BOOK REVIEWS

UNDERSTANDING THE MALPRACTICE WARS

MEDICAL MALPRACTICE ON TRIAL. By Paul C. Weiler.¹ Cambridge: Harvard University Press. 1991. Pp. xiii, 240. \$27.95.

Reviewed by Thomas B. Metzloff²

Medical malpractice has proven to be law's Vietnam — an unpleasant quagmire of unending skirmishes and full-scale engagements spread across a shifting battlefield. The armies — the doctors on the one side and the trial lawyers on the other — are well financed and well armed. Although each side has achieved some notable victories, there have been no climactic encounters that have markedly shifted the balance of power. No truce is in sight; indeed, the battle has recently escalated from the arena of state legislatures to the halls of Congress.³ Through it all, legal academics have provided a running commentary that describes recent campaigns and analyzes new strategic plans; at times, they have even become unwilling pawns in the execution of the disputants' selfish agendas. Only occasionally, however, have academics reflected more generally on the causes of the conflict and the prospects for a global solution.

Paul Weiler's *Medical Malpractice On Trial* is an important and welcome addition to the literature. The book rises above the partisan conflict by avoiding the polemic at virtually every turn in favor of the high road of neutrality.⁴ The crisis image, used so often by others to justify their interest in medical malpractice, is invoked sparingly.⁵ Throughout the book, Weiler is driven by the challenge of assessing the system-wide performance of the litigation process and its relation-

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³ For a discussion of recent federal legislative initiatives, see Clark C. Havighurst & Thomas B. Metzloff, *S. 1232 — A Late Entry in the Race for Malpractice Reform*, 54 LAW & CONTEMP. PROBS., Spring 1991, at 179, 179-92; and W. John Thomas, *The Medical Malpractice "Crisis": A Critical Examination of a Public Debate*, 65 TEMPLE L. REV. 459, 474-76, 503-26 (1992).

⁴ Others have commented that Weiler's approach is "balanced." See Stephen D. Sugarman, *Doctor No*, 58 U. CHI. L. REV. 1499, 1513 (1991) (book review). My point is slightly stronger in that Weiler is simply not as interested as other commentators have been in the current events and issues; this is perhaps because of his apparent assumption that the various players in the litigation process are all performing appropriately. See *infra* pp. 1173-74.

⁵ The only obvious concession to the political debate is the book's questionable title, which can be excused as an expression of the author's dramatic license. In fact, the book does not resemble a trial at all. There is no marshalling of arguments on behalf of the disputants, no overstated generalizations about moral blame; nor is there any judgment rendered against a particular party.

ship to the medical system. Whether doctors are upset by the current regime — which of course they are — is of secondary importance. The book's aim is strikingly bold: to determine "whether the present tort system, a revised tort system, or an alternative liability system can actually produce sufficient savings in patient losses, in patient anguish and suffering, and even in patient lives to warrant the substantial direct and indirect expenditures that American law now imposes on American health care" (p. 7).

Weiler's foray into the malpractice conundrum is perhaps surprising to those familiar with his earlier, extensive contributions to the seemingly unrelated realm of employment law.⁶ From that springboard, however, Weiler recently became involved in two major projects that provided him with a rich background of empirical data and conceptual insights to apply in the malpractice context. The first was his involvement as a principal investigator for the massive Harvard Medical Practice Study Group, which examined iatrogenic injuries in a sampling of New York hospitals.⁷ The second was his service as the chief reporter for the American Law Institute's study of *Enterprise Responsibility for Personal Injury*.⁸

Weiler's book serves both as a useful history of malpractice litigation and as an important exposition of the merits of possible policy reforms, particularly the feasibility of no-fault compensation approaches. Its balance, as well as accessibility, have already contributed to its achieving status as a standard reference. Weiler moves deftly through issues and concepts that have taken others reams of paper to analyze.⁹ Instead of relying on anecdotes,¹⁰ Weiler prefers

⁶ See, e.g., PAUL C. WEILER, *GOVERNING THE WORKPLACE: THE FUTURE OF LABOR AND EMPLOYMENT LAW* (1990); Paul Weiler, *The Wages of Sex: The Uses and Limits of Comparable Worth*, 99 HARV. L. REV. 1728 (1986).

⁷ See 1 HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 6 (1990) [hereinafter HARVARD MEDICAL PRACTICE STUDY]. Although the initial study has been discussed or analyzed in various other articles, the most accessible discussion is contained in PAUL C. WEILER, HOWARD H. HIATT, JOSEPH P. NEWHOUSE, TROYEN A. BRENNAN, WILLIAM G. JOHNSON & LUCIAN L. LEAPE, *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION* (1993) [hereinafter *A MEASURE OF MALPRACTICE*].

⁸ See AMERICAN LAW INSTITUTE, *ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY* (1991).

⁹ See, e.g., Thomas B. Metzloff, *Resolving Malpractice Disputes: Imaging the Jury's Shadow*, LAW & CONTEMP. PROBS., Winter 1991, at 43, 44-46 (containing an extensive discussion of the role of juries in malpractice litigation); David J. Nye, Donald G. Gifford, Bernard L. Webb & Marvin A. Dewar, *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L.J. 1495, 1501-60 (1988) (extensively analyzing insurance trends). In contrast, Weiler's short text numbers only 161 pages.

¹⁰ See, e.g., *infra* pp. 1178-81 (discussing the anecdotal approach of Walter Olson). To be sure, Weiler's economy of text is at times also achieved through simplification. For the avid student, Weiler's extensive notes admirably fill any gaps.

to draw upon the growing base of empirical information that concerns various aspects of the malpractice problem.

The book divides naturally into two sections. In the first, Weiler provides a concise overview of the theory of medical malpractice law and an historical account of recent developments. Informed by the Harvard Study's findings, Weiler paints a bleak picture. The current system fails, Weiler claims, to compensate the vast majority of those who are entitled to recovery under existing tort principles, while at the same time it causes hardship and emotional distress to those physicians subjected to suit. This systemic failure is not easily solved; because no single factor accounts for the problems, there are no quick solutions. Furthermore, the extensive efforts to revamp the existing system through piecemeal reforms have had, at best, only a marginal impact, and current reform initiatives are unlikely to improve the situation. Weiler quickly concludes — perhaps too quickly — that consideration of other, as yet untested, tort reforms would be equally unproductive (p. 122).¹¹ Although he stops long enough to make a few useful, but not necessarily original, tort reform suggestions, his strongly negative assessment of the current approach compels him to contemplate a more drastic transformation.

In the second section, Weiler explores potential non-tort solutions. This challenging endeavor leads him first to appraise the value of private contracts. His views are notably reserved, for he questions both the desirability of private approaches and their feasibility. Instead, he prefers the adoption of a radically altered “no-fault” compensation system. This bold vision seeks to replace the fault-based “morality play” of current malpractice litigation, in which the defendant doctor's abilities are challenged by the plaintiffs' experts, with a compensation scheme that provides recoveries primarily to seriously disabled individuals at the relative expense of those less seriously hurt. Weiler's views are controversial not because his approach would be unfair, but because of the inherent difficulties of assessing a conceptual approach that differs so remarkably from current practices. It is perhaps understandable if many policy makers do not yet have the imagination required to explore the ramifications of his proposal.

