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Medical Malpractice: A Time for More Talk and Less Rhetoric

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by Robert M. Ackerman*

I. INTRODUCTION

In late 1984, the American Medical Association (AMA) released three reports on Professional Liability in the 1980's.[1] An early passage in the first of these reports proclaims:

> Claims and suits against physicians and hospitals have proliferated. Settlements and awards have broken all records, with million-dollar payouts becoming increasingly common. As a result, physicians' costs for professional liability insurance protection have risen to extraordinary levels in many areas, threatening to divert some physicians out of their major specialties and barring young physicians from practicing in places or specialties where premiums are especially high. The effect of today's professional liability climate is to restrict patients' access to quality medical care.[2]

According to the AMA, a mid-1970's crisis in availability of medical malpractice insurance now has been supplanted by a crisis in affordability.[3] The AMA further reports that what was once largely an urban phenomenon has spread to rural areas as well, with all doctors viewed as potential victims of crippling malpractice awards.[4]

Critics of the AMA position view it as unduly alarmist. The Association

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1. AMERICAN MEDICAL ASSOCIATION SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE, PROFESSIONAL LIABILITY IN THE '80S, REPORTS 1, 2 AND 3 (1984) [hereinafter cited as AMA REPORT].

2. AMA REPORT 1, *supra* note 1, at 3.

3. *Id.* at 8-11.

4. *Id.* at 11.

of Trial Lawyers of America (ATLA), an organization composed largely of plaintiffs' personal injury and criminal defense lawyers, contends that the AMA is once again 'crying wolf' in the hope of obtaining special interest legislation akin to that enacted in the mid-1970's.[5] Claiming that proposals for tort reform would protect physicians at the price of a substantial forfeiture of patients' rights, an ATLA position paper states, "There is a medical malpractice problem. It is too much medical malpractice."[6]

This Article first examines the competing claims of the AMA and ATLA with respect to medical malpractice litigation.[7] The next section of the Article explores some legal reasons for excessive exposure of physicians to malpractice liability. The balance of the Article analyzes some possible solutions. Legislative reform proposals are divided into those that would arbitrarily curtail patients' rights in order to reduce the threat of malpractice verdicts and those that are designed to address the very real problems of medical malpractice litigation. The Article considers alternative means of resolving disputes related to medical services. The Article concludes that the present atmosphere of "confusion and recrimination"[8] is conducive to neither the enactment of fair and rational tort reform legislation nor the amicable resolution of disputes, and that a new climate of understanding is needed if doctors, lawyers, and patients are to find solutions to the medical malpractice problem.

II. Is There A Medical Malpractice Crisis?

By the AMA's own account, a mid-1970's crisis in the availability of medical malpractice insurance was abated by the "enactment of some 300 different tort reform measures."[9] These measures included, *inter alia*, compulsory or voluntary use of arbitration[10] or pretrial screening panels,[11] limitations on attorneys' fees,[12] modification of the collateral source

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5. Association of Trial Lawyers of America, The American Medical Association is Wrong—There is No Medical Malpractice Insurance Crisis 1, 8 (1985) [hereinafter cited as ATLA Report].

6. *Id.* at 11.

7. The terminology these two groups employ demonstrates the gap between them. The AMA prefers 'professional liability' to ATLA's 'medical malpractice.' *See generally* AMA Report, *supra* note 1.

8. The words are those of Prof. Richard A. Epstein, writing in 1976. They are every bit as applicable today. Epstein, *Medical Malpractice: The Case for Contract*, 1976 Am. B. Found. Research J. 87, 89.

9. AMA Report 1, *supra* note 1, at 6.

10. *E.g.*, Cal. Civ. Proc. Code § 1295 (West 1982).

11. *E.g.*, Wis. Stat. Ann. § 655, subch. II (West 1980).

12. *E.g.*, Cal. Bus. & Prof. Code § 6146 (West Supp. 1985); Ind. Code Ann. § 16-9.5-5-1 (Burns 1983).

rule,[13] and shortening of statutes of limitations.[14] The AMA reports a decline in the number of claims in the mid-1970's, probably as a result of these tort reform measures.[15] The doctors' organization, however, also reports growth in the size of the average claim during that period,[16] followed by a surge in medical malpractice claims in the early 1980's. According to the AMA, the average incidence of claims per one hundred physicians increased from 3.3 claims per hundred prior to 1978 to 8 claims per hundred during the years 1978 to 1983.[17] The AMA concludes that the growth in claims (in terms of both number and size) had an impact on both the size of doctors' medical malpractice premiums and the profitability of the medical malpractice insurance industry.[18] "Between 1975 and 1983, medical liability premiums increased by more than eighty percent in general. But in some areas of the country, harder hit by more and costlier claims, high risk physicians were being forced to pay annual premiums running $20,000, $30,000 and even as high as $70,000."[19]

ATLA dismisses many of the above claims. Stating that medical malpractice insurance premiums represent less than one-half of one percent of health care costs, ATLA notes that a comparison between premium income and claims paid "fails to mention . . . that a particularly important component of profitability of malpractice insurers is investment income"[20] and, therefore, understates total insurer income. The AMA, however, suggests that some malpractice insurers are now past the point where investment income can offset underwriting losses.[21] The ATLA position paper notes instances in which doctors have successfully sued their insurance companies for overcharging.[22] If the trial lawyers are to be believed, claims of a medical malpractice 'crisis' amount to alarmist calls for protectionist legislation based on unreliable figures and unrepresentative horror stories.

Indeed, some of the statistics cited in the AMA Report appear to be

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13. *E.g.*, CAL. CIV. CODE § 3333.1 (West Supp. 1985) (also precluding subrogation); FLA. STAT. ANN. § 768.50 (West 1985) (no reduction if right of subrogation exists); IOWA CODE ANN. § 147.136 (West Supp. 1985) (partial abrogation of rule).

14. *E.g.*, ARIZ. REV. STAT. ANN. § 12-542 (West 1982) (reduced from six to three years).

15. AMA REPORT 1, *supra* note 1, at 6.

16. *Id.*

17. *Id.* at 10.

18. AMA figures indicate underwriting losses in excess of professional liability premiums paid in every year since 1979. *Id.* at 7 (chart).

19. *Id.* at 8.

20. ATLA REPORT, *supra* note 5, at 2.

21. AMA REPORT 1, *supra* note 1, at 8. The insurance companies' income problems reflect at least in part a general income problem among liability, property, and casualty insurers. *See* Berg, *Another Challenge to Insurers*, N.Y. Times, July 31, 1985, at D1.

22. ATLA REPORT, *supra* note 5, at 3. *See also* Londrigan, *The Medical Malpractice 'Crisis': Underwriting Losses and Windfall Profits*, TRIAL, May 1985, at 22.

quite selective, almost anecdotal. For example, the AMA Report cites a Florida Medical Association survey indicating that twenty-five percent of obstetricians/gynecologists in that state no longer deliver babies.[23] Statistics from limited geographic areas can be misleading, especially when they are drawn from a state in which a disproportionate number of resident physicians are retired. Recent empirical studies by Professor Marc Galanter[24] suggest that we should take a harder look at claims of a 'litigation explosion' supported by 'atrocity stories'[25] or 'war stories.'[26] The AMA's own report indicates that "60% of the liability dollars lost arise from approximately two percent of the cases and 70% from about three percent."[27] Another source reports that one percent of all physicians who pay premiums to Pennsylvania's Catastrophic Loss Fund account for over twenty-five percent of all such fund's actual and expected loss payments.[28] Caution must be exercised about making generalizations based on anecdotal experiences of a few physicians, or upon data concerning certain high-risk specializations or limited geographic areas.

A 1982 Rand Corporation study[29] provides objective data that would appear to support the thesis that mid-1970's tort-reform legislation at least temporarily reduced the incidence of medical malpractice litigation. "Since 1976," the study reports, "the frequency of claims has leveled off and has even fallen in some states, notably those with the highest frequency in 1975. Severity has continued to increase, but less rapidly in states that had relatively high awards in 1975."[30] The declining frequency

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23. AMA REPORT 1, *supra* note 1, at 11.

24. *See, e.g.*, Galanter, *Reading the Landscape of Disputes: What We Know and Don't Know (and Think We Know) About Our Allegedly Contentious and Litigious Society*, 31 UCLA L. REV. 4 (1983).

25. That is, "citation of cases that seem grotesque, petty or extravagant." *Id.* at 10.

26. That is, "accounts of personal experience by business and other managers about how litigation impinges on their institutions, ties their hands, impairs efficiency, runs up costs, etc." *Id.* at 11.

27. AMA REPORT 3, *supra* note 1, at 7.

28. A. HOFFLANDER & B. NYE, MEDICAL MALPRACTICE INSURANCE IN PENNSYLVANIA 72 (1985). Hofflander and Nye report a disproportionate number of losses attributable to a relatively small number of physicians in many areas of specialization. *Id.* at 88 (Table V-7). This 'hazardous physicians analysis' strongly suggests that the reason for malpractice awards is, in fact, malpractice. In light of this data, Hofflander and Nye suggest that "experience rating as opposed to class or even specialty rating would not only permit reduced medical malpractice insurance premiums for quality physicians . . . but would also produce economic incentive to reduce malpractice incidence overall." *Id.* at 84.

