Beyond Malpractice: Compensation for Medical Injuries (1978)

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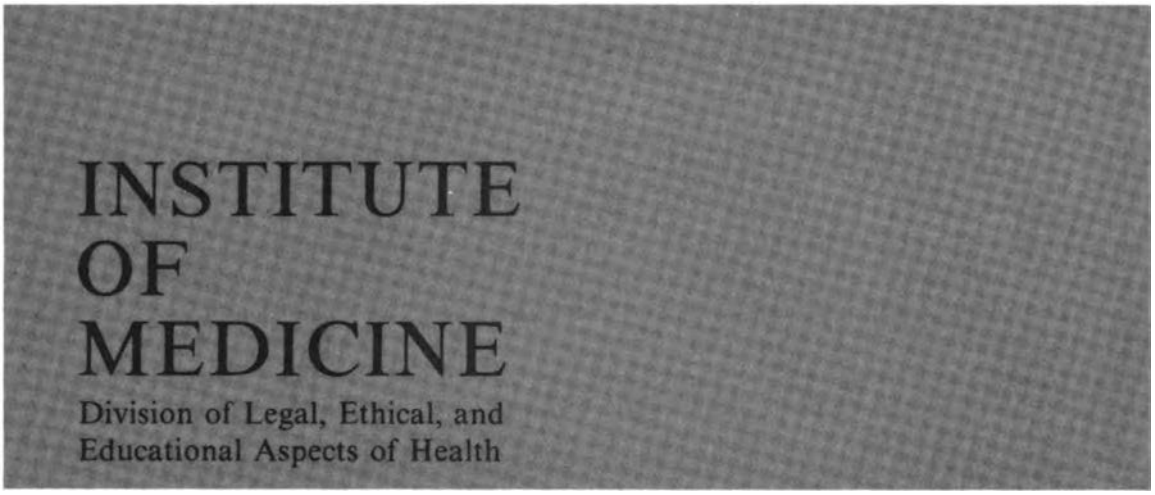

A POLICY ANALYSIS

Beyond Malpractice: Compensation for Medical Injuries

March 1978

NATIONAL
ACADEMY of
SCIENCES

Washington, D.C.

NOTICE

The project that is the subject of this report was approved by the Governing Board of the National Research Council, whose members are drawn from the Councils of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine. The members of the Committee responsible for the report were chosen for their special competencies and with regard for appropriate balance.

This report has been reviewed by a group other than the authors according to procedures approved by a Report Review Committee consisting of members of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

Supported by grants from The William and Flora Hewlett Foundation and The Henry J. Kaiser Family Foundation.

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of appropriate professions in the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 Congressional charter responsibility to be an advisor to the Federal Government, and its own initiative in identifying issues of medical care, research, and education.

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DAVID A. HAMBURG, M.D.
PRESIDENT

March 17, 1978

Robert J. Glaser, M.D.
President
The Henry J. Kaiser Family Foundation
2 Palo Alto Square
Palo Alto, California 94304

Dear Bob:

I am pleased to present the final report of a study of medical injury compensation conducted by the Division of Legal, Ethical, and Educational Aspects of Health, Institute of Medicine, National Academy of Sciences, pursuant to a grant from The Henry J. Kaiser Family Foundation, authorized November 19, 1975.

In the enclosed report, our steering committee indicates the necessity of a change in focus from the narrow problem of medical negligence, or malpractice, to the broader context of equitable compensation for all medical injuries. This shift applies both to policymakers and to the public. The committee evaluates the most important existing and proposed alternative schemes for medical injury compensation and presents its conclusions in Chapter 5, entitled "Future Directions for Policy and Research."

We greatly appreciate your support of this project and will be happy to discuss the report in greater detail with you. We will see to it that the report gets national attention and hope it will be useful in the long-term resolution of this problem.

With warm regards,

Cordially,

Dave

DAH:mrp

Enclosure

INSTITUTE OF MEDICINE

BEYOND MALPRACTICE:
COMPENSATION FOR MEDICAL INJURIES

A Policy Analysis

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Division of Legal, Ethical, and Educational
Aspects of Health

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BEYOND MALPRACTICE:
COMPENSATION FOR MEDICAL INJURIES

A Policy Analysis

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Several members of the Institute's professional staff participated at various points during the Medical Injury Compensation project. They include Joanne Gittleson, Lupi Robinson, Richard Scheffler, and Rebecca Smith.

Special thanks go to Barbara W. Cohen who was project director until July 1977. Subsequent to her departure from the Institute due to a family move, she continued to review draft material and provide helpful advice to the staff.

Frances Walton was responsible for general administrative support and preparation of the manuscript; her efforts are especially appreciated. Gladys Bostick and Jean Donnelly were also a great help.

Many other people, too numerous to mention, assisted the committee and staff in the preparation of the report. Consultants to the project included Lawrence Miike and Rick Carlson.

Michael R. Pollard
Project Director

Institute of Medicine

Beyond Malpractice: Compensation for Medical Injuries A Policy Analysis

Chapter 1

INTRODUCTION

During recent years, attention has been drawn to the increased frequency of medical malpractice claims, the size of settlements and jury awards, and the rapid rise in premiums for malpractice liability insurance. 1/ The high cost and unavailability of liability insurance during the period 1973 to 1975 became characterized as a "crisis" in medical care. 2/ The insurance problems are important. But they are only part of a much larger public policy issue, the Institute of Medicine believes. That issue, which gained in emphasis as the study progressed, is compensation for injuries that arise during the course of medical care.

In December 1975, The William and Flora Hewlett Foundation and The Henry J. Kaiser Family Foundation approved grants to the Institute of Medicine in support of a policy analysis of medical injury compensation. A twelve-member committee was appointed in June 1976 to conduct the project. The analysis of the Institute's Medical Injury Compensation Committee, reported in this document, addresses the following questions:

- What is a medical injury? How does it differ from medical negligence?
- Should all medical injuries be compensated? Should injuries that result from risks of life be distinguished from injuries arising from risks inherent in medical care?
- What should a medical injury compensation system try to achieve? Should it be directed toward preventing injury in addition to compensating for losses incurred by injured patients?
- What compensation systems have been proposed? What are the relative advantages and disadvantages of each?
- What are the implications for medical care providers, insurers, and patients of implementing new approaches for compensation of medical injury?

Concept of Medical Injury

All medical procedures--preventive, diagnostic, and therapeutic--carry some risk of harm to patients. For most procedures, the risk is very low. When an adverse outcome occurs, it is more than likely to be transient and cause losses only of some additional medical expense or time away from work. 3/ However, there are other procedures where the potential for an adverse outcome is quite high and the resulting losses are financially burdensome to patients. Some of these outcomes occur as the result of provider negligence, others are simply unavoidable consequences of risky procedures. The financial losses from medically related adverse outcomes are sometimes recouped through legal actions against providers, but they are more often absorbed by the patient, health and disability insurance, and social welfare programs.

For purposes of this analysis, a medical injury is considered to be the result of an untoward event arising during the course of medical care. The concept includes losses resulting from negligence as well as unavoidable complications of diagnostic and therapeutic procedures.

A medical injury may be a consequence of either an action or a failure to act by a medical care provider. Examples of medical injury include pulmonary embolism as a post-operative complication, serum hepatitis in the absence of drug addiction, loss of hair subsequent to radiation therapy, trauma associated with falls during a hospital stay, removal of the wrong organ or limb, post-operative presence of a foreign body, or failure to diagnose a disease or condition resulting in harm to the patient.

Medical care is used here in its broadest sense to include the care provided by physicians, nurses, physical therapists, and psychologists, as well as by institutional providers, such as hospitals, clinics, and long-term care facilities. Although the bulk of litigation for medical malpractice was previously directed at physicians, the current trend toward increased responsibility and autonomy of nonphysician providers carries with it an increased burden of financial liability in the event an injury occurs during the provision of care.

A major difficulty with this concept of medical injury is that it encompasses all adverse outcomes of care. Many of these adverse outcomes impose neither permanent nor serious ill effects on the patient. Distinctions must be made between those medical injuries that cause losses for which compensation should be made and those that do not. Such distinctions require societal value judgments about compensable losses, rather than determination of causation of the injury as in current fault-based compensation.

The incidence of medical injury is unknown. Attempts at measuring the occurrence of injury during medical care have indicated that the number of medical injuries is much greater than the number of malpractice claims filed. A recent study of approximately 21,000 hospital records in California found that injury occurred in approximately 5 percent of the cases. 4/ This incidence included all injuries without reference to causation or severity. The investigators designated these injuries as potentially compensable events (PCEs). 5/ The California data also indicate that less than 0.8 percent of all the records reviewed indicated clear cases of provider liability under prevailing legal principles. 6/ Another sample of 800 patient records from two urban hospitals, studied by Pocincki, Dogger, and Schwartz in 1972, found that injuries occurred in nearly 8 percent of the cases reviewed. 7/ In Boyden's study of 400 hospital records, 45 medically induced disabilities were identified, an incidence of more than 11 percent. 8/

The reliability of estimates of injury incidence based on patient records is questionable. Such records are admissible as evidence in malpractice suits; thus, if providers are sensitive to situations of potential liability, they may produce patient records that tend to under-report the incidence of medical injuries, whether or not induced by provider fault.

The California study indicates that the incidence of medical injuries is much greater than can be attributed to provider fault. Furthermore, even within the realm of fault-based injuries, it appears that a substantial amount of loss arising from such injuries is not compensated. The primary policy question that attends this discrepancy concerns the desirability and feasibility of compensating for medically related losses more broadly than is currently being done.

Four types of losses are generally recognized as associated with medical injuries: (1) the cost of additional medical treatment, including rehabilitation, (2) loss of earnings (including imputed values for homemakers and other unpaid workers) 9/ and of dependents' support, (3) loss of function over and above direct income loss compensated above, and (4) pain and suffering. Most organized compensation schemes--including public and private health and disability insurance plans as well as recovery under tort law--cover all or part of the losses in the first two categories. Losses in the third category sometimes are covered, at least in part. The fourth category is unique to litigation or the threat of it.

The difficulty in moving away from negligence as the standard for determining which injuries are compensable is that a new standard must be devised to put some bounds on the compensation scheme. Given the lack of information on the incidence and causes of medical injury, this committee believes it unwise to suggest that all medical injuries

should be compensated. The prudent course of action is to begin by compensating certain losses and at the same time begin to collect data on injury incidence, severity, and losses associated with injury. The development of a standard for compensability is the key to the design of a medical injury compensation system.

Goals of Medical Injury Compensation

Regardless of the causes of medical injury, the losses are real and have a financial impact. The committee believes that the primary goals of medical injury compensation are: 1) fair and equitable distribution of loss associated with medical care, 2) efficiency in the distribution of compensation, and 3) conservation of resources through reduction of injury and minimization of loss. The distribution of loss related to additional medical care and rehabilitation after injury should be accomplished through mechanisms that spread these costs widely. Examples of such mechanisms are health insurance and disability insurance. The cost of replacing basic levels of income lost because of a medical injury also should be paid by primary mechanisms, without regard to the cause of the disablement. Efficiencies should be realized by eliminating costly procedures to determine causation and fault. Injury reduction as a goal is important because it insures that attention will be paid to prevention, provider accountability and quality control.

The professional and public concern over inadequacies of current methods for medical injury compensation stimulated the committee to examine existing and proposed approaches to compensation. The committee developed criteria by which to compare the advantages and disadvantages of each approach. These criteria, discussed in Chapter 3, reflect the committee's views about what a compensation system should include if it is to be complete. Chapter 2 is included as background and a review of medical malpractice. Chapter 4 is a discussion of legal issues raised by modifications of tort law and the development of alternative compensation systems. Chapter 5 reflects the committee's views about future directions for policy and research concerning medical injury compensation.

This policy analysis does not purport to design a specific compensation system. The committee did not collect primary data on medical injury, which would be necessary to develop a model system. Existing data on malpractice claims, surgical complication rates, hospital discharges, and problems arising during ambulatory care are inadequate to support the kinds of projections that must be made during such an endeavor. Instead, this policy analysis is an attempt to redirect the focus of current interest in medical malpractice toward the much more complex issue of compensation for medical injuries.

REFERENCES AND NOTES

1. Department of Health, Education, and Welfare: Report of the Secretary's Commission on Medical Malpractice (DHEW Publication No. [OS] 73-88) and Appendix (DHEW Publication No. [OS] 73-89), 1973 (hereafter cited, respectively, as Secretary's Commission Report and Appendix, Secretary's Commission Report). Several states have also conducted inquiries into medical and liability insurance problems. See, for example, Joint Legislative Audit Committee, Office of the Auditor General, California State Legislature: Doctors' Malpractice Insurance (interim report), September 1975; also, Assembly Committee on Finance, Insurance and Commerce, California State Legislature: Proceedings on the Subject of Medical Malpractice Insurance and the Role of the Private Insurance Market During the Post Reform Period, Los Angeles, November 1975; State of Florida: Report of the Florida Medical Liability Insurance Commission to the Governor and Florida Legislature, January 1976; State of Hawaii: Medical Malpractice, Issues, Discussion and Proposals for Change, February 1976; State of New York: Report of the Special Advisory Panel on Medical Malpractice, January 1976 (hereafter cited as New York Report); State Corporation Commission, Bureau of Insurance, State of Virginia: The Scope and Severity of the Problem and Alternative Solutions, Richmond, November 1976; and Health Policy Analysis Program, Dept of Health Services, U of Washington: The Malpractice Issue in Washington, November 1975

2. See, for example, New York Report, as referenced note 1, p 9; also, Preface, Symposium on Medical Malpractice, Duke Law J 1975:1177, 1975; also, Somers HM: The Malpractice Controversy and the Quality of Patient Care. Milbank Mem Fund Q, Spring 1977, p 195

3. National Association of Insurance Commissioners: Malpractice Claims, Vol 1, No. 4, Milwaukee, May 1977, pp 74-75

4. California Medical Association and California Hospital Association: Report on the Medical Insurance Feasibility Study, August 1977, p 50. Hospitals in the study were selected on the basis of factors such as size, ownership, and whether they had a house staff. The records examined were for calendar year 1974.

5. Ibid., p 7. A PCE was defined as a medically caused patient disability and included such events as hospital-incurred trauma, adverse drug reaction while a patient in the hospital, unplanned removal of an organ or part of an organ during an operative procedure, and wound infection present on last full day prior to discharge. See pp 21-31 at note 4 above, for a full description of the 20 criteria used to identify PCEs.

6. Ibid., p 101

7. Pocincki LS, Dogger SJ, Schwartz BP: The Incidence of Iatrogenic Injuries. Appendix, Secretary's Commission Report, as referenced note 1, p 63

8. Boyden JS: Medical Injuries Described in Hospital Patient Records. Appendix, Secretary's Commission Report, as referenced note 1, p 41

9. Cooper and Rice: The Economic Cost of Illness Revisited, SSA Bulletin, February 1976, p 24. The authors use a market value approach to determine the cost of housewife services. The values were derived by isolating types of services performed, estimating hours associated with each, and using market prices for performance of these services. Adjustments were made for age, number of children, and age of youngest child. Also see, Weisbrod BA: Economics of Public Health: Measuring the Economic Impact of Diseases. University of Pennsylvania Press, Philadelphia, 1961, Appendix II, pp 114-119

Chapter 2

BACKGROUND ON MEDICAL MALPRACTICE

The DHEW Secretary's Commission on Medical Malpractice in 1973, described and reviewed the various medical, legal, sociological, psychological, and economic factors that contribute to the situation commonly referred to as the "malpractice problem." The Commission provided a historical perspective for the increase in malpractice claims and attempted to quantify the magnitude of the problem by means of injury and claim occurrence rates for certain diagnostic and treatment procedures. 1/ These data were obtained during two years of intensive study. The work of the Institute of Medicine Committee on Medical Injury Compensation was broader in scope, in that it looked at the issue of compensation for losses resulting from from medical care. This chapter is a brief overview of medical malpractice primarily as it relates to the compensation of injured patients.

Losses associated with medical injuries are dealt with in a variety of ways. Individuals with similar losses from medical injury can have very different experiences in trying to obtain compensation for their losses. One person might bring a legal action against the treating physician, proceed to trial, and receive compensation through damages assessed against the physician. Another person might initiate a lawsuit and then decide to settle for a dollar amount offered by the physician's liability insurer prior to trial. A third person might choose not to sue, being covered for most of the losses by health and disability insurance benefits. A fourth person might absorb some of the losses by using savings or public welfare programs to offset loss of income.

The variety of direct and indirect, public and private sources of compensation makes the current mosaic of possible compensation sources difficult to describe. No one system manages to compensate for all losses stemming from medical injuries. Tort law remedies for fault-induced injuries are, at present, the closest approximation to a systematic approach for medical injury compensation. It is important to understand the elements of tort law, as applied to medical injury, because it is likely to remain an important part of compensation for medically induced losses in the immediate future.

The legal principles underlying malpractice actions are part of the law of torts. The specific doctrine applied in most malpractice suits is negligence. 2/ Negligence is based on the assumption that when losses occur as the result of someone's action, or failure to act, those losses should not be borne solely by the injured individual. Instead, the party causing the injury is held financially accountable for the loss. Medical malpractice is, for the most part, the application of the law of negligence to the special duties and responsibilities of a medical practitioner. In theory, negligence law does not seek to make physicians guarantors of the service they provide, but instead grounds liability on a failure to perform according to accepted modes of medical practice. 3/ What is considered "acceptable practice" is an issue to be resolved in each case, and the definition varies according to regional differences and applicable state law. The mere fact that an adverse outcome occurs is rarely sufficient to establish liability. 4/

Perceptions of the Problem

Despite its derivation from standard principles of tort law, medical malpractice is perceived differently by various groups, depending on the way their financial, social, political, and professional interests are affected by malpractice claims. Differences in perception have led to accusations that have contributed little to the resolution of the immediate problems associated with liability insurance. Conflict among interested groups also has not been conducive to resolution of differences or to improvements in the system.

