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MEDICAL MALPRACTICE INSURANCE: THE DISEASE AND HOW TO CURE IT

JONATHAN BRANT*

INTRODUCTION

One of the first principles of tort liability has always been that the party at fault pays for any damages inflicted upon an innocent victim. In the simple torts paradigm, the triers of fact are confronted with the task of ascertaining whether the defendant was at fault and, if he is determined to be, to what extent he should pay to compensate for the inflicted injury. In situations where accidents are common and where the possibility exists that persons will be ruined financially if judged at fault in an accident, it is common that insurance be purchased to guard against that possibility of financial ruin. Most persons encounter liability insurance in regard to insurance of their automobiles, and it is in that field where the practical difficulties of the fault system have attracted the most public attention. Although the fault system may appear to be fundamentally fair in that it seeks to have the "guilty" party pay for his errors, practical difficulties with operating an insurance system using a fault basis have led persons to consider alternative means of insurance. These practical difficulties include the inherent problems of extended delays and high costs in using the court system as the means for apportioning fault. In addition, actuarial methods, underwriting procedures and other practices of the insurance industry contribute to the difficulties in using the fault system. Various proposals for remedying the problems in the area of automobile accident insurance which present alternatives to or modifications of the fault system have been suggested.[1] Although proposals for legislative changes have met with strenuous opposition and little success, the movement toward some modification of the fault system in automobile insurance seems to be gaining adherents rapidly.[2]

Automobile insurance is not the only form of liability insurance which has attracted the attention of reformers. Because of many of the

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1. *See* G. CALABRESI, THE COSTS OF ACCIDENTS (1970).

2. Forms of no-fault automobile insurance have been in effect for several years in Puerto Rico and in the Canadian province of Saskatchewan. Massachusetts adopted a limited form of no-fault insurance early in 1971, and recently Delaware, Florida, Illinois and Oregon have passed similar no-fault legislation. Numerous other states are considering no-fault proposals. *See, e.g.,* Keeton and O'Connell, *Alternative Paths Toward Nonfault Automobile Insurance,* 71 COLUM. L. REV. 241 (1971).

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same symptoms, *i.e.*, rising costs, delays and cancellation of policies, the topic of medical malpractice insurance has received considerable attention in recent years. In this article, the current system of settling medical malpractice claims using a fault system is analyzed, and various proposals for modifying or replacing the fault system are considered.

PROBLEMS IN INSURING MEDICAL MALPRACTICE

In many ways, medical malpractice suits are similar to other actions for damages brought because of negligent conduct. Malpractice itself is defined as the "wreaking of bodily harm by virtue of neglect, abandonment or the omission or commission of certain actions which fall below the standards of the average medical practitioner."[3] Malpractice requires negligent or unskillful practice on the part of the physician which results in injury to the patient.[4] Among medical malpractice suits, 85 percent allege negligence, 10 percent allege lack of consent and the remainder involves various other theories of tort.[5]

The standard of care required of physicians is reasonable skill and learning possessed and exercised by members of the profession who follow the same school of medical thought as the defendant and who practice in the same or similar localities.[6] Each of these modifying clauses limits the operational standard by which negligence can be determined. For example, where there are different schools of medical thought, it is held that the dispute cannot be settled by a per se rule; the doctor is entitled to be judged according to the tenets of his own school of medical practice if it has definite principles of therapy and is followed by at least a respectable minority of the profession.[7] Similarly, a country doctor cannot be judged by the standards of a large medical center. Rather, his conduct must be compared to the reasonable standard for a physician within his or a similar locale. This has often led to strict rules of evidence requiring that only physicians from the same locale as the defendant be permitted to testify as to the applicable standard of care. However, strict application of these rules has been breaking down recently in the face of rising numbers of claims.[8]

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3. Brooke, *Medical Malpractice: A Socio-Economic Problem from a Doctor's View*, 6 WILLAMETTE L. REV. 225 (1970).

4. *See, e.g.*, Hicks v. United States, 368 F.2d 626 (4th Cir. 1966); Atkins v. Humes, 107 So. 2d 253 (Fla. 1958) (failure to exercise the required degree of care, skill and diligence); Gault v. Sideman, 42 Ill. App. 2d 96, 191 N.E.2d 436 (1963).

5. Letourneau, *Medical Malpractice*, 109 HOSPITAL MANAGEMENT, April, 1970, at 18.

6. McCoid, *The Care Required for Medical Practitioners*, 12 VAND. L. REV. 549, 559 (1959).

7. *E.g.*, W. PROSSER, HANDBOOK OF THE LAW OF TORTS 166 (3d ed. 1964); RESTATEMENT (SECOND) OF TORTS § 299A, comment *g* at 75 (1964).