Although Weiler tackles a number of issues, including the complex debate over whether malpractice law contributes significantly to unnecessary “defensive” medicine or in fact serves to deter undesirable physician conduct (pp. 70–92),¹² most of his analysis relates to the

¹¹ Weiler notes that efforts to analyze most aspects of the current tort reform agenda represent a “heated but ultimately fruitless controversy over which peripheral tort doctrines should be preserved or ‘reformed’” (p. 122).

¹² On the extent of unnecessary defensive medicine, see Walter J. Wadlington, *Legal Responses to Patient Injury: A Future Agenda for Research and Reform*, LAW & CONTEMP. PROBS., Spring 1991, at 199, 206–07.

functioning of the litigation system and the prospects for its improvement. He is unabashedly skeptical. Even though his analysis is persuasive, and may well prove correct after the test of time, Weiler's readiness to recommend the wholesale replacement of the litigation system should give us serious pause.

I. THE CURRENT SYSTEM: A STUDY IN FAILURE

The first half of the book is primarily about how poorly the litigation system currently serves to compensate those injured by physician negligence. Weiler adopts a conventional approach to describing the current malpractice system by noting that a full appreciation of the issues requires an understanding of the interplay among three institutional contexts: the health care system (in which medical injuries take place), the legal system (which translates patient injuries into legal claims and resolves them), and the insurance system (which links legal costs to malpractice liability premiums) (pp. 7-8). According to Weiler, the current system fails miserably.

A. Doing the Best It Can: The Current Malpractice System in Operation

Weiler begins with an exploration of recent trends in claim severity and frequency. He particularly notes the sharp increase in claims that result in very large awards (pp. 2-4), and then debates whether malpractice premium rates are affordable. This question may strike some readers as too challenging for an introductory discussion, but it reveals the bold nature of Weiler's focus. The book is driven by the need to assess systemic performance; it is therefore essential to place the relevant evidence in a larger setting. The mere fact that insurance rates have increased is, to Weiler, not as significant as somehow measuring whether they are excessive. His conclusion is that rates are not, on average, exceptionally high in light of physician revenues; however, concerns regarding local variations and modest market imperfections remain (p. 4).

Weiler also engages in a brief overview of substantive law principles, including a recap of legislative efforts to deal with expanding malpractice liability. He notes that these early reforms were modest, and that the applicable tort rules remain basically the same as those that existed in the halcyon days, with perhaps slight expansions in the doctrine of *res ipsa loquitur* and in the area of informed consent (p. 22-25). On the latter point, Weiler notes that the physician's ethical obligation to communicate relevant information to the patient has long existed; the difference lies in the new willingness of the judicial system to seek to enforce existing ethical norms in the liability

context (p. 24). Despite the slightly expanded liability risks entailed by these developments, the overall impact has been minor.¹³

If the law has not meaningfully changed, what accounts for the continuing increases in the frequency and severity of claims? Popular lore is that Americans have a strong propensity to sue and that juries are eager to find in favor of injured victims, thereby encouraging more suits. Given the criticisms he eventually levels against the litigation system, Weiler is surprisingly complimentary about the performance of its participants. With respect to the commonly expressed criticisms of the jury,¹⁴ for example, Weiler is skeptical; the empirical evidence simply does not support the critiques as studies of jury decisions in malpractice cases have found a relatively low rate of plaintiff victories.¹⁵ Indeed, Weiler rejects all the commonly targeted scapegoats. With respect to the insurance industry, he dismisses the allegation that high insurance premiums are a function of profiteering insurers, a conclusion he bases on an interpretation of available empirical data and the observation that almost half of all doctors are insured by physician-owned companies that are unlikely to gouge their owners (pp. 8-11).

Weiler's overall conclusions in this section are expressed by the following passage: "[W]e should begin the undertaking [of assessing the performance of the malpractice system] with no illusion that the current fault-based program is sharply different in practice from what it professes to be in principle" (p. 26). In other words, Weiler's assessment of the best available evidence is that plaintiffs' lawyers are, by all accounts, doing their best to identify meritorious claims; that juries are taking their work seriously; and that insurers are trying to charge reasonable insurance rates based upon their best estimates of future claims. The increasing number of claims is thus not a function of a few "bad" doctors, sympathetic jurors, greedy insurers, or unscrupulous plaintiffs' attorneys.

Weiler's statement of apparent satisfaction is not intended to suggest that policy makers should adopt a "leave well enough alone" approach. Quite to the contrary, Weiler's positive assessment of the participants' roles is an important, if not essential, link in his argument. The fact that the litigation system operates so poorly *despite*

¹³ Weiler's views are shared by other commentators. See, e.g., *id.* at 208-09 (describing the "rise and decline of the informed consent doctrine").

¹⁴ See, e.g., M. Roy Schwarz, *Liability Crisis: The Physicians' Viewpoint*, in *MEDICAL MALPRACTICE — TORT REFORM* 16, 24 (James E. Hamner & B.R. Jennings eds., 1987) (describing juries as "seemingly incapable of separating their personal feelings from the evidence in the cases and instinctively wish to help the plaintiffs as they would want others to help them if they were in a similar situation").

¹⁵ See Metzloff, *supra* note 9, at 64 n.77 (citing numerous studies that found relatively low plaintiff victory rates in medical malpractice cases).

the generally good efforts of its players reveals the intractability of the malpractice problem. In trying to explain precisely what accounts for the historical increase in claims, Weiler points to the inevitable consequences of increased liability risk created by technological developments in the practice of medicine.¹⁶ The increase in claims, he concludes, is primarily a function of the participants doing a somewhat better job of identifying cases of malpractice from an expanding pool of potential claims (pp. 13–14).

B. Too Little, Too Early: Appraising Past Tort Reform Efforts

Weiler also uses the introductory section to begin the book-long task of considering possible solutions to the malpractice “problem” by analyzing common “tort reform” measures enacted during the 1970s and 1980s. Weiler’s discussion of traditional tort reform serves as an historical point of reference, given the plethora of changes already implemented, as well as a current agenda for change. In the initial section, Weiler describes a conventional view of the malpractice crisis beginning with the outbreak of the first crisis of the mid-1970s that raised serious questions of insurance *availability*.¹⁷ Although the first wave of tort reform measures appeared to assist in stabilizing insurance rates, a second crisis nonetheless arose in the mid-1980s that was manifested by sharp increases in premiums that raised concerns regarding insurance’s *affordability*. In response, a second wave of tort reform measures that focused on what Weiler refers to as the “pressure points” of the system swept the country: these efforts focused on access to the courts, standards of liability, and plaintiff entitlement to damages (pp. 26–30).¹⁸

What did these tort reform efforts accomplish? Weiler begins by noting the difficulty in studying the question of cause and effect, as well as the difficulty of controlling for variations among jurisdictions (p. 33). He relies extensively on a series of empirical studies designed to establish a causal link between litigation performance and tort reform. The reviews are decidedly mixed, with a few studies sug-

¹⁶ Weiler’s views are admittedly strongly influenced by the analysis of Professor Grady that concerns the impact of technological advances on malpractice risk (p. 201 n.14). See Mark F. Grady, *Why Are People Negligent? Technology, Nondurable Precautions, and the Medical Malpractice Explosion*, 82 NW. U. L. REV. 293 (1988). For a further discussion of Professor Grady’s views that relate to Weiler’s book, see Mark F. Grady, *Better Medicine Causes More Lawsuits, and New Administrative Courts Will Not Solve the Problem*, 86 NW. U. L. REV. 1068, 1091–93 (1992).

¹⁷ For another useful analysis of the first malpractice crisis, see Glen O. Robinson, *The Medical Malpractice Crisis of the 1970’s: A Retrospective*, LAW & CONTEMP. PROBS., Spring 1986, at 5, 5–26.