During the period from 1969 to 1975, increasing premiums for liability insurance generated concern among medical care providers, health insurers, state and federal officials, and patients. Some physicians refused to provide services until the uncertainties of the liability insurance situation were resolved. The rise in liability insurance premiums was unprecedented. 5/ For example, the Insurance Services Office (ISO), an actuarial advisor to malpractice insurers, recommended premium increases in 1974 of 70.1 percent for physicians and surgeons and 56.5 percent for hospitals. 6/ In 1975, the percentage increases recommended by ISO were 110.8 percent and 87.0 percent respectively. 7/ The withdrawal of malpractice insurers in some states, and the threatened withdrawal in others, from writing medical liability insurance heightened the apprehension of providers and patients. Concern about insurance availability and the capacity of physicians and hospitals to absorb markedly higher premiums was widespread.

Uncertainties about the causes of increased claims and premiums contributed an emotional tone to discussions of medical malpractice. Accusations have been made by each of the groups involved in malpractice litigation. Physicians and institutional providers blame lawyers, who are alleged to encourage patients in bringing spurious

claims. The contingent fee arrangement for most liability suits is often regarded as an incentive for such behavior. 8/ Providers also express frustration with lay juries as the arbiters of causation and fault. Lay persons are seldom credited by providers as capable of understanding the complexity of many procedures that give rise to injury. Patients are blamed for the increase in malpractice claims on the basis of their supposedly increased willingness to sue their physicians. 9/

Attorneys and patient advocates point to factors in the delivery of medical care as the "cause" of the malpractice problem. One contention is that there simply is more medical negligence. Another is that physicians fail to establish the necessary rapport with patients to make them satisfied with their care. 10/ The cost of medical care and awareness of the size of physician incomes are also cited as factors that generate resentment among patients when the outcome of care is less than expected. 11/ The malpractice problem has been characterized by some commentators as simply an "insurance crisis" attributable to poor management by the insurers as well as bad experiences with investments. 12/

The Committee on Medical Injury Compensation believes that these and other attempts to assess blame for medical malpractice illustrate the frustration this issue raises but offer little toward solutions for either the short or long term. The problem is being defined in terms of insurance and liability for fault-induced injury rather than in the larger context of all medical injury. The increase in malpractice claims during the early 1970s was certainly not an isolated phenomenon. Claims for personal injury in all areas, including products liability and workers compensation, increased substantially in this same period. Civil litigation of all types commenced in federal district courts between 1967 and 1977 experienced a marked increase. 13/

The search for solutions to the "malpractice problem" led to legislative activity in almost every state by 1977. 14/ State legislation was primarily aimed at correcting perceived deficiencies in existing procedures for handling medical malpractice litigation. The laws addressed a wide range of procedural rules and aspects of substantive tort law. The most common legal changes were establishment of mandatory pretrial screening panels, limitations on total recovery in damages for malpractice actions, shortening of the time period within which a malpractice action can be brought, and consideration of recovery from collateral sources of compensation in determining damages. 15/ These changes were directed toward reduction of the number of claims brought by patients or their survivors. Some of the laws limit both access to the courts and the size of awards. While the committee cannot assess the effect of these laws on the number of claims made or on the incidence of medical injury, some raise questions of fairness and equity to patients. These questions are discussed in Chapter 4.

Insurance Practices and Problems

The role of professional liability insurers is a basic issue to be addressed in an examination of medical malpractice. Insurance companies that carried malpractice in 1973 and 1974 encountered more claims than they had anticipated. 16/ At the same time, higher average amounts were being paid for each successful claim. The average indemnity for claims where payment was made increased from $10,600 in 1970 to $16,000 in 1975. 17/ Some companies responded by drastically increasing premiums; others abandoned this line of business altogether. When insurance companies threatened to discontinue coverage for high-risk specialties, some states, such as Maryland, New York, and California, enacted emergency measures in order to maintain insurance availability. A few of these emergency measures have been extended to become permanent modifications in the organization and financing of professional liability insurance. New financial arrangements that have been implemented include the offering of policies with premiums based on claims made and claims paid, joint underwriting associations (JUAs), physician-owned or hospital-owned companies, hospital self-insurance programs, and state-administered excess-limits insurance programs.

Most professional liability insurance has been based on occurrence of the injury-precipitationg incident. An occurrence-based policy covers all claims that result from an event that occurs during the term of the policy, no matter when the claim is made or paid. The insurer's difficulty with this type of policy is in predicting when and how much will be paid out to resolve claims. The uncertainty stems from the frequently long interval between time of the incident and time of resolution of a claim. The delay is referred to by insurers as the "long tail" effect. Data collected by the National Association of Insurance Commissioners illustrate this effect. Of those claims for which indemnity was paid, about 45 percent were paid within two years of reporting the incident; however, less than 20 percent were paid within two years of the actual occurrence of the incident. 18/

One method of dealing with the long tail effect is to issue liability insurance on either a claims-made or claims-paid basis. Claims-made insurance covers only those claims actually made during the policy year, regardless of when the injury leading to the claim occurred. Claims-paid policies cover only those claims that are actually paid in a given policy year. There are difficulties with claims-made and claims-paid policies, however, in that the lower premiums for physicians in the earlier years of practice, and for more experienced physicians during the first few years of coverage, can be offset by the necessity for coverage after physicians reach retirement. Studies of closed claims have shown that it takes about 10 years before all expected claims are resolved. 19/ With claims-made and claims-paid policies, retiring physicians would have to continue their insurance for a number of post-practice years in order to protect their assets. 20/

Joint underwriting associations (JUAs) are another device by which insurance availability can be assured. JUAs are nonprofit organizations usually established by new legislation and composed of all liability insurance carriers operating in a state. By pooling resources, the risks for total liability are shared. More commonly, JUAs are used for excess liability policies that provide coverage for losses only above a specified amount. The amount below the threshold for the JUA policy is either covered by an individual liability policy or through self-insurance. The reserves required by state insurance laws are generally established by a surcharge on premiums. JUAs are primarily seen as temporary measures with the sole purpose of guaranteeing insurance availability until the insurance market stabilizes. 21/

Physician-owned companies also have emerged as a device to reduce high premiums or to alleviate the diminished availability of other forms of professional liability insurance. These are independent insurance companies, usually set up through state or county medical societies. Although there is variation in the structure and requirements of physician-owned companies from state to state, they all are based on the assumption that the selective insuring of physicians and the imposition on them of rigorous injury prevention programs will result in lower premiums for participating physicians. For example, physician-owned companies in northern California specify which policyholders are covered for different types of surgery and what controls must be adopted by participating groups, such as anesthesiologists. 22/

State administered insurance programs have several purposes, the most common being to minimize the potential liability costs of individual providers and to spread the impact of the costs of higher awards over a broader base. Providers usually are required to carry minimum insurance or prove that comparable assets are available; they are then charged a premium to fund the state program. In states that have legislated a limit on malpractice awards, the state fund will cover the difference between the limits of the basic policy and the maximum award possible. In those states with no awards limit, some mechanism may be provided to avoid depletion of the fund. If a fund is in danger of being depleted, further awards are made on a pro rata basis and considered paid in full, or an automatic limit is placed on awards. 23/

A substantial number of physicians and hospitals responded to rising malpractice rates by dropping their professional liability insurance. Providers who terminate their commercial insurance usually decide either to self-insure by setting up a reserve fund that will cover most claims or to practice without any form of insurance. Institutional providers have been more involved in establishing malpractice reserve funds than individual physicians. 24/

Physicians who drop their insurance have been encouraged to protect their assets from confiscation in the event of a malpractice judgment rather than to establish an individualized or small group self-insurance plan. 25/

An insurance proposal referred to as "channeling" would shift coverage from individual providers to health care institutions for malpractice incidents occurring within the institution. Because 75 to 80 percent of malpractice claims arise within institutional settings, this approach would consolidate liability at the site where injury usually occurs. 26/

There are three advantages to the channeling approach. They are: (1) broadening the base for distributing the risk of loss, (2) strengthening quality control efforts and injury avoidance, and (3) consolidation of legal defense and cost savings. 27/ A serious problem with channeling is that it would require a major redefinition of the legal relationship between hospitals and individual providers. At present, physicians practicing within an institution are usually considered independent contractors and are individually liable for their acts and those of the personnel under their supervision. Because of the concentration of legal liability in the institution that channeling would necessitate, any such plan would entail centralized institutional control of all providers practicing therein and legal changes in the nature of the physician-hospital relationship. 28/

Most indications are that the large increases in professional liability insurance have tapered off and that, for the most part, such insurance is available. One of the largest malpractice insurers reduced its premium rates in 17 states during 1976 and early 1977, due primarily to more favorable claims experience. 29/ Other major insurers and some jurisdictions with doctor-owned companies still report increases in premiums, but the annual percentage increase is substantially less than those in 1974 and 1975. 30/ It is not clear whether the reduction in rate of increase is a temporary lull or the beginning of a more stable insurance situation. The impact on the frequency of claims by legislative changes enacted in most states, by the development of alternative adjudicatory mechanisms, and by the emergence of countersuits by physicians against patients and attorneys is also unclear at this time.

Claims and Compensation

The compensatory function of malpractice litigation has been severely criticized by numerous reports on medical malpractice. 31/ The object of much of the criticism is that fault-based compensation produces some curious results. Data on the disposition of claims indicate that almost two-thirds of all claims are resolved with no payment to the claimant. Very few claims proceed to final resolution

at trial (7.0 percent); in fact, most claims are either settled or dropped prior to trial (90.2 percent). While the average indemnity paid per claim has increased markedly since 1970, there was a 5.8 percentage point decline in the number of claims resulting in payment between 1970 and 1975. Table 1 illustrates these changes in the disposition of malpractice claims.

Although the law of torts and civil litigation are referred to in this report as the prevailing "system" by which malpractice claims are resolved, in actuality the private contractual arrangement known as "settlement" is the means by which most claims are resolved. Settlement is a process of accommodation between two parties who have a conflict. The conflict is resolved by negotiating an agreement that sets forth the terms and conditions by which the complaining party agrees to waive his legal right to bring a lawsuit and proceed to trial. The claimant usually agrees to release the defendant from liability upon receipt of a specified amount of money. The agreement is a contract between the parties and performance under the contract can be enforced by the courts.

Various estimates have been made of the percentage of the malpractice premium dollar that is actually received by successful claimants. 32/ In 1975, the California Auditor General reported that approximately 56 percent was received by claimants as indemnity, with the remaining 44 percent going to legal fees and other direct claim costs. 33/ The transactional costs of civil litigation are high because compensation is only one goal of the process. Rules of evidence and procedure, while time-consuming and costly, help to assure that the goals of fairness and protection of basic legal rights are also realized. It should be noted, however, that these rules afford maximum protection of individual rights only in that small percentage of claims that are actually resolved by trial (Table 1).

There is some evidence that as economic loss increases (that loss defined as medical expenses, other demonstrable financial expenses related to the injury, wage loss, and anticipated future medical expense and wage loss), the proportion of loss covered by indemnity received actually decreases (Table 2). The closed claims study conducted by the National Association of Insurance Commissioners (NAIC) indicates that claimants with economic losses of less than $10,000 are likely to be compensated by a factor of four to five times the amount of loss. However, for alleged losses totaling more than $100,000, the indemnity paid is more likely to be about one-half the losses. There are some problems with these data that must be noted. They were derived from insurer records, and the alleged losses were not always verified. Also, it seems that the information on losses in the records was not always complete; thus, losses may be understated. 34/ However, the attempt by NAIC to compare alleged loss with actual indemnity paid was worthwhile and merits further work to refine the technique.

Table 1. Characteristics of Closed Claims
Selected Years: 1970 and 1975

	1970 1/	1975 2/
Disposition		
Closed with Payment	41.5%	35.7%
Closed without Payment	58.5%	64.3%
Total	100.0%	100.0%
Manner of Disposition		
Settled or Dropped Prior to Trial	91.0%	90.2%
By Trial	5.0%	7.0%
Settled During Trial	3.0%	1.9%
Other	1.0%	0.9%
Total	100.0%	100.0%
Average Indemnity Paid		
(where payment was made)	$10,600	$16,000

Sources:
1. Dietz SK, Kaufman S: Study of Medical Malpractice Claims Closed in 1970. Westat Inc, PB 247-812, October 1973, pp 26-27, 80 Table IV-1, 82 Table IV-2
2. NAIC Malpractice Claims, obtained from Tables 20-21, pp 95-96 and Tables 22a-c, pp 97-99

Note: Although the methodologies employed in these two studies are different, comparison of findings is not precluded.

Table 2. Economic Loss and Indemnity Paid

Alleged Economic Loss of Injured Persons*	Cumulative Percent of Incidents	Average Indemnity Paid	Ratio of Average Indemnity Paid to Economic Loss**
None	38.0	$ 22,001	
1 - 2,999	71.1	8,177	5.5:1
3,000 - 5,999	81.1	18,325	4.1:1
6,000 - 9,999	86.0	30,641	3.8:1
10,000 - 39,999	94.2	48,443	1.9:1
40,000 - 99,999	96.3	81,015	1.2:1
100,000 - 499,999	99.5	153,857	0.5:1
500,000 - 999,999	99.9	271,517	0.4:1
1,000,000 or more	100.0	474,297	0.5:1

Source: NAIC Malpractice Claims, data obtained from Table 25a, p 103

*Includes medical expense, unspecified "other" expense, and loss of wages; these figures represent both current losses as well as anticipated future losses

**This was computed using the average indemnity paid and the midpoint of the range of economic loss

Effects on Provider Behavior

One would expect that the concern of medical care providers about the cost and availability of liability insurance, and about the underlying issue of being sued by patients, would affect the behavior of providers. Many assertions are made about the inverse relationship between the quality of patient care and malpractice suits. The phrase "defensive medicine" has emerged to describe alterations in medical practice for the principal purpose of building a good defense in the event of a lawsuit for medically induced injury. Risk management for institutional providers has become increasingly popular as a means for reducing the number of claims, and perhaps eventually the incidence of medical injury. Some providers have resorted to countersuits against patients and attorneys in an attempt to curb the initiation of spurious claims.

But the impact of malpractice litigation on medical practice is very difficult to assess. First, relatively little time has elapsed since the issue became of national concern. Preliminary studies by Lipson 35/ and the California Medical Association 36/ indicate some minor changes but no major disruption in medical practice. The one change that is reported to have occurred is self-imposed limitation on areas of practice that are perceived by physicians as risky and likely to generate claims. 37/ Second, while malpractice premium rates have been alleged to influence provider decisions about choice of specialty, geographic location, and organizational setting for practice, many other factors are known to enter into these decisions.

Defensive Medicine The committee discussed the assumption that the threat of malpractice suits has spawned additional costly and inefficient practices. A few studies have addressed the issue of defensive medicine, but they are highly anecdotal. 38/ While no statistically supportable conclusions from studies of defensive medicine can be made, there is a strong feeling among providers that many actions are taken during diagnosis or treatment that are motivated by a sense of having to "build a good record" rather than for purposes of providing better patient care.

Ascertaining the physician's motivation in deciding whether to order or withhold a given procedure is extremely difficult. In many instances the committee felt it would be virtually impossible to distinguish between good medical practice and defensive medicine. 39/ The physician could be motivated by fear of malpractice, belief that the procedure is in fact beneficial, both, or any of a number of other subjective considerations. Even if the motivation is entirely fear of subsequent litigation, defensive medicine may have positive effects. For example, at the 1977 annual meeting of the American College of Obstetrics and Gynecology, it was reported that the rate of cesarean births had more than doubled in the past ten years. Some physicians blamed the increase in rate on the fear of malpractice

litigation. However, during this same period, techniques of fetal monitoring became widespread and fetal distress could be ascertained much earlier. Futhermore, the rise in cesarean births has been accompanied by a decrease in the perinatal mortality rate. Thus, it is not clear whether increased use of cesarean delivery should be considered "good" or "bad" medicine. 40/

The complexity of the defensive medicine issue is illustrated by the question of obtaining an X-ray of the skull in cases of suspected head trauma. In several malpractice cases, the failure to order such films was found to be negligence when the patient's subsequent deterioration could be linked to inadequate diagnosis and lack of appropriate intervention. 41/ However, Bell and Loop analyzed 1,500 skull X-ray examinations on patients of all ages and concluded that the procedure was of limited utility when performed on a routine basis for all patients with head trauma. They found that by limiting X-rays to those patients with at least one "high-yield finding," which the authors defined as certain clinical symptoms determined retroactively from the patient record, 435 X-rays could have been avoided. 42/ The "cost" of this approach, however, was the failure to identify the one skull fracture that Bell and Loop argued would not have been detected without X-ray examination.

Risk Management Because 75 to 80 percent of all malpractice claims arise from medical care provided in hospitals, increasing attention has been focused on the concept of institutional risk management. 43/ Although there is no standard definition of risk management, the elements commonly associated with it are the identification, evaluation, and reduction of risk of loss due primarily to patient injuries. 44/ In addition, risk management programs attempt to limit institutional liability once an injury has occurred by offering compensation for medical expense or associated financial losses before a claim is filed. The concept of risk management is not new; some institutions have practiced a limited form of risk management for as long as ten years. 45/

The relatively small number of institutions with formal risk management mechanisms belies the extent of organizational activities in this field. The Federation of American Hospitals has recently developed a Risk Management Manual containing general guidelines for the establishment of programs by its member hospitals. 46/ The American Hospital Association has urged all member hospitals to implement effective risk management measures directed to the following six goals: (1) identification of the risk of financial loss, (2) evaluation of the frequency and severity of the risk, (3) elimination of the risk, (4) reduction of exposure if risk cannot be eliminated, (5) transfer of risks that cannot be eliminated or reduced to third parties, and (6) insurance of risks that cannot be handled any other way. 47/

Four states have enacted legislation to require that risk management programs be established in all hospitals. 48/ The Florida statute calls for the appointment of an "incident committee" and a "risk manager" within each institution, sets guidelines for awarding compensation for injuries, requires a showing of financial responsibility by each hospital, and authorizes channeling malpractice liability to the hospital. 49/ However, the measure was recently declared unconstitutional by a trial court because of its alleged infringement upon state constitutional guarantees of the right to trial by jury.