8. W. PROSSER, HANDBOOK OF THE LAW OF TORTS 167 (3d ed. 1964).

An allegation of negligent professional conduct is proved either by showing that the applied procedure did not meet the applicable standard of care or by asserting under the doctrine of *res ipsa loquitur* that the bad result itself warrants a conclusion of negligent conduct.[9] Except in a few instances, expert testimony is required to establish the breached standard.[10]

The reluctance of one physician to testify against another has led to charges that a conspiracy of silence exists among physicians. A well-known study by the Law-Medicine Institute at Boston University revealed that from a survey sample of 214 physicians, only 31 percent of specialists and 27 percent of general practitioners would be willing to testify against a fellow doctor who, in an operation to remove a diseased kidney, had removed the healthy one.[11] One court complained that

> [a]nyone familiar with cases of this character knows that the so-called ethical practitioner will not testify on behalf of a plaintiff regardless of the merits of his case. This is largely due to the pressure exerted by medical societies and public liability insurance companies which issue policies of liability insurance to physicians covering malpractice claims. . . . But regardless of the merits of the plaintiff's case, physicians who are members of medical societies flock to the defense of their fellow member charged with malpractice and the plaintiff is relegated, for his expert testimony, to the lone wolf or heroic soul, who for the sake of truth and justice has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy.[12]

Although courts have condemned in the strongest possible language the reluctance of doctors to testify,[13] and despite the American Medical Association's own Principles of Medical Ethics which would seem to impel testimony,[14] the practice continues because of fear of retribution.

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9. Curran, *Professional Negligence—Some General Comments*, 12 VAND. L. REV. 535 (1959).

10. *See, e.g.*, Loudon v. Scott, 58 Mont. 645, 194 P. 488 (1920).

11. Pascoe, *How Malpractice Suits Get Started*, MEDICAL ECON., Aug. 28, 1961, at 85.

12. Huffman v. Lindquist, 37 Cal. 2d 465, 484, 234 P.2d 34, 46 (1951) (dissenting opinion).

13. In *Steiginga v. Thron*, 30 N.J. Super. 423, 105 A.2d 10 (App. Div. 1954), the court called the doctor's conduct "a shocking unethical reluctance on the part of the medical profession to accept its obligations to society and its profession . . . ." *Id.* at 425, 105 A.2d at 11.

14. AMA PRINCIPLES OF MEDICAL ETHICS art. I, § 4, ch. III *reprinted in* 167 J.A.M.A., June 7, 1958, at 20, provides: "A physician should expose, without fear

This fear is realistic; physicians have lost hospital privileges and have had their malpractice insurance cancelled as the result of testifying for a plaintiff in a malpractice suit.[15] The possibility of cancellation has been increased because of cooperation between many medical associations and the insurance companies.[16] Rather than protect their members, medical associations have been known to threaten reporting to a physician's insurer that he intended to testify, thereby encouraging the insurance company to cancel any physician willing to testify for a plaintiff.[17] In a recent case, however, a federal appeals court held that use of the contractual right of cancellation by an insurance company against a dentist who had given expert testimony constituted breach of contract.[18] While this case is unique, it may serve as a precedent for eliminating many of the threats which preserve the conspiracy of silence.

Despite all these difficulties, the number of malpractice claims is increasing at a rapid rate.[19] Although good statistical data is lacking, the best estimates are that between 6,000 and 10,000 malpractice claims are filed every year.[20] Another estimate is that one out of every six physicians has had one malpractice claim against him and that one out of every twenty-five has had two or more.[21] One insurance company has estimated that there has been a 43 percent increase in the number of claims during the past five years with a concomitant 200 percent increase in the cost per claim.[22]

The rising amount of litigation concerning alleged medical malpractice has apparently affected the practices of many physicians and has boosted the cost of medical care.[23] This has resulted in what the physicians call defensive medicine, with the doctor viewing each patient

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or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession."

15. Carlson, *Suing the Doctor,* Wall St. J., Feb. 29, 1969, at 1, col. 1.

16. Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment,* 1 VILL. L. REV. 250 (1956).

17. Case Note, 11 B.C. IND. & COM. L. REV. 545, 549 (1970).

18. L'Orange v. Medical Protective Co., 394 F.2d 57 (6th Cir. 1968). *But cf.* Agnew v. Parks, 172 Cal. App. 756, 343 P.2d 118 (Dist. Ct. App. 1959).

19. Bernzweig, *Lawsuits: A Symptom Not a Cause,* 6 TRIAL, Feb.-Mar., 1970, at 14 [hereinafter cited as Bernzweig, *Lawsuits*].

