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# Resolving the Medical Malpractice Crisis: Alternatives to Litigation

Allen K. Hutkin  
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RESOLVING THE MEDICAL MALPRACTICE CRISIS:  
ALTERNATIVES TO LITIGATION

ALLEN K. HUTKIN\*

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I. INTRODUCTION

While the consumer revolt against auto insurance companies dominates the news,<sup>1</sup> the older more detrimental medical malpractice crisis still remains unresolved.<sup>2</sup> In 1985, the annual national cost of medical mal-

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<sup>1</sup> Hammer, *California's Insurance War*, NEWSWEEK, Nov. 28, 1988, at 10; Waldman, Foote & Williams, *The Prop 103 'Prairie Fire': California's car-insurance referendum is only the start of a move to cut rates across the country*, NEWSWEEK, May 15, 1989, at 50.

<sup>2</sup> Korcok, *"I'll See You in Court": US Still Looking for Malpractice Cure*, 138 CAN. MED. ASSOC. J. 846 (1988); Sahney, Peters, & Nelson, *Health Care Delivery System: Current Trends & Prospects for the Future*, 34 HENRY FORD HOSP. MED. J. 227, 230 (1986); Permut, *Medical Malpractice: Arbitration and Other Potential Solutions*, 58 DEL. MED. J. 463 (1986).

practice insurance increased to \$2.3 billion.<sup>3</sup> This was an increase of 46.8% from 1984 figures.<sup>4</sup> Malpractice insurance costs increased 336% over the ten year period starting in 1974 and ending in 1984.<sup>5</sup> In many medical specialties, insurance premiums increased from 50% to 100% in a single year.<sup>6</sup> A recent estimate places the combined costs of insurance premiums, defensive medicine (utilization of unneeded visits, tests and procedures), and settlements at an annual cost of \$12 to \$14 billion.<sup>7</sup>

The rise in the number of malpractice claims filed against doctors is the primary cause of the sharp increase in insurance premiums. In 1985, the number of claims filed per 100 doctors rose to 17.8. This figure represents a 57% increase over the 1981 rate.<sup>8</sup> Although most claims deal with surgical cases, the number of claims against physicians who do not perform surgery, invasive procedures, or obstetrical procedures swelled by 100% from 1981 to 1985.<sup>9</sup> These numbers are expected to continue to increase dramatically in the future.<sup>10</sup>

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<sup>3</sup> Sahney, et. al., *supra* note 2 at 230.

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> *Id.* This unabated rise in the cost of malpractice is showing signs of slowing or even stopping. In several areas, malpractice insurance rates have recently been reduced. It is too early to make predictions about whether or not this trend will continue. A number of different factors may have contributed to this change in malpractice insurance. One factor is that fewer claims are being filed because fewer plaintiffs' lawyers are accepting contingency fee cases on anything but sure winners. Furthermore, there has been recent adverse publicity regarding malpractice insurance companies. Freudenheim, *Costs of Medical Malpractice Drop After an 11-Year Climb*, New York Times, June 11, 1989, at 1, col. 1.

<sup>7</sup> Meyers, "Lumping It": *The Hidden Denominator of the Medical Malpractice Crisis*, 77 AM. J. PUBLIC HEALTH 1544 (1987). Malpractice premiums paid in other countries are substantially lower than the high premiums paid in the United States. For example, in 1986-87, British physicians paid a premium equivalent to about \$950.00. In the same year, New York state medical malpractice premiums were more than \$20,000 per year. Miller, *Medical Malpractice Litigation: Do the British have a Better Remedy?*, 11 AM. J. LAW & MED. 433, 434, 453 (1986).

<sup>8</sup> Castellani, *Malpractice: Is Competence or Caring In Question?*, 77 J. MED. ASSOC. GA. 223 (1988). While the percentage of claims filed against allopathic physicians (M.D.s) is high, a study performed in Michigan reveals that osteopathic physicians (D.O.s), who generally spend more time with their patients and have a different theory of medical treatment, have only one fifth as many claims filed against them. Powsner & Hamermesh, *Why Not Arbitrate?*, 85 MICH. MED. 408, 411 (1986).

<sup>9</sup> Sahney, *supra* note 2, at 230.

<sup>10</sup> Castellani, *supra* note 6, at 223. A recent study by the Minnesota Department of Commerce challenges these findings. The study analyzed data collected from two insurers who sell 100% of the physician malpractice insurance in Minnesota, South Dakota and North Dakota. A total of 4,700 files were reviewed covering the periods of 1981 - 1987. The study concluded that neither the frequency nor the severity of the claims has discernably changed over the past six years. Hatch, *Minn. Dept. of Com., Medical Malpractice Claims Study: 1981 - 1987* 31 (1988). Similarly, a Florida study concluded that the frequency of paid medical malpractice claims, when corrected for the growth in the population, has increased only slightly. Dewar, Gifford, Nye, & Webb, *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L. J. 1495, 1499, 1500 (1988).

While one might accuse our litigious society as being responsible for the rise in claims and associated costs, studies reveal that the number of iatrogenic illnesses and injuries, i.e., conditions caused by medical treatment, is large. In a study of 815 consecutive admissions to a teaching hospital, 290, or 36% of the patients displayed evidence of at least one iatrogenic illness.<sup>11</sup> Other hospital studies have found similar results.<sup>12</sup> Since these studies are based solely on a review of hospital records, one is led to wonder how many iatrogenic illnesses or injuries take place in the outpatient or long-term care setting.

With the rapid increase in claims,<sup>13</sup> their skyrocketing costs,<sup>14</sup> and the realization that the health care system is in a crisis, thought must be given as to how malpractice claims might be prevented or more efficiently managed. The following questions need to be asked in order to effectively address the malpractice crisis: how can the quality of medical care improve?; how should malpractice claims be handled?; what remedies should be provided?; and how can the system be made more responsive to the needs of the parties?

This article will review the societal and individual costs of the present medical malpractice system, analyze current efforts to reform the system, and propose several alternatives for consideration. These alternatives include expanding the use of alternative dispute resolution, reformulating the doctor/patient relationship, expanding the scope of conventional hospital risk management and modifying the manner in which medical malpractice insurance is presently provided.

## II. "COSTS" OF THE CURRENT MALPRACTICE SYSTEM

The conspicuous "costs" of the medical malpractice system, both financial and emotional, arise primarily from litigation. The financial costs, such as fees for lawyers, are directly or indirectly paid by both parties. Doctors and hospitals pay litigation costs through high malpractice insurance premiums<sup>15</sup> and patients pay these costs through higher medical

<sup>11</sup> Meyers, *supra* note 7, at 1544.

<sup>12</sup> *Id.*

<sup>13</sup> See *supra* note 10, for two studies that challenge this conclusion.

<sup>14</sup> A study conducted in Florida concluded that the substantial increase in loss payments to claimants was the main reason the cost of malpractice insurance has skyrocketed. Exorbitant profits by the insurance company were not found to be the cause of the high cost of malpractice insurance. Dewar, et. al. *supra* note 10, at 1499, 1515. A contrary conclusion was reached in a recent Minnesota study. The Minnesota study found that:

[i]t is obvious that insurers are charging considerably higher rates than are necessary to cover losses and expenses and also realize a healthy profit . . . . Despite unchanging claim frequency and declining loss payments and loss expense, on average, physicians paid approximately triple the amount of premiums for malpractice insurance in 1987 than in 1982.

Hatch, *supra* note 10, at 31.

<sup>15</sup> While the cost of malpractice insurance may be spiraling, the percentage of gross income spent by doctors on malpractice insurance has remained roughly the same for a decade, at less than four percent of income. Whelan, *Litigation and Complaints Procedures: Objectives, Effectiveness and Alternatives*, 14 J. MED. ETHICS. 70, 73 (1988).

bills.<sup>16</sup>

The emotional and psychological costs of litigation are also very high.<sup>17</sup> While lawsuits emotionally burden both parties, they are especially troubling to physicians. Physicians tend to view malpractice suits as personal attacks on their competence.<sup>18</sup> Studies show that being sued for malpractice is a major life stress for most physicians. Many physicians develop transient emotional symptoms, such as depression and anxiety.<sup>19</sup> Physicians have even retired or committed suicide in response to malpractice claims against them.<sup>20</sup>

While the conspicuous financial and emotional costs are large, the hidden costs of the malpractice crisis make it especially detrimental to our society. These costs include the following: decrease in availability of malpractice insurance; increase in insurance premiums; increase in use of defensive medicine; fear of new techniques and technologies; erosion of the physician/patient relationship; and reduced availability of physician services in specific specialties and geographic areas.<sup>21</sup>

One example of the reduced availability of physician services occurred recently in Florida. Physicians protesting spiraling malpractice premiums went on strike, "closing down some emergency rooms and forcing others to operate with skeleton staffs."<sup>22</sup> This situation was described as the "Beirut of American Health Care." The ill or injured had to rely on the paramedics and hope that they knew which emergency facilities were still open.<sup>23</sup> Under these circumstances the human "cost" of the malpractice crisis was quickly felt by those in need.

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<sup>16</sup> Mnookin & Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950, 972-73 (1979); Henderson, *Agreements Changing the Forum for Resolving Malpractice Claims*, 49 LAW & CONTEMPORARY PROBLEMS 243, 243-44 (Spring 1986).

<sup>17</sup> Mnookin, *supra* note 14, at 972.

<sup>18</sup> Wilbert, Charles, Warneck & Lichtenberg, *Coping with the Stress of Malpractice Litigation*, 171 ILL. MED. J. 23, 25 (1987).

<sup>19</sup> *Id.* at 23; See generally, Fokes, *You and Malpractice Stress: III. Two Spouses' View A Kernel of Social Value?*, 75 J. MED. ASSOC. GA. 723 (1986); H.C. Snider, *JURY OF MY PEERS: A SURGEON'S ENCOUNTER WITH THE MALPRACTICE CRISIS* (1989).

<sup>20</sup> In one sad case, a seventy-two year old general practitioner, who had never before been sued, felt so degraded and dishonored by the process of a lawsuit he killed himself. Fokes, *You and Malpractice Stress v. A Death in the Family*, 76 J. MED. ASSOC. GA. 115 (1987).

<sup>21</sup> Meyers, *supra* note 5, at 1544. One illustration of the impact medical malpractice has had on physician services is that "nearly 90% of all practicing OB's [obstetricians] can expect a lawsuit in their professional lifetime, and that has led many of them to quit delivering babies. Nearly a quarter of them have quit in just the past eight years. Most of these doctors are under 45, and the most common reason they give for leaving obstetrics is the threat of a malpractice lawsuit." *60 Minutes: Sue the Doctors*, [hereinafter *60 Minutes: Sue the Doctors*] (CBS television broadcast, May 7, 1989). The National Academy of Sciences will soon issue a report that will say that the United States is facing a critical shortage of obstetricians "that will result in inadequate services for pregnant American women, especially the poor." *Id.*

<sup>22</sup> Korcock, *supra* note 2, at 846.

<sup>23</sup> *Id.*

Defensive medicine is another product of the malpractice crisis. Defensive medicine is the use of tests, procedures, and office visits which normally would not be ordered but for the fear of litigation.<sup>24</sup> The result is high medical costs for both the patient and society. Medical services recommended strictly for defensive reasons are estimated to cost from three to five billion dollars each year.<sup>25</sup>

Another product of the medical malpractice crisis is the erosion of the doctor/patient relationship. Doctors start to view patients as potential litigants, and consequently start to appear uncaring and aloof to the patient. The patient may sense this aloofness and be less open with the physician. This results in poor medical care because the most "useful information in a medical encounter is gathered through a doctor/patient relationship based on trust rather than doubt."<sup>26</sup>

In short, the societal and individual costs of the present medical malpractice system are unacceptably high. The costs are destructive to society and necessitate change in our current approach to medical malpractice. If the system is not changed, the "costs" and their tragic impact on those inside and outside the medical field will continue to rise.

