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FOREWORD

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For the third time, *Law and Contemporary Problems* is devoting its attention to the topic of medical malpractice. The first medical malpractice issue of *Law and Contemporary Problems* explored how paradigms from contract law and private regulation of risk could be better incorporated into existing tort principles to improve the workings of the malpractice system or improve the quality of medical care.[1] The second issue focused on legislative reforms and initiatives that were being actively considered and in some cases implemented by state legislatures or the Congress.[2] This issue reports on the growing influence of outside forces on the malpractice system.

Prior to the 1990s, interest in malpractice law was driven almost exclusively by the perception among medical care providers of a "crisis" in malpractice. The crisis mentality resulted in extensive legislative debates relating to a host of reform issues. Throughout the mid-1970s and 1980s, political interest and legislative activity in this area was high. Although the reform mentality has definitely cooled over the past few years, like a dormant volcano, the potential of another eruption remains ever possible should insurance rates or claims spike upwards. This current period of dormancy is due, in large part, to the general availability of malpractice insurance—the fuel for past tort reform efforts supported by physicians—at relatively constant if not decreasing costs. Over this same period, malpractice-specific legislation has also decreased, which may be due to the medical establishment's resignation that tort reform

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1. *See* Symposium, *Medical Malpractice: Can the Private Sector Find Relief?*, 49 LAW & CONTEMP. PROBS. (Spring 1986) (Clark C. Havighurst & Randall R. Bovbjerg, special editors).

2. *See* Symposium, *Medical Malpractice: Lessons for Reform*, 54 LAW & CONTEMP. PROBS. (Winter/Spring 1991) (Randall R. Bovbjerg & Thomas B. Metzloff, special editors).

efforts, even if passed, are likely to have only modest impact on how malpractice cases are handled. Another factor may be the growing unwillingness of policymakers to treat medical malpractice as a special situation requiring special protection; other types of defendants are now claiming that they, too, are unfairly treated by the litigation system in some of the same ways that physicians have long complained. More fundamentally, the lack of interest in traditional types of tort reform in the malpractice context reflects the belief held by many commentators that more fundamental changes, such as a move to no-fault forms of compensation, are necessary to achieve any meaningful improvement in the workings of the system.

This symposium issue of *Law and Contemporary Problems* examines some of these important influences and how they are in fact impacting the medical malpractice environment.

1. *The Interaction of Medical Malpractice, Physician Discipline, and Quality Control.* The liability system does not operate in a vacuum. Rather, it is part of a larger system that is concerned with the overall quality of medical care. Other important aspects of the total system include the internal system of risk management in hospitals and other managed care providers, and the system of regulation of physician quality through formal disciplinary procedures. The relationships of these sub-systems are of increasing importance.

Providers of medical care have strong incentives for constantly assessing the quality of care they provide. It is their business to provide quality care, and, as the marketplace for medical care becomes more competitive, quality is increasingly an issue upon which providers compete. Although the field of risk management recognizes that decisions about how medical care is provided have significant implications for potential malpractice exposure, a clear understanding about the relationship between quality of care and malpractice is not clearly developed. The first article in this issue aids in this understanding by reporting on an empirical study that examined the pattern of patient complaints in a hospital setting. The data demonstrate that certain "high risk" physicians generate a very high percentage of patient complaints.[3]

Another important link exists between malpractice results and physician discipline. Historically, disciplinary authorities took little notice of malpractice results. The authorities were finally encouraged to review malpractice results more carefully by reports of individual physicians who continued to practice despite numerous malpractice claims that revealed obvious deficiencies. What role disciplinary authorities should have in the continuing effort to ensure quality medical care is addressed here in an article that relates disciplinary developments with other changes in the structure of the provision of medical care.[4]

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3. *See* Gerald B. Hickson et al., *Development of An Early Identification and Response Model of Malpractice Prevention*, 60 LAW & CONTEMP. PROBS. 7 (Winter 1997).