29. P. DANZON, THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS (1982) [hereinafter cited as the RAND STUDY].

30. *Id.* at 2. Other significant findings of the RAND STUDY: (1) The density of lawyers per capita does not significantly affect claim frequency, after controlling for physician density per capita and urbanization; (2) proplaintiff changes in common law doctrines contributed significantly to the rapid growth of medical malpractice claims in some states in the

of medical malpractice claims since 1975 would appear to reflect a general decline in tort litigation during that time period.[31] One must take caution, however, not to draw too many inferences from the Rand data, most of which the authors of the report assembled no later than 1980. As the Rand report itself notes, claims data for recent years may be unreliable, because of the long 'tail' on medical malpractice litigation.[32]

Given the inconclusiveness of available statistics, it is all the more important to examine the conduct that underlies the statistics, along with the legal rules governing that conduct. ATLA's position on this subject is clear and concise: "The cause of malpractice litigation is medical negligence."[33] Indeed, the AMA concedes that "[t]here are legitimate instances of medical negligence."[34] Yet the AMA Report devotes very little attention to the root causes of medical malpractice, instead focusing upon the unavailability of affordable insurance and problems within the legal system. In its "action plan to address professional liability problems," the AMA targets four major areas for attention: (1) Education and community action (to make the public more sympathetic to the doctor's plight); (2) legislation: state and federal tort reform and judicial reform (for which the AMA has a number of proposals, some of which are discussed below); (3) defense coordination; and (almost as an afterthought) (4) risk control and quality review.[35] It would appear peculiar that the nation's leading organization of physicians should devote only one-and-one-half pages of a sixty-four page report to that last subject.[36] As one example of the AMA's emphasis on legal problems over medical ones, the AMA report cites Harvard President Derek Bok's 1983 report, which was critical of the legal profession,[37] but does not cite President Bok's report one year

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early 1970's; (3) of the post-1975 tort reforms, caps on damage awards and mandatory offset of collateral compensation appear to have had the greatest effect. *Id.* at v-vi.

31. *Id.* at 5-6.

32. *Id.* at 4. This 'tail' is described by Danzon as the "lag between filing and disposition of claims." *Id.* To medical malpractice insurance underwriters, the 'tail' represents the time between conduct giving rise to a claim and the disposition of the claim. Because of the trend toward 'discovery' statutes of limitation in medical malpractice actions (under which the time for filing a claim does not begin to run until the patient has or should have discovered the injury), the 'tail' on medical malpractice claims can be quite long. This has led some malpractice insurers to begin writing policies on a 'claims made' rather than on an 'occurrence' basis. AMA REPORT 1, *supra* note 1, at 5.

33. ATLA REPORT, *supra* note 5, at 6.

34. AMA REPORT 1, *supra* note 1, at 23. One AMA spokesman said that "[t]he reason for malpractice claims is malpractice." *Id.*

35. AMA REPORT 3, *supra* note 1, at 9-16.

36. In all fairness, the AMA now appears to be taking some steps to bolster peer review. *See* Brinkley, *U.S., Industry and Physicians Attack Medical Malpractice*, N.Y. Times, Sept. 2, 1985, at 1.

37. Bok, *A Flawed System*, HARV. MAG., May-June 1983, at 38 (cited in AMA REPORT 3,

later criticizing the manner in which physicians are trained.[38] One cannot read the AMA report without getting the sense that lawyers are viewed as the true villains,[39] and that the AMA's solution to the medical malpractice problem lies in an overhaul of the legal system.

The trial lawyers, at times, have similarly engaged in finger-pointing at the expense of problem solving. ATLA literature is quick to attack medical malpractice law reform as 'special interest legislation,'[40] while failing to acknowledge the substantial stake of trial lawyers in the present system of contingent fees and inflated jury awards. At times the ATLA literature portrays the medical profession in caricature; a recent article on medical malpractice in ATLA's *Trial* magazine is introduced with a large photograph of three surgeons garbed as the Marx Brothers.[41]

Viewed together, the AMA's and ATLA's assessments of the medical malpractice problem resemble ships that pass in the night. To doctors, the problem is lawyers. To lawyers, the problem is doctors (and occasionally their insurance companies). While neither the AMA nor ATLA represent the opinions of all members of their respective professions,[42] the

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supra note 1, at 13).

38. Bok, *Needed: A New Way to Train Doctors*, HARV. MAG., May-June 1984, at 32. An excerpt from President Bok's report follows:

> In a profession that emphasizes scientifically determined findings, rather than the rough judgments characteristic of lawyers and business executives, professors are inclined to impart knowledge didactically, as truths to be described rather than problems to be discussed. Matters outside the domain of science command little attention. Although everyone knows that psychological and behavioral factors can influence health, doctors have tended to regard these matters as unscientific and have left them largely to others . . . . It is only natural, then, for medical schools to push such subjects to the margins of the curriculum. Similarly, since ethical issues and patient values have little effect on the scientific determination of disease, they have not loomed large in the thinking of physicians or faculty committees, at least until recently, when the law courts and the media began to make such problems too prominent to ignore.

Id. at 36. Bok goes on to cite studies indicating that despite the large number of patients who have no physical ailments, "physicians are much more likely to overlook significant emotional and cognitive disorders than physical ailments and symptoms" and that a distressingly high percentage of patients fail to take prescribed medicines or follow prescribed treatment because they "do not even understand what they were told to do" due to the fault of their doctors. *Id.* at 37.

39. One excerpt (from a 'roundtable' discussion): "Every [insurance] company . . . should make the plaintiffs' attorneys earn their money and make it tough to earn." AMA REPORT 2, *supra* note 1, at 8.

40. ATLA REPORT, *supra* note 5, at 8.

41. Londrigan, *The Medical Malpractice Crisis: Underwriting Losses and Windfall Profits*, TRIAL, May 1985, at 22-23. Groucho appears to be puffing away at his omnipresent cigar as Chico, Harpo, and he scrub up for surgery.

42. For example, the Pennsylvania counterparts of these two organizations have begun to work together to arrive at mutually satisfactory solutions to the medical malpractice

rhetoric employed by these two organizations is conducive to neither the enactment of legislation beneficial to doctors and patients alike, nor the pursuit of less disruptive and costly means of resolving disputes. What is needed at this stage is a dispassionate inquiry into the underlying causes of doctors' increased exposure to liability and the development of solutions designed to address these causes in a fair and just manner. While the underlying causes of medical malpractice problems can be traced to medical practices and social phenomena as well as to legal problems, this author, a lawyer by training, will focus upon the legal problems in medical disputes and some possible solutions.

III. Legal Bases For Physicians' Increased Malpractice Exposure

One need not conclude that medical malpractice litigation has reached crisis proportions to perceive that problems exist in the field. While available statistics may be inconclusive about the precise dimensions of the problem, one can readily perceive that both physicians and patients have legitimate concerns. Problems in medical malpractice are magnified by a consideration not present in most other areas of tort law—a societal commitment to quality medical care for everyone, regardless of financial means.[43] This commitment has a major impact on legal standards applicable to medical malpractice cases. Doctrines such as enterprise liability (in which costs of injuries are incorporated into the price of the product or service regardless of fault) are inappropriate when services are viewed as a vital entitlement regardless of one's ability to pay.[44] Similar considerations do not exist in most other fields of tort law, such as products liability. Most Americans would agree that all are entitled to quality health care regardless of financial condition; few would find a like entitlement to a new automobile or a new power lawn mower.

With the above consideration as a constraint, the author would like to

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problem.

43. This commitment is demonstrated by public assistance programs such as Medicaid and Medicare. One author recently commented, "An egalitarian ethic regarding access to health services influences standards of care by requiring hospitals and physicians to adhere to a unitary standard regardless of a patient's financial condition." Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 Harv. L. Rev. 1004, 1010 (1985). Recent government initiatives to reduce health care costs may bring about conflict between doctors attempting to adhere to this ethic and cost-conscious hospitals, and create a need for new legal standards. *See generally id.*

44. An argument could be made that liability for defamation stands on the same footing, due to the vital communications function played by the media and the first amendment considerations inherent in protection of defendants in this field. *See* New York Times v. Sullivan, 376 U.S. 254 (1964); Gertz v. Robert Welch, Inc., 418 U.S. 323 (1974).

focus upon three systemic problems that produce 'inaccurate' results[45] in medical malpractice cases. The first of these concerns the problem of limiting liability to negligence; the second, the problem of inflated damages; and the third, the problem of excessive transaction costs. The author will address each of these in order.

A. Limitation of Liability to Cases of Actual Negligence: The 'Maloccurrence' Problem

The first problem concerns the tendency of some juries to find liability in cases falling short of actual malpractice or negligence. These cases, in which juries erroneously equate a bad result with negligence, are sometimes referred to as 'maloccurrence' cases.[46] By imposing liability based on a bad result attributable to medical treatment, notwithstanding the exercise of reasonable care, juries in effect impose strict liability on physicians.[47] Advocates of tort law as a loss-spreading device may see little wrong with this form of liability.[48] Indeed, a deliberate change in legal rules under which doctors would be held liable for maloccurrences (that is, injuries caused by medical treatment without regard to fault) might represent an improvement over the present system, under which juries *improperly* find liability for maloccurrence, in that (1) the stigma of mal-

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45. By inaccurate results, the author means judgments or settlements in excess of or short of that which should properly be rendered to compensate fully patients who are victims of negligence.