### III. CIRCUMSTANCES LEADING TO A MEDICAL MALPRACTICE CLAIM

Surprisingly, few people who believe they or a close relative have suffered an iatrogenic illness or injury ever discuss their experiences with an attorney. In 1987, 249 adult residents from Maine were surveyed regarding public perceptions of iatrogenic illness and injury.<sup>27</sup> Approximately twenty-six percent of those surveyed indicated that they or a close relative had been harmed by medical treatment, yet only seven percent of them (three people) discussed their experiences with an attorney.<sup>28</sup> The study found that generally patients first discuss such injuries with health care professionals, and the professional who caused the injury. Those patients who later informed their attorneys did so by circuitous paths.<sup>29</sup> Thus, contrary to the stereotypical patient, many do not pursue a legal claim. Instead they live with their iatrogenic injury.<sup>30</sup>

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<sup>24</sup> One widely cited example of defensive medicine is the caesarean section. The caesarean section is now the most frequently performed major hospital surgery; more than one million a year are performed in the United States. Doctors often perform caesarean sections as defensive measures to avoid potential lawsuits that are more likely to follow a vaginal birth. *60 Minutes: Sue the Doctors*, *supra* note 21.

<sup>25</sup> Permut, *supra* note 2, at 463-64.

<sup>26</sup> *Id.* at 464.

<sup>27</sup> Meyers, *supra* note 7, at 1545.

<sup>28</sup> *Id.* at 1547. Those surveyed indicated a number of different reasons for not contacting an attorney, including the feeling that the injury was not serious enough to merit a lawsuit, concerns over the cost of litigation, the low probability of a favorable outcome, and a general dislike for lawyers. *Id.*

<sup>29</sup> *Id.* Whelan, *supra* note 15, at 73.

<sup>30</sup> Meyers, *supra* note 7, at 1544.

The health care industry and its insurance companies have pointed to the high percentage of patients who decide to live with their iatrogenic injury as the basis for their approach to malpractice. For example, the health care providers and insurers hope the potential problem resolves itself and wait passively until a Notice of Intent to Sue is received.<sup>31</sup> The fatal flaw in this "wait and see" approach is the detrimental impact that malpractice has had on society. Although only a small percentage of people do sue, this litigation has had a disproportionate effect on the health care system. The physician/patient relationship must be examined in order to understand why some people decide to file lawsuits.

### A. *The Patient's Perspective*

People go to the doctor when they are "ill." "Illness" is comprised of physical, emotional, societal, and cultural components.<sup>32</sup> The ill or sick person is not at fault for being sick, but is expected to work toward getting better. To achieve this goal of wellness, the sick person is compelled to obtain and cooperate with "expert" advice. This expert advice is generally given by a physician.<sup>33</sup>

A sick person wants to know more than just what is physically wrong. Classically, the sick person "wants to know why he is sick, how he and his family will manage complex treatments, how much discomfort will be involved . . . , when, and if, he can return to a normal lifestyle, and how he will pay for treatment."<sup>34</sup> In addition, the patient may be concerned with "events that are missed and obligations left unfulfilled as a result of the sickness."<sup>35</sup>

An individual becomes a patient upon seeking treatment. As a patient, he is met with "unaccustomed feelings of fright, dependence, neediness, precariousness, and insecurity — feelings that are generally either kept under control or disregarded."<sup>36</sup> "Even before their initial meeting, patients have formed an intense bond with the doctor, engendered by a positive transference-readiness that is rooted in infancy, re-evoked by illness, and fed by hopeful expectations . . . ."<sup>37</sup> Patients come to view doctors as "gods," and this god-like persona increases the patient's trust. Trust and unswerving confidence in the physician's ability to heal has a placebo effect. It also makes the patient feel comfortable enough to openly confide in the physician. However, the danger in this god-like belief in

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<sup>31</sup> Telephone interview with Susan Finklestein, Professional Risk Management Group, San Diego, California (Jan. 27, 1989) [hereinafter Finklestein].

<sup>32</sup> Comment, *Healing Angry Wounds: The Roles of Apology and Mediation in Disputes Between Physicians and Patients*, 1987 J. DISPUTE RESOLUTION 111, 113 (1987).

<sup>33</sup> P. CONRAD & R. KERN, *THE SOCIOLOGY OF HEALTH AND ILLNESS* 123 (2d ed. 1986).

<sup>34</sup> Comment, *supra* note 32, at 114 [footnotes omitted].

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

the doctor is that it is often accompanied by unreasonable expectations. Patients feel "that all diseases should be treatable, all disabilities repairable."<sup>38</sup>

### *B. The Physician's Perspective*

Physicians tend to view patients through the "broken machine model."<sup>39</sup> Health care professionals use various methods to gather information from the patient. Physicians then label or diagnose the problem, and prescribe treatments to cure it. The detached vantage point of the "broken machine model" is helpful in that it allows the physician to concentrate on the symptoms presented and to ignore outside stimuli.<sup>40</sup> Consequently, the emergency room doctor is not impaired by the thoughts of the patient's wife, children, and mortgage, while he works to save the patient's life.

Physicians must deal with several issues not commonly appreciated by patients. First, there is much which is still unknown about the human body. Second, the diagnostic process is not always easy, and therefore, mistakes are common. Finally, the field of medicine is not an exact science.<sup>41</sup> Such factors create a level of uncertainty, yet the physician cannot consider them while providing treatment because of the patient's need for assurance.

In addition to ignoring these factors, patients are unaware of the huge impact that medical corporations ("health factories"), insurance companies, and medicare<sup>42</sup> have had on patient care. As medical costs have skyrocketed so has the number of prepaid health plans and health organizations. Today, over half of all doctors work in some type of group practice.<sup>43</sup> The majority of these doctors work for health maintenance organizations (HMOs). While enrolling in an HMO has benefitted both physicians and patients, it also has had its drawbacks:

<sup>38</sup> Gibbs, *Sick and Tired*, TIME, July 31, 1989, at 49.

<sup>39</sup> The "broken machine model" is an approach used by physicians where they only consider the patient's symptoms and do not consider the effects of these symptoms on the patient's personal life style. Comment, *supra* note 32, at 117.

<sup>40</sup> Comment, *supra* note 30, at 116-17.

<sup>41</sup> Recently, the fact that medicine is an inexact science was well illustrated. In the span of a single week, researchers found that two approved medical therapies, one for irregular heartbeats and the other for treatment of enlarged prostates have killed a large number of the patients; patients these treatments were supposed to help. As more and more medical records are placed on computers, it is predicted that more flawed therapies and drugs will appear. *The Imperfect Art of Healing*, U.S. NEWS & WORLD REPORT, May 8, 1989, at 10.

<sup>42</sup> The medicare system has provided strict guidelines regarding the reimbursement of certain treatments. Insurance companies are often as strict as medicare in their guidelines for reimbursement.

<sup>43</sup> Gibbs, *supra* note 38, at 50.



Patients relinquish much of their freedom to choose who will treat them, and can be lost in a shuffle between rotating doctors. The physicians, meanwhile, are transformed from professionals into employees, with a duty to serve not only the interests of the patients but the demands of the corporation as well . . . . Many doctors can no longer decide how often they see a patient, when one can be hospitalized, or even what drugs may be prescribed. Those decisions are now in the hands of third parties, hands that have never touched the patients directly.<sup>44</sup>

The quality of care provided under prepaid health plans/organizations suffers due to cost considerations. "On the one hand, doctors urge the most prudent care without regard to the bill, and, on the other hand, for-profit businesses, such as HMOs, watch cost closely out of economic self-interest."<sup>45</sup> The more the HMO can contain the cost of health care, the more money it will make. Many HMOs offer bonuses and other incentives to doctors who reduce costs by ordering fewer tests and making fewer referrals.<sup>46</sup>

In addition, the time pressures placed on physicians who work for HMOs and the anonymous quality of treatment prevent the creation of a strong physician/patient relationship.<sup>47</sup> Similarly, the level and quality of communication between the physician and patient is decreased. As discussed later in this paper, the communication and the relationship between the physician and patient are integral factors in determining whether a medical malpractice claim will be filed or not.

### C. The Clash of Perspectives

There is a great likelihood that conflict and anger will result when doctor, patient, and in some cases when the viewpoints of a health care organization come together.<sup>48</sup> The patient who has sought help may find

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<sup>44</sup> *Id.* at 505-51; In 1987, a Maryland HMO provided an excellent example of the effect an HMO can have on health care. In that case, one-third of the obstetricians affiliated with the HMO quit in protest over a new policy instituted by the HMO. This policy decreased the doctor's fees, if they ordered excessive tests for their patients. The HMO also was criticized for prohibiting members from using certain hospitals which did not grant discounts to the HMO. Abramowitz, *Obstetricians Quit Over HMO's Fee Plan*, WASHINGTON POST, Feb. 12, 1987, at 10.

<sup>45</sup> Forbes, *Cut Health Costs, Get Sued?*, DUN'S BUS. MONTH, July 1986, at 38.

<sup>46</sup> *Id.*

<sup>47</sup> Interestingly, experts have stated that the largest hurdle to HMO acceptance was the reluctance of patients to terminate longstanding relationships with their family doctors. Arnold, *After a Sluggish Start, Georgia HMOs Flourish*, ATLANTA BUS. CHRONICLE, Jan. 27, 1986, § 1, at 10.

<sup>48</sup> This paper's model of the physician-patient relationship is somewhat inaccurate as it ignores the significant role that social workers, nurses, clergy, patient advocates, and others play in defusing anger and preventing malpractice claims. Telephone interview with Linda Slade, Lead Social Worker - Clinical Counseling Services, Sharp Memorial Hospital in San Diego, California (Jan. 23, 1989) [hereinafter Slade].

that the health care system is "dehumanizing and anxiety provoking."<sup>49</sup> The physician stands ready to offer a scientific approach to "fix the machine," often ignoring the patient's subjective experiences and anxieties. For example, while the illness provokes anxiety in the patient, the physician treats it as ordinary and routine. The patient may conclude that the physician's behavior denotes a lack of caring about the patient's welfare.<sup>50</sup> This clash of perspectives is well illustrated by a recent *Newsweek* article in which the author describes her treatment for breast cancer:

I wanted to be treated as a human being, not as the owner of a defective breast. Some doctors seem to forget that breast-cancer patients have feelings. They prefer to deal with facts, ma'am, just the facts. They don't seem to realize that these facts evoke sadness, guilt, insecurity and terror in the woman hearing them. . . . The instant some pathologist, whom you've never met, looks through a microscope and delivers a verdict that your tumor is malignant, your life is in the hands of medical professionals, whom in most cases you don't know but you're supposed to trust.<sup>51</sup>

Another illustration of this clash of perspectives appeared in the "Letters to the Editor"<sup>52</sup> section of a medical journal. One doctor wrote "I've encountered more and more patients over the last several years who are doctor shopping because they feel that their current physician is hostile or insensitive or perhaps even employed by the insurance or the Worker's Compensation carrier."<sup>53</sup>

Aggravating an already critical situation is the fact that physician/patient relationships are often plagued by poor communication. Physicians sometimes feel that they have special knowledge which their patient cannot understand.<sup>54</sup> Conversely, "[p]atients today believe it is their right to know the whole truth about their own bodies, and doctors are no longer regarded as paternalistic figures dispensing information, like medicine, at their discretion."<sup>55</sup> Furthermore, patients may be very intimidated and afraid to ask questions which further compounds the problem. This lack of communication causes patients to feel disregarded, ignored, patronized, and dismissed.<sup>56</sup>

<sup>49</sup> Comment, *supra* note 32, at 115.

