not require costly and time-consuming litigation.<sup>94</sup>

Compensable events could be defined in two ways. First, following the general principles of workmen's compensation and no-fault automobile plans, compensation might be paid to any patient suffering an "injury arising out of or caused by medical treatment."<sup>95</sup> This general definition approach has several weaknesses. First, considerable

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91. See Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 614-15 (1973) [hereinafter cited as Keeton]; O'Connell, *An Alternative To Abandoning Tort Liability: Elective No-Fault For Many Kinds of Injuries*, 60 MINN. L. REV. 501, 520-21 (1976). But see Epstein, *Medical Malpractice: The Case For Contract*, 1976 AM. BAR FOUN. RES. J. 87, 143-44.

92. NATIONAL CONF. OF COMM'RS ON UNIFORM STATE LAWS, UNIFORM MOTOR VEHICLE ACCIDENT REPARATIONS ACT, § 2 (Approved Draft, Nov. 1, 1972).

93. See 1 A. LARSON, WORKMEN'S COMPENSATION LAW § 6.00 (1972).

94. See O'Connell, *No-Fault Liability by Contract For Doctors, Manufacturers, Retailers and Others*, 1975 INS. L.J. 531, 533.

95. This approach is adopted by the proposed "Kennedy-Inouye" Bill. See S. 215, 94th Cong., 1st Sess. § 1711(a) (1975) (under which compensation would be payable "for loss from any injury suffered as a result of health care services").

disagreement can be expected concerning the cause of a claimant's disability in particular cases. Litigation to determine whether the disability was caused by medical treatment or by the patient's underlying medical condition will be necessary. The expense of resolving this causation issue will increase the cost of operating the system.<sup>96</sup> Second, the general definition cited above would compensate all treatment-related injury. If a limitation on the range of compensable injuries is desired, the definition will have to be qualified by exceptions. Regardless of whether these exceptions are phrased generally or are specifically enumerated, there will be disputes over borderline cases. Some of these will be litigated, thus adding to the overall costs of compensation. Finally, the use of a general definition as the touchstone for compensability will raise what Professor Guido Calabresi has called the "substitutability" problem.<sup>97</sup> Because health care providers' insurance premiums will be based in part on the number of compensable events occurring, they will have an incentive to try to avoid the occurrence of these events. In fact, since many more persons would be entitled to compensation than under the current tort system, the no-fault approach might produce greater incentives to avoid adverse outcomes of treatment. For the most part, this is a valuable feature of the system, but it might also encourage the provider to choose a mode of treatment (or no treatment) that has a lower probability of resulting in a compensable event than one that is medically preferable. Unless both results are compensable, there will be undesirable incentives. Creating the necessary catalogue of substitute treatments could prove to be a Herculean task. Moreover, compensation should in theory also be paid when a substitute treatment (such as no treatment at all) is followed by a disability resulting from the claimant's underlying medical condition and that treatment was not the medically preferable choice. Application of this criterion is likely to involve problems similar to those of determining whether a physician has made a negligent choice of treatment<sup>98</sup> and may also produce the stigma and costs involved in applying that standard.

A second method of defining compensable events is to list the injuries for the occurrence of which the patient would be entitled to compensation. Professor Havighurst has published first drafts of such lists for three medical specialties as part of his proposal for Medical

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96. See Keeton, *supra* note 91, at 594, 614-15.

97. Remarks made at the Maryland Conference, *supra* note 6.

98. See Epstein, *Medical Malpractice: The Case For Contract*, 1976 AM. BAR FOUN. RES. J. 87, 145-46.

Adversity Insurance (MAI).<sup>99</sup> The advantage of this approach is that the events that are compensable can be limited until experience in operating the system is gained. In addition, some of the difficulties inherent in applying a general definition can be eliminated by careful construction of the list of compensable events.<sup>100</sup> For example, complicated questions of causation can be circumvented by including only conditions whose etiology is normally certain. Likewise, the cost of making close examination of individual conditions in borderline cases of compensability may be avoided by compensating only for those disabilities that are easy to distinguish from noncompensable disabilities. Finally, the substitutability problem can be addressed by structuring the list of compensable events so that whenever the adverse effects of a preferred mode of treatment are compensable, the undesirable effects of choosing a substitute treatment are also listed.<sup>101</sup>