The increasing interest in institutional risk management is attributable to several factors. The realization that the vast majority of incidents resulting in liability occur in institutional settings is a strong incentive to focus on hospital practices in an attempt to reduce risk. The decision by some hospitals to underwrite their own liability coverage has also been an inducement to pursue aggressive risk management. Very little evaluation of the effectiveness of these programs has been initiated. 50/

Countersuits A fairly recent phenomenon has been the emergence of physician countersuits against patients and their attorneys for pursuing frivolous or unfounded malpractice actions. Countersuits usually have been based on either the tort of malicious prosecution or the tort of defamation. Perhaps due to the numerous defenses applicable to defamation, 51/ malicious prosecution has been the most common approach. However, suing a patient or his attorney for malicious prosecution is not an easy matter. The physician must show that 1) there was a prior judicial proceeding by the patient against the physician; 2) the prior proceeding was terminated in favor of the physician; 3) there was no probable cause for initiating the prior proceeding; 4) the patient initiated the prior proceeding with malice; and 5) the physician suffered some damage as a result of the prior suit. 52/ Although the number of countersuits filed to date is very small, 53/ many providers are hopeful that such suits will reduce the initiation of claims.

A third possible, but unlikely, basis for malpractice countersuits is the tort of abuse of legal process. Abuse of process is based on the argument that a legal procedure has been used by a plaintiff to achieve a purpose wholly unrelated to the legitimate objectives of the procedure. 54/ This seldom-used action requires showing that 1) the defendant made an improper use of legal or judicial process, 2) the defendant had an ulterior purpose, and 3) damage resulted to the plaintiff. Unlike malicious prosecution, the plaintiff does not have to prove malice or lack of probable cause. The application of the tort of abuse of process to malpractice litigation would appear to be very limited.

One of the few successful malpractice countersuits is the 1976 Illinois case of Berlin v. Nathan. 55/ Berlin, a radiologist, had x-rayed the defendant Nathan's finger two years prior to commencement of the action, finding a dislocated finger with no fracture. Nathan later sued for $250,000, alleging a failure to properly diagnose a fracture and imbedded bone chip. Berlin then counter-sued, basing his claim on a novel legal basis; he alleged in his complaint that Nathan had breached a duty "to refrain from willfully and wantonly bringing suit against him and involving him in litigation without having reasonable cause to believe he had been guilty of malpractice that proximately caused injury to (the defendant)." 56/ Berlin sought to establish lack of probable cause based on the fact that the defendant's attorneys never sought a second opinion on the X-rays in question from another radiologist and never obtained a medical opinion on the proximate cause of the injury. He also alleged that the defendant's action was motivated by malice in the form of personal animosity toward him. The trial court jury found in favor of Berlin and awarded him $8,000 ($2,000 in compensatory damages and $6,000 punitive). The case is presently on appeal by the defendant.

Breach of the duty not to file frivolous or unfounded malpractice actions is a novel approach for initiating a countersuit. If the Berlin decision is affirmed on appeal, it could stimulate malpractice countersuits. This is important to note, because one commentator feels that malicious prosecution, as it exists, is not a viable remedy for most physicians. 57/ In addition to the difficulty of establishing absence of probable cause and the existence of malice, there is a strong public policy consideration that has traditionally militated against the expansion of malicious prosecution:, increased use of countersuits could discourage legitimate claims from being brought by injured patients for fear of reprisal if unsuccessful. 58/

REFERENCES AND NOTES

1. Department of Health, Education, and Welfare: Report of the Secretary's Commission on Medical Malpractice (DHEW Publication No. [OS] 73-88), 1973, pp 5-9 (hereafter cited as Secretary's Commission Report)

2. Malpractice actions also can be based on claims arising from common law battery ("a harmful touching") because of a failure to inform and on breach of contract. However, the bulk of such actions are based on negligence. To establish negligence, a plaintiff must show that 1) the defendant physician owed a duty to him--generally the duty to exercise the due care expected of a practitioner under the same circumstances, 2) the defendant breached that duty by failing to render the acceptable standard of care, 3) the defendant's breach of duty was the proximate cause of the plaintiff's injury, and 4) the plaintiff suffered an injury resulting in some actual damage or loss. See, Prosser WL: The Law of Torts. Fourth edition. St Paul, West Publishing Co, 1971, sec 30

3. But see, Helling v. Carey, 83 Wash.2d 514, 519 P.2d 981 (1974)

4. However, there is a doctrine in tort law known as res ipsa loquitur (literally, "the thing speaks for itself") in which liability may be established without affirmative proof that any one defendant was negligent. The principle generally is applied where an injury is of the kind which ordinarily does not occur in the absence of someone's negligence, it was caused by the defendant or someone under his supervision, and it was not due to any voluntary action or contribution on the part of the plaintiff. See generally, Prosser, as referenced note 2, sec 39. In medical malpractice, the doctrine is perhaps most often applied in cases involving foreign objects left in the patient's body. For a case which includes a good discussion of res ipsa loquitur as applied to medical malpractice, see Mayor v. Dowsett, 240 Ore. 196, 400 P.2d 234 (1965)

5. For example, the Insurance Services Office recommended the following annual percentage increases in premiums for physicians, surgeons, and hospitals:

Physicians and Surgeons

Year	Percentage Change
1970	+ 17.4
1971	+ 14.8
1972	+ 12.2
1973	+ 8.7
1974	+ 70.1
1975	+110.8
1976	+ 25.0
1977	+ 13.0

Hospitals

Year	Percentage Change
1974	+ 56.5
1975	+ 87.0
1976	+ 42.4
1977 - 9 mos.	+ 14.9

Insurance Services Office: ISO Countrywide Professional Liability Rate Revisions (Filed and Approved), internal working memoranda, Washington, DC

6. Ibid.

7. Ibid.

8. But see, Dietz SK, Baird CB, Berul L: The Medical Malpractice Legal System. Appendix, Report of the Secretary's Commission on Medical Malpractice, Dept of Health, Education, and Welfare (DHEW Publication No. [OS] 73-89), 1973, pp 97-101 (hereafter referred to as Appendix, Secretary's Commission Report)

9. Health Policy Analysis Program, Dept of Health Services, U of Washington: The Malpractice Issue in Washington, November 1975, p 12 (hereafter cited as Washington Report)

10. See, Barondess JA: Science in Medicine: Some Negative Feedbacks. Arch Int Med 134:152, 1974; also, Somers HM, Somers AR: Specialism, General Practice, and Comprehensive Care, in Medical Care: Readings in the Sociology of Medical Institutions. Edited by WR Scott. New York, J Wiley, 1966, p 125

11. Based on a 1975 survey by the National Opinion Research Center of 1,000 practitioners in general practice, general surgery, pediatrics, obstetrics/gynecology, and internal medicine, the Department of Health, Education, and Welfare found that gross income per practitioner averaged $100,000. Average net income after all expenses and taxes was $60,000. Malpractice premiums were found to represent approximately three percent of average gross income. Personal communication with Nancy Greenspan, Office of Policy, Planning, and Research, Health Care Financing Administration (DHEW), Washington, DC, December 21, 1977

12. Somers HM: The Malpractice Controversy and the Quality of Patient Care. Milbank Mem Fund Q, Spring 1977, pp 197-199; also, A Close Call, Forbes, April 1976, pp 30, 35-36

13. Administrative Office of the United States Courts: A Pictorial Summary, Washington, DC, 1977, p 12

14. Department of Health, Education, and Welfare, Public Health Service: Legal Topics Relating to Medical Malpractice, January 1977. The American Bar Association's Fund for Public Education, under contract with the Department of Health, Education, and Welfare, found that 43 states had enacted some form of remedial legislation in 1975 or 1976.

15. These and other modifications of existing laws are described in Chapter 4.

16. For example, the Insurance Services Office reported an average increase in claims frequency of 12.1 percent for the period 1967 to 1975. For the three years immediately preceding 1975, there was a cumulative increase of 68 percent in claims frequency. All Industry Medical Malpractice Insurance Committee: The Problems of Insuring Medical Malpractice, November 1975, pp 19, 20

17. The 1970 figure was derived from Dietz S, Kaufman S: Study of Medical Malpractice Claims Closed in 1970. Westat Inc, PB 247-812, October 1973, p 80 Table IV-1, p 82 Table IV-2 (an interim report of this is found in the Appendix, Secretary's Commission Report, as referenced note 8, pp 1-25); the 1975 figure was derived from National Association of Insurance Commissioners: NAIC Malpractice Claims, Vol 1, No. 4, Milwaukee, May 1977, pp 95-96 Tables 20-21, pp 97-99 Tables 22 a-c (hereafter cited as NAIC Malpractice Claims)

18. NAIC Malpractice Claims as referenced note 17, obtained from data presented in Table 3a-4a, p 19

19. Roddis RSL, Stewart RE: The Insurance of Medical Losses. Duke Law J 1975:1295, 1975

20. Other financing arrangements could be devised to prevent or ameliorate this situation. Premiums could be subsidized by a surcharge on those physicians still in practice or by the state-administered funds that provide excess liability coverage in some states.

21. Institute of Medicine, National Academy of Sciences: Selected Issues in Mandated Health Insurance, Appendix A, November 1972, p 5

22. Murray AF: The Medical Malpractice Situation in California. Health Policy Program, School of Medicine, U of California at San Francisco, September 1976, p 29

23. The general characteristics of state plans are similar, but there is considerable variation in the means used to safeguard against fund depletion. Two examples are described below. In Oregon physicians must purchase basic coverage of $100,000 to $500,000 depending on the risk class. Amounts more than these basic limits are paid from the excess fund, but no more than 10 percent is paid per year, and if the funds are insufficient, payment is on a pro rata basis and considered paid in full. HB 2647, Ch 796, Oregon Laws of 1975. In Wisconsin, there is a minimum basic coverage of $100,000/$300,000. Judgments exceeding $200,000 per person or $600,000 per incident are paid by the excess fund. If the funds are exhausted, awards are paid out of next year's funds. If the fund falls below $2.5 million in any one year or below $6 million for any two consecutive years, an automatic limit of $500,000 per occurrence is applied. AB 725, Ch 37, Wisconsin Laws of 1975

24. Welch BB: Self-Insurance: An Approach to Solving the Malpractice Problem. Hospitals 51:81-83, 1977. It has been estimated that as many as 45 percent of the acute care hospital beds in New York are self-insured. Lewis I, Clayman S: Hospital Malpractice Insurance in New York State: A Policy Analysis. Dept of Community Health, Albert Einstein College of Medicine, 1977

25. Dornette WHL: Going Bare. J Legal Med 5:3, March 1977

26. Rudov MH, Myers TI, Mirabella A: Medical Malpractice Claims Files Closed in 1970. Appendix, Secretary's Commission Report, as referenced note 8, p 10

27. See, Steves MF: A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability Insurance System. Duke Law Rev 1975:1325-1326, 1975; also, Virginia State Corporation Commission: Medical Malpractice Insurance in Virginia: The Scope and Severity of the Problem and Alternative Solutions, Richmond, 1975, pp 81-84

28. See, Darling v. Charleston Community Memorial Hosp., 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966)

29. St Paul Fire and Marine Insurance Co: Malpractice Digest, April-May 1977, p 1

30. Preliminary data compiled by the Office of Policy, Planning, and Research, Health Care Financing Administration (DHEW), indicate that for standard policy limits of $100,000/$300,000, the weighted average for percentage increase in malpractice premiums for all risk classes of physicians and surgeons was 84 percent between 1974 and 1975, and 42 percent between 1975 and 1976. Personal communication with Nancy Greenspan, Washington, DC, December 21, 1977

31. See, for example, State of New York: Report of the Special Advisory Panel on Medical Malpractice, 1976, pp 53-54 (hereafter cited as New York Report); also, Washington Report, as referenced note 9, pp 17-18

32. New York Report, as referenced note 31, pp 249-254

33. Joint Legislative Audit Committee, Office of the Auditor General, California Legislature: Doctors' Malpractice Insurance: An Interim Report, September 10, 1975, p 9

34. Telephone conversation with Patricia Sowka, National Association of Insurance Commissioners, Milwaukee, December 1977

35. Lipson A: Medical Malpractice: The Response of Physicians to Premium Increases in California. Rand Corporation, Santa Monica, November 1976; also, Brook RH, Brutoco RL, Williams KN: The Relationship Between Medical Malpractice and Quality of Care. Duke Law Rev 1975:1209-1210, 1975. Lipson, who utilized the results of surveys of third-year resident physicians and medical and specialty societies in California, as well as existing data on premium rates, physician supply, and hospital occupancy in California, found that medical malpractice had not had a substantial effect on any of the eight factors studied. These factors were (1) choice of geographic location, (2) choice of medical specialty, (3) choice of type of medical practice, (4) spectrum of care offered, (5) choice of insurance coverage, (6) quality of care offered, (7) defensive medicine practiced, and (8) political action.

36. Report of the Special CMA Member Survey of Professional Liability (May 1976). This survey of 778 physicians found that 1.5 percent of respondents retired and 0.5 percent moved to another state citing high insurance premiums as the reason. See p 4

37. Lipson, as referenced note 35, p 54

38. See, for example, Hershey N: The Defensive Practice of Medicine, Myth or Reality. Milbank Mem Fund Q, January 1972, pp 69-77; also, Project, The Medical Malpractice Threat: A Study of Defensive Medicine, Duke Law J 1971:939, 1971

39. See, Bernzweig EP: Defensive Medicine. Appendix, Secretary's Commission Report, as referenced note 8, p 40

40. See, Health Insurance Association of America: A Review of the Medical Malpractice Problem in the United States, October 1975, p 1

41. Holder AR: Roentgenograms of Head Injuries. JAMA 222:613-614, 1972, citing: Orendino v. Clarke, 402 P.2d 527 (1965); Cooper v. Sisters of Charity, 272 N.E.2d 97 (1971); Keene v. Methodist Hospital, 324 F.Supp. 233 (1971); Reeves v. North Broward Hospital District, 191 So.2d 307 (1966); Bourgeois v. Dade County, 99 So.2d 575 (1957); Roston v. Klein, 178 N.W.2d 675 (1970)

42. Bell RS, Loop JW: The Utility and Futility of Radiographic Skull Examination for Trauma. N Engl J Med 284:236, 238, 1971; also, Roberts F, Shopfner CE: Plain Skull Roentgenograms in Children with Head Trauma. Am J Roentg 114:231, 236, 1972

43. Rudov, et al., as referenced note 26

44. Macro Systems, Inc: A Preliminary Assessment of Risk Management in Health Care Settings, prepared for National Center for Health Services Research, Rockville, MD, July 1975, pp 7-8 (mimeographed). The American Hospital Association defines risk management as "the science for the identification, evaluation and treatment of the risk of financial loss." See, Applied Management Sciences: A Study of Hospital Patient Injury Prevention Programs, prepared for Office of the Assistant Secretary for Health, DHEW, 1976, 1976, p 1.6, citing letter from James L Groves, American Hospital Association

45. For example, Plantation General Hospital, Plantation, Florida. Federation of American Hospitals: Florida Law Requires Hospitals to Have Internal Program on Risk Management, FAH Review 10:27, 1977

46. Ibid., p 13

47. See, Holloway ST, Sax AB: AHA Urges, Aids Hospitals to Adopt Effective Risk Management Plans. Hospitals 51:57-9, 66, 1977; also, National Conference of State Legislatures: Medical Malpractice and the State Legislatures, Iss 4, 1976, p 6

48. Ludlam JE: States Move Toward Legislated Hospital Risk Management. Hospitals 51:63-66, 1977. The states are Florida (1975), Alaska (1976), Rhode Island (1976), and Minnesota (1976--grievance procedures only)

49. Ibid., pp 64-65

50. See, Applied Management Sciences study, as referenced note 44, pp 2.1-2.9

51. In the context of medical malpractice countersuits, the most important defenses to a defamation action are 1) good faith [Foster v McClain, 251 So.2d 179 (La. Cir. Ct. App. 1971)], 2) publication during the course of a judicial proceeding [Prosser, as referenced note 2], and 3) constitutional privilege based on first and fourteenth amendments which prohibits recovery by "public figures" absent actual malice [New York Times v. Sullivan, 376 U.S. 254 (1964)]; but see, Jankelson v. Cisel, 3 Wash.App. 139, 473 P.2d 202 (1970), a successful malpractice countersuit based on defamation

52. Prosser, as referenced note 2, secs 119, 120

53. Sullivan v. Terry, Civil No. 75-565-CA (Fla. Cir. Ct., filed Oct. 18, 1975); Rogers v. Hills, Civil No. W 76 G 268 L (Ill. Cir. Ct., filed Jan. 29, 1976); Balthazar and Schoenfeld v. Dowling, Safanda, and Reyes, Civil No. 76-6-799 (Ill. Cir. Ct., filed Jan. 23, 1976); Rogers v. Mirabella, Facktor, Mirabella, and Kincaid, Civil No. W 75 G 191 L (Ill. Cir. Ct., filed Jan. 23, 1976); Berlin v. Nathan, Civil No. 75 M2 542 (Ill. Cir. Ct., filed Oct. 22, 1975); Burkons v. Rogoff, Civil No. 953,503 (Ohio C.P., filed Mar. 9, 1976)

54. Prosser, as referenced note 2, sec 121

55. No. 75-L 16838, 75 M2-542, (Cir. Ct., Cook County, Ill., June 2, 1976)

56. Berlin Complaint, Count I, para 14

57. See, Note: Malicious Prosecution: An Effective Attack on Spurious Medical Malpractice Claims, Case Western Res Law Rev 26:683-684, 1976

58. Ibid., pp 656, 674

Chapter 3

EVALUATION OF APPROACHES TO COMPENSATION

Several alternatives have been proposed to medical malpractice litigation. Some of them emphasize medical injury compensation, while others are stop-gap measures to reduce the burden of high insurance premiums or to limit the number of patient claims. The proposals range from minor modifications of the existing fault-based tort system to the development of a social insurance scheme. If the proposals are grouped according to the standard for determining compensability, the committee finds that there are three main categories: 1) those proposals that limit compensation to the injuries caused by an act or failure to act by a provider; 2) those in which compensation is determined in advance of occurrence of the injury according to lists of specified events; and 3) those in which compensation is available for all adverse consequences of medical care, irrespective of provider fault.