20. *Compare* Bernzweig, *Soothing Patient Psyche May Prevent Lawsuit,* 122 MODERN HOSPITAL 83 (1969) (6,000-9,000 malpractice claims per year) *with* Cazac, *Professional Liability—The Preventive Aspect,* 16 WORLD MEDICAL J. 57 (1966) (8,000-10,000 malpractice claims per year).

21. SUBCOMM. ON EXECUTIVE REORGANIZATION OF THE SENATE COMM. ON GOVERNMENTAL OPERATIONS, 91ST CONG., 1ST SESS., MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN 8 (Comm. Print 1969) [hereinafter cited as SENATE MEDICAL MALPRACTICE REPORT].

22. Brooke, *supra* note 3, at 227.

23. Bernzweig, *Lawsuits.*

as a potential litigator. As a result, the physicians are likely to order an excessive number of tests for their patients to insure an accurate diagnosis. This extra cost, of course, is passed along to the patient and his health insurance company.[24] Despite these precautions, a congressional study concluded that

> most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. The majority of suits are justifiable from the standpoint that the patient did suffer some injury which he felt gave him grounds for bringing legal action.[25]

There are several factors which help to explain the rising number of medical malpractice claims. The most important sociological factor has been the breakdown of the traditionally close-knit relationship between physician and patient. Increasingly, medical care in this country has become impersonal. In turn, this impersonality has resulted from increasing demands for health care coupled with chronic manpower shortages.[26] The lack of a close relationship with the physician plus an unsatisfactory result from the medical treatment appear to be the factors leading to a suit for malpractice.[27] Add to these the discontentment caused by a physician's bill which seems too high or the tactics of a collection agency to force payment, and a suit is almost inevitable.[28] The correlation between the doctor-patient relationship and a suit for malpractice is illustrated by statistics. Physicians in general practice and pediatrics, where closer physician-patient contact is maintained, are among the least likely to be sued, while physicians in more impersonal surgical specialties are the most likely to face suits for malpractice.[29] Since 70 percent of all claims arise from hospital situations, it seems to follow that the further the patient is removed from individualized, personal treatment, the more likely he is to sue.[30] This is especially probable if certain psychological studies of the patient-litigant are accurate. These describe him as an emotionally immature neurotic who has subconscious

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24. SENATE MEDICAL MALPRACTICE REPORT 2.
25. *Id. But see* THE MEDICO-LEGAL READER 237 (S. Polsky ed. 1959).
26. SENATE MEDICAL MALPRACTICE REPORT 20.
27. Frankel, *Medico-Legal Communications,* 6 WILLAMETTE L. REV. 193, 202 (1970).
28. SENATE MEDICAL MALPRACTICE REPORT 20.
29. The likelihood of physicians being sued is, in decreasing order: orthopedic surgeons, general surgeons, neurologists, anesthesiologists, obstetricians and gynecologists, radiologists, ophthalmologists, urologists, general practitioners, otolaryngologists and pediatricians. 7 MEDICAL WORLD NEWS, May 6, 1966, at 116.
30. Bernzweig, *Lawsuits* 14-15.

fears of illness, doctors and death. He wants to have complete faith in the physician who is a father-figure to him, and he sues as a hurt child when the treatment fails to restore him to health quickly.[31]

Whatever the patient's deeper motivation, one thing which leads him to seek redress from the courts has been the medical profession's unwillingness to carefully police itself. In 1968, only 64 doctors in the country had their licenses revoked, another 59 received revocations but had them stayed and another 60 had their licenses suspended for a period of one year.[32] One commentator has stated that physicians only have their licenses suspended when they are convicted of felonies involving moral turpitude or of violations of the narcotics laws.[33] The same protectiveness which leads doctors to avoid testifying against each other has led them to avoid careful scrutiny of each other's work. Perhaps it is true that professionals cannot be expected to police themselves.[34]

At any rate, the primary battleground for settling disputes between doctor and patient has been the court system. The threat of a large judgment has naturally led physicians to seek indemnity protection through insurance. Because of the increased number and size of judgments in malpractice litigation, and the resulting increase in the cost of malpractice insurance, the subject of medical malpractice insurance has received considerable attention in recent years.

To illustrate the magnitude of these increases, consider the increase in the cost of medical liability insurance. Between 1950 and 1967 the size of the average malpractice insurance premium in New York State rose 332 percent. During the same period the gross national product rose 170 percent, the consumer price index 36 percent, physician's fees 81 percent and hospital costs 246 percent.[35] The price of malpractice premiums nationwide increased an average of 30 percent in 1967, but in California, where the malpractice problem is considered worst, the rates nearly doubled.[36] Furthermore, as the result of the increasing size of

31. *Id.;* Perrin, *Can You Spot the Patient Who'll Sue?,* MEDICAL ECON., Jan. 5, 1959, at 103.