46. AMA REPORT 3, *supra* note 1, at 4. Professor Richard Epstein provides an excellent example of one such case in his 1975 article on medical malpractice. In the unreported case of Gail Kalmovitz, a premature infant was administered large doses of oxygen by the defendant-doctor. While this procedure may have saved plaintiff's life and/or prevented mental retardation, it also caused a severe visual impairment. Notwithstanding the fact that defendant adhered to standard practice and probably exercised reasonable care, the jury was nevertheless prepared to award $900,000 when, ignorant of the jury deliberations, plaintiff settled for $165,000. Professor Epstein would equate plaintiff's judgment in this case to the imposition of strict liability, and the author is inclined to agree. Epstein, *supra* note 8, at 114.

47. Some juries might even go a step further, holding the physician liable for forces of nature that would have injured the patient regardless of any action (or inaction) by the physician. In such cases, the physician is miscast in the role of an insurer, a particularly undesirable position in light of the fact that most patients seek out physicians because they are ill in the first place.

48. *See, e.g.*, Justice Tobriner's concurring opinion in Clark v. Gibbons, 66 Cal. 2d 399, 419, 426 P.2d 525, 539, 58 Cal. Rptr. 125, 139 (1967) (Tobriner, J., concurring), in which he argues:

> A system openly imposing liability without any pretense of negligence . . . can insure that the burdens of unexplained accidents will not fall primarily upon the helpless but will be borne instead by those best able to spread their cost among all who benefit from the surgical operations in which these misfortunes occur.

Id.

practice would not attach to the physician, and (2) there would be a more consistent and reliable basis for the underwriting of insurance.

A rule of strict liability, however, would present some very serious problems. First, there is the problem of distinguishing "adverse results properly attributable to medical treatment from conditions more likely due to the complaint which led a patient to seek medical treatment in the first place (the 'presenting complaint')."[49] Second, the insurance premiums necessary to support such a system would entail massive costs, which would place medical care out of reach for many people.[50] Neither the federal budget nor the present political climate appear to be amenable to the assumption of these costs by the American taxpayer at this time. Third, there is an objection to the use of the physician as the means of effectuating this loss-spreading.[51]

While the above objections are valid, they are not the most compelling reasons for rejecting the strict liability approach. Strict liability should be limited to situations when the defendant has exposed the victim to nonreciprocal risks to which the victim has not consented.[52] Strict liability is inappropriate in cases (such as medical treatment) in which the injured party has freely entered into the enterprise and is fully aware of the normal risks involved.[53] Unless the physician's conduct has created addi-

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49. O'Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 30 (1975). *See also*, Epstein, *supra* note 8, at 104.

50. The unacceptability of this result is discussed *supra* notes 43-44 and accompanying text.

51. Professor Epstein has described this problem as follows:

> [A] person who suffers sickness not cured by his physician has in principle no claim for relief against another patient of that physician, another consumer of medical services, or any fellow citizen. If these persons are not directly responsible to a sick patient, why should the law seek to impose upon them responsibility to him by indirection? . . . [E]ven if it is thought that some redistribution of wealth should take place from the healthy to the sick, there is no reason why the physician should be conscripted into service as a middleman in the process. The redistribution is erratic at best, and there are cheaper means of both public and private insurance that allow us to achieve the stated goal at lower costs and at much greater precision. The private tort action is a clumsy device to implement social welfare legislation.

Epstein, *supra* note 8, at 104.

52. *See* Fletcher, *Fairness and Utility in Tort Theory*, 85 HARV. L. REV. 537 (1972). Blasting cases provide the clearest examples of this basis of liability. *See, e.g.*, Spano v. Perini Corp., 25 N.Y.2d 11, 250 N.E.2d 31, 302 N.Y.S.2d 527 (1969).

53. In such cases, the patient is in effect a part of the enterprise; if enterprise liability is to be imposed, there is no more reason to impose it on the physician than on the patient. The public policy reasons for the rejection of this argument in the context of employment-related injuries (leading to the enactment of workers' compensation legislation) are not present here. If anything, public policy favors an atmosphere in which the 'chilling effect' of

tional risks to which the patient has not consented (that is, unless the physician has been negligent or has failed to obtain the patient's informed consent), there is no reason to shift the loss from patient to physician.

The preceding paragraph suggests the central role of informed consent in the distinction between malpractice and maloccurrence. The doctrine of informed consent requires the physician to inform the patient of the possible adverse results of treatment, results which could arise notwithstanding the exercise of reasonable professional care on the part of the physician. Only by discharging the duty to obtain the patient's informed consent to treatment does the doctor remove the specter of liability for the unavoidable bad result.[54] Given the physician's superior knowledge of possible adverse consequences of treatment, this by no means imposes an unfair burden on the doctor.[55] One suspects that at least a few cases of liability for maloccurrence are, in effect, informed consent cases that may never have arisen if the doctor had fully informed the patient of the unavoidable risks inherent in the treatment to be provided.[56]

Notwithstanding the foregoing, it is quite likely that many juries, acting out of sympathy for the injured plaintiff, a misunderstanding of legal standards, or other motives, have found negligence in cases in which dispassionate observers would have found no more than maloccurrence.[57] Courts also have played a role in this phenomenon. In the Washington case of *Helling v. Carey*,[58] an ophthalmologist who, following standard

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strict liability is not imposed on the practice of medicine.

54. In essence, the otherwise nonnegligent doctor who has failed to obtain the patient's informed consent is held strictly liable for adverse results because the patient is no longer viewed as a freely consenting party to the enterprise.

55. The duty does not extend to informing the patient of *every* possible adverse consequence; only those material risks likely to affect the patient's decision to undergo treatment need be disclosed. Scott v. Bradford, 606 P.2d 554, 558 (Okla. 1979). The problem becomes one of distinguishing between those risks that are significant and material enough to be brought to the patient's attention and those that are not.

56. Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd* 85 Wash. 2d 151, 530 P.2d 334 (1975), provides an excellent example of the application of the informed consent rule to a maloccurrence case. In *Miller*, plaintiff lost his kidney as a consequence of a kidney biopsy. The court stated that "[a] bad result is not, of itself, evidence of negligence." *Id.* at 279, 522 P.2d at 859. For that reason, the court found no error in jury instructions concerning the absence of liability for the decision to perform the biopsy or the manner in which it was performed. *Id.* at 279-80, 522 P.2d at 859. The court nevertheless reversed and remanded the case because of error in the instruction concerning informed consent and the doctor's failure to advise the plaintiff of the risk of losing the kidney. *Id.* at 290, 522 P.2d at 865.

57. There are no objective means of determining just how often this happens, although a means of weeding out maloccurrence cases is suggested later in this Article. *See infra* text accompanying notes 98-105.

58. 83 Wash. 2d 514, 519 P.2d 981 (1974).

practice, failed to administer a simple and inexpensive pressure test for glaucoma to a woman under the age of forty, was found negligent *as a matter of law* when the patient contracted glaucoma. The Washington Supreme Court thereby abandoned the traditional and prevalent rule that a physician would not be held negligent if she conformed to standard medical practice.[59] Professor James A. Henderson has criticized the *Helling* decision as an example of the abandonment of traditional rules of law (under which the trier of fact makes relatively simple, 'linear' decisions) in favor of a more general 'reasonableness under the circumstances' test, requiring open-ended, 'polycentric' decisions for which juries are ill-suited.[60] Henderson feels that the problem is particularly acute in those areas, such as medical malpractice, "where an evaluation of the defendant's conduct requires an assessment of complex technology."[61]

Certainly, the use of a more generalized 'reasonable doctor' standard would reduce the number of cases in which a court could grant summary judgment or directed verdicts on behalf of the doctor-defendants and give juries more freedom to impose liability absent clear proof of negligence. The allowance of conformity with custom as a defense, however, allows the medical profession to set up a self-serving standard in which inadequate customary procedures are tolerated.[62] Professor Richard Epstein has observed that "the opinion in *Helling v. Carey* breaks no new ground

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59. *Id.* at 519, 519 P.2d at 983.

60. Henderson, *Expanding the Negligence Concept: Retreat from the Rule of Law*, 51 IND. L.J. 467 (1976). Professor Henderson borrowed the term 'polycentric' from Professor Fuller to suggest "the non-linear way in which the issues in such problems are interrelated." *Id.* at 475.

Henderson, writing in 1976, was reluctant to attribute the existence of a medical malpractice crisis to this 'retreat from the rule of law.'

> If a crisis does exist, it is probably caused by factors other than the increasing willingness of courts to face polycentric problems. These factors may include a decrease in the public trust and confidence in doctors; a growing claims-consciousness on the part of everyone in society, including medical patients; and significant increases in the quantity of doctor-patient contact over recent years.

Id. at 491 n.67.

61. *Id.* at 484. Henderson believes that this generalized negligence concept also poses serious difficulties "where an evaluation of the defendant's conduct requires defining the contours of special relationships," and "where practical limits must be placed upon the extent of potential liability." *Id.*

62. The court in *Helling* cited Learned Hand's famous statement that:

> In most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It may never set its own tests, however persuasive be its usages. *Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.*

84 Wash. 2d at 519, 519 P.2d at 983 (quoting The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932) (emphasis added)).

except, perhaps, by bringing the law of medical malpractice into belated harmony with the rest of the law of negligence."[63] Professor Epstein, nevertheless, is critical of this case, at least in part because of the manner in which the court applied the law to the facts. Given the extremely low (one in 25,000) incidence of glaucoma in persons under forty, Epstein observes that "[t]he court's cost-benefit analysis is clearly incomplete in that it ignored both the probability and expected magnitude of harm and thus the distinct possibility that even the cheapest of precautions is unwarranted."[64] In essence, the court's use of twenty-twenty hindsight in the *Helling* case may serve as yet another example of liability for maloccurrence, this time imposed by an appellate court without the assistance of a jury.

