

Medical Liability Insurance Overview

Time:	Thursday, January 9, 2003, 3:30 p.m. - 5:00 p.m.
Format:	Presentation and Discussion
Presenters:	<p>Barry R. Furrow, J.D. Professor, School of Law Widener University Wilmington, DE</p> <p>Edward A. Dauer, LL.B., M.P.H. Dean Emeritus and Professor of Law University of Denver, College of Law President National Center for Preventive Law Denver, CO</p>
Objectives:	<ul style="list-style-type: none">• Identify the underlying causes of increases in malpractice insurance premiums.• Understand the resulting impact of insurance premium increases.• Discuss policy options being considered by States; (e.g., alternative resolution tools, self-insurance funds and medical malpractice tort reform.)
Materials:	<ul style="list-style-type: none">• Furrow presentation• Furrow BR, Greaney TL, Johnson, SH, Jost TS, and Schwartz, RL. Health Law: Cases, Materials and Problems. Appendix B. Teachers Manual. WestGroup 2001.• Dauer presentation• Dauer EA et al. Prometheus and the Litigators: A Mediation Odyssey. Journal of Legal Medicine. Vol 21. No. 159. 2000.• Bibliography prepared by Edward Dauer



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Barry R. Furrow, J.D.



MEDICAL LIABILITY INSURANCE OVERVIEW

2003 Florida Health Care Summit

Session 5

January 9, 2003

Barry R. Furrow

Professor of Law

Widener University School of Law

Wilmington, Delaware

Understanding Changes in Medical Liability Insurance Premiums

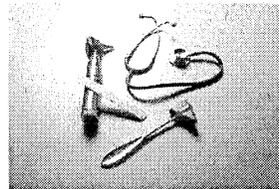
Presentation Outline:

Possible Explanations for the Crisis

- Malpractice litigation
- Medical errors
- Insurance cycle

Factors Influencing Premiums

- Ratemaking
- Market characteristics
- Investment earnings



POSSIBLE EXPLANATIONS FOR THE CRISIS

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3

Increases in Malpractice Litigation?

- No evidence supports the hypothesis of rapid increases in tort litigation and rapid jumps in the size of jury verdicts and settlements over the past three years.*
- Number of suits filed are much less than potential valid negligence claims.

*Data Sources: Lance deHaven-Smith, Analysis of Florida Medical Malpractice Claims (prepared for Governor's Task Force on Healthcare Professional Liability (Nov. 22, 2002)

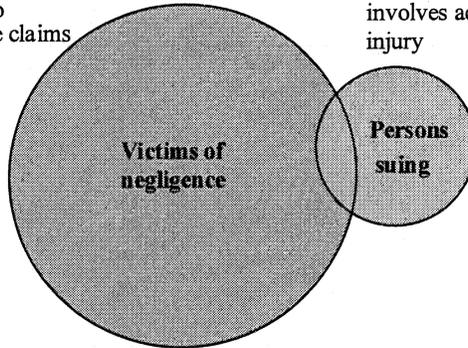
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4

The Tort System Undercompensates Victims of Negligence

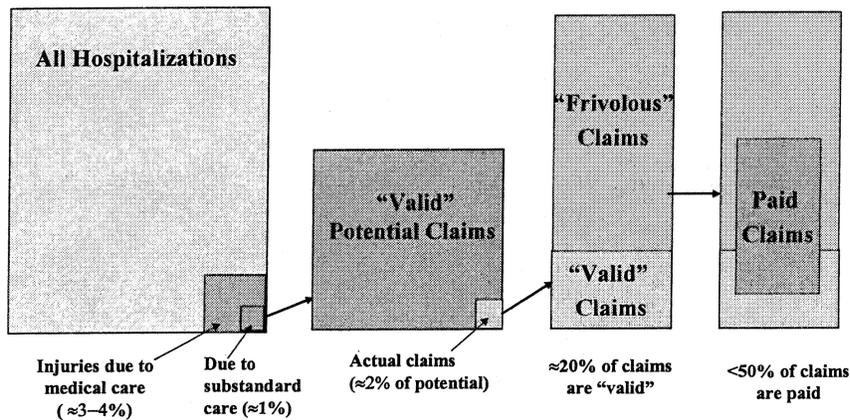
7.6 times as many patients are injured due to negligence as file claims

Only 1 claim in 6 involves actual negligent injury



Data source: Harvard Medical Practice Study (1984 data).
Graphical conceptual design derived from Don Harper Mills and Randall Bovbjerg

Relationship Between Injuries & Claims*



*Data sources: HMPS (1984 data), Utah-Colorado study (1992 data).
Diagram scale is only approximate. Conceptual design derived from Don Harper Mills and Randall Bovbjerg.

More Provider Errors?

- Rapid increase in the production of medical errors and resulting patient injury by health care providers?
- Medicine causes more patient injury due to more powerful drugs and more complicated procedures, but this has happened gradually over two decades.*

David W. Bates et al., The Costs of Adverse Drug Events in Hospitalized Patients: Adverse Drug Events Prevention Study Group, 277 JAMA 307, 307 (1997)



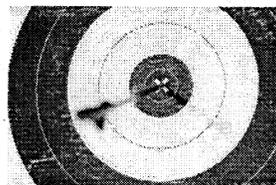
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7

Insurance Cycle?

- The lumpiness of insurance underwriting-- the fact that premiums are invested in the stock and bond markets -- explains most of the current crisis.*

*Testimony, James Hurley (Am. Acad. Actuaries, Subcommittee on Health, Comm. On Energy and Commerce, U.S. House of Representatives, July 17, 2002



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8

CAUSES OF THE CRISIS

- Insurance “crisis” is created for physicians, trauma centers, and hospitals by rapid “unexpected” premium increases paid for annual malpractice coverage.
- Premium “shock” increases costs for providers through its unexpected upward pressure on their revenue.
- Ability to pass increases along is diminished.

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9

WHY SUCH PREMIUM JUMPS?

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10

Premium Changes Are Based On Three Major Factors

1. **Ratemaking:** Actuarial calculation of expected claims payouts.
2. **Market Characteristics:** Nature of the local/state market for malpractice insurance.
3. **Investment Earnings:** Expected returns on invested reserves.

FACTOR 1. Ratemaking

- **Expected Severity of Judgments.**
 - What will the mean judgment and settlement be for the pool of insured providers?
 - What will the largest judgment be?
- **Expected Frequency of Claims.**
 - Is an increase in filings expected?
 - Will settlements increase?

Ratemaking: Pricing Premiums

- Malpractice ratemaking attempts to predict future claims and expenses based on past experience.
- Ratemaking is very complicated for several reasons:
 - small numbers
 - lack of independence of risks
 - risk production
 - changing circumstances

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13

Small Numbers

- Predicting future losses is based on the law of large numbers, but the malpractice insurance market has a small pool of potential policyholders and claims.
- Awards vary tremendously, with 50% of the dollars paid out on 3% of the claims.
- A single multimillion dollar claim can have a tremendous effect on total losses and therefore average loss per insured doctor.

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14

Lack of Independence of Risks

- Neither claims against an individual doctor nor against doctors as a group are independent.
 - Multiple claims against a doctor relate usually to some characteristic of his practice or his technique.
 - Lawyer can use knowledge gained in one suit in another.

More Risks Are Being Produced

- The risk of patient injury has increased, through rapid proliferation of drug prescribing, more drug interactions, more procedures being done.
- The Institute of Medicine estimates that up to 98,000 deaths per year are attributable to avoidable medical injuries. *

*Data Source: L.T. Kohn, J.M. Corrigan, and M.S. Donaldson, eds., Committee on Quality of Health Care in America, Institute of Medicine, To Err Is Human: Building a Safer Health System (Washington, D.C.: National Academy Press, 2000) [IOM Report].

Changing Circumstances

- Medical cost inflation changes the severity (dollar amount) of payouts over time.
- Payouts have risen in sync with medical inflation.*
- Changes in legal theory may increase the severity and/or frequency of claims.

*AIR, Medical Malpractice Insurance: Stable Losses/Unstable Rates 4 (Oct. 10, 2002).

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17

Legal Doctrine Expands

- New tort doctrines have developed, such as “loss of a chance” and “hedonic” (loss of pleasure) damages*
- Social attitudes toward health care providers have changed, as patients become more informed consumers, aware of medical errors and system failures.

Barry R. Furrow et al, Health Law, Ch. 6 (2nd Edition Hornbook Series, WestGroup 2001)

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18

FACTOR 2. Insurance Market Characteristics

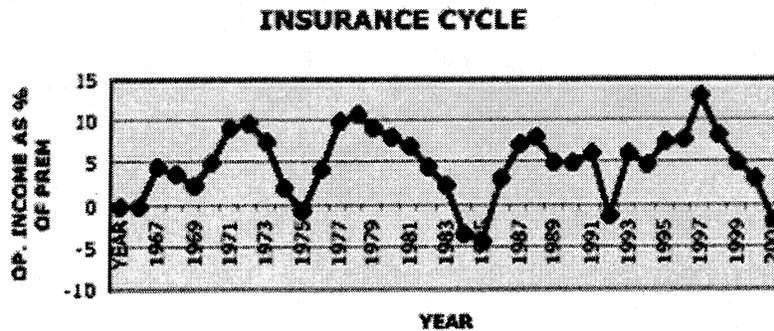
- Number of physicians and their distribution among specialties.
- Nature and extent of competition from other insurers in the state.
- Availability of state insurance funds to protect physicians from excess losses.

FACTOR 3. Investment Earnings

- Insurance cycle: insurance companies collect premium dollars and invest them in securities and other financial instruments.
- Past malpractice crises were driven by precipitous drops in the rate of return of invested reserves. *

*Data Source: James R. Posner, Trends in Medical Malpractice Insurance, 1970-1985, 49 Law & Contemp.Probs. 37 (1986); David J. Nye, Donald G. Gifford, Bernard L. Webb, and Marvin A. Dewar, "The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances," 76 Georgetown L.J. 1495 (1988).

INCOME AS A PERCENTAGE OF PREMIUMS COLLECTED



AIR, Medical Malpractice Insurance: Stable Losses/Unstable Rates 4 (Oct. 10, 2002).

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21

WHY THE CYCLE?

- The stock and bond markets dropped precipitously in 1974, 1986, 2000.
- These drops explain problems in insurance premium pricing and availability in many markets in 1974-75; 1987; and today.



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22

LUMPINESS IN INSURANCE MARKET

- This is a lumpy market, that is, prone to cycles of underpricing and catch-up by insurance companies.
- “Sudden” price increases include deferred costs passed on when premiums and investment income no longer cover payments plus profit.

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23

CASH FLOW UNDERWRITING

- Once premiums reach actuarially sound levels, profits rise, new insurers enter the market offering lower rates, competitive pressures return, and the cycle begins all over.
- Premium shock has little to do with either the frequency or severity of claims filed against health care providers.

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24

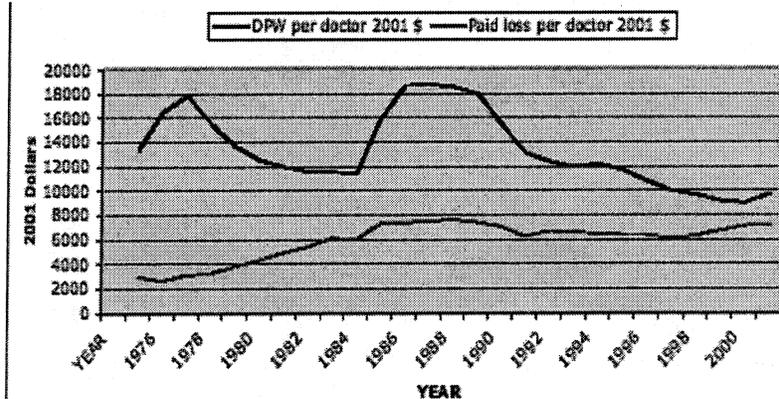
Low Pricing to Attract Business.

- High levels of competition in the medical malpractice market.
- Barriers to entry are low, buyers are sensitive to costs. Carriers are therefore reluctant to increase rates and sacrifice market share. Insurers forego small annual rate increases, waiting for a few years to impose higher rate increases.
- These premiums, when invested, produced a good rate of return in the 1990s economy.

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25

Per Doctor Premiums and Losses



DPW: direct premiums written is amount of money insurers collected from doctors in that year.
 Paid loss: what insurers actually paid out that year to people injured--all claims, jury awards and settlements--plus what insurers pay their lawyers to defend claims.

Data Source: A.M. Best data compilation 2000.

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26

Market Response

- Returns on investment diminish with drops in returns in the bond and stock market
- Insurers respond by:
 - Raising premiums to cover the actuarial costs of paying claims
 - Dropping some lines of insurance that have proved hard to predict or expensive to cover.
 - Dropping out of the market altogether. St. Paul's has recently dropped its malpractice insurance line.

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27

RESULT: MEDICAL DISTRESS

- The rise in premiums causes distress to providers whose revenue planning was based on lower expected premium costs.



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28

WHY DOES THE INSURANCE CYCLE MATTER?

- Physicians are forced to cope with sudden premium increases or even unavailability of insurance in some markets or for some specialties.
- Physicians fear “higher risk” patients, fearing that they will be forced to absorb any costs of suit.

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29

Summary

- The current malpractice crisis is fueled in large part by an insurance cycle crisis.
- Providers are suffering from higher costs and limited access to insurance in some cases.
- Reforms should consider solutions to insurance pricing and availability to even out the “lumpiness” in the insurance market.

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30

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31

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32

BACKGROUND MATERIALS

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Barry R. Furrow, J.D.



REFORMING THE TORT SYSTEM FOR MEDICAL INJURIES

[excerpted from Barry R. Furrow, Thomas L. Greaney, Sandra H. Johnson, Timothy S. Jost, and Robert L. Schwartz, **Health Law: Cases, Materials and Problems** (Appendix B, Teachers Manual, WestGroup 2001)]

Litigation over patient injury caused by health care professionals can be found in early English and American law. The application of a negligence test against physicians can be found as early as 1375, in *Stratton v. Cavendish*, where the King's Bench considered the botched surgery performed by Dr. Swanlon on the hand of the plaintiff. The court compared the surgeon's error to that of a smithy: "If a smith undertakes to cure my horse, and the horse is harmed by his negligence or failure to cure in a reasonable time, it is just that he should be liable". Carleton, *Stratton v. Swanlon: The Fourteenth-Century Ancestor of the Law of Malpractice*, "The Pharos" 20 (Fall 1982). The earliest recorded American case is *Cross v. Guthery*, 1 Am.Dec. 61 (1794) (husband permitted to sue surgeon for damages resulting from an unskillful operation on his wife, causing her death). Malpractice cases are reported in the early 1800s, increasing in number by midcentury. See Kenneth A. DeVille, *Medical Malpractice in Nineteenth-Century America* (1990); White, G., *Tort Law in America: An Intellectual History* (1980).

As medical practice became more dependent upon technologies such as surgery, drugs, and diagnostic tools, litigation began to increase as well. After World War II, as malpractice insurance coverage became increasingly expensive, the frequency of claims against physicians and hospitals came to be viewed as a source of medical cost inflation. In the 1960s the Federal government began to take on responsibility for financing health care through the Medicare and Medicaid programs, and quality of care and cost issues raised by malpractice became national concerns. By the 1970s, malpractice had become a visible problem. The magnitude of the increase in litigation is illustrated by the fact that 80% of the malpractice suits filed between 1935 and 1975 were filed in the last five years of that forty year period.

I. THE SOURCES OF THE MALPRACTICE CRISIS

Malpractice suits require a plaintiff who suffers a medical injury at the hands of a health care provider. Have more patients suffered medical misadventures over the past two decades? In the first detailed look by the federal government at malpractice litigation, the Commission on Medical Malpractice in 1973 speculated as to the causes for the increase in malpractice litigation:

In part, [the increase] was due to the simple fact that many more people were able to afford, and received, medical care, automatically increasing the exposure to incidents that could lead to suits.

At the same time, innovations in medical science increased the complexities of the health care system. Some of the new diagnostic and therapeutic procedures brought with them new risks of injury; as the potency of drugs increased, so did the potential hazards of using them. Few would challenge the value of these advances, but they did

tend to produce a concomitant number of adverse results, sometimes resulting in severe disability.

Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice (1973) at 3.

What was true in 1973 is equally true today. The hazards of health care are substantial. Error rates in medicine are too high compared to other industries, and to what is possible to achieve in reduction of errors. As the Harvard Medical Practice study discovered in surveying medical iatrogenesis in New York hospitals, as many as four percent of hospitalized patients suffer an adverse medical event which results in disability or death. The Harvard Study projected that approximately one percent of all hospital patients suffer injury due to negligently provided care. Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, Exec.Summ. 3-4 (1990). See Chapter 1 *infra*.

The emerging technologies of modern medicine held out the prospects of remarkable new treatments for patients. Have patients caused the malpractice crisis by their very litigiousness, driven by unrealistic expectations as to what physicians can deliver? The 1973 Commission on Medical Malpractice, after describing the forces that led to more patient injury, shifted the blame back to patients:

Lacking an appreciation of the complexities and hazards of modern medical practice, many patients undervalued the inherent risks and assumed negligent conduct when the final outcome was less than had been expected; thus the number of malpractice claims and suits increased.

Id.

Is this a fair assessment? Malpractice suits from this perspective are attributable to a groundswell of consumer assertiveness and insistence on rights, driven by rising and often unrealistic expectations as to entitlements to security and well-being. See also Lawrence Friedman, *Total Justice* (1985). The malpractice crisis is thus related to a "litigious society", with "a flawed system" that promotes litigation. See Derek Bok, "A Flawed System", *Harvard Magazine* 38 (May-June 1983). Juries are often demonized as a major contributor to this crisis: Huber describes juries as "committed to running a generous sort of charity." Peter Huber, *Liability: The Legal Revolution and Its Consequences* 12(1988).

Some observers have noted that criticism of this "litigiousness" is overblown:

Portentous pronouncements [about the litigation explosion] were made by established dignitaries and published in learned journals. Could one imagine public health specialists or poultry breeders conjuring up epidemics and cures with such cavalier disregard for the incompleteness of the data and the untested nature of the theory?

Marc S. Galanter, "Reading the Landscape of Disputes: What We Know and Don't Know (and Think We Know) About Our Allegedly Contentious and Litigious Society", 31 UCLA L.Rev. 4, 70-72 (1983); Michael Saks, In Search of the 'Lawsuit Crisis', 14 Law, Medicine & Health Care 77 (1986); Kenneth Chesebro, Galileo's Retort: Peter Huber's Junk Scholarship, 42 Am. Univ. L. Rev. 1637 (1993).

A. THE NATURE OF THE INSURANCE INDUSTRY

Any serious analysis of the malpractice "crisis" begins with the insurance industry. The increase in the frequency of litigation against health care professionals and institutions coincided in the 1970s with a crisis of malpractice insurance availability. The most visible manifestation of the malpractice crisis in the 1970s and again in the 1980s was increases in premiums for malpractice insurance purchased by health care professionals and institutions. Several insurance carriers dropped out of the malpractice market during the 1970s, while others raised their malpractice premiums precipitously to compensate for investment losses. The insurance market shrank, rates rose, and physicians and hospitals felt the pinch. In the mid-1970s state legislatures passed a first wave of reform legislation, and new insurance entities, such as physician-owned insurance companies, were created. The malpractice problem, as measured by the rate of increase of insurance premiums, seemed to stabilize. Then in the 1980s a new round of premium increases and large visible jury verdicts reignited the debate. Today insurance premiums have stabilized and few complaints are heard from the medical community. Insurance is readily available and price increases have been moderate for several years.

The "malpractice crisis" thus began primarily as an insurance crisis, with a rapid escalation in the costs to physicians and health care providers generally of malpractice insurance.

U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OR SOLUTIONS

66-72 (1986).

Most health care providers buy medical malpractice insurance to protect themselves from medical malpractice claims. Under the insurance contract, the insurance company agrees to accept financial responsibility for payment of any claims up to a specific level of coverage during a fixed period in return for a fee. The insurer investigates the claim and defends the health care provider.

Medical malpractice insurance is sold by several types of insurers—commercial insurance companies, health care provider owned companies, and joint underwriting associations.

In addition, some large hospitals elect to self-insure for medical malpractice losses

rather than purchasing insurance, and a few physicians practice without insurance.

* * *

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. Although created by a number of states as interim measures to help health care providers find sources of malpractice insurance during the mid-1970s, joint underwriting associations continue to be an important source of coverage in some states.

* * *

Malpractice insurance is written as either an occurrence or claims-made policy. Under an occurrence policy, the insurance company is liable for any incidents that occurred during the period the policy was in force, regardless of when the claim may be filed. A claims-made policy provides for coverage for malpractice incidents for which claims are made while the policy is in force. Premiums for claims-made policies are generally lower and increase each year during the initial 5 years of the policy because the risk exposure is lower. However, usually after 5 years, the premiums mature or stabilize. About one-half of total premiums now written for medical malpractice insurance are for claims-made policies.

To cover claims filed after a claims-made policy has expired, health care providers can purchase insurance known as "tail" coverage.

Typically, medical malpractice insurance policies have a dollar limit on the amount that the insurance company will pay on each claim (per occurrence) and a dollar limit for all claims (in aggregate) for the policy period, which is usually 1 year. Insurance companies usually have minimum and maximum levels of coverage they will write which may vary depending on the risk or physician's specialty.

Malpractice insurance coverage may be purchased in layers because many insurance companies have maximum limits of coverage they will write for individual risks. If the health care provider desires additional coverage above the company's maximum limits, additional coverage may be purchased from one or more other insurance companies. The first layer of coverage is commonly known as basic coverage; the liability coverage above the basic level is known as excess coverage. Umbrella policies usually cover in a single policy professional, personal, and premises liability up to a specified limit. Generally, umbrella policies provide coverage when the aggregate limits of underlying policies have been exhausted.

The objective in establishing insurance rates is to develop rates that will be appropriate for the period during which they apply. To be appropriate, the rates must generate funds to cover (1) losses occurring during the period, (2) the administrative costs of running the company, and (3) an amount for unknown contingencies, which may become a profit if not used. The profit may be retained as capital surplus or returned to stockholders as dividends.

Ratemaking attempts to predict future claims and expenses are based on past experience. For two reasons, ratemaking is very complicated. First, circumstances change over time, and many of these changes affect the number (frequency) of claims or the dollar amount (severity) of losses—the two primary factors that affect the cost of insurance. Inflation increases the average severity of claims, and changes in legal theories may increase the frequency and severity of claims. Second, the use of historical statistics to predict future losses is based on the law of large numbers—as the number of insured physicians and hospitals increases, actual losses will approach more closely expected losses. The medical malpractice insurance market is small, thus the statistical base for making estimates of future losses is relatively small. As a result, it is difficult to set accurate premium prices.

The "long tail" of malpractice insurance (the long length of time that may elapse after an injury occurs before a claim is filed and settled) is a further complicating factor because the data base used for estimating future losses may not reflect current actual losses. For example, the St. Paul Fire and Marine Insurance Company's experience indicates that " * * * 30 percent of its claims are filed in the year of treatment, 30 percent in the year after treatment, 25 percent in the third year, 7 percent in the fourth year, and 8 percent in years five through 10."

* * *

Malpractice insurance rates for physicians vary by specialty and geographic location and generally increase proportionate to the amount and complexity of surgery performed. Rates may vary from state to state and within a state. For rating purposes, insurance companies usually group physician specialties into distinct classes. Each class represents a different level of risk for the company.

The number of and composition of rating classes may vary from company to company. For example, the St. Paul Company uses 8 rating classes for physicians, whereas the Medical Liability Mutual Insurance Company of New York uses 14. Rates are typically determined based on the claims experience of the rating class rather than on the experience of the individual physician. Some insurance companies assess a surcharge, in addition to the standard rate, for physicians with an unfavorable malpractice claims experience. Malpractice insurance rates for hospitals are frequently based on the malpractice loss experience (in terms of numbers of claims filed and the amount per paid claim) of the individual hospital. For example, in determining its rates, the St. Paul Company includes a factor to adjust its standard rates for the individual hospital's historical malpractice loss experience.

* * *

Insurance companies are required by state law to establish reserves to cover future losses from claims. Reserves are liabilities based on estimates of future amounts needed to satisfy claims. In addition to amounts covering indemnity payments, the reserves may also include amounts to cover the company's administrative and legal expenses in handling the claims.

Determining proper reserves for medical malpractice claims presents difficulties for insurance companies because such claims may require years to be resolved. Accurate reserves

are difficult to establish because the companies must estimate losses incurred but not reported, losses reported but not paid, and losses partially paid but which continue for several years.

Insurance companies derive investment income from those assets encumbered for loss and loss expense reserves, from unearned premium reserves, and from the company's capital and surplus.

Insurance companies buy reinsurance from other insurers to cover potential losses that may be too large for the individual company to absorb. Reinsurance allows companies to share their risks with other companies and to stabilize insurance losses, which may fluctuate considerably.