32. SENATE MEDICAL MALPRACTICE REPORT 6. These figures, however, certainly underestimate the amount of review of individual physicians by organizations within the profession. Most commonly, such review occurs in the private, high-status hospitals where so-called tissue committees may review samples from operations to determine whether the operation was necessary and proper. Determination of improper conduct could lead to loss of hospital privileges.

33. SENATE MEDICAL MALPRACTICE REPORT 32.

34. Curran, *supra* note 9, at 539.

35. Uhthoff, *Medical Malpractice—The Insurance Scene,* 43 ST. JOHN'S L. REV. 578, 586 (1969) [hereinafter cited as Uhthoff, *Insurance*].

36. AMA, *Medical Liability, reprinted in* SENATE MEDICAL MALPRACTICE REPORT 997; Brooke, *supra* note 3, at 232.

judgments, some of which have exceeded one million dollars, the amount of insurance held has also increased. In 1950, there were rarely policies in which the protection exceeded $100,000; today 90 percent of physicians are insured above that figure, with the average policy protecting to an aggregate total of $300,000.[37] Of course, many physicians, particularily those in the specialties where suits are most common, are insured to greater amounts.

A majority of physicians obtain their insurance through private agents, while one in four obtains his insurance through medical societies. Despite the cost, only 8 percent of physicians nationwide (3.6 percent in California) are uninsured, and the vast majority of physicians report themselves satisfied with their insurance coverage.[38]

There are four basic types of private insurance carriers. The first is the limited, low risk operation which extends its coverage over a wide geographical area but limits itself to coverage of a select group of medical specialties which are least likely to be sued. Because of its attempt at risk selection, the company is quick to cancel any large risks which develop. The second type is the insurer who will only write medical malpractice insurance along with other types of insurance. This type of insurance carrier also tends to be quick to cancel when the malpractice line becomes unprofitable. The third type of insurer, though largely in the discussion stage today, is the physician's cooperative insurance company. Because of the rising costs of malpractice insurance, several state medical societies are considering formation of their own companies. However, the high costs in this field probably do not make this very feasible.[39] The most stable type of insurer has been the large company or combination of companies which insures a volume business, often insuring medical societies at a group rate. Their size has permitted them to survive the economic difficulties.[40]

There is no doubt that the carriers' costs have been increasing at a disproportionate rate. All evidence shows that the average closing cost of each claim has increased dramatically. The average closing cost in Los Angeles in 1969 was six times the 1957 rate; in New York there has been a steady 18 percent annual increase for several years.[41] Among

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37. Uhthoff, *Insurance* 586; SENATE MEDICAL MALPRACTICE REPORT 1015.

38. *1963 Professional Liability Survey,* 189 J.A.M.A. 859, 864 (1964); SENATE MEDICAL MALPRACTICE REPORT 477.

39. *Compare* Jarrett, *Arizona's Medical Association Malpractice Insurance Plan,* 27 ARIZ. MEDICINE, Oct., 1970, at 12, *with* Landau, *Our Most Immediate Threat,* 27 ARIZ. MEDICINE, Oct., 1970, at 13.

40. Allen, *Report,* 8 WEST. MEDICINE 147 (1967).

41. *See* SENATE MEDICAL MALPRACTICE REPORT 1043; Uhthoff, *Handwriting on*

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the major causes for the increase in average cost per claim has been the cost of defense preparation, which is typically greater than for the typical tort defense because of the complexity of the litigation. The needs for expert testimony, diagnostic procedures and expert legal counsel all boost the costs for the insurance company. It appears that malpractice insurance has proven to be a losing proposition for the insurance companies. Not one insurance company has made money in writing medical insurance in recent years. The Nettleship Company, a combine of major insurance companies providing malpractice insurance in the Los Angeles area, lost 22 million dollars in 1969, with the result that six companies ended their participation with the combine.[42] The evidence from New York has been that even while premiums were increasing 332 percent, the loss increase has been approximately 375 percent.[43] The Medical Society of New York told its readers:

> A company official has stated that as of the end of last year, the company had lost money writing malpractice insurance for the Medical Society of New York, even taking into account their investment income from the premiums received. Our own actuary does not dispute this statement.[44]

The following chart indicates the extent of loss in New York.[45]

TABLE 1—MALPRACTICE INSURANCE LOSSES IN NEW YORK 1962-1967

Year	Premiums	Permitted loss ratio	Available for loss	Total Loss	Underwriting Loss
1967	5,906,181	79.3	4,683,890	9,090,216	4,406,326
1966	5,003,960	79.0	3,953,128	7,394,705	3,441,577
1965	4,428,074	79.0	3,498,186	6,644,271	3,146,085
1964	4,324,575	79.0	3,416,414	6,178,575	2,762,161
1963	4,121,291	79.0	3,255,820	4,907,828	1,652,008
1962	3,790,189	79.0	2,994,249	4,117,903	1,123,654

Another way of demonstrating the loss is through an analysis of the distribution of the malpractice insurance premiums. This also shows a significant loss.[46]

the Wall, 70 N.Y. ST. J. MEDICINE 1673 (1970) [hereinafter cited as Uhthoff, *Handwriting*].