The committee developed six criteria by which to evaluate proposed approaches for medical injury compensation. 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. Unfortunately, these comparisons could not be drawn because of the lack of data on costs. However, the 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.

These criteria are discussed in the following sections generally in the order specified above. A tabular comparison of compensation systems using the six criteria is included as Chart 1 (pages 47 and 48).

The selection of the evaluation criteria is an attempt to isolate certain key aspects that ought to be addressed by any compensation system. Because the committee wished not to have presuppositions about the desirability of one approach over another, the use of these explicit criteria was helpful. Whenever possible, the committee based its evaluation on existing data. However, on such topics as costs and financing, the data were so incomplete as to preclude any projections. In those instances, the committee relied on its judgment about advantages or disadvantages of a particular approach. The committee recognizes the limitations of comparing existing compensation mechanisms and hypothetical proposals for new compensation schemes.

Approaches Based on Fault

One approach for compensating an injured patient is based on the injury being associated with the fault of a provider. Fault can stem from negligent or intentional acts. In order to recover from the provider, an injured patient must show that the injury caused some damage or harm. Fault-based approaches include traditional civil litigation, pretrial screening panels combined with litigation, and arbitration.

In theory, compensation for medical negligence is obtained through the legal process commonly referred to as litigation. Although litigation is often thought of as a courtroom procedure, it also comprises numerous pretrial and occasional post-trial activities. In fact, the bulk of malpractice claims are disposed of by negotiation and settlement before trial.

A recent analysis of medical malpractice claims indicates that approximately 90 percent of all claims are settled by mutual agreement or abandoned before trial. 1/ Any evaluation of fault-based compensation therefore must take into account not only trial procedures, but also the process by which claims are settled or dropped before trial. In addition, it is important to question why certain losses arising from provider negligence do not result in claims. While trial procedures are more easily described and evaluated, they are applicable only to a small fraction of malpractice claims.

The private nature of the settlement process may account for the dearth of research and evaluation on it. What little there is focuses on sociological factors, such as characteristics of the parties to a lawsuit, and examines how these factors influence outcomes. Factors that enhance settlement include the difficulty of proving liability, the nondemonstrability of the injury, large disparity in the economic positions of the two litigants, and the congestion of the court docket. 2/ In formulating their settlement strategy, attorneys take into account known settlement propensities of the liability insurer, the probability of success in a particular court before specific judges, and the credibility of both plaintiff and defendant as witnesses. 3/

Despite the lack of detailed information on settlement, it is the means by which most malpractice claims are resolved. Therefore, the following discussion of traditional negligence suits, screening panels, and arbitration is currently applicable to a small portion of fault-based compensation claims.

Traditional Litigation

Access to compensation through litigation begins with filing a complaint against a provider alleging that any injury has occurred as the result of provider fault. Bringing a claim, however, is hindered by several factors. At the outset, claimants must evaluate the facts of their particular situations based on unfamiliar medical and legal considerations. In most cases, the procedural complexities of bringing a tort claim necessitates obtaining the services of an attorney. Attorneys who take personal injury cases usually work on a contingency fee basis, which means they receive payment only if judgment is favorable to their client. A claim must be of sufficient size with a high likelihood of success to merit the investment of an attorney's time. A recent survey found that a claimant has less than

one chance in eight of convincing an attorney to take a medical malpractice case. 4/

The fact that litigation is very time-consuming may serve to restrict access to compensation. Studies of closed claims indicate considerable delay from time of injury to time of final disposition. 5/ Delay in receiving compensation for medical costs and income losses is a hardship for injured patients, particularly those with low incomes.

Access is also constrained by certain procedural rules, such as statutes of limitations stipulating the period of time within which a lawsuit can be initiated. For a malpractice claim, the statute of limitations may begin from the time of injury or from the time an injury comes to the attention of the injured party. Most states apply the latter, more liberal, rule. However, in an attempt to limit the number of malpractice suits, some states have adopted the "time of occurrence" rule. Shortening the time in which a claim may be brought has the effect of denying compensation to those patients whose injury becomes apparent only after some time has elapsed since the incident that caused it.

Compensation under tort law can be made for medical expenses, loss of income, marital losses (referred to as "loss of consortium"), and pain and suffering. The requirement that a causal relationship be established between the acts of a medical care provider and the injury greatly reduces the number of compensable injuries. In most jurisdictions, injured patients must show that their losses exceed certain minimum dollar amounts. At least 11 states have established ceilings on the amount of compensation that can be awarded to a successful claimant in litigation. 6/ Limitations on awards are aimed at reducing the decision-making powers of the jury and discouraging claimants who seek damages through tort law in the hope of receiving a large jury award.

Although tort law purports to make an injured person financially whole again, several factors cause the system to over- or under-compensate. These include 1) the requirement that physical and emotional losses must be translated into financial loss on a case-by-case basis, 2) determination of the size of awards by a lay jury, 3) unusually large awards for pain and suffering in instances of particularly egregious behavior by a provider, 4) routine elimination of small claims because of statutory minimums for losses or contingency fee arrangements, and 5) upper limits on total awards in some states.

As a compensation mechanism, traditional litigation is concerned only with assuring that the injured party receives a dollar award, not with the source of compensation. Theoretically, payment is made by the party who is found at fault. However, liability insurance spreads loss among all insured persons and softens the impact of a malpractice judgment against a provider.

A number of states have recently enacted laws that reduce awards in malpractice cases by the amount of collateral recovery, such as proceeds from the plaintiff's insurance policies. These statutes tend to diminish the possibility of over-compensation where the tort system is not the sole mechanism for obtaining financial compensation.

Information is lacking on the costs of traditional litigation for medical negligence cases. The amount paid in premiums for professional liability insurance is only one part of the costs. Much of the administrative cost of maintaining courts is borne by taxpayers. Other costs are spread among providers, patients, and the general public in the form of health and disability insurance, social and rehabilitative services, income assistance plans, and uncompensated losses by patients.

The tort system only indirectly encourages the reduction of medical injuries. While a relationship is assumed between malpractice suits and the practice of defensive medicine, as the committee noted in Chapter 2, conclusions about the nature and extent of defensive medicine cannot be drawn from the few studies that exist. The publicity associated with a trial may have a deterrent effect on providers. At a minimum, judicial decisions on appropriate standards of care alert providers to the legal limits of acceptable risk.

The relationship between litigation and other aspects of medical care such as quality assurance is unclear. Litigation functions on a case-by-case basis, viewing each malpractice incident individually and retrospectively. In theory, court decisions should influence providers to avoid liability by exercising more care in their practices or by discontinuing risky or marginally beneficial procedures. In fact, the widespread reliance on professional liability insurance mitigates any direct effect of litigation on the quality of care.

Advantages of traditional litigation:

- The substantive and due process rights of individuals who gain access to the system are protected.
- Unreliable or prejudicial testimony is carefully controlled by formal rules of evidence.
- The process is impartial and has not been shown to favor providers or patients as a class.

Disadvantages of litigation:

- Access to compensation is hindered by the necessity of and difficulty in obtaining an attorney.
- Compensation for injury hinges on proof of provider fault, thereby eliminating all other medical injuries from compensation.
- Compensation is unpredictable and losses are frequently over- or undercompensated.
- Professional liability insurance reduces the injury avoidance incentives generated by tort liability.

Pretrial Screening Panels

Pretrial screening panels are an additional component of litigation rather than a substitute compensation system. Screening panels were developed to permit the early settlement of meritorious claims and discourage frivolous litigation. 7/ They may be organized pursuant to state statute, by court order, by physician groups in conjunction with a bar association, or by physician groups acting on their own. Submission of a claim to a pretrial screening panel may be either voluntary or mandatory, depending on applicable state law. Thirty states have enacted statutes establishing pretrial screening panels in some form--21 make it compulsory that a claim be taken to a screening panel before trial. 8/ The composition of the panel and its scope of inquiry vary from state to state; a typical panel has three to seven members, most of whom are physicians, attorneys, and judicial officers. 9/

The primary difference between litigation and screening panels is that immediate access to the courts is hindered when pretrial screening is compulsory. As an adjunct to litigation, screening panels utilize the same concept of a compensable medical injury as does the tort system. The determinative issue for most screening panels is whether a substantial likelihood of malpractice exists. When created by statute, most screening panels make only preliminary determinations of liability and do not establish the level of compensation.

Screening panels differ from traditional litigation in the means by which the merits of injury claims are assessed. Screening panels are procedurally less formal than a court: methods for obtaining access to evidence are non-adversarial, oaths are rarely required during hearings, 10/ review by the screening panel is private, transcripts are generally prohibited, 11/ and cross-examination is seldom permitted. 12/

Screening panels also differ from traditional litigation in the lack of finality of their decisions. The findings of a screening panel are only advisory and may or may not be introduced into evidence at a subsequent trial. Some plans, however, secure an agreement from the claimant to drop the claim if the finding is for the physician. 13/

The composition of a screening panel affects the likelihood of a decision favorable to plaintiffs. 14/ It appears that panels made up entirely of physicians are less likely to find in favor of the plaintiff than are other types of panels; regional and court-sponsored panels, which include attorneys and laymen, improve the likelihood of plaintiff success. 15/

There is no information on administrative and overhead costs of pretrial screening panels. Proponents of them contend that the overall costs of tort litigation will be reduced by expediting the settlement of claims at the prelitigation stage and by eliminating frivolous claims. It remains to be seen, however, whether screening panels will prevent enough claims from reaching the courts to offset the duplicate costs of reviewing claims twice in those instances where the claimant proceeds to trial.

The injury avoidance incentives of screening panels are essentially the same as in traditional litigation. However, the private nature of a screening panel eliminates any impact the public nature of a trial may have on the future actions of medical care providers. Panel judgments on standards of care would not necessarily be communicated to other providers or the public.

Advantages of screening panels:

- They tend to encourage early settlement of meritorious claims and discourage frivolous litigation.
- Decisions by screening panels do not foreclose the option of proceeding to litigation for those who are dissatisfied with the panel's decision.
- Informal discovery, procedural, and evidentiary rules facilitate speedier decision-making.

Disadvantages of screening panels:

- The lack of finality of decisions adds another layer to the resolution of injury claims.
- Panels consisting solely of physicians appear to be biased in favor of providers.

- Relaxed discovery, procedural, and evidentiary rules may be insufficient to protect the due process and substantive rights of the parties.

- Where screening panel decisions are admissible at trial, juries may be unduly influenced by the findings of a decision-making body which operated without formal rules of procedure.

- The private nature of screening panels lessens whatever deterrent effect publicity about a finding of negligence provides.

Arbitration

Arbitration is a dispute-settling process that can be a substitute for litigation. Based primarily on principles governing private contracts, it is an agreement between two parties to submit their dispute to a group of arbitrators for resolution. Arbitration can be mandatory or voluntary, binding or nonbinding, conducted by professional arbitrators or by a group of impartial lay persons. Medical malpractice claims can be arbitrated under general arbitration laws in 36 states; specific medical malpractice arbitration statutes have been enacted in 11 other states. 16/ In those states that do not have arbitration statutes, common law contract principles allow providers and patients to enter into similar agreements. Arbitration agreements have been used by a variety of medical care providers, including individual physicians, hospital associations, medical groups, and prepaid group health plans. 17/

An agreement to arbitrate eliminates access to traditional litigation, except under rare circumstances and for narrowly limited purposes. 18/ Once an arbitration agreement is made between provider and patient, access to potential compensation is more predictable than in traditional litigation. As is the case with all fault-based approaches, a compensable medical injury under arbitration must have been caused by the negligent or intentional acts of a medical care provider.

Parties to an arbitration agreement may invoke the arbitration procedure whenever a personal injury claim is made. The same range of prehearing discovery devices are available as in litigation, but usually with a minimum of formal requirements. 19/ Most records or documents are voluntarily made available by the parties, the setting and procedures for arbitration are informal, and review of a claim is conducted in private. In general, the process of arbitration is similar to the operation of a screening panel. The main differences are that arbitrators may be specially trained in the techniques of dispute resolution, and they have the authority to make a final determination of liability and can assess damages. An arbitration award is filed with the appropriate court for enforcement.

The committee noted a possible procedural problem with arbitration. An arbitration agreement only obligates the parties to it. For example, a hospital might require patients to agree to arbitrate claims, but physicians practicing in the same hospital might not agree to arbitrate claims against them. An injury that results from the conduct of multiple institutional and individual providers could cause patients to seek compensation through both arbitration and litigation if an arbitration agreement was only executed with one, but not all, of the providers.

Another concern is that the arbitration process may be vulnerable to the development of bias in favor of organized providers as opposed to unorganized patients. Even initially neutral parties, such as nonphysician arbiters, may defer to provider members of the arbitration team because of their technical knowledge and expert judgment.

Data are insufficient on the size of arbitration awards and the types of losses for which compensation is granted. This is due, in part, to limited experience with arbitration in resolving malpractice disputes.

Proponents of arbitration have asserted that administrative costs should be much lower than for traditional litigation. Arbitration hearings can be held anywhere, thus reducing costs for personnel and facilities. Informality of procedure should lead to shorter hearings and more timely resolution. However, preliminary findings of the National Association of Insurance Commissioners (NAIC) closed-claims studies indicate that, although the formal hearing procedure may be faster and simpler under arbitration, the actual time elapsed between making a claim and final resolution may offer no great advantage over traditional litigation. 20/ Only a small number of claims reach final determination by the arbitrators; most claims are settled through private negotiation, which can be slow and therefore costly to the claimant.

Arbitration appears to offer no advantage over litigation regarding injury avoidance, and may even reduce incentives for providers. Participation by medical experts as arbitrators, the diminished possibility for social stigma resulting from publicity because the process is private, and the relatively lower cost of the process for providers could serve to lessen provider concern with the incidence of injury. Also, arbitration has not been formally linked with licensure or quality assurance mechanisms.

Advantages of arbitration:

- Arbitration agreements facilitate access to review of malpractice claims by a third party.

- The process is a complete substitute for litigation and could help to alleviate the burden of malpractice cases in the courts.

- Arbitration proceedings are less complex than litigation.

Disadvantages of arbitration:

- Relaxation of procedural and evidentiary rules may erode protection of due process and substantive rights of the parties.

- The private nature of the process does little to encourage injury avoidance.

- The voluntary nature of arbitration is seriously undermined when providers or insurers require an arbitration agreement to be executed as a condition of receiving medical care.

Specified Events Approaches

The limitations and deficiencies of fault-based approaches have stimulated the development of a few related proposals that retain certain desirable characteristics of litigation and attempt to remedy some of its shortcomings. These proposals are based on the beliefs that compensation for injured patients limited to a finding of provider fault is much too cumbersome and costly, 21/ and that many potentially compensable claims go uncompensated, or are undercompensated. 22/

The two proposals described in this section, Medical Adversity Insurance and elective no-fault, share certain basic assumptions. First, changes in present tort law and procedures will have little long-term impact on medical malpractice insurance premiums. Second, providers can be persuaded to designate in advance of occurrence a list of specified events that ought not to occur during the course of medical care. These events, assuming adherence to certain standards of procedure, are generally recognized as "avoidable" by providers. Third, the specified events should be compensable with no further evidence or verification required than that the event occurred. Fourth, the injury avoidance incentives of provider financial responsibility found in fault-based approaches should be retained.

There are several difficulties with specified-events approaches in trying to move them from a theoretical framework to practical application. A key problem is the consensus required among expert judges about the avoidability of a specific outcome of medical care. Medicine is not an exact science and there is great variation in the responses of patients to medical interventions. These characteristics of medical care make it difficult to specify in advance that a particular outcome ought not to have occurred. Adding to the

difficulty of compiling lists of specified events is the fact that medical practices or techniques often are in the process of changing, thus creating some uncertainties about what is considered "acceptable practice" by the profession.

Medical Adversity Insurance

Medical Adversity Insurance (MAI), originally developed by Havighurst and Tancredi, has three essential characteristics: (1) a list of automatically compensable events designated in advance of occurrence, (2) an insurance system, with premiums for providers based on their claims experience, and (3) reliance on a parallel adjudicatory system, such as traditional litigation or arbitration, for resolving claims that fall outside the list of automatically compensable events. The rationale of MAI is that avoidable medical injuries can be deterred through financial incentives. Accordingly, the list of compensable events is limited primarily to outcomes of medical care that are deemed "relatively avoidable."

The notion of relative avoidability means that medical experts would select those adverse outcomes of medical care that they believe to be usually avoidable. While MAI is directed to avoidable outcomes, it is not inconceivable that some unavoidable injuries also might be included. Progress has been made in developing lists of compensable events in two areas of medical practice--anesthesiology and surgery. 23/

The initiation of a claim and access to compensation under an MAI plan would simply entail filing a claim with the insurer, either directly or through the covered provider. For events not on the list, the patient would seek compensation through a parallel adjudicatory system, which in most instances would be traditional litigation.

Compensation under MAI is limited to injuries on the list of specified compensable events. MAI would provide automatic indemnification for medical expenses and lost wages up to a predetermined amount. Damages for pain and suffering could be included by designating in advance a specific dollar amount for that type of relief.

A primary objective of MAI would be to provide more widespread and prompt compensation for injuries than do the fault-based systems. To accomplish this, MAI would reduce the average size of individual damage awards and provide a uniform method for compensating different patients for the same injury. Benefits under MAI would be highly predictable for those outcomes on the list of automatically compensable events. In return for predictability, individualized case-by-case assessments of injury and loss would be forfeited. Benefits from collateral sources also would be deducted from the final award. There are no data on the promptness of compensation

under MAI because it is only a proposed system. However, it does have potential for reducing delay as well as eliminating many of the costs of litigation for injuries on the compensable list.

A weakness of the MAI approach is the difficulty of predicting administrative costs. Havighurst acknowledges this weakness when he questions whether concentrating on relatively avoidable outcomes will in fact reduce such costs. 24/ Compiling a compensable events list initially, and then keeping it up to date, would entail substantial costs.