Note: Conditions for an Ideal Insurance Market

The market for malpractice insurance fails to satisfy many of the economist's conditions for an ideal insurance market. The ideal market consists of a pooling by the insurer of a large number of homogeneous but independent random events. The auto accident insurance market is perhaps closest to fulfilling this condition. The large numbers of events involved make outcomes for the insurance pool actuarially predictable. Malpractice lacks these desirable qualities of " * * * large numbers, independence, and risk beyond the control of the insured." Patricia Danzon, **Medical Malpractice: Theory, Evidence, and Public Policy** 90 (1985) (hereafter Danzon). The pool of potential policyholders is small, as is the pool of claims, and a few states have most of the claims. The awards vary tremendously, with 50% of the dollars paid out on 3% of the claims. In small insurance programs, a single multimillion dollar claim can have a tremendous effect on total losses and therefore average loss per insured doctor.

Second, losses are not independent, since neither claims against an individual doctor nor against doctors as a group are independent; multiple claims against a doctor relate usually to some characteristic of his practice or his technique, and a lawyer can use knowledge gained in one suit in another. Claims and verdicts against doctors generally reflect social forces—shifts in jury attitudes and legal doctrine. Social and legal attitudes toward medicine recently have been in flux. Given the long tail, or time from medical intervention to the filing of a claim, the impact of these shifts is increased.

Finally, the problems of moral hazard and adverse selection distort the market. Moral hazard characterizes the effect of insurance in reducing an insured's incentives to prevent losses, since he is not financially responsible for losses. Adverse selection occurs when an insurer attracts policy holders of above-average risk, ending up with higher claim costs and lower profits as a result. This may have occurred because a competing insurer has attracted away lower risk policyholders through the use of lower rates and selective underwriting. Danzon at 91.

The malpractice crisis is as much a product of the way the insurance industry does

business as of changes in the frequency of medical malpractice litigation or the severity of judgments. The cyclical nature of interest rates, as a measure of return on investments, plays a central role in insurers' pricing decisions. The insurance industry engages in cash-flow underwriting, in which insurers invest the premiums they collect. When interest rates and investment returns are high, insurance companies accept riskier exposures to acquire more investable premium and loss reserves. The insurance industry managed to be profitable from 1976 to 1984. If underwriting and investment results are combined during this period, investment gains more than offset losses.

The Government Accounting Office concluded of the insurance "crisis" of the early 1980s that "[t]he underwriting losses resulted, in part, from the industry's cash flow underwriting pricing strategy in which companies sacrificed underwriting gains in an attempt to attract more business and thereby enhance investment gains." Government Accounting Office, *Insurance: Profitability of Medical Malpractice and General Liability Lines* (1987). See also Stephen Zukerman, Randall R. Bovbjerg, and Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 *Inquiry* 167, 181 (1990); Frank A. Sloan, Randall R. Bovbjerg and Penny B. Githens, *Insuring Medical Malpractice* 7-10 (1991).

This underwriting strategy creates instability in the market, since losses have to be paid. If interest rates and investment yields drop, insurance companies must raise their premiums and drop some lines of insurance, in order to compete. Hunter and Borzilleri, *The Liability Insurance Crisis*, 22 *Trial* 42, 43 (1986). For other similar critical perspectives, see James R. Posner, *Trends in Medical Malpractice Insurance, 1970-1985*, 49 *Law and Contemp. Problems* 37 (1986) (vice-president of Marsh & McLennan, a large professional liability insurer, on the crisis); Jack Olender, *The Great Insurance Fraud of the '80s*, 8 *The National Law Journal* 15 (July 21, 1986); Hunter, *Taming the Latest Insurance "Crisis"*, *The New York Times*, April 13, 1986, at F3.

B. INSURANCE AVAILABILITY AND COST: SOME EVIDENCE

Malpractice insurance costs are not a major cost for either hospitals or doctors generally; about ½ of one percent of the total American health care bill goes to pay for malpractice insurance. Real premiums rose at about 5% annually between 1974 and 1986, with some evidence of a faster rate of increase after 1980. Since malpractice recoveries are largely used to pay plaintiff medical bills, and since health care cost inflation has exceeded the general rate of inflation, damage awards have grown progressively larger, with corresponding premium increases. In the nineties, however, the rate of increase of insurance premiums has slowed or even declined in some years. See Stephen Zukerman, Randall R. Bovbjerg, and Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 *Inquiry* 167, 178 (1990).

However, for surgical specialties and obstetrics, particularly in five states—California, Florida, Illinois, Michigan, and New York—the problem has been acute. And for young doctors, medical school professors, and physicians with below-average incomes, increases in malpractice premiums can consume a large percentage of gross income. The insurance affordability problem therefore is concentrated in certain areas of medicine. For physicians and hospitals generally, moreover, the shock effect of sudden rapid increases in premium costs has caused a strong reaction by providers. In 1984 such an upward swing occurred, following a four to six year "soft" market. See James R. Posner, Trends in Medical Malpractice Insurance, 1970–1985, 49 *Law & Contemp.Probs.* 37 (1986).

A study of the Florida experience is instructive. Florida is one of the small number of states in which physicians have experienced substantial increases in premiums, as have physicians in Minnesota and adjoining Midwestern states. A study of the Florida malpractice environment, using malpractice closed claims from 1975 to 1986, has provided the best evidence to date as to the causes of malpractice premium increases. See David J. Nye, Donald G. Gifford, Bernard L. Webb, and Marvin A. Dewar, "The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances," 76 *Georgetown L.J.* 1495 (1988).

The Florida study concluded that the primary cause of malpractice premium increases, measured over a nine year period, was the increase in loss payments to claimants. The frequency of claims payments was not primarily responsible for increased claims costs, since the likelihood that a Florida physician would be sued for malpractice has not changed from 1975 to the present. It is rather the "huge increase in the size of claims payments, particularly the increasing frequency of very large payments", that accounted for the total increase in paid losses.

The causes of the increases in claims payments in Florida are not clear. The increases may reflect the belief of defense lawyers and insurance claims managers that their risk at trial would be greater than in 1975. This might be derived from "more serious iatrogenic injuries, a concern that juries are more likely to award larger verdicts and that judges are less likely to control them, a sense that the plaintiffs' trial bar is more able than before, or a concern that the insurer will be held liable under a bad faith claim if it fails to settle within policy limits." *Id.* at 1560.

A study of the Minnesota market, by contrast, found no changes in either the frequency or severity of claims when it examined malpractice insurance over a five year period. 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 compared to 1982. The Minnesota Insurance Commissioner concluded that the insurance companies overestimated exposure of pending claims by two to three times the amount eventually paid.

Other studies of liability insurance generally, not limited to medical malpractice coverage, have concluded that dramatic premium increases have been due to growth in the

discounted value of expected liability losses. Median inflation-adjusted awards in jurisdictions such as California and Illinois appear to have increased substantially over the past three decades. Premiums failed to keep up with losses through 1984, requiring insurers in 1985 and 1986 to impose large premium increases to catch up. See Scott E. Harrington and Robert Litan, *Causes of the Liability Insurance Crisis*, 239 *Science* 737 (1988).

Other variables that affect insurance premiums have been considered by researchers. Zukerman et al, in their study of insurance closed claims, found that:

- * premiums are higher when a population's exposure to iatrogenic injuries increases. A 10% increase in surgery rates increases premiums by 3.8%;
- * as the number of practicing physicians increases, premiums fall. This may be due to quality competition or increased monitoring within the profession; or a higher volume of services that improve quality;
- * higher real income per capita increases premiums, indicating that plaintiffs with higher incomes are better compensated for lost earnings;
- * urbanization is unrelated to premiums (contrary to Danzon's findings), and population mobility lowers premiums, perhaps because it is too difficult to follow through on a claim;
- * the percentage of the population over 65 is strongly correlated to premiums, for no clear reason;
- * more lawyers do not mean higher premiums;
- * premium regulation based on prior approval by the state insurance regulator is associated with lower premiums.

See Zukerman, Randall R. Bovbjerg, and Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 *Inquiry* 167, 180 (1990).

Malpractice insurance rates have stabilized over the past few years, after declining from 5% to 35% around the country by 1990. See Pear, *Insurers Reducing Malpractice Fees for Doctors in U.S.*, *The New York Times* A1, p. 26 (September 23, 1990). Is the crisis over?

II. RESPONSES TO THE CRISIS

The response to the perceived "crisis" in malpractice litigation and insurance availability over the past twenty years has been twofold. First, the availability of insurance has been enhanced by a variety of changes in the structure of the insurance industry. Second, physicians have lobbied with substantial success at the state level for legislation to impede the ability of plaintiffs to bring tort suits and to restrict the size of awards. The effects of these legislative reforms will be considered in Section 2, but criteria for evaluation of reform must first be considered.

A. BENCHMARKS FOR EVALUATING REFORMS

The crisis atmosphere in the 1970s and 1980s led to a variety of legislative acts their proponents hoped would ease the pain of the crisis. Such malpractice reform proposals can be evaluated by three overall standards. First, do the reforms improve the operation of the tort system for compensating victims of medical injuries? Second, will the reforms create incentives for the reduction of medical error and resulting injury to patients? Third, are changes likely to encourage insurers to make malpractice insurance more available and affordable?

The debate over reform of the tort system is reminiscent of the earlier debate over automobile no-fault insurance in the sixties. The goals against which to evaluate reform efforts are similar. An influential report by the Institute of Medicine of the National Academy of Sciences in 1978 proposed six criteria for judging the effect of various reforms on the tort system.

The criteria, which reflect key characteristics of compensation systems and assure that the various proposals are compared according to certain common elements, are:

* *Access to compensation.* This criterion assesses the relative ease or difficulty of entry to a given compensation system as well as the probability of receiving compensation. The voluntary or compulsory nature of a compensation system and incentives for bringing claims are also analyzed.

* *Scope and depth of compensation.* This criterion includes discussion of predictability of receiving compensation, adequacy of the compensation received, and methods used to limit compensation.

* *Procedures for resolving claims.* This criterion is used to review procedures by which a claim is initiated, validated, and ultimately resolved. The procedural aspects of a compensation system are important because of their implications for overall fairness and efficiency.

* *Costs and Financing.* This criterion was included with the intent of comparing costs of each approach. * * * [T]he committee feels this is an essential element in the development of a compensation scheme, given current interest in cost containment. Financing describes allocation of costs attributable to medically related injuries among providers, patients, and society as a whole.

* *Incentives for injury avoidance.* This criterion looks at the capacity of a compensation scheme for reducing the incidence of medical injury. Injury reduction measures may be direct, indirect, or a combination of both.

* *Relationship to other methods of compensation and quality assurance mechanisms.* This criterion assesses whether specific proposals are freestanding or complementary to existing approaches to compensation. The committee considered the impact of compensation systems on other activities in the health sector, such as quality assurance programs and existing reimbursement mechanisms, as part of this criterion.

Institute of Medicine, *Beyond Malpractice: Compensation for Medical Injuries* 29–30 (1978). For a federal study that builds upon the Institute of Medicine report, see U.S. General Accounting Office (GAO), *Medical Malpractice: No Agreement on the Problems or Solutions* (1986). (hereafter GAO Malpractice Report)

Can you think of other goals by which we should test tort reform? Should we rank the goals which the Institute of Medicine proposes in a particular order of priority? If so, what should come first and how do you decide? As you read through these materials, ask yourself if the various reforms are likely to promote or impede particular goals, and at what cost.

B. IMPROVING INSURANCE AVAILABILITY FOR PHYSICIANS

Two major changes, beginning in the mid-70s, have increased the availability of medical malpractice insurance. First, new sources of insurance have been created. Second, the type of policy offered has been changed.

A variety of new sources of insurance have been created, either by the states or by providers. Joint underwriting associations, reinsurance exchanges, hospital self-insurance programs, state funds, and provider owned insurance companies have sprung into being. By the end of 1977, 15 physician-owned insurance companies, most linked to medical societies, covered about 76,000 physicians. By 1984, the number had risen to 30 physician-owned companies writing 50% of malpractice coverage. Hospitals have begun to self-insure. Some states have adopted state programs, such as patient compensation funds, to limit doctor liability to individual patients.

Medical malpractice insurers changed in the late seventies to writing policies on a claims-made rather than an occurrence basis. Before 1975, most policies had been occurrence policies, covering claims made at any time as long as the insured doctor was covered during the time the medical accident giving rise to the claim occurred. The increase in the frequency and severity of claims in the mid-70s revealed the long tail problem of this kind of insurance. Insurers struggled to reliably predict their future losses and set premium prices, and often failed. Most insurers therefore have shifted to a claims-made policy, allowing them to use more recent claims experience to set premium prices and reserve requirements. The claims-made policy covers claims made during the year of the policy coverage, avoiding the predictability problem of the occurrence policy. Such policies arguably have allowed companies to continue to carry malpractice insurance lines, serving the goal of availability by keeping premium costs lower than they would otherwise have been.

Claims-made policies can however create problems for insured physicians, particularly if they are not careful to keep coverage intact when they change policies or employers. See *Langley v. Mutual Fire, Marine, and Inland Insurance Company*, 512 So.2d 752 (S.C.Ala.1987). See generally William L. Hutton, *Physicians' Suits Against Medical Malpractice Insurers: An Analysis of Current Issues in Professional Liability Insurance Litigation*, 11 J.Leg.Med. 225 (1990).

C. ALTERING THE LITIGATION PROCESS

Starting in the 1970s, states enacted tort reform legislation. The preamble to the California Medical Injury Compensation Reform Act is typical of the legislative perceptions of the malpractice crisis:

The Legislature finds and declares that there is a major health care crisis in the State of California attributable to skyrocketing malpractice premium costs and resulting in a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of this state.

Tort reform measures were intended by their proponents to reduce either the frequency of malpractice litigation or the size of the settlement or judgment. The goal was not to improve the lot of the injured patient, but instead to satisfy both the medical profession and the insurance industry.

These measures can be subdivided into four groups:

- those affecting the filing of malpractice claims;
- those limiting the award recoverable by the plaintiff;

—those altering the plaintiff's burden of proof through changes in evidence rules and legal doctrine;

—those changing the role of the courts, usually in the direction of substitution of an alternative forum.

This section will outline the nature of these reforms, characterized by Eleanor Kinney as 'first generation' reforms, and consider briefly some of the judicial responses to challenges brought against these reforms. The chapter will then briefly review 'second generation' reform proposals. See generally Eleanor D. Kinney, Learning from Experience, Malpractice Reforms in the 1990s: Past Disappointments, Future Success?, 20 J. Health Pol. Pol'y & L. 99 (1995)

1. Common Tort Reforms

a. Reducing the Filing of Claims

If the frequency of litigation is lowered, it is reasonable to assume that insurance companies will have to pay out less money, which in turn should lower premiums. Several reforms are intended to either bar certain claims that could previously have been brought, or create disincentives for the bringing of suits.

(1) *Shortened statutes of limitations.* Over forty states have now modified their statutes of limitations, in response to the criticism that long statutes of repose complicate insurance prediction of claims and result in uncertainty in portfolio management. Historically, the time period for a medical injury was tolled, or began to run, when the injury was discovered. This created the "long tail" problem. States have reduced the time period, typically by requiring that claims be brought within a short time, for example within two years of the injury or one year of the time that the injury should have been discovered with due diligence. The "discovery rule" and its problems are discussed in Chapter 2.

(2) *Controlling legal fees.* More than twenty states have regulated attorney fees in a variety of ways, including establishing rigid contingency fee structures or requiring judicial review of the "reasonableness" of the fees. The intended effect of these statutes was to make lawyers more selective in screening out nonmeritorious claims, thus eliminating excessive litigation. Danzon found that contingent fees tend to result in equalizing plaintiff attorney compensation to that of the defense bar (whose income is not controlled), and that controls reduce not only lawyers' income, but also plaintiff compensation. Danzon, *supra* at 198.

(3) *Payment of costs for frivolous claims.* Under such a statute or court rule, a malpractice claimant found to have acted frivolously in suing must reimburse the provider for reasonable legal fees, witness fees, and court costs. See American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the '80's, Report II, American Medical Association, (updated as of July 1985) at p. 23.

b. Limiting the Plaintiff's Award

If the previous reforms aim to cut down on the number of cases in court, the next category of reforms is designed to reduce the overall size of the award.

(1) *Elimination of the ad damnum clause.* This clause, as part of the initial pleading, states the total monetary claim requested by the plaintiff, an amount presumably inflated beyond the level of actual damages suffered. It is feared that such claims expose the defendant to harmful pretrial publicity, damage his reputation, and induce juries to make larger awards than the evidence supports. Thirty-two states have legislated to eliminate the ad damnum clause.

(2) *Periodic Payments.* Provisions, now in effect in 18 states, allow or require a court to convert awards for future losses from a single lump sum payment into periodic payments over the period of the patient's disability or life. Such a mode of payment is intended to eliminate a windfall payment to heirs if the injured party dies.

(3) *Collateral source rule modifications.* The collateral source rule has operated to prevent the trier of fact from learning about other sources of compensation (such as medical insurance) which the plaintiff might possess. The rule arguably permits double recovery. The modifications have either required the court to inform juries about payments from other sources to the patient, or to offset against the award some or all of the amount of payment from other sources. Seventeen states have modified this rule.

(4) *Limits on liability.* The most powerful reform in actually reducing the size of malpractice awards has been a dollar limit, or cap, on awards. Caps may take the form of a limit on the amount of recovery of general damages, typically pain and suffering; or a maximum recoverable per case, including all damages. Indiana has a \$500,000 limit per claim, Nebraska \$1 million, South Dakota a limit of \$500,000 for general damages, California \$250,000 on recovery for noneconomic damages, including pain and suffering.

One interesting reform proposal has been to "schedule" pain and suffering awards, rather than capping them, to narrow the range of variability in jury awards. See Randall R. Bovbjerg, Frank Sloan, and Blumstein, *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 *Northw. Univ. L. Rev.* 908 (1989).

c. Altering the Plaintiff's Burden of Proof

Several reforms have altered evidentiary rules or legal doctrine to increase the plaintiff's burden of proof.

(1) *Res ipsa loquitur.* *Res ipsa loquitur* was judicially expanded during the 1970's by a number of state courts, creating an inference of negligence (or in three states a presumption) even where expert testimony was needed to establish the "obviousness" of the defendant's

negligence. See Chapter 2. Doctors objected that they were forced to shoulder a defense burden for some patient harms that were not the result of their negligence. Ten states now have barred the use of the doctrine or limited its operation.

(2) *Expert witness rules.* As Chapter 2 demonstrates, the plaintiff is normally required to present expert medical testimony as to the standard of care, the defendant's deviation from it, causation, and damages. Some states have now adopted specific requirements that plaintiff experts be qualified in the particular specialty at issue or devote a large percent of their practice to the specialty. The intent of these reforms is to reduce the ability of the plaintiff to use a so-called "hired gun", a forensic doctor who has never practiced, or no longer practices, in the area of the defendant physician.

(3) *Standards of care.* The standard of care has evolved from a locality rule to a national standard in most states, not only as to specialists, but also as to general practitioners. Some states have redefined the standard by statute to specify the particular locality (local, similar, state) that governs the litigation. The purpose of these changes has been fairness to rural practitioners, and again to limit the use of forensic experts from other states.

d. Changing the Judicial Role

The role of the jury as trier of fact has been perceived by critics of the tort system as introducing bias against defendants and causing delay in compensating plaintiffs. Some argue that development of either screening or alternative dispute resolution devices (ADRs) will speed resolution of cases and screen out frivolous claims more effectively than common law litigation. These reforms are important, because they set up a complicated parallel track for disputes which reduces the judicial role.

(1) *Pretrial screening devices.* Twenty-five states have implemented screening panels. These panels are intended to rule on the merits of the case before it can proceed to trial and to speed settlement of cases by pricing them in advance of trial. Screening panel laws vary significantly from state to state, but usually require that all cases be heard by the panel before the plaintiff is entitled to trial. A plaintiff is not prevented from filing suit after a panel's negative finding, but the panel's decision is admissible as evidence at trial. The panels range in size from three to seven members, and often include a judge or a lay person, at least one lawyer, and one or more health care providers from the defendant's specialty or type of institution. The panel conducts an informal hearing in which it hears testimony and reviews evidence. The finding of the panel may cover both liability and the size of the award. For a detailed discussion of such panels, see Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 *Geo. Wash.L.Rev.* 181 (1990).

Proponents have contended that such panels are less formal and less time consuming, and therefore less expensive as a way of resolving claims. Better informed panel members, including health care professionals, may also reach more accurate decisions than a lay jury could. See generally Institute of Medicine, *Beyond Malpractice: Compensation for Medical Injuries*, National Academy of Sciences, 33 (1978); GAO Report at 133; Peter E. Carlin, *Medical Malpractice Pre-trial Screening Panels: A Review of the Evidence*, Intergovernment

Health Policy Project 15 (1980).

The concerns as to the panels are that they will delay dispute resolution, will favor the provider, and will be ignored unless their use is mandatory.

(2) Arbitration. While screening panels supplement jury trials, arbitration is intended to replace them. Thirteen states have laws promoting arbitration of malpractice disputes. The expected advantages of arbitration include diminished complexity in fact-finding, lower cost, fairer results, greater access for smaller claims, and a reduced burden on the courts. See GAO Report at 139-40; American Arbitration Association, *Arbitration—Alternative to Malpractice Suits*, 5 (1975); Irving Ladimer, Joel Solomon, and Michael Mulvihill, *Experience in Medical Malpractice Arbitration*, 2 *J.Legal Med.* 443 (1981). No state requires compulsory arbitration. Like screening panels, the arbitration process uses a panel to resolve the dispute after an informal presentation of evidence. The panel typically consists of a doctor, a lawyer and a layperson or retired judge. The arbitration panel, however, uses members trained in dispute resolution and has the authority to make a final ruling as to both provider liability and damages. The process is initiated only when there is an agreement between the patient and the health care provider to arbitrate any claims.

2. Judicial Responses to Legislative Reform

Reforms have been challenged on a variety of state and federal constitutional bases and under the common law.

a. Equal Protection

Tort reform legislation enacted in the states since the 1970s has generally survived constitutional challenge. The major federal challenges have been based on denial of equal protection and violation of substantive due process guarantees under the 14th Amendment. These challenges have been aimed at state statutes imposing special procedural barriers or damage limitations against medical malpractice claimants, thus singling them out as a class. The courts have generally held that states may discriminate in social and economic matters so long as there is a "rational relationship" between the classification and a permissible state objective. Most state reforms have been held to pass the rational basis test, as they arguably serve the valid state purposes of reducing health and insurance costs and assuring adequate health care delivery. In *Etheridge v. Medical Center Hospitals*, 376 S.E.2d 525 (S.C.Va. 1989), the Virginia Supreme Court upheld the state's \$750,000 cap on malpractice awards. The plaintiff had presented the ideal equitable case for the unfairness of a cap on damage awards. She was a 35-year-old mother of three children, a normal, healthy woman. On May 6, 1980, however, she underwent surgery at the hospital to restore a deteriorating jaw bone. The surgery consisted of the removal of five-inch-long portions of two ribs by Trower, a general surgeon, and the grafting of the reshaped rib bone to Wilson's jaw by an oral surgeon. The jury found that both Trower and the hospital were negligent and that their negligence proximately caused Wilson's injuries. The plaintiff Wilson's injuries were severe and

permanent. She was brain damaged with limited memory and intelligence, paralyzed on her left side, confined to a wheelchair, and unable to care for herself or her children. Trial evidence was that she had expended more than \$300,000 for care and treatment up to the trial and will continue to incur expenses for her care for the rest of her life. Her life expectancy is 39.9 years. She was a licensed practical nurse who had earned almost \$10,000 in 1979, the last full year she worked.

The jury returned a verdict for \$2,750,000 against both defendants. The trial court then applied the recovery limit prescribed by the Virginia cap in Code § 8.01-581.15 and reduced the verdict to \$750,000 and entered judgment in that amount. Plaintiff attacked the validity of this provision on the grounds that it violated the Virginia Constitution's due process guarantee, jury trial guarantee, separation of powers doctrine, prohibitions against special legislation, and equal protection guarantee, as well as certain parallel provisions of the Federal Constitution.

The court noted that the General Assembly passed the Virginia Medical Malpractice Act in large part due to concerns about the "premium cost for, and the availability of, medical malpractice insurance." The legislature had concluded that the increase in the cost of malpractice premiums was causing Virginia physicians to retire early or not enter practice in the state. A crisis of accessibility to health care for the citizens of Virginia was imminent.

The Virginia Supreme Court then applied the rational basis test, holding that " * * * the legislature could have reasonably concluded that the challenged classification would promote a legitimate state purpose. "]

The court continued:

Wilson seeks to "second guess" the General Assembly by claiming that its factual findings do not constitute a reasonable basis for limiting recoverable damages in a medical malpractice action. Wilson also claims that "[e]ven if there were some factual premise for the legislation," it must fail because there is no relationship between the General Assembly's goal and the means it chose to attain the goal. We do not agree.

* * * Code § 8.01-581.15 was enacted only after a thorough study had been made of the problem. The General Assembly made specific findings and a legislative judgment as to how the problem could be best addressed. Bearing in mind that the General Assembly is presumed to have acted within its constitutional powers and according its action the presumption of validity to which it is entitled, we cannot say that the means the General Assembly chose to promote a legitimate state purpose are unreasonable or arbitrary. Accordingly, we hold that the classification does not violate the Equal Protection Clause.