¹⁸ Access issues included the erection of barriers to litigation, such as the modification of liberal statute of limitations provisions, restrictions on plaintiffs’ attorneys’ contingency fees, and the creation of screening panels to review malpractice claims prior to the filing of a lawsuit.

gesting that one reform or the other had some modest impact (pp. 32-38).¹⁹ Weiler's interpretation, however, is that the early reforms had no, or at best modest, impact. He suggests that the marginal influence of these measures was virtually inevitable once one recognizes that many of the reforms sought only to "lock-in" existing substantive doctrines before courts could further expand theories of liability. Few reforms meaningfully altered existing legal principles, and thus predictably served only to slow the rate of increase of claims.²⁰ Indeed, from the available empirical studies, Weiler establishes a working presumption that individual reforms will be ineffective given the complex factors that determine whether an injured patient will assert a claim, how that claim will be resolved, and how litigation trends are translated through the insurance market into premium rates (pp. 36-37).²¹ On this score, Weiler is almost certainly correct. One could question, however, whether tort reforms have had sufficient time to operate before being tested and whether the reforms were, in fact, implemented in the manner intended by the state legislatures.

The one exception to the general ineffectiveness of individual reforms, a point that becomes increasingly important in Weiler's subsequent analysis, is the impact of rules that limit damages, especially statutes that establish caps on damages, which Weiler deems the "single most important and controversial issue in tort reform" (p. 32). There is a general consensus that jury flexibility in awarding damages poses a serious obstacle to the efficient resolution of malpractice claims.²² Providing greater certainty in the award of damages through the establishment of an upper limit on recovery could therefore significantly impact the outcome of suits. As Weiler notes, an imposed ceiling on malpractice verdicts cannot be easily finessed by either juries or attorneys. It also predictably dampens attorneys' incentives to file claims by limiting their potential return (p. 37). Weiler's concern, however, is that damages caps also raise serious fairness concerns because they reduce recoveries for only the most severely injured patients (p. 37).²³

¹⁹ See, e.g., Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, LAW & CONTEMP. PROBS., Spring 1986, at 57, 72 (noting that the enactment of a rule that requires collateral source offsets resulted in significant reductions in the amount paid out for serious injuries).

²⁰ See Wadlington, *supra* note 12, at 204.

²¹ "As long as juries are still asked to apply the basic common law paradigm of physician fault, tinkering with doctrines such as informed consent or *res ipsa* is unlikely to have a pronounced effect on claims or premium levels, even though the new rules will make some difference in the disposition of particular cases." (pp. 36-37).

²² See, e.g., Randall R. Bovbjerg, Frank A. Sloan, & James F. Blumstein, *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 NW. U. L. REV. 908, 909-17, 925-26 (1989) (describing the problems of jury flexibility in tort cases generally); Metzloff, *supra* note 9, at 84-86, 90-92.

²³ Weiler also repeatedly notes that another cause of unfairness is present as a practical

Weiler concludes with a brief recap of the extensive litigation challenges to the early tort reform efforts. His discussion presents a succinct catalogue of the different theories of constitutional challenge and a list of the results (pp. 38–43).²⁴ Weiler's substantial conclusions, however, are more problematic. He contends that courts have been legitimately reluctant to uphold malpractice "reforms" in light of their enactment as a result of lobbying by the medical profession for the express purpose of undoing what the courts had accomplished without providing potential plaintiffs with anything of value in return (p. 40). Absent a quid pro quo, many courts required a heightened justification for impairing plaintiffs' litigation rights. Weiler concludes that "[e]ncouragingly, however, almost all state courts that have spoken on the matter have indicated that tort reform would be possible if the state legislature truly balanced detriments to tort plaintiffs with meaningful gains to injury victims" (p. 42). But Weiler is almost certainly drawing a clearer message than is possible from the jumble of contradictory state court decisions.²⁵ Rather than summarizing the rulings, Weiler instead enunciates his own prescription for how courts should measure malpractice tort reform. On the one hand, he suggests that courts should be disdainful of "take-away" efforts inspired by a "crisis" mentality. On the other hand, he argues that courts should uphold bold legislative efforts to reform the system if it serves to improve patient access. Weiler espouses this quid pro quo rationale — previously employed to justify the abolition of the traditional tort system's operation in the worker's compensation context but which to date has played only a minor role in malpractice litigation — as a principled basis for separating narrow-minded efforts to restrict malpractice suits from possibly beneficial improvements in the compensation scheme.

Weiler implies that many courts have been unwittingly sucked into the partisan debates, which has resulted in their unduly crediting the positions of the warring factions without a meaningful basis for assessing malpractice reform measures (p. 43).²⁶ But rather than criti-

matter because most states that have enacted caps have not indexed them to inflation. As a consequence, the caps over time serve as an increasingly significant limit on plaintiff recoveries (p. 37). Of course, this latter point is relevant only to the design of the specific cap, and not to the conceptual utility or fairness of caps in general.

²⁴ For an overview of relevant constitutional arguments, see Martin H. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 769–800 (1977).

²⁵ For example, on the critically important issue of limiting the amount of damages, it is simply impossible to reconcile existing state law precedent. Compare *Etheridge v. Medical Ctr. Hosps.*, 376 S.E.2d 525, 527–34 (Va. 1989) (upholding a \$750,000 limit on all damages in a medical malpractice case) with *Brannigan v. Usitalo*, 587 A.2d 1232, 1236–37 (N.H. 1991) (declaring a \$875,000 limit on noneconomic damages unconstitutional under the state's constitution).

²⁶ "The need that is perceived for such changes in malpractice law seems to be as great as the apparent inequity such changes produce." (p. 43).

cizing courts for blindly accepting the opposing contenders' tort reform characterizations, Weiler tolerates the self-imposed dilemma as a function of imperfect empirical information about the inherent weaknesses of the litigation process. Lacking hard facts, it was difficult for these courts to develop workable theories for reviewing constitutional challenges. With the information gap closed by efforts such as the Harvard Study, Weiler offers the quid pro quo analysis as the appropriate solution for resolving the judicial quandary.

C. The Failure of Litigation

The central theme of Weiler's initial section is that, as a reliable system of compensation for negligently-injured patients, the malpractice litigation process fails (p. 15). This theme, the linchpin upon which much of Weiler's subsequent analysis is based, draws primarily upon the results of the Harvard Study on the incidence of iatrogenic injuries.²⁷ For additional support, Weiler repeatedly points to the high level of emotional trauma inflicted upon malpractice defendants necessitated by the fault-based system's need to make moral judgments about a physician's performance.²⁸ Although in other areas, tort law has been moving away from negligence towards strict liability approaches, Weiler notes that malpractice law "continues to place a strong premium on a finding of personal blameworthiness on the part of a doctor before affixing liability for a particular injury" (p. 19).

To begin to understand Weiler's thesis we must first turn to the Harvard Study's core findings that so strongly influence his negative assessment of the litigation process. The study itself was a massive project. Medical experts reviewed over 30,000 hospital files in fifty-two New York hospitals in a search for evidence of injury and to assess the cause of any injury found (p. 12). The study's focus on the delivery of medical care affords it with a unique perspective for assessing negligently-inflicted injury. By focusing on the provision of medical care rather than on filed malpractice suits, the study avoided any sample selection biases inherent in analyzing only claims.