MAI would be financed primarily through provider-purchased insurance. Each provider, whether individual or institutional, would purchase from a private insurer a policy of "medical adversity insurance." This would cover the losses associated with certain specified events. Premiums would be merit-rated according to the number and types of claims brought against a provider.

The MAI proposal incorporates financial incentives for providers to avoid medical injuries. Merit-rated premiums preserve the tort law concept of provider accountability for adverse results of medical treatment. But, by moving away from fault as the basis for compensation, MAI recognizes that technical medical proficiency does not eliminate all adverse outcomes. The fact that certain avoidable outcomes on the specified events list might not always result from negligence could stimulate attempts to perfect the technique or to minimize the consequences of the adverse outcome once it occurs. 25/ MAI has the potential for encouraging improvements in the quality of care through re-examination of procedures where the probability of an adverse outcome is high. Provider-initiated and maintained lists of compensable events could be an effective means of peer review and professional self-regulation.

For outcomes included on the list of specified events, MAI would supplant traditional litigation. Some questions remain about the structure and operation of the proposed "parallel adjudicatory system" for other adverse outcomes. Until this system is described more fully, the extent to which it would utilize existing tort law principles and procedures is unclear.

Advantages of MAI:

- Access to compensation for covered events entails a simple administrative procedure.
- Provider accountability for the financial losses resulting from certain medical injuries is retained through merit-rated premiums.
- Compensation for outcomes included on the list of specified events is highly predictable.

- MAI could begin as a limited compensation program and be expanded after experience was obtained and data on cost were available.

Disadvantages of MAI:

- The distinction between avoidable and unavoidable outcomes of medical care is difficult to make and changes over time.

- Individual review of losses and determination of awards is eliminated. Provider selection of less appropriate interventions in order to avoid the likelihood of a compensable event or refusal to treat high-risk patients are possible negative effects.

Elective No-Fault

Elective no-fault is a proposed system of compensation that would apply to all accidents and resultant injuries, such as those arising from automobile accidents, defective products, and medical care. As proposed by O'Connell, any individual or institution potentially liable in tort for accidental injuries could choose to purchase elective elective no-fault insurance for specific occurrences. 26/

For medical injuries, health care providers would define in advance the adverse events for which they desired to be covered. Claims would be paid on an occurrence basis with no determination of causation or legal culpability. Fault-based litigation would be retained for claims falling outside the list of specified events. Providers would select not only those injuries to be covered, but also the type of losses to be reimbursed. Losses attributable to pain and suffering would not be included.

Access to compensation would be virtually automatic for a claimant who sustains a covered injury. As in most forms of indemnity insurance, the injured patient would file a claim and the provider would certify whether the injury had occurred. Elective no-fault would be voluntary in the sense that a provider could choose no-fault coverage for certain injuries or rely on traditional liability insurance for all losses. Patients would be free to contract for services with the providers of their choice. However, once a patient entered into an agreement with a provider who had an elective no-fault plan, the system would be compulsory for those medical injuries covered by the provider's election. Resort to traditional litigation would be precluded for those claims falling within the prescribed sphere of losses and limitations on damages stipulated by the provider.

Theoretically, there would be few deterrents to patients bringing claims under elective no-fault. If the claim fell within the sphere of covered losses and dollar amount of coverage, payment would be certain. This would encourage patients to bring claims composed primarily of demonstrable, financial losses. The fact that a patient would not need a lawyer to make the claim would also encourage patients to seek compensation. A recent Department of Transportation (DOT) study of automobile no-fault insurance concluded that it compensated "more accident victims more completely and more equitably for their economic losses than did the tort liability system." 27/ It is likely that patient awareness of access to compensation would expand the number of claims made and perhaps compensate for more losses than do existing mechanisms.

O'Connell's elective no-fault proposal defines injury as any "bodily harm, sickness, disease, or death." 28/ The scope and depth of compensation would be decided unilaterally by providers. The lack of patient involvement in these decisions raises serious questions about the basic fairness of elective no-fault.

Compensation would not be based on a fixed schedule but rather on a case-by-case determination of injury and actual economic loss. Payment would not be open-ended, since providers could place a ceiling on the no-fault benefits available under the policy. It should be noted that providers could elect relatively large deductibles, and in so doing create a floor below which the tort system would still operate.

The procedure for resolution of claims would be largely administrative. If a loss fell within the prescribed boundaries of elected coverage, validation of a claim would be simple. The only issue would be whether the injury and resultant losses were covered by the patient-provider contract. Review of claims and determination of the amount of compensation under elective no-fault would be final, within the range of events elected by the provider for coverage. O'Connell makes no provision for appellate review of decisions. The finality of such decisions is strengthened by the voluntary, contractual nature of the arrangement between provider and patient.

There are no data on the costs of an elective no-fault system. The DOT study of auto insurance concluded that no-fault is cost-effective in terms of benefit-premium ratio. 29/ However, it is difficult to generalize from these findings to a no-fault medical injury compensation plan. Elective no-fault would be affected by other sources of compensation since it requires that any awards to the patient from sources other than the no-fault scheme be taken into account in determining the amount of compensation.

As proposed, elective no-fault is not linked to regulatory measures such as licensure and certification. The effects on quality of care through the use of financial incentives are unclear.

Advantages of elective no-fault:

- Access to compensation for covered events is simple.
- Providers would be able to elect the injuries and type of losses to be covered, set limits on no-fault benefits, and specify appropriate deductible levels.
- There is certainty of compensation for the injured patient within a specified range of elected events.
- Delays and costs inherent in traditional litigation would be eliminated for covered events.

Disadvantages of elective no-fault:

- Elective no-fault would be confusing to patients, because the type and amount of compensation would vary from provider to provider.
- The ability of providers to elect substantial deductibles for the purpose of discouraging nuisance claims would do little to assure compensation to those with small but meritorious claims.
- There are no linkages to regulatory or quality assurance activities and no provision for merit-rated premiums.
- The greater knowledge of providers could bias the election of covered events in favor of providers.

Social Insurance Approaches

Another possibility as an approach to medical injury compensation is social insurance, but because no specific social insurance proposals have been developed, the concept is essentially theoretical. 30/ State workers compensation programs and the Social Security Disability Insurance program have been referred to as models for a social insurance scheme to compensate medical injuries. These programs do not address medical injury compensation, but they do consist of administrative structures, procedures, benefits, and cost considerations common to any social insurance approach. However, neither of the two is "pure" social insurance, because they are premised on work force participation and financed by employer and employee contributions rather than being comprehensive in coverage and financed by general revenues.

The underlying rationale for social insurance is that society as a whole is better able to bear the cost of adverse outcomes of risky activities than is the injured individual. Social insurance

benefits are usually defined in advance and limited in size as well as duration, particularly if they are paid over time. Other characteristics common to social insurance approaches include 1) scheduled benefits, which means that the amount of compensation is established by a standard formula applied to the same types of injury, and 2) the use of an administrative agency to process and validate claims, to make findings of fact regarding extent of loss and appropriate benefits, and actually to dispense compensation. Determination of who is at fault for the injury is generally irrelevant in social insurance schemes.

Access to compensation, as in elective no-fault and MAI, is virtually automatic for losses covered by the scheme. There are incentives for an injured patient to bring claims, such as access to the system without the assistance of an attorney, and the predictability of compensation if the claim is clearly within the scope of coverage. The predictability of payouts under such a system also makes it attractive to providers.

True social insurance for medical injury compensation might differ most from the workers compensation and Social Security disability programs by being comprehensive in coverage. At a minimum, a comprehensive plan would cover medical and rehabilitative expenses and lost wages, either fully or up to a percentage of average monthly earnings. Currently, lost wages are typically undercompensated by workers compensation programs for three reasons: low maximum payments, disregard for rising income potential, and failure to account for inflation. 31/ A comprehensive social insurance system might remedy this by covering lost wages fully and by building a cost-of-living adjustment factor into awards.

Losses under most social insurance plans are compensated according to a fixed schedule of benefits. For example, cash awards for impairment with no loss of wages are granted under most workers compensation plans; under such an approach, a day laborer and concert pianist would each receive the same dollar award for the loss of a hand. Compensation is highly predictable since the award is based on a fixed formula and usually subject to limits on duration and size of dollar award. Like MAI, the bargain to be struck by social insurance is that a claimant would gain predictability of compensation at the cost of lower average awards and the elimination of individualized valuation of loss.

The administrative agency model provided by workers compensation and Social Security disability is perhaps the only aspect of these systems which could be adopted totally by a social insurance scheme for medical injury compensation. Claims would be initiated by filing with a governmental or quasi-governmental agency, which would then make a decision regarding compensability of the injury. If displeased with the decision, the claimant would have the right to a fair and impartial hearing by a review board set up by the agency, as is the case in

Social Security disability disputes. If still not satisfied, the injured party might be given the right of appeal to the courts. If the administrative aspects of the scheme were kept to a minimum, the time between filing a claim and its resolution should be much less than the delay encountered in litigation.

Two important issues to be addressed in developing a social insurance approach are costs and financing. In 1975, administrative costs for Social Security disability were only three percent of total benefit payments of approximately $7.6 billion. 32/ For workers compensation plans, 53 to 70 percent of premiums paid in to commercial carriers were returned in benefits and 72 to 90 percent of premiums were paid out in state-administered plans. 33/ It would be extremely difficult to project the administrative costs of a comprehensive social insurance system for medical injuries, because compensation would be provided for a far greater number of adverse outcomes than are currently being compensated under existing mechanisms.

Financing of a true social insurance system would come from general tax revenues. In the context of medical injuries, this means that society as a whole would bear the financial burden for medically induced losses. 34/ Modified systems, such as workers compensation and Social Security disability, are financed by premiums paid by employers (workers compensation) and employer-employee contributions to a centrally administered fund (Social Security). Decisions about the method of financing are inextricably linked to the question of injury avoidance.

Injury avoidance is the weakest aspect of social insurance proposals. In the pure system mentioned above, there would be no financial incentives for a provider to reduce the incidence of medical injury. Direct regulatory measures such as licensure and certification would be the only means by which provider performance could be influenced. Although the committee believes that licensure and certification are important aspects of provider accountability, it is unlikely that these measures alone would have a substantial impact on injury avoidance.

Workers compensation has done little to encourage the avoidance of workplace injuries. There is little, if any, correlation between workers compensation premiums and the safety record of a given employer. 35/ The fact that these premiums are usually rated by industry, not by the injury experience of individual employers, may account for part of this. However, even if employer experience were taken into acccount, it may be less costly for the employer to pay increased insurance premiums than to rectify the situation giving rise to the injuries. 36/

For social insurance to assure provider accountability for adverse outcomes and encourage injury avoidance, several conditions would have to be met. First, financing for the compensation system

would have to be linked to the injury experience of providers. Second, coverage would have to be cancellable for repeated or flagrant instances of substandard medical treatment. Third, the system should be linked to licensure, accreditation, and certification for reimbursement under publicly sponsored health programs in order to promote peer review and assure minimum levels of quality.

There could be some overlap of a social insurance system and other sources of disability compensation, as there is in the overlap of workers compensation benefits and Social Security disability. This is generally remedied either by offsetting one award against another or by limiting the total amount of benefits from all sources, perhaps to a fixed percentage of lost wages.

It would be feasible to link a social insurance mechanism to existing quality assurance programs. Although the primary goal of such a plan would be to compensate the injured, data concerning the number and type of adverse outcomes per provider could be maintained and evaluated periodically.

Advantages of social insurance:

- Access for injured patients to compensation would be enhanced.
- More medical injuries would be compensated, but probably at a lower average amount per claim than in existing approaches.
- Awards would be predictable.

Disadvantages of social insurance:

- The budgetary cost would be high.
- In exchange for predictability of awards, individualized valuation of loss would be eliminated.
- Certain social insurance plans would retain no provider accountability nor offer incentives for providers to avoid medical injuries, although this is not a necessary characteristic of social insurance.

CHART 1. EVALUATION OF DIFFERENT APPROACHES TO COMPENSATION

	Approaches Based On Fault		
	Traditional Litigation	Pretrial Sreening Panels	Arbitration
ACCESS TO COMPENSATION	Self-initiating; claims must be large enough to be attractive to an attorney on contingent fee basis; most claims settled outside formal system; delays in receiving compensation; numerous procedural rules	May be voluntary or mandatory; panels may discourage frivolous claims because of panel composition; mandatory panels' limitation of access to courts raises constitutional questions	Initial decision to submit claim voluntary--then becomes mandatory; more predictable access
SCOPE AND DEPTH OF COMPENSATION	Often statutory minimums for claim size; unpredictable case-by-case determinations by lay juries	Statutory panels generally determine only likelihood of liability, do not award compensation	Very little information on relative award size and types of loss covered because of small number of claims reaching final arbitration
PROCEDURES FOR RESOLVING CLAIMS	Formalized procedures; numerous procedural and evidentiary rules protect substantive and due process rights for those who gain entrance to the system but also disqualify some bona fide claimants	Composition of panel may vary; relatively informal procedures; generally private; findings not final, usually advisory, may or may not be admissible at trial; often followed by traditional litigation	Same prehearing discovery devices as in litigation; setting and procedures informal; private; can make final determination of liability and assess damages
COSTS AND FINANCING	No firm estimates of cost; financing is a combination of private and public sources	No data on administrative costs; certain duplicate costs in reviewing some claims twice may offset savings in eliminating frivolous claims	Lower administrative costs because of informal and expeditious procedures--very few claims proceed to final determination by formal arbitration
INJURY AVOIDANCE	Affected only indirectly; judicial decisions establish standard of care; liability insurance weakens financial incentive	Private nature of proceeding may eliminate any possible public stigma attached to provider; decisions regarding standard of care not communicated to others	Private process which diminishes possibility for stigma; few indirect financial incentives since cost of process relatively low
RELATIONSHIPS TO OTHER SYSTEMS	No direct link to other health activities; tenuous link to peer review and state licensure for flagrant abuses	Identical to traditional litigation	No direct relationships

	Specified Events Approaches		Social Insurance
	Medical Adversity Insurance	Elective No-Fault	
ACCESS TO COMPENSATION	Automatic for adverse outcomes on list of compensable events; if not on list must seek compensation through parallel adjudicatory system	Automatic for claimant with covered injury; voluntary regarding choice of provider but mandatory once agreement is made between provider and patient	Automatic for covered losses; likely to be mandatory if enacted
SCOPE AND DEPTH OF COMPENSATION	Primarily limited to "relatively avoidable" medical injuries; fixed schedule of awards for given injuries; highly predictable for covered events	Unilateral provider decisions regarding types of losses covered; case-by-case determinations of injury and actual financial loss	Predictability of compensation because it is determined by a fixed schedule of benefits; no personal valuation of losses except for wages
PROCEDURES FOR RESOLVING CLAIMS	Not specified; presumed to be automatic once claim is made if event is on compensable list; potential for reducing delay and transactional costs	Administrative procedure; validation simple, if claim within specified boundaries; elimination of most costs of litigation; no appellate review of decisions	Administrative agency model; standard procedures for hearings and possibly right of appeal to courts; elimination of delay and costs associated with litigation
COSTS AND FINANCING	No data on costs; possibly substantial because of necessity to compile and update list of compensable events; financed by provider-purchased private insurance	No data on costs; could be cost-efficient in terms of premium/benefit ratio because of reduction of "friction costs"	No data on costs; financing has not been specified; comprehensiveness of system could offset savings in administrative costs
INJURY AVOIDANCE	Strong financial incentives because provider premiums would be merit-rated; generation and maintenance of compensable events list could improve peer review	Not tied to direct regulatory measures such as licensure and certification; indirect incentives not clear since no mention of basing premiums on claims experience	No financial incentives in a "pure" social insurance system; limited provider accountability
RELATIONSHIPS TO OTHER SYSTEMS	Would supplant tort system for covered events; details of parallel adjudicatory system unclear	Would eliminate duplicate compensation from collateral sources	Overlaps existing social insurance measures such as workers compensation and Social Security disability; feasible to link with quality assessment mechanisms

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24. Havighurst, as referenced note 22, p 1270

25. Ibid., p 1264

26. O'Connell J: Ending Insult to Injury. U of Illinois Press, 1975; see also, O'Connell J: No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others. Insurance Law J, 632:531-545, 1975; also, O'Connell J: An Elective No-Fault Liability Statute. Insurance Law J 628:261-293, 1975; also, O'Connell J: Elective No-Fault Liability Insurance for All Kinds of Accidents: A Proposal. Insurance Law J 628:495-515, 1973

27. United States Department of Transportation: State No-Fault Automobile Insurance Experience - 1971-77, June 1977, p 31

28. O'Connell J: An Elective No-Fault Liability Statute, as referenced note 26, p 268

29. United States Department of Transportation, as referenced note 27, p 73

30. See Schwartz DH: Societal Responsibility for Malpractice. Milbank Mem Fund Q, Fall 1976, pp 481-485; State of New York: Report of the Special Advisory Panel on Medical Malpractice, January 1976, pp 56-60. Both Schwartz and the Special Advisory Panel endorse the concept of social insurance but do not describe a specific plan.

31. Ashford NA: Crisis in the Workplace: Occupational Disease and Injury. Cambridge, The MIT Press, 1976, p 395

32. Department of Health, Education, and Welfare, Social Security Administration: Social Security Bulletin (DHEW Publication No. [SSA] 76-11703), January 1976, p 51, Table M-6

33. Ibid., pp 40-42; also, State of New York: Report of the Special Advisory Panel on Medical Malpractice, as referenced note 30, pp 250-255, Tables 10-16

34. Havighurst, as referenced note 22, p 1241

35. Ashford, as referenced note 31, p 398

36. Ibid., pp 403-404

Chapter 4

LEGAL ASPECTS OF MEDICAL INJURY COMPENSATION

A number of legal issues have been raised in challenges to state statutes enacted in response to problems with medical malpractice insurance. This chapter examines these issues as well as other legal considerations that might influence the structure and implementation of new approaches to medical injury compensation.

New laws pertaining to medical malpractice have been challenged in the courts by injured patients, individual and institutional medical care providers, attorneys, and insurers. These challenges have been based on both federal and applicable state constitutional grounds.