42. Jarrett, *supra* note 39.

43. Uhthoff, *Insurance* 587; *cf.* letter from William J. Curran to 282 N.E.J. MEDICINE 817 (1970).

44. Editorial, *Important Information on Professional Liability and Defense,* 69 N.Y. ST. J. MEDICINE 2427, 2428 (1969).

45. *Id.*

46. Dornette, *Professional Liability Insurance,* 33 ANESTHESIOLOGY 535, 539 (1970).

TABLE 2—DISTRIBUTION OF PREMIUM PAYMENTS

Awards to Patients	27%
Plaintiff Counsel and Investigation	29%
Defense Costs	24%
Solicitation of Business	20%
Overhead	13%
Total	113%
Loss	13%

These losses must be made up from reserves. One company reported that malpractice insurance accounted for only 5 percent of the company's total premiums but for 10 percent of its reserves.[47] In addition, the reserves often have proven inadequate in a particular year and have had to be bolstered.[48] The effect of the economic difficulty with malpractice insurance has been that smaller companies have dropped out altogether or have sought to be selective about their choice of persons to insure.[49] Larger companies have remained because their profits in the fields of fire, theft, automobile and life insurance have subsidized their losses in medical liability insurance. Often, however, these companies have remained only when they could negotiate their insurance contracts through large groups such as medical societies or group health plans.[50]

The major cause of the turmoil in malpractice insurance has been the difficulty in setting rates. Because the initial rates have proven too low, the recent marked increases have been necessary to meet the greatly increased costs. In theory, rate setting for medical malpractice insurance should be little different from rate setting for any type of casualty insurance. The size of the premium for a particular physician is determined according to the doctor's specialty and practice, his geographical location, the amount of coverage he seeks and whether he purchases the insurance singly or as part of a group.[51]

However, apparently the theory has thus far proven inadequate to meet the realities of the situation. Malpractice claims are unique in that there is an extended period of time between the injury and the initiation of the suit. Statistics show that only 6 percent of all claims are filed during the year of the injury, 48 percent are filed by the end of the next year and 80 percent within four years after the accident. This means that one-fifth of all claims are not filed until at least the fifth year

47. Uhthoff, *Handwriting* 1675.
48. *Id.*
49. Morris, *supra* note 38, at 464.
50. Jarrett, *supra* note 39.
51. SENATE MEDICAL MALPRACTICE REPORT 1025.

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after the injury occurs.[52] This delay in filing malpractice suits coupled with the rise in malpractice claims in recent years has proven that the actuaries have underestimated their needed reserves.[53] Inflationary pressures have further aggravated the cost problem for the insurance companies.[54] More than anything else, this difficulty in estimating costs has led many insurance companies to withdraw from the malpractice field.[55] Nonetheless, thirty companies continue to write medical malpractice insurance although none of these companies participates on a national scale.[56] As stated before, the most successful sellers of this type of insurance have been the large, high-volume companies dealing primarily with entire memberships of medical societies or through special group arrangements. If the group is large enough, the insurance companies feel they can give its members substantially reduced rates because the medical society or group practice can assist the insurance company through review committees, prevention programs and other similar arrangements.[57] Savings on insurance bought through the local medical society have been estimated at 30 percent for the Washington, D.C., area.[58]

Much of the blame for the rising rates must rest with the insurance companies. Although it is probably true that they were neither able to adequately anticipate the rising number of claims nor to cope with the delays inherent in malpractice litigation, they have been lax in developing new methods for risk selection, rate making or prevention of claims.[59] Their only major experimental step has been to protect themselves by use of reinsurance for claims over $10,000.[60]

DIFFICULTIES INHERENT IN THE FAULT SYSTEM

Once the claim is filed, the doctor and his insurance company must decide what to do about it. There are several possible outcomes: The case can be settled out of court; the patient-litigant can be persuaded to drop the suit; the case can go to trial with a verdict for either party. One study has estimated that out of 100 claims, 15 will be pending, 22 will be dropped, 42 will be settled and 21 will go to trial with the doctor winning in 17.[61] The figure given for the result at trial is disputed by