Judge Russell, dissenting, had strong objections to the selective focus of the legislation. He noted:

* * * the unintended consequence of the Act was the creation of a class, described as "health care providers," clothed with a special privilege in the courts. Alone among the multitudes of corporations, associations, groups, and individuals who are daily subjected to tort actions in the courts, the members of this privileged elite (and those who insure them) are granted a special immunity from all damages exceeding \$750,000 (now \$1,000,000). All defendants not falling within the favored class lack that shield and must pay the full amount a jury may decide to award.

The other side of this unhappy equation is that Code § 8.01-581.15 creates a corresponding disfavored class—those who are so unfortunate as to suffer injury as a result of the negligence of a health care provider. Their right to recover damages is limited by the Act while those injured by the torts of accountants, airlines, architects, barbers, bandits, banks, bus drivers, cooks, dog owners, engineers, financial advisors, horse trainers, golfers, hotel keepers, inebriates, jailors, kidnappers, lawyers, etc., retain an unlimited right of redress in the courts. This is precisely the kind of economic favoritism as which the special-laws prohibitions were aimed.

* * *

I have no doubt that the General Assembly has full constitutional authority to limit or restrict all damages, or all unliquidated damages, or all non-economic damages, or all punitive damages, with respect to all plaintiffs and all defendants regardless of their identities. Having determined that a "liability crisis" exists, the legislature may take rational and proper steps to create a remedy, including limitations on "the practice in, and jurisdiction of the courts." But it must do so evenhandedly. The remedy must not depend upon the identity of the defendant.

The familiar figure holding the scales of justice wears a blindfold. She should not be required to peer around it to ascertain whether the defendant is a "health care provider" before deciding what judgment to pronounce. The Virginia Constitution is particularly emphatic in proscribing laws which protect a select group of defendants or which limit the rights of a select group of plaintiffs to obtain redress in the courts of the Commonwealth.

Most state courts that have considered caps have rejected equal protection challenges. See *Davis v. Omitowaju*, 883 F.2d 1155 (3d Cir., 1989); *Fein v. Permanente Medical Group*, 38 Cal.3d 137, 211 Cal.Rptr. 368, 695 P.2d 665 (1985).

A few jurisdictions have held a reform provision unconstitutional on Equal Protection grounds, applying a more rigorous and intense level of scrutiny. In *Austin v. Litvak*, 682 P.2d 41 (Colo.1984), the provision was the three-year statute of repose as it applied to persons whose claims are premised on a negligent misdiagnosis claim. The statute contained two

exceptions to the three-year period of repose. The court held that the exceptions constituted an arbitrary classification. See *Crier v. Whitecloud*, 496 So.2d 305 (La.1986)(upholding state's statute imposing an absolute bar of three years from the date of the alleged act or omission causing injury; *Boucher v. Sayeed*, 459 A.2d 87 (R.I.1983)(rejecting Rhode Island's mediation panel system for medical malpractice cases).

Most state courts that have considered equal protection challenges to malpractice legislation have been deferential to reform legislation, upholding statutes by applying the rational basis test. *Hoffman v. Powell*, 298 S.C. 338, 380 S.E.2d 821 (1989). Others have backed away from earlier statements of intensified review. Compare *Leiker v. Gafford*, 245 Kan. 325, 778 P.2d 823 (1989), with *Farley v. Engelken*, 241 Kan. 663, 740 P.2d 1058 (1987). See generally Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 *Geo.Wash.L.Rev.* 181, 206 (1990).

b. Due Process

Federal constitutional guarantees of due process insure that state action will not deprive a citizen of "life, liberty, or property without due process of law." A cause of action is considered to be property protected by the Due Process clause. See *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 102 S.Ct. 1148, 71 L.Ed.2d 265 (1982) (employee's right to Fair Employment Practice Act's adjudicatory procedures are property protected by the due process clause). See David R. Smith, "Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws", 38 *Okla.L.Rev.* 195 (1985); Martin H. Redish, "Legislative Responses to the Medical Malpractice Insurance Crisis: Constitutional Implications", 55 *Tex.L.Rev.* 759 (1977). Compensation schemes that eliminate or restrict a patient's ability to bring a negligence action can therefore be challenged as a taking of the patient's property—his right to sue—without due process of law.

The North Dakota Supreme Court, in *Arneson v. Olson*, 270 N.W.2d 125, 137 (N.D.1978), found that the state's Medical Malpractice Act violated substantive due process requirements. The cumulative effect of the limitations of the act was to violate patients' rights to due process.

One of the most interesting debates on these constitutional issues is found in *Roa v. Lodi Medical Group*, 37 Cal.3d 920, 211 Cal.Rptr. 77, 695 P.2d 164 (S.C. 1985), where the California Supreme Court upheld a statutory limitation on contingency fees. The dissent's discussion of the empirical complexities of contingency fee limits makes for fascinating reading. Justice Bird in dissent noted that the Medical Injury Compensation Reform Act (MICRA) limits on contingency fees, section 6146) "prohibits severely injured victims of medical negligence from paying the general market rate for legal services, while permitting defendants to pay whatever is necessary to obtain high quality representation."

Section 6146 imposes heavy burdens on the ability of severely injured plaintiffs to obtain adequate legal representation. It sets forth a sliding scale of fee limits—the greater the recovery, the lower the allowable percentage. The effect of this approach is

to impose drastically low limits on fees in precisely those cases which require a large recovery to make the plaintiff economically whole. * * *

Since section 6146 affects only medical malpractice cases, attorneys may avoid these problems by refusing to represent medical malpractice victims. Only those lawyers not sufficiently competent or well-established to attract unrestricted business have any financial incentive to represent a severely injured medical malpractice victim.

One study concluded that attorney fee controls affect severity of claims, but not premiums, a result that is opposite the intended effect.

This suggests that attorneys may be screening out the small cases and concentrating on cases with greater expected payments; that is, the small cases may no longer be worth their effort, because of large fixed costs of investigation and litigation, even though sliding scales allow a higher percentage fee for small recoveries. However, frequency does not show a corresponding decline and no effect on premiums appears. Thus, we would treat conclusions about this reform tentatively.

Zukerman, Randall R. Bovbjerg, and Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 *Inquiry* 167, 180 (1990). Should this finding be relevant to the constitutional issues? If so, how?

c. State Constitutional Provisions

State constitutional law may also be invoked to challenge tort reforms. The right to trial by jury can be asserted to challenge administrative mechanisms that aim to either supplant a jury's resolution of the plaintiff's claims, or to replace the jury completely. Elective arbitration, as in Michigan, substitutes for the common law jury, and screening panels condition the right to a trial upon submission of a claim to the panel. Jury right attacks have generally not been successful where the right to a jury trial was not completely abrogated for malpractice claims. In *Keyes v. Humana Hospital Alaska, Inc.*, 750 P.2d 343 (Alaska 1988), the court held that the panel decision was an expert opinion, to be evaluated by the jury in the same manner it would evaluate any expert's opinion. Accord, *Beatty v. Akron City Hospital*, 424 N.E.2d 586 (Ohio 1981) (jury remains "final arbiter of all the factual issues presented."). But see *Mattos v. Thompson*, 491 Pa. 385, 421 A.2d 190 (1980) (statistical evidence as to delays created by arbitration, held to infringe on the right to a jury).

Caps on damages have also been attacked as violating a plaintiff's right to a jury trial, or as invading the province of the jury as trier of fact. See *Boyd v. Bulala*, 877 F.2d 1191 (4th Cir.1989) (upholding damage cap, the court found that "once the jury has made its findings of fact with respect to damages, it has fulfilled its constitutional function; it may not also mandate compensation as a matter of law."). Contra, see *Sofie v. Fibreboard Corp.*, 771 P.2d 711 (Wash 1989) (Washington's damage cap impermissibly invaded the province of the jury, since jury's role extends to the remedies phase of litigation and a damage cap "adjusts" the jury's award; "pays lip service to the form of the jury but robs the institution of its function." 771 P.2d at 721.) See also *Kansas Malpractice Victims Coalition v. Bell*, 243 Kan.

333, 757 P.2d 251 (1988). The United States Supreme Court seems to interpret the Seventh Amendment differently. See *Tull v. United States*, 481 U.S. 412, 426 n. 9, 107 S.Ct. 1831, 1840 n. 9, 95 L.Ed.2d 365 (1987) ("Nothing in the Amendment's language suggests that the right to a jury trial extends to the remedy phase of a civil trial * * * We have been presented with no evidence that the Framers meant to extend the right to a jury to the remedy phase of a civil trial.")

Any administrative substitute for the tort system that aims to replace the civil system, including the right to a jury trial, must face a more substantial constitutional challenge. State provisions, whether involving compulsory or elective arbitration or mediation, still allow for the jury to ultimately decide the factual questions. When the jury is removed altogether from the process, as in a Worker's Compensation type system, constitutional problems become more severe. Worker's Compensation systems have uniformly been held constitutional as not impermissibly burdening a plaintiff's right to a jury. The arguments for their constitutionality has been that workers impliedly consented to the statutory scheme when they accepted employment; and the system imposes a *quid pro quo*, or tradeoffs on both parties (strict employer liability for exclusivity of the worker's remedy). See, e.g. *New York Central Railroad Co. v. White*, 243 U.S. 188, 37 S.Ct. 247, 61 L.Ed. 667 (1917). Any proposed new administrative system must therefore not favor physicians more than injured patients, and some semblance of implied consent must be found. Some commentators predict that proposals that try to create new administrative schemes replacing the civil system will founder on constitutional issues. See, e.g. Reynolds, Lockwood, Smart, and Schiferi, *A Constitutional Analysis of the American Medical Association's Medical Liability Project Proposal*, 1 *Courts, Health Science and the Law* 58 (1990).

In a few states, plaintiffs have successfully argued that challenged reforms violate the state's "Open Courts" requirement, which provides that citizens have access to the courts in all cases. Thus in *Lucas v. United States*, 757 S.W.2d 687 (Tex.1988) the court held that the Texas cap of \$500,000 on liability violated the Texas constitution. See also *Kenyon v. Hammer*, 688 P.2d 961, 967 (Ariz. 1984).

The constitutional themes that the courts articulate in these cases, evaluating reform schemes that restrict plaintiffs' common law rights, are as follows:

—the legislation fails to provide plaintiffs with a substitute remedy to obtain redress for injuries. The court in *Lucas* noted:

Defendants argue that there is a societal *quid pro quo* in that loss of recovery potential to some malpractice victims is offset by "lower insurance premiums and lower medical care costs for all recipients of medical care." This *quid pro quo* does not extend to the seriously injured medical malpractice victim and does not serve to bring the limited recovery provision within the rationale of the cases upholding the constitutionality of the Workmen's Compensation Act.

- caps are arbitrary, given the differences in injuries among victims;
- the burden of reducing the social costs of high premiums is forced onto only one category of injured parties;
- a special group of defendants is being singled out for special favorable attention.

d. Common Law Arguments

Arbitration systems involve a contract between a provider and the patient, stipulating the method of resolution of the claim for medical injury. In *Engalla v. The Permanente Medical Group, Inc.*, 43 Cal.Rptr.2d 621 (Court of Appeal, First District, Division 2, 1995), the California Court of Appeal considered a broad attack on the arbitration program established by The Permanente Medical Group, Inc., Kaiser Foundation Hospitals, and Kaiser Foundation Health Plan, Inc. for disposing of medical malpractice claims. Wilfredo Engalla, a Kaiser patient, had died of lung cancer in October 1991. The trial court refused to enforce an arbitration provision contained in the Group Medical and Hospital Service Agreement (the Service Agreement) under which Mr. Engalla had health care coverage, holding that Kaiser had engaged in fraud in the inducement of the arbitration provision, by knowingly misrepresenting the speed and efficiency of its arbitration program, and that the collective bargaining agent for Mr. Engalla's employer reasonably relied on those representations in agreeing to accept the arbitration clause in the Service Agreement.

The court noted:

The fact that Kaiser has designed and administers its arbitration program from an adversarial perspective is not disclosed to Health Plan members or subscribers. It is not set forth in the arbitration provision itself, or in any of Kaiser's publications or disclosures about the arbitration program, and it was unknown to Mr. Engalla's employer, who signed the Service Agreement on his behalf. The employer's representative read the provisions of the Service Agreement, and believed that the arbitration process would be equally fair to both the employee-subscriber and to Kaiser, and that it would allow employees to resolve disputes quickly and without undue expense. His expectation in that regard was consistent with the intent of Health Plan's general counsel, Scott Fleming, who originally drafted the arbitration provision, as well as various publications disseminated to Kaiser members. In those materials, Kaiser represented that an arbitration in its program would reach a hearing within several months' time, and that its members would find the arbitration process to be a fair approach to protecting their rights.

[The court then details a long series of delays after the Engallas' lawyer filed a demand for arbitration on May 31, 1991. Mr. Engallas was terminally ill, and timing was critical, but Kaiser delayed appointing the arbitrator, who then turned out not to be available.]

[The court, after a lengthy analysis, found that insufficient evidence was presented as to warrant "revocation" of the agreement to arbitrate; that fraud claims based on the actions of Kaiser in stalling the process must be presented to the arbitrator, but are not enough to set aside the agreement. The court noted that there might be substantial evidence that Kaiser and its counsel exhibited "a cavalier attitude toward time limits," but it is not sufficient to base a claim of fraud upon.]

The expectation has been that arbitration will produce quicker payouts for medical injuries that occur in hospitals, even though the payments will be smaller than a jury verdict is likely to be. In *Engalla*, the court noted that claimants who demand arbitration wait 674 days for the appointment of a neutral arbitrator, and additional delays result after the appointment of the neutral arbitrator. The court referred to a 1989 study that concluded that "it took an average of 863 days (approximately 28.8 months) to reach a final resolution of a claim filed in the Kaiser arbitration system. Although the analogy is far from perfect, Kaiser's track record in arbitration compares unfavorably to the roughly 15 to 19 months it took to litigate an average case from the filing of the at-issue memorandum through trial in Alameda County Superior Court during the 1980s."

Arbitration has many advocates, particularly in the managed care setting. They argue that an express contract to arbitrate all disputes allows the parties to adjust their preferences to their needs, to have a quicker resolution of issues, and to receive compensation more swiftly. Arbitration through contract becomes an extension of the express contracts that already define the provider-HMO-subscriber relationship. See, e.g., Carl M. Stevens, *The Benefits of ADR for Medical Malpractice: Adopting Contract Rather Than Tort Law*, 50 *Disp. Resol. J.* 65 (June 1995); Armand Leone, Jr., *Is ADR the Rx for Malpractice?*, *Dispute Resolution Journal* 7 (September 1994); Carl M. Stevens, *Medical Malpractice: Some Implications of Contract and Arbitration in HMOs*, 59 *Milbank Memorial Fund Quarterly/Health and Society* 1 (1981).

Arbitration also has distinct limitations from a consumer perspective. Lawyers can drive up the costs and length of arbitration to match litigation, as the *Engalla* court suggests. Evidence is also emerging that the "repeat player" phenomenon means a much higher victory rate for employers and other institutional players who regularly engage in arbitration in contrast to one-shot players such as employees or consumers. In employment arbitration cases, one study found that the odds are 5-to-1 against the employee in a repeat-player case. Much of this imbalance may be due to the ability and incentive of repeat players to track the predisposition of arbitrators and bias the selection process in their favor. See Richard C. Reuben, *The Lawyer Turns Peacemaker*, 82 *ABA Journ.* 55, 61 (August 1996).

For discussion of the pros and cons of arbitration in the health care setting, see generally Amy E. Elliott, *Arbitration and Managed Care: Will Consumers Suffer if the Two Are Combined?* 10 *Ohio St. J. on Disp. Resol.* 417 (1995); Alan Bloom et al., *Alternative Dispute Resolution in Health Care*, 16 *Whittier L.Rev.* 61 (1995); Norman P. Jeddelloh, *Use of Arbitration in the Health Care Industry: Non-Labor Matters*, 22 *J. Health & Hosp.L.* 350

(1989); Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, IX Alaska L.Rev. 429 (1992).

e. Encroachment on the Judicial Function

Many of the reform statutes circumvent existing judicial procedures. Screening panels in particular involve a sharing of judicial power with lay decisionmakers. The panels can be viewed either as providing merely an expert assessment of the merits of a case, or as improperly performing quasi-judicial functions vested by the state constitution in the judiciary alone. In *Keyes v. Humana Hospital Alaska, Inc.*, 750 P.2d 343 (Alaska 1988), the petitioner challenged the constitutionality of an Alaska statute that provided for mandatory pre-trial review of medical malpractice claims by an expert advisory panel and made the panel's written report admissible in evidence at trial. She argued that the statute deprived her of due process of law, impaired her right to a jury trial, and violated separation of powers principles by impermissibly delegating judicial power to members of the panel. The Supreme Court of Alaska found the statute to be constitutional, holding that the finding of the panel functioned only as an expert opinion at trial, leaving to the courts the final power to "render and enforce a judgment".

See generally Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 Geo.Wash.L.Rev. 181 (1990). For a heated attack on Arizona's panels, see Roy Spece, "The Case Against (Arizona) Medical Malpractice Panels", 63 Univ.Det.L.Rev. 7 (1985).

III. THE EFFECTS OF REFORM: A PRELIMINARY ASSESSMENT

The Robert Wood Johnson Foundation, the federal government, and others have funded several major studies to determine the effects of reform. The results of these studies are solidifying our understanding of the benefits and the limits of reform.

A. CAPS ON AWARDS AND STATUTES OF LIMITATIONS

Caps on damage awards and reductions in the amount of time the plaintiff has to file suit have proved effective in lowering the amount paid to plaintiffs, by almost 40% according to one study of closed insurance company claims. See Frank Sloan, Paula M. Mergenhagen & Randall R. Bovbjerg, *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 *J. Health Pol., Pol'y., & Law* 663 (1989).

Limits on payments produce savings per claim, which insurers are passing on to physicians through lower premiums. Shortening statutes of limitations also lowers premiums by reducing the number of claims against physicians, although severity of claims is not affected. See Stephen Zukerman, Randall R. Bovbjerg, and Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 *Inquiry* 167, 180 (1990).

B. PRETRIAL SCREENING PANELS

The use of screening panels reduced obstetrics/gynecology premiums by about 7% the year after they were introduced and about 20% in the long run. The study by Zukerman et al. followed up on an earlier study by Sloan, which had evaluated the effect of several reforms on the levels and rates of change in insurance premiums paid from 1974 through 1978 by general practitioners, ophthalmologists, and orthopedic surgeons. Frank Sloan, *State Responses to the Malpractice Insurance 'Crisis' of the 1970's: An Empirical Assessment*, 9 *J. Health Pol., Pol'y., & Law* 629 (1985). Sloan concluded that only screening panels displayed a statistically significant connection to lower malpractice insurance premiums.

A 1988 study of Maryland arbitration panels concluded that the panel system had reduced the number of claims requiring formal adjudication in the courts and decreased the average length of time for resolution. They also were more likely to find in favor of claimants. See Laura L. Morlock and Faye E. Malitz, *Nonbinding Arbitration of Medical Malpractice Claims: A Decade of Experience with Pretrial Screening Panels in Maryland* (1988); Thurston, *Medical Malpractice Dispute Resolution in Maryland*, 1 *Courts, Health Science & The Law* 81 (1990).

Several earlier studies had looked at panels or arbitration. A 1980 study of screening panels concluded that the panels were effective in disposing of claims before trial, resulting in a significant percentage of claims being dropped or settled after a panel hearing, from a high of 88% of claims disposed of after a panel decision in New Jersey to a low of 38% disposed of

in /Virginia. Carlin, *Medical Malpractice Pre-Trial Screening Panels: A Review of the Evidence*, 29, 31 (1980). The very threat of a panel hearing seemed to promote early disposition of claims in some states. The panels in some states also processed claims more quickly than conventional litigation. However, some states were having problems that impaired panel operation. In particular, panels were rarely used where their use was voluntary. Carlin at 32, 37, 39.

A study by the Florida Medical Association in 1985 found that the results of panels were mixed, with some states using panels effectively and others experiencing case backlogs and administrative problems. The authors concluded that panel effectiveness was unproven, and that other court efforts such as a special malpractice court, or other procedural reforms, might be more effective. Florida Medical Association, *Medical Malpractice Policy Guidebook* 188 (1985). Studies by several states of the performance of their panels have not been encouraging. New Jersey and New York both recommended that a mandatory screening approach be dropped in favor of some form of voluntary system, such as optional mediation. See *Perna v. Pirozzi*, 92 N.J. 446, 457-59, 457 A.2d 431, 437 (1983) (presenting findings of a committee appointed by the New Jersey Supreme Court to evaluate New Jersey's panel system); see also *Ad Hoc Committee on Medical Malpractice Panels*, described in Bower, *Malpractice Panels and Questions of Fact*, 14 *Trial L.Q.* 4 (1982). An Arizona study found several problems with the Arizona panels, concluding that (1) settlements increased and claims filed decreased between 1976 and 1978 (the good news); but (the bad news) (2) neither the frequency or level of recovery by claimants was affected; (3) the time to process the malpractice case was lengthened by the panel system; (4) the panel system aggravated problems of difficulty and expense in handling cases, from the lawyers' and panel members' perspectives; (5) the panel hearings took longer than expected. See National Center for State Courts, *Medical Liability Review Panels in Arizona: An Evaluation* (1980); Roy G. Spece, *The Case Against (Arizona) Medical Malpractice Panels*, 63 *U.Det.L.Rev.* 7 (1985).

C. OTHER REFORM MEASURES

Earlier studies had evaluated the effects of the reforms of the mid-1970's and 80's. One study looked at the effect of post-1975 reforms on the frequency of claims per capita, the amount per claim paid, and the claim cost per capita, using data from closed claims from 1975 to 1978 by all insurers writing malpractice premiums of a million dollars or more in any year since 1970. Patricia Danzon, *The Frequency and Severity of Medical Malpractice Claims* (1982). Its conclusions were:

—states with caps on awards had awards 19% lower two years after the effective date of the statutes;

—states with contingency fee limits had a somewhat lower amount paid per claim and total claim cost;

—states eliminating the ad damnum had lower total claim costs; there was otherwise no effect on the frequency or amount paid per claim;

—states requiring collateral source offset had 50% lower awards two years after the statute's effective date, but states admitting evidence of collateral sources without required offset displayed no significant effect;

—several reforms displayed no significant effects, including pretrial screening panels, arbitration, res ipsa loquitur or informed consent limitations, and periodic payments.

Another study by Patricia Danzon updated her earlier studies, based upon analysis of claims nationally over the decade 1975 to 1984, for 49 states in some years, based on data from insurance companies that insured approximately 100,000 physicians. Patricia Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 *Law & Contemp.Probs.* 57 (1986). Her conclusions are:

—the severity of claims rose twice as fast as the Consumer Price Index, a fact related to the fact that health care prices rose faster than consumer prices generally;

—claim severity continues to be higher in urbanized states, consistent with earlier studies, and is also higher in states "with a high ratio of surgical specialists relative to medical specialists," *id* at 76;

—severity is less in states with larger elderly populations, a fact related to the low wage loss of the elderly and the low potential for damages in a tort suit;

—no correlation was found between the number of lawyers per capita and claim severity;

—the newer data was consistent with earlier findings as to the impact of tort reforms. Statutory caps reduced average severity by 23%. Collateral source offsets appeared to reduce awards by a range of 11 to 18%. Arbitration reduced claim severity by 20%, compared to states without such statutory arbitration. Screening panels did not have a consistent effect in reducing claims severity.

What do these widely varying, and often conflicting, results mean for the future of reform of the tort system? The results reflect to some extent the limits of the studies and the relative novelty of the reforms such as panels or arbitration at the time studied. Time will tell whether procedural reforms, requiring an elaborate administrative structure, will mature and prove effective. But any ultimate conclusions as to the merits and nature of reform still depend upon the goals sought for the system. Some of the reforms, such as caps and collateral source offset, appear to have slowed the growth of awards in some states. Some reforms, such as statutes of repose, reduce claims filings over the longer term. The claims-made insurance policy and mutual insurance companies may also be a more efficient way of allocating risk and protecting insurance availability.

The reforms of the tort system were enacted with the expectation that liability insurance premiums could be lowered, or at least stabilized, by a reduction in the frequency of malpractice suits and the severity of awards in such suits. It has proved difficult to assess the impact of the reforms. The GAO Report of 1985 surveyed six interest groups as to the effect of existing reforms. No consensus was found in their results, although a majority of providers felt that caps had a major impact on the severity of judgments, and a majority of consumers felt that screening panels had a major impact on decreasing the time to close claims. GAO Malpractice Reports, *supra*.

An assessment of reforms of the tort system and the insurance mechanism leaves the same question: is the conventional, fault-based litigation system worth keeping for medical accidents? In the next section, several proposals are presented as potential candidates to replace the current system.