The *Helling* case demonstrates the difficulty of formulating rules that prevent the medical profession from setting a self-serving standard, but that also prevent juries from marching headlong into verdicts based on maloccurrence, instead of malpractice. Greater recognition by physicians of the uses of informed consent may result in fewer cases in which this problem arises; some legislative and judicial means of addressing this problem are suggested in part IV of this Article.

B. Bringing Damages Under Control

While multimillion dollar medical malpractice verdicts may be far less commonplace than popular literature would suggest, such verdicts are not altogether unusual.[65] One cannot underestimate the devastating effect of a series of such awards on an insurance carrier, or of even one such award on a doctor's reputation and self-esteem. Not only are the size of the verdicts important, but the disparity between verdicts in similar cases, particularly when different geographic areas are compared.[66]

Verdict inflation is largely attributable to that component of damages called general damages (*i.e.*, damages for 'pain and suffering'), as distinguished from special damages (*i.e.*, damages for out-of-pocket losses such

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63. Epstein, *supra* note 8, at 109.

64. *Id.*

65. The AMA reports that by 1978, three out of every thousand claims represented an award in excess of one million dollars. AMA REPORT 1, *supra* note 1, at 6.

66. *See* RAND STUDY, *supra* note 29, at 9; U.S. DEPT. OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, 8 (1973) [hereinafter cited as HEW REPORT]. The desire that like cases produce like results derives from a need for "predictability for firms trying to plan their business lives" and "from a sense that inconsistency of results on similar facts is, in an abstract sense, unjust." AMERICAN BAR ASSOCIATION, THE SPECIAL COMMITTEE ON THE TORT LIABILITY SYSTEM, TOWARDS A JURISPRUDENCE OF INJURY: THE CONTINUING CREATION OF A SYSTEM OF SUBSTANTIVE JUSTICE IN AMERICAN TORT LAW 4-141 (M. Shapo reptr. 1984) [hereinafter cited as ABA REPORT].

as medical care and lost wages). While special damages can be kept within reasonable limits due to the requirement that they be supported by proof of reasonable expenses or actual wage loss,[67] there are no such constraints on general damages. Juries, therefore, are free to arrive at inflated and disparate awards for pain and suffering. Juries cannot really be blamed for this; in the absence of any standards, consistency cannot be expected, and it is difficult to attack any figure as irrational. It is here, however, that one finds the greatest potential for unfairly disparate treatment of defendants, crippling judgments, and inaccurate insurance underwriting. It is in the area of damages that Henderson's plea for rules of law to avoid exposing juries to open-ended decision making might best be applied. Some suggestions to this effect are included in part IV of this Article.

C. *Controlling Transaction Costs*

There have been frequent complaints that the transaction costs of medical malpractice litigation, in terms of both dollar expenditures and delay, are disproportionate to the amounts recovered by victims of malpractice.[68] The largest components of these transaction costs are the attorneys' fees expended by plaintiffs and defendants. One explanation for high transaction costs is the complicated fact issues inherent in medical malpractice litigation, which require prolonged discovery, employment of expert witnesses, and lengthy trials.[69] Arguably, there may be some value to subjecting people to the protracted ordeal of medical malpractice litigation. A recent American Bar Association study notes the importance of the torts process to the vindication of personal rights[70] and the legitimate role of tort law as a 'grievance mechanism.'[71] When the adjudication process, however, causes costs that are disproportionate to the results produced, something is wrong. Excessive transaction costs can be measured

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67. *E.g.*, Seffert v. Los Angeles Transit Lines, 56 Cal. 2d 498, 364 P.2d 337, 15 Cal. Rptr. 161 (1961); Mercante v. Southern Bell Tel. & Tel. Co., 148 So. 2d 875 (La. Ct. App. 1963).

68. Estimates of transaction costs vary. One article cites estimates that "as little as 18-20% of the total malpractice dollars actually reach the injured patient." Shapiro, *The History of Medical Malpractice in the United States and its Effect upon Medical Practice*, in THE INFLUENCE OF LITIGATION ON MEDICAL PRACTICE 7 (C. Wood ed. 1977). Another source estimates the cost of adjudication to plaintiffs at 38-45% of gross recovery, with defendants' costs at 12% of gross recovery. Reder, *Medical Malpractice: An Economist's View*, 1976 AM. B. FOUND. RESEARCH J. 511, 546.

69. "Medical malpractice cases are among the most difficult to try. They usually take two to three times longer than other personal injury cases because of the complexity of the requisite expert medical testimony." HEW REPORT, *supra* note 66, at 18. *See also* Epstein, *supra* note 8, at 90.

70. ABA REPORT, *supra* note 66, at 3-1.

71. *Id.* at 3-16.

not only in dollars and cents, but in the stress of the litigation process on both doctor[72] and patient.[73] Clearly, some means of containing these costs must be found.

IV. Legislative Remedies: Sorting Out The Grab-Bag

Before suggesting some means of combatting problems in medical malpractice litigation, we should recognize that some of these problems are not peculiar to cases of medical malpractice. As the Rand Study indicates, "malpractice experience has been more extreme than that in other lines of tort law, but it is not unique."[74] Complaints regarding plaintiff-oriented juries, inflated judgments, and rising litigation costs have beset the fields of products liability and defamation, to mention just two other areas of tort law. Any discussion of tort reform proposals, therefore, should consider whether proposed solutions to the medical malpractice problem should be applied across the board, encompassing all cases of personal injury. Such an analysis may also have the residual effect of casting tort reform in terms other than special interest legislation subject to challenge on equal protection grounds.[75]

A. Federal Solutions

At the outset, one can dismiss as a practical present-day option the notion of federal legislation to address the medical malpractice problem. True, a comprehensive, federally-administered system of compensation for injury or illness on a no-fault basis has its appeal. A system of national health insurance would provide compensation to everyone in need; to the victim of accident or illness, it matters little whether his condition

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72. " 'The biggest cost . . . is the emotional injury that a physician experiences . . . . Decreases in physician productivity as a result of such dysfunction cannot be estimated.' " AMA Report 1, *supra* note 1, at 18 (quoting AMA Committee on Professional Liability).

73. "Personal injury cases often pit a lonely, needy, pathetic injured person against a large, wealthy, impersonal corporate institution (either an insurance company or a large self-insuring corporation). No other class of cases, not even criminal cases, so uniquely, as a general proposition, involves this one-sided aspect." J. O'Connell, Ending Insult to Injury 7 (1975).

74. Rand Study, *supra* note 29, at v.

75. *See* Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) (striking down a statute of limitations provision, abrogation of collateral source rule, limitations on damages, and periodic payment provisions on equal protection (and other) grounds); *see also* Arneson v. Olsen, 270 N.W.2d 125 (N.D. 1978) (striking down limits on damages as a violation of equal protection); *but see* Anderson v. Wagner, 79 Ill. 2d 295, 402 N.E.2d 560 (1979) (statute of limitations not special legislation); Johnson v. Saint Vincent Hosp., Inc., 273 Ind. 374, 404 N.E.2d 585 (1980) (holding that medical review panels, limits on damages, limits on fees, and statute of limitations provisions were not violative of equal protection).

is the product of negligence, nonculpable physician conduct, or the forces of nature.[76] A system not dependent on individualized findings of fault would reduce transaction costs substantially. It also could eliminate the inefficiencies of the collateral source rule without the unfairness that rule is designed to prevent.[77] Medical malpractice/maloccurrence/illness may be a particularly good area in which to institute a no-fault system because (notwithstanding some earlier remarks herein) the threat of a tort verdict is not needed nearly as much as an incentive for reasonable care in this field as in, for example, products liability.[78] At a time of massive federal deficits and domestic belt tightening (in which even the future of the Social Security system is in doubt), however, the political climate for such a sweeping reform would not appear to be ripe.[79]

Nor is substantive tort reform appropriate on the federal level. The medical malpractice field, like other areas of negligence law, traditionally has been reserved to the states, and federal intrusion would likely be regarded as heavy-handed and perhaps even unconstitutional. While products liability and defamation might be suitable areas for federal intervention because of either substantial interstate ramifications (in the case of products)[80] or important constitutional issues (in the case of defama-

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76. *See generally* Franklin, *Replacing the Negligence Lottery: Compensation and Selective Reimbursement*, 53 VA. L. REV. 774 (1967).

77. Because compensation based on fault would be eliminated, a system based entirely on first-party national health insurance would avoid the overlap of fault-based and collateral sources. (For a description of the collateral source rule, *see infra* note 85).

78. The author has long held (perhaps naively) the view that most physicians, due to their personal regard for their patients, their pride in their work, and concern for standing in the medical community, will police themselves. As for that minority of physicians who will not, the author doubts that the threat of a malpractice verdict will teach those physicians how to perform a careful diagnosis, more effectively wield a scalpel, or better inform their patients.

The contrast with products liability is at least in part due to the fact that the physician is a human being with direct responsibility and personal contact with her patients, as compared with the products liability defendant, which is usually a corporation with fragmented responsibility and little or no direct contact with the accident victim.

79. During the Great Society days of 1967 (when anything seemed possible), Professor Marc A. Franklin wrote, "The path was . . . cleared for 'socialization' of the accident problem by the acceptance of expanded notions of appropriate government spending and a willingness to pay taxes to socialize injury and welfare costs." Franklin, *supra* note 76, at 784. We have since entered an age of limits in which ambitious plans have (perhaps unfortunately) been placed on the back burner. Professor Epstein's comments in 1975 are, if anything, more in tune with today's political climate: "Incremental improvements, not messianic reforms, are the order of the day." Epstein, *supra* note 8, at 91.