4. *See* Frances H. Miller, Medical Discipline in the Twenty-First Century: Are Purchasers the Answer?, 60 LAW & CONTEMP. PROBS. 31 (Winter 1997).

Another important issue is the extent to which particular results from the tort system should be utilized beyond the realm of litigation. Put differently, what can be learned from a particular case outcome in which a jury finds liability or a physician agrees to a settlement of a malpractice claim? Historically, the only externality associated with such findings was a small risk that an insurer would decline to offer a particular physician continuing coverage or perhaps add an insurance surcharge. Over time, however, interest in using the results of the malpractice system has grown. Perhaps the clearest manifestation of the interest is the work of the National Practitioner's Data Bank, which serves as a clearinghouse for data on physicians who have had disciplinary actions or malpractice claims that resulted in monetary payments. An article in this issue delivers a ringing criticism of the Data Bank's philosophy and approach, arguing instead for a more careful use of malpractice results.[5]

A principal purpose of the malpractice system is to create incentives so that health care providers take appropriate steps to minimize the extent of negligently imposed medical injuries. For malpractice, the question that has been repeatedly asked is whether the liability system sends too strong a signal, resulting in physicians being over-deterred. The "defensive medicine" debate has remained unresolved in large part because of the inherent difficulty in measuring any undesirable impacts on the profession resulting from malpractice. An article included here revisits the issue by considering new sources of information on claims data from an economics perspective.[6]

2. *The Effect on Medical Malpractice of Alternative Approaches to Resolving Disputes.* Recent developments in the procedural aspects of handling malpractice litigation present another example of how outside forces have come to influence the malpractice setting. From the beginning salvos in the malpractice wars, there have been important procedural dimensions. For example, physician interest groups proposed the use of special malpractice screening panels (composed of at least some physicians), special statutes to promote arbitration in malpractice cases, and a host of procedural rule changes, such as shortening the statute of limitations or establishing specialized discovery rules. Overall, the impact of these malpractice-specific initiatives was limited.

In the past fifteen years, interest in alternatives to traditional litigation practices have flourished in a much broader context, and has been manifested in a variety of ways. Courts have experimented widely with various forms of alternative dispute resolution ("ADR") in an effort to develop efficient methods of case management. Not surprisingly, the broad interest in alternatives has now come to have significant potential impact on how malpractice disputes are handled. One important development is the commitment of numerous states to requiring some form of ADR intervention as a prerequisite to trial.

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5. *See* Lawrence E. Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 LAW & CONTEMP. PROBS. 59 (Winter 1997).

6. *See* Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS. 81 (Winter 1997).

These states' programs were not designed with malpractice in mind; rather, they were designed as general initiatives to be used routinely in all forms of civil litigation. An article in this issue examines how well these general ADR initiatives work in the malpractice context.[7]

Another important procedural trend is the clear availability of arbitration to resolve virtually any type of dispute. For at least the past decade, the Supreme Court has been making it abundantly clear that it reads the Federal Arbitration Act as a broad mandate to promote the use of binding arbitration, often at the expense of state efforts to regulate or limit arbitration. For many years, physicians have expressed interest in arbitration. Now, with the power to arbitrate confirmed by the Court, have health care providers moved to take advantage of the opportunity? An article in this symposium issue summarizes recent survey data and other information from California indicating that interest in using arbitration in the malpractice context may not be as extensive as predicted.[8]

Also of growing interest in the field of dispute resolution is the use of mediation as a way to diffuse anger and conflict before a legal claim is filed. Although medical malpractice disputes have for the most part involved formal assertion of claims and legal rights through litigation, it is clear from existing literature that many malpractice disputes are rooted in the patient's or the patient's family's anger about lack of communication with or perceived slights from the medical care providers, which may or may not be related to any negligently imposed injuries. In this context, mediation may be the most effective form of dispute resolution. It allows the aggrieved patients and health care providers to work together to improve communication and with it, one hopes, the quality of care. The conceptual benefits of a "purer" form of mediation and thoughts on how these benefits could be realized are the focus on another contribution to this symposium.[9]