IV. ALTERNATIVE APPROACHES TO COMPENSATION OF PATIENT INJURY

Several reform proposals would substitute an alternative compensation system for the present tort system. The automobile accident debate of the sixties first focused attention on the problems of common law litigation—the costs of fact finding; the delays involved in court proceedings; unevenness in payments, whereby small claims are overpaid and large claims underpaid; the insufficiency of awards getting to plaintiffs after legal fees and administrative costs. To these criticisms, the malpractice crisis has added the psychological costs imposed on physicians by being sued and the alleged added social and economic costs of defensive medicine. See Peter A. Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 *Syracuse L.Rev.* 939 (1984).

A. THE RATIONALE FOR AN ALTERNATIVE SYSTEM

The American Medical Association and other groups argue that the existing tort system is flawed and an alternative approach would better serve both patients and physicians. Their criticisms are as follows.

Criticism 1. The Tort System Fails to Compensate Injured Patients.

The critics observe that too few malpractice suits are brought, for reasons that include the costs of bringing lower dollar amount claims, the lack of return for the plaintiff lawyer on small cases, and a lack of awareness on the part of many injured patients that they even had a potential claim for malpractice. Patients with small claims rarely sue, so that a substantial number of potential claims are never brought into the civil justice system. The current system therefore compensates far fewer patients than actually suffer injury, at least in the hospital setting. The Harvard Medical Practice Study concluded as follows:

We estimated that the incidence of malpractice claims filed by patients for the study year was between 2,967 and 3,888. Using these figures, together with the projected statewide number of injuries from medical negligence during the same period, we estimated that eight times as many patients suffered an injury from negligence as filed a malpractice claim in New York State. About 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system.

Report of the Harvard Medical Practice Study to the State of New York (1990), *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*. One investigator concluded, based on a match between hospital files and litigated actions, that fewer than 2% of negligent adverse events, or less than 1 in fifty, resulted in claims, since many claims filed reflect cases where researchers found no negligent adverse event. See Troyen A. Brennan, *An Empirical Analysis of Accidents and Accident Law: The Case of Medical Malpractice Law*, 36 *St. Louis U.L.J.* 823, 847 (1992).

An alternative system might well improve the ability of plaintiffs to sue, and thereby extend compensation to more injured patients. The problem is the current lack of political will to enact such complex reforms. The current system at least functions adequately for larger claims, and any alternative system promising expanded compensation is going to be resisted by both the insurance industry and health care providers.

Criticism 2. The Tort System Sends an Inaccurate Deterrence Signal.

Critics argue that physicians are haphazardly exposed to litigation, regardless of their practice or skill. Physicians believe that claim filings and jury awards bear little relationship to physician negligence. Since jury awards cast a long shadow over the settlement process, irrational jury awards dilute or cancel any deterrent effect of successful plaintiff suits. If jury awards are largely random, then why should providers reform their practices?

This criticism is overstated. Malpractice suits are not simply random events that unfairly single out physicians. The authors of a study of closed claims for anesthesia-related injuries concluded that payment was made in more than 80% of the claims in which patients were judged to have received substandard anesthetic care. But payment was also made in more than 40% of the claims when the anesthesia care was judged to be appropriate. The authors concluded that the tort system has a high probability of awarding injuries caused by substandard care (true positives), but also compensates claims that physician reviewers would describe as undeserving (false positives). See Frederick Cheney, Karen Posner, Robert A. Caplan, and Richard J. Ward, *Standard of Care and Anesthesia Liability*, 261 JAMA 1599 (1989). This false positive rate may well be a cost of a functioning compensation system, however. The burden of persuasion in a jury trial is not the same as the burden imposed by a physician reviewer examining insurance closed claims. It is arguable that the tort system intentionally tolerates a higher level of false positives than would physician reviewers, in order to insure that the true positives are more often awarded. See Frank Sloan and Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 Law & Soc'y Rev. 997 (1990).

The AMA and other critics also attack the jury system as irrational and biased, the primary source of whatever irrationality and randomness the system produces in its verdict distribution. The evidence is to the contrary. Most scholars of the jury system have concluded that it is reasonably competent at assessing liability.

...juries do not favor claimants over doctors and do not make negligence judgments based on the depth of defendants' pockets or the severity of patients' injuries. In fact, their verdicts are remarkably consistent with doctors' ratings of negligence. There is even some evidence to suggest that far from holding prejudice against doctors and health care providers juries display a tilt slightly in favor of them.

Neil Vidmar, *Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets, and Outrageous Damage Awards* 265 (1995).

Obstetrics has been one of the hardest hit medical specialties, experiencing a high level of claims and high severity of awards. Obstetrics practice is thus a good test of the hypothesis that juries give large awards based primarily on the sympathy they feel for brain-damaged babies and their families. One study of jury decisions in obstetric/gynecological cases concluded that (1) juries can distinguish clear violations of a standard of care, (2) they will find for the defendant readily in the absence of such a clear violation, and (3) they will find for the plaintiffs in cases where an older technology, such as the use of oxytocin to speed delivery, is abused in the face of clear limitations and contraindications. Stephen Daniels and Lori Andrews, *The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases*, in Institute of Medicine, *Medical Professional Liability and the Delivery of Obstetrical Care: An Interdisciplinary Review* (Vol. II) 161, 191 (1989). The evidence therefore suggests that the jury based fact finding process, while not optimal, is neither arbitrary nor unfair. See also Frank Sloan, et al., *Medical Malpractice Experience of Physicians: Predictable or Haphazard?* 262 J.A.M.A. 3291 (1989).

Tort litigation clearly has a substantial psychological impact on physicians in excess of the diluted financial incentives created. See generally Peter A. Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 Syracuse L.Rev. 939 (1984). For a general discussion of the deterrent value of malpractice suits, see Randall R. Bovbjerg, *Medical Malpractice on Trial: Quality of Care is the Important Standard*, 49 Law & Contemp.Probs. 321 (1986).

The standard critique also points to defensive medical practices as an overreaction to the fear of liability, and as an inflationary force in health care. The evidence for a high degree of defensive medical practices is equivocal at best. The strongest influence on physician use of medical resources is clinical information and how it is processed. While physicians express concern about liability, they choose treatments and tests based on other factors than fear of suit. See generally David Klingman et al., *Measuring Defensive Medicine Using Clinical Scenario Surveys*, 21 J.Health Pol., Pol'cy & Law 185 (1996); Peter A. Glassman et al., *Physicians' Personal Malpractice Experiences Are Not Related to Defensive Clinical Practices*, 21 J.Health Pol., Pol'cy & Law 219 (1996); *The Use of Low-Osmolar Contrast Agents: Technological Change and Defensive Medicine*, 21 J.Health Pol., Pol'cy & Law 243 (1996).

Is the deterrent value of the tort system worth its costs? Consider the comments of Patricia Danzon in her book **Medical Malpractice: Theory, Practice, and Public Policy** 225-227 (1985):

* * * [T]he fault-based system is worth retaining if the benefits, in terms of injuries deterred, exceed the costs of litigating over fault and other associated costs, such as defensive medicine. * * * [W]e can make a very rough calculation of the benefits, in terms of injury reduction, that would be required to offset the additional costs of operating the tort system, rather than simply compensating victims through first-party insurance and forgoing all aim at deterrence. * * * if the tort system deters at least one injury of comparable severity for every injury currently compensated, the

deterrence benefits outweigh the additional costs of the liability system.

We do not know how many injuries are actually deterred, but we can estimate the percentage reduction in the rate of negligent injury that is required. Using the 1974 estimate that 1 in 10 incidents of negligence leads to a claim and 1 in 25 receives compensation, only a 4 percent reduction in the rate of negligent injury is required to justify the costs of the tort system. If the rate of compensation per negligent injury is currently, say, twice as high as it was in 1974, then an 8 percent reduction in the rate of negligent injury would be required. Similarly, if the tort system entails significant costs other than the litigation costs considered so far—such as defensive medicine, public costs of operating the courts, time and psychic costs of litigation to patients and providers—then the deterrence benefits would have to be higher. On the other hand, to the extent that the compensation received by victims through tort understates their willingness to pay for injury prevention, the deterrence necessary to justify the system is less.

This rough calculation suggests that if the number of negligent injuries is, generously, 20 percent lower than it otherwise would be because of the incentives for care created by the malpractice system, the system is worth retaining, despite its costs. Danzon at 225–227.

In other words, despite its flaws, the current tort system may well serve its deterrent function well. But the evidence is not yet available to confirm this.

Criticism 3. The Administrative and Social Costs of the Malpractice System are too High

Another common criticism is that the tort system imposes excessive costs on physicians and their insurance companies, with too little of the malpractice premium dollar going to the plaintiff in a malpractice suit. The critics correctly observe that the portion of the health insurance premium dollar that goes to a claimant is much higher than the amount returned by the tort system. A study of medical accidents in the United States and Canada offered a ringing critique of the current system :

* * * tort compensation for medical injuries is doctrinally inappropriate, procedurally inefficient, and distributively unjust. Available benefits are often excessive, but very few victims are eligible to recover at all. When it is paid, malpractice compensation is slow, insufficient, and costly to administer. Finally, the manner in which malpractice insurance is generally financed achieves a regressive transfer of resources.

Optimal compensation should reflect a patient's hypothetical decision about the purchase of insurance. But when one considers its regressivity, overhead costs, benefit structure, individualized method of claims assessment, delays in payment, settlement incentives, maldistribution, and highly restricted criteria of eligibility, it is evident that no rational consumer would voluntarily purchase the insurance that is implicitly offered through the civil liability system.

Don Dewees, David Duff, and Michael Trebilcock, **Exploring the Domain of Accident Law: Taking the Facts Seriously** 117 (1996).

Frank Sloan et al. respond to this criticism:

An insured seeks out a high-return policy for first-party coverage; the insured's own money is returned to him under circumstances specified by contract. The insured's "entitlement" to payment and the aggregate amounts of payment are relatively clear cut. In contrast, liability insurance defends the insured against claims of negligence (mainly) and also pays compensation to third parties not involved in the insurance contract. Major inquiry by claims adjustors and possibly also by courts and lawyers must individually determine whether payment is due, and, if so, how much. Damages are multifaceted, often with uncertain prospects of future loss. A tort law and insurance system may cost "too much" for the benefits achieved, but they are very different benefits from those of health insurance, so simple comparisons do not advance thoughtful policy. Perhaps provider negligence is dealt with more efficiently and more fairly under a third-party system.

See Frank Sloan, Paula M. Mergenhagen & Randall R. Bovbjerg, *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 *J. Health Pol., Pol'y., & Law* 663, 680 (1989). For an argument that the tort system works well as an insurance mechanism, giving people what they want, see Steven P. Croley and Jon D. Hanson, *The Nonpecuniary Costs of Accidents: Pain- and-Suffering Damages in Tort Law*, 108 *Harvard L. Rev.* 1785, 1897 (1995).

Various reforms of the tort system, discussed *infra*, might well improve the payout to a claimant and reduce administrative costs. An administrative system modelled on workers compensation would be more efficient. The tradeoff with such systems is the loss of deterrence effect as the system moves toward compensation and downplays the search for medical error. See generally Paul Weiler et al., **A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation** 149-51 (1993).

Criticism 4. Patient Access to Health Care has been Impaired by Rising Malpractice Insurance Costs and by Physicians' Fears of Suits

Rising malpractice exposure, particularly in obstetrics, has allegedly driven physicians from practice, leaving many rural areas in particular without obstetricians. Rising premium costs have cut deeply into obstetric income, causing physicians to alter their practice patterns. It is claimed that access to care has suffered, with the malpractice system the culprit. Some states such as Virginia have enacted special legislation just to "solve" the "obstetrics" problem, primarily created by a threat by insurers to leave the state and thereby leave obstetricians without any coverage for malpractice.

Income trends suggest that obstetrician-gynecologists as a group have maintained their

real net income during the past two decades. Institute of Medicine, **Medical Professional Liability and the Delivery of Obstetrical Care: An Interdisciplinary Review** (Vol. I) 105 (1989) (hereafter IOM Study I). Although premium costs between 1982 and 1986 grew by 171%, the average net income of obstetrician-gynecologists grew by 21%. This may mean that these specialists are offering more services, and charging more, since professional liability premium expenses are a higher proportion of expenses for obstetricians than for other specialties, and the percentage is rising. *Id.* at 106–107.

Rural areas have been unattractive locations for physicians for a long time, for reasons related more to the amenities of daily life and the need for professional colleagues than malpractice insurance cost and availability. However, the insurance premium costs for family physicians and nurse-midwives have been excessive in relation to their income, and disproportionate to their actual likelihood of being sued. Both availability of coverage and high cost has limited the availability of obstetrical care by nurse-midwives. See IOM Study I at 51. A survey of maternity care centers concluded that the access problem for low-income women is created by unconscionable practices by malpractice insurers. Insurers have imposed "astronomical rates" on physicians and midwives, rates that bear no relation to claims profiles. Dana Hughes et al., *Obstetrical Care for Low-Income Women: The Effects of Medical Malpractice on Community Health Centers* 59, 74 in Institute of Medicine, **Medical Professional Liability and the Delivery of Obstetrical Care: An Interdisciplinary Review** (Vol. II) 74 (1989).

In summary, the tort system for medical accidents is surprisingly accurate in ascertaining negligent physician conduct; provides compensation for more serious injuries but not for smaller ones; and makes a delicate tradeoff between an effective level of deterrence of future provider error and levels of compensation. Access to care appears to be a special case limited primarily to obstetric care, with its risk of high dollar claims for brain damaged infants. While the system is far from perfect, the issue is always whether an alternative system will function any better, or instead trade off too much deterrence for more compensation, administrative savings for accurate fact finding. In any case, the political will to enact a new system is lacking at present in American politics, given stability in malpractice insurance premiums and provider awareness that they win many of the cases that are filed. Neither insurers nor providers are likely to be willing to face an uncertain new system that may end up costing more and exposing them to more claims.

B. NO-FAULT REFORMS

Second generation reform proposals aim to eliminate or reduce some of these perceived flaws of the current system, without impairing consumer access to compensation. Such proposals can be categorized in light of several central attributes. The following article offers a framework for thinking about such reforms.

ABRAHAM, MEDICAL LIABILITY REFORM: A CONCEPTUAL FRAMEWORK

260 Journal of the American Medical Association 68-72 (1988).

Medical liability reform is essentially an exercise in choosing variables from a series of categories representing the different components of the system. The variables chosen then can be assembled into a single package that modifies existing law. There are five categories from which these variables must be selected: (1) the compensable event, (2) the measure of compensation, (3) the payment mechanism, (4) the forum used to resolve disputes, and (5) the method of implementing the new rights and responsibilities. Traditional medical malpractice law is just one of many possible combinations of variables from each category. Virtually every proposed and adopted reform of medical liability is simply a different combination of these variables. Because each of the five categories contains several variables, the range of reform alternatives is considerable.

The Compensable Event

The compensable event is the combination of medical treatment and resulting injury or disease that triggers a patient's right to compensation. The event may be based on malpractice, on the occurrence of a treatment-related injury even in the absence of malpractice, or on the occurrence of a defined loss regardless of whether it is related to malpractice or treatment. For convenience, I refer to these three different triggers as *fault*, *cause*, and *loss*.

Fault

A medical injury caused by malpractice is the compensable event embodied in traditional medical liability law. * * * [I]n theory, malpractice is defined as the failure to conform to an accepted medical standard of performance, although in practice there is often doubt that the jury is capable of understanding and applying such standards. * * *

Cause

Instead of basing the right to compensation on the occurrence of a malpractice-related injury or disease, that right could be triggered whenever the patient suffers an iatrogenic injury or disease or some defined subset of these adverse outcomes. * * * By encompassing a range of compensable injuries far broader than those caused only by malpractice, this approach removes any fault inquiry from the compensation decision.

There are two other important implications, however, entailed in the cause-based approach to compensation. First, because iatrogenic injury is a far more inclusive notion than malpractice-related injury, cause-based compensation may radically expand the number of persons entitled to compensation. For example, one study estimated that only 17% of the potentially compensable events that occur in hospitals result in tort compensation. A system that compensated close to 100% of these injuries would either raise the overall cost of providing compensation or require a reduction in the amount of compensation payable to any given patient.

Also, it is by no means clear that a cause-based standard can be easily applied in practice. Determining what "caused" a patient's injury or disease accounts for a considerable portion of the litigation costs of the current system. * * *

Loss

An even more broadly applicable set of compensable events can be defined by reference to specified losses without regard to cause. This is the method adopted by health and disability insurance whether it is publicly or privately financed. * * *

At present, a loss-based system of compensation composed of health and disability insurance operates parallel to malpractice liability. * * * The loss-based system could be relied on more heavily or exclusively, however, if liability for malpractice were limited or abolished. This could be accomplished either by requiring the universal purchase or provision of private health and disability insurance or through expansion of the governmentally provided forms of social insurance for medical expenses. * * *

The Measure of Compensation

The second important feature of any approach to medical liability is the measure of compensation available to those who suffer compensable events. * * *

Full Tort Damages

A successful plaintiff in any tort liability suit, including those for medical malpractice, is entitled to recover compensation for all losses proximately caused by the defendant's actions. These losses normally include medical expenses and lost wages together with a sum that may vary a great deal from case to case to compensate for the conscious pain and suffering associated with these other losses. * * *

Full Out-of-pocket Losses

An alternative measure of compensation would award no sum for pain and suffering but full compensation for actual expenses incurred in connection with the compensable event. * * *

Partial Out-of-pocket Losses

Most non-tort systems of compensation do not award even full out-of-pocket losses. Rather, they tend to contain copayment provisions—floors in the form of deductibles, ceilings on amounts payable, and coinsurance requirements. * * *

"Scheduled" Damages for Specified Losses

The administrative expense of making individualized loss determinations is a cost of any of the measures of compensation discussed so far. In cause- and loss-based systems this expense is likely to be small, because payments normally are limited to objectively determinable expenses. When the losses in question are subjective, however—damages for pain and suffering payable in the tort system, for example—the cost of determining the extent of a plaintiff's loss can be high. Moreover, jury awards for similar losses are likely to vary considerably precisely because of the subjectivity of both the suffering and each jury's valuation of it.

An alternative to complete denial of compensation for such subjective losses—whether in tort suits or under other approaches—would be to award payments in a way that makes no effort to individualize. This is the compromise struck in workers' compensation, in which there is no explicit award for pain and suffering, but scheduled sums above out-of-pocket losses often are awarded. * * *

In a sense, the legislative ceilings on pain and suffering damages adopted in a number of states in the past several years are a crude example of this approach. * * *

Periodic Payment of Losses

Cutting across the preceding variables is the distinction between lump-sum and periodic payment of losses. Medical liability awards generally are paid in a lump sum to compensate for actual past and estimated future losses. * * * Such awards might of course be calculated only at the time of the trial and then be paid periodically as annuities, but they might also be recalculated periodically to avoid overpayment or underpayment. Many cause- and loss-based systems adopt this latter approach, incurring extra administrative costs to achieve greater accuracy and avoid making windfall payments. * * *

Limits on Counsel Fees

The typical medical malpractice plaintiff pays his or her attorney a percentage of any amount recovered. Since recoveries for pain and suffering are generally understood to help finance such payment, placing limits on counsel fees that can be charged plaintiffs is an indirect method of reducing the measure of compensation. * * *

The Payment Mechanism

There are three basic approaches to the payment of compensation for injury and disease and a fourth variation that is largely a hybrid. The payment mechanism adopted depends on the party or parties selected to bear "liability" under the system in force—health care providers,

patients, the government, or some combination of the three.

Third-Party Insurance

Third-party insurance is an appropriate financing mechanism when a party other than the patient is responsible for paying compensation. Thus, third-party insurance is the payment mechanism used preponderantly to pay medical malpractice judgments. Third-party insurance could also be used to finance payment under cause-based systems such as medical no-fault. * * *

First-Party and Social Insurance

In contrast, first-party and social insurance are used to finance the payment of compensation under loss-based approaches. Both these forms of insurance, however, could also be used to finance payment under cause-based systems of compensation. Under first-party insurance, patients would purchase coverage before treatment, with premiums roughly calibrated to the probability that the patient (or patients in the same risk class) would suffer a compensable iatrogenic injury. * * *

The Patient Compensation Fund

In some states, ceilings on the amounts for which health care providers are liable in malpractice suits have been adopted, but without restricting the amounts that can be paid to the successful plaintiff. This apparent anomaly is resolved by the creation of a state-operated "Patient Compensation Fund" that is responsible for the portion of any award above the ceiling. Such funds need not be limited to awards above the ceiling, however; they can be employed to finance sums awarded under any of the systems explored so far. Moreover, the method of creating and replenishing the fund might also vary, including assessments against health care providers alone, assessments against patients alone, general revenue, or some combination of these sources. * * *

The Forum for Resolution of Disputes

The next feature of any approach to liability/compensation issues is the forum that resolves disputes over the rights of patients and providers. This is an important issue, for the identity and qualifications of the decision maker can dramatically influence both the outcome of the dispute and the parties' attitude toward the decision.

Trial by Jury

The chief characteristic of the American jury system that impinges on the medical liability problem is the use of lay jurors. Several consequences follow from this practice. One is potential inconsistency. * * * Moreover, partly because jurors are lay people and partly for reasons of history, trials by jury are highly formal. Rules of evidence apply, information is produced mainly through questions by counsel, and jurors may not question the parties or witnesses. * * * Finally, because of the medical complexity of the issues, because of the need

to educate the jury from scratch about both the facts and these medical issues, and because of the formal procedure of the trial itself, the typical medical malpractice case is preceded by years of pretrial information gathering or "discovery". * * *

The great advantage of this approach is its political legitimacy. For the most part, trial by jury in civil cases is constitutionally required at both the state and federal levels. Jury trials are accepted by the public as an important protection for the powerless as well as a means by which decisions about legal rights may be made without relying on an entrenched bureaucracy or on rule by a class of experts. In addition, the right to bring a lawsuit before a lay jury may satisfy the primitive impulse for vindication in a way that should not be overlooked. * * *

Expert Review Panels

One variation on pure trial by jury that would retain the jury is to provide an impartial expert assessment of the technical issues to the parties before the trial and to the jury during the trial. Such an assessment might encourage settlement or guide the jury if a settlement does not occur. The panel may consist exclusively of medical experts (a medical review board) or include legal or lay members as well (a screening panel). Unfortunately, experience in many states over the past decade with different versions of the expert review panel suggests that this device has minimal if any impact on rates of settlement or results at trial.

Bench Trial

This is simply a trial without a jury—that is, a trial before a judge alone. The principal difference between this approach and the use of a jury is that bench trials provide less opportunity for emotionalism and can proceed with somewhat less formality. * * *

Binding Arbitration

Under binding arbitration, an arbitrator or arbitrators chosen by the parties hear a presentation of the claim and the provider's response to it and decide the case. The recent proposal of the American Medical Association Specialty Society Medical Liability Project for fault-based arbitration is a version of this approach. Normally, the arbitrator has some expertise in the subject area of the case, and his or her decision can be appealed to a court only if there is a failure to follow the terms of the arbitration agreement. Because of the arbitrator's expertise, the proceeding can be streamlined and can be shorter than a trial by jury or a bench trial, and it is much less likely to involve emotionalism than trial by jury. * * *

Administrative Panels

Once the requirement of malpractice is eliminated as a feature of the compensable event, there is little need to use any of the above devices to determine whether that event has occurred. Typically, a cause-based system financed by health care providers would use an administrative system of compensation under which a board either in permanent existence or specially convened would determine whether the patient had suffered a compensable event and the amount of the losses suffered. * * *

Insurance Company Determination

In contrast, a cause- or loss-based system based on first-party insurance would not even require administrative panels. Health, life, or disability insurers would simply determine whether the insured compensable event had occurred and award the compensation required by the insurance policy embodying its contract with the claimant. * * *

The Method of Implementation

The last determination that must be made in fashioning medical liability reform is how to implement the reformed system. There are two basic approaches: legislation and contract.

Legislation

One legislative alternative would be simply to prescribe a new mandatory system that would replace the current malpractice liability approach. By statute, a new set of variables would be adopted, and patients and health care providers would be required to act accordingly. On the other hand, legislation implementing the new system need not be mandatory; instead, it might be "elective" in one or more ways, specifically authorizing patients and health care providers to fashion their own legal relationship. Such an approach would of course require detailed description of the contract options available and the options (if any) foreclosed.

* * *

Categories and Choices of Reform Alternatives

Compensable Event	Measure of Compensation	Payment Mechanism	Forum for Resolution of Disputes	Method of Implementation
Fault Cause Loss	Full tort damages Full out-of-pocket losses Partial out-of-pocket losses Scheduled damages Lump-sum payment Periodic payment	First-party insurance Third-party insurance Taxation Hybrid Funding	Jury trial Expert review panels Bench trial Binding arbitration Administrative boards Insurance company decision	Legislation Mandatory reform Elective options Private contract

Private Contract

The nonlegislative method of implementing reform is for patients and health care providers to fashion their own legal relationship by contract. Under this approach, they might adopt any combination of variables that would constitute their legal rights and responsibilities.