<sup>50</sup> A 1987 survey revealed that 37% of those polled did not believe that doctors take a genuine interest in their patients. Gibbs, *supra* note 38, at 49.

<sup>51</sup> Kaufman, *Cancer: Facts vs. Feelings*, NEWSWEEK, Apr. 24, 1989, at 10.

<sup>52</sup> Garner, *Malpractice and Patient Alienation*, 30 ALASKA MED. 81 (1988).

<sup>53</sup> *Id.*

<sup>54</sup> Surprisingly, the "United States is now the most advanced country in the area of patients' rights." In many countries, doctors still believe it is better not to tell the patient about a grim diagnosis because the patient will lose any hope of getting better. For example, deceased Japanese Emperor, Hirohito, was never told he had cancer. Darton, *Whose Life is it, Anyway?*, NEWSWEEK, Jan. 23, 1989, at 61.

<sup>55</sup> *Id.*

<sup>56</sup> Comment, *supra* note 32, at 121.

When medical complications or unexpected results occur, physicians generally make themselves unavailable. This often time angers patients and causes them to look elsewhere for answers. "The behavior of the doctor, combined with the preexisting flaws in the health care system's treatment of patients, is the straw that breaks the camel's back."<sup>57</sup>

The patient may seek assistance from people other than the physician, such as an attorney. "As the physician-patient relationship falters, the attorney-client relationship strengthens."<sup>58</sup> Studies suggest that most patients sue not because their physician was negligent, but because they are angry or surprised by unanticipated clinical outcomes.<sup>59</sup> Patients become plaintiffs when a poor outcome is coupled with a bad feeling.<sup>60</sup> Suits are not filed against incompetent physicians but against qualified doctors, "most of whom have never been sued before and have received excellent peer review reports."<sup>61</sup> The majority of these claims are resolved in favor of the doctor or hospital because the patient could not prove legal negligence.<sup>62</sup>

#### *D. The Role of Lawyers*

It is not surprising that once a lawyer is contacted, the physician/patient relationship is altered. Lawyers view the physician and patient as adversaries.<sup>63</sup> The lawyer's role is that of the "modern-day knight" who will fight the patient's battle in court.<sup>64</sup> Lawyers concentrate on the precipitating injury and focus on the elements of a negligence claim, rather than the true interests of the parties. Aggravating the situation is the fact that "[l]awyers generally counsel their client to refrain from all direct contact with the other party, opposing counsel and officers of the court. In their zeal to protect their client and prepare for litigation, attorneys forestall any opportunities for apologies and reconciliation."<sup>65</sup> If the lawyer is victorious, the patient/plaintiff generally receives money damages.

#### *E. Litigation Does Not Address Either Party's Interests*

Today's malpractice litigation process only addresses the monetary interests of those who view malpractice as their path to riches. It fails to adequately address the societal objectives of the great majority of patients who file malpractice claims: reparation, emotional vindication, and deterrence.<sup>66</sup>

<sup>57</sup> Slade, *supra* note 48.

<sup>58</sup> Kraushar, *Malpractice and the Physician Patient Relationship*, 13 COMP. THE-ORY 3 (1987).

<sup>59</sup> *Heed Consumers on Malpractice to Avoid Suits*, HOSPITALS, Sept. 20, 1987, at 64 [hereinafter *Heed Consumers*].

<sup>60</sup> Edwards, *How to Keep Yourself Out of the Courtroom*, 83 OH. MED. 391 (1987).

<sup>61</sup> *Heed Consumers*, *supra* note 59, at 64.

<sup>62</sup> *Id.*

<sup>63</sup> Comment, *supra* note 32, at 128.

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> Miller, *supra* note 7, at 435.

What essentially is a communication problem between two people (doctor and patient) is addressed with money concerns. The case becomes a battle between the plaintiff's lawyer who wants his contingency fee and the insurance company and its lawyers who want to hold onto the money as long as possible. What brought the patient to the attorney in the first place is generally ignored.<sup>67</sup>

Litigation may soothe the patient's anger, but it cannot eliminate it.

One study<sup>68</sup> concluded, "our current approach to medical malpractice does not perform well. Significant numbers of respondents believe that they have been neither vindicated nor compensated for their own or their relatives' illness, injury, or death; and that they have not had the opportunity to protect others from harm."<sup>69</sup> In essence, the societal interests of malpractice litigation, reparation, emotional vindication, and deterrence, must be better addressed.

A further weakness in the litigation approach is its propensity to limit the parties' creativity and ability to reach a settlement that satisfies both of their interests.<sup>70</sup> Litigation results in a winner and a loser. Thus, while litigation is the most common approach to malpractice claims, it is clearly a troublesome approach that fails to meet the objectives of either the patient/plaintiff<sup>71</sup> or the physician.

#### IV. CIRCUMSTANCES WHERE LITIGATION MAY BE THE MOST APPROPRIATE RESPONSE

In some situations litigation cannot be avoided, and may even create substantial benefits as a dispute resolution process.<sup>72</sup>

1. *Ego or Anger*. When either the doctor or the patient is driven by ego, spite, or anger, litigation may be necessary. Physicians often find it difficult to settle cases short of trial because they hate to "admit they may have done something wrong."<sup>73</sup> This ego problem has forced a number of medical malpractice claims to go to trial which might otherwise have settled. Patients or members of their families often are motivated by the desire to punish the physician for an injury or unexpected result.<sup>74</sup> "In some cases suing is the only way they know how to put this matter to rest. They don't want the money, but rather to punish the doctor and/or the hospital for what has occurred."<sup>75</sup> Thus, the opportunity to see the

<sup>67</sup> Interview with Frank D. Heckman, Senior Vice President, Professional Risk Management Group., in Long Beach, California (Feb. 1, 1989) [hereinafter Heckman].

<sup>68</sup> See *supra* note 27 and accompanying text.

<sup>69</sup> Meyers, *supra* note 7, at 1547.

<sup>70</sup> Heckman, *supra* note 67.

<sup>71</sup> Miller, *supra* note 7, at 453-54.

<sup>72</sup> This point is debatable because mini-trials and summary jury trials may deal better with these situations.

<sup>73</sup> Miller, *supra* note 7, at 401.

<sup>74</sup> Comment, *supra* note 32, at 122-24.

<sup>75</sup> Slade, *supra* note 48.

physician publicly chastised prevents the parties from reaching any agreement short of trial.

2. *Dislike or Fear of Negotiation.* Even though litigation is more costly, the plaintiff/patient may prefer the litigation process to alternative dispute approaches because a third party makes the decisions. Due to a prior relationship with the physician, the plaintiff/patient often feels incapable of negotiation — even with lawyers present — on an equal basis with the physician. The patient/plaintiff may feel intimidated or inhibited by the presence of the physician and feel a fair agreement cannot be achieved.

3. *Calling the "Hand."* "Negotiation may resemble a game of 'chicken' in which two teenagers set their cars on a collision course to see who turns first. Some crack-ups may result."<sup>76</sup> When parties take hard-line stances in negotiating, the negotiation often escalates. If one party makes threats, the other party may respond with counter threats. Consequently, they will probably end up in court.

4. *Unknown or Unreasonable Objectives.* Sometimes the patient/plaintiff files his/her lawsuit without a clear objective in mind. The patient/plaintiff may simply be angry and have no specific reason for suing the physician. In this situation, settlement cannot be reached because the patient/plaintiff is not working toward any goal. In addition, the parties to a lawsuit typically overestimate their chances of winning.<sup>77</sup> Hence, each party expects to win in court and is reluctant to settle prior to trial.

In these situations, litigation may be the best alternative for settling malpractice claims. Nevertheless, as will be explained later, other methods for settling the dispute should always be tried first.

## V. ADVANTAGES OF AVOIDING THE LITIGATION ROUTE

Although the litigation process is appropriate in some circumstances, the parties obtain obvious and substantial benefits when they avoid this route. The financial and emotional costs of a malpractice suit are very high. The costs build quickly whether or not the physician is guilty of malpractice. Rather than treating patients, the physician must spend time gathering defense evidence, answering interrogatories, being deposed by the plaintiff's attorneys, watching depositions of the plaintiff's expert witnesses, and answering general correspondence.

Given the substantial delays typically found in judicial proceedings, settlements reached before trial<sup>78</sup> can save substantial time, money, and

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<sup>76</sup> Mnookin, *supra* note 16, at 975.

<sup>77</sup> *Id.*

<sup>78</sup> In reality, only a small number of malpractice claims actually go to trial. For example, of 2,000 claims filed yearly against members of the Southern California Physicians Insurance Exchange, 75% are dropped during the investigation by the Exchange, 17% are settled, and 8% go to trial or arbitration of which doctors win 85%. Diamond, *Arbitration - Just What the Doctor Ordered*, L.A. TIMES, Jan. 29, 1988, § 4, col. 1, at 1.

emotional costs. In addition, judges and jurors commonly make errors in settling disputes.<sup>79</sup> By reaching settlements prior to trial, the parties can also avoid the risks and uncertain outcomes of litigation.

Avoiding the courtroom also reduces the reputational losses associated with being a "defendant" (even a successful defendant) in a public malpractice trial. Whether a malpractice claim has merit or not, the physician's reputation still suffers.

Finally, a consensual agreement or settlement between a physician and patient is more likely to be consistent with the interests and preferences of both parties. A consensual agreement is much more likely to mend the physician/patient relationship than a result forced on the two parties by the court.<sup>80</sup> Physicians are more likely to change their practices following a negotiated settlement rather than after a publicly humiliating trial. Under these circumstances, doctors are also more likely to apologize for any mistakes or unexpected results. Although physicians do not like to admit they have done something wrong, they might, in retrospect, admit they should or could have done things differently.<sup>81</sup> When a consensual agreement is reached, both parties' interests are addressed and both parties come out "winners."

## VI. CURRENT EFFORTS TO HANDLE THE MALPRACTICE CRISIS

The medical malpractice crisis has been in existence for some time. A number of programs have been implemented in order to try and resolve the crisis. Some of these efforts have had limited success, while others, like the litigation approach, have been unsuccessful. The current magnitude of the malpractice crisis is evidence that these programs have failed to curtail the problem. The following section reviews current efforts to handle the malpractice crisis.

### *A. Legislative Reform*

Over the past few years, the U.S. General Accounting Office (GAO) issued eleven reports on medical malpractice.<sup>82</sup> According to the GAO, legislative (tort) reform is the most commonly proposed solution to the malpractice crisis.<sup>83</sup> Suggested reforms include:

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<sup>79</sup> Henderson, *supra* note 16, at 243-44.

<sup>80</sup> Mnookin, *supra* note 16, at 956.

<sup>81</sup> Porter, *So You're Being Sued For Malpractice*, 83 OH. MED. 395, 401-02 (1987).

<sup>82</sup> U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-50, *Medical Malpractice: No Agreement on the Problems or Solutions* at 13 (1986) [hereinafter U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-50].