The Harvard Study's principal finding — which is well known, if not well understood — was that approximately one in twenty-seven hospitalizations resulted in an iatrogenic injury to the patient (labelled

²⁷ See HARVARD MEDICAL PRACTICE STUDY, *supra* note 7, at 42-59; WEILER, *supra* note 6, at 12, 13.

²⁸ The emotional tension inherent in malpractice cases, and its role in explaining the medical profession's consternation with the malpractice system, is more fully explored in F. Patrick Hubbard, *The Physicians' Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform,"* 23 GA. L. REV. 295, 328-49 (1989). For a first-hand account of the trauma of malpractice litigation, see SARA C. CHARLES & EUGENE KENNEDY, *DEFENDANT: A PSYCHIATRIST ON TRIAL FOR MEDICAL MALPRACTICE* (1985).

by the researchers as an "adverse event"), and that, among those injuries, one in four was due to negligence (p. 12). From this, the study concluded that approximately one percent of all hospital admissions resulted in an injury caused by physician or hospital negligence (p. 12).²⁹ To be sure, many of these cases involved minor, and perhaps even insignificant, injuries; however, many involved serious impairments (p. 13). Extrapolating from this rate, Weiler estimates that there were over 150,000 fatalities and 30,000 serious injuries per year in the United States caused by physician or hospital negligence (p. 12).

The second principal finding, and the one that directly implicates the litigation system's performance, was that the number of malpractice claims fall far short of reaching the actual level of negligently-inflicted injuries. The Harvard Study calculated that, at best (which assumed that all lawsuits filed involved actual cases of negligence), only about one in eight potential claims ripened into a lawsuit. Even only looking at serious injuries, fewer than one in three potentially meritorious claims was asserted. From these two key observations, Weiler's inescapable conclusion "is that it is wrong to charge the tort system with inflating the true incidence of medical negligence" (p. 13); in fact, there is serious *underlitigation* of malpractice claims.

At first glance, Weiler's sharp criticism of the litigation system's performance appears consistent with the views of other litigation critics. Indeed, two other important books, both published in 1991, directly challenged the malpractice system. An examination of these other attacks, however, reveals the fundamentally different approach taken by Weiler's critique.

The thesis of Walter K. Olson's *The Litigation Explosion: What Happened when America Unleashed the Lawsuit*³⁰ can be simply summarized: The American civil litigation system is a "grotesque failure."³¹ Olson's analysis is replete with colorful anecdotes drawn from malpractice cases that serve to illustrate various litigation problems.³² Several of Olson's key assertions about the malpractice system, however, are demonstrably wrong. For example, Olson contends that doctors are routinely sued years after the alleged negligent event, when, in fact, the evidence demonstrates that this occurs relatively infrequently.³³

²⁹ For a more elaborate description of the methodology, see A MEASURE OF MALPRACTICE, cited above in note 7, at 34.

³⁰ WALTER K. OLSON, *THE LITIGATION EXPLOSION: WHAT HAPPENED WHEN AMERICA UNLEASHED THE LAWSUIT* (1991).

³¹ *Id.* at 339.

³² No fewer than six chapters begin with malpractice illustrations. See, e.g., *id.* at 15-16 (describing a malpractice suit filed many years after the date of the alleged negligence); *id.* at 152-53 (describing an outrageous jury verdict in a malpractice case).

³³ See *id.* at 15; see also U.S. GENERAL ACCOUNTING OFFICE, *MEDICAL MALPRACTICE:*

Worse still, however, is Olson's misuse of the Harvard Study. Rather than discussing the implications of the two principal findings discussed above,³⁴ Olson claims instead that the Harvard Study proved that four out of five malpractice suits did not involve negligent conduct.³⁵ The Harvard Study found nothing of the sort.

Based upon a preliminary examination of the actual claims filed in New York, the Harvard Study at most raised a warning flag: it found that the actual court cases did not match well with observed instances of negligence. Instead, the researchers noted that many of the suits involved cases for which they had concluded that there had been either no injury or no negligence. It appeared, therefore, that not only were relatively few claims filed, but also that the plaintiffs had filed the wrong claims. This point, of great potential importance, is admittedly preliminary;³⁶ the researchers are still conducting a com-

CHARACTERISTICS OF CLAIMS CLOSED IN 1984, at 32 (1987) (indicating that 93.6% of all malpractice claims are asserted within 36 months of the date of incident).

Similarly, Olson states that doctors cannot tell the nature of the claim from the initial complaint. In fact, however, this is not a serious litigation problem as evidenced in part by the American Medical Association's proposal to replace the current procedure with an administrative process that would permit patients to provide even less detail. See OLSON, *supra* note 30, at 89. Olson also argues that doctors are routinely sued in inconvenient forums by out-of-state patients when the prevailing doctrine compels malpractice suits to be filed in the state where the medical care was rendered. See *id.* at 178-79; *Wolf v. Richmond County Hosp. Auth.*, 745 F.2d 904, 909-12 (4th Cir. 1984), *cert. denied*, 474 U.S. 826 (1985); see also ROBERT C. CASAD, JURISDICTION IN CIVIL ACTIONS § 7.02[2][b][v] (2d ed. 1991) (noting that if a hospital's "contacts are not purposeful, systematic, or significant enough" with the forum state, the forum lacks personal jurisdiction over the hospital, and that "[i]n by far the greatest number of cases, jurisdiction over the non-resident practitioner has been denied").

One would expect Olson to be equally apoplectic about the jury's role in the litigation system. Certainly in the malpractice context, jury critics abound. See Metzloff, *supra* note 9, at 44-45 (summarizing anti-jury sentiments in malpractice context). Instead, Olson believes that juries have historically served a useful role as a "superb brake against tyranny," OLSON, *supra* note 30, at 175, and would therefore continue their use, albeit armed with more sharply defined legal standards: "A jury system with believably objective rules would be the best of all legal worlds." *Id.* Olson, however, ignores the inherent expense of the jury process identified by many of the jury critics. See Metzloff, *supra* note 9, at 53-59 (detailing the high cost of jury trials); see also George L. Priest, *The Role of the Civil Jury in a System of Private Litigation*, 1990 U. CHI. LEGAL F. 161, 164-65 (noting that the right to trial by jury constitutes a major cause of the delays observed in most urban court systems).

³⁴ Olson, for example, notes that some callous plaintiffs' attorneys may use the Harvard statistics to justify lawsuits in situations in which the doctors were not negligent in order to somehow "make up" for the many meritorious cases which were never brought at all. See OLSON, *supra* note 30, at 270.

³⁵ See *id.* at 6, 270 ("A Harvard study of medical malpractice in New York found that in the overwhelming majority of cases where suits were filed the doctor had *not* been negligent."). In his sparse notes, Olson does not directly refer to the Harvard study itself, but rather to the analysis in *Forbes* by his philosophical compatriot Peter Huber. See *id.* at 351 (citing Peter Huber, *Malpractice Law — A Defective Product*, FORBES, Apr. 16, 1990, at 154, 154).