52. *Id.* at 9.
53. Uhthoff, *Insurance* 587.
54. *Id.*
55. Allen, *supra* note 40, at 150.
56. SENATE MEDICAL MALPRACTICE REPORT 9.
57. Uhthoff, *Insurance* 594.
58. D. SHARPE & M. HEAD, PROBLEMS IN FORENSIC MEDICINE 115 (3d temp. ed. 1965).
59. Bernzweig, *Lawsuits*, *supra* note 19.
60. Allen, *supra* note 40, at 148; Dornette, *supra* note 46, at 535.
61. Averback, ℞ *for Malpractice*, 1970 INS. L. J. 69, 77 (1970).

another study which concluded that the doctors and the patients each win about half the time on a national scale, although there are regional variations.[62] In California the physicians are believed to win 90 percent of these suits.[63] The exact result is not terribly significant. What is significant is the distribution of the money from the settlements. Of the 75 million dollars paid in medical malpractice premiums, only about 18 million dollars will actually reach the hands of the claimants themselves.[64] To put this another way, of the money actually expended in litigation costs including settlements and damages, the patient will receive only approximately one-third, his attorney will receive approximately one-fourth and the remainder will be defense costs.[65] No matter which of these studies is more accurate, it is apparent that under the existing fault system the lion's share of the total cost in malpractice insurance claims which are settled goes to persons other than the injured party.[66]

There are several possible explanations for this. One is that the legal profession encourages the filing of contingent fee suits in the malpractice area. Most observers, however, contend that the contingent fee system leads attorneys to discourage frivolous suits. Such evidence as exists indicates that lawyers, particularly experienced malpractice attorneys, attempt to screen out weak cases.[67] Critics of the contingent fee system often point to the few malpractice cases in Canada where lawyers do not operate on contingent fees in tort cases. However, the apparent reason for the small number of medical malpractice cases in Canada appears more closely related to the greater control of individual physicians by the professional medical society than to the absence of contingent fees.[68]

One explanation for the high costs of malpractice claims is that there are strong pressures on physicians to refuse to settle malpractice claims in this country. Most physicians no doubt feel that any admission of malpractice (*i.e.*, bad practice) will be a serious detriment to their careers. As a result, most medical malpractice contracts, unlike other

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62. SENATE MEDICAL MALPRACTICE REPORT 8.

63. *Id.*

64. Dornette, *supra* note 46, at 539.

65. SENATE MEDICAL MALPRACTICE REPORT 10. One study indicates that the proceeds from medical malpractice litigation were apportioned as follows: 30 percent for the patient, 15 percent for his lawyer and 55 percent for defense costs. Another study, however, states that the distribution was 38 percent for the patient, 35 percent for his lawyer and 27 percent for defense costs. *Id. Compare* the figures cited by Dornette, *supra* note 46 and accompanying text.

66. Letourneau, *supra* note 5, at 20.

67. SENATE MEDICAL MALPRACTICE REPORT 16. Sharpe, *Contingent Fee = Patient Protection*, 6 TRIAL, Feb.-Mar., 1970, at 21.

68. Harland, *Anesthetic Malpractice in Canada*, 10 CLEV.-MAR. L. REV. 19 (1961).

insurance contracts, deny the insurer the right to make any settlement without the physician's permission. No doubt many cases which could be settled easily with low administrative, judicial and legal costs are dragged through the courts only because the physician is unwilling to accept a settlement since his name and honor can be vindicated only through litigation.[69]

The effects of the present fault system on the practice of medicine would probably be considered beneficial if the difficulties enumerated above did not exist. At one level, because the nonmonetary penalty of being judged negligent is neither insurable nor shiftable, and because the financial risk itself may become too great to bear, a small number of physicians who have been judged negligent should be expected to abandon the practice of medicine altogether. Theoretically, if fault and negligence could be accurately determined by the courts, only the unskillful would be forced out of practice.[70] Similarly, if the problems were merely those of cost, physicians could be forced to practice in sizable groups or in other ways where the malpractice insurance costs would be lower. Indeed, there is some evidence that costs are affecting medical practice, including the encouragement of group practices as a means of cutting insurance costs.[71] To the extent that medical malpractice insurance costs are borne by an individual physician's patients according to their ability to pay, the physicians, in passing their costs along, would be creating a limited form of income distribution by means of a type of progressive tax on the patients.[72]

The problem with the current system, as with automobile insurance, is that the costs are spiraling beyond control. In large part, this results from inadequate planning and innovation by insurance companies which failed to anticipate the great increase in the number of malpractice suits. The cost problem was further compounded because their rate structures failed to take into account the long delays in the filing of malpractice claims. Once the rash of suits began, other pressures have exacerbated the situation. Particularly, the courts have been loosening doctrines which formerly protected hospitals and physicians from suit—*e.g.*, charitable immunity, statutes of limitations and the locality rule. At the same time, the administrative costs of the fault system increase its inefficiency. When a system filters only 20 million dollars to the patient-litigants out