80. Recognition of a possible federal role in products liability has prompted the introduction of a series of Congressional proposals. The latest incarnation, S. 100, 99th Cong., 1st Sess. (1985), was rejected by committee in May, 1985.

tion),[81] the medical malpractice field presents neither of these rationales for federal intervention. The marked disparities between states in terms of the magnitude of the malpractice problem and the types of problems that arise also suggest the use of state-by-state solutions. Medical malpractice is, therefore, an appropriate area for application of Justice Brandeis' conception of the states as laboratories of legislative experimentation.[82] While this philosophy may result in a lack of uniformity, little confusion or harm is thereby generated (unlike, for example, in products liability), and the states may learn from each other's successes and failures. As a recent ABA study states, the tort system "derives its strength from its incremental, case-centered approach, and from its status as a decentralized and constantly experimental feature of a federal system."[83]

B. Treating the Symptoms Instead of the Cause

Some of the measures proposed as cures for the medical malpractice problem appear to be designed for the sole purpose of reducing physicians' exposure to malpractice judgments, with little regard for fairness, logic, or the rights of patients. Proposals to arbitrarily shorten statutes of limitation,[84] abolish the collateral source rule,[85] or abandon the doctrine

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81. *See supra* note 44.

82. "It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

83. ABA REPORT, *supra* note 66, at 13-1.

84. For example, a Texas statute requiring the commencement of an action within two years from the date treatment was completed (in contrast to a more liberal and fair 'discovery' rule) was recently struck down as violating the 'open courts' provision of that state's constitution. Neagle v. Nelson, 685 S.W.2d 11 (TEX. 1985). That statute (TEX. REV. CIV. STAT. ANN. art. 4590i, § 10.01 (Vernon 1985)) is but one example of protective legislation that would arbitrarily deny fundamental rights to injured patients.

85. The collateral source rule prevents the trier of fact from taking into account compensation payable to the plaintiff from sources other than the defendant (*e.g.*, the plaintiff's own medical insurance policy). A few states have now abandoned this rule, deducting from the judgment all forms of collateral compensation received by the plaintiff. *E.g.*, CAL. CIV. CODE § 3333.1(b) (West Supp. 1985); FLA. STAT. ANN. § 768, pt. II (West Supp. 1985) (except where right of subrogation exists); IOWA CODE ANN. § 147.136 (West Supp. 1985) (partial abrogation). While there is some logic to avoiding a double recovery, abandonment of the collateral source rule penalizes those plaintiffs who have had the prudence and foresight to make provision for certain expenses through the payment of insurance premiums. "[T]o allow defendants to deduct collateral sources from tort judgments would clash with prevailing concepts of fairness and individual responsibility and would undermine socially valuable incentives for self-protection." ABA REPORT, *supra* note 66, at 13-16. Perhaps a reasonable compromise has been struck by Nebraska, which allows the deduction of the proceeds of private medical insurance at the discretion of the court, but credits the plaintiff with all premiums paid for such insurance. NEB. REV. STAT. § 44-2819 (1984).

of *res ipsa loquitur*[86] (to cite only a few) strike mainly at the symptoms, rather than at the root causes of the medical malpractice problem. Commencing the running of the statute of limitations when an injured minor reaches the age of six or eight,[87] for example, may serve to reduce the number of malpractice judgments against doctors, but is unlikely to provide an adequate remedy for persons of tender years.

The most prominent example of a 'reform' measure designed to address the symptoms rather than the root causes of the medical malpractice problem is the attack on attorneys' contingent fees. Proposals to limit or eliminate contingent fees typify the view of many in the medical establishment that lawyers are the cause of excessive medical malpractice litigation. Ironically, an argument can be made that "the contingency fee system makes the frivolous suit less likely,"[88] because:

> [T]he lawyer who is paid a contingency fee . . . is not likely to invest time and several thousand dollars in out-of-pocket expenses on a case with little prospect of success. Under the system of contingency fees, lawyers thus have the incentive to filter out capricious suits, which otherwise would overload the courts, harass physicians and produce no social benefits.[89]

Even the AMA acknowledges this possibility.[90]

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86. The doctrine of *res ipsa loquitur* aids a plaintiff, unable to prove a specific negligent act, in establishing that the defendant's conduct was nevertheless negligent. Because of the widespread use of this doctrine in medical malpractice cases (when the plaintiff frequently lacks the resources to prove negligence, or was unconscious during the conduct in question), *res ipsa loquitur* has been a bane to many physicians who have attempted to have the doctrine repealed or modified. Some states have required that expert testimony be used to establish that the plaintiff's injury resulted from a failure to conform to the accepted standard of care. *E.g.*, WASH. REV. CODE ANN. § 7.70.040 (West Supp. 1985). Such a formulation does no havoc to the principle behind *res ipsa loquitur*, at least to the extent that the 'conspiracy of silence' (under which it was virtually impossible to find a physician to testify on behalf of a plaintiff in a medical malpractice action) is no longer viewed as a serious problem. However, the complete abandonment of *res ipsa loquitur*, as urged by some doctors, would once again place plaintiffs at an unfair disadvantage. A New Hampshire statute (N.H. REV. STAT. ANN. § 507-C (Supp. 1979)), which would have eliminated the use of *res ipsa loquitur* in medical malpractice cases, has been declared unconstitutional. Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980).

87. This proposal may be found in AMA REPORT 3, *supra* note 1, at 14. Statutes containing similar provisions have been enacted in a few states. *E.g.*, IND. CODE ANN. § 16-9.5-3-1 (Burns 1983).

88. ATLA REPORT, *supra* note 5, at 10.

89. *Id.* at 10 (quoting Schwartz & Komesar, *Doctors, Damages and Deterrence*, 298 NEW ENG. J. OF MED. 1282, 1288 (1978)).

90. *See* AMA REPORT 2, *supra* note 1, at 18; AMA REPORT 3, *supra* note 1, at 6. There is also the possibility, however, that some lawyers will accept virtually any claim, hoping that a few long shots will come in, and more than cover their losses.

Most of the measures that would limit attorneys' fees would set limitations on the percentage of recovery that the attorney may collect, with the percentage allowable to the attorney decreasing as the size of the recovery increases.[91] These limitations are calculated to eliminate windfalls to plaintiffs' lawyers and possibly to create a disincentive to the acceptance of medical malpractice cases.[92] Of course, insofar as the limitations do pose such a disincentive, the limitations restrict plaintiffs' access to the court system. Furthermore, insofar as these limitations apply only to medical malpractice cases (and not toward litigation generally), the limitations are vulnerable to challenge on the basis of equal protection. It is difficult to imagine any rational basis for distinguishing between the type of fee allowable in a medical malpractice case from that allowable in a products liability case, traffic injury case, or any other tort litigation.[93]

There are, indeed, substantial problems with contingent fees; but these problems deal largely with making the attorney's compensation commensurate with her effort and the inherent conflict of interest when the lawyer has a financial stake in her case. There is good reason to believe that many contingent fees do in fact represent windfalls to plaintiffs' attorneys. As one distinguished commentator has pointed out: "There is little, if any, relationship between the efforts of the lawyer and the size of the verdict, once we assume a verdict in favor of the plaintiff. The size of the verdict is determined by the nature and extent of the plaintiff's injury and resulting damages."[94] Similar problems arise out of the early settlement of cases in which the attorney has invested very little time. Assuming that interference with the contractual relationship between attorney and client is to be allowed,[95] it might make more sense to place limitations on fees based on the hours and effort expended, rather than the amount recovered. For example, a state might allow an attorney to charge a percentage rate for her services, but with an upwards cap of, perhaps,

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91. *E.g.*, CAL. BUS. & PROF. CODE § 6146 (West Supp. 1985) (placing limits on contingency fees as follows: 40% of first $50,000; 33 ⅓% of next $50,000; 25% of next $100,000; 10% of any amount greater than $200,000); Act of July 2, 1985, ch. 294, 1985 N.Y. Laws 696-97 (limiting fees to 30% of first $250,000, 25% of next $250,000; 20% of next $500,000; 15% of next $250,000; 10% of any amount over $1,250,000).

92. Percentage limitations which decline as the amount recovered increases create an incentive for plaintiffs' lawyers to agree to inadequate settlements arrived at with great haste and little effort. While this may expedite the process and reduce total dollar expenditures, it is hardly in the patient's best interest.

93. *See* Carson v. Maurer, 120 N.H. 925, 945, 424 A.2d 825, 839 (1980). *But see* Roa v. Lodi Medical Group, 54 U.S.L.W. 3340 (1985) in which the United States Supreme Court dismissed a challenge to California's fee limitation legislation for want of a substantial Federal question.

94. Grady, *Some Ethical Questions About Percentage Fees*, LITIGATION, Summer, 1976, at 20, 21.

95. See Epstein, *supra* note 8, at 134 for criticism of this interference.

$1,000 per hour on the amount paid.[96] Such a measure would protect the patient-client without imposing a disincentive to malpractice litigation brought in good faith.

C. *Wedding the Solution to the Problem*

The author will now turn to some possible legislative remedies to the medical malpractice problem tailored to address those aspects of medical malpractice litigation that produce unfair or 'inaccurate' results. While the root causes of inflated or unfair awards may be traced back to any number of sources,[97] the author will concentrate on reform proposals that address the legal problems discussed in the preceding section.