<sup>83</sup> *Id.*

shortening the statute of limitations for the filing of claims; revising joint and several liability rules so that defendants are liable only for their share of the fault being contested and are not forced to pay all costs . . . , eliminating double recovery by preventing defendants from collecting damages from several sources; limiting or structuring attorneys fees to give injured parties a larger share of the award and encourage early settlement of large cases; placing reasonable caps on awards for non-economic damages, such as pain and suffering.<sup>84</sup>

Legislative reforms have had some impact on the malpractice crisis, even though they are incomplete in a number of areas. Reforms which provide for damage award caps and limitations on attorney's fees may also make it more difficult for legitimate plaintiffs to find representation.<sup>85</sup> Legislative reforms also fail to clearly address the patient's interest in "reparation, emotional vindication, and deterrence"<sup>86</sup> which are at the root of malpractice suits.

### B. No Fault

A "no fault" system of compensation for medical malpractice, analogous to the original approach used in the Workers' Compensation system, has been suggested to be able to handle the malpractice crisis.<sup>87</sup> No fault

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<sup>84</sup> Korcok, *supra* note 2, at 846. "No Fault" insurance is also a popular legislative reform and will be discussed in depth later in the paper.

<sup>85</sup> Attacks on attorney's fees have a long history. Unquestionably the favorite target of these attacks is the contingent fee agreement. In 1980, the Rand Corporation conducted a study on the effect of contingent fee agreements on litigation. Opponents of contingent fee agreements maintain that allowing lawyers the right to finance litigation compels them to "stir up" cases, hoping for lavish financial rewards. The Rand report disputes this belief stating "the common allegation that contingent fee agreements induce attorneys to bring claims with little legal merit has no basis in logic. [To the contrary] the fact that the fee depends on winning provides an incentive to screen out cases with little merit — an incentive that is lacking with an hourly fee." RAND CORP., PUB. NO. R-2458-HCFA *Contingent Fees for Personal Injury Litigation*, at viii (1980). The report also disputed "the allegation that contingent fees result in excessive (above competition) rewards for attorneys. Rational allocation of time by the attorney between contingent fee and hourly rate cases and market competition both act to control fees." *Id.* at vi. Available evidence "confirms that, averaging over cases won and lost, the effective hourly earnings of attorneys paid on a contingent basis are similar to the hourly earnings of defense attorneys paid by the hour." *Id.* The report concluded that "[c]eilings on the contingent fee percentage may significantly reduce the number of hours an attorney will spend on a case and effectively bar certain cases from trial. . . . Restriction on contingent fees would also tend to be regressive, deterring low- and middle-income plaintiffs from filing even meritorious claims." *Id.* at vii.

<sup>86</sup> Miller, *supra* note 7, at 434-35.

<sup>87</sup> One author claims that statistical evidence demonstrates that over 60% of all the dollars spent on medical malpractice cases are spent to pay legal costs and attorney's fees. The author also claims that a comparison of expenses under the present tort system with like costs under the proposed no fault system reveals a savings of almost 50% under no fault. The injured party also would receive more net benefits than they do now. Wedekind, *An Alternate Proposal for Compensating Injuries Occurring in the Health Care Delivery System*, 29 ALASKA MED. 169 (1987).

schemes compensate accident victims regardless of fault. This system is similar to a legislative system of justice. No fault schemes have been instituted in a few countries, notably New Zealand<sup>88</sup> and Sweden. The health care systems in these countries are markedly different than the system used in the United States.<sup>89</sup> Nevertheless, in order to consider adopting the no fault system in the United States, two crucial questions must be answered: "Which incidents qualify for compensation, [and] who would be covered by such a scheme?"<sup>90</sup> The answers to these questions will determine whether no fault is feasible in the United States.

The major criticism of no fault is its failure to control the quality of service, i.e., the deterrence objective of malpractice litigation. "If the no fault scheme creates no incentive for the medical profession to take care and if civil liability is abolished, from where are the incentives and controls to come from?"<sup>91</sup> No fault is also criticized because there would likely be a marked increase in the number of claims filed if proof of causation were no longer required.<sup>92</sup> "Litigation, which entails time, financial costs, and, most significantly, contact with attorneys, appears to discourage large numbers of people from seeking redress. If this barrier were removed, there might be a vast reservoir of potential claims against a no-fault pool."<sup>93</sup> This increased number of claims would absorb, and probably exceed, any savings the system might provide.

In addition to the criticisms discussed above, no fault would not ensure that all of a malpractice victim's treatment would be compensated. Insurance companies would decide which illnesses and treatments should be reimbursed. This would create<sup>94</sup> "an incentive for physicians to employ less preferable treatments for a particular illness merely because that treatment was not associated with a compensable event."<sup>95</sup>

### C. Channeling

Closely related to the no fault compensation scheme is the idea of "channeling." The theory of "channeling" is to remove the burden of malpractice liability from a comparably small number of people (physicians) and channel it to either a large number of people (patients) or to a group of institutions (hospitals) which could more easily absorb the costs.<sup>96</sup>

<sup>88</sup> In New Zealand, the Accident Compensation Corporation provides compensation for all injuries, regardless of fault. "Ninety-one percent of its total disbursements go directly to the patient-victim as compared with 28% to 33% of total insurance disbursements that eventually reach the successful claimants in medical malpractice and product liability cases under our tort system." Gullickson, Book Review, 257 J. AM. MED. A. 3423 (1987) (reviewing J. O'CONNELL & C. KELLY, *THE BLAME GAME: INJURIES, INSURANCE AND INJUSTICE* (1987)).

<sup>89</sup> An in depth comparison is beyond the scope of this paper.

<sup>90</sup> Whelan, *supra* note 15, at 75.

<sup>91</sup> *Id.*

<sup>92</sup> Permut, *supra* note 2, at 472-73.

<sup>93</sup> Meyers, *supra* note 7, at 1547.

<sup>94</sup> Permut, *supra* note 2, at 472.

<sup>95</sup> U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-50, *supra* note 82, at 48.

<sup>96</sup> Permut, *supra* note 2, at 471.



Channeling would require patients to provide their own malpractice insurance which, in turn, would relieve physicians from malpractice liability.<sup>97</sup> Experts who have studied this approach have identified several major drawbacks. First, poor patients might not be able to afford the required insurance.<sup>98</sup> Second, this approach is likely to create an even greater distrust between physicians and patients as physicians will need to inquire whether a patient has medical malpractice insurance. Consequently, patients may wonder why the physician feels that the insurance is necessary. "This would create an unprofessional atmosphere for treatment and might even necessitate having insurance machines in doctors' offices and hospital admitting areas much the same way flight insurance is sold in airports."<sup>99</sup> Finally, like the no fault system, this channeling approach has few controls or incentives for medical professionals to provide a high level of care.

A second proposed method of channeling is to require hospitals to provide malpractice insurance for both the hospital and physicians against any claims resulting from treatment that occurred in the hospital.<sup>100</sup> Hospitals are employing this practice more and more to encourage physicians to use their hospital.<sup>101</sup> Hospitals then add the cost of malpractice insurance to the cost of hospitalization on a per diem basis. Physicians who are covered by the hospital's insurance still need to carry malpractice coverage for care given in their offices. However, since seventy-five percent of malpractice incidents occur in a hospital, the physician's liability is greatly reduced.

One benefit of this second channeling approach is that costs are equitably apportioned among different types of patients. Furthermore, hospitals can handle the costs more efficiently than physicians or patients.<sup>102</sup> Hypothetically, patients receiving care through the physician's office would pay lower costs because of the decreased insurance premiums. Conversely, hospitalized patients would pay high costs due to the increased costs of malpractice insurance. This method of channeling provides incentives for physicians to provide quality care since hospitals will institute stronger quality assurance programs. In addition, the threat of the loss of hospital privileges would guarantee that physicians achieve an appropriate standard of care.<sup>103</sup> Physicians would continue to avoid malpractice in their offices since they would be responsible for providing their own insurance for these visits.<sup>104</sup>

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<sup>97</sup> *Id.*

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> Finklestein, *supra* note 31.

<sup>102</sup> A current trend in hospitals is to move into the medical malpractice insurance business. For example, Premier Hospital Alliance, Inc., Westchester, IL, recently purchased an insurance firm to underwrite professional liability coverage for member hospitals, affiliates, and their medical staff. A number of other hospitals have also developed self-insurance funds and captive offshore insurance companies. Sahney, *supra* note 2, at 230; Finklestein, *supra* note 31.

<sup>103</sup> Permut, *supra* note 2, at 472.

<sup>104</sup> *Id.*

## D. Arbitration

Arbitration "is the referral of a dispute by the voluntary agreement of the parties to one or more impartial arbitrators for a final and binding decision."<sup>105</sup> Arbitrators are generally chosen by the disputing parties and act as judges although the setting is less formal than in a typical courtroom. Arbitration results may or may not be final. Even where the arbitrator's decision is non-binding, it may strongly influence the party against whom the decision is made to arrive at a settlement. Presently, there are several states which by law mandate that medical malpractice claims for less than a specified amount of money are subject to arbitration.<sup>106</sup>

The chief benefit of arbitration is that it saves time<sup>107</sup> and money as compared to the overcrowded court system.<sup>108</sup> Lower medical fees could be charged to patients to take their malpractice claims to binding arbitration due to the reduced costs. Patients who want to preserve their right to the traditional court system would pay higher fees.<sup>109</sup>

Authorities cite numerous problems with the use of the arbitration system in the medical malpractice setting. First, the arbitration agreements themselves are often of questionable validity. One issue that is commonly litigated is "whether at the time the agreement was entered into, the recipient, or someone authorized to act for the recipient, was adequately informed of the relevant implications and was in a position to exercise reasonably free choice in the matter."<sup>110</sup> This level of knowledge is especially difficult to show when the agreement was signed while the patient was being admitted to a hospital for treatment. A second problem with arbitration is that physicians are generally reluctant to ask patients to sign documents which discuss the consequences should something go wrong.<sup>111</sup> A third problem with arbitration is that it may

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<sup>105</sup> *Id.* at 465 [quote omitted].

<sup>106</sup> *Id.*

<sup>107</sup> In California, major arbitration cases typically take no more than a year to go to trial, while typical civil cases take four or five years. Diamond, *supra* note 78, at § 4, col. 1, at 1.

<sup>108</sup> One study revealed that in cases determined by arbitrators, the average length of the hearing is 2.0 days and the cost of the proceedings, including arbitrators' fees and expenses, administrative expenses, and electronic recordings of the proceedings, averaged \$1,499 per case. Powsner, *supra* note 8, at 408. The study also shows that, with the exception of a few special cases, the outcomes of cases settled in arbitration are virtually the same as in court. *Id.* at 419. Another benefit of arbitration is that it can result in better decisions since expert arbitrators are better informed than lay jurors. U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-50, *supra* note 79, at 45.

<sup>109</sup> One author of this article concludes "[b]ased upon the proposals and experiences of the 1970s and early 1980s, arbitration in combination with channeling may provide a possible solution to the 'malpractice crisis' of the 1980s and beyond." Permut, *supra* note 2, at 473-74.

<sup>110</sup> Henderson, *supra* note 16, at 245.