The major federal constitutional issues are denial of equal protection of the law under the fourteenth amendment and violation of substantive due process guarantees under the fifth amendment, applied to the states through the fourteenth amendment. These constitutional challenges have been directed to state statutes that establish special procedural requirements for medical malpractice claimants, thereby singling them out as a class for legal purposes. Although the equal protection clause of the fourteenth amendment forbids unfair or prejudicial state classification, 1/ courts have held that states may discriminate among classes of litigants if there is a "rational relationship" between the classification and attaining a permissible state end. 2/ In general, state laws directed to medical malpractice have passed the "rational relationship" test.

Constitutional guarantees of substantive due process insure that statutes or other official governmental actions will not deprive any citizen of "life, liberty, or property without due process of law." 3/ While procedural due process is more often the basis for court decisions on fifth or fourteenth amendment questions, the Supreme Court has invoked substantive due process in recent years to protect values such as privacy in cases involving abortion and the use of contraceptives. 4/ Compensation schemes that eliminate negligence as the basis for liability are subject to challenge as constituting a "taking" of the injured patient's property--the right to sue--without due process of law.

State constitutional provisions and statutes also impede the implementation of some approaches to compensation. The committee discussed the following bases for challenging alternatives to or modification of traditional litigation: equal protection and due process guarantees contained in state constitutions, prohibitions against special legislation, 5/ the right to trial by jury, common law and statutory contract principles, and usurpation of the judicial function.

Almost every state constitution guarantees the right to a jury trial in civil cases. Some proposed approaches for medical injury compensation would substitute other procedures for this right or condition the right on an agreement that claims be submitted first to another forum, such as a screening panel.

A contract between provider and patient that stipulates the means by which medical injury claims will be resolved is the basis for most forms of arbitration and for an elective no-fault approach. Such contracts are predicated on an assumption of equality in knowledge and bargaining position between the parties. However, equality may be illusory in many cases because of the greater knowledge and experience of medical care providers. If the knowledge or bargaining power of the parties is vastly different, or if coercion is applied in the execution of the contract, such agreements may be nullified by the courts as unconscionable. Most contracts are voidable on these grounds, either by statute or by the common law. 6/

Most state constitutions vest all judicial functions in the state's judiciary system. Some compensation systems are designed to circumvent existing judicial procedures, either partially or completely. This could be construed as an unconstitutional usurpation of the judicial function.

These legal considerations are examined below as they apply to various modifications of the present system of medical injury compensation. Constitutional issues raised by the Medical Adversity Insurance approach are considered. The committee does not see any constitutional problems in establishing a social insurance scheme for medical injury compensation. The legal challenges that could have been made have been settled by the precedent of workers compensation laws in all 50 states.

Screening Panels

Twenty-nine states and the Virgin Islands provide by statute for the nonbinding, pretrial review of medical malpractice claims. 7/ One state, New Jersey, makes screening panels available by court rule. Challenges to the legality of screening panels have been based on three grounds: 1) whether requiring a potential medical injury claimant to first bring his action before a screening panel places an unacceptable restriction on that claimant's access to the

courts; 2) whether the screening panel proceedings encroach on the judicial function; and 3) whether the findings of the panel are admissible as evidence in court when a particular case cannot be resolved at the pretrial level.

Restriction on Access to the Courts A plaintiff's direct access to the courts is restricted when a medical malpractice claim must be submitted first to a pretrial screening panel. This additional procedure imposes several burdens on the plaintiff: his right to trial by jury is delayed and conditioned upon having first submitted the case to a screening panel; the costs of utilizing the panel are often assessed against the losing party; 8/ and the claimant may have to present his case twice, thereby increasing his expenses.

Because these impediments are imposed only on medical malpractice claimants and not on all plaintiffs pursuing tort claims, screening panels have been challenged on equal protection grounds. The equal protection issue was raised before the Supreme Court of Florida in a case that questioned the constitutionality of a mandatory state screening panel requirement. In upholding the statute, the court noted that the requirement was a valid legislative attempt to deal with the rising cost of medical malpractice litigation. 9/ A similar decision was reached by a lower New York court, which found a rational relationship between enactment of the legislation and a legitimate state end. 10/

Encroachment on the Judicial Function Another legal question raised by screening panels is whether the practice of allowing judges to sit on screening panels along with laymen makes the process a trial substitute that lacks the constitutional protections of regular judicial proceedings. Screening panels represent an unusual sharing of judicial power with nonjudicial persons. 11/ While the judicial member of the panel may rule separately on procedural and evidentiary matters, he shares responsibility for making determinations of liability and damages with lay members of the panel. 12/ In traditional civil trials without a jury, all these decisions are made by the judge. If the proceedings of a screening panel are considered to be a substitute for a trial, the judge's conventional role may be seen as usurped by the nonjudicial members.

If pretrial screening panels function as substitutes for trial, another issue is raised: does the legislature have the power to circumvent constitutional guarantees of a jury trial? Or are screening panels simply analogous to required pretrial settlement conferences rather than to the trial itself? This analogy ignores the issues of encroachment on the judicial function and elimination of the right to trial by jury, 13/ and instead views the judge's duties as similar to those routinely performed by judges in pretrial conferences.

In a decision negating several parts of the Illinois medical malpractice law, the Illinois Supreme Court found the mandatory screening panel requirement invalid on the grounds that it was a trial substitute. 14/ The court found that the panel engaged in decision-making regarding substantive law which was a traditional judicial function. In Illinois, attorneys and physicians who sat on screening panels were sharing in this role.

A recent Maryland trial court decision used reasoning similar to the Illinois Supreme Court in striking down a Maryland statute establishing malpractice screening panels consisting of an attorney, a health care provider, and a member of the general public. 15/ The court held that such panels unconstitutionally usurped the power delegated to the judiciary by the state constitution. The screening panels were distinguished from other administrative agencies in that those agencies performed quasi-judicial functions incidental to their administrative functions, while the pretrial screening panels performed only judicial functions.

In contrast to Illinois and Maryland, the Nebraska Supreme Court upheld the constitutionality of a medical review panel consisting of three physicians and one nonvoting attorney. 16/ The court found that the panel functioned merely to provide expert testimony rather than to perform a judicial function.

The Admissibility of Panel Findings into Evidence at Trial In 17 states, the findings of the screening panel are admissible as evidence in court; in six states they are not. 17/ Admissibility is often conditioned on the panel's findings being unanimous, and the admissible portion is generally its findings as to liability. 18/ Where the screening panel's opinion is admissible, the statutes usually require a jury instruction that such findings are not binding and should be accorded whatever importance the jury may choose.

Admission of screening panel findings into evidence at trial can drastically affect the traditional role of the jury as the decision maker about the facts of a particular case. The effect is to allow into evidence an opinion on the ultimate issue of liability that would not be allowed under standard rules of evidence. 19/ The question is whether the substance of the jury function has been so altered as to violate the right to trial by jury.

Two recent court decisions upheld the admissibility of screening panel findings on the issue of liability. The Appellate Division of the New York Supreme Court found that panel recommendations would not unduly influence a jury. 20/ The court noted that juries jealously guard their role as fact finders and that this function was not altered by the New York screening panel statute. The Nebraska Supreme Court held that admission of panel findings into evidence was similar to expert testimony--both aid the jury in making determinations of fact. 21/

Limitations on Liability

A number of states have enacted laws that place a maximum on the amount of damages recoverable in medical malpractice actions. 22/ Some states have applied the limits to all components of loss while others have applied them to certain types of loss. For example, California, Ohio, and South Dakota place a maximum on damages for pain and suffering. Wisconsin invokes a ceiling of $500,000 on awards in the event the reserves in the state patient compensation fund fall below $2.5 million in any one year.

Statutes that limit liability have been challenged in the courts. The Illinois Supreme Court held that a statutory limitation of $500,000 in medical malpractice actions violated the Illinois Constitution. The court found that the ceiling on recovery, which was limited to malpractice claims, was arbitrary and constituted a special privilege for malpractice defendants. 23/ The court distinguished the limitation on recovery for malpractice claims from limitations on recovery under workers compensation plans. An employee receives compensation for a work-related injury without having to prove employer fault. In exchange for relieving the employee from proving fault, the employer is guaranteed that damages will not exceed a predetermined amount. The court said malpractice plaintiffs do not receive similar benefit for the imposition of a ceiling on recovery.

The Idaho Supreme Court upheld a statute limiting hospital and physician liability, ruling that its legislature had the inherent power to change Idaho common law without providing a substitute remedy or procedure. 24/ Similarly, the Nebraska Supreme Court upheld a statute imposing a $500,000 limitation on damages, noting that the state constitution was no bar to the legislature either creating new rights or abolishing old ones in order to attain a permissible legislative objective. 25/

Collateral Source Rule

The collateral source rule is a doctrine that precludes a defendant in a tort case from introducing evidence regarding other benefits or sources of compensation received by the plaintiff. The most common benefits to which courts apply the collateral source rule are private health or disability insurance, pension plans, and welfare payments. Some states have passed laws abolishing the application of the collateral source rule to medical malpractice cases in an attempt to reduce overcompensation for loss. 26/ However, the Ohio statute was struck down on the grounds that it violated equal protection requirements. 27/

The committee believes that elimination of the collateral source rule is of questionable value. Proponents of the rule point to several reasons for retaining it: it prevents unnecessary confusion and

complication in making damage awards; a plaintiff, not a defendant, deserves any benefit resulting from multiple compensation; the defendant, being at fault, deserves the burden of the loss; damages awarded to the injured party are often inadequate; a plaintiff who has been prudent by obtaining insurance deserves to receive those benefits over and above any damages awarded. 28/ Those who would dispense with the rule give the following reasons: a jury is fully capable of determining the impact of collateral benefits on its award; the plaintiff deserves only to be made whole and not the beneficiary of windfall awards; whether the defendant should bear the burden of loss depends on the type of tort in question--intentional, negligent, or strict liability; if damages are inadequate, modify the process by which damages are established rather than invoke the collateral source rule. 29/

Ad Damnum Clause

The ad damnum clause is part of a complaint in a civil action which states the dollar amount of damages being sought by the plaintiff. The requirement that an ad damnum be included in the pleadings is primarily for the purpose of establishing that the action falls within the jurisdiction of the courts. 30/ For example, federal courts require that the amount in controversy in a given case exceeds $10,000. Also, the amount specified by the claimant in the ad damnum clause generally serves as a maximum limit on the amount of damages which may may be awarded. 31/

Many medical care providers have criticized the ad damnum clause as prejudicial to defendants in malpractice cases. Some states have responded by enacting statutes that either eliminate the ad damnum clause or prohibit the jury from being informed of the amount of damages stated in the complaint. 32/ The committee questions whether elimination of the ad damnum clause will have any demonstrable effect on the size of medical malpractice awards.

Medical Adversity Insurance (MAI)

The constitutionality of a Medical Adversity Insurance (MAI) plan can be questioned on two grounds: (a) whether abolition of the patient's right of action in tort abridges due process rights under the federal and state constitutions; and (b) whether the parallel adjudicatory system, if distinct from the tort system, violates state constitutional provisions that guarantee the right to trial by jury and reserve judicial powers to the courts. If enacted as a federal program, MAI would raise the additional issue of whether Congress can, in this instance, abolish a state right of action.

The contention that a MAI compensation plan would violate substantive due process holds that the injured patient's property--his right of action in tort against the medical care provider--is taken without due process of law. This argument would only apply to claims

that existed at the time MAI was established. The most direct precedents on this issue are court decisions upholding workers compensation laws, which abolished the employee's right of action in tort against his employer for work-related injuries. These statutes were found not to violate due process rights because they provided a certain remedy for all employment-related injuries. 33/ The certainty of a remedy was seen as a fair exchange for giving up the right to sue.

The elimination of the right to sue for losses stemming from a medical injury without gaining an equivalent right would not necessarily invalidate MAI. 34/ More recent than the workers compensation cases have been judicial decisions on automobile no-fault statutes. The validity of these statutes has been upheld, without reference to a quid pro quo, under the rationale that legislation enacted in furtherance of the general welfare must be upheld if any possible set of facts may reasonably justify it. 35/ Compensation of medical injuries under MAI could be justified as an appropriate public good.

Different considerations would arise if a federal rather than state MAI program were instituted. The constitutional authority of Congress to initiate the insurance and administrative features of MAI could be found under the commerce power, 36/ or the taxing power if the MAI compensation program were financed through general revenues or specific taxes, such as Social Security. A problem does arise concerning the authority of Congress to abolish a claimant's right of action in state courts for medical injury claims. A challenge of this sort might be overcome if MAI were enacted in conjunction with a national health insurance program. By accepting federal funds for payment of health care expenses, a patient could be required to look to a federal compensation scheme for losses stemming from injuries sustained during treatment.

REFERENCES AND NOTES

1. This same issue also may arise under a variety of state constitutional provisions that guarantee equal protection of the law.

2. Jones v. Union Guano Co., 264 U.S. 171 (1924); Lindsey v. Normet, 405 U.S. 56 (1972); Railway Express Agency v. New York, 336 U.S. 106 (1946); Lindsley v. Natural Carbonic Gas Co., 200 U.S. 61 (1911). For an overview of constitutional problems raised by automobile no-fault insurance, see J. Bishop, Validity Under the Constitution of the United States of Basic Protection Insurance and Similar Proposals for the Reform of the System of Compensating Victims of Automobile Accidents, in Constitutional Problems in Automobile Accident Compensation Reform (Dep't of Transportation, 1970). Many of the issues discussed in this paper are applicable to proposed changes in medical injury compensation.

3. U.S. Const. amend. V, amend. XIV.

4. See Roe v. Wade, 410 U.S. 113 (1973) (holding state ban on abortion unconstitutional); Griswold v. Connecticut, 381 U.S. 479 (1965) (holding state ban on use of contraceptives unconstitutional).

5. Some states have clauses in their constitutions that prohibit the enforcement of special legislation. Special legislation clauses operate the same as equal protection clauses, thereby requiring the same type of analysis and standard of judicial review.

6. See generally Kessler, Contracts of Adhesion, 43 Colum. L. Rev. 629 (1943).

7. American Bar Association, Legal Topics Relating to Medical Malpractice 49 (1977). In twenty-one states, submission of the claims to a panel is mandatory: Alaska, Arizona, Florida, Hawaii, Idaho, Illinois, Montana, Indiana, Louisiana, Maryland,

Massachusetts, Missouri, Nebraska, Nevada, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, and Tennessee. In nine states submission is voluntary: Arkansas, Connecticut, Maine, Delaware, Kansas, New Hampshire, New Jersey, Virginia, and Wisconsin. States also vary as to whether the panel's decision is admissible into evidence at a subsequent trial.

8. See, e.g., Ill. Rev. Stat. ch. 110, sec. 58.9 (3) (Supp. 1975).

9. Carter v. Sparkman, 335 So.2d 802, 805-06 (Fla. 1976).

10. Comiskey v. Arlen, 390 N.Y.S.2d. 122 (App. Div. 1976).

11. See, Ill. Rev. Stat. ch. 110, sec. 58.6 (Supp. 1975); Fla. Sta. Ann. secs. 768.133 (1,c,2), 768.133 (5,6) (West Supp. 1975).

12. Id.; see also N.Y. Jud. Law sec. 148-a(2) (McKinney Supp. 1975).

13. Carter v. Sparkman, 335 So.2d at 808 (concurring opinion).

14. Wright v. Central Du Page Hospital Ass'n, 63 Ill.2d 313, 347 N.E.2d 736 (1976).

15. Johnson v. Burch, No. 111/978/6-099191 (Balt. City Ct. Jun. 1977).

16. Pendergast v. Nelson, No. 41199 (Neb. Sup. Ct. Jul. 1977).

17. American Medical Association, 5 State Health Legislation Report 18 (1977) [hereinafter cited as AMA Legislation Report]. States which provide that panel decisions are admissible in evidence at trial are: Alabama, Alaska, Arizona, Delaware, Florida, Indiana, Louisiana, Maryland, Massachusetts, Nebraska, Nevada, New York, Pennsylvania, Rhode Island, Tennessee, Virginia, and Wisconsin. Findings are not admissible at trial in Arkansas, Hawaii, Idaho, Kansas, Missouri, and New Mexico.

18. N.Y. Jud. Law sec. 148-a(8) (McKinney Supp. 1975); contra, Fla. Stat. Ann. sec. 768.134 (2) (West Supp. 1975).

19. Fed. R. Evid. 701.

20. Comiskey v. Arlen, 390 N.Y.S.2d 122 (App. Div. 1976).

21. Pendergast v. Nelson, No. 41199 (Neb. Sup Ct. Jul. 1977).

22. AMA Legislation Report, supra note 17, at 4. The states are: California, Idaho, Illinois, Indiana, Louisiana, Nebraska, New Mexico, Ohio, South Dakota, Virginia, and Wisconsin.

23. Wright v. Central Du Page Hospital Ass'n, 63 Ill.2d 313, 347 N.E.2d 736 (1976).

24. Jones v. State Board of Medicine, 555 P.2d 399 (Idaho 1976).

25. Pendergast v. Nelson, No. 41199 (Neb. Sup. Ct. Jul. 1977).

26. AMA Legislation Report, supra note 17. Seven states have adopted this form of legislation: Arizona, California, Delaware, Kansas, New York, Rhode Island, and Washington. Another approach is to let the jury make its findings as to damages and then deduct the amount received from collateral sources from the award. This is the practice in nine states: Alaska, Florida, Idaho, Illinois, Iowa, Nebraska, Ohio, Pennsylvania, and Tennessee.

27. Graley v. Satayatham, 343 N.E.2d 832 (Ohio 1976).

28. Sanders, The Texas Collateral Source Rule: A Critical Survey, 54 Tex. L. Rev. 805 (1976).

29. For further debate on the collateral source rule, see Fleming, The Collateral Source Rule and Loss Allocation in Tort Law, 54 Calif. L. Rev. 1478 (1966); Note: Unreasonableness in the Law of Damages--the Collateral Source Rule in Personal Injury Litigation, 77 Harv. L. Rev. 741 (1964); Moceri and Messina, The Collateral Source Rule in Personal Injury Litigation, 7 Gonz. L. Rev. 310 (1972).