Screening Panels

The use of screening panels (typically composed of doctors, lawyers, and laypersons) to review medical malpractice claims before they reach a jury was advocated during the mid-1970's medical malpractice crisis and adopted in several states.[98] Unfortunately, in some states, this device tended to prolong, rather than expedite, the litigation process.[99] Indeed, if screening panels provide nothing more than a "preliminary cantor before the real business of trial takes place,"[100] they serve little useful purpose. If, however, they are used to narrow the issues for the jury, distinguishing genuine cases of malpractice from those involving only maloccurrence, screening panels composed of experts in medicine and law can have a

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96. If this amount appears overly generous, consider that an attorney settling a $180,000 case after six hours of work (i.e., the time spent drafting a complaint and negotiating an early settlement of a fairly clear-cut case) would receive $60,000 (or $10,000 per hour) for her efforts, assuming a one-third contingency fee. Granted, many cases consume far more time and produce less fruit, but a $1,000 per hour cap hardly shortchanges the attorney, and it is unfair to expect those clients with good cases to subsidize the fees of those with bad ones.

97. For example, a rights-oriented, 'entitlement'-minded society; jury sympathy for the injured plaintiff; or enmity toward a negligent physician.

98. *E.g.*, IND. CODE ANN. § 16-9.5-9 (Burns 1983) (submission of claim compulsory; panel consists of one attorney, three health care providers); WIS. STAT. ANN. § 655, subch. 2 (West 1980) (submission of claim compulsory; panels are 'formal' for claims over $10,000 and consist of one doctor, one attorney, and two public members appointed by the governor; informal panels consist of one attorney, one health care provider, and one juror from the county where the suit has been filed).

99. Mattos v. Thompson, 491 Pa. 385, 396, 421 A.2d 190, 196 (1980) (striking Pennsylvania's arbitration panels as "impermissibly infring[ing] on the constitutional right to a jury."); *see also* Aldana v. Holub, 381 So. 2d 231 (Fla. 1980) (declaring Florida's medical mediation act unconstitutional because enlargement of jurisdictional periods, which proved arbitrary and capricious in operation, would constitute denial of access to courts. *Id.* at 238).

100. Epstein, *supra* note 8, at 137.

beneficial effect. The special fact problems inherent in medical malpractice cases[101] justify the use of medical and legal experts to make those fact-findings for which juries are ill-suited, that is, 'polycentric' findings as to the use of reasonable care under the circumstances.

Procedurally, the findings of a screening panel might be used in a number of ways. They conceivably could be used in lieu of jury findings, with instructions to the jury to accept the facts found by the panel as binding. Such a practice, however, might run afoul of the 'open courts' provisions of many state constitutions, which guarantee the right to jury trial.[102] More likely to pass muster would be an arrangement under which the panel's findings would be presented to the jury as presumptively correct, subject to rebuttal through competent evidence.[103] Alternatively, penalties might accrue to a party who persists on going forward to trial with claims inconsistent with the findings of the panel, if the outcome at trial is essentially in agreement with that of the panel.[104] In effect, that party could be saddled with the costs, including attorneys' fees, of a trial process that proved unnecessary.

Screening panels, therefore, can serve to rectify the first and third problems mentioned earlier with respect to medical malpractice litigation, involving plaintiff's verdicts based on maloccurrence and high transaction costs. While in the past screening panels have been subject to constitutional challenge, it would appear that this challenge is best withstood: (1) when the panels tend to expedite resolution of the claim without denying access to a jury,[105] and (2) when a rationale for disparate treatment of medical malpractice claims (as opposed to other tort claims) can be shown.[106] The complex 'polycentric' fact-finding problems presented by medical malpractice cases provide this rationale.

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101. *See supra* notes 61, 69 and accompanying text.

102. *E.g.*, IND. CONST. art. I, § 12; PA. CONST. art. I, § 11; TEX. CONST. art. I, § 13; GA. CONST. art. 1, § 1 para. 11(a).

103. This is the current practice in Maryland. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-06 (1984).

104. The system could operate in a manner similar to court-annexed 'mediation' (which more closely resembles arbitration) in Michigan. *See* MICH. STAT. ANN. R. 1, § 2.403 (Callaghan 1985), which provides that one party pay the other's 'actual costs' (including attorney's fees) if the first party has rejected the mediator's evaluation, proceeded to trial, and failed to obtain a verdict that is more favorable to him (*i.e.*, ten percent above or below the original evaluation).

105. *Compare* Johnson v. Saint Vincent Hosp., Inc., 273 Ind. 374, 404 N.E.2d 585 (1980) (holding that panels do not deny access to jury) *with* Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980) (holding that panels unconstitutionally delay and infringe upon the right to a jury).

106. *See* Johnson v. Saint Vincent Hosp., Inc., 273 Ind. 374, 393, 404 N.E.2d 585, 597 (1980) (upholding medical review panels against equal protection arguments).

Modification of Rules Pertaining to Damages

Perhaps the best means of increasing the predictability of medical malpractice awards would be to give the court and jury more guidance concerning damages that may be awarded. The following rules are suggested:

Elimination of Punitive Damages. Punitive damages are really an anomaly in tort law since their function is more properly served by criminal law.[107] Punitive (or exemplary) damages give juries far too great an opportunity to vent their sympathy for an injured plaintiff based on little or no evidentiary support and with little or no control over the total amount awarded. Furthermore, given the formal and informal sanctions that may be imposed by the medical profession, there is less need for punitive goals to be served through damages in malpractice cases.[108] Because the plaintiff is fully compensated through actual damages, the elimination of punitive damages is one reform that benefits the medical profession and its insurance underwriters without short-changing injured patients. Other reforms expressly providing for payment of the winning party's attorneys' fees[109] can supplant a function for which punitive damages might improperly be considered by juries. Punitive damages, therefore, should be eliminated, except in cases in which clear and convincing evidence (or perhaps evidence beyond a reasonable doubt) establishes that a physician has intentionally injured a patient.[110]

Limitations on General Damages. As indicated earlier, the absence of any standards for the jury to apply tends to render general damages (for example, damages for pain and suffering) speculative and unpredictable. To address this problem, several states have imposed limitations on damages, normally ranging from $250,000 to $500,000.[111]

A major valid criticism of a limitation on general damages is that it tends to treat different cases alike, imposing an arbitrary cap on the total

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107. For a discussion of the role of punitive damages in tort law, see Taylor v. Superior Court, 24 Cal. 3d 890, 901-11, 598 P.2d 854, 861-66, 157 Cal. Rptr. 693, 700-06 (1979) (Clark, J., dissenting). See also Mallor & Roberts, *Punitive Damages: Toward a Principled Approach*, 31 HASTINGS L.J. 639, 651 (1980), suggesting that the sanction of punitive damages should be "reserved for conduct that exceeds the bounds of normal fumbling."

108. Formal sanctions refer to suspension and revocation of professional licenses and denial of access to hospitals. This avenue may not be a very viable one so long as medical discipline remains a rare and inconsistent phenomenon. *See* Brinkley, *Medical Discipline Laws: Confusion Reigns*, N.Y. Times, Sept. 3, 1985, at A1. By 'informal sanctions' the author means the drying up of referrals, professional disgrace, and similar occurrences.

109. *See infra* note 122 and accompanying text.

110. Punitive damages would be reserved for the type of conduct that prompted Ronald Reagan's classic line in the movie *King's Row*, "Where's the rest of me?" uttered after his legs had been amputated by a vengeful physician.

111. *E.g.*, CAL. CIV. CODE § 3333.2 (West Supp. 1985) (limit of $250,000 for noneconomic losses); IND. CODE ANN. § 16-9.5-2-2 (Burns 1983) ($500,000 limitation on total recovery).

amount recovered.[112] For example, given a limit of $250,000, juries faced with cases in which plaintiff has relatively little pain and suffering may be inclined to view the $250,000 limit as a target, thereby bringing general damages up. The more egregious cases, when even the most dispassionate observer might feel substantial general damages are justified, would still be limited to $250,000 for pain and suffering. Thus, a problem is created by any rule of law, be it court-made or statutory: the inability to adapt to variations in circumstances.[113] Indeed, a cap on general damages arguably may be likened to those measures discussed earlier that arbitrarily limit plaintiffs' right to recover for malpractice.[114] Given the inherent difficulty of placing *any* dollar value on pain and suffering,[115] however, a statutory limit is probably no less arbitrary than a figure arrived at by a jury, and probably far less disruptive. The measure is also justified by its salutary effect on transaction costs,[116] the guidance it affords the jury,

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112. Limitations on damages applicable only to medical malpractice cases are also prone to attack on equal protection grounds. Courts in at least five states have found such provisions violative of equal protection guarantees under their respective state constitutions. Wright v. Central DuPage Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976) (striking down $500,000 limitation on all damages); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978) ($300,000 limitation on all damages); Baptist Hosp., Inc. v. Baber, 672 S.W.2d 296 (Tex. App. 1984) ($500,000 limitation on all damages); Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) ($250,000 limitation on 'non-economic' loss); Simon v. Saint Elizabeth Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (1976) (dicta indicating invalidity of $200,000 limitation on general damages). In summarily dismissing an appeal from the California Supreme Court, however, the United States Supreme Court has recently held that California's $250,000 cap on noneconomic damages is rationally related to legitimate state interests and, therefore, denies neither due process nor equal protection under the United States Constitution. Fein v. Permanente Medical Group, 106 S. Ct. 214 (1985).