<sup>111</sup> Diamond, *supra* note 78, § 4.

not decrease the cost of malpractice claims overall. While big claims may be paid in a smaller percentage of cases, small claims are paid at a slightly higher rate.<sup>112</sup> Finally, arbitration, like litigation, is a win-or-lose system that fails to address the reason why malpractice claims are initially filed. Arbitration does not allow the parties to reconcile their differences.<sup>113</sup>

### *E. Review Panels/Pretrial Screening Panels*

Review panels in the United States generally consist of two types. The first is the medical quality review panel commonly found in hospitals.<sup>114</sup> The second type of review panel is created by agreements between bar associations and medical societies.<sup>115</sup>

The objective of medical/law review panels is to provide an alternative forum to which plaintiffs or physicians can submit claims. These panels reduce the number of cases which go to trial by screening the cases for merit, thereby promoting early resolution.<sup>116</sup> Medical/law review panels are generally comprised of physicians and attorneys who review medical records and other relevant evidence, consult with needed medical experts, and determine if medical malpractice caused the patient's injury.<sup>117</sup> If the panel finds malpractice has occurred, it encourages settlement. Should the case go to court, the panel will provide experts who will document its findings at trial. In contrast, if the panel does not find malpractice, it encourages dismissal of the claim and will supply experts to support its position.

The majority of review panels have been unable to achieve the high level of cooperation between physicians and attorneys which is necessary for the panel to be productive.<sup>118</sup> This level of cooperation is very difficult to find in both large and small communities.

<sup>112</sup> *Id.*

<sup>113</sup> Comment, *supra* note 32, at 129. The GAO listed several additional disadvantages of arbitration:

- 1) May allow patients to seek compensation through both arbitration and the courts when multiple defendants are involved, some of which have agreed to arbitrate, while other have not.
- 2) May favor providers if a provider is part of the arbitration panel and other members defer to that person for technical expertise.
- 3) May not adequately compensate injured person.
- 4) May reduce provider's incentive to reduce incidence of malpractice due to the private nature of arbitration process versus the public stigma associated with court system.
- 5) Agreements to arbitrate future malpractice claims may not be fully understood by patient to the advantage of the providers.
- 6) Informality of the arbitration hearings may violate the due process rights of the parties involved.

U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-50, *supra* note 82, at 45.

<sup>114</sup> Permut, *supra* note 2, at 463.

<sup>115</sup> Stabenow, *Avoiding Patient Complaints? Communicate! Communicate! Communicate!* [interview], 75 IOWA MED. 492 (1985).

<sup>116</sup> U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-50, *supra* note 82, at 44.

<sup>117</sup> Permut, *supra* note 2, at 473.

<sup>118</sup> *Id.*

There are several criticisms of the medical/law review panels. The chief criticism is that time and money are wasted if the case continues to remain unsettled after the panel's hearing. Furthermore, review panels tend to favor the physician as most have a physician who is a member of the panel.<sup>119</sup> Finally, panels have been unsuccessful because they do not have the power to enforce their decisions, to discipline doctors, or to change medical practices and procedures.

## VII. NEW PROPOSALS FOR HANDLING THE MALPRACTICE CRISIS

While current efforts have been somewhat successful, there are many ways in which the malpractice claims system can be improved. Proposals for improvements range from expanding the use of alternative dispute resolution, reformulating the doctor/patient relationship, expanding the scope of conventional hospital risk management and modifying the manner in which medical malpractice is presently provided. These proposals, combined with some of the current efforts, would help to resolve the crisis.

### A. Rewrite the Physician/Patient Relationship

One proposal for handling the malpractice crisis is to revise the physician/patient relationship. As discussed earlier, in the physician/patient relationship, the physician generally is viewed as "god-like." While this god-like status may be helpful in treating patients, it is dangerous as the patient may have unreasonable expectations. In addition, physician/patient communication is adversely affected. Communication between physicians and patients is especially important because it cultivates a strong relationship.<sup>120</sup>

Physician/patient communication problems have long been recognized as a major cause of malpractice claims.<sup>121</sup> A recent article in the *Maryland Medical Journal* noted:

As early as 1973, 37 percent of malpractice suits in the United States were the result of poor communication between physician and patient. It was the single most common cause of such suits. Clearly, the quality of the physician-patient relationship is the most important factor in decreasing medical liability.<sup>122</sup>

<sup>119</sup> *Id.* at 475.

<sup>120</sup> Fortunately, the modern trend in medical education is to concentrate on the physician/patient relationship from the first day of instruction. Classes in physician-patient communication should be a required part of any medical school curriculum. Many hospitals also are offering innovative classes on the physician/patient relationship. Gibbs, *supra* note 38, at 53. These type of classes should also be mandatory for practicing physicians. Insurance companies would save money if they offered incentives to their insured to take these classes.

<sup>121</sup> Valente, *The Importance of the Physician-Patient Communication in Reducing Medical Liability*, 37 MD. MED. J. 75 (1988).

<sup>122</sup> *Id.* at 76 [footnotes omitted].

If the physician were to communicate the possible outcomes of the proposed treatments, patients would relax when adverse results occur. Failure to fully reveal the possible consequences will later be detrimental to the physician.<sup>123</sup> Thus, the strong physician/patient relationship is the best prevention against malpractice suits.<sup>124</sup>

In order to re-formulate the classical "doctor/patient relationship," the physician must be seen as a partner in the relationship rather than as an unerring, unchallengeable authority.<sup>125</sup> Physicians and patients must communicate and interact on an equal level and discuss different choices of treatment.<sup>126</sup> Patients must realize that complications can and do occur. The common misconception of most patients that everyone can be completely cured or that every surgery has perfect results must be changed. Physicians should admit their uncertainty and more carefully explain risks.<sup>127</sup> In essence, the patient and/or family must be presented with enough information, and in language that is understandable to the patient, to enable them to act as a partner with the physician to manage the patient's treatment.

A benefit of this new approach is that it allows the patient to share in the decision-making process. The patient believes that the physician recognizes him not as a child but as an intelligent person capable of making important decisions. It also allows, the patient to share in the responsibility of unfavorable outcomes.

When complications occur, the physician must be available to truthfully explain the situation. The physician does not need to say "I made a mistake,"<sup>128</sup> but instead, should explain the problem and the possible alternatives for treatment. The physician should be sincere and remorse-

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<sup>123</sup> Edwards, *supra* note 57, at 391-92.

<sup>124</sup> Kraushar, *supra* note 55, at 3. An excellent example of how a strong physician relationship prevents malpractice is the case where malpractice seems apparent:

Retrospective analysis of this case suggests several areas where one would strongly suspect physician negligence . . . . Since no claim was pressed in this case, we can conclude that the physician/patient relationship was strong enough to negate any feelings of anger on the part of this patient despite the possibility . . . that both the gynecologist and the urologist should have made a different decision.

Avery, *Good Rapport and Good Record: Antidote for Litigation*, 79 J. TENN. MED. ASSOC. 646 (1986).

<sup>125</sup> Rosenberg, *Law and Medicine in Confrontation*, 50 CONN. MED. 471, 472-73 (1986).

<sup>126</sup> The medical profession, as a whole, must change the way it treats patients if the physician is to be seen as a partner. Patients need to be treated in a humane fashion not "like airline baggage: checked in, weighed, X-rayed, tagged, thrown on a conveyer belt and forgotten unless it gets lost." Kaufman, *supra* note 51, at 10.

<sup>127</sup> Meyers, *supra* note 7, at 1547.

<sup>128</sup> This type of statement might later be used as an admission of liability.

ful, and perhaps forgive a fee.<sup>129</sup> Furthermore, the physician should encourage the patient to seek outside consultations. While a physician's apology for alleged malpractice would ameliorate the patient's anger, the apology might be regarded as an admission of liability. Hence, it is better for the physician to wait until the parties are in some type of settlement situation before offering an apology.<sup>130</sup>

### *B. Comprehensive Internal Dispute-Resolution Systems*

As discussed earlier, patients file malpractice claims against doctors for a number of reasons. Most proposals to resolve the malpractice crisis fail to address the majority interests of both physician and patient.

Interestingly, in other countries, malpractice claims are not filed as frequently as in the United States. For example, medical malpractice claims are filed almost ten times more often in the United States than in England.<sup>131</sup> One difference in the countries' two systems is the pronounced legislative and judicial bias against malpractice claims in England. British patients are discouraged from suing because of the "taint" of litigation. There is also a reduced propensity to sue as medical care is free due to the socialized medicine system.<sup>132</sup> Still, one of the most important differences in the two systems is the greater number of alternative forums British patients are given to pursue satisfaction for a medical service complaint.

Several alternative forums are available in Britain where patients . . . can air their grievances or merely seek information. The mandatory Hospital Complaints Procedure, which handles complaints about in-patient care, the Health Service Ombudsman, who mediates disputes involving hospital administrative matters, and the Medical Service Committees, who hear complaints about general practitioners, have no direct analogues in the United States health care delivery system. Each plays an important role in defusing patient unhappiness about the NHS [National Health Service], since each offers a formal process by which patients can bring their concerns to the attention of authorities who are in the position to obtain information and to propose improvements. The General Medical Council, which imposes disciplinary action on errant physicians, provides another forum for hearing complaints, but it performs a function similar to that of state licensing agencies in this country.<sup>133</sup>

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<sup>129</sup> While this practice would not be practical on a regular basis, a physician faced with "a poor result and a patient who appears litigious, forgiving that portion of the fee not covered by insurance may prove a sound investment in the physician's peace of mind." Kraushar, *supra* note 58, at 3-4.

<sup>130</sup> Comment, *supra* note 32, at 127.

<sup>131</sup> Miller, *supra* note 7, at 434-35.

<sup>132</sup> *Id.* at 450.

<sup>133</sup> *Id.* at 454.

The English alternatives to litigation meet the true interests of most patients and potential plaintiffs. These grievance forums address patients' reparation objectives by allowing small payments to injured patients when appropriate.<sup>134</sup> The English system also provides avenues for patients to affect change in physician behavior. Consequently, patients gain emotional vindication, as well as deter future negligent conduct by the physicians.<sup>135</sup> The United States would make great progress toward resolving its malpractice crisis if it created alternative forums to meet these interests.

### 1. AMA Proposal to Create an Alternative System

In 1988 the American Medical Association (AMA) proposed an alternative to the present tort system to reduce medical malpractice claims.<sup>136</sup> The AMA based its proposal on two facts. First, the existing judicial system is unfair to patients because not all injured patients can acquire legal representation. Second, the system is unfair to physicians because lay jurors are not qualified to decide malpractice cases and as a result, their awards tend to be excessive.<sup>137</sup>

The AMA proposal calls for replacing the present court and jury system with an administrative claims tribunal. Medical malpractice disputes would be adjudicated before an expert administrative agency that would either be newly created, or be a modified version of present state licensing boards. Under the AMA plan, malpractice complaints would be evaluated by an expert administrative agency that would try to assist<sup>138</sup> the parties in reaching a settlement and/or determine the merits of the case.<sup>139</sup> The

<sup>134</sup> *Id.* at 456 [footnotes omitted].

<sup>135</sup> *Id.* at 461.

<sup>136</sup> Am. Med., Specialty Soc'y Med. Liability Project, *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based, Administrative System* (1988) [hereinafter *A Proposed Alternative*].

<sup>137</sup> *Id.* at ii.

<sup>138</sup> When claims are first filed, the agency decides if a claim has merit, thereby operating as a pretrial screening panel.