The great advantage of this approach, of course, is that it would allow the parties freedom of choice. There are two disadvantages, however, that might be difficult to overcome: (1) It is doubtful that the courts would approve such a contractual approach in the absence of prior legislative authorization, at least in cases in which a patient's legal rights seemed to be limited rather than expanded. (2) The pure contract approach requires the agreement of both parties; in contrast, a legislatively authorized optional system could permit the replacement of malpractice liability at the election of only one of the parties in cases in which this seems desirable. * * *

The Variables Combined: A Full Range of Reforms

A full range of reform alternatives can be created by combining the variables chosen from all five of the categories discussed into systems that could replace current medical liability law. The choices available are reflected in the Table. * * *

* * *

In sum, the possibilities for medical liability reform are no longer limited to tinkering with tort law by altering a few technical legal doctrines governing litigation. There is more to potential reform than merely making lawsuits more accurate, predictable, or cost efficient. Retaining the basic model of adversarial litigation is by no means the only available approach. A whole range of alternatives has developed, providing the reformer with a series of choices that must be made on the way to reform. No combination of reforms is without its problems, but no effort to adopt the most appropriate system of liability and compensation should ignore the variety of options that are available to deal with the concerns raised by the critics of reform.

C. Second-Generation Reforms

Second-generation reforms are designed to alter central attributes of the tort system to improve both accuracy in factfinding and compensation of malpractice claims, without reducing either the severity or the frequency of claims filed. The two most popular proposals, as measured by Congressional bills and academic writing, are mandated alternative dispute resolution (ADR) and mandated medical practice guidelines. No-fault systems have been tried for certain classes of injuries in two states and enterprise liability has been proposed by the American Law Institute.

1. Medical Practice Guidelines as the Standard of Care

Medical practice guidelines can be treated as the standard of care. The guidelines could be given a negligence per se effect, or at least treated as a rebuttable presumption that could then be countered with evidence. The American Medical Association (AMA) has opposed direct adoption of practice guidelines as a legal standard, urging instead that they be offered only as evidence of the customarily observed professional standard of practice and that their degree of authority depend on the degree of their acceptance among medical practitioners. Why would the AMA object to the use of guidelines as a presumptive standard of care?

Such guidelines provide a particularized source of standards against which to judge the conduct of the defendant physician. A widely accepted clinical standard may be presumptive evidence of due care, but expert testimony will still be required to introduce the standard and establish its sources and its relevancy. See generally Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform*, 5 *Health Matrix* 369 (1995); Institute of Medicine, *Clinical Practice Guidelines: Directions For A New Program* 8 (Marilyn J. Field & Kathleen N. Lohr eds., 1990). See generally Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform*, 5 *Health Matrix* 369 (1995); Institute of Medicine, *Clinical Practice Guidelines: Directions For A New Program* 8 (Marilyn J. Field & Kathleen N. Lohr eds., 1990).

2. *Alternative Dispute Resolution (ADR)*

Mandatory alternative dispute resolution has been proposed as an alternative to the tort system. See *Engalla*, supra. The ADR decision is comparable to a jury verdict and could be overturned only if corruption, fraud, or undue influence is shown or new evidence unavailable at the ADR proceeding is presented. Judicial review of ADR decisions would be similar to review of adjudications by administrative agencies, limited to questions of whether the decision is sufficiently supported by the evidence or otherwise is in accord with the law. See Thomas Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 *Alaska Law Review* 429 (1992); Simpson, D., *Compulsory Arbitration: An Instrument of Medical Malpractice Reform and a Step towards Reduced Health Care Costs?* 17 *Seton Hall Legislative Journal* 457 (1993); U.S. Congress, Office of Technology Assessment, *Impact of Medical Malpractice Tort Reform on Malpractice Costs* (1993).

3. No-Fault Systems

a. The Virginia Experience

The State of Virginia has led the states in implementing a no-fault system for obstetric mishaps. Effective January 1, 1988, the state enacted the "Birth-Related Neurological Injury Compensation Act", creating a compensation fund for neurologically damaged newborns. Virginia Code Ann. §§38.2-5000 to -5021 (1990 and Supp.1989); *King v. Virginia Birth-Related Neurological Injury Compensation Program*, 242 Virginia 404, 410 S.E.2d 656 (1991). The critical definition for compensation purposes in the Virginia statute is "[b]irth-related neurological injury". This is defined as "injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living. This definition shall apply to live births only."

A claim under this Act excludes all other tort remedies, with the exception of a suit "against a physician or a hospital where there is clear and convincing evidence that such physician or hospital intentionally or willfully caused or intended to cause a birth-related neurological injury, provided that such suit is filed prior to and in lieu of payment of an award under this chapter."

Compensation under the statute is for "net economic loss" only, including medical expenses, rehabilitation expenses, residential and custodial care and service, special equipment or facilities, and related travel. Loss of wages from age eighteen (50% of the average weekly wage in Virginia), and reasonable expenses and attorneys' fees incurred are also included. Compensation for non-economic loss, "pain and suffering", is disallowed, as are expenses covered by insurance.

The Industrial Commission of Virginia, the state's worker's compensation commission, handles the claims filed. The Commission will decide whether the claimed injury falls within the definition of a birth-related neurological injury, aided by an expert panel of three impartial physicians. This panel will operate according to guidelines developed by the deans of the state's medical schools. A hearing must be held within 120 days of the date of filing. One member of the expert physician panel must be available to testify at this hearing.

Each claim filed under this program will also be referred automatically to the state Board of Medicine for evaluation to decide whether the injury resulted from substandard care.

Physicians licensed to practice medicine in Virginia who practice obstetrics or perform obstetrics either full- or part-time, including family physicians, may, but are not required to, participate in the program. Participating physicians must agree in advance with the state Board of Medicine to submit to a review of their obstetric practice in the case of a finding of

substandard care. They must also certify to the Commissioner of Health that they will participate in the development of a program to provide maternity care to Medicaid and other low-income patients.

Participating obstetrician-gynecologists and family physicians will be required to pay \$5,000 into the compensation fund annually, while all other physicians in the state will be required to pay \$250 per year into the fund. Hospital participation is also voluntary. Participating hospitals will be required to pay \$50 per delivery per year into the fund, with an absolute cap of \$150,000 per hospital per year. Participating hospitals are also to assist in the development of a state-sponsored maternity care program for low-income women.

Both the Virginia \$750,000 cap on damages (see *Etheridge*, supra) and the Birth-Related Neurological Injury Compensation Act were responses to the availability of malpractice insurance in the state. In 1986, both St. Paul and Virginia Insurance Reciprocal had declared a moratoria on new obstetric coverage, and PHICO had terminated coverage for all physicians in groups of less than 10. Enactment of the Act in particular led to expansion of malpractice coverage by a new carrier, and the offering of larger policies by another.

It was predicted that the eligibility provisions for brain damage would apply to approximately forty live births in the state each year. In fact, only a handful of claims have qualified each year under the statute, and no claim has been filed. The definition is so narrow that only the most severe injuries are covered, and most of those eligible die as infants.

See generally James Henderson, *The Virginia Birth-Related Injury Compensation Act: Limited No-Fault Statutes as Solutions to the "Medical Malpractice Crisis"*, Institute of Medicine, *Medical Professional Liability and the Delivery of Obstetrical Care: An Interdisciplinary Review* (Vol. II) (1989); David G. Duff, *Compensation for Neurologically Impaired Infants: Medical No-Fault In Virginia*, 27 *Harv.J.Legis.* 391 (1990). For criticisms of the Virginia system, see Richard A. Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, in Institute of Medicine, *Medical Professional Liability and the Delivery of Obstetrical Care: An Interdisciplinary Review* (Vol. II), 115 (1989). Florida also adopted a no-fault system. See Florida State. Ann. §408.02 (West 1993 and Supp.1994); Florida Stat. Ann. §§766.301 to .316 (West 1986 and West Supp.1993); *Coy v. Florida Birth- Related Neurological Injury Compensation Plan*, 595 So.2d 943 (Florida 1992).

b. Medical Adversity Insurance

Medical adversity insurance, first proposed by Clark Havighurst and Lawrence Tancredi, is a system whereby a patient experiencing a medical outcome which is on a list of avoidable outcomes would be automatically compensated for certain expenses and losses, and foreclosed from any other recovery for those outcomes. Litigation or arbitration could be pursued for outcomes not covered by the policy.

The lists of adverse outcomes would be developed by panels of doctors, lawyers, and consumers. These outcomes would be clearly described to reduce the potential for claims disputes. The panels would also establish the amounts of compensation for lost wages. Pain and suffering awards could vary based on the temporary or permanent nature of the injury. Panels would periodically review covered outcomes and compensation in order to make adjustments reflecting changes in medical practice and costs.

When the adverse outcome first occurred, the patient or provider would file the claim with the insurer, who would decide whether the injury was covered. If so, it would make prompt payment. Disputes would be resolved through the courts or arbitration.

The plan as proposed would experience rate insurance premiums paid by providers, in order to create incentives for the providers to improve the quality of care, thereby reducing their exposure for the adverse outcomes listed. Provider experience under the plan would also be used to strengthen peer review within hospitals.

The original Havighurst-Tancredi proposal assumed that legislation would be needed to effectuate the plan. More recently, Havighurst has suggested that private contracts rather than legislation should be used. Under the contractual approach, providers would voluntarily contract with insurers to cover certain outcomes, which would then be paid on a no-fault basis. Patients would also contract with the providers to accept those amounts listed in the policy. This would allow more flexibility, with variations possible in both covered events and compensation amounts among providers. Noncovered injuries could be handled through the courts or arbitration.

See Clark Havighurst and Laurence Tancredi, "Medical Adversity Insurance"--A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 *Milbank Memorial Fund Quarterly* 125 (1973) Clark Havighurst, "Medical Adversity Insurance--Has Its Time Come?", 1975 *Duke L.J.* 1254; Laurence Tancredi, Designing a No-Fault Alternative, 49 *Law & Contemp. Probs.* 277 (1986).

A newer version of the Tancredi concept is called "accelerated-compensation events" (ACEs). The central idea, as with medical adversity insurance, is that lists of medically caused injuries should be drawn up, covering those injuries that should not normally occur and are avoidable if good care is given. These lists are based on professionally selected classes of bad outcomes that medical professionals consider avoidable on a probabilistic basis. See Lawrence Tancredi and Randall R. Bovbjerg, *Creating a Selective No-Fault System to Replace*

Malpractice: Methodology of Accelerated-Compensation Events (ACEs), University of Texas Health Science Center Paper (Houston Texas, 1990).

A variation on the Tancredi proposals is provided by Professor O'Connell, who has proposed a variety of elective no-fault options using a list of covered injuries and contract agreements between providers and patients. See Jeffrey O'Connell, No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage, 24 Emory L.J. 35 (1975); Jeffrey O'Connell, Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives, 49 Law & Contemp.Probs. 125 (1986); O'Connell, Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses, 77 Nw.U.L.Rev. 589 (1982); Institute of Medicine Report at 43.

c. Offers to Pay Patient Losses

A medical offer proposal has circulated in Congress since the early 1970s, resurfacing in a variety of legislative proposals. The GAO Malpractice Report summarized the content of the legislation as follows:

The proposal is considered a quasi-no-fault plan because, under the plan, health care providers can selectively decide to foreclose a patient's right to sue the provider for damages from medical malpractice. Under the proposal, health care providers within a designated period of time (180 days from an occurrence) can offer to pay a patient's net economic losses arising from medical injuries and, by tendering the offer, foreclose the patient's right to sue the provider for medical malpractice *except* for cases in which the provider intentionally caused the injury or a wrongful death occurred. Under the proposal, the health care provider and his or her insurer could choose which cases would be in the provider's interest to tender an offer.

Only the patient's economic losses, above amounts paid by other sources such as private health insurance, from the injury would be paid under the proposal. Economic losses include medical expenses, rehabilitation and training expenses, work losses, and replacement services losses. Reasonable attorney's fees to collect benefits would also be allowed. No compensation would be available for any noneconomic losses from the injury, such as pain, suffering, mental anguish, or loss of consortium.

* * * [T]he vast majority of payments would be made to patients as the losses are incurred rather than in lump sum. Patients would submit reasonable proof of net economic losses incurred to the health care provider's insurer, which would be required to make payments within 30 days. Payments would be available as long as the patient's injury continues. However, future payments for the injury would not be available if no payments have been made within the last 5 years. Provisions also allow the health care provider or his insurer to require the injured party to submit to a mental or physical examination if the injured party's mental or physical condition is material and relevant

to compensation benefits.

The proposal requires that any lump-sum settlement over \$5,000 be reviewed by the court to ensure that it is fair to the injured party.

In cases where the health care provider does not make an offer, the patient can request within 90 days that the claim be resolved by binding arbitration. Recovery from arbitration would be limited to the patient's net economic losses and reasonable attorney fees.

To participate in the program, health care providers would be required to carry sufficient malpractice insurance or post sufficient bond. This provision is designed to protect patients from providers unable to pay compensation.

The concept of the offer of compromise has also shown up in more recent legislative proposals as an option on a menu of choices to be offered the states for adoption. Senator Orrin Hatch sponsored S. 489, entitled Ensuring Access Through Medical Liability Reform Act of 1991. S. 489 contains mandatory provisions and elective provisions. One of the elective provisions is an Early Offer and Recovery Mechanism, pursuant to which hospitals and physicians could avoid lawsuits by offering to compensate injured patients for economic losses, with disputes concerning the amount of the loss to be resolved by arbitration.

One of the primary goals in a no-fault system is to reduce the cost of insurance to providers. Measured by this goal, a proposal like the Medical Offer and Recovery Act may fail. The California study in the 1970s estimated that a no-fault system in California could increase malpractice premiums 300% higher than the tort system's insurance costs. California Medical and Hospital Associations, Report on the Medical Insurance Feasibility Study (1977). A critique of the Harvard New York study likewise concluded that the costs of a no-fault system could be greater than the present tort system, when the costs of many more claims and system administrative costs are combined. See Mehlman, Saying "No" to No-Fault: What the Harvard Malpractice Study Means for Medical Malpractice Reform (New York State Bar Association 1990).

From the insurance industry perspective, these proposals are worrisome, since there seems to be far more malpractice in the world than is ever detected or litigated. A no-fault system may set off an avalanche of litigation. For an account of such fears, see the comments of the Jerry Engelerter, government affairs officer for St. Paul's insurance, in Kleinfield, The Malpractice Crunch at St. Paul, The New York Times, Sunday, February 24, 1985 at p. 4F.

If a compensation system rewards many more claimants, particularly small ones, in an evenhanded and more rapid fashion than does the current tort system, it may well be an improvement. But it is unlikely to be a cheaper system. This suggests that we move directly to a social insurance scheme that moves financing out of the private insurance market and into the taxation structure of the government.

For the academic origins of many of these proposals, see generally Jeffrey O'Connell, *Offers that Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 Nw. Univ. L. R. 589(1982); Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives, 49 *Law and Contemporary Problems* 125 (1986).

D. Enterprise Liability

President Clinton's original health reform proposal in 1993 made enterprise liability the cornerstone of malpractice reform. See Health Security Act, s. 1775, 103rd Cong., 1st Sess., Nov. 22, 1993, s. 1400 (hereafter "Health Security Act"). The original proposal called for the Health Plans to bear all liability for medical malpractice. After opposition arose from organized medicine, however, the proposal was downgraded to a demonstration project in the Act. Enterprise liability continues, however, to be a favorite of tort reformers. Current tort reform efforts in Congress have focused on product liability rules, especially punitive damage awards, while malpractice reform has slipped out of the spotlight. At the moment, it is unclear that any major legislation will emerge from Congress addressing professional liability issues.

Enterprise liability, also referred to as "organizational liability" by the American Law Institute, changes the locus of liability for patient injuries without other significant alterations to the rules of proof and damages. The idea is not new; developments in vicarious liability and corporate negligence have moved the locus of much medical liability from independent contractor physicians to the hospital. See generally George Priest, *The Invention of Enterprise Liability: A Critical History of the Intellectual Foundations of Modern Tort Law*, 14 *J.Leg.Stud.* 461 (1985). This proposal, as articulated by the American Law Institute, would make a hospital liable for physician negligence that injures patients within the hospital:

...we would exculpate doctors from personal liability for negligence (and thus eliminate their need to purchase insurance against such liability), on the condition that the hospital assume such liability and provide the insurance, a change that would leave untouched the patient's present entitlement to recover for injuries caused by the doctor's negligence.

The American Law Institute, *Reporters' Study, Enterprise Responsibility for Personal Injury*, Vol.II: Approaches to Legal and Institutional Change (April 15, 1991) 115 (hereafter ALI Study).

Such channeling of liability to the hospital is justified by several arguments. First, insurers would have an improved ability to price insurance, since difficulties in pricing for individual physicians in high-risk specialties will be eliminated; in most other areas of tort law, from environmental to products risks, business enterprises bear the cost of insuring against liability. Second, by eliminating the insurance problems inherent in the fragmented malpractice market, specialties such as obstetrics would no longer face onerous burdens, nor

will physicians have to face premiums that fluctuate excessively from year to year. Third, physicians would be freed from the psychological stress inflicted by being named defendants in malpractice suits. Fourth, administrative and litigation costs would be reduced by having only one defendant, rather than the multiplicity of providers named in the typical malpractice suit. Fifth, and most important, patterns of poor medical practice would be deterred by placing liability on institutions rather than individuals, since organizations have superior data collecting abilities and management tools for managing risks. See William M. Sage and James M. Jorling, *A World that Won't Stand Still: Enterprise Liability By Private Contract*, 43 DePaul L. Rev. 1007 (1994); Lewis A. Kornhauser, *An Economic Analysis of the Choice Between Enterprise and Personal Liability for Accidents*, 70 Cal.L.Rev. 1345 (1982).

The critique of such enterprise liability begins with its impact on the autonomy of physicians. Physicians fear that such liability will force them from the status of autonomous practitioners into the status of employees for large health care institutions, with attendant loss of power. The ALI proposal acknowledges that enterprise liability will treat physicians as staff physicians in managed care settings. But such forces are already in operation, as evidenced by the rapid growth of managed care organizations, the purchase of group medical practices by hospitals, and other forces that have reduced the autonomy of physicians.

The issue for health care reform in the next decade will be how to implement such a liability approach in a changing health care environment where care is as likely to be delivered through loose networks of providers as through hospitals. The benefits of deterrence and risk management may be elusive if enterprise liability is applied to broad regional health authorities or other networks that lack the centralizing powers of individual hospitals. Enterprise liability may also increase compensation costs due to the increased volume of claims filed. The California study in the 1970s estimated that a no-fault system in California could increase malpractice premiums 300% higher than the tort system's insurance costs. California Medical and Hospital Associations, *Report on the Medical Insurance Feasibility Study* (1977). A critique of the Harvard New York study likewise concluded that the costs of a no-fault system could be greater than the present tort system, when the costs of many more claims and system administrative costs are combined. See Maxwell Mehlman, *Saying "No" to No-Fault: What the Harvard Malpractice Study Means for Medical Malpractice Reform* (New York State Bar Association 1990).

From the insurance industry perspective, these proposals are worrisome, since there seems to be far more malpractice in the world than is ever detected or litigated. A no-fault system may set off an avalanche of litigation, depending upon the design of the system, methods of discussing misadventures to the injured patient, and other structural issues, as yet unresolved. Patients are also more likely to sue their HMO or Health Alliance than their personal physician.

If a compensation system rewards many more claimants, particularly small ones, in a more evenhanded and rapid fashion than does the current tort system, it will be an improvement even if it is not cheaper. See generally Paul C. Weiler et al., *A Measure of*

Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation (1993) for an excellent economic discussion of the costs of a no-fault system to replace medical malpractice litigation. Weiler et al estimate that a no-fault scheme would cost somewhat more than liability under the current system, but argue that "...a reasonably comprehensive patient compensation scheme--which would fully reimburse all actual longer-term financial losses that patients suffer as a result of iatrogenic injury--would be a small and readily affordable item in the budget of the health care system that generates these injuries..." Id at 109.

See Kenneth S. Abraham and Paul C. Weiler, Enterprise Liability and the Evolution of the American Health-Care System, 108 Harv. L.Rev. 381(1994); Barry R. Furrow, Enterprise Liability, 39 St. Louis L. Rev. 79(1995); Paul C. Weiler, The Case for No-Fault Medical Liability, 52 Md.L.Rev 908 (1993); Paul C. Weiler, Medical Malpractice on Trial (1991).

The only Federal no-fault program now in operation covering a health care related injury is the National Childhood Vaccine Injury Act of 1986, effective in 1988. It covers solely those individuals injured or killed by vaccines. The program requires a petition to the U.S. Claims Court and an adjudication by that court. The petitioner must elect to accept or reject the judgment of the court. Acceptance bars any tort suit against the manufacturer. The federal government will pay compensation to those who develop specified symptoms or reactions to a vaccine within specified periods of time and suffer a vaccine-related injury that lasts for at least six months. See 42 U.S.C.A. § 300aa-1 et seq., Pub.L. 99-660, tit. III, § 311(a), 100 Stat. 3756 (Nov. 14, 1986). For an account of the program and its current operation by a Special Master who handles petitions filed under the Act, see Denis J. Hauptly and Mary Mason, The National Childhood Vaccine Injury Act: The Federal No-Fault Compensation Program That Gives a Booster for Tort Reform, 37 Fed.Bar News & J. 452 (1990). See also Jenelle C. Prins-Stairs, The National Childhood Vaccine Injury Act of 1986: Can Congressional Intent Survive Judicial Sympathy for the Injured?, 10 J.Leg.Med. 703 (1989); Lenchek, "A Shot in the Arm: The National Childhood Vaccine Injury Act of 1986," 3 The Washington Lawyer 24 (1989).

E. SOCIAL INSURANCE

The last set of proposals draws upon the experience of the United States with the Worker's Compensation System, and that of other countries with pervasive social welfare systems. Such a major reform would achieve the advantages of the other three proposals, plus the advantage of a pure insurance system funded out of general tax revenues.

The common characteristics of such systems, as summarized by the GAO, are:

- * Programs are established on the premise that society is better able to bear the cost of adverse outcomes than the injured party.
- * Compensation is usually predetermined and limited in amount and duration.
- * Benefits are scheduled, that is, a standard formula is applied to the same types of injuries.
- * An administering agency processes and validates claims and makes payment of the benefits.
- * Determination of fault is usually irrelevant.
- * Compensation is essentially automatic for covered losses.
- * General tax revenues would fund a "pure" social insurance system.

New Zealand's Accident Compensation Act, effective in 1974, removed all damage claims for accidental injuries from the tort system. All New Zealand residents are covered at all times. The compensation available includes payment for loss of earnings (80% of average weekly earnings at the time of the accident, with a limit of about \$340 U.S. dollars per week); reasonable costs of medical treatment; lump sums for permanent disability and pain and suffering and payments to a dependent spouse (with limits on the lump sums), payment to dependents for loss of support, and a variety of other expenses. The Accident Compensation Corporation administers the program. An injured person must file a claim with the Corporation, which then decides whether the claim is covered and if so, how much should be paid. The decision can be appealed to the courts. Forty percent of the claims for medical injury are denied, and awards are generally processed promptly.

Under the New Zealand system, providers help patients to collect compensation. They have an incentive to help their patients qualify for compensation under the no-fault system to avoid direct liability. Forty percent of the claims for medical injury were denied, and awards were generally processed promptly. This scheme was criticized for its lack of deterrence of medical malpractice and its failure to distinguish among classes of victims.

The New Zealand system has now been substantially limited as to benefits paid to accident victims, as the result of a change in government and its response to rapidly escalating payout costs. The new Act, in effect in 1992, creates a Medical Misadventure Account to finance benefits to victims of malpractice. Accident Rehabilitation and Compensation Insurance Act 1992, No. 13. Unlike the previous Act, which lumped accident victims together, this new Account creates a means of finance of compensation by premiums paid by certified health professionals. Experience rating is also applied to health professionals. The Act appears to resurrect the malpractice suit. Under the 1972 Act, the claimant had to establish "medical, surgical, dental, or first aid misadventure", 1982 Act, § 2(1), 1982 N.Z.Stat. 1560; the new Act now requires that claimants establish "medical error", which requires proof of negligence. In the 1992 Act, § 5(10)(a): medical error is defined as "the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances." The burden on the claimant has thereby been increased, while the deterrent effect of the new Act is also enhanced by the introduction of experience rating.

See Accident Compensation Corporation, *Accident Compensation Coverage—The Administration of the Accident Compensation Act 9* (7th Ed.1983); GAO *Malpractice Report* at 155; Walter Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.)*, 73 *Cornell L.Rev.* 170 (1988). For a critique of the new Act, see Richard S. Miller, *An Analysis and Critique of the 1992 Changes to New Zealand's Accident Compensation Scheme*, 52 *Maryland L.Rev.* 1070 (1993).

The Swedes and the Finns have also created a self-contained, separate patient compensation scheme. See Marilyn Rosenthal, *Dealing with Medical Malpractice: The British and Swedish Experience* (1988); Oldertz, *The Swedish Patient Insurance System—Eight Years of Experience*, 52 *Med.-Legal J.* 43 (1983); Timothy S. Jost, *Quality Assurance in Medical Practice: An International Comparative Study* (1990); Braham, *No-fault Compensation Finnish Style*, *Lancet* 733 (Sept. 24, 1988)

F. Conclusion.

First generation reforms are now in place in most states. Second generation reforms, ranging from enterprise liability to contractual arbitration models, are far less likely to be adopted by either Congress or the states. As Kinney writes:

Without a strong consumer push for second-generation reforms, their widespread adoption is unlikely. Consumer-oriented tort reform in other fields of tort has always had a strong consumer constituency to mobilize pressure for reform.... If past experience with workers' compensation and no-fault automobile liability schemes is a precedent, an active consumer constituency independent of the trial bar would be needed to effect innovative second-generation reform, such as a no-fault approach, at either the state or federal level.