30. T. McCormick, Handbook on the Law of Damages, at 36 (1935).

31. Cincinnati Siemens-Lungren Gas Illuminating Co. v. Western Siemens-Lungren Co., 152 U.S. 200 (1894); but see Schwartz v. Schneuriger, 269 Wis. 535, 69 N.W.2d 756 (1955), and, Troutman v. Modlin, 353 F.2d 382 (8th Cir. 1965), indicating that a claimant may be awarded damages in excess of those specifically alleged in the complaint.

32. States which have either eliminated the ad damnum clause or restricted jury access to information in the ad damnum are: Alabama, Alaska, Arizona, California, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Missouri, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Ohio, Rhode Island, Tennessee, Texas, Utah, Washington, and Wisconsin.

33. Tipton v. Atchison, Topeka, and Santa Fe R.R. Co., 298 U.S. 141 (1936); Cromwell v. Benson, 285 U.S. 22 (1932).

34. See Wright v. Central Du Page Hospital Ass'n, 63 Ill.2d 313, 347 N.E.2d 736 (1976).

35. Montgomery v. Daniels, 38 N.Y.2d 41, 340 N.E.2d 444 (1975).

36. See generally Katzenbach v. McClung, 379 U.S. 294 (1964).

Chapter 5

FUTURE DIRECTIONS FOR POLICY AND RESEARCH

This report reaches one fundamental conclusion, which has widespread implications: the focus of public policy and research that relate to medical injury should not be unduly restricted to instances of medical malpractice. Malpractice accounts for a small part of the injuries and attendant losses that occur during the course of medical care. The time has come for policymakers and researchers to focus on the incidence of medically related injury, possible techniques for preventing injury, and financially sound methods for compensating injured patients.

The committee discovered that there are no ready-made solutions to the conceptual and practical issues raised by medical injury compensation. The committee's analysis of existing or proposed approaches to compensation identified strengths and weaknesses of each. However, gaps in available information on these approaches precluded an endorsement of any one approach. Three factors contributed to the failure of a single approach to emerge as clearly superior.

First, it is medical malpractice that has attracted most of the research and legislative activity, not medical injury compensation. The malpractice issue has been defined in terms of insurance availability, premium increases, and provider liability for fault-induced injury, rather than in terms of compensation for medical injuries. That emphasis is evident in the numerous state statutes modifying the substantive and procedural law governing medical malpractice litigation.

Second, experience is lacking in methods of compensation for medical injury that are not based on finding medical care providers at fault (see Appendix B). The experience with modified fault-based approaches, such as arbitration, is so limited that it is difficult to assess the potential of arbitration as a compensation system. Specified events approaches, such as Medical Adversity Insurance and elective no-fault, are purely theoretical. Existing compensation systems for other than medically induced injury, such as automobile no-fault insurance, workers compensation, and Social Security disability, are not applicable as analogies for a variety of reasons.

Third, there are a number of practical and conceptual issues that must be resolved before specific recommendations can be made about the choice of a particular compensation system or the practical aspects of its implementation. The committee discussed these issues, but decided that many of them were not amenable to resolution in the abstract. Rather, the committee chose to identify those issues that, in its judgment, are crucial in the development of a compensation scheme.

Unresolved Issues

The committee selected six unresolved issues as the most important ones for policymakers to address. They are: 1) distinguishing between risks of medical treatment and "risks of life," 2) definition and measurement of the amount and severity of medical injury, 3) the types and extent of loss from medical injury that should be compensated, 4) appropriate measures for injury prevention in medical care, 5) accountability of medical care providers for injury and the relationship of that, if any, to quality assurance, and 6) reaching a balance between preserving all existing legal rights of injured patients and achieving efficient, widespread compensation for medically induced losses. These issues involve basic value judgments and some can only be resolved in the specific context of resources available for compensation. The committee decided that its best effort would be to make more explicit the questions raised by these issues.

Risks of Treatment vs. Risks of Life

Risks of medical treatment are a subset of all risks of life. Every medical procedure entails some degree of risk, which either may be directly attributable to medical intervention or merely to a risk of life that happens to occur during the course of medical care, such as a myocardial infarction during a routine physical examination.

Differentiation of risks of medical treatment from risks of life is important because of the direct relationship between this issue and the scope of compensation. For example, workers compensation plans undoubtedly compensate for incidents that are essentially risks of life, but happen to occur in the workplace, due to the breadth of the concept of "work-relatedness" and difficulty of establishing causation. At least for losses due to medical expenses, the enactment of a comprehensive national health insurance program would diminish the necessity of distinguishing risks of treatment from risks of life. The committee is uncomfortable with the idea that medical care providers or the medical care system as a whole should be held financially responsible for ordinary risks of life.

The committee feels that within the general category of risks of life, there will be some medical injuries that a compensation system should cover simply because making the distinction between risk of treatment and risk of life would be too difficult and expensive. Another set of concerns must be addressed for those medical injuries that are clearly identifiable as risks of treatment. The decision to compensate for losses arising out of treatment is dependent on value judgments about the relative responsibilities of provider and patient for certain types of adverse outcomes. Practical considerations, such as the budgetary cost of a comprehensive system, also must be weighed.

The Incidence of Medical Injury

There are too few statistics to establish the incidence of medical injury. This is both a conceptual and practical problem. There is no consensus on the definitions of medical injury or compensable medical injury. Without generally accepted definitions for these concepts, effective data collection and analysis are difficult and of questionable value. However, without accurate data on the incidence of medical injury, it is extremely difficult to develop and implement a system for compensating medical injuries. Data are essential for projecting total claims cost, administrative expenses, and overall efficiency of a compensation system.

Types of Loss Compensated

What types of loss should be covered and to what extent should they be compensated? Is it appropriate, on either equity or efficiency grounds, that society assume financial responsibility for losses occasioned by medical care, as distinguished from provider or patient responsibility?

Most compensation plans, both real and proposed, cover some portion of demonstrable economic loss: medical expenses, income loss, loss of function, and loss of consortium. The plans differ markedly in their treatment of intangible losses, such as "pain and suffering," because these losses are not measurable by any objective standard. Under existing fault-based approaches, there is individualized valuation of such losses by lay juries and considerable variation in the size of awards. Although some compensation systems would simply eliminate all recovery for pain and suffering, intangible losses may substantially alter the quality of life for the injured party.

The extent to which various types of loss are compensated is important for two reasons. First, if a compensation system included no minimum dollar amount for claims, there is the possibility that it would be inundated by claims for very small losses (so-called nuisance claims), which are costly to administer relative to the magnitude of the loss. Second, there is a strong argument borrowed from workers compensation and Social Security Disability Insurance

that there should be a statutory maximum on replacement of income loss. Otherwise, the argument goes, the compensation awarded will serve as a disincentive for the claimant to return to work. The difficult task is to determine at what levels such minimums and maximums should be set to insure equitable compensation to patients while at the same time promoting efficiency of the compensation scheme.

Injury Prevention

The committee believes that an important goal of medical injury compensation should be reduction of the incidence of injuries. Incentives to prevent or avoid injuries should be built into any compensation system. There are two distinct types of incentives: 1) regulation and monitoring of providers through mechanisms such as medical licensure, professional disciplinary action, certification, accreditation of facilities, peer review, and PSRO norms, standards, and criteria, and 2) financial incentives linked to provider performance or exposure to risk of injury. It is unclear which of these methods is more effective in promoting injury prevention. Nonetheless, decisions will have to made about such incentives in the development of a system for compensating injured patients.

Provider Accountability

Is there a relationship between provider accountability and the quality of medical care? Proponents of fault-based compensation contend that, if medical care providers are held accountable for negligent or intentional acts that harm a patient, there is strong incentive for providers to maintain higher standards of practice than they would otherwise.

Accountability is alleged to occur by several means: financial, through the payment of damages; professional, through the awareness of peers that a claim has been made or that negligence is found; and public awareness, through public access to the trial, judgment of the facts by lay persons, or the stigma of being found negligent. While little is known about the effectiveness of these three factors, the committee believes that the impact of financial accountability is mitigated by professional liability insurance.

Patients' Rights and Efficiency

Despite weaknesses as a compensation mechanism, civil litigation of medical injury claims under the principles of tort law places a premium on protecting the legal rights of patients and providers. Proposed modifications of tort law applicable to medical malpractice would curtail or sacrifice some of these legal rights in exchange for more efficient and predictable compensation. The committeee feels that accommodating these two interests is a difficult but necessary step in designing a compensation scheme for medical injuries.

Research Priorities

The committee identified four areas in which research is needed for a better understanding of medical injury and for the development of compensatory mechanisms: 1) characteristics of medical injuries, 2) methods for prevention or reduction of medical injury, 3) development of cost estimates for different approaches to compensation, and 4) additional analysis of medical malpractice claims.

Before research can proceed on medical injury, consensus must be achieved among medical care providers and patients as to what constitutes a medical injury. The committee defined it very broadly in Chapter 1, but considerable work remains in sharpening the definition and obtaining widespread agreement with it. Some work has been done in classifying injuries by the group responsible for developing the International Classification of Diseases. 9th Revision, Clinical Modification (ICD-9-CM). The utility of this classification system for coding injuries, however, remains to be tested. Data on medical injury should be collected from a number of different practice sites and should identify such factors as age and sex of the injured patient, place of injury, severity and duration of injury, specific types of associated financial losses, such as income and additional medical expense, and characteristics of the provider, such as specialty, length of time in practice, and procedures routinely performed.

Professional Standards Review Organizations (PSROs) could help in identifying medical injuries by means of medical care evaluations (MCEs) or medical audits. PSROs should respond to their legal mandate and develop profile analyses, which are retrospective studies of patterns of care, so that the identification and monitoring of medical injury could be incorporated as an integral part of their monitoring activities.

Research on injury prevention should include evaluation of the effectiveness of risk management programs now being used by many institutional providers, experimentation with different types of incentives for providers to report an injury occurrence, and development of financial incentives for providers to reduce injury by means of professional liability insurance premiums. The committee feels that research in this area could be very productive. Very little is known about the etiology of medical injury, let alone the most appropriate points of intervention for reducing incidence. Because the bulk of malpractice claims arise from medical care received in hospitals, the committee believes that research on injury prevention should begin with institutional providers. The variety of mechanisms available for influencing provider practices is greater in an institutional setting. These include continued peer review, systematic intake and discharge procedures, reporting requirements for adverse or unexpected incidents, extensive record keeping systems, and regulatory requirements imposed by government and voluntary private bodies. Peer

review and other monitoring activities are already under way in most of these institutions, and they can be evaluated for their injury prevention potential without establishment of expensive demonstration programs.

The costs of compensating for losses associated with a medical injury are difficult to determine. The committee believes that this critical gap in knowledge hinders the development of practical compensation arrangements. Research on specific costs associated with medical injuries should be encouraged. Existing data sources do not adequately portray many of the hidden costs, such as losses that are covered by health or disability insurance benefits, or administrative costs of processing disputes over claims. If these costs were ascertained, cost estimates could be developed for models of alternative compensation systems.

Better information also is needed about medical malpractice claims (see Appendix A for an overview of research in this field). The type of information obtained should be comparable to that collected on medical injuries, but also should include duration of impairment, specific associated costs, and more information on how claims are resolved.

Omissions in the way that data on malpractice claims are collected and analyzed should be examined. First, data on claims are collected and analyzed by liability insurers or associations that represent them. The committee feels it is advisable to encourage greater involvement by appropriate governmental entities in monitoring and evaluating these activites. Given the heavy involvement of state and federal governments in financing medical care, it is important that this aspect of care should be more carefully examined.

Second, there has been no continuing analysis of malpractice claims from which trends can be discerned. Instead, several discrete research projects have been initiated for the purpose of studying claims during one or another period of time.

Third, very little work has been done on relating claims to provider encounters. This is an essential element in the development of a more complete picture of the burden of injury arising out of medical care. Injury rates cannot be obtained until the relationship between injury occurrence and exposure to risk of injury can be determined.

Conclusions about Approaches to Compensation

Despite the areas of uncertainty noted above, the committee arrived at certain conclusions about the three approaches to compensation described in Chapter 3--fault-based, specified events, and social insurance approaches. Social insurance is the only approach

that is primarily concerned with the compensation of financial or other losses associated with medical injury. Litigation, with or without the use of pretrial screening of claims, is structured to protect the substantive and procedural due process rights of claimants. It is essentially a forum for dispute resolution rather than a compensation mechanism; this is reflected in the relatively low percentage of claimants who actually receive a monetary award. Similarly, arbitration is basically a technique for dispute resolution, with compensation a secondary consideration. Medical Adversity Insurance and elective no-fault attempt to give providers some control over specifying the medical injuries for which they will be financially accountable, as well as the ability to limit potential liability. Yet, neither of these proposals assures adequacy of compensation or fairness in the selection of specified events for compensation. Pure social insurance--such as a comprehensive national health insurance plan that includes coverage of injury-related losses, or a general injury compensation plan that includes medical injury--would have compensation as a primary goal. Because such systems do not exist in the United States, an evaluation of their effectiveness for medical injury compensation here is not feasible.

The committee believes that fairness both to injured patients and medical care providers should be fundamental to a compensation scheme. This means that patients who suffer significant loss as the result of medically induced injury ought to have recourse to compensation. The committee is concerned about the impact of so-called reform legislation that systematically discourages patients from bringing legitimate claims or places arbitrary limitations on awards regardless of demonstrable financial loss. The committee is also concerned about unduly burdening providers with losses from unavoidable adverse effects of care. While medical care providers ought to be financially responsible for some of the loss associated with medical injuries, it is the opinion of the committee that providers ought not be asked to bear the burden of all losses incurred during medical care.

Some of the state modifications in tort law and procedure may contribute to more equitable compensation of medical injuries while preserving a sense of fairness to the parties involved in the claim. One example is the provision for pretrial screening of claims by panels composed of providers, attorneys or judges, and lay persons. Panels made up of individuals with medical, legal, and patient perspectives on injury and compensation have the potential for rendering decisions that will be perceived as fair. Another example is the elimination of the *ad damnum* clause (see Chapter 4, page 58) from the complaint in a malpractice suit. This action is likely to have a beneficial psychological impact on providers who are sued but would not impose a hardship on injured claimants.

Although there are numerous flaws in existing arrangements for compensation of medical injury, the committee concludes that before a new approach is adopted it should represent an improvement in access

to compensation and should address prevention of injury. Litigation, screening panels, and arbitration are all relatively unpredictable in terms of compensation; they emphasize case-by-case valuation of loss. Under MAI and social insurance, personal valuation of loss would be sacrificed in return for relatively predictable compensation. With the exception of MAI, which emphasizes avoidability of adverse outcomes and merit-rated provider premiums for liability insurance, none of the existing or proposed mechanisms for medical injury compensation includes adequate incentives for injury avoidance by providers.

The committee believes that arbitration could be used more extensively as a dispute-resolution technique in medical injury cases. The decision to arbitrate a claim should be voluntary for both patients and providers. If an arbitration agreement has been entered into prior to injury, the parties should be given the opportunity to disaffirm the agreement during a brief period after the patient discovers that an injury has occurred.

The committee believes that a system of arbitration could be designed to provide a desirable alternative to litigation. Arbitration panels composed of equal numbers of providers, attorneys, and lay persons could safeguard the process from becoming dominated by providers or attorneys, although the arbitration process may be vulnerable to the gradual development of an institutional bias in favor of medical care providers. Procedures should be adopted to insure that the due process rights of patients are protected during both formal arbitration and settlement in anticipation of arbitration. The use of state-employed patient ombudsmen would be one method for protecting the rights of injured patients.

Appendix A

RESEARCH EFFORTS IN MEDICAL MALPRACTICE

The following is a synopsis of the major research activities to date on medical malpractice. It is not intended to include all works on the subject, but merely to indicate the direction and magnitude of research efforts in the field. Where possible, the committee has attempted to delineate the scope, conclusions, overall strengths, and major weaknesses of each project.

In 1973, the Report of the (HEW) Secretary's Commission on Medical Malpractice was published. The Commission, formed in 1971, was charged with undertaking an intensive research effort into the problems and questions associated with malpractice claims. The Report, strongly criticized by providers as being biased against the medical community and in favor of the legal profession, made numerous conclusions and recommendations, most of a very general nature on such subjects as the physician-patient relationship and informed consent. 1/ The Commission also identified, authorized, and published the results of several research activities.

For example, a survey of malpractice insurance claims closed in 1970 was analyzed to establish the frequency and dollar cost of incidents leading to claims, and to describe the incidents, patients, and health care providers involved in alleged instances of medical malpractice. 2/ In another study, Boyden examined the feasibility of insurance to compensate patients injured by medical management. Compensation, as defined for the study, included both negligently caused injuries and those injuries occurring in the absence of fault. Boyden examined 400 medical records for injuries and found that the majority of such injuries were side effects of treatment. The value of the study was its development of a methodology for a larger, follow-up study of medical injury. 3/

The Commission also authorized a study by Pocincki, Dogger, and Schwartz to determine the extent of hospital-related medical injuries and medical malpractice incidents. The authors examined approximately 800 medical records from two Baltimore hospitals. They attempted to develop rates for medical injury and negligent medical injury and to

compare these rates with the number of claims filed against the two institutions. There were problems with the reliance on hospital medical records and especially with the use of a small sample size. 4/

Dietz, Baird, and Berul conducted a study entitled The Medical Malpractice Legal System, which looked at the effect of lawyers and their practices on medical malpractice in the United States. It included a random sample National Survey of 800 attorneys and a Selective Survey of about 400 attorneys, a section on legal doctrines in malpractice, and a mathematical systems model concerning economic factors in decisions of lawyers to accept or reject claims. Problems with sample selection cast doubt on the findings of the Selective Survey. 5/ An analysis of the original study was published in 1976 by Curran, who concluded that the study provided insight into popular assumptions about the role of lawyers in medical malpractice. 6/

A 1975 summary of medical malpractice prepared by the Congressional Research Service relied heavily on the data generated by the Secretary's Commission. It included sections dealing with malpractice insurance questions and various approaches to malpractice claims. 7/

To help fill the numerous data gaps left by the Secretary's Commission Report, the American Insurance Association sponsored a major study of claims closed in 1974. The study examined approximately 10,000 claims closed by 11 insurance companies and analyzed their distribution by state, type of insured, family size, and occupation. Among the study's findings were that the average time between date of incident and date of settlement was 30 months, and that there was over- and undercompensation of economic loss. 8/

The American Bar Association established a 15-member Commission on Medical Professional Liability in 1975 to identify underlying problems in medical malpractice insurance and to make recommendations for solving them. The Commission was organized into six subcommittees to study (1) the standard of care for health care providers as actually applied by the courts, (2) suggested changes in the tort system, (3) the use of arbitration and/or panels of experts, (4) alternatives to the tort system, (5) insurance aspects, and (6) prevention of medical "incidents." The Commission recently released its final report, and it included recommendations supporting voluntary arbitration and modification of several areas of substantive tort law. The Commission concluded, among other things that the tort system is conceptually appropriate for medical malpractice and should not be abandoned in favor of absolute liability or social insurance unless research indicates that it would not be possible to correct the existing deficiencies in fault-based compensation. 9/ In addition, the Commission is currently developing a pilot project that would attempt to test a system that provides compensation for specifically defined medical incidents.