<sup>139</sup> The administrative claims system would work in the following way:

The administrative system for adjudicating medical liability [would] be divided into three parts: (1) the pre-hearing and initial hearing stage; (2) the final decision of the Board; and (3) judicial review . . . . Under proposed pre-hearing procedures, claims reviewers from the Medical Board will quickly evaluate claims and dismiss those without merit. For claims with merit, the claims reviewers will submit the matter to an expert in the same field as the health care provider. The expert will review the claim and make a judgment as to whether it has merit. The claims reviewer will also assist in evaluating the claim and any settlement offers. If the claim is not settled it will be assigned to one of the Medical Board's hearing examiners . . . . The hearing examiner [will have broad authority over discovery and the hearing.] . . . . The hearing examiner will be required to render a written decision within 90 days of the hearing . . . . The hearing examiner's decision is subject to review by the Medical Board [on appeal] . . . . Appeal from the Medical Board's decision will be to the intermediate appellate court of the state, where the review will be limited to whether the Board acted contrary to statute or the Board's own rules.

*A Proposed Alternative*, *supra* note 136, at ii-iii.

proposal also empowers the administrative agency to discipline doctors who demonstrate a pattern of substandard conduct.<sup>140</sup>

While the AMA's proposal is commendable, it is somewhat shortsighted. As discussed earlier, patients sue because they are angry or surprised by unanticipated outcomes, not because they have evidence that their physician was negligent.<sup>141</sup> Suits are generally not filed against incompetent physicians but against qualified doctors, "most of whom have never been sued before and have received excellent peer review reports."<sup>142</sup>

Like the litigation process, the AMA proposal fails to address the societal objectives of malpractice litigation: reparation, emotional vindication, and deterrence.<sup>143</sup> The system might be quick and efficient, but it overlooks the patient's interests and resolves disputes in a problematic win-or-lose fashion. Patients and their families would not feel vindicated or compensated for their own or their relatives' illness, injury, or death. In addition, they would feel unable to protect others from harm. Lastly, the AMA administrative system would limit the ability of the doctor and patient to reach a settlement that satisfies both of their interests. Thus, the AMA proposal needs to be expanded before it should be placed into practice.

## 2. Third Party Facilitation

Another alternative to the present malpractice system is the use of a medical malpractice third party facilitator who would serve as a mediator/ombudsman.<sup>144</sup> This facilitator could be used either in conjunction with or independent of the AMA administrative agency. People from both the legal and medical communities would comprise the facilitator's office. The malpractice third party facilitators would investigate complaints filed by patients, physicians, or hospitals, and then mediate a settlement between the parties. Mediation, as used here, is a process where the disputants, together with "assistance of a neutral person or persons, systematically isolate disputed issues in order to develop options, consider alternatives, and reach consensual settlement that will accommodate their needs."<sup>145</sup> Mediation tends to diffuse hostilities by fostering cooperation.

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<sup>140</sup> An additional part of the AMA proposal would change the rule governing the standard of care a physician owes to a patient. The standard of care "based on custom and locality would be abolished in favor of a standard that focuses on whether the challenged actions fall within a range of reasonableness, to be determined by reference to the standards of a prudent and competent practitioner in the same or similar circumstances." *Id.* at vii. The rule of joint and several liability also would be abolished under the AMA proposal so that defendants would be liable for damages in proportion to their actual liability. *Id.* at vii.

<sup>141</sup> *Heed Consumers*, *supra* note 56, at 64.

<sup>142</sup> *Id.*

<sup>143</sup> Miller, *supra* note 7, at 435.

<sup>144</sup> See generally, Waxman, *A Nonlitigational Approach to Conflict Resolution: The Medical Center as a Model*, 42 *ARBITRATION JOURNAL* 25 (1987).

<sup>145</sup> Comment, *supra* note 32, at 129 [quotation marks and footnotes omitted].



In practice, the third party facilitator would investigate the claim and then bring the patient and physician together and attempt to resolve the dispute. The facilitator also would help the parties recognize their interests and would work with them to generate options and possible solutions to their conflict. If the dispute can be resolved without legal action, it will save the parties time and money. Even if the parties are unable to come to an agreement, they will have a better understanding of their opponent's position.

Mediation has several disadvantages. One danger of using mediation with physicians and patients is the imbalance of power. Furthermore, statements made during the course of mediation might be used later in court. If lawyers accompany both parties in the mediation session, the foregoing problems might be overcome. Although attorneys tend to be adversarial, they are often good negotiators. The presence of an attorney would also limit patient intimidation by physicians during mediation. In addition, attorneys would ensure that any statements made during mediation would be considered offers of compromise, and therefore would be inadmissible in court.

Another possible solution, never suggested before for use in medical malpractice disputes, is the "med-arb" or "conferencing" approach which is used in labor law cases.<sup>146</sup> Med-arb, as its name suggests, is a combination of mediation and arbitration. An arbitrator, who is empowered to decide the dispute, attempts to involve the parties in dispute resolution through informal mediated meetings. The arbitrator's hope is that the parties will reach a satisfactory agreement.<sup>147</sup> If the parties fail to reach an agreement, the arbitrator, as a last resort, will exercise his power to resolve the dispute. "The arbitrator has considerable authority and control. Thus, if the arbitrator suggests a caucus to confer with the opposing [parties and/or] lawyers, they will usually agree."<sup>148</sup> In the private caucus, the mediator/arbitrator has an assortment of tactics<sup>149</sup> available for encouraging the patient and physician to negotiate and reach an agreement that satisfies both of their interests.

Lawyers are useful in a variety of ways in mediation or med-arb. The patient's lawyer would equalize the power between the parties. Furthermore, the presence of an attorney would influence the patient to mediate rather than litigate as he will have an increased sense of security. The physician's attorney would encourage the physician to be flexible and remind her that, "You've got to pick and choose your fights carefully and ask yourself, is this one worth fighting?"<sup>150</sup> Lawyers would also serve as

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<sup>146</sup> McKersie, *Tis Better to Confer than to Decide*, 3 NEGOTIATION JOURNAL 329-32 (1987).

<sup>147</sup> The settlement could be as simple as an apology from the doctor.

<sup>148</sup> McKersie, *supra* note 146, at 329.

<sup>149</sup> The arbitrator could use likely arbitral outcomes as a persuasive tactic to encourage the parties to reach an accord. This information would decrease the parties' uncertainty about failing to reach an agreement and would place each in a better position to negotiate and come to an agreement.

<sup>150</sup> Porter, *supra* note 81, at 402 [quotation marks omitted].

sources of information. For example, they could explain applicable standards, probable trial outcomes and transaction costs for each case.

The role of negotiator is another role which could be filled by an attorney. In cases where the imbalance of power is a problem, or the parties have a distaste for negotiation, lawyers could conduct the entire negotiation. Finally, the presence of lawyers will make it easier for the parties to speak freely as they could stipulate that the mediation discussions are considered to be offers of compromise and thus assure confidentiality. Physicians could apologize within this forum without fear that the apology would later be used as an admission of liability. Studies have shown that some patient/plaintiffs feel that their injuries can only be repaired by the physician's apology.<sup>151</sup>

### *C. Broaden the Scope of Classical Risk Management*

Beginning in July of 1988, the Joint Commission on Accreditation of Hospitals (JCAH) required hospitals to maintain risk management programs.<sup>152</sup> Classically, risk management services are set up to identify and reduce causes of "potentially compensable events."<sup>153</sup> In other words, risk management departments determine where losses are occurring, identify them for hospital management, and thus reduce them. Side rails for hospital beds and wristband identification are two examples of risk management control and loss prevention innovations.<sup>154</sup> Risk management data also has caused some hospitals to limit their obstetric services because of potential loss.<sup>155</sup>

Risk management services may exist in-house or may be provided by outside consulting services. The scope of services provided by the risk management department is determined largely by the hospital's malpractice carrier. Insurance companies traditionally limit the scope of such services. Insurance companies recognize that most patients will not sue. Guided by money concerns, insurance companies generally take the old-fashioned approach of waiting until they receive a "Notice of Intent to Sue," rather than authorizing the risk management department to expend funds to mollify an upset patient or family.<sup>156</sup> As more and more hospitals have become either totally or partially self-insured, risk management departments have taken on much broader roles.<sup>157</sup> The control exercised

<sup>151</sup> Comment, *supra* note 32, at 127.

<sup>152</sup> Richman, *Hospitals Explore Innovative Techniques to Prevent Litigation and Hold Down Costs*, MODERN HEALTHCARE, May 8, 1987 (special section).

<sup>153</sup> *Id.*

<sup>154</sup> R. Christensen, O. Lindgren, & D.H. Mills, *Prediction and Prevention of Medical Malpractice Claims*, Institute for Medical Research Studies 31 (*Proceedings of the Research Conference on Health Care Improvement and Medical Liability*, April 27, 1988) (sponsored by the U.S. Dept. Health and Human Service).

<sup>155</sup> Telephone interview with Janet Schmitt, Associate Director - Risk Management, Cedars-Sinai Medical Center, Los Angeles, California (Jan. 27, 1989).

<sup>156</sup> Control of insurance companies over the health care providers risk management departments is discussed extensively *infra*.

<sup>157</sup> Sahney, *supra* note 2, at 230; Finklestein, *supra* note 31; U.S. GEN. ACCT. OFF. PUB. NO. HRD-86-50, *supra* note 82, at 67.

by risk management departments may range from forgiving fees owed, to directing the actions of defense attorneys.<sup>158</sup>

One particularly successful and innovative risk management program is run by the Professional Risk Management Group (PRM).<sup>159</sup> PRM is a consulting firm that contracts with hospitals to provide risk management services.<sup>160</sup> "PRM's program stresses the importance of an effective incident-reporting system, timely and intensive investigation of incidents, vigorous defense when indicated, innovative settlements, and data feedback."<sup>161</sup>

As discussed earlier, the medical profession has always been worried about malpractice. Most physicians and nurses practicing today did not attend schools where classes on malpractice or law were offered.<sup>162</sup> Medical care providers often view malpractice suits as personal attacks on their competence.<sup>163</sup> Unfortunately, rather than confronting potential malpractice claims before litigation ensues, the medical profession's classic reaction, like that of insurance companies, is to ignore these claims until the patient initiates a lawsuit.<sup>164</sup>

PRM works with medical practitioners to demystify the medical malpractice process. PRM conducts continuing education sessions for all physicians, nurses, and other medical staff. These classes outline the early reporting mechanism and stress the importance of early reporting. Medical staff are taught not to be afraid of the "malpractice boogie man"<sup>165</sup> as the PRM system is designed to be nonpunitive. Physicians are assured that every effort will be "made to support them and other involved staff members in any suits filed, and that whenever possible, claims will be settled out of court. In this way, the time physicians must spend giving depositions or testifying in court [is] reduced significantly."<sup>166</sup>

To aid in early reporting, PRM provides a twenty-four-hour-a-day, seven-days-a-week, telephone hot line so that medical incidents can be reported instantly. Medical staff are told only to report incidents, while

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<sup>158</sup> An informal survey of a number of California hospitals illustrates this point. Personal or telephone interviews were conducted with: Janet Schmitt, Associate Director - Risk Management Department, Cedars-Sinai Medical Center; Doug Pinnui, Director - Risk Management and Loss Control Department, Sharp Health Care; Susan Finklestein, Account Executive, Professional Risk Management, University of California at San Diego; Frank D. Heckman, Senior Vice President - Professional Risk Management Group (which provides risk management services to the five University of California Medical Centers), University of Southern California Medical Center, Drew Medical Center, San Bernadino County Medical Center, and Stanford Medical Center.

<sup>159</sup> McNulty, *Director Patient Settlements Best for All Parties*, HOSPITALS, May 1, 1990 at 129.

<sup>160</sup> See *supra* note 158 for a list of PRM hospitals.

<sup>161</sup> McNulty, *supra* note 159, at 129.

<sup>162</sup> Cavalier, *Strong Medicine*, CHICAGO TRIBUNE, Dec. 7, 1986, at 63.