69. Brown, *Social Resource Allocation Through Medical Malpractice*, 6 WILLAMETTE L. REV. 235 (1970).
70. *Id.* at 242.
71. *Id.* at 248.
72. *Id.* at 244.

of 75 million dollars in premiums and loses money, it is prima facie inefficient. These inefficiencies are the direct result of the use of the judicial process with its expensive hearings, witness fees, investigative expenses and attorney's fees. Just as the no-fault concept in automobile insurance purports to be less expensive simply because the expense of litigation to determine fault is saved, so medical malpractice insurance costs would seem susceptible to reduction by elimination of the need for expensive litigation.

ALTERNATIVES TO THE PRESENT FAULT SYSTEM

Modification of Tort Liability

One possible alternative to the present fault system is to adjust current judicial attitudes of negligence in malpractice actions by not holding physicians accountable to patients under an expanded theory of assumption of risk. This argument in its baldest form has considerable appeal. When a dying patient is brought to a hospital, he should be thankful that there is a physician who will attempt to save him. The argument has been accepted in most states in the instance of medical emergencies occurring away from hospitals. Physicians are under no legal obligation to treat someone found lying beside a roadway. Doctors had often declined immediate treatment because they feared that snap decisions under improper conditions could well lead to error. Today, however, so-called Good Samaritan statutes[73] in most states protect the physician in such impromptu situations from all but gross negligence.

While the emergency situation provides an appealing example for relaxing physician's liability, most medical malpractice does not occur under such circumstances. When a physician takes out the wrong kidney or when a nurse under his command fails to remove a sponge from a patient, it is harder to develop any sympathy for the doctor. Physicians even have a word—iatrogenic—to describe conditions which have been exacerbated by medical personnel.

Since patients are sometimes injured by negligent physicians, the traditional tort standard of reasonable care under the circumstances seems to be desirable to make physicians liable for truly negligent behavior while protecting them against frivolous claims by revengeful patients. Some accountability of physicians seems required to protect against negligent conduct, and that accountability can be financial. How-

73. A typical "Good Samaritan" statute provides that a doctor or nurse can render aid at the scene of an accident without being held liable in a negligence action for malpractice. *See, e.g.*, Note, *Good Samaritan and Liability for Medical Malpractice*, 64 COLUM. L. REV. 1301 (1964).

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ever, it does not seem a wise social policy to make any financial accountability direct by forbidding the purchase of medical malpractice insurance. Such a rule would make the practice of medicine too risky and would create a potential burden too drastic to permit most physicians to practice. As a result, some accommodation is necessary which both permits physicians to afford to practice and in some way places a burden upon negligent conduct. If the fault system, which fulfills these goals in theory, is inadequate in practice, another system of insurance or insurance payment should be devised to replace it.

Modification of Settlement Concepts

There have been several proposals for modifying the fault system or for abandoning it altogether as a means of settling malpractice claims. The proposed modifications seek to make litigation more difficult to bring and settlement easier. Litigation would be made harder by requiring the litigant to post a bond before suit and by broadening the immunity doctrines. Settlements would be encouraged by permitting the insurance carrier to settle a claim without an admission of fault. These suggestions seem like mere first-aid treatment attempting to ameliorate only the superficial wrongs of the fault system rather than treating the deeper problems. While they may act to reduce the volume of suits brought and the number of suits which go to trial, they do not appear to be directed toward the distribution of claim money or the problems of forecasting, which are the major reasons for the increase in costs. Moreover, these suggestions are not designed to correct the cost pressures created by the use of the judicial system as the means for determining fault.

A second possibility designed to reduce the amount of judicial and administrative machinery necessary for a medicial malpractice insurance system is the implementation of a form of arbitration.[74] Some form of arbitration is in use in fifteen states. As presently constituted, an arbitration panel of 12 to 16 persons consisting of doctors and lawyers considers each malpractice claim. All needed experts agree to testify for no fee. The group votes on the question of malpractice by secret ballot. If the panel votes for the plaintiff, it has no power to award damages but agrees to find an expert witness for subsequent court action. Of course, an adverse finding will generally stimulate a settlement attempt by the insurance company. A decision against the plaintiff does not bar his

74. The prototype is the Pima County, Arizona, Plan described in Feldman, *A Constructive Answer*, 6 TRIAL, Feb.-Mar., 1970, at 23.

bringing suit, but his lawyer has agreed that he will not sue unless personally satisfied that overriding reasons compel the suit.