³⁶ There are several explanations that might qualify the Harvard study's preliminary observation on this point. First, because the study was based on a review of hospital records only,

plete review of the filed cases and the litigation results. Without full examination of the litigated cases — using the same detailed expert review as was employed in the study of the hospital files — this tentative criticism of the matching process constitutes no more than a strong signal that the litigation process should be examined more closely (pp. 14–15).³⁷

The point is anything but trivial. How well the litigation system differentiates among asserted claims is probably as important in assessing the effectiveness of the tort liability system as are the insights of the Harvard Study relating to the incidence of iatrogenic injury. Based on these preliminary findings and by drawing further upon speculation and anecdote, Olson concludes that the substantive merits of the *case* — as opposed to non-merit based factors such as the sympathetic qualities of the *plaintiff* — are but a minor factor in determining litigation results.³⁸

Weiler, on the other hand, resists extrapolating too much from the Harvard Study's preliminary findings. He instead turns to other empirical studies, including Frederick W. Cheney's study of anesthesiology claims.³⁹ Cheney's study involved expert review of over 1,000

evidence of injury or negligence manifested after discharge would not have been included in the medical records. Furthermore, if the injury or negligence occurred at another medical facility, the relevant files would not have been included in the hospital records reviewed by the Harvard researchers. Second, the cases may have involved situations in which the Harvard researchers were uncertain as to either injury or negligence. Also, to the extent that a plaintiff's claim was based upon a failure to diagnose a medical problem, one would not expect to find evidence of either negligence or injury in the original medical file. *See infra* note 39.

³⁷ Weiler concludes that "we are unable to say whether the tort litigation/settlement process will successfully winnow out the spurious from the valid claims" (pp. 14–15).

³⁸ *See* OLSON, *supra* note 30, at 267–68 (charging that substantive merits are merely one "ingredient" in the determination of settlement values). As further evidence of Olson's lack of faith in the current system, consider this comment: "Few hearts can resist the plight of a deformed, paralyzed, or brain-damaged infant, or of the family that faces great expense trying to care for it. When someone can be blamed to a jury's satisfaction, million-dollar verdicts are routine." *Id.* at 163.

³⁹ *See* Frederick W. Cheney, Karen Posner, Robert A. Caplan & Richard J. Ward, *Standard of Care and Anesthesia Liability*, 261 JAMA 1599 (1989). Weiler's and his colleagues' most recent writings, although they acknowledge the weaknesses of the Harvard study on this point, are nonetheless subject to some criticism for overreaching as to the significance of the study's findings. They found that 47 patients involved in their study went forward and filed claims, a small sample upon which to draw firm conclusions in any event. *See* A MEASURE OF MALPRACTICE, *supra* note 7, at 72. For example, of the 26 cases in which no injury was found to be present by the researchers, 12 of the claims involved the alleged failure to diagnose an injury. *See id.* at 71. In such cases, it may well be that the hospital file would not contain any evidence of the subsequently discovered injury. Similarly, according to the research protocol, a neutral expert reviewer who had concluded that either there was an injury or negligence could later be overruled, which indicates the likelihood of uncertainty in these determinations. *See id.* at 41. I therefore would not conclude, as Weiler does in his new book that "a substantial majority of malpractice claims do not flow from true negligent injuries inflicted by doctors or other health care providers." *Id.* at 75.

case files to determine whether inadequate medical care was in fact rendered. The study found that fifty-four percent of the claims involved inappropriate care and, in those cases, over eighty percent of the plaintiffs received a recovery.⁴⁰ In those cases in which appropriate care was received, most plaintiffs, albeit a slight majority, did not receive any compensation.⁴¹ Although observers may disagree over whether one should be favorably or negatively inclined toward the litigation system based upon these findings, the results do not support Olson's indictment.

Olson perceives the problem as too much litigation within a system that is unable to differentiate the good claims from the bad. Olson's solution is the radical transformation of the elements of modern American civil procedure to require greater specificity in complaints, limited discovery, and greater lawyer accountability for filings (p. 13). Conversely, Weiler's main conclusion is that there is too *little* litigation; he is only secondarily concerned with how the existing procedural system handles claims once filed.

More difficult to assess is the central thesis offered by Peter Huber in his book *Galileo's Revenge: Junk Science in the Courtroom*.⁴² Huber's concern is the role of expert witnesses and the litigation system's willingness to tolerate unproven legal theories.⁴³ Huber cites as a central example reliance by plaintiffs on electronic fetal monitors in obstetrics malpractice litigation that involves children who suffer from severe neurological injuries.⁴⁴ Such cases are often based on claims that the obstetrician negligently misinterpreted the results from electronic fetal monitoring and thus failed to order a necessary caesarian section. According to Huber, however, recent evidence demonstrates that fetal monitoring has not reduced the incidence of cere-

⁴⁰ See Cheney, Posner, Caplan & Ward, *supra* note 39, at 1601.

⁴¹ See *id.* However, over 40% of these patients did receive some compensation, but on average at a much lower level than those with comparable injuries for whom the care was found to be inappropriate. See *id.* at 1601-02. Other studies of actual malpractice claims have also found a statistically significant correlation between litigation outcomes and intrinsic case merit. A study of 252 malpractice claims involving one hospital found that of the 80 claims determined to involve inappropriate medical care, settlements in favor of plaintiffs were made in approximately 90% of the cases. Among the 95 cases found to involve appropriate care, approximately 65% were dropped without payment. See Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199, 203-04 (1991); see also Metzloff, *supra* note 9, at 82-83 (finding that jury outcomes on liability issues were predictable and generally in line with insurer assessments of whether a physician was negligent); Mark I. Taragin, Laura R. Willett, Adam P. Wilczek, Richard Trout & Jeffrey L. Carson, *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS OF INTERNAL MED., 780, 781 (1992) (finding that the payment of damages occurs much more frequently when physician care is indefensible).

⁴² PETER W. HUBER, *GALILEO'S REVENGE: JUNK SCIENCE IN THE COURTROOM* (1991).

⁴³ See *id.* at 75-91.

⁴⁴ See *id.* at 78-79.

bral palsy. Instead, it now appears that non-delivery events (such as genetics or other factors that originate earlier in the pregnancy) are more likely to cause cerebral palsy than any delivery trauma.⁴⁵ Nonetheless, obstetricians are routinely sued based upon such allegations.

Although supported by several citations to specific cases, Huber's criticism is far from anecdotal.⁴⁶ Huber's argument adds an important element to the litigation critique by suggesting that even well-intentioned experts, and not just the "hired gun" shysters elegantly criticized by Olson,⁴⁷ are responsible for low-quality litigation results. Because courts — and indeed the medical profession itself — do not know how to distinguish between good science and junk science, the litigation process may well impose liability when, in fact, it should not. The solution, according to Huber, is to install new safeguards to ensure the quality of the expert evidence submitted in court.⁴⁸ For example, one suggested standard is that only scientists whose relevant work has been published in refereed journals should be permitted to testify.⁴⁹

Weiler, although aware of this junk science debate,⁵⁰ surprisingly refuses to respond directly. Instead, Weiler uses the obstetrics example as a paradigm of the difficulties involved in separating undesirable defensive medicine from medical practices that result from the financial self-interest of the profession (pp. 86–87).⁵¹

⁴⁵ See *id.* at 82–85. See generally Kirkwood K. Shy, David A. Luthy, Forrest C. Bennett, Michael Whitfield, Eric B. Larson, Gerald van Belle, James P. Hughes, Judith A. Wilson & Morton A. Stenchever, *Effects of Electronic Fetal-Heart-Rate Monitoring, as Compared with Periodic Auscultation, on the Neurologic Development of Premature Infants*, 322 NEW ENG. J. MED. 588, 589–92 (1990) (concluding that electronic fetal monitoring does not improve neurologic development or decrease the likelihood of cerebral palsy in prematurely born children).