The staff of the ABA Commission, under contract to the Office of the Assistant Secretary for Health in HEW, produced a report containing many of the same recommendations that appear in the final Commission report. They deal with virtually all of the tort modifications enacted by various state legislatures. 10/

The National Association of Insurance Commissioners conducted a survey of approximately 24,000 claims closed between July 1, 1975 and June 30, 1976 by participating insurers or groups of affiliated insurers. The claims were reviewed for data such as date, location, severity of injury, causes, costs, and some demographic information on claimants and insured defendants. All four volumes of the study are available, and it represents the most comprehensive collection of statistical information on malpractice claims to date. However, it does not provide such information as the ratio of claims to either the incidence of all medical injuries or physician-patient encounters, estimates of provider premiums as a percentage of gross provider income and total professional expense, or detailed socio-economic data on claimants. 11/

The Department of Health, Education, and Welfare conducted a three-month study of approximately 7,000 closed claims in 1976. The cooperation of the insurance industry was requested but participation was not mandatory. The study concentrated on the type and cause of injury, diagnostic and procedural problems encountered, drugs involved, and the type and characteristics of the facility where the injury occurred. Data collection and analysis have been completed, but the report has not been released. The shortcoming of this study is that it merely examines claims closed during one period of time and does not attempt to identify trends.

Mills, Rubsamen, and Boyden, in cooperation with the California Medical Association and the California Hospital Association, have completed a study to estimate the incidence of medical injuries occurring in California hospitals. The study reviewed approximately 21,000 patient records in 28 California hospitals and employed 20 generic screening criteria for medical injury. The authors concluded that injuries were found in 4.65 percent of the records reviewed; however, only 0.8 percent of the records were thought to represent clear cases of provider negligence and liability. Despite the limitations of hospital records as a data source, this study provides the best estimate to date of the incidence of medical injuries. 12/

The California Citizens' Commission on Tort Reform, an organization sponsored by the California Medical Association, was formed in May 1976, for the purpose of conducting a study of the tort system. Although the study is not limited solely to medical malpractice, there will be one report devoted to professional liability.

The medical malpractice problem has stimulated a great deal of state activity. This has taken the form of studies of the problem as well as legislative action. Some of the larger and more extensive state studies are from the states of California, 13/ Florida, 14/ Hawaii, 15/ New York, 16/ Virginia, 17/ and Washington. 18/

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Appendix B

SELECTED FEDERAL AND FOREIGN APPROACHES TO MEDICAL INJURY COMPENSATION

Compensation for medical injuries is dealt with in a variety of ways by programs of the United States government and by specific foreign systems. Some were developed to compensate medical injuries arising within a specified context, while others include medical injury as only one of many types of claims that may be encountered. Because most of these approaches incorporate aspects of more than one of the generic approaches to compensation outlined in Chapter 3 (fault-based, specified events, and social insurance), they are not easily categorized. The committee wished to examine briefly the strengths and limitations of these federal and foreign approaches, because they are frequently cited as models for the establishment of a comprehensive medical injury compensation system.

Federal Systems

Federally funded programs for the delivery of primary health care have necessitated the development of program-specific medical injury compensation mechanisms. Due to the historical immunity of the federal government from tort (civil) liability, statutory provisions for compensation were enacted to provide recourse to injured persons who could not otherwise sue to recover damages. The three following examples of federal approaches to medical injury compensation are examined: 1) the compensation of claims against the federal government under the Federal Tort Claims Act, with the Veterans Administration experience as an example, 2) the unique federal model of compensation for claimants under the Swine Flu Immunization Progam, and 3) the HEW Task Force proposal for compensating subjects injured in federally funded research programs.

The Federal Tort Claims Act and the Veterans Administration Experience

Under the common law concept of sovereign immunity, the federal government generally is immune from suit for all alleged wrongs, both civil and criminal. The Federal Tort Claims Act (FTCA), enacted by

Congress in 1940, provides statutory authority for individuals to bring claims against the federal government and its employees or agents for certain civil wrongs or torts. 1/ A claimant essentially has recourse against the government for negligent acts or omissions, including medical malpractice. The United States is not responsible, however, for claims arising out of such intentional torts as assault, battery, false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, misrepresentation, deceit, or interference with contract rights. 2/

All claims asserted under the FTCA must be presented to the administrative agency against which the allegations have been made prior to seeking relief through the courts; the agency may then negotiate directly with the claimant. If the claimant is dissatisfied with the agency action, he may file suit in United States District Court not later than six months after the date of mailing of the notification of agency action. 3/

As a primary provider of medical services, the Veterans Administration (VA) network of hospitals and employees is liable under the FTCA for injuries allegedly caused by medical malpractice. The number of malpractice dispositions related to VA treatment has increased in recent years.

VA Malpractice Suit Disposition, 1972-1977

Year	Number of Dispositions
FY 1972	59
FY 1973	76
FY 1974	78
FY 1975	103
7/1/75 - 6/30/76	138
10/1/76 - 3/31/77 (6 months)	105

Source: Medical-Legal Affairs Report: Summary of Comparative Workload, Veterans Administration, Dept of Health, Education, and Welfare (internal document)

The specific procedures for administrative claims review within the VA can be compared to arbitration. A panel, usually consisting of a physician and an attorney, hears the claimant's case, evaluates the evidence, and renders a decision regarding liability. If the panel finds that malpractice did occur, it may offer to settle with the claimant for a specific dollar amount. The claimant may accept or reject, but acceptance is binding and bars further action in court.

This administrative pretrial process does an effective job of preventing many claims from going to trial, as evidenced by the 105 claims disposed of between October 1, 1976 and March 31, 1977:

VA Claims Dispositions, October 1, 1976 to March 31, 1977

Total	Compromise	Judgment for Plaintiff	Judgment for Government	Dismissal
105	35 $1,008,350 (amount paid)	2 $121,200 (amount paid)	6	62

Source: Medical Legal Affairs Report: Summary of Comparative Workload, Veterans Administration, Dept of Health, Education, and Welfare (internal document)

Compromises are those settlements made any time prior to final judicial resolution; dismissals also may occur at any time. Only eight of the 105 dispositions in the six-month period required a final court determination. Although it is difficult to generalize from the few cases resolved by trial, the average award of the two cases where the plaintiff won was approximately $60,000, while the average compromise award was less than $30,000.

These procedures appear to encourage efficient claim settlement prior to court adjudication, but there is insufficient information to evaluate the system's fairness, which may be a problem in light of the relatively high dismissal rate. It is also difficult to determine whether the claims costs would increase substantially if the process were applied on a broader basis, either in terms of number of claimants or types of medical injuries covered.

Compensation for Injury Under the Swine Flu Program

The 1976 Federal Influenza (Swine Flu) Immunization Program encountered serious problems regarding liability and compensation for losses associated with the vaccine. Liability for medical injuries resulting from the immunization program first became an issue when manufacturers of the vaccine and some states--through which immunization activities were to be coordinated--could not obtain liability insurance coverage for their proposed activities. Insurance companies were unwilling to offer liability insurance because of uncertainties regarding the efficacy of the vaccine and the number of personal injury claims that might result. 4/

In enacting Public Law 94-380, which authorized the Swine Flu Program, Congress provided an exclusive remedy for personal injury or death resulting from the manufacture, distribution, or administration of swine flu vaccine. The Act provided that all claims for injury or death resulting from the program must be filed against the federal government and decided through Federal Tort Claims Act procedures, as amended for purposes of the Swine Flu Program. 5/ It also made the federal government responsible for developing and implementing a written informed consent form to assure that the risks and benefits of

the vaccine were fully explained to each individual to be immunized. The government reserved the right to recover costs to defend and settle any claims in which negligent conduct is found on the part of the manufacturers or other program participants, such as physicians or public health officials. To insure against the federal government's right to recover, the vaccine manufacturers bought $230 million of liability insurance; because the premium for this insurance, $8.65 million, was considered a vaccine production cost, it was funded by the federal government. The federal government also funded the first $10 million of the $230 million liability coverage, which represented self-insurance for the manufacturers. 6/

Under the FTCA, claims normally would be processed through the responsible agency, as is the case with claims brought against the VA. In order to screen claims arising out of the Swine Flu Program more effectively, they are first reviewed directly by the Department of Justice rather than by the Department of Health, Education, and Welfare. If deemed valid on its face, the claim is sent to HEW for a review by physicians based on two criteria: 1) whether the claim is beyond the substantive limits of the informed consent warning, and 2) whether the injury was medically caused by the vaccine. If these medical criteria are satisfied, legal review of liability is conducted by the Department of Justice to determine whether, under the state law where the injury occurred, the United States is liable in its own right or as a substitute defendant for a program participant.

A recommendation is then made to HEW supporting one of the following courses of action: a) denial based on medical and/or legal reasons, b) payment of the claim as submitted, or c) a recommendation for a negotiated settlement. HEW reviews the recommendation and, if approving, transmits a recommendation letter to the claimant. If dissatisfied with the results of this process, the claimant has the right to seek relief in the appropriate United States District Court. 7/

As of September 9, 1977, the Department of Justice had received 816 claims, totalling approximately $1.4 billion in alleged losses. It is expected that more than 2,500 claims eventually will be filed. Final disposition had been reached in 86 claims, with an additional 30 to 35 claims at the point where recommendations could be prepared, 40 were under review by physicians, and 40 to 50 were ready for transmittal to physicians. Of the remaining claims, supplementary information or medical records had not been received. The average time required for the Department of Justice to process claims is approximately three months. 8/

At present, no claims have proceeded to final judicial resolution under the Swine Flu Program and, although settlement figures are not available, it appears that the claims for which compensation has been made represent relatively minor amounts. Nevertheless, the

the total amount of claims filed ($1.4 billion) is substantial. This is important to note, because the Swine Flu Program is one of the few examples of a compensation mechanism in the United States that has attempted to absorb all costs.

An HEW Task Force Proposal for Compensating Injured Research Subjects

In February 1975, the Secretary of HEW established a Task Force to develop a means of compensating persons injured as a result of participation in federally funded research projects. The Task Force was asked to examine the following questions: a) should subjects injured in the course of HEW-supported research be compensated for such injury, whether or not negligence is involved, and b) if it is concluded that such compensation should be made available, what mechanisms would best be suited for such a program? 9/

The Task Force concluded that all persons who suffer injury as a result of their participation in biomedical or behavioral research, whether therapeutic or nontherapeutic, should be compensated, provided that injury is narrowly defined. The Task Force specified that, in addition to being proximately caused by the research in question, the injury--whether harm, disability, or death--must exceed that reasonably expected from the disease from which the patient suffers. 10/

The compensable injury definition derived by the Task Force is broader than traditional fault-based injury. The Task Force felt that a fault-based system would not adequately meet the needs of most injured research victims because of the very nature of most biomedical research; that is, the anticipated risks would be obviated by consent forms and unanticipated risks would not result in liability. 11/ The Task Force therefore proposed that all subjects injured as a result of participation in a federally funded research project should be treated in a similar fashion, regardless of whether injury was predicated on fault. The Task Force also concluded that warnings of potential injuries did not negate the obligation of society to provide compensation. 12/

Having determined that a compensation program was morally and ethically justified, the Task Force reviewed a number of methods of compensating persons injured in HEW-supported research programs. For volunteers participating in purely governmental programs, the Task Force recommended that they be considered government employees, eligible for coverage under the Federal Employees' Compensation Act (FECA). Under FECA, payments of dollar and health benefits may be authorized to persons other than military personnel who are injured or disabled in the performance of their duties in service to the United States; benefits also may be authorized to the surviving dependents of such persons. 13/

The Task Force concluded that nongovernmental institutions performing federally supported research should be free to make appropriate financial arrangements to fund their respective compensation systems. It also recognized private insurance as an important alternative, but noted that the private insurance industry has not shown much interest in providing coverage for research subjects. The consideration of other methods, such as self-insurance or "pool" coverage, was recommended. 14/

Compensation for research subjects is another example of a unique solution to a specific medical injury compensation problem. The Task Force broadened the traditional compensable injury definition to include virtually all research-related injuries. The mechanism to provide compensation for subjects of purely governmental research--the FECA system--is already in place. The no-fault type of approach described here would eliminate the need to investigate causation and would virtually guarantee compensation.

Foreign Systems

The committee decided that it would be constructive to review the efforts of two countries which have established specific systems for compensating medical injuries--Sweden and New Zealand. It was felt that these countries would be more useful examples than Great Britain and Canada, where some losses from medical injury are covered under comprehensive national health insurance plans but no specific mechanism for medical injury compensation exists. The committee recognizes that the applicability of foreign models to the United States may be limited generally by differing social, political, economic, and legal philosophies and goals; specifically, they may be of limited use because of differences in the magnitude of the medical injury problem, number of potential claimants, and standards for compensation.

Sweden

A no-fault patient compensation program--the Patient Insurance Program--was established in Sweden on January 1, 1975. It is financed by public funds through contractual agreements between the regional governments (County Councils) and a consortium of insurance companies. The Councils are responsible for the provision of all health services to their residents. Although nationwide in scope, the plan is not an activity of the federal government. Private physicians and health care institutions are covered under separate contracts. These are private transactions not required by law. 15/

Since few injured patients previously had received compensation through the tort liability system, the program was intended to provide increased financial protection for the patient. It is based on the recognition that a number of adverse events inevitably occur in the course of medical treatment, many of these in the absence of provider

negligence. 16/ Patients are not indemnified for injuries that are the expected result of the condition for which treatment was sought. Compensable events are categorized into three broad groups: 1) injury related to treatment, but not necessarily to the health problem for which treatment was sought; 2) injuries related to the treatment and/or the problem for which treatment was sought when treatment procedures are judged unacceptable; and 3) accidents within health care institutions or during transport. 17/ Compensation for treatment-related injury is dependent upon a minimum need for hospitalization or sick leave for two weeks, permanent disability, or death. Compensation for pain and suffering is also paid. There is a two-year limit within which claims must be made under the no-fault provisions of the plan. 18/

Cases falling outside the general guidelines for the program and contested decisions are reviewed by an appointed committee of experts called a claims panel. If the decision of the panel is not accepted by the injured patient, the County Council, or the insurer, the claim is referred to arbitration. The patient also retains the right to sue a hospital or physician in the courts. 19/

Premiums for the entire country average $.50 per capita for Sweden's eight million people. Of the total amount of premiums collected, 70 percent is available for payment of claims against the County Councils. The remaining 30 percent constitutes a special risk premium for excess damages. The coverage for each individual under the plan is limited to $500,000. 20/ Malpractice insurance premiums for physicians cost about $25 per year, regardless of specialty. Although 1,500 claims had been anticipated for 1975, only 808 had been processed by the system as of January 1976. Of those, 237 were denied, and the total award for the remaining 571 claims was $2.5 million, or an average of $4,800 per claim. 21/

It is too early to evaluate the effectiveness of Sweden's no-fault program, although some observations may be made. The national-regional notion of coverage approximates the workers compensation model in this country. The program features a no-fault/claims panel/arbitration/trial court continuum of claims resolution, which in some cases may be costly or repetitive, but provides several opportunities for review of claims and settlement of the dispute. Apparently, the no-fault concept has been applied to the field of medical injury--despite the common criticism that complex questions of causality militate against its use--without encouraging a tremendous increase in the number of claims filed. However, these findings must be tempered by the fact that, unlike the United States, Sweden is a relatively small country with a homogeneous population.

New Zealand

New Zealand's Accident Compensation Act of 1972, which became effective April 1, 1974, originally was intended to cover only wage earners who suffered personal injury by accident, regardless of place,

time, or cause. 22/ The Act was amended in 1973 to cover accidental personal injury for all of New Zealand's three million people. 23/ It proscribes any and all tort actions for recovery of damages for such injuries. 24/

A lump sum up to $5,000 is payable to persons suffering permanent loss or impairment of any bodily function as a result of accidental personal injury. Up to $7,500 is payable for loss of "amenities of capacity for enjoying life, including loss from disfigurement," as well as for pain and mental suffering. Payment of earnings-related compensation ceases when the worker attains age 65, if the accident occurs before he reaches age 60. A series of later dates of cessation are provided if the injury occurs after age 60. 25/ Revenue for the plan is drawn from (a) levies on employers (including the government) and on the self-employed to pay for the Earners' Scheme, (b) levies on motor vehicle owners to pay for the Motor Vehicle Accident Scheme, (c) general taxation to pay for the Supplementary Scheme covering non-earners, and (d) interest from invested funds. 26/

In return for guaranteed compensation for all types of accidental personal injury, including medical injury, the amount of compensation available for loss of bodily function, social loss, or pain and suffering is sharply limited. Income loss also is circumscribed. Injury avoidance incentives in the medical care field appear to be totally absent, since physicians are not required to contribute to the plan. It is not yet clear what effect this may have on the quality of medical care. No statistical information is currently available regarding the number of claims brought, average amount awarded or sufficiency of the compensation.

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