Many persons approve of this arbitration method as a means for reducing pre-trial expenses and for breaking down the conspiracy of silence. The effect of arbitration seems to be that it weeds out the best and worst cases, leaving the most controversial and evenly balanced to be tried in courts of law.[75] Nonetheless, the plans as currently used are unsatisfactory because they are not binding on the plaintiff. The insurance companies are now refusing to go before the arbitration panel because they believe that arbitration merely serves as a discovery device for the plaintiff.[76] These criticisms are valid; they demonstrate the difficulty with incomplete alternatives. Although the concept of an arbitration panel of doctors and lawyers is sound, each party must risk something if he uses this method of settling the dispute. Although an arbitrator's decision should be appealable to a court of law, the arbitration must be more than merely a discovery device for the plaintiff. Use of a medical-legal arbitration panel with appeal to a state's superior or highest court for review of the reasonableness of the arbitrator's award, rather than a trial de novo, would create a simpler administative process analogous to workmen's compensation awards and labor arbitrations.

It is unclear how much financial saving would result from a stricter form of arbitration. The vast majority of cases brought before the Pima County, Arizona, panel were found to be without merit, but many were taken to court anyway.[77] Giving the arbitration panel power to award damages and providing limited review would encourage attorneys to consider the result of the arbitration as conclusory. The plan is probably politically feasible since it does not attack the contingent fee system directly and may have some surprise benefits since it requires greater cooperation between the legal and medical professions. Since the administrative systems would be simplified, some cost savings could be anticipated, although the extent of any savings is impossible to estimate.

A third possibility is to adopt a true system of no-fault insurance. It has been calculated that if patients paid 25 cents per day for every day of hospitalization, the amount of money collected would be considerably greater than the total amount of premiums now paid by physicians for malpractice insurance and would be nearly ten times greater than the total amount of claim money which actually reaches the

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75. Featherston, *The Medical Review and Advisory System*, 63 J. MEDICAL SOC'Y N.J. 43 (1966).

76. Feldman, *supra* note 72; Frankel, *supra* note 27, at 200.

77. Brooke, *supra* note 3, at 229.

hands of claimants. This plan would reimburse the patient automatically for all actual iatrogenic injury.[78] A slightly modified form of the same plan would create the fund from payments by patients, hospitals and physicians, so that physicians and hospitals would bear part of the burden for the malpractice.[79] The advantage of these proposals is that they would eliminate all of the bureaucratic machinery necessary to keep the fault system going. Although patients would technically receive less money because they would only be reimbursed for actual injury, the fact that they would keep the entire amount and not pay attorney's fees might well mean that patients would receive more money than they do presently under the fault system. Elimination of findings of fault by courts against individual physicians could keep some negligent physicians in business. However, under the fault system, the only thing which might tend to drive them out of practice is an inability to insure after cancellation. Such cases of inability to insure are rare because of the financial well-being of most physicians.

There would be nothing, of course, to prevent the medical societies from developing stronger controls over the professional activities of their memberships under a no-fault system except the reticence which has prevented such control under the present fault system. One factor which might stimulate peer group review in hospitals would be pressures by the federal government to require establishment of peer review before federal moneys are paid. Similarly, the hospital's tithe to the malpractice fund could be made higher if no such investigative body existed.

CONCLUSION

Presently, the cost pressure of insurance falls not upon the negligent physician, but upon the young physician who may not be able to begin private solo practice because of the high rate of premiums. The no-fault concept seeks to make the cost situation more tolerable for physicians and to make payment for injury easier for patients to obtain. It assumes that creation of the simpler system necessarily reduces costs by eliminating the process of determining fault. Because of the small number of physicians and the small amount of money involved, a true system of no-fault insurance should be easily implemented in the medical malpractice area. If a no-fault system is simply politically unfeasible, then an expanded and strengthened arbitration system seems justified. Both

78. Dornette, *supra* note 46, at 541; *cf.* Editorial, *Professional Liability and Patient Care*, 111 CAL. MEDICINE 401 (1969).
79. Frankel, *supra* note 27, at 222.

seem preferable to the present fault system, which has proven to be inefficient.

The major difficulty with all of these reforms is that they assume that increased discipline of malpracticing physicians is virtually impossible because of the inaction of the organized medical profession which must necessarily control any investigatory body. Except for the forces tending toward greater federal control which may spawn investigatory controls, there is no reason to expect any increase in professional discipline, especially considering that laymen probably cannot evaluate the conduct of medical professionals. This assumption having been made, the favored proposals for reform become those which put money in the hands of the injured patients most easily. With these limitations on their effectiveness, the adoption of a no-fault concept for medical malpractice insurance is recommended as an improvement over the present fault system.

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