Although enumeration of specific compensable events may mitigate these causation, borderline and substitutability problems, the concessions involved in accomplishing these objections should be recognized. A no-fault system that is limited in scope will have to begin as a partial substitute for tort liability. While there will be no recovery in tort for any event compensable on a no-fault basis, "noncompensable" events will remain subject to tort liability. The relationship between compensability under a no-fault system and continuing (though partial) tort liability is therefore crucial. In order to avoid difficult questions of causation, providing compensation for adverse effects whose etiology is difficult to trace must be foregone. Similar sacrifices must be made to avoid incurring the costs of resolving borderline cases: disabilities without clear characteristics must be uncompensable. Furthermore, to ensure that

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99. See Havighurst, *supra* note 89, at 1256-63; Havighurst & Tancredi, *supra* note 49, at 76.

100. See Havighurst, *supra* note 89, at 1256 n.71:

The list was compiled by reviewing the most common surgical complications and considering them in light of the following questions:

1. To what extent is the incidence of this complication related to the technical skill, judgment, or attentiveness of the surgeon?
2. Is this complication a clinically distinct entity? Can its existence be readily substantiated?
3. How early in the postoperative period is this complication detectable?
4. How costly are the sequelae of this complication?
5. Would an incentive to minimize the occurrence of this complication bias the choice of treatment in unfortunate ways?

101. This device, of course, leads back into the thicket of attempting to optimize, rather than minimize, the occurrence of compensable events. See text accompanying notes 97 & 98 *supra*. Professor Havighurst makes no claim that MAI will induce optimal behavior but only that it could introduce "more effective financial incentives." See Havighurst, *supra* note 89, at 1249.

the system does not create perverse treatment incentives, there must be no compensation for the adverse effects of certain treatments when it is unfeasible to compensate for the adverse effects of substitute treatments. These sacrifices may also contribute to the perceived unfairness of the system by providing one group a no-fault remedy while leaving the other to the tort liability system simply because of a difference in the types of medical treatment involved. The task that has not yet been faced is to strike a workable balance between contradictory goals: on the one hand are the desirability of removing a large portion of claims from the current compensation system and the need to structure equitably the system that replaces it; on the other hand is the requirement that the range of compensable events be carefully limited in order to achieve the efficiency that will render the system economically feasible.

2) *The Form and Amount of Compensation.* The total cost of instituting a no-fault compensation system is unknown. One reason for this uncertainty is that there is no consensus as to which events would be compensable nor as to the level of compensation that would be paid to patients entitled to receive it. It should be recognized, however, that a portion of this cost, whatever it is, will represent a re-categorization of costs previously incurred elsewhere rather than a new expense.<sup>102</sup> For example, a patient who currently suffers a medical complication not caused by negligence may receive compensation from several sources. His medical and hospitalization insurance may pay all or a portion of the additional medical expenses incurred in treating the complication. Further, if the patient is out of work because of the complication, disability or unemployment insurance may reimburse him for lost wages. The cost of purchasing these forms of insurance would be reduced if no-fault compensation were available for some of these losses.<sup>103</sup> This apparent saving, of course, would reappear immediately as part of an apparent increase in insurance premiums (in this case no-fault premiums) paid by health care providers. In short, although the dollar cost of a no-fault plan may appear high, a portion of this sum will be costs that have merely been shifted to the no-fault system.

Nevertheless, it is probably a basic political fact that a no-fault system will not gain acceptance if it requires health care providers to pay premiums in excess of what they now pay for tort liability insur-

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102. See Havighurst & Tancredi, *supra* note 49, at 89-91.

103. This assumes that the patient would not be entitled to receive compensation from his collateral insurers if he were entitled to no-fault compensation or that the collateral insurers would be subrogated to the patient's no-fault rights in the event that the patient had already been paid by these sources. See Havighurst & Tancredi, *supra* note 49, at 89-90.

ance. The problem, then, is to fashion a system in which the cost of paying compensation for the events that are covered does not exceed the cost of the part of the present system that it supersedes. Since the occurrence of an injury caused by medical malpractice is not a condition to receipt of compensation, the number of persons entitled to compensation will be vastly increased. A reduction in outlays must therefore be achieved if premiums are to remain at current levels. For the most part, funds for compensating the "additional" beneficiaries (those whose injuries have not been caused by malpractice) would have to be produced by reducing the average amount of compensation paid to any one of them. The category of compensation that is a prime candidate for elimination is pain and suffering.<sup>104</sup>