⁴⁶ See generally 1 INSTITUTE OF MEDICINE, MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 1–13 (1989) (describing various concerns that relate to the impact of malpractice on obstetrics); 2 *id.* at ix–xiv (reporting on a symposium on the impact of professional liability issues on obstetrical cases in the United States).

⁴⁷ Olson also uses the example of the "bad-baby case." See OLSON, *supra* note 30, at 163. His concern with experts, however, is less typically anecdotal. Focusing on the costs of turning to experts, he states that some malpractice experts charge \$15,000 to \$20,000 per case for testimony and notes the unseemliness of their advertising practices. See *id.* at 157, 160–61. Although I am not aware of any empirical study that focuses on plaintiffs' success rate using "hired gun" professional witnesses, my own informal analysis of this point suggests that plaintiffs' success rates are far lower than in cases in which plaintiffs obtained competent practitioners or academics. Ironically, a complaint that I have heard from some physicians is that the testimony of leading physicians employed by major academic teaching hospitals often results in the adoption of inappropriately high standards of care, possibly because those physicians' facilities and expertise cause them to be disdainful of their colleagues in less well-equipped practice settings.

⁴⁸ See HUBER, *supra* note 42, at 198–204.

⁴⁹ See *id.* at 202.

⁵⁰ Weiler cites evidence that suggests the fetal monitor's lack of benefit (p. 209 n.51).

⁵¹ Weiler also uses the obstetrics example to illustrate the market imperfections in the insurance industry. He notes that a general practitioner's premiums rise even if he or she

Weiler's unwillingness to engage the debate about the quality of the litigation process is not surprising given his early declaration that the system has failed. Having quickly concluded that the problem is one of underlitigation, Weiler misses the point made by Huber that even quality medical experts may not be able to provide accurate assessments of negligence. Huber's analysis strikes at the heart of Weiler's thesis — if not at the very methodology of the Harvard Study itself.

Several possible rejoinders lessen, but do not eliminate, the validity of Huber's critique. First, it is unclear how Huber's obstetrics example is relevant to other malpractice contexts in which the causation issues are less obscure. Second, Huber's approach does not provide a workable means of handling the more routine cases in which reasonable access to competent experts for both parties is more important than securing the most renowned expert.⁵² Creating new requirements for the introduction of expert testimony would serve only to exacerbate the underlitigation of malpractice claims.⁵³ Third, the litigation process should be able to react to any serious errors by moving towards the "better view" espoused by the best experts. Even in the obstetrics example, as new types of evidence become more compelling, defending obstetrical malpractice claims will become easier. Finally, on a more practical level, ignoring Huber's argument may be historically defensible; previous "quick fix" solutions relating to experts have not alleviated the problems of malpractice litigation (p. 30).

Nonetheless, Huber's observations present a legitimate point of contention that Weiler obscures by refusing to address meaningfully the significant problems that exist in the litigation process. As demonstrated in the next section, Weiler appears unwilling to consider seriously any solution to existing litigation problems short of an outright rejection of the tort-based approach.

*D. Weiler and the Current Tort Reform Agenda:
Picking Through the Left-Overs*

Although Weiler's preference is for a radical alteration of the current system, he does address the merits of those proposals that, in his

delivers only a few babies, and the further suggests that the cost of insurance, and not the impact of malpractice litigation itself, is responsible for the exodus of obstetricians from the practice (p. 85-86).

⁵² Cf. *Mulder v. Parke Davis & Co.*, 181 N.W.2d 882, 885 (Minn. 1970) (stating that "[a]ll too frequently, and perhaps understandably, practicing physicians are reluctant to testify against one another").

⁵³ Cf. Rickee N. Arntz, Note, *Competency of Medical Expert Witnesses: Standards and Qualifications*, 24 CREIGHTON L. REV. 1359, 1379 (1991) (encouraging flexibility in the specific qualifications for expert witnesses because of the general difficulty of finding physicians to testify against colleagues).

opinion, offer the greatest impact on the evolution of the litigation process (pp. 44-69). This endeavor serves an important transitional role by describing those reforms that are currently in play, as well as by sensitizing the reader to his bold prescription for what should follow.

Weiler begins by debunking the traditional corrective justice goal of punishing individual tortfeasors in the malpractice context (pp. 44-47). According to Weiler, the corrective justice model simply does not work at a practical level primarily because insurance spreads malpractice losses among all physicians — and ultimately among all patients — and not just among those doctors found liable for negligence (pp. 46-47).⁵⁴ Malpractice awards thus serve only the more limited purpose of providing another source of compensation for injured persons, and supplement — among other sources — health care insurance payments, worker's compensation benefits, and individual's personal savings. Furthermore, Weiler asserts that the administrative costs associated with the malpractice system are higher than the costs of other possible systems of compensation because of the need to focus on the physician's fault (p. 53).⁵⁵ Weiler's vision is informed by two principles: first a preference for more direct compensation methods (such as first party insurance similar to worker's compensation) as the primary means of assisting injured persons; and second, a goal of reducing the administrative expense of malpractice litigation by instilling greater predictability into the process.

Weiler's suggestions relate primarily to malpractice damages. He begins with a recitation of state legislatures' recent efforts to cap damages in response to the rapid escalation of large awards (pp. 49-50). Weiler seems to approve of efforts to inject greater consistency into the process of determining damages. However, Weiler condemns the efforts of some states, such as Indiana, to cap all damages (in effect, to simply terminate a physician's financial liability at an arbitrarily low level) as "unfair and unconscionable" (p. 49).⁵⁶ As previously mentioned, caps primarily impact the claims of the most seriously injured. Those with minor injuries already receive adequate compensation from other sources and therefore do not require immunization from the caps. Instead of caps, therefore, Weiler urges

⁵⁴ Theoretically, many of the largest potential awards could exceed an individual physician's malpractice insurance coverage. In fact, however, few physicians are ever required to pay any award from their own assets. See Mark Crane, *Could a Malpractice Suit Wipe Out Your Assets?*, MED. ECON., July 6, 1992, at 146, 146.

⁵⁵ Weiler estimates that "malpractice insurance now expends approximately 55 to 60 cents to deliver 40 to 45 cents of the claims dollar into the hands of injured patients" (p. 53).

⁵⁶ Ironically, recent empirical research relating to the Indiana system suggests that, in operation, the system has developed elements commonly associated with no-fault systems of the type proposed by Weiler. See Eleanor D. Kinney & William P. Gronfein, *Indiana's Malpractice System: No-Fault by Accident?*, LAW & CONTEMP. PROBS., Winter 1991, at 169, 188-92.

the adoption of collateral source offsets that would reduce a plaintiff's malpractice damage award by the amount of compensation received from other sources. For temporary injuries, this approach may well obviate any need for allowing a malpractice claim as compensation for a plaintiff's economic damages already covered by other sources (p. 51).⁵⁷

Weiler is particularly critical of the current system because it overcompensates those with minor injuries and seriously undercompensates those with major injuries.⁵⁸ The primary reason that some plaintiffs who sustain minor economic losses obtain relatively large recoveries is their entitlement to compensation for noneconomic damages, such as pain and suffering. Weiler assumes that pain and suffering awards constitute the major source of the large monetary increase in claims.⁵⁹ Here, Weiler criticizes the current regime for offering virtually no guidance on how juries should determine awards (p. 55);⁶⁰ however, he unfairly skirts the debate over whether pain and suffering awards are substantively legitimate. Weiler delicately casts doubt on the propriety of any awards for noneconomic harm, given that individuals do not commonly purchase insurance to protect against nonpecuniary losses (p. 56). Weiler apparently assumes that the law tolerates these damages in part to provide working capital for contingent fee plaintiffs' attorneys (p. 62).⁶¹ This may be a practical justification, but it still begs the question of the legitimacy of noneconomic damages. In most malpractice cases, the claim for pain and

⁵⁷ Weiler prefers the collateral source offset approach to the "subrogation" approach, which would provide health care insurers and others who have paid compensation a right to seek reimbursement of their payments from prevailing plaintiffs. His preference is based upon the high transaction costs and delays associated with the malpractice process as compared to the other systems (pp. 51-54).