113. *See* Pokora v. Wabash Ry. Co., 292 U.S. 98 (1934), in which Justice Cardozo notes the limitations inherent in rules of law.

114. See *supra* notes 84-93 and accompanying text. Wisconsin's patient's compensation fund (which pays judgments or settlements to health care providers to the extent they exceed $200,000) is subject to a $500,000 limitation for damages (other than medical expenses) whenever the amount of money in the fund falls below $2,500,000 in any one year or $6,000,000 in any two consecutive years. WIS. STAT. ANN. § 655.27(6) (West 1980). By treating some December judgments differently than January judgments, this provision may be viewed as arbitrary, and perhaps prone to an equal protection challenge.

115. Pain and suffering damages reveal their most serious lack of justification if one considers the overriding objective of tort law to be a proper allocation of risks and resources . . . . Awarding compensation for pain and suffering almost certainly produces economic distortions because it gives weight to a factor—pain—that has no definite economic measure.

Peck, *Compensation for Pain: A Reappraisal in Light of New Medical Evidence*, 72 MICH. L. REV. 1355, 1374 (1974).

116. Transaction costs are reduced not so much at trial, although there might be slight reductions in time spent proving and discussing damages, but by expediting the settlement process because damages now become more predictable.

and the predictability it lends to outcomes in medical malpractice cases, thereby aiding both underwriting and settlement of claims.[117]

Structured Damages. Statutory provisions should allow for the delayed payout of certain elements of damages.[118] Structured settlements along these lines have long been used by parties who recognize that plaintiffs do not require all their damages at once, and that defendants may be better able to pay large sums over an extended time period.[119] Courts should take special care, however, in the structuring of damage awards. Not all components of damages should be subject to long-term payout. For example, damages representing expenditures already made for plaintiff's medical care should be paid immediately, perhaps with interest added from the date incurred, to compensate the plaintiff fully and inhibit delaying tactics. Damages representing future medical expenses might be payable over an extended period of time, and perhaps even adjustable (up or down) as facts develop.[120] Obviously, courts should not apply a discount to present value to damages that are to be paid in the future. Finally, due to the delicate mathematics involved, the judge should structure damages after the jury has rendered a verdict indicating the amounts allocated to various categories of damages. Requiring the jury to itemize damages by category also may have a salutary effect in terms of jury control.

Note that modification of rules pertaining to damages is one reform that need not be limited to the field of medical malpractice. In particular, the arguments regarding limitations on general damages and structured

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117. A similar limitation on special damages (*i.e.*, plaintiff's out-of-pocket costs such as medical care and lost wages) cannot be justified, as this element of damages is capable of measurement, and the limitation on recovery would deny plaintiffs funds necessary to their rehabilitation and/or maintenance. Such a limitation would result in dramatic secondary costs (*i.e.*, additional costs to society due to the failure to take effective cost-spreading measures). *See* G. CALABRESI, THE COST OF ACCIDENTS (1970). A limitation on total damages could have the same effect by reducing special damages to an amount insufficient to care for plaintiffs' needs. Such a limitation, nevertheless, has survived judicial scrutiny in at least one state. Johnson v. Saint Vincent Hosp., Inc., 273 Ind. 374, 404 N.E.2d 585 (1980) (upholding $500,000 limitation on total recovery); *but see* Wright v. Central DuPage Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

118. *E.g.*, CAL. CIV. PROC. CODE § 667.7 (West 1980) (providing for payment of future damages in excess of $50,000 in periodic payments); WIS. STAT. ANN. § 655.015 (West 1980) (providing for future medical expenses in excess of $25,000 to be paid into a patient's compensation fund and disbursed as periodic payments for expenses); MODEL PERIODIC PAYMENT OF JUDGMENTS ACT (1980).

119. *See* Krause, *Structured Settlements for Tort Victims*, 66 A.B.A.J. 1527 (1980).

120. Future adjustments do pose problems both in terms of transaction costs and the desire for finality in litigation. Expedited procedures (perhaps arbitration) might be created to address these problems. It might also be unfair to subject general damages to *both* a cap and a delayed payout. A general damage limitation of $250,000, for example, should probably be subject to a requirement that all such damages be paid at the conclusion of trial.

payouts apply with equal force to other tort actions.

Penalties for Frivolous Claims and Defenses

While some transaction costs of malpractice litigation are necessary evils, those costs incurred due to frivolous claims and defenses, or due to unreasonable delay should be deterred by taxing them to the responsible party. Several jurisdictions already have in place statutory schemes imposing penalties for frivolous claims and defenses;[121] it would appear, however, that the courts are rarely willing to impose such sanctions. The presence of objective standards to determine whether a claim or defense is frivolous might create a more effective deterrent to overly litigious parties. Objectively determined penalties for frivolous claims and defenses (including unreasonable delay) can be linked to other reforms. For example, a party who proceeds to trial against the recommendation of a screening panel may be required to pay the opposing party's attorney's fees if the trial produces substantially the same result as the panel.[122]

A reasonable *quid pro quo* for the structuring of damages to produce a delayed payout for damages not yet incurred (or for the more common discount to present value of future damages) would be the payment of prejudgment interest on damages incurred prior to trial.[123] Defendants should consider taking advantage of rule 68 of the Federal Rules of Civil Procedure (and its state rule counterparts) providing for offers of judgment, under which "if the judgment finally obtained by the offeree is not more favorable than the offer, the offeree must pay the costs incurred after the making of the offer."[124] All of the above devices should serve to reduce the number of frivolous claims and defenses, promote settlement, and avoid unnecessary delay.

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121. *E.g.*, COLO. REV. STAT. §§ 13-17-101 to -106 (Crim. Supp. 1984); *see also* FED. R. CIV. P. 11 (imposing sanctions, including attorneys' fees, on litigants and attorneys responsible for pleadings not filed in good faith).

122. *See supra* note 104 and accompanying text. Some commentators have suggested that American courts adopt the English rule in which the loser pays the winner's attorney's fees in all cases. *See* Epstein, *supra* note 8, at 135. While this proposal has some merit (and might reduce the sting to deserving plaintiffs produced by the elimination of punitive damages), we should consider whether such a proposal would have a chilling effect on the bringing of good faith actions to test the boundaries of the law.

123. New Jersey has a rule providing that "the court shall, in tort actions . . . include in the judgment simple interest at 12% per annum on the amount of the award from the date of the institution of the action or from a date 6 months after the date the cause of action arises, whichever is later . . . ." N.J. COURT RULES, 1969, R. 4: 42-11 (West 1985).

124. FED. R. CIV. P. 68.

V. PRIVATE REMEDIES: AN OPPORTUNITY FOR CREATIVE LAWYERING

A. *Contracting Out of the Tort System*

Parties to medical malpractice litigation need not rely on legislative intervention to fashion more rational and efficient remedies. Commentators such as Professors Jeffrey O'Connell and Richard Epstein have drawn attention to the role that the contractual relationship between physician and patient may play in tailoring the issues to be decided at trial or in removing disputes from the trial process altogether.[125] Unlike most tort actions, which arise between strangers, the medical malpractice action arises out of a contractual relationship between physician and patient. This contract presents, in most instances, opportunities for the parties to define clearly their relationship and respective duties, and the remedies and procedures available in the event of breach.[126] This Article discussed above how the proper use of informed consent distinguishes the 'malpractice' case from the 'maloccurrence' case.[127] The doctrine of informed consent obtains its life from the contractual nature of the relationship; contracts, in turn, are based on a meeting of the minds, a circumstance in which communication plays a vital role.[128] By fully informing their patients and reaching an explicit understanding about the medical treatment to be rendered and its limits, doctors have it within their control to shape the parameters of professional liability claims.[129]

Professor Jeffrey O'Connell (long an advocate of no-fault plans) has suggested that doctors and patients might voluntarily enter into contracts

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125. *See generally* O'Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21 (1975); Epstein, *supra* note 8.

126. In some limited instances (*e.g.*, the hospital emergency room), the contract is no more than implied, with little or no opportunity to negotiate enforceable changes in terms.

127. *See supra* notes 55-56 and accompanying text.

128. Doctors are not alone with respect to the need to establish better communications. Many lawyers have left their clients in the dark regarding fee arrangements, prospects for success, the time frame (and stress) caused by litigation, and the like. These communication failures have strained relationships between lawyers and clients, adding to the burgeoning load of legal malpractice litigation. *See* Gates, *Lawyers' Malpractice: Some Recent Data About a Growing Problem*, 37 MERCER L. REV. 559 (1986). To the extent lawyers fail to consult with their clients, cases take on lives of their own, involving time and expenditures well beyond those contemplated by the parties. The effect of this phenomenon on *medical* malpractice litigation cannot be underestimated.