Even if pain and suffering damages are not paid and only economic losses are compensable, it may be difficult to maintain no-fault premiums at an acceptable level. First, it is unclear whether the reduction in administrative and legal expenses realized from eliminating disputes related to the standard of care will offset the cost of resolving the new issues that may arise. Second, the cost of determining losses on a patient-to-patient basis is high. This expense could be reduced by creating schedules of benefits payable for specified compensable events, but a system that standardizes benefits is susceptible to criticism in that it treats some victims inequitably by denying them their actual losses while paying others more than they should receive.<sup>105</sup> A more fundamental problem is that the number of persons who suffer non-negligently caused treatment-related injuries may be so large that compensating them even for economic losses alone may be prohibitively expensive.<sup>106</sup> It is yet to be demonstrated whether the increased incentives to avoid adverse outcomes of treatment will produce sufficient savings (in the form of a decreased incidence of treatment-related injuries) to keep the total cost of compensation within practical financial limitations.

3) *Instituting the System.* A no-fault system could be created in a variety of ways, each necessitating a choice among several variables.

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104. See Havighurst & Tancredi, *supra* note 49, at 72; O'Connell, *Contracting For No-Fault Liability Insurance Covering Doctors and Hospitals*, 36 MD. L. REV. 533 (1977).

105. See Keeton, *supra* note 91, at 609-10.

106. Studies of the incidence of treatment-related injuries have discovered that a surprisingly high percentage of patients suffer such occurrences. See Boyden, *Medical Injuries Described in Hospital Patient Records*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 41; Pociński, Dagger & Schwartz, *The Incidence of Iatrogenic Injuries*, SECRETARY'S COMMISSION REPORT (Appendix), *supra* note 4, at 50; Schimmel, *The Hazards of Hospitalization*, 60 ANNALS OF INTERNAL MED. 100 (1964).



One way is to make participation in the system mandatory for all patients and health care providers by means of legislation prescribing both compensable events and award levels.<sup>107</sup> The cause of action for injuries not compensable on a no-fault basis could either be abolished or preserved. The more extensive the compensable events, the greater would be the justification for a complete abolition of tort liability, because patients as a class would receive more in return for the surrender of common law rights.<sup>108</sup> If the cause of action for malpractice is preserved, new issues will arise. Some claimants who believe that they have suffered injuries caused by malpractice will attempt to prove that their injuries are not compensable on a no-fault basis. Similarly, the desire of health care providers to avoid malpractice actions might induce them to disclose borderline events to patients as compensable. This "defensive disclosure" might confound the system's operation unless there are strict controls on the manner in which health care providers disclose to their patients that a compensable event has occurred and sanctions are imposed for false disclosure.<sup>109</sup>

A no-fault system need not be mandatory. Instead, statutory authorization for health care providers and patients to contract for the provision of no-fault insurance could achieve many of the objectives of

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107. Although the earliest discussion of MAI seems to contemplate this approach, the later elaboration entertains the possibility that the system could be elective. Compare Havighurst & Tancredi, *supra* note 49, at 69-71, with Havighurst, *supra* note 89, at 1277-79.

108. The *quid pro quo* provided patients in return for abolition of the cause of action for malpractice would be: patients would be relieved of the burden and cost of proving malpractice in those cases where there would have been liability in tort under the old system; they would receive prompt and presumably simple payment instead of payment after possibly long delay; where disclosure to the patient of the right to compensation is mandatory, those patients who, under the existing system are entitled to compensation but for one reason or another fail to make claims would now be compensated; and finally those persons who are not currently entitled to compensation would be compensated under the no-fault system. For a discussion of analogous problems under no-fault automobile legislation, see Bishop, *The Validity Under the Constitution of the United States of Basic Protection Insurance and Similar Proposals for the Reform of the System of Compensating Victims of Automobile Accidents*, DEP'T OF TRANSPORTATION AUTOMOBILE INSURANCE AND COMPENSATION STUDY, CONSTITUTIONAL PROBLEMS IN AUTOMOBILE ACCIDENT COMPENSATION REFORM 35 (1970).