An additional and important constituency for malpractice reform are third-party payers who see defensive medicine as a major cause of health care cost inflation. Indeed, the more policy makers agree with this premise, the greater their interest in malpractice reform as a cost-containment measure. ...

A political basis for second-generation reform in either states or Congress does not exist. Clearly the political power of the medical profession and liability insurers is great as well as focused. On the other hand, the organized power of consumers is diffuse and not focused on malpractice. The only focused advocate for the consumer in the malpractice debate is the trial bar, and it has much at stake in maintaining the common law tort system without reforms. Finally, the third constituency of third-party payers, which cuts across party lines, is interested in the issue only as it affects health system costs. ... There is simply too much focused opposition to and no political constituency for other second-generation reforms in the current debate over health system reform.

Eleanor D. Kinney, *Learning from Experience, Malpractice Reforms in the 1990s: Past Disappointments, Future Success?* 20 *J. Health Pol. Pol'y & L.* 99, 124-25 (1995).



OVERHEADS

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Edward A. Dauer, LL.B, M.P.H.



Legal Responses to Medical Malpractice

2003 Florida Health Care Summit
January 9, 2003

Edward A. Dauer LL.B, M.P.H.
University of Denver

Lessons from the past:

Legislation during two
earlier rounds of tort
reform:

What worked to lower
insurance losses? What
didn't?

Note: Insurance losses
and premium prices are
not necessarily the same.

Framing the problem:

What is malpractice law
for? Compensation?
Deterrence? "Patient
Safety"?

Other Current Proposals:

Enterprise Liability

Updated "No-Fault"

Alternative Dispute
Resolution ("ADR")

Shifted Focus: From Crisis to Concern

The liability insurance “crises” of 1974 and 1985:

Problems: geographical distortions,
defensive medicine, healthcare costs.

The “Patient Safety” focus of 1995 to today:

Problems: medical error, rational
compensation and effective policing of
provider competence.

Dauer

3

Insurance-Premium Crises: Responses and Effects

Legislative responses to the '74 and '85 rounds:

Damage caps

“Collateral Source” offsets

Periodic payments

Shortened limitation periods

Pre-filing screening panels

Mandatory “ADR” (arbitration, mediation)

Others – attorney fees, cost-shifting, etc.

Dauer

4

Miscellaneous Initiatives

State-run insurance pools (IN)
Ease of entry for joint underwriting
associations (CO)
Limited no-fault systems (VA and FL)
“Practice parameters” (MN and ME)
Standards of care and rules of evidence

And the effects?

Dauer

5

Here we are again

The Office of Technology Assessment “meta-
study” of Legislative Reforms and Effects

A caveat: insurance *losses* vs. insurance *pricing*.

As to insurance losses / payments:

Damage caps (esp. noneconomic)

Collateral source rule change

And *none* of the others.

Source: U.S Office of Technology Assessment 1993, and others.

Dauer

6

As to insurance premium pricing:

Caps on damage awards

Restrictions on joint-and-several liability

Shortened statute of limitations

Maybe screening panels

However, a methodological caveat – premium pricing is a complex multifactor variable.

Today's question: More "reform"? Or a different approach?

Dauer

7

Reassessing Liability – Contemporary Approaches

Conventional Assignments:
Compensation and Deterrence

Compensation

Inefficient (72% system load)

Over- and under-inclusive

Inequities in award distribution

Not responsive to patient need

Sources: Harvard Medical Practice Study (1989), Brennan (1996); Hickson (1994); Conrad (1998)

Dauer

8

Deterrence

Best evidence: on the margin, no consequence.

Adverse effects of liability risk.

Impedes “systems” approach

Distorts risk management

May affect clinical competence

Sources: Weiler (1993); Dauer (1997); Charles (1988); Passineau (1998)

Dauer

9

Contemporary Ideas

Enterprise liability

Theoretical advantages

The realities of managed care

Fostering a systems approach

Experience-based underwriting

Challenges: *Which* enterprise?

Boosting regulatory capability

Sources: Kohn (2000)

Dauer

10

“No-Fault” or “Avoidable Injury” Schemes

Theoretical Advantages

- Equitable compensation
- Reduced administrative costs
- Adverse effects avoided (information)
- Favorable for therapeutic relationship
- Effect on deterrence? Unknown . . .

The BIG question: What will it cost?

Sources: Bovbjerg & Sloan (1998); Studdert et al. (2001)

Dauer

11

Compensable Events Model in Utah and Colorado

(Studdert & Brennan Data, 1992 Events)

Types of events by state	Compensation package	Injuries compensated	Cost (\$ mill.)
UT: No-fault model based on Swedish compensable events	<ul style="list-style-type: none"> · 4-week disability threshold · 66% wage replacement · No household production · Health care costs · Pain and suffering up to \$100,000 	1465	55
Medical malpractice system	Standard tort award	~126	55-60
CO: No-fault model based on Swedish compensable events	<ul style="list-style-type: none"> · 8-week disability threshold · Full wage replacement · No household production · Health care costs · Pain and suffering 	973	82
Medical malpractice system	Standard tort award	~268	100-110

Dauer

12

Alternative Dispute Resolution – Another Look?

The failure of mandatory systems

Screening panels

Arbitration

Mandated mediation

The successes of *voluntary* systems

What we know; what we don't

Confidentiality and related rules

Sources: Burton & McIver 1989; Rolph (1997); Farber & White (1994).

Postscript and Summary

"Contractual liability" – no real evidence.

Disclosure, reporting, and confidentiality: the debate about punishment and the absence of data.

"Every system [including the legal system] is perfectly designed to get exactly the results it gets."



BACKGROUND MATERIALS

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Edward A. Dauer, LL.B, M.P.H.



PROMETHEUS AND THE LITIGATORS

A MEDIATION ODYSSEY

Edward A. Dauer, LL.B.*
 Leonard J. Marcus, Ph.D.†
 Susan M. C. Payne, Ph.D., M.P.H.‡

INTRODUCTION

For at least a generation, the traditional process of suit and settlement by which medical malpractice claims are resolved has been fully satisfactory to almost no one. Physicians see its adversarial tenor as professional prosecution and personal vilification; patients with modest claims find the legal procedures too costly to be useful and often unsatisfying when they are employed; and insurers have complained for decades about the costs and inefficiencies of medicine's share of the "litigation explosion." To these perceptions, there recently has been added another, even more significant, observation. Incremental liability for today's medical errors does not seem to be correlated with the incremental prevention or reduction of the risk of tomorrow's medical errors.¹

By and large, however, the conventional process has resisted change. As unappealing as the picture may be, there has not been much effective

* Dean Emeritus and Professor of Law, University of Denver. The authors wish to express their gratitude to the Robert Wood Johnson Foundation for its support of the research, and to the following people who read and critiqued earlier versions of this article: Arthur Best (University of Denver); Thomas Carbonneau (Tulane University); Susan Daicoff (Capital University); Steven Pepper, Joyce Sterling and Dennis Lynch (University of Denver); and David Wexler (University of Arizona and University of Puerto Rico). Address correspondence to Professor Dauer at University of Denver College of Law, 1900 Olive Street, Denver, CO 80220.

† Director, Program on Health Care Negotiation, Harvard School of Public Health.

‡ Associate Professor of Health Policy and Management, Edmund S. Muskie School of Public Service, University of Southern Maine.

¹ The most recently reported study that sought and failed to find a deterrent effect of medical liability is Douglas Conrad et al., *The Incentive Effects of Malpractice Liability Rules on Dental Practice Behavior*, 36 MED. CARE 706 (1998). The earlier literature and proposed explanations for the phenomenon are summarized in Edward Dauer & Leonard Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185 (1997).

movement toward rearranging the pieces of the puzzle in any different or more satisfying way. There are nonetheless excellent reasons to believe that change would be useful; and that, among the changes most often proposed, voluntary mediation is an alternative that can contribute significantly both to the efficiency of the malpractice claim process and to its ability to promote "deterrence," or what health care managers call "patient safety."²

This article describes some of the originally unanticipated results of one effort undertaken to explore that hypothesis. In 1997, a series of focus groups was conducted in three different cities, from which some very interesting information was gleaned about why, in the face of widespread criticism, the malpractice claim system stays essentially unchanged. In other papers describing that investigation, the authors have examined the "fit" between the attributes of mediation and the interests of the several constituencies of the malpractice system—patients, physicians, insurers, attorneys, and public policymakers.³ Our goal in those papers was to recount what we learned about mediation and its potential in medical malpractice, and about how and why the private parts of the legal process respond—and do not respond—to problems that are deeply felt and widely perceived. This article offers a set of more generalized observations about the durability of the sue-and-settle process: What keeps change from occurring?

I. THE ODYSSEY

We should first acknowledge a perspective that perhaps inevitably framed the general approach. It can be illustrated with an anecdote. At an early point in the odyssey, we had an opportunity to present an analysis of medical malpractice mediation to a group of legal academicians, followed as these law school presentations always are by a rigorous discussion and debate (also known among law professors as the "rubber hose" routine). A question was put by a member of the seminar: "Suppose an injured client does mediate some resolution of the case. How can you be sure that the result gets for them what they would have gotten in court?"

It was a veneer of polity that prevented the answer from being stunned silence. Instead, the question was met with a question: "Why are litigation outcomes the standard by which other outcomes should be measured?" That question was met with a period of stunned silence. We wish therefore to reach

² See Dauer & Marcus, *supra* note 1; Edward Dauer et al., *Patient Safety Implications of Medical Malpractice Claim and Resolution Procedures*, in AAAS, *ENHANCING PATIENT SAFETY AND REDUCING ERRORS IN HEALTH CARE* (1999).

³ Leonard Marcus, *Mediating to Advance Mediation—Multidimensional Problem-Solving Applied to the Introduction of Medical Liability Mediation* [forthcoming]; Susan Payne et al., *Stakeholders' Perspectives on Methods of Resolving Medical Injury Disputes* [forthcoming].

across this chasm, or at least to explain why in this research we began where we did.

Our group was interested in understanding the winds and anchors of change. Those who are committed to the present legal culture require reasons to consider change. Those who are not, require reasons why the conventional legal process should retain the hegemony it presently enjoys. In these investigations, we have been respectful of the former point of view, though we approached the subject from the latter. The first effect of this position is the choice of the very question posed: We began not by asking how the legal system could be improved but, instead, by examining what the people who are involved in events of medical injury appear, in the aftermath of that injury, to want. With this starting point, we felt we could measure how well any system meets the needs of those it serves, rather than being limited to assessing how well one alternative system (mediation) approximates the outputs of another (litigation).

A. The Interests of the Participants

There is a conventional assumption that malpractice plaintiffs want money, and that physicians and their insurers want not to give money up. It is also widely believed that imposing liability for careless errors induces people to avoid making errors in the future. Compensation and deterrence are accordingly the usual assignments for the law of torts. That is no less so in medical malpractice. The data, however, do not bear that theory out.

Studies by Hickson and others throughout the past decade have evidenced a much richer, and rather different, set of concerns on the part of injured patients.⁴ Examining what variables distinguish those patients who bring claims from those others, equally injured and similarly situated, who do not, these empirical investigations have identified a richer hierarchy of motivations and needs among patients who become plaintiffs. Financial concerns explain only a part of their behavior. Anger and rectitude are even more important.⁵ And at or near the top of every list are a desire that the error that happened this time should not occur again, and the need to find out—in the face of a recalcitrant system operating in a closed and defensive mode—exactly what it was that happened to cause the injury.

⁴ The empirical studies have been collected and analyzed by Gerald Hickson et al., *Development of an Early Identification and Response Model of Malpractice Prevention*, 60 *LAW & CONTEMP. PROBS.* 7 (1997); Roy Penchansky & Carol Macnee, *Initiation of Medical Malpractice Suits: A Conceptualization and Test*, 32 *MED. CARE* 813 (1994).

⁵ In a study of the Florida and Virginia programs for compensating families whose neonates suffered a birth-related neurological injury, Sloane and his colleagues learned that families who brought their actions to the nonadversarial no-fault system largely were motivated to do so by their need for compensation. By contrast, families who chose to bring their claim to the tort system largely were motivated by a desire for retribution. Frank Sloane et al., *The Road from Medical Injury to Claims Resolution: How No-Fault and Tort Differ*, 60 *LAW & CONTEMP. PROBS.* 35 (Spring 1997).

Money and litigation are for most patients surrogates for these other needs. Parents of neurologically impaired neonates, for example, can carry disabling yet undeserved burdens of guilt about the role they may have played in their child's condition.⁶ Their use of the legal system and its authoritative inquiries and potential admonishment of the attending physician may serve less the need for compensation than the need for emotional peace.⁷

We have been equally concerned with the place of defendant-physicians in the malpractice process. As Passineau and Thomasson have found, physicians who become involved in one malpractice claim face an elevated risk of incurring a second claim during the year following the date the first claim was filed.⁸ Thomasson's explanation portrays a physician not only defending a professional reputation against the excesses encouraged by legal advocacy but, more importantly, distracted and ruminating, experiencing isolation from patients and professional colleagues, and subject to the adverse consequences that a loss of confidence brings to all who must make important decisions with incomplete information under conditions of extraordinary stress.⁹

It should not be surprising, therefore, that malpractice litigation¹⁰ also has not been shown to achieve deterrence. As Leape and others have explained, medical malpractice liability focusing on the behavior of physicians is inconsistent with several of the principal requisites of effective quality assurance.¹¹

The focus group investigations were conducted, therefore, with an open but admittedly skeptical disposition about the pros and cons of the conventional legal system and its operation in medical malpractice. The more important debate is not whether litigation's productivity in compensation and deterrence justifies its costs in time and money and disruption. Because there is reason to question how well the system's supposed gains are achieved regardless of their costs, the more significant issue is whether the needs of the parties most directly affected by events of medical injury are more effectively served by the conventional legal system, or in some other way. That was the

⁶ This is a personal observation. For nearly 20 years, one of the authors (Dauer) has been affiliated with the United Cerebral Palsy Association and has had ample opportunity to observe children and parents affected by cerebral palsy.

⁷ Gerald Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 J.A.M.A. 1359 (1992). See generally FRANK SLOANE ET AL., *SUING FOR MEDICAL MALPRACTICE* (1993).

⁸ See Dauer et al., *supra* note 2; Theodore Passineau, *Why Burned-Out Doctors Get Sued More Often*, *MED. ECON.*, May 1998, at 210.

⁹ Dauer et al., *supra* note 2.

¹⁰ As used here, the word "litigation" means the entire process from claim to trial, rather than just the trial. Trials are referred to by the word "lawsuit." Litigation includes trials and, far more frequently, the pre-trial processes of discovery, motions and associated procedures regulated by the law and conducted by attorneys. The phrase "conventional legal system" means even more—namely, litigation (as just defined) plus the settlement negotiations conventionally engaged in by attorneys who also represent clients in the litigation.

¹¹ Lucian Leape, *Error in Medicine*, 272 J.A.M.A. 1851 (1994).

question with which the odyssey began. It is that background against which our interest in the viscosity of the conventional was piqued.

B. Mediation in Medical Malpractice

To many of the people whom we met on the odyssey, mediation is a form of negotiation designed to achieve compromise settlements of disputed lawsuits. Within this conception, the attractiveness of mediation lies solely in its ability to save time and money as compared to litigation. Whether mediation can in fact achieve those goals is itself a disputed matter—a question about which hard evidence is extraordinarily difficult to obtain.¹²

This perception of mediation—the settlement tool model—was the dominant understanding of mediation held by our focus group participants.¹³ It is not, however, the only way in which mediation may be seen or used. Taken in another way, mediation is a procedure that can restore communication to a situation in which communication has failed; that can offer safe harbor for introspection and correction; and that can achieve through both its process and its pretensions a more broadly satisfying set of outcomes for those who participate in it. These disparate conceptions of the process are not mutually exclusive, except in the sense that the former sees mediation as just another way to further the monetary settlement aims of conventional sue-and-settle, while the latter supposes in the case of mediation some outputs that are quite distinct from those that the litigation process presumes.

The point is that it is incorrect to think of litigation as bad and mediation as good, or vice versa. Each has a contribution to make. And—this being the main point—we suspect that there is less likely to be an optimal usage of alternative strategies if mediation is saddled with a burden of proof that litigation is not. That uneven playing field currently is in place. It is the origin of our interest in the process of making and resisting change, and was the grail of our odyssey.

C. The Itinerary

Our most recent investigations into medical malpractice mediation began with a set of questions different from those reported here. Our group had

¹² The many studies of mediation to date have focused on mandatory or court-annexed mediation, simply because that kind of mediation more easily allows for study. Controlled experiments are very difficult to accomplish in a world in which attorneys—for good reasons—are not allowed to commit their clients' causes to a randomized selection of procedures. For a number of significant reasons, court-annexed mediation and voluntary private mediation are fundamentally different. Data describing one should not be expected to accurately describe the other. This point is often overlooked in the field.

¹³ There are several explanations for why this narrow view of mediation is so widely held. For one, many malpractice insurers and attorneys practice in jurisdictions that have experimented with court-annexed mandatory mediation. Court-mandated programs tend strongly to be run along settlement-model lines. As such, the mediation procedure is almost of necessity linked to the litigation system, with a docket-clearing settlement objective, and is entered into relatively late in the maturation of a claim—that is, after the claim has already spent its adolescence in litigation.

originally set out to conduct a pair of controlled experiments that would examine empirically the effects of mediation in malpractice claims, an enterprise still in the offing. The focus groups from which the present findings were derived were one part of the preparatory stage of that broader agenda.¹⁴

In 1997, also as part of that larger study, we updated an earlier survey of hospitals and health care providers, in an effort to measure the usage and effects of malpractice mediation.¹⁵ We were aided in this endeavor by a survey among its member companies conducted at our request by the Physicians Insurance Association of America (PIAA), an organization of physician-owned mutual medical liability companies.¹⁶ Those surveys consistently demonstrated that mediation was being used less than might have been predicted, and much less than the theories about its advantages would support. For that reason, an additional purpose of the original research plan, and an added objective of the focus groups, became finding out why that was so.

II. THE FOCUS GROUPS

The focus groups were convened in three cities (Boston, Denver, and Washington) over a period of three months in 1997. Two of the groups were led by professional facilitators who had no previous or continuing connection with the project. In each session, the research team was present and began with brief presentations of the proposed mediation experiment¹⁷ and its purposes. The research team members then retired to the back of the room and, with few exceptions, did not participate in the group's discussions. The third session was led by one member of our research group. Each of the three groups included representatives of the plaintiffs' and defense bars; physicians and

¹⁴ A full description of the parent study can be found in Payne et al., *supra* note 3.

¹⁵ One of the authors (Dauer) conducted such a survey in 1993. The 1997 effort was therefore a smaller follow-up sampling to see whether within its scope any changes had occurred since 1993. Essentially, they had not. A few more programs were in place and, in those states with mandatory mediation programs, some additional experience was being gained, but there was little more by way of voluntary mediation in 1997 than there was in 1993. See generally EDWARD DAUER ET AL., *HEALTH INDUSTRY DISPUTE RESOLUTION: STRATEGIES AND TOOLS FOR COST-EFFECTIVE DISPUTE MANAGEMENT* (CPR 1993). For an earlier focus group investigation into attorneys' views about ADR generally, see Edward Dauer, *Impediments to ADR*, 18 *COLO. LAWYER* 839 (1989). For the preliminary results of a pilot program in medical malpractice mediation, see Dauer & Marcus, *supra* note 1.

¹⁶ The results of the PIAA survey have been analyzed by Susan Payne et al., *Use of Alternative Dispute Resolution Methods to Resolve Medical Injury Liability Claims* [forthcoming].

¹⁷ "The experiment" refers to the initial objective of our research, described above—namely, a controlled study of mediation procedures in malpractice claims. Two additional limitations therefore should be noted about our use of the focus group discussions for the more limited questions being addressed in this article. One is that this article relies on data that were collected principally for one set of questions to help illuminate another set of questions. The second limitation is that, because we chose to establish the experiment with the assistance of insurers, we were constrained to examine incidents only after they had become recognizable claims. There are reasons to believe that mediation is most helpful at the earliest stages of a matter. This application was not before the group.

medical societies, patients and patient advocates, liability insurers, regulatory agencies, such as a board of medical examiners or the National Practitioners Data Bank, judges or representatives of the organized bar, and mediators experienced in medical injury cases.

A. A Note on Method

In a separate article, we have quantified the findings of the three events through a form of focus group content analysis.¹⁸ Content analysis methodology is in some ways more rigorous than is qualitative interpretation. Its conclusions enjoy a higher level of statistical confidence while, at the same time (and for the same reasons), it constrains interpretation more tightly. The findings that emerged from our quantitative analyses¹⁹ are consistent with the conclusions presented here. The two discussions complement each other. The discussion in this article takes what the focus group participants said not as empirical counts of how all attorneys or physicians or insurers think and feel, but as the real voices describing how the attorneys, physicians, insurers, and others in our groups think and feel,²⁰ thus affording both the risks and the benefits of using the data in that way. The analysis concedes, therefore, the perils of using information gathered for one purpose—the planned mediation experiment—to interpret another, namely the added question about the forces that keep the present system so firmly in place.

The present discussion focuses on how and why the parties who use the conventional legal system resist opportunities to change it. The malpractice context serves as a case study of the phenomena and, at the least, may suggest factors that operate similarly in other areas equally suffused by the law. As a way of organizing the presentation, the findings are divided somewhat arbitrarily into five parts, as follows: (1) beliefs about the legal system; (2) artifacts of the system that tend to perpetuate the use of litigation despite the dissatisfaction frequently voiced about it; (3) the needs and views of its prime operators, attorneys; (4) the needs and views of physicians; and (5) the institutional behavior of liability insurers.

B. Beliefs About the Legal System

*It's the only game in town.*²¹

¹⁸ See Payne et al., *supra* note 3.

¹⁹ *Id.*

²⁰ Focus groups are, of course, usually not statistically valid samples of the populations in question.

²¹ Moderator, City Z, summing up. This and the following footnotes preserve in confidence the identity of the speakers by referring to them by their role (insurer, physician) and their city. Multiple references, such as "Defense Attorney, City X," may refer to any one of the several defense attorneys who participated in the focus group in City X. Verbatim transcripts of the three focus groups are on file with the authors.

The legal system is authoritative if not coercive. In health care, or at least with respect to the behavior of physicians in the health care process, some patients and their representatives feel that there is "no other avenue" than conventional malpractice liability for imposing accountability on practitioners:²² "The whole system is broken down . . . Physicians' peers aren't getting involved in solving some of these problems and hospitals aren't getting involved in solving some of these problems, [and neither are] the professional organizations."²³ The legal process therefore has a regulatory function that operates in parallel, and consistently, with the individual interests of patients who call it into play: "The malpractice system is probably the only place where the patient gets a chance to deal with accountability issues."²⁴

Specifically, legal procedures are seen as fostering accountability by, among other things, adding visibility: "I remember [hearing] that the major reason why claims are filed is so the patient can find out what happened. I think that gets right at a part of accountability."²⁵

Deterrence is closely related to accountability, though somewhat more focused. A perception of the need for both leads many participants to conclude that the legal system "isn't so bad." By raising the cost of negligent practice, either through liability or simply by the "burdensome nature" of the legal aftermath of a negligent error,²⁶ "sloppy" behavior is made more expensive and thus it becomes relatively cheaper to be safer.²⁷ The plaintiff's legal pursuit of compensation thus brings into play a mechanism that promotes quality assurance.²⁸ (One liability insurer was less convinced: "We insure everyone that comes to the door . . ."²⁹)

We characterize these very traditional perceptions of the civil liability process as being parts of the litigation belief system, because they are widespread and often invoked to justify the system's continuity even though, in fact, they may be false. The evidence actually found for a deterrent effect in medical malpractice ranges from scant to none.³⁰ Participants in the system³¹ believe nonetheless that, whether or not it is the only game in town, it

²² Consumer Advocate, City X. To the same effect, Government Representative, City Z.

²³ Consumer Advocate, City X.

²⁴ Government Representative, City Z.

²⁵ *Id.* This theme was echoed in each of the three groups. For example, Defense Attorney, City Y, stated: There is literature to suggest that one of the reasons people go to a lawyer is to find out answers to questions that physicians don't give them. And one of the reasons that lawsuits are filed is because even if there is a lawyer and they do get the record there's [*sic*] still questions they don't have the answers to.

²⁶ Physician, City X.

²⁷ *Id.* (observing the "societal interest in optimizing access to safe health care at reasonable cost").

²⁸ Plaintiff's Attorney, City Z.

²⁹ Insurance Claims Agent, City Z.

³⁰ *See, e.g.,* Conrad, *supra* note 1 (concluding that "there seems to be no consistent relationship between liability rules and quality of care").