<sup>163</sup> Wilbert, *Coping with the Stress of Malpractice Litigation*, 171 ILL. MED. J. 23, 25 (1987).

<sup>164</sup> Heckman, *supra* note 67; Finklestein, *supra* note 31.

<sup>165</sup> Heckman, *supra* note 67.

<sup>166</sup> McNulty, *supra* note 159, at 129.

the evaluation will be conducted by PRM.<sup>167</sup> This approach is proactive. "We take control of the events rather than be effected by them."<sup>168</sup> When an incident is reported, by telephone or in writing, the investigation is initiated.<sup>169</sup> The PRM administrator, who directs risk management at the reporting hospital, then chooses and directs the course of action selected.

The following is an illustration of the PRM system. A pregnant patient's delivery is not progressing properly and the doctor decides to do a routine Caesarean section. The patient and her husband are warned of the dangers associated with the surgery, but trust the doctor and agree to the surgery. During the operation, the anesthesiologist makes a mistake. The baby is delivered successfully, but the patient is now in a coma. Upon receiving a report of this incident, the PRM administrator would take the following steps: (1) Identify the issues: "What are they [the patient and family] contending with here? People often try to solve problems that don't exist."<sup>170</sup>; and (2) Analyze the issues: This analysis is similar to a triangle approach. The administrator deals with the most important issues first within the constraint of presently available resources (i.e., doctors, nurses, social workers, etc. presently on hand). The objective is to help the patient or the patient's family deal first with the most important issues. For example, the husband may not understand why he cannot see his wife. The PRM administrator will arrange for a member of the medical team to explain why, and to explain when the husband can see her; (3) Initiate the investigation at the hospital to determine what transpired; (4) Execute the indicated actions.

After evaluating the situation, the administrator would quickly decide who should contact the family<sup>171</sup> to discuss the problem and possible solutions. The doctor, anesthesiologist, and nurses involved are most likely upset, and thus should not meet with the family. Nevertheless, it

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<sup>167</sup> The medical staff is instructed to report any incident where an "untold, unforeseen, or unexpected result occurs."

<sup>168</sup> Heckman, *supra* note 67.

<sup>169</sup> PRM, who pioneered the extensive use of computerized incident reporting, has a very extensive computer data-bank that allows administrators to evaluate which cases could include an element of fault. In addition to helping the administrators spot possible fault, the computer data bank allows PRM to spot incident patterns and take corrective action. For example, a rise in injuries to the collarbone of newborns was traced to an improper technique taught by an instructor. Students of this instructor were then given a remedial class. Cavalier, *supra* note 162, at 61; R. Christensen, et. al., *supra* note 154, at 32. Presently, the Institute for Medical Risk Studies, a nonprofit institute which is the research arm of PRM, is working on a 3-year grant in which it is examining ways to improve malpractice "incident-reporting and occurrence-screening systems . . . used to provide early identification, investigation, and resolution of potential malpractice claims." *Id.* at 33.

<sup>170</sup> Heckman, *supra* note 67.

<sup>171</sup> In our hypothetical, someone would need to meet with the husband immediately. They would need to deal with his immediate and tangential concerns about his wife. For instance, a neighbor may be watching his children only for the night: What will he do with them tomorrow or even next week?

is important that the family be given a "fair and unbiased opinion without delay. They need to be given the information about what has occurred and the skills to deal with this information. Families fear the unknown."<sup>172</sup> Hence, the PRM administrator would likely assign the most senior staff physician, an anesthesiologist, other than the one involved, and a social worker to talk to the family. Frequently, the PRM administrator accompanies these medical professionals to the family meeting.<sup>173</sup>

The PRM administrator would also evaluate the family's concerns. For example, the family may have concerns about the payment of medical bills.<sup>174</sup> The PRM administrator has the power to authorize the hospital to hold or cancel the patient's hospital and other medical bills. Furthermore, the administrator has the power to arrange for the hospital to pay for the patient's follow-up care. Additionally, the administrator has wide discretion in handling the claim which may range from hiring a babysitter to watch the family's children, to paying for the hotel rooms of out-of-town relatives who come to see the patient. In short, the PRM administrator may take any creative action that will improve the situation.

After the initial crisis has ended, the administrator continues to monitor several aspects of the case. The administrator must oversee additional treatment and decide whether to bill the patient and/or family. The administrator must also take continuing steps to defuse the anger of the patient and family.

PRM's approach is designed to resolve cases quickly. If the administrator's analysis indicates that the hospital is liable, the administrator contacts the patient or family. The administrator's objective is to negotiate and settle the case. PRM's method "clears the air" by having doctors admit mistakes.<sup>175</sup> The aim is to give the patient the "best and fairest compensation arrangement possible."<sup>176</sup> PRM has found in the development of its program that prompt and complete disclosure of injuries coupled with generous settlement offers have produced more cooperative patients and less costly claims. PRM discovered that when they were

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<sup>172</sup> Heckman, *supra* note 67.

<sup>173</sup> *Id.*

<sup>174</sup> Our hypothetical situation obviously contains a very traumatic event. Beyond the family's initial concerns about what has happened to their loved one, the family has other important concerns: "What really happened? What will happen? Who is going to pay for this? Who's going to take care of our children? etc." One hospital administrator outlined how she creatively worked with one aggrieved family. In this situation, the grandfather had gone into the hospital for surgery. Due to a mistake in surgery, the grandfather became a quadriplegic. Prior to surgery, the grandfather had been the family babysitter, watching his grandchildren while his daughter was at work. The single working mother now had to deal with finding someone she could trust and afford to watch her children. Thus, she was suddenly forced to deal with a very important parallel issue other than those just concerning her father. This type of concern is largely ignored by traditional risk management departments. In this situation, however, the risk management administrator immediately helped the mother by sending a nurse from the hospital to baby-sit the children. This was done prior to the determination of any liability. As part of the final settlement of the case, a baby-sitter was supplied until the children no longer needed one.

<sup>175</sup> Cavalier, *supra* note 162, at 63.

<sup>176</sup> Finklestein, *supra* note 31.

humanistic, they tended to save more money. "The earlier the reporting, the earlier the identification, the earlier the investigation, the earlier the resolution-the happier the outcome."<sup>177</sup>

If the administrator is unable to settle the case and the patient retains an attorney, PRM cooperatively contacts opposing counsel to "find out what his needs are. Harassing the patient's attorney widens the gap and hardens the sides."<sup>178</sup> If liability or damages are at issue, PRM pays an outside private physician to evaluate the patient. This physician, by stipulation, cannot be called as an expert.

PRM's approach to discovery "is to get all the facts out early so that both sides can properly evaluate the case."<sup>179</sup> The objectives of the evaluation process are to deal with the merits of the case and to discover the "hidden agendas" of the patient, family members, and the patient's attorney. For example, the patient's family and attorney may think of the medical incident as their path to riches. Generally, the merits of the case are rapidly addressed while other agendas dominate the process.<sup>180</sup>

In a typical medical malpractice case, defense attorneys for the physician's insurance company control the flow of litigation. Insurance lawyers generally must bill a set number of hours each year which may create an incentive to perform unnecessary legal work. To counter this incentive, PRM controls the flow of litigation. PRM administrators work closely with defense counsel to reduce litigation costs. They also have authority to negotiate directly with the patient's attorney. If PRM determines the claim to be meritless, they will allow it to go to court. This willingness to fight meritless claims discourages frivolous lawsuits.

PRM's clients (mostly self-insured hospitals) must make yearly payments into a trust account which PRM manages and uses for settlements. No profits are made from these accounts and there is no incentive for an administrator to retain these funds.

PRM designs the settlement of a claim to fit the patient's needs as much as possible.<sup>181</sup> Throughout the settlement process, the PRM administrator generates creative alternatives to the classic lump sum payment which is typically used to settle claims.<sup>182</sup> If the injured party requires on-going medical care, the hospital's services are offered as part of the settlement. If the patient chooses not to use the hospital's facilities, the money is placed in a trust account to pay for future medical care. After a specified number of years, money which is not used for the patient's medical care reverts to the hospital. Hence, PRM's program meets the patient's needs and lowers medical malpractice costs.

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<sup>177</sup> *Id.*

<sup>178</sup> Heckman, *supra* note 67.

<sup>179</sup> *Id.*

<sup>180</sup> *Id.*

<sup>181</sup> McNulty, *supra* note 159, at 130.

<sup>182</sup> Creative settlements have ranged from creating college trust fund accounts for the patient's children, to hiring a baby-sitter to watch the family's children.

As a result of PRM's progressive approach, PRM's transaction costs are substantially reduced. For example, insurance companies not using this approach report that out of every dollar spent in a malpractice claim the patient's attorney receives 16 cents, defense counsel receives 60 cents, and the injured party receives only 24 cents. Thus, 76 cents out of every dollar goes toward attorney fees.

In contrast, under PRM's approach, patient's counsel receives 30 cents, the defense counsel receives 25 cents, and the injured party receives 45 cents of every dollar. Hence, transaction costs are reduced by 24 cents on every dollar. In addition, these figures do not take into account the fact that claims against PRM clients are generally settled much earlier than traditional malpractice claims. "Claims are settled earlier and more effectively without just giving cash away."<sup>183</sup>

PRM's approach provides for fair patient compensation. In addition, an environment is created where physicians can admit mistakes. Finally, patients know that PRM will take action to assure that these types of incidents will not recur. In essence, PRM's approach effectively addresses all of the injured patient's interests of reparation, vindication, and deterrence.

The successful use of progressive approaches in handling medical malpractice claims is by no means limited to PRM. Many hospital risk management departments and private consulting firms have adopted some of the PRM methods.<sup>184</sup> Nevertheless, the majority of hospitals continue to limit the scope of their risk management departments solely to the identification of potentially compensable events. A number of obstacles must be surmounted before the role of risk management programs can be broadened to better handle medical malpractice claims in a progressive PRM-like approach. The first obstacle is the resistance of the medical field to the risk management concept in general. As one writer concluded:

[s]elling risk management as an integral component of hospital operations has always been difficult. Since many clinicians view the quality assurance program (which is usually clinically based) as an unnecessary overlay of committees and paperwork that is grudgingly accomplished only to receive accreditation from the Joint Commission [on Accreditation of Hospitals], the startup of a risk management program (which is usually legally oriented) faces a bruising gauntlet.<sup>185</sup>

Another obstacle which has delayed the use of the PRM-like approaches is the different interests of the insurance company compared to the interests of the health care provider and the patient.<sup>186</sup> Because insurance companies have a profit motive, they will invest the money to increase

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<sup>183</sup> Heckman, *supra* note 67.

<sup>184</sup> Schmitt, *supra* note 155; Interview with Doug Pinnui, Director, Risk Management and Loss Control Department, Sharp HealthCare (1989).

<sup>185</sup> Warren, Book Review, 13 J. OF HEALTH POL., POL'Y AND L. 365, 369 (1988).

<sup>186</sup> This statement excludes health care providers who are self-insured since their interests should be similar.

profits, and consequently, delay settlement. This delay weakens the patient's case as witnesses' memories will become less clear and it is difficult to retain these witnesses for long periods.<sup>187</sup> In essence, the original malpractice claim, which was essentially a people problem, is treated like and becomes a financial concern. While health care providers clearly have an incentive to settle malpractice claims and avoid bad publicity, such as headlines that read "Big City Hospital Refuses to Pay Damages for Brain Damaged Baby", insurance companies are less affected by unfavorable publicity.