109. The creators of MAI recommend that there be a statutory obligation to inform the patient of the existence of a claim and that the provider have personal liability for failure to do so. In addition, they propose that providers who wilfully withhold information lose their immunity from tort liability for that injury. See Havighurst & Tancredi, *supra* note 49, at 73. See also the Kennedy-Inouye Bill, S. 215, 94th Cong., 1st Sess. § 1705(c)(2) (1975). Neither of these proposals, however, deals directly with the fraudulent overdisclosure which would occur in "defensive classification" of injuries.

a mandatory system.<sup>110</sup> Legislation would prescribe the injuries to be compensable in the event the option to participate in the system is exercised. An enabling statute should also specify whether the patient's participation in the system will constitute a complete waiver of the common law cause of action for malpractice or only a waiver as to those injuries that are compensable.<sup>111</sup> Possibly even a dual listing of compensable events, one more extensive than the other, could be constructed. Election to participate in the extensive coverage system might require a complete waiver of the cause of action for malpractice, whereas participation in the less extensive system might require waiver only as to those events covered. In addition, an enabling statute should specify the conditions under which the election to participate would be valid. These would include the requirement that the nature of the system be explained to the patient so that he understands its operation, as well as (perhaps) a right to revoke within a specified period.

An "elective" system need not grant an option to participate to both the patient and health care provider.<sup>112</sup> Rather, participation could be mandatory for patients upon the provider's election to provide no-fault compensation in conformity with the statutory requirements. This system would be elective from the health care provider's point of view but not from the patient's. Legislation structuring an option in this fashion should address several other issues. If the health care provider may elect to provide no-fault coverage, must this election cover all his patients? A universal election would allow patients to "physician shop" so as to choose the kind of coverage they desire. This approach might also induce physicians to decline to treat patients suffering from conditions having a higher than average probability of resulting in a com-

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110. For proposals that envision this method of instituting the system, see Havighurst, *supra* note 89, at 1278; O'Connell, *An Elective No-Fault Liability Statute*, 1975 *Ins. L.J.* 261.

111. See note 108 *supra*.

112. The proposals vary in this respect. Under Professor O'Connell's plan, whether or not the no-fault system is legislatively authorized, both parties would have the option to participate — *i.e.*, mutual agreement would be necessary. See, *e.g.*, O'Connell, *An Alternative To Abandoning Tort Liability: Elective No-Fault Insurance For Many Kinds of Injuries*, 60 *MINN. L. REV.* 501, 529 (1976); O'Connell, *Contracting For No-Fault Liability Insurance Covering Doctors and Hospitals*, 36 *MD. L. REV.* 533 (1977). Professor Havighurst, on the other hand, now appears to contemplate that the right of election to participate would be the health care provider's alone. See Havighurst, *supra* note 89, at 1278 n.133. The "Kennedy-Inouye" Bill, while granting the provider alone the right to participate, also grants the patient an analogous option in allowing him, after injury, to elect to receive no-fault benefits in return for waiving his right to institute a tort action. See S. 215, 94th Cong., 1st Sess. § 1717 (1975). There appears to be no proposal that makes the health care provider's participation mandatory upon the patient's advance election in favor of no-fault coverage.

pensable event. If the statute requires that coverage, once elected by the health care provider, be applied to all of a physician's patients, fees could be adjusted to account for "high risk" patients. If, on the other hand, coverage need not be universal, providers might be encouraged to offer their patients the option of choosing no-fault or tort liability coverage with the price for the medical services rendered varying according to that choice.<sup>113</sup>

Alternatively, health care providers might be required to offer all their patients the right to elect no-fault coverage. Legislative decisions would also have to be made here. Should the health care provider be allowed to influence the patient's choice of coverage by varying his fees according to that choice or according to the patient's medical condition? Distressing as this possibility may seem, severe price differentials would be unlikely for a number of reasons: the possibility of a tort action for abandoning a patient, the availability of peer-group review, the ethical obligation to provide needed care,<sup>114</sup> and the difficulty of predicting high risks on an individual basis.

The validity of the agreements is the major issue confronting a no-fault compensation system created solely by contract between health care providers and patients without statutory authorization. Challenges based on the patient's competence to bind himself would turn on the situation existing at the time of the agreement's execution, the patient's physical and mental condition being highly relevant. Challenges based on the terms of the contract should also be anticipated. Health care providers (or insurance companies) drafting no-fault contracts would probably be inclined to exclude from the list of compensable events those medical complications that are rarely the bases of malpractice claims, while including complications that are often the subject of litigation.<sup>115</sup> It is easy to visualize contracts being declared unconscionable if they were to contain low compensation levels or lists of compensable events heavily biased in favor of physicians.<sup>116</sup> Moreover, it is questionable whether the advisory committees of professional and business people, which under Professor O'Connell's recommendation would work with state insurance commissioners as part of the

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113. See R. Rosett, *The Medical Malpractice Insurance Crisis*, (paper presented to the Maryland Conference, *supra* note 6).