⁵⁸ Weiler cites a General Accounting Office study in support of this proposition (pp. 53-54 (citing U.S. GENERAL ACCOUNTING OFFICE, *supra* note 33, at 46-47)).

⁵⁹ Weiler makes the claim that approximately 50% of current tort damage awards consist of payments for noneconomic damages (p. 55). The sources cited by Weiler, however, are not conclusive on this point. In fact, most juries do not itemize their awards into specific categories of damages. Similarly, most insurers are under no obligation to differentiate between economic and noneconomic damages. Accordingly, at least in the malpractice context, I am skeptical about any purported claim of what percentage of awards represent a particular category of damages.

⁶⁰ Although this is true, Weiler perhaps overplays the point. There is nothing unique in the malpractice context; damage awards are often subjective. Indeed, the problem is even more severe in the punitive damages context, in which juries are given few guidelines upon which to base their decisions. *Cf. Pacific Mut. Life Ins. Co. v. Haslip*, 111 S. Ct. 1032, 1043-44 (1991) (holding that jury instructions that leave the jury with "significant discretion" do not necessarily offend due process).

⁶¹ "Yet in the real world of tort litigation, that assumption [of unduly generous compensation] is largely mythical, for the money provided these so-called luxury damage items is typically used by successful plaintiffs to pay for another significant financial cost of injury: legal fees." (p. 62).

suffering represents a legitimate, but admittedly difficult to quantify, component of the plaintiff's injury.

There is, to be sure, a serious concern with the litigation system's process for determining the appropriate level of compensation.⁶² Weiler urges that legislatures not adopt caps on noneconomic damages, but rather sliding scales that provide more specific guidance for determining the appropriate levels of relief. Weiler's approach — albeit not original⁶³ — is well suited to this particular weakness of the litigation system.

In combination, the collateral source offset proposal and the notion of a limitation on the recovery of noneconomic damages according to a schedule or a sliding scale would predictably lower plaintiffs' recovery. As a practical matter, Weiler recognizes that this would exacerbate an already serious problem of access for injured plaintiffs by lowering contingent-fee lawyers' expected returns from handling malpractice cases.⁶⁴ Collectively, plaintiffs' attorneys play a key role as "financiers" of malpractice litigation by using the large recoveries from winning cases to subsidize their expenditures in losing cases. With lower potential awards under Weiler's regime, plaintiffs' attorneys would be even less likely to take malpractice cases. In order to compensate for this unintended impact and to insure that a cadre of

⁶² See Metzloff, *supra* note 9, at 84–86 (describing the uncertainty in predicting damage awards by juries in malpractice cases).

⁶³ Others have made similar proposals. See Bovbjerg, Sloan & Blumstein *supra* note 22, at 956–60.

⁶⁴ Weiler also opines on the desirability of directly regulating contingency fees (pp. 61–65). The notion of limiting large contingency fees has proven a major battlefield, one defined both by the medical profession, which hopes to reduce the amount of "frivolous" litigation, and by legal academics, who attempt to define reasonable compensation for plaintiffs' attorneys. State reforms have included both case-by-case reviews of plaintiffs' fees as well as a sliding scale approach, in which the contingency rates decrease with the size of the recovery. See Richard M. Birnholz, Comment, *The Validity and Propriety of Contingent Fee Controls*, 37 UCLA L. REV. 949, 950 n.6, 951 n.9 (1990) (reporting various states' contingency fee limitations). This particular "tort reform" effort was intended to reduce the number of malpractice claims filed based upon the belief that high contingent-fee rates inspire attorneys to file unwarranted lawsuits, to seek exaggerated damages, and to refuse reasonable settlement offers in search of "jackpot" recoveries at trial. See Robinson, *supra* note 17, at 22.

Weiler is critical of imposing a simple sliding scale on contingency fees, in part because states have not similarly seen fit to limit defense expenditures. To Weiler, such a scale may function similarly to a contingent-fee cap and represents "an even cruder and more inequitable policy than the problem it is intended to cure" (p. 64). He would prefer to base the attorneys' percentage on the stage of resolution, and thus award less to an attorney who settles early. Although sensible, this creates unacceptable incentives for lawyers to litigate rather than settle early; instead, a key goal should be to limit plaintiffs' attorney's fees in those malpractice cases in which recovery is almost certain. See Metzloff, *supra* note 9, at 100–01; see also Lester Brickman, *Contingent Fees Without Contingencies: Hamlet Without the Prince of Denmark?*, 37 UCLA L. REV. 29, 126 (1989) (advocating proportionality between attorneys' risk and reward in contingent-fee cases).

plaintiffs' lawyers remain to provide potential plaintiffs with access to the litigation system, Weiler proposes to make the plaintiffs' reasonable attorneys' fees an explicit element of damages in malpractice cases (pp. 67-68).⁶⁵ This is perhaps Weiler's most original, and most controversial, suggestion.

In combination, Weiler asserts that his reform package would result in a better and less costly system. In my view, many of his ideas are perfectly appropriate steps that, if implemented, would significantly improve the litigation system.⁶⁶ Scheduling pain and suffering damages, although posing the practical problem of reaching a consensus on appropriate levels, would help facilitate settlement through minimizing uncertainty of the range of likely jury results (p. 61). Other ideas that Weiler rejects, however, such as capping overall damages, could provide appropriate legislative responses if fairly implemented. For example, a reasonable cap on damages, or perhaps a damages schedule indexed to inflation, might yield significant benefits.

Some of Weiler's other proposals are more problematic. For example, his idea of including plaintiffs' attorneys' fees as an element of damages raises a host of practical concerns. On the surface, such a change would seem to create incentives for plaintiffs' attorneys to do more work than necessary. Although courts might later review the reasonableness of any fee requests, such post-hoc reviews are both administratively time consuming and imprecise. Also, it is unclear how shifting plaintiffs' costs to defendants would lower overall transaction costs. Because the fee would not be based upon the amount of the award, but rather on the time expended, such a rule would enable plaintiffs' lawyers to pursue small claims. Although in some cases this would be appropriate, in others it would simply promote litigation in cases of marginal injury.

⁶⁵ This is not a cost-shifting proposal, for Weiler would not routinely permit defendants to recover their attorneys' fees if they prevail. Weiler's refusal to shift fees in favor of defendants is based largely upon the fact that most doctor-defendants do not personally pay their attorneys, who are instead commonly compensated by the physician's malpractice insurer. On the other hand, Weiler urges that costs should be assessed against plaintiffs' counsel in the event that the claim is deemed frivolous as an appropriate sanction for not properly screening the claim (p. 68).

⁶⁶ For example, Weiler supports the development of a procedural rule that would permit malpractice litigants to make offers of settlement (p. 68). Indeed, given his proposal to incorporate attorneys' fees into a successful plaintiff's damages entitlement, some meaningful incentive for plaintiffs' attorneys to settle, like an offer-of-settlement rule, is needed. Cf. *Marek v. Chesny*, 473 U.S. 1, 5 (1985) (describing the operation of an offer-of-judgment rule in context of a fee-shifting provision).