The present malpractice insurance system allows the interests of the insurance carrier to dominate. Insurance companies wait and see whether they will be sued and limit the scope of risk management services as they hope to pay nothing to the patient. As a result, progressive risk management services are not widely utilized, and patients and health care providers bear the loss. Patient and physician interests can only be addressed if risk management services are expanded. The present systems of malpractice insurance must be modified to allow for progressive risk management.

#### *D. Modify the Way Medical Malpractice Insurance is Provided*

Health care providers typically protect themselves from medical malpractice claims by purchasing medical malpractice insurance. Malpractice insurance is sold by several different types of insurance companies: commercial insurance companies; health care provider-owned companies (i.e., mutual insurance companies); and joint underwriting associations (JUA).<sup>188</sup> For a fee, the insurance company assumes financial responsibility for injuries to any patient limited to a specific amount of money and for a set time period.<sup>189</sup> The insurance company also investigates claims and defends the health care provider against a malpractice action.

As stated above, the scope of services provided by risk management departments is limited largely by the hospital's malpractice carrier. Although the interests of patients and health care providers should be addressed first, the interests of the insurance company dominates. Changing how the present medical malpractice insurance is provided would remedy this situation. One method would be to modify and expand the present use of mutual insurance companies and joint underwriting associations.<sup>190</sup>

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<sup>187</sup> Conventional wisdom in the insurance industry is to hide injuries and deny fault. Cavalier, *supra* note 162, at 61.

<sup>188</sup> U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-50, *supra* note 82, at 66.

<sup>189</sup> *Id.*

<sup>190</sup> Joint Underwriting Association and Physician/Hospital Mutual Companies were products of the mid-seventies medical malpractice crisis. Hatch, *supra* note 10, at 2.



Joint underwriting associations are nonprofit pooling arrangements created by state legislatures to provide medical malpractice insurance to health care providers in the states in which they are established . . . . Joint underwriting associations are established on the premise that they will be self-supporting through the premiums collected; however, laws establishing the associations generally provide that policyholders can be assessed, up to a specified amount, for deficits experienced by the association. JUA's (joint underwriting associations) generally are comprised of all companies writing insurance in a particular state or all companies writing property/casualty insurance in a state and are controlled by a group of public and private sector representatives. The purpose of JUA is to write liability insurance for health care providers who are unable to obtain coverage in the private market.<sup>191</sup>

Physician/hospital mutual insurance companies are owned by the insured. In other words, the mutual company is controlled by its physician or hospital members. These insurance companies were created because analysts believed that doctor/hospital nonprofit companies would issue more affordable insurance to physicians and hospitals than the traditional malpractice carriers.<sup>192</sup> In a mutual company each member contributes "to a fund for the payment of the losses and expenses . . . the relationship between the members being a dual one, in that each member is in a sense both an insured and an insurer."<sup>193</sup> Mutual companies require payments on the basis of cash premiums, premium notes, assessments, or a mixture of these.<sup>194</sup> The company's assets are trust funds comprised of the premium payments.<sup>195</sup>

Mutual insurance companies and joint underwriting associations have provided both malpractice insurance at a slightly lower cost, and insurance for those who are unable to obtain it in the private market. Nonetheless, mutual companies and JUA's generally handle malpractice claims in a traditional fashion.<sup>196</sup> Once an incident is reported or a claim is filed, the association or mutual company investigates and defends the hospital in much the same way as private malpractice insurance companies. The risk management departments of the JUA or the mutual insured health care providers are limited. Progressive approaches in dealing with potential claims are largely ignored.

The failure of JUAs and mutual insurance companies to adopt the successful methods of risk management companies like PRM in handling malpractice claims is unreasonable. JUAs and mutual companies could modify their charters and bylaws to allow expansion of insureds' risk

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<sup>191</sup> U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-50, *supra* note 82, at 67.

<sup>192</sup> Hatch, *supra* note 10, at 2.

<sup>193</sup> *Id.* at 3.

<sup>194</sup> Couch on Insurance § 19:14 (2d rev. ed. 1988) [footnotes omitted].

<sup>195</sup> *Id.* at § 19:18.

<sup>196</sup> *Id.* at § 19:24.

management department operations. These companies could set guidelines in their charters and bylaws which limit which hospitals to admit as members to those that adopt progressive risk management approaches.<sup>197</sup> Risk management administrators could help tailor management decisions by serving on the board of directors of the companies.

Alternatively, hospitals with similar attitudes toward malpractice could pool their money into trust accounts to create their own insurance companies. A stipulated amount of money would be placed into the account by each hospital. The trust account would work along the same lines as a "claims made insurance policy,"<sup>198</sup> i.e., only those claims reported during the period when the trust account was in effect and would be covered by the money in the account. Members would be assessed for any deficits experienced by the company.

Hospitals with historically lower malpractice costs could contribute less to the trust account. Members' contributions could be adjusted annually based on the length of time they are members and their malpractice costs.<sup>199</sup> Thus, the members of these limited non-profit companies would pool their resources to provide both low cost insurance and progressive approaches to handle malpractice. This scheme could be slightly modified by hiring outside professional risk management groups, like PRM, to provide risk management services.

Another possible system of insurance coverage would be to have health care providers contract with existing mutuals, JUAs and commercial insurance companies, to set up interest earning trust accounts. The insurance company would establish a ratio, based on the hospital's past and estimated malpractice costs, to determine the amount which the hospital must deposit for a certain amount of coverage. For example, for every \$100,000 the hospital places into the trust account, the insurance com-

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<sup>197</sup> One recent study indicates that mutual insurance companies are more efficient than commercial insurance companies. The study found that St. Paul Companies, Inc. (the largest commercial insurer in the malpractice market) "spent on an average more than twice as much in allocated loss adjustment expenses per claim" compared to the mutual insurance company (MMIE). Hatch, *supra* note 10, at 29. In addition, St. Paul "paid a higher average loss per claim, one and one half times the average loss payment of MMIE." *Id.* St. Paul also took a longer time to close a claim. For example, in 1986 and 1987, MMIE closed approximately 20% more total claim files than did St. Paul. *Id.*

<sup>198</sup> Couch, *supra* note 194, at § 19:30 [footnotes omitted].

<sup>199</sup> Traditionally, medical malpractice insurance was offered in the form of an occurrence-based policy. With occurrence-based insurance, the transfer of the risk from the hospital to the insurance company took place when the incident occurred. In malpractice cases a great deal of time often passes between the occurrence of the malpractice and the settlement of the claim. This made it difficult for insurance companies to make accurate actuarial measures to determine the malpractice loss for a set period. To reduce some of these difficulties the 1970's malpractice crisis produced the "claims made policy". A claims made policy provides that the transfer of risk occurs only when the claim or incident is reported to the insurance carrier. Currently, 70-80% of written malpractice insurance policies are "claims-made" policies. Hatch, *supra* note 10, at 3.

pany would deposit \$1,000,000. The director of the hospital's risk management department would be a trustee of the trust account. After a specified period of time, the money remaining in the trust account would revert to the insurance company. This amount would usually exceed the amount originally placed into the account so the insurance company would receive a net profit.<sup>200</sup>

The trustee of the trust account would be under a fiduciary duty not to waste the corpus of the trust. The risk management administrator or trustee would also have an added incentive not to waste the corpus because the future hospital/insurance company ratio could be changed to be less favorable to the hospital. As a further incentive for the administrator or trustee, the hospital could receive a percentage of the corpus after the trust period ends.

These options minimize the profit incentive by modifying the manner in which malpractice insurance is provided. This gives the hospital risk management more autonomy to prevent, react to, and properly deal with medical malpractice incidents. Hospital risk management departments could adopt and improve on the model used by PRM. Early reporting, early identification, early investigation, and early resolution result in a happier outcome and go a long way toward reducing the "costs" of the medical malpractice crisis.

### VIII. CONCLUSION

Unfortunately, breakthroughs in the malpractice crisis are often slowed by finger pointing. Physicians tend to blame the malpractice crisis on lawyers. "Yet to focus on lawyers as a primary cause of rising malpractice costs is to deny that physicians' errors actually generate malpractice suits."<sup>201</sup> Physicians' fail to recognize the leading causes of malpractice claims: the breakdown in physician/patient communications, and the perception of patients that they are uninformed and that physicians are uncaring or not sincerely remorseful for negative outcomes.<sup>202</sup> Furthermore, it is important to recall that the majority of people who have suffered an iatrogenic injury do not discuss their injuries with lawyers.<sup>203</sup>

Once lawyers are contacted, however, the physician/patient relationship changes. Lawyers, who see the physician and patient as adversaries,<sup>204</sup> envision themselves as the champions who will fight their clients'

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<sup>200</sup> Couch, *supra* note 194, at § 19:40 [footnotes omitted].

<sup>201</sup> A formula would need to be established to determine the trust account contributions of the hospital and insurance company. This would ensure that the insurance company would generally make a profit. In a bad year, where a high number of claims are filed, the insurance company would get no return on its money. If the amount placed in the trust account is insufficient to cover claims, then the health care provider and the insurance company would be assessed the excess in the pre-existing ratio.

<sup>202</sup> Korcok, *supra* note 2, at 846-47.

<sup>203</sup> Valente, *supra* note 121, at 75-76.

<sup>204</sup> Meyers, *supra* note 7, at 1547.

battles in court. The doctor or patient becomes the enemy. Clients are told to refrain from all direct contact with the other party, opposing counsel and officers of the court. In their fervor to guard their clients and prepare for litigation, attorneys thwart "any opportunity for an apology and reconciliation."<sup>205</sup> Consequently, the patient/plaintiff who wins the legal battle generally receives money damages, but his true interests are overlooked.<sup>206</sup>

Although lawyers are partly to blame for the malpractice crisis, solutions which solely alter the lawyers' involvement are a mistake. Instead, it is important to examine the underlying objectives of reparation, emotional vindication, and deterrence which convert a patient into a plaintiff. The present tort system fails to address these objectives. In effect, solutions to the medical malpractice crisis must entail a broad based approach that addresses these interests.

Legislative reforms can partially resolve the malpractice crisis. "Channeling" malpractice insurance through hospitals will help to reduce some costs. The AMA's proposal for creating an alternative forum to resolve claims is commendable though shortsighted as it adopts too many of the weaknesses of the present tort system.

While everyone agrees that the interests of patients and health care providers should be addressed, the insurance companies' interests currently dominate. Sources of malpractice insurance should be modified to allow for more progressive risk management. Risk management must be allowed to properly address both the patient's and health care provider's interests. This would substantially lower the number of claims filed and the cost of settling claims.

Other important steps necessary in order to solve this crisis are to rewrite the physician/patient relationship and to create an alternative forum where the parties can reach agreement (e.g., third party facilitation). Communication between physicians and patients must improve. Malpractice carriers, HMOs, and hospitals should require their physicians to attend occasional seminars on physician/patient communication. The physician must be seen as a partner in the relationship rather than as an unerring, unchallenged authority.

When the physician/patient relationship breaks down, the use of a third party facilitator should be encouraged. Physicians and patients must be brought together to try and resolve their differences. Attorneys should be allowed to accompany the parties at the meeting with the third party facilitator.

A consensual agreement is likely to be consistent with the interests and preferences of both parties. Both parties will come out "winners." The result will be fewer malpractice claims, less defensive medicine, lower malpractice insurance premiums, lower medical costs, and a rise in the quality of health care; all very worthy ends.

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<sup>205</sup> Comment, *supra* note 32, at 128.

<sup>206</sup> *Id.*