114. See Havighurst, *supra* note 89, at 1267-68.

115. See *id.* at 1276.

116. For the argument that such contracts should not be held unconscionable, see O'Connell, *An Alternative To Abandoning Tort Liability: Elective No-Fault Insurance For Many Kinds of Injuries*, 60 MINN. L. REV. 501, 529-37 (1976); O'Connell, *Contracting For No-Fault Liability Insurance Covering Doctors and Hospitals*, 36 MD. L. REV. 533 (1977).

regulatory process, would exert sufficient influence to guarantee the creation of equitable agreements.<sup>117</sup> In short, although it seems possible for a no-fault system to be instituted without legislative authorization, the risks of this approach make it unlikely that the strong support from the insurance industry and from health care providers necessary to operate it on a large scale can be enlisted.

4) *Administration of the System.* None of the existing proposals has yet discussed the means of making a no-fault compensation system operational. Much of the thinking about implementation can profitably be delayed until agreement on the basic features of the system is reached. Nevertheless, it may be useful to note that matters easily dismissed as "mechanics" may surface later as significant obstacles in the administration of the system. For example, unless health care providers bear the burden of evaluating the condition of patients they treat and of disclosing the occurrence of compensable events, a second tier of experts (probably physicians) will be necessary to examine and advise patients of their rights. Unless the patient's condition before and during treatment is accurately documented, this second-tier evaluation system may be unable to determine whether a compensable event has occurred, and the gap between the right of compensation and the actual receipt of it, which exists in the current system, will reappear. If there is no obligation to disclose and the relatively impartial second-tier evaluation is unavailable, recourse to an attorney or some patient-advocate, with all the additional costs of such assistance, may be necessary.

Although mandatory disclosure of compensable events may impose rather simple (though irritating) obligations on physicians providing office treatment, operation of a disclosure system could prove more complicated for hospitals. Formal responsibility will have to be allocated for the maintenance of records that are sufficiently detailed to reflect the occurrence or nonoccurrence of compensable events, for the evaluation of patients to determine these occurrences, and for the disclosure of the right to compensation. If no-fault coverage is not mandatory, some centralized system for determining which patients are entitled to disclosure would probably also be necessary. Although these mechanisms can be achieved, they may entail substantial administrative reorganization in some institutions.

A final problem that might arise in a nonmandatory system pertains to claims against multiple parties for the same injury. It is probably sufficient at this stage to suggest that when each of the health

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117. See O'Connell, *An Alternative To Abandoning Tort Liability: No-Fault Liability Insurance For Many Kinds of Injuries*, 60 MINN. L. REV. 501, 543 (1976).

care providers is a participant in the no-fault system, allocation of responsibility should be based on a determination of which party is the "cheapest cost-avoider."<sup>118</sup> But where no-fault coverage is optional for each provider, more serious questions of contribution among the parties and implied waiver of the patients' claims in tort may arise. What should be the rights of the parties when the patient has a no-fault agreement with his surgeon but not with the hospital? Should a provision in the no-fault contract with the surgeon relieve the hospital of its tort liability if the "cause" of the subsequent injury is unclear? Should legislatures address these questions or leave them to market determination? The answers to these questions are not crucial to the theory of no-fault compensation, but the issues that the questions raise must eventually be addressed in assessing the feasibility of such systems.

#### CONCLUSION

Medical malpractice reform involves a curious relationship between price and principle. On the one hand, it is necessary to ask whether we can afford to pay for the objectives sought by some reforms. On the other, we must ask whether cost savings are worth the principles that must be sacrificed in order to achieve the savings. A legal system with goals as "mixed" as ours will inevitably be forced to make such decisions based as much on calculations of marginal benefit as on clearly posed choices among conflicting values. Medical malpractice reform is no exception. The process has been made especially difficult, however, by the dearth of definitive data, by the pressure for action, and by the absence of commonly held notions concerning the nature of the problems to be addressed. Only as the character of the choices available and their probable outcomes become more clearly understood is there likely to be any consensus concerning the proper approaches for resolving the medical malpractice "problem." In the meantime, we can expect continued experimentation with a variety of approaches.

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118. See Havighurst & Tancredi, *supra* note 49, at 79-80.