³¹ It is plain from the larger literature that not every participant agrees. The *Harvard Medical Practice Study*, for example, found that there is little respect among physicians for the deterrent effect of the

is at least in a social sense a game that works; and, for that reason, it deserves the allegiance it receives.

While it is mainly patients and their representatives who feel that the litigation system works well from a social point of view, some on the defense side—physicians and their attorneys—believe, more pointedly, that it works well for their individual interests.³² For one thing, there is a widely held belief that physicians do well at trial: “And when we talk to our clients and tell them about the pros and cons of mediation we have to say [that] at trial the results are 87 to 92% defense verdicts in favor of the doctor and in mediation you’re lucky to come out 50/50.”³³

The importance of this perception is more than just money. A physician who loses a malpractice trial or who settles one for a sum of money very seldom feels the financial pinch.³⁴ Most medical liability insurance is not retro-rated. Few policies have significant deductibles or self-insured retentions. Malpractice settlements are, however, reportable events. The mere fact that a loss or payment was made is far more important than its size,³⁵ and so the “stakes are just too high” to abandon the possibility of a clean win.³⁶ The system preserves that possibility by offering a procedurally fair forum,³⁷ and the chance to achieve the win. Mediation, by contrast, connotes compromise,³⁸ and compromise to these participants means a monetary payment reportable to the National Practitioner Data Bank.

This perception, that the litigation process statistically favors defendants, is a particularly interesting belief. In fact, it is at least superficially true, though

liability process. Because the majority of physicians believe that they can be sued for a bad outcome whether they were negligent or not, their incentive to avoid negligent behavior is not nearly what the deterrence theory would propose. HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION IN NEW YORK 9-58 (1990). In the face of a liability process they regard as irrational, physicians seem driven to avoid liability more than to avoid error.

³² This is not inconsistent with the well-known phenomenon of physicians criticizing the liability process for its excess costs and burdensome procedures. The comparison discussed in our focus groups was not litigation versus no liability, but rather litigation in a world in which liability exists vis-à-vis mediation in the same world.

³³ Defense Attorney, City Y. Physician, City Y, stated: “Of eighty cases that went to trial . . . seventy of those in trial went for the defendant.”

³⁴ Health Plan Attorney, City Y. Physician, City Y, commenting on settlements achieved through mediation, stated: “[Just] because the money settlement is less than it would have been if it didn’t go to mediation, that doesn’t do a lot for the physician, I don’t think, because the other consequences are exactly the same no matter what the dollar amount is.”

³⁵ A report to the National Practitioner Data Bank, for example, and to many state boards of medicine, is triggered whenever a payment is made on behalf of a physician following a written allegation of negligent practice, regardless of the size of the payment. 42 U.S.C. § 11131.

³⁶ Health Plan Attorney, City Y. “With Med Mal cases it’s never a [bottom-line dollars analysis]. We want to know what an outside expert says; did we do something wrong? Is it defensible? What do we owe this doctor by way of defense? The stakes are just too high.”

³⁷ Moderator, City Y, summing up: “[O]ne of the things that has evolved out of the current system is protection for the defendant in this case, and if you don’t have that, if you don’t have that protection that people need, there’s such a danger of people not being treated fairly”

³⁸ Defense Attorney, City Y.

it also may be very misleading. When considering that 80% of all trials result in defense verdicts, it is important to note as well that only a small fraction of filed lawsuits ever go to trial at all—typically only five to seven per cent.³⁹ Of those that do not go to trial, some are abandoned and the majority are settled for some amount, larger or smaller. Thus, while the trial portion of the liability system favors physicians, the overall effect of the process goes just the other way—many more cases end with a payment to a plaintiff than are won at trial by a physician.

In practice, attorneys and insurers undertake a more sophisticated analysis, assessing the trial risk first and committing to trial only those cases that seem most defensible, thus skewing the apparent outcome statistics in favor of defense verdicts. It is, however, the immanent trial that informs the settlement process, and so the possibility of a risk at trial is an inseparable aspect of the negotiations that, in fact, conclude the largest number of cases, with a win-lose ratio quite different from the defense-verdict numbers our participants were discussing. We understand their point therefore to be the importance of having a trial process available for those cases that are defensible; and, at the same time, we wondered whether there is too little attention paid to the way in which the probability of a trial and its risk affects the defendant's overall outcomes.

Trials are believed by some to be cathartic, for both sides—or at least so believed by both sides' attorneys: "There is tremendous advantage to [physicians] in having been able to have the dispute resolved in a forum where they had someone who could speak on their behalf, cross-examine the witnesses against them and show the fallacy in those witnesses' testimony and have a champion, so to speak, to present their side."⁴⁰ And for the plaintiffs, "there's an emotional validation, healing kind of process that goes on . . . Every family member, or every person who's been injured comes back and says, 'Well, I'm glad the jury awarded money, but more important than the money was the fact that I got the chance to tell my story, and people told this doctor that what he was doing was wrong.'"⁴¹

It is interesting to note that these same participants implicitly believed that mediation could not achieve similar cathartic effects. The adversary process requires that, for the defendant to be right, the plaintiff must be wrong—one aspect of the win-lose approach or, more broadly, of the adversary culture of which litigation is both a cause and an effect. Mediation imposes no such requirement; restoring personal validity can be achieved in many different ways, not all of which require an adjudication of whose perceptions of reality

³⁹ Recent data relating to medical malpractice claims in particular are reported in Payne et al., *supra* note 16.

⁴⁰ Defense Attorney, City Y.

⁴¹ Bar Association Representative, City Z.

are valid and whose are not. Achieving catharsis through litigation is not a costless good. From a systemic perspective, there may be great value in the patient's story, and value in the discovery process that elicits the actual facts of the event.⁴² That process, however, very quickly takes on a life of its own:

[Depositions are] really games. It's a zero sum game here. There's a winner and loser. And your goal in being deposed is not to get the truth out, it's to make sure that you're going to win for the home team, and not hurt the home team. Because again, we're playing for high stakes here. We're not playing for truth, justice and the American way. We're playing for survival and money.⁴³

The yes-no, win-lose aspect of the litigation process became a focal point of the discussions in two of three groups. The litigation system, as one participant put it, "is designed for truth." Other processes, such as mediation, are not.⁴⁴ To most defendants and insurers, mediation connotes compromise,⁴⁵ or even makes it inevitable: "There is always going to be compromise if there isn't going to be battle."⁴⁶ And for physicians who feel they did nothing wrong, compromise is not a good solution⁴⁷ and therefore any change in the process that is perceived as advancing the possibility of compromise will not easily be accepted.⁴⁸ The norm of right and wrong is quite vital. The litigation system glorifies that norm; its adversary process and win-lose personality respond to beliefs that pursuing the truth is a good thing.⁴⁹

If there is a difficulty with this belief, it is that the litigation process has, by fostering it, hoisted itself into being the criterion by which any other procedure's results must be measured. This point has already been explored

⁴² Physician, City Z.

⁴³ *Id.*

⁴⁴ Government Representative, City Z. "[Proposing mediation is] like trying to impose another system on a system. This system's designed for truth. [Unless] we've got a better one we'll get to the truth this way. [Mediation] is not really about that, it's about there may not be a truth, there's just a better way to resolve it."

⁴⁵ Plaintiff's Attorney, City Y. Plaintiff's Attorney, City Y, noted that the belief that mediation equals compromise "is a given."

⁴⁶ Plaintiff's Attorney, City Y.

⁴⁷ Health Plan Attorney, City Y. Physician, City Y, stated: "As a physician [who has] been there . . . the problem, for me, the problem with mediation and the advantage to the current system is that it does allow a yes/no answer."

⁴⁸ "There are three things that we've got to address. One is . . . if there's not a carrot for the doctors, i.e. if their attorneys can't advise them [that they are] going to have approximately the same chance of success in this mediation [as in a] trial, then doctors don't have any incentive to go into mediation."

Plaintiff's Attorney, City Y.

⁴⁹ Plaintiff's Attorney, City Y:

I don't think we should be afraid of the controversy in decision making . . . These things are inherently controversial . . . Maybe we can create a system that can do the job better, but there are going to have to be some decisions made by somebody at some point in some cases where either the doctor's told that [the behavior or act in question] is not acceptable, or the patient is told that's what happens . . . and it's not the doctor's fault.

in terms of statistical “win” rates and the preference in many cases for clean victories, and will be returned to below in the discussion of the “artifacts” of the present system. It is worth noting the same point here, however, because this belief in the relevance (and accessibility) of truth also has the effect of preserving some of the adjunctive procedures of litigation, even in the minds of those for whom an alternative such as mediation might otherwise be attractive.

Mediation, for example, appears to some people to be a “quick and cheap” procedure for reaching a compromise settlement of a disputed claim. The quality of the settlement might therefore be reduced by the lower quality of the process. Quality, of course, means money.⁵⁰ Pre-trial procedures⁵¹ thus seem to many attorneys to be indispensable, as if there is no other way in which to acquire the information necessary to evaluate the case for purposes of settlement.⁵² In their view, litigation’s discovery procedures might well be necessary to mediation, but mediation cannot replace that part of litigation.⁵³

Thus, we were advised, do not try to sell mediation as a substitute. It might be salable as an enhancement of the conventional system, but it will not be accepted at the expense of the values that only litigation offers.⁵⁴ Mediation

⁵⁰ Plaintiff’s Attorney, City X:

[O]ne [concern about mediation] is [whether] the quality of the outcome of the settlement is going to be compromised because there’s a pressure to get it done early and quickly. If the case can be settled . . . quick and cheap now, which may not be to the patient’s benefit, as opposed to down the line where you establish a case pretty well and you have a better foundation for suggesting a higher figure for settlement.

⁵¹ And, to some extent, to evaluate the case for the possibility of trial as well, as noted by Plaintiff’s Attorney, City Y:

I see [mediation] as working only if ultimately you can have the finality of the jury decision, if you need it. And not many of us want to push it that far. I don’t know how many warriors really and truly, unless they know they have to go to war, get excited about going to war. Each side is going to get hurt. [But] it seems to me that the timing . . . is so important, and that there does have to be some kind of testimony under oath most of the time.

⁵² Plaintiff’s Attorney, City X, describing the need for depositions and documentary discovery: “I would find it hard to do all I had to do in two or three months, if in taking into account that I had done my homework before filing the suit or the complaint.”

⁵³ Defense Attorney, City X:

The good thing about the current system is you have a formal processing place where you can apply to the court for hospital records, you can notice the deposition of the subsequent treating physician, or the sister who was there when the informed consent was or wasn’t obtained properly. Without those formalities in place, I’m wondering . . . how quickly I could get into a mediation process and feel comfortable that I would be able to articulate my client’s position effectively and properly.

Defense Attorney, City X, questioning whether mediation really would save costs as compared to litigation, stated: “Because you don’t want to do sudden discovery before you come to the mediation . . . are you going to go there blindly without taking the deposition? Do you want to go there without the plaintiff’s [deposition]? . . . Aren’t you going to want to have your own independent expert review anyway [even if the mediation incorporates a neutral expert panel?].” Similar comments were made by Defense Attorney, City Y, and Government Representative, City Z.

⁵⁴ Insurer, City X.

is just a tool to help a bit in a process whose soul resides in litigation.⁵⁵ Saving time and money “doesn’t necessarily equate to value.”⁵⁶

Two additional observations sharpen the point of this recitative about beliefs. The first, examined further below, is that beliefs are addictive; they create entrapments. People may come to the litigation process because of any one or more of these beliefs; once they are there, they find it hard to leave. Litigation transforms complaints into money and then makes money necessary.⁵⁷ As one of the focus group participants put it, in the litigation process the only currency is currency.⁵⁸ That transformation in turn brings in actors (like attorneys)⁵⁹ and apparatuses that themselves become indispensable, thereby closing the circle of dependency. This consequence of the belief system also is addressed below.

Finally, the participants noted the power of tradition: “[Litigation] is kind of a background against which we proceed. Historically, traditionally, it is set [and] it is very difficult to change”⁶⁰

C. Artifacts of the Legal System

*I’ve been sitting here and I feel compelled to say something good about the system. First, it seems to be keeping us all employed.*⁶¹

By the phrase “artifacts” of the legal system is meant those features or characteristics that are not intentional or, in an anthropic sense, self-conscious on the system’s part. In contrast to certain of the beliefs just discussed, such as deterrence, artifacts are not part of what the legal system either intentionally requires or explicitly advertises. For example, the fact that statements or notations made by a physician may be discovered in litigation, and therefore put that party in additional peril of incurring liability, results in a significant reluctance to engage in any process that calls for the making of any such statements.⁶² Thus, litigation tends to create or perpetuate its own *raison d’etre*, as the absence of safety for discussions held in any alternative forum

⁵⁵ Insurer, City X: “As I see mediation, it’s a tool in managing a conflict. That’s really all it is, just another tool, and there are a lot of tools that you have in managing a conflict.”

⁵⁶ Insurer, City X.

⁵⁷ Defense Attorney, City Y:

So when we think about mediation we have to think about those groups of cases where really people just want the answer, and they want to know what happened—who did what. And once that is understood—though that [achieving that understanding] is rare because I think most of the time once you get a lawyer you’re looking for money.

⁵⁸ Physician, City Z.

⁵⁹ “The problem we have is that . . . no plaintiff’s attorney can afford to represent clients who go to mediation and are told that they’re not getting any money. Then the plaintiffs aren’t going to get involved with the system.” Plaintiff’s Attorney, City Y.

⁶⁰ Hospital Attorney, City X.

⁶¹ Hospital Attorney, City X.

⁶² Thus, for example, the observation by Insurer, City X:

leaves litigation as the only workable procedure. That effect is an inadvertent one, or what is called here an artifact of the system. A number of such artifacts were identified in the analysis of the focus groups' discussion, in addition to a number of beliefs.

The focus groups were designed, both ostensibly and actually, for learning about attitudes toward mediation in medical malpractice cases. They did not address explicitly, nor did the moderators put directly to the groups, any questions about the sources of resistance to change with respect to the legal system generally. The following discussion of "artifacts" therefore rests not on the express statements made by our participants, but rather on our interpretations of how the parties were reacting to the prospects for change with respect specifically to mediation. The following are among the comments that nevertheless offered us insights into why the viscosity of change is as high as it is.

An insurer, for example, was concerned with what he termed the second-order consequences of any change away from litigation. The litigation process is expensive, and especially so for medical malpractice. While some of the patient's costs may be recouped if the case is pursued successfully, the largest part cannot be. In addition, the cost to the attorney measured in terms of dollars and time and opportunities foregone can be significant. These economic artifacts deter many small claims from ever being brought,⁶³ a factor that is not intentional on the legal system's part, but which is nevertheless a significant and attractive feature from the defendants' point of view. This insurer was therefore reluctant to begin a program of mediation for fear that it would result in "encouraging smaller cases to be brought into the mediation process, or encouraging further claims because patients or their attorneys will perceive that this is a better, more expeditious way to do it—an undesirable objective from a carrier's perspective."⁶⁴

Somewhat more subtle are the interactions between the system and the people, modulated by their perceptions of their own place within the process.

We now have an environment where people are afraid to talk to each other and express any kind of human emotions or show any kind of weaknesses for fear that it's going to be blown up in a court room somewhere [A]lthough it's supposed to be open and honest participation in a mediation, from a legal standpoint you don't necessarily want to play all your cards at a mediation, because if mediation falls through, then any special thing you may want to bring out at trial will already be revealed to the plaintiff

Physician, City X, added a similar concern:

[O]ne of the barriers that we will have to overcome [is] the notion that speaking up won't come back and being open in the process won't come back and bite you. . . . [T]he statutes might provide that everything discussed in the mediation is confidential [but] the statutes is [sic] one thing. You are going to have to convince physicians certainly, that in practice and in reality that information will not be [revealed and used against them.]

Finally, as Risk Manager, City Y, observed: "[S]ome physicians believe that they should not in fact continue the discussion with the patient once there's a conflict issue."

⁶³ It may be true for larger ones as well. See HARVARD MEDICAL PRACTICE STUDY, *supra* note 31, at C.7.

⁶⁴ Insurance Representative, City X.

We heard, for example, that some professionals in the process—physicians and attorneys—face a competition between their duties, and their interests. Duty as a professional may point in one direction; self-interest in the particular case may point in another. One way to avoid the stress of that competition is to submerge it in the play-rules of acceptable legal “gamesmanship”—thus an abstraction of the adversariness away from its intended purposes and toward this other, unarticulated, end:

And the gamesmanship is all over the place. It’s not just on one side or the other side, but it even starts to feed into the practices of the folks even in their day-to-day professional lives. [The gamesmanship] is all kind of a way to deal with these poorly defined competing interests.⁶⁵

The adversary process thus becomes self-justifying. In this very subtle way it creates a need for itself. Once it does, alternatives become more difficult. Because the “gamesmanship” is difficult to put aside, our participants thought it would infect even mediation, thereby reducing the usefulness of that process when it is used in a culture dominated by the artifacts of litigation.⁶⁶

“Gamesmanship,” which we take to mean the attractiveness of adversariness (and thus the attractiveness of the adversary process), has other origins as well:

I’m sure if you check you’ll find most litigators were athletes and competitive, and you have that fire in you, and it becomes, I hate to use this word, this macho thing, but it’s like, hey, you know, I got my side, you got your side. . . . And too often in this process this mediation comes up as a last resort because people don’t want to show a sign of weakness.⁶⁷

In some cases, neither the attorney, who may find the sport congenial, nor the client, who has little competence to judge the value of alternatives, acts as a check on the other. They have become “enmeshed,” as one attorney and mediator put it.⁶⁸ The client becomes dependent on the attorney; the attorney responds well to the call for a champion and protector; and the ludic attraction of the sport propels them forward in that embrace. The costs—hidden and otherwise—of the advocate’s zeal may be known,⁶⁹ yet the system accommodates readily the propensities to continue zealously.

⁶⁵ Defense Attorney, City X.

⁶⁶ Insurer, City X:

I wouldn’t bother going to mediation if I didn’t think that everybody at least had aligned their interests in their perception of their duties in such a way that they could move forward with it. Otherwise . . . it’s a waste of time. People’s duties and interests are still all over the block, and they’re not aligned with the mediation. . . . What happens is you just bring the gamesmanship into the mediation. . . .

⁶⁷ Plaintiff’s Attorney, City Y.

⁶⁸ Mediator, City Y.

⁶⁹ For example, from Risk Manager, City Y:

A previous section of this article examined the problem of discovery—that many attorneys view discovery as the best (if not the only) way by which to acquire the information necessary to evaluate a case and position it for resolution, and that the intrinsic time requirements of the discovery apparatus postpone the usefulness of mediation to a stage much later in the litigation process.⁷⁰ That phenomenon takes on added significance with respect to expert witnesses.

Unlike other actions in tort, medical malpractice employs a professional standard of care rather than the general rule of the “reasonably prudent person.” Physicians’ actions are tested by how well they accord with what other practitioners in the same specialty and in the same or similar circumstances would have done in the situation at hand. By rule of law virtually everywhere, only experts may testify about these facts. The professional standard of care thus makes expert testimony indispensable at trial. And because competing expert testimony lies at the heart of the malpractice trial, it is seen as essential to know how that testimony would develop⁷¹ before being able to assess the value of the case for settlement.⁷² This fact was stressed in all three of our groups.⁷³ One attorney felt it appropriate to confess: “We’re just not culturally changed enough” to use mediation without first engaging in this part of the litigation process.⁷⁴

The legal standard of care thereby generates costs that make the system respond effectively to those cases in which larger sums are at stake,

[T]he hidden costs of litigation and the hidden expenses [to physicians] are the ones . . . we [usually] don’t even talk about—the family, the practice, other patients, what happens to the people that are involved. It affects their lives totally and in many ways and the stress of malpractice and the litigation process is tremendous and it goes on for years and it can really destroy lives.

⁷⁰ See *supra* text accompanying notes 52-53. Plaintiff’s Attorney, City Y, stated:

[T]he plaintiff needs to be deposed, the defendant needs to be deposed and the key expert on each side needs to be deposed. A lot of times things come out in deposition that you are unaware of. . . . [I]n a car accident you have physical evidence, you have a police report, you have photographs, you have sometimes eye witness testimony aside from the people involved and you can more or less make an assessment of liability. Medical malpractice is a different animal. Things come out that are not in the records, invariably, and those can only be challenged and tested by way of depositions.

⁷¹ “The other area to think about is the use of expert witnesses . . . We’re not just dealing with a claimant and a defendant. We are also dealing with . . . an area where by legal necessity . . . you’re going to have another participant or several other participants involved . . .” Judge, City Y.

⁷² It may of course be necessary for a claimant and attorney to obtain an expert assessment of the injuries and their cause even in mediation, because mediation is negotiation and negotiation without information about the value of alternatives is foolish. This use of expertise, however, is different from the costly examinations required as part of preparation for trial.

⁷³ Insurer, City X:

You’re working within a framework that has certain milestones that you reach in discovery, and you don’t want to make any decision about what you want to do with that case until you’ve gotten through all of that and you feel like you’ve left no stone unturned and you’ve checked out every possibility in the case.

Similar comments were made by Plaintiff’s Attorney, City Y, and Government Representative, City Z.

⁷⁴ Government Representative, City Z.

transforming whatever complex of motivations the patient originally may have had into the only currency that can pay those costs, viz. currency. Money thus becomes the *lingua franca*, the Latin that everyone understands even though it ignores the nuances of the separate vulgates that the parties spoke before they came to the law. And this in turn creates the attorneys' conventional and persistent standard that litigation's procedures are indispensable.⁷⁵ The religion thus needs the priests; and the priests, as we shall see anon, need the religion.

Although these effects are artifacts, they wield the power to resist change. And it is once again important not to underestimate the force of the traditional: "[Mediation is] completely different from the way we do business now. So [doing] it is going to be a giant leap of faith for the [insurance] carrier . . ."⁷⁶

D. The Needs and Views of Attorneys

*I tell a client that there are very limited objectives which can be reached in a civil law suit. I can't get back their loved one. I can't get the doctor to say they're sorry. I can't tell them that it will affect licensure. I can't tell them that it will do anything else to make the doctor practice more safely. I have a limited objective I can achieve, and that's a monetary compensation . . ."*⁷⁷

At the beginning of each of the focus groups, the researchers described the more elaborate, communication-based conception of mediation. To repeat that briefly here, it is a process that can include restoring communication between the disputing parties while indulging no preconception about the nature of the outcome. In actual experience, mediation outcomes can range from large money settlements to apologies; they have often included explanations followed by restoration of the physician-patient relationship; and, in many cases, the outcomes have been agreements by the physician to undertake corrective action for the future, with little or no payment of money in the present.

⁷⁵ The use of experts also was described as necessary to the consultation between attorney and client, by Insurer, City X:

In order to give [the physician] his day in court or show him that he can or cannot be in that forum, we have to obtain expert opinions. And obtaining expert opinions that's an attempt to satisfy the doctor's need to know whether he performed within the standard of care or not is difficult to get, and very expensive. Once you get the report in then there's a whole other time period where you have to sit down with the doctor and say, "OK, this is what the expert says. Do you agree? with this, do you not agree? How do you feel about this person criticizing or not criticizing your care?" They may criticize the liability aspect of the care which means yes the doctor screwed up, but they may be supportive of the ultimate outcome, meaning we have a positive causation. Well, then, even though the doctor screwed up, he still wants to say this would have happened anyway, and he wants his day in court. So that takes us back into the litigation process.

⁷⁶ Insurer, City X.

⁷⁷ Plaintiff's Attorney, City X.

This vision of mediation is not the one usually held by insurers and defense attorneys.⁷⁸ They tend to think of mediation as a commitment to a monetary settlement—one agrees or, more rarely, offers to mediate only after the decision has been made to settle, and when the signal given by a willingness to talk about settlement is no longer inconsistent with the overall strategy of the case. This is a narrower conception shaped, of course, by the fact that a malpractice claim is presumed to be a matter for submission to the litigation system.

Having thus described the broader vision of mediation and added it, for the moment at least, to the participants' repertoires, we were able to hear a widened array of reactions from the attorneys. Some addressed the difficulties with mediation in its narrower, settlement-focus form; others reacted to the newer notion. In both cases, there were criticisms and questions proceeding from the attorneys' own interests in the malpractice process. Attorneys, for example, often presume that their cases involve power differentials between the parties, and that the playbook of the adversary system is the proper, if not the most decent, venue in which those differentials may be handled. Doing that, of course, necessarily costs money.

Perhaps most obvious, and most frequently mentioned, is the fact that plaintiffs' attorneys cannot survive by charging their clients 33% of an apology.⁷⁹ Malpractice cases are legal matters and legal matters require attorneys. Attorneys need to be paid and only money will do. Most often, attorneys cannot be paid money unless their clients collect money.⁸⁰ Therefore, once a patient is moved to act with respect to a perceived medical injury, the system causes the attorneys to steer the clients toward money, and thus away from any process in which money is not a likely outcome.⁸¹

⁷⁸ The focus group data do not permit a description of how patients and physicians without attorneys envision the process.