3. *Assessing the Potential of a "No-Fault" System of Compensation for Medical Injury.* Interest in replacing traditional tort concepts with some form of no-fault application for malpractice has a long history. A no-fault system that provides adequate compensation to a greater number of claimants without the trauma imposed by our litigation system is alluring. However, the affordability of such a system is a major issue, which has limited efforts to experiment with no-fault in the malpractice context. A no-fault system would expand the potential pool of claimants to include persons who suffer an injury as a result of medical treatment, which is certainly a greater number than those who suffer an injury as a result of negligent medical treatment. The authors of

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7. *See* Thomas B. Metzloff et al., *Empirical Perspectives on Mediation and Malpractice*, 60 LAW & CONTEMP. PROBS. 107 (Winter 1997).

8. *See* Elizabeth Rolph et al., *Arbitration Agreements in Health Care: Myths and Reality*, 60 LAW & CONTEMP. PROBS. 153 (Winter 1997).

9. *See* Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185 (Winter 1997).

the well-known Harvard Study contribute to this issue and consider specific models that can be used to make a no-fault approach affordable.[10]

Until recently, the debate about the possible merits of no-fault was strictly academic. Despite growing empirical evidence of shortcomings in both the compensatory and deterrent function of tort law, no state had committed to replace malpractice tort law with a no-fault system. In the late 1980s, however, Virginia and Florida enacted limited no-fault programs to compensate those severely injured during the birthing process. This effort to deal with some of the most expensive and emotionally charged cases of alleged malpractice represented important test cases for the viability of no-fault in the malpractice context. Two articles in this issue address how well the Virginia and Florida programs have worked. The first explores the relationship between tort law and no-fault, including an analysis of how claimants react to the differing processes.[11] The second focuses on whether these no-fault experiments have been efficient methods of compensating injured claimants.[12]

4. *Malpractice and Managed Care.* The final section in this symposium issue considers the continuing problem of how tort law should respond to the massive changes that have occurred in the delivery of medical services. We are now firmly ensconced in an era characterized by "managed care," even if that term is not well defined or understood. The economic realities of the health care industry are in a state of enormous flux. Malpractice law itself has not been a major influence driving the change; rather, it is in a position of reacting to the change. Courts throughout the country are struggling to develop a coherent approach to describing the managed care provider's potential tort liability. Despite dire predictions of expanding liability, the expected deluge of suits against managed care providers has not yet been realized, and the face of malpractice law has not yet been transformed. Yet it now appears that the battle is being joined as plaintiff's attorneys appear increasingly willing to take on managed care companies despite the barriers of ERISA protections and other corporate issues. This symposium issue includes two articles that address this continuing controversy. The first analyzes how existing tort law paradigms could be employed to reach an effective level of control without radically altering the existing tort law framework.[13] The second provides a broad overview of the managed care issues, focusing on the central question as to what benefits would be attained as a result of a paradigm shift away from traditional malpractice suits towards enterprise liability.[14]

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10. *See* David M. Studdert et al., *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1 (Spring 1997).

11. *See* Frank A. Sloan et al., *The Road From Medical Injury to Claims Resolution: How "No-Fault" and Tort Differ*, 60 LAW & CONTEMP. PROBS. 35 (Spring 1997)

12. *See* Randall R. Bovbjerg et al., *Administrative Performance of "No-Fault" Compensation for Medical Injury*, 60 LAW & CONTEMP. PROBS. 71 (Spring 1997).

13. *See* William S. Brewbaker III, *Medical Malpractice and Managed Care Organizations: The Implied Warranty of Quality*, 60 LAW & CONTEMP. PROBS. 117 (Spring 1997).

14. *See* William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS. 159 (Spring 1997).

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