129. Informed consent also can play a role in the regulation of 'defensive' medicine. By informing patients of the costs and purposes of contemplated tests, as well as the risks of administering or foregoing such tests, doctors can eliminate the expense of tests that they would consider unnecessary except for the specter of a malpractice suit. Of course, when 'defensive' medicine consists of the exercise of reasonable care to avoid malpractice liability, it should be encouraged, not avoided.

under which the patient foregoes her tort remedy in exchange for certain recovery for injuries arising out of adverse results, regardless of the existence of fault on the part of the physician.[130] Legislatures could lend support by enacting statutes declaring that such contracts are not unconscionable, provided that the contracts are entered into voluntarily and contain certain conspicuous language. In fact, courts should not find these contracts unconscionable because: (1) They need not be offered on a take-it-or-leave-it basis, as most contracts of adhesion are, and (2) they offer a *quid pro quo*, that is, in exchange for the waiver of the tort remedy, the patient is guaranteed compensation for injury (albeit at a reduced amount) on a no-fault basis.[131]

B. Employment of Alternative Means of Dispute Resolution

The availability of alternative means of dispute resolution presents another means by which the parties to medical malpractice litigation may engage in fair and expeditious resolution of their disputes without legislative intervention. Screening panels (established either by statute or by private agreement of the parties) are but one such means of dispute resolution.[132] Mediation provides another means by which a disinterested third party may help the disputants find some common ground.

The summary jury trial, pioneered by Judge Thomas D. Lambros of the United States District Court for the Northern District of Ohio, has served as a useful tool for the promotion of settlement by forcing the disputing parties to come to terms with the likely resolution of the case.[133] While the summary jury trial has been employed primarily by the federal courts in commercial disputes, its utilization to promote settlement of tort claims should be explored by the state courts. Perhaps of greater value with respect to such claims is the mini-trial. Like the summary jury trial, the mini-trial consists of the presentation of each side's case in condensed form. Unlike the summary jury trial, the mini-trial is usually conducted privately and a single, neutral adviser is employed not to render a verdict,

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130. O'Connell, *supra* note 125; *see also* O'Connell, *Elective No-Fault by Contract—With or Without an Enabling Statute*, 1975 U. ILL. L.F. 59.

131. Compare Henningsen v. Bloomfield Motors, 32 N.J. 358, 161 A.2d 69 (1960), in which a standard form, industry-wide adhesion contract providing for a limited warranty in connection with the sale of an automobile was deemed unenforceable against the buyer. In the court's words, the warranty's language "gave little and withdrew much." *Id.* at 388, 161 A.2d at 85.

132. *See supra* notes 98-106 and accompanying text.

133. T. LAMBROS, THE SUMMARY JURY TRIAL AND OTHER ALTERNATIVE METHODS OF DISPUTE RESOLUTION (1984) (A Report to the Judicial Conference of the United States Committee on the Operation of the Jury System). Note that the summary jury trial, which requires the intervention of the court, should not be considered a private dispute resolution mechanism.

but to consult with the parties regarding the likely outcome.[134] The major benefit of the mini-trial is that it forces both parties to view the opponent's case in the best light possible, as presented by skilled advocates utilizing and summarizing all the best evidence at hand. It thereby creates an opportunity for the parties to disabuse themselves of unrealistic expectations and arrive at a fair settlement.[135]

Note that any one of the above private dispute resolution mechanisms can be incorporated into a contractual agreement between physician and patient at the outset of the relationship. Of course, none of these devices is likely to prove successful if the parties maintain extreme, unrelenting positions. The successful employment of alternative dispute resolution techniques, therefore, may require some significant attitudinal changes, which are the focus of the next section.

VI. Agreeing On How To Disagree

Attitudinal changes will be necessary to promote a new climate of understanding and greater communication among the parties to disputes concerning medical services. On the part of physicians, there must be a realization that for all their training and status, they are also capable of error. The defensive posturing of the medical profession (or, perhaps more accurately, its leadership) inhibits rational legislative change, prevents amicable resolution of disputes, and, most seriously, frequently acts as a barrier to communication between physician and patient. Indeed, it is the failure of physicians to communicate adequately with their patients that frequently leads to the alienation and misunderstanding that brings about lawsuits.[136] Doctors must realize that the malpractice problem is

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134. *See* Green, *Growth of the Mini-Trial*, Litigation, Fall, 1982, at 12.

135. The private mini-trial has the additional advantage of not exposing the participants to publicity, thereby protecting the physician at no cost to the patient (who also, for reasons of her own, may prefer not to litigate in public). A major obstacle to the mini-trial (as well as other private means of dispute resolution) is the fear (often unfounded) that the suggestion of alternative means of dispute resolution will be interpreted as a sign of weakness. This problem is not inherent in a summary jury trial ordered by a judge, or in a compulsory screening panel or arbitration system. Perhaps if a major malpractice insurer were to announce a general policy of employing mini-trials in *all* cases in which liability is unclear, individual cases would not be stigmatized with the 'sign of weakness' that might attach to the more selective use of the mini-trial.

136. Persons reporting . . . negative [medical care] experiences were more likely to report also that today's doctors maintained poor doctor-patient relationships. Major reasons given for the view that physicians have become less dedicated were that they are too interested in money, that they are less accommodating and more difficult to reach, and that they are more impersonal or inconsiderate . . . . [T]hese data are . . . consistent with the hypothesis that deteriorating and impersonal doctor-patient relationships contribute to the malpractice problem.

due at least in part to malpractice, which, in turn, may be a manifestation of a failure of communication.

For lawyers (particularly members of the plaintiffs' trial bar), there must be a recognition that medicine, like law, is an inexact science. There is in all professions a tendency to view the work of one's own profession as difficult and subtle while that of other professions is seen as simple and clear-cut.[137] Lawyers, as well as judges and juries, must realize that not all bad results are attributable to malpractice, and that medical science has its limitations.

For patients, there is a need to recognize the limitations of medical care, and the fact that the doctor also is a human being. Indeed, the resolution of problems in medical malpractice, as in other areas, proceeds from a recognition of one another as human beings with needs and shortcomings. A major advantage of alternative means of dispute resolution is the opportunity presented for solutions based on the respective *needs* of the parties, as distinguished from solutions based on legal *rights* alone.[138] The collateral source rule presents but one example. The fact that a plaintiff may be legally *entitled* to recover damages without a reduction

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Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 DUKE L.J. 1179, 1184.

137. *Compare e.g.*, Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974) *with* Hodges v. Carter, 239 N.C. 517, 80 S.E.2d 144 (1954). *Hodges* was a legal malpractice action brought against two attorneys who failed to properly serve process against plaintiff's fire insurers in an earlier action. While defendants' manner of service in the underlying action had never before been challenged, time had not yet expired to serve the insurers in an unquestionably correct manner at the time the insurers filed motions to dismiss for want of proper service. The state supreme court found defendants' manner of service improper (Hodges v. Home Ins. Co., 233 N.C. 289, 63 S.E.2d 819 (1951)), and plaintiff, deprived of his action against the insurers, sued his attorneys. The same court that had found service improper now held that the defendant attorneys had not been negligent in "following a custom which had prevailed in this State for two decades or more." Hodges v. Carter, 239 N.C. at 520, 80 S.E.2d at 146.

Juxtaposition of the *Helling* and *Hodges* decisions presents the irony of a Washington court finding negligence (as a matter of law) on the part of an ophthalmologist who had followed widespread practice, while a North Carolina court protects lawyers who, given ample notice that their adherence with custom had placed their client in jeopardy, pursued a case to the state's highest court rather than taking simple steps to preserve their client's claim. There are three possible explanations: (1) one case arose in Washington in 1974, the other in North Carolina in 1954; (2) courts (composed of lawyers) view medicine as simple and clear-cut, while law is seen as mystifying and difficult; or (3) lawyers protect their own.

138. These two considerations are not necessarily inconsistent. The law of damages, for example, generally entitles a plaintiff who has established liability to recover what she *needs* to become whole. Legal entitlements, however, need not dictate our result. While the parties negotiate in the shadow of the law, they remain free to tailor their own solutions. This emphasis on the parties' respective needs has been described elsewhere as focusing on interests, not positions. *See* R. FISHER & W. URY, GETTING TO YES: NEGOTIATING AGREEMENT WITHOUT GIVING IN 41-47 (1981). This focus enables the parties to invent options for mutual gain. *Id.* at 48-83.

for contribution from collateral sources does not negate the fact that such collateral sources, nevertheless, may reduce the plaintiff's actual *needs*. A plaintiff, therefore, may be willing and able to forego some recovery in exchange for the certainty of an out-of-court settlement with a doctor who is willing to part with some money, but cannot afford to have her reputation tarnished by trial. By addressing the mutually compatible needs of the parties, a more satisfactory solution is obtained.[139] The shedding of defensive postures, then, can produce a result that is often more palatable than that obtained through the trial process.

VII. CONCLUSION

Charges and counter-charges by doctors' and lawyers' organizations regarding the existence of a medical malpractice crisis have created an atmosphere of recrimination that is hardly conducive to the development of fair and rational solutions. Whether or not the specter of medical malpractice litigation has reached 'crisis' proportions, it is clear that problems do exist. These problems are best addressed not by special interest legislation, which reduces the number and size of malpractice judgments without regard for patients' rights, but through legislative, judicial, and private remedies tailored to counteract those forces that produce unfair or inaccurate results in medical malpractice litigation.

Doctors need not wait for legislative intervention to deal with the problem of malpractice litigation. Through better communication with patients, contract (and in particular, the principle of informed consent) can be used to shape the doctor-patient relationship and eliminate problems before they develop. Private means of dispute resolution can serve similar ends. All of this requires better communication among doctors, lawyers, and patients alike. It is a time for heightened human concern in place of scapegoating and caricaturing. It is a time for lowered voices in place of hyperbole. It is a time for more talk, and less rhetoric.

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139. Structured settlements address similar goals. In this area the goals are the plaintiff's need for compensation (whether or not the doctor is actually at fault) and the defendant's financial need to stretch payout over a longer period of time. The zero-sum game is avoided, and there is mutual benefit.