⁷⁹ "The problem we have is that . . . no plaintiff's attorney can afford to represent clients who go to mediation and are told that they're not getting any money. Then the plaintiffs aren't going to get involved with the system." Plaintiff's Attorney, City Y. Similar opinions were expressed by Physician, City Z; Insurer, City X; and Plaintiff's Attorney, City X.

⁸⁰ In response to a suggestion that a plaintiff's attorney might be paid a flat fee for a successful mediation from which the patient received satisfaction in other than money, one of the focus group participants reported the perception that "[an attorney] could not take away from this process more money than the client got. If the client got zero, it's unethical for [the attorney] to take payment for [his or her] time. Even if what the client needed was to be restored psychologically." Physician, City Z, reporting a conversation with an attorney outside the focus group. The authors are not aware of any such ethical restraint. People hire attorneys frequently to achieve nonmonetary goals, and they pay them with money. The point, however, is that this perception illustrates the power that derives from having a bar that is simultaneously necessary and in it for a living.

⁸¹ This is not meant as a criticism of the profession, and even less so as a criticism of the attorneys who participated in the focus groups. Not all attorneys act according to that caricature. Many attorneys, perhaps most, are genuinely concerned with those cases in which harm has been done but in which there is not sufficient recovery possible to compensate both the client and the attorney. Regardless of their humanitarian concerns, no plaintiff's attorney in private practice could survive for long with a roster of clients who are satisfied with nonmonetary outcomes.

The same is true for the defense side, although it operates through the policies of the liability carrier.⁸² Many carriers will not hire counsel to defend an insured physician until the plaintiff has retained an attorney, thus assuring that, by the time the case becomes important, it will be about money. The effect of this policy on the physician, however, is another story:

If no money's involved, I can't call my malpractice carrier and get them engaged in helping me. I may be feeling depressed, or frightened or scared . . . That's a very lonely moment in the life of a professional. [T]he Sword of Damocles is about to fall on you. [N]o money though, so nothing [gets done.] That doctor's alone in that circumstance, just like the patient's alone. So we have two lonely people . . . [O]ur system only snaps to attention when the dollar figure comes up.⁸³

Among the most interesting of the observations came from a plaintiff's attorney who bemoaned the situation in which the practice is embedded. It deserves to be quoted at length and without commentary, except to note the plait of interests it describes:

Unless a case has a certain value, for an attorney to become involved it must be above some floor. And the reason a lawyer would not want to become involved in a case of five or ten or twenty five thousand dollars is very simply this: As we all have our professions and our obligations, we also have professional credibility on the line. And we spend a lifetime developing a reputation and if you begin to take cases and try to arbitrate or settle it early on, and it's not going to be successful, are you then committed to that client to bring a lawsuit which has a value of \$10,000 or \$20,000 . . .?⁸⁴

The effects on the prospects for change that come from the attorneys' own interests are thus inevitable, subtle, and diverse. On the one hand, some attorneys feel that the contingent fee (which, as we have seen, forces the process to a monetary focus) is of great value to the plaintiff, who by virtue of that form of payment sees the attorney as a partner—they are both on the same side.⁸⁵ And on one of the many other hands, the risk that alternatives pose to the balance of cost and reward casts the burden on the alternative: "I think those perceptions are only going to change if we come up with a good reason for them to change. They're not going to change by themselves."⁸⁶

⁸² Some liability carriers also perceive the issues as monetary: "[P]eople want money, and attorneys will not take cases unless they will earn some money from it, and \$100,000 is still a lot of money to me, and if you think I'm going to hand that over to somebody . . . without using the system that is there for us to use . . . you're out of your mind. I mean, it's a lot of money. People want a lot of money . . ." Insurer, City X.

⁸³ Physician, City Z.

⁸⁴ Plaintiff's Attorney, City X.

⁸⁵ "[W]hat a lot of attorneys in the trial bar would feel is being lost [in a mediation system] is the fact that when you have a contingency fee set up, the client that you've picked looks at you, and says, '[T]his is my attorney, this is my guy. If I win at least I'm paying this person, he's on my side.'" Bar Association Representative, City Z.

⁸⁶ Bar Association Representative, City Z.

E. The Needs and Views of Physicians

The doctor who's being sued wants his day in court because somebody is going right after the heart of his profession.⁸⁷

Once accused by a patient of having committed a negligent act, physicians see the stakes in the ensuing process as personal vindication and professional survival for them versus money for the plaintiff.⁸⁸ To the physician, money is seldom an issue. Defense costs⁸⁹ and settlements or verdicts are paid by insurers; and, as noted earlier, few liability insurers retro-rate their premiums. Deductibles and self-insured retentions are likewise typically modest. A payment to the patient is in itself not usually a cost to the defending physician.

Physicians accused of malpractice suffer anger, guilt, and denial, and a need to reconfirm their personal capabilities withal, in part by proving that the outcome was not a function of their error. The physician therefore expects to have this opportunity, and the attorney must advise whether having it in court is wise. This is done partly by engaging experts to assess the case. Experts are expensive and sometimes difficult to arrange, and create a sense of investment that propels the case forward to a full defense.⁹⁰ When their opinions about either liability or causation are encouraging, the physician's wish for the day in court is nourished.⁹¹

A trial offers the prospect of having a champion speak for your side, to cross-examine opposing witnesses and to hear and convince others that you (the physician) were right. Mediation, by contrast, is understood to mean compromise, and vindication does not occur.⁹²

Physicians also are concerned with professional survival. A malpractice payment, of any amount, made by way of settlement, is a "reportable event" resulting in a record being made in the National Practitioner Data Bank, as well as any applicable state systems, from which it is retrieved each time a hospital or health plan considers affiliating with or offering practice privileges to that physician.⁹³

⁸⁷ Insurer, City X.

⁸⁸ Physician, City Z:

And your goal in [taking depositions] is not to get the truth out, it's to make sure that you're gonna win for the home team, and not hurt the home team. Because again, we're playing for high stakes here. We're not playing for truth, justice and the American way. We're playing for survival and money. Especially survival versus money.

⁸⁹ The researchers were told of occasions in which physicians felt it necessary to hire their own counsel because, in their view, counsel for the insurance carrier was operating in the carrier's interest and not in theirs.

⁹⁰ This is, of course, a sunk cost, which should have no bearing on decisions made after it has been incurred. But then, that is why the sunk cost fallacy is called the sunk cost fallacy.

⁹¹ Insurer, City X.

⁹² Defense Attorney, City Y.

⁹³ Physician, City Z. The National Practitioner Data Bank law is at 42 U.S.C. § 11135(a).

Given the market for physicians in this country, and the fact that [health] insurers determine who works and who does not, . . . having any claim against you that goes to [the] national data bank is now tantamount to losing your ability to practice medicine because having more doctors than we need, plans are going to cherry pick, and one of the ways they're going to do it is by looking at your data bank record.⁹⁴

Litigation then seems to offer a way to avoid this effect. Physicians believe that the large majority of cases that go through trial—85% or more—are resolved in the physician's favor. Although they may not understand that verdicts are handed down in only the 5% or so of all cases that actually go to trial, and thus that these win-lose ratios are highly misleading, physicians compare the trial loss probability with the mediation outcome probability (seen as at least 50-50 in favor of paying some settlement amount), and are understandably moved toward trial.⁹⁵ Then, as we know from countless other studies, litigation once begun takes on a life of its own.⁹⁶

F. The Institutional Behavior of Insurers

*I have to admit there's a part of me that says, holy mackerel, if you can't settle a case by now, what the hell have you been doing for the last ten years?*⁹⁷

The relationship between the physician and the liability insurer is not a constant. Among the focus groups were found very different expectations about who was in charge and to whom the defense attorney was responsible. In one city, defense counsel takes instruction from the insurer. If the insurer does not want to mediate, then no mediation occurs.⁹⁸ It is, after all, the insurer's

⁹⁴ Physician, City Z.

⁹⁵ As one experienced insurance claims manager (Insurer, City X) pointed out, this is not the time to expect dispassionate decisions from physicians:

The claim has been made, and [for] the physicians and nurses that we deal with, it's like it's the lowest point of their life. And, whether their reaction is anger, or guilt, or denial, or whatever, you have to remind yourself that you're probably not seeing the real person. You're seeing a person who has just been attacked at the very essence of their professional life, and I know if someone did that to me, I hope I wouldn't be judged for the rest of my life for how I was reacting at that moment.

⁹⁶ See, e.g., JAMES HENRY & JETHRO LIEBERMAN, *THE MANAGER'S GUIDE TO RESOLVING LEGAL DISPUTES* 17 (1985).

⁹⁷ Insurer, City X.

⁹⁸ It was not surprising, at least in retrospect, that the two locales differed as well in their willingness to participate in the proposed mediation experiment. In the city where the insurer observed the physician-attorney relationship from a closer distance, the insurer was less convinced to mediate by the enticement that more satisfying outcomes could be achieved. To two insurers in that city, what mattered was the bottom line—the physicians, they felt, were concerned with the costs of premiums and thus with the costs of indemnity and defense. In the other city, where the insurer was intentionally distant from very important aspects of the attorney-client relationship, the carrier was more willing to participate but cautious about not wanting to be involved in that relationship by urging or encouraging its insureds to elect mediation.

money; and the insurer's interests in optimizing its strategies in a large number of cases is not always coincident with the physician's goal of optimizing the outcome of that one case.⁹⁹ In another city, the situation is almost the reverse. There, the insurer pays the defense attorney's fee but takes great pains to avoid coming between the attorney and the physician during the management of the case. The insurer's agreement still must be obtained for any settlement, but the attorney's client is, after all, the physician.¹⁰⁰

We were interested, therefore, and particularly in the former venue, in the factors considered important by insurers when faced with the suggestion that an alternative to the conventional process be considered. Perhaps the most significant—and one of the most robust—of our findings was that the carrier granted considerable autonomy to its claims agents¹⁰¹ (the people who actually set the practices used in managing a claim) and, at the same time, gave them every incentive to do nothing new.¹⁰² More than one claims agent asked aloud why they should undertake the risk¹⁰³ of an unproven procedure. They were not rewarded for creativity; they were rewarded for doing well what they had always done. What they had always done was conventional win-lose settlement. To some degree, having to resort to mediation was seen as a failure in their duty to exercise traditional claims handling skill¹⁰⁴—a very difficult job in which there was not just a little professional pride.

⁹⁹ Plaintiff's Attorney, City X:

Now, there's a tremendous dichotomy of interest between the objective and the desires of an insured physician, and that of the physician's carrier. And, before you get into how do you resolve the issue between the patient and the doctor, you have to address what is the interest of the carrier? And the carrier's interests are several, and not necessarily coincident either in the case or in the overall view with that of the insured. For instance, the carrier as part of their business obligation would have an interest in discouraging further lawsuits because if you make it relatively easy to settle a case or mediate it, it's going to, by extension, encourage other cases.

¹⁰⁰ In many states, the insurance policy includes a "consent to settlement" requirement, which addresses the converse issue—when the insurer wishes to settle but the physician does not, by contract or by law the insurer may not settle the case without the physician's consent. This has become particularly important since the National Practitioner Data Bank has made it a reportable event when any settlement is made by an insurer on behalf of a physician.

¹⁰¹ See, e.g., Insurer, City Z.

¹⁰² One agent described her company's requested participation in the mediation experiment as "a leap of faith." Insurer, City X.

¹⁰³ The risk was seen as both the indeterminable outcomes of an untried process, and the more personal risk of not doing well. As one claims agent put it:

I have to be quite frank with you. I would be a little nervous about being involved in a forum that sounds a little touchy-feely that I'm not trained or equipped to maybe handle the very strong emotions that are going around at this forum, and may or may not result in the payment of money. And I suggested to [a plaintiff's attorney] that I felt very few on her side of the fence were equipped with that either. Never mind taking on a case that might result in the doctor feeling a lot better, the patient feeling a lot better, but people not getting paid on either side for . . . performing their jobs.

¹⁰⁴ Insurer, City X:

[A]s a supervisor, I have to ask [my staff] "Why are you choosing mediation when you can pick up the phone and call this person and say: You want to settle the case, I want to settle the case. Your demand is fairly reasonable. Why can't we just talk? What other role is mediation going to play for you or for me?" And again, as a supervisor, I sometimes have to ask myself

Insurers are society's stakeholders; and as the institutions that pay for and, in many cases, establish the modalities by which claims are managed, their internal cultures and the incentives and nonincentives they offer their agents tend to cement the usual in place. The usual in this area is, of course, the tort system's conventional mode of mixed litigation-and-settlement:

[B]eing very dogged in our approach to the claims that come into our company is our job, and I think that as a company we are very pragmatic and we just work with the system that we have. And the system that we have is a tort system based on fault. I didn't make it up. I didn't create it. That's the way it is. That's the system that we have to deal with.¹⁰⁵

The "system" then drives the substantive norms and establishes the procedures. The value to be maximized is what the tort system affords and protects: money.¹⁰⁶ Thus, mediation, for example, is seen only as a way to achieve a favorable money settlement.¹⁰⁷

More important, perhaps, is the fact that, because mediation is seen as a commitment to settlement,¹⁰⁸ and because the value of a settlement is established with respect to the probabilities of financial success or failure in litigation, mediation is not considered until the probable litigation outcome is determined, including the probability of a finding of fault.¹⁰⁹

if I see someone in my unit using mediation a lot, why don't you want to talk to this attorney one-on-one. Because that's like a really integral part of our job, and we're supposed to be settling and negotiating cases. . . . I have to admit there's a part of me that says, Holy mackerel, if you can't settle a case by now, what the hell have you been doing for the last ten years?

At another point the same respondent described a proposed mediation:

[T]he plaintiff's attorney and I were deadlocked, and before we got there we were gonna take six attorneys, two doctors, and have this whole dog and pony show go out to [this town] to pay for the mediator and the hotel. I picked up the phone and settled the case. . . . And sometimes [mediation is] suggested. And if you really want to go, OK, but why don't you just call the plaintiff's attorney up and say, "Why can't we settle this today? I have settlement authority. You've made a demand. Let's talk."

¹⁰⁵ Insurer, City X.

¹⁰⁶ "[P]eople want money, and attorneys will not take cases unless they will earn some money from it. . . ." Insurer, City X.

¹⁰⁷ Thus, one claims agent said that the proper cases for mediation are those in which the parties have deadlocked over the amount of the settlement, and where the carrier is certain that the mediator will value the case, in terms of money, favorably to them:

I felt that I could settle the case, but they [plaintiffs] were being unreasonable. Part of the problem lies in, everybody knows what the issues are on both sides. So, the mediator you [sic] have this fullblown discussion about the whole case all over again, and everyone really knows. I see a mediator as someone who knows the value of a case, or can show someone that their value of the case is unrealistic.

See Insurer, City X. Plaintiffs' counsel felt likewise. Plaintiff's Attorney, City X.

¹⁰⁸ "[B]oth parties should get to the point where they agree a case should be settled before they agree to go to mediation. . . . [I]f someone at [this insurance company] will go in mediation, you can be pretty much assured that we have a very strong interest in settling that case." Insurer, City X.

¹⁰⁹ "The system we have allows us to get a lot of information. Yes, it takes a lot of time and it costs a lot of money, but we're not gonna cut a check to somebody until [we get] the information that we want, and until we're satisfied that there is negligence there." Insurer, City X.

Litigation lies at the center of the participants' thinking in several ways. It is, first, the process by which the value of a claim is assessed—the “BATNA,” or best alternative to a negotiated agreement, as negotiation theorists have styled it. And while, in this sense, it is not irrational to have such a view, what is interesting is how uncritically it is accepted. There was wide agreement within the groups, with the view of one attorney being that “there’s not a carrot for the doctors [to participate in mediation] if their attorneys can’t advise them that [they are] going to have approximately the same chance of success in this mediation that [they would have by] going to trial.”¹¹⁰

Insurers and attorneys, already having agreed that mediation is employed only after it is determined that the case will be settled,¹¹¹ agreed further that settlement (and therefore mediation) could not occur until sufficient information about the case had been collected. For that purpose, litigation’s discovery tools were the principal vehicle.¹¹²

Litigation is “the only game in town.” If an incident is not actually or imminently a lawsuit, then it is of far less concern to some insurers. In one case, mediation as an alternative to suit was thought to be impossible because mediation (seen as a legal strategy) without attorneys was inconceivable and attorneys were not hired by this insurer to represent the physician until the patient filed a lawsuit.¹¹³ The possibility of a trial is therefore always in the wings, making any process that occurs first a source of legal risk. As it was noted in an earlier section, mediation has the drawback that revealing information during that process can jeopardize the always-possible trial,¹¹⁴ and opposing

¹¹⁰ Plaintiff’s Attorney, City Y.

¹¹¹ As one insurance representative put it at the end of the discussion: “I think also that I know that I feel this way and I still view mediation in that very narrow realm of helping me to get to that final settlement.” Insurer, City X. And the carriers’ views, usually well-known to the attorneys in their area, affect the plaintiffs’ attorneys’ attitudes and practices as well: “Obviously [the only cases a carrier will take to mediation] will be those cases whom [sic] the carrier initially feels there is a real potential for settling the case down the road. If initially there’s a determination [by the carrier], no we’re not going to settle this case, why participate in mediation at all?” Plaintiff’s Attorney, City X.

¹¹² Insurer, City X:

[P]eople want money, and attorneys will not take cases unless they will earn some money from it, and \$100,000 is still a lot of money to me, and if you think I’m going to hand that over to somebody based on the mere fact that they claim to have been injured by a physician, without asking a lot of questions, and without using the system that is there for us to use and I mean the discovery tools that are there and to get all the information I can, you’re out of your mind. I mean, it’s a lot of money. People want a lot of money, and I have the right to defend the physician and ask a lot of questions before I turn that money over.

¹¹³ Insurer, City X:

I think that the claims staff in general, and maybe the physicians might feel a little more comfortable agreeing to be part of this process if they knew they had counsel assigned to them, and for us that means the case needs to be in suit. We’re not going to assign counsel unless it’s in suit . . . that would be an expense that we wouldn’t normally incur on a simple claim letter.

¹¹⁴ “[You] don’t necessarily want to play all your cards at a mediation, because if mediation falls through, then any special thing you may want to bring out at trial will already be revealed to the plaintiff . . .” Insurer, City X.

counsel are not necessarily to be trusted.¹¹⁵ To some attorneys, managing a claim is, after all, a “war of attrition.”

III. ADDITIONAL OBSERVATIONS

*What I'm hearing is, things are going well, let's not rock the boat, let's not experiment, let's not try anything new.*¹¹⁶

Litigation is the default procedure. It is the historical tradition and the expected process once a formal claim is made, and is, in that way, the norm against which proposed alternatives are measured. Many of our participants assessed mediation, for example, not by asking what it did or did not do, but by asking how well it did what litigation did, or whether it could improve on some feature of litigation¹¹⁷ that was seen as important but difficult or troublesome—without necessarily undoing the process wholesale.

Even those of our respondents who were attracted by mediation's pretensions often assessed it not as an independent mode for resolving disputes, but rather in relation to the conventional system. For example, because mediation leads to settlement (so perceived), it is believed necessary to continue with at least bits of the litigation process¹¹⁸ because that is how the case can be priced and prepared for settlement.¹¹⁹ Mediation thus becomes not a substitute for litigation but an enhancement of one of litigation's own modalities, namely single-axis settlement.¹²⁰ The question for these respondents was not what mediation could do for claims of medical malpractice, but what mediation could do for the process of malpractice litigation.

The objective of this article, however, is not to assess attitudes about mediation in medical malpractice, but rather to describe the heuristic templates and jigs that shape our thinking about any procedure offered as an alternative to conventional suit-and-settlement. In the world of medical malpractice, litigation resists change by casting the burden of proof on its competitors—a position aided by a variety of artifacts and beliefs and supported by the perception on the part of some of its practitioners that, “with all its warts and problems, the [litigation] system works.” Patients injured through a physician's negligence need money to cope with the aftermath of their injuries.

¹¹⁵ Insurer, City X.

¹¹⁶ Insurer, City Z.

¹¹⁷ Recall the definition of litigation, *supra* note 10, which includes not only trials but the pre-trial procedures and conventional settlement negotiations that occur within its scope.

¹¹⁸ See *supra* text accompanying note 52.

¹¹⁹ Insurer, City X.

¹²⁰ *Id.*

Litigation is a way to get it.¹²¹ Legitimate cases get a fair hearing and, in most of them, "justice is done."¹²²

Litigation "works" in another sense as well; this one is artifactual rather than intentional, but perhaps more powerful still. A large industry has grown up around medical malpractice—an industry populated by insurance carriers, attorneys, and others whose livelihoods are created by and may depend upon the stability of the system. This is not to criticize that population by saying that their own reluctance to change is motivated by inappropriate self-interest. They may only perceive that their present role would be more difficult to play if they abandon certain salient features of the present system.

Insurance carriers offer a case in point. During our odyssey, we devoted a good deal of time to learning about liability insurers, whose cooperation was essential to the proposed mediation experiments. Each of these organizations considered its role in the malpractice system to be valuable to the well-being of the physicians whom it insured, even though each of the several organizations we came to know understood that role somewhat differently.

By and large, insurers are organized around money. They collect premiums and pay expenses and claims, and manage risk principally to prevent the kinds of activities that result in payable claims. In the present system, insurers are very much in control, and seem to care about that control as a technique for husbanding the monies flowing through them. As they see mediation empowering the parties and thereby possibly jeopardizing that control, they are reluctant to give over to it.¹²³

Moreover, in those areas where the liability insurance market is competitive, insurance organizations are equally concerned to maintain or enlarge their market share. Some see the technique for doing so to be a stable or lower premium price. Focusing then on their internal costs, which in some part determine their premium prices, some insurance carriers have been reluctant to accept a set of functions for themselves that do not clearly support their interest in financial economy. Consequently, the burden placed upon proposals for change requires convincing proof that mediation will reduce the dollars flowing out for indemnity or expense. At the same time, the techniques insurers know well and use now seem to be working well enough. Society's managers of risk sometimes seem to be risk averse.¹²⁴

¹²¹ Patient Advocate, City X.

¹²² Mediator, City X. There is no way of counting, from these focus groups, whether this is a majority view among attorneys or not. It is, however, a view that some of the attorneys expressed; and it is therefore of significance to the question of barriers to change.

¹²³ These observations are, of course, the authors' own, and come from numerous conversations over a year-long period, apart from the controlled circumstances of the focus groups. They are therefore offered only as personal impressions, not as data from the research project.

¹²⁴ Insurers vary considerably in this regard. Some were more reluctant to explore alternatives than others. In the small sample of insurers included in the focus groups, those with more comprehensive visions of their role seemed to be more interested in alternative ways of playing their roles. It cannot be said

Medical liability has created the need for liability insurers. Liability insurers know how to use their role within the liability system to preserve themselves and thus their ability to play that role. The legal system is acting properly within its frame of reference; insurance organizations are operating properly within theirs. It is their symbiosis that results in resistance to change. Hence again it is suggested that litigation's hegemony rests not entirely on any demonstrably superior ability to deal with the social values implicit in medical injury disputes, but instead, and in substantial part, on the fact that the litigation system has created, albeit unwittingly, an apparatus necessary for its operation—which apparatus in turn finds the litigation system conducive if not necessary to its viability as well.

We were also impressed during our odyssey by the power of the actual. An interesting example of this came during one focus group's discussion of the "expert panel." A neutral panel of physicians and attorneys was a facility we had suggested to enhance the mediation process by making a nonbinding fact-finding capability available to the parties and the mediator.¹²⁵ One physician in the group expressed great doubt about its workability:

I look at these panels with a jaundiced eye. Anytime I hear that doctors are willing to do something for nothing, I'm asking myself why are they willing to do it? Especially in the same state. . . . So I question the independence of a panel in [this state] with [this state's] physicians trying to assess the practice of [this state's] doctors.¹²⁶

We could not help but note the anomaly: A volunteer panel could not promote justice because the physicians must have some other motive that would impair their objectivity. But in litigation the same concern does not arise when, as the same speaker in another context pointed out, physicians acting as experts in litigation do that because they are paid \$250 an hour by one side to do so. Admittedly, the two situations are not entirely comparable (because the experts in one profess to neutrality, but not in the other), yet it is not stretching too far to say that the adversary process is so inured in our culture that we question it less than we question departures from it.

CONCLUSION

To conclude where we began, as explorers of mediation in medical malpractice, we encountered during our odyssey a world of interests and artifacts

on this basis alone that the two propensities are related in any meaningful way. Still, even within this wide variation of attitudes toward the novel, almost every insurer examines the new with an obvious degree of caution.

¹²⁵ The expert panel was originally proposed by a medical society with which the authors had been working to create a mediation facility available to its members.

¹²⁶ Physician, City Y.

that challenged the quest, to the effect of resisting changes to the ongoing ways of life. The focus groups offered insights into the sources of this resistance. We plan, as our work goes on, to use these findings as windows through which to glimpse an environment shaped by forces more authentically related to the parties' needs than money alone is, and in which attorneys' interests need not constrain the objects of their clients' quests. For the present, however, we are led only to conclude that the persistence of the present regime is a product not of its demonstrated superiority, but of artifacts and of individual and organizational needs that support its resistance to change. In this system, they do good; and it helps in doing good that they do well.





Session 5: Medical Liability Insurance Overview

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