Weiler once again is in good company with numerous commentators who have discussed the viability of an offer-of-settlement rule in the malpractice context. See, e.g., Metzloff, *supra* note 9, at 94-99; cf. W. Henson Moore & John S. Hoff, *H.R. 3084: A More Rational Compensation System for Medical Malpractice*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 117, 118-19 (supporting a proposal to allow health care providers to escape tort liability by paying all economic damages associated with a treatment-related injury).

More troublesome is Weiler's overriding assumption that a mere change of existing rules will never serve to make the litigation system work fairly enough. The spectre of the Harvard Study's pessimism hangs heavy. Yet if Weiler is correct that much of the current problem stems from uncertainty over damages, one would think he would be more optimistic about the prospects for improving the situation through reform of the existing system. Given his proposals in this area and his identification of their likely benefits of facilitating settlement, Weiler's omission of any discussion in this section of other promising litigation reforms, most notably the development of alternative dispute resolution mechanisms, is particularly curious.⁶⁷

Part of my disagreement with Weiler stems from his assumption that all the participants in the current litigation system are performing well. Although I fully concur that the best available evidence cannot isolate any "culprits" in the malpractice crisis, this is not the same as concluding that there is no basis for change. Especially with respect to plaintiffs' attorneys and juries, numerous reforms promise meaningful improvement.

II. RECONSTRUCTING THE TORT SYSTEM

In the final chapters of the book, Weiler warms to the task intended all along: elaborating proposals to change fundamentally the fault-based tort system. Weiler considers reforms based upon private contracts between provider and patient, and public laws that establish new compensation schemes. He opts for the latter course, but only after extensive consideration of the possibility of private ordering.

A. Damning with Faint Praise: Private Contract and Litigation Alternatives

Private contractual solutions are premised on the belief that market forces can be trusted to determine sound rules for both liability and procedure.⁶⁸ Although conceding the benefits of private arrangements, Weiler clearly prefers public law revisions to the compensation scheme. Weiler's begrudging attitude toward private contractual solutions is well illustrated by his analysis of the potential utility of

⁶⁷ See *infra* pp. 1189-90.

⁶⁸ The vision offered by private contractual reform is perhaps best articulated in the writings of Clark Havighurst. See, e.g., Clark C. Havighurst, *Altering the Applicable Standard of Care*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 265, 266-70 (suggesting the use of contractually determined alternatives to the traditional "customary practice" standard of care). See generally Symposium, *Medical Malpractice: Can the Private Sector Find Relief?*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 1, 243-77 (discussing possibilities for reforming malpractice litigation largely through contractual arrangements).

private contracts that require the use of arbitration or other forms of alternative dispute resolution (ADR).

Weiler's treatment of ADR is disjointed, with bits and pieces of discussion appearing in various sections. In his historical overview, Weiler comments in passing on the experience of many states with pretrial screening panels that he characterizes as performing generally unsatisfactorily (p. 29).⁶⁹ In the "current reforms" portion of the book, he includes no discussion of ADR programs that might impact malpractice litigation. Although recent ADR efforts have hardly transformed malpractice litigation,⁷⁰ potentially significant ADR applications are underway.⁷¹ Given the widespread support for ADR among policy makers and commentators,⁷² Weiler should have included a discussion and assessment of its potential.

Weiler does not begin a serious analysis of alternatives to litigation until his discussion of the potential for binding arbitration pursuant to private contract.⁷³ His attitude towards arbitration, as with other

⁶⁹ Weiler describes the structure of screening panels and notes that courts and commentators have "questioned the mechanics, the effectiveness, and the constitutionality of these boards" (p. 29). Weiler's negative estimation corresponds with prevailing opinion, as evidenced in part by several states that have recently abolished their panels. See Jona Goldschmidt, *Where Have All the Panels Gone?: A History of the Arizona Medical Liability Review Panel*, 23 ARIZ. ST. L.J. 1013, 1078-93 (1992). For a description of current ADR approaches in the malpractice context, see Thomas B. Metzloff, Comment, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429, 438-46 (1992). Although the states' experiences with panels could be more fully analyzed, I am not critical of Weiler's conclusions because I generally share his negative assessment.

⁷⁰ For example, the summary jury trial, a recent ADR process that utilizes nonbinding jury verdicts to assist the parties in reaching a settlement, see Thomas D. Lambros & Thomas H. Shunk, *The Summary Jury Trial*, 29 CLEV. ST. L. REV. 43, 43 (1980), is, according to its proponents, suited to a broad range of cases including personal injury disputes. See D. MARIE PROVINE, SETTLEMENT STRATEGIES FOR FEDERAL DISTRICT JUDGES 69 (1986). Few malpractice cases have utilized the process, however, and, as I have argued elsewhere, the process as commonly formatted is probably inappropriate for most malpractice disputes. See Thomas B. Metzloff, *Reconfiguring the Summary Jury Trial*, 41 DUKE L.J. 806, 841-50 (1992).

⁷¹ For example, several states have recently enacted legislation that empowers trial court judges to mandate the use of mediation or nonbinding arbitration in any civil dispute, including malpractice cases. See, e.g., FLA. STAT. ANN. §§ 44.1011, 44.102-.108 (West Supp. 1992).

⁷² See, e.g., U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION 30 (1987) (noting the desirability of evaluating ADR mechanisms for resolving malpractice claims); Neil D. Schor, Note, *Health Care Providers and Alternative Dispute Resolution: Needed Medicine to Combat Medical Malpractice Claims*, 4 OHIO ST. J. ON DISP. RESOL. 65, 66 (1988).

⁷³ Attempts to facilitate the use of arbitration in malpractice cases were an early aspect of the 1970s wave of tort reform passed in response to the first malpractice crisis. In the mid-1970s approximately 12 states enacted specific legislation designed ostensibly to "promote" the use of arbitration. See Irving Ladimer & Joel Solomon, *Medical Malpractice Arbitration: Laws, Programs, Cases*, 653 INS. L.J. 335, 337-38 (1977). Despite these previous attempts to promote arbitration, Weiler considers it a reform that has largely been untested (p. 101). Although one might quibble with this characterization, the treatment is defensible given arbitration's relative lack of use. According to a recent study of malpractice claims closed in 1984, only 0.2% of

means of private ordering, is one of lukewarm acceptance (p. 102). In the text, he suggests, based upon limited empirical research,⁷⁴ that arbitration tends to skew results in favor of plaintiffs who have suffered severe permanent disabilities as compared to those claimants with only minor injuries (p. 102). As this bias accords with Weiler's own general approach to damages, he adopts a mildly proarbitration stance. In addition, Weiler anticipates that arbitration could reduce the costs of the system and provide plaintiffs easier access; physicians would also benefit, presumably, from improved accuracy in decision-making and greater privacy (p. 102).⁷⁵

The text's favorable stance contrasts with the endnotes' more negative assessment. In the notes, Weiler details the judicial hostility directed against physician efforts to employ arbitration agreements,⁷⁶ and describes restrictions commonly included in malpractice arbitration statutes.⁷⁷ Combined, these factors have "considerably undercut the possible gains from arbitration as an expeditious and economical procedure," leading Weiler to "retain a healthy degree of skepticism about prescriptions of arbitration as a powerful antidote for the ailments of malpractice litigation" (p. 217 n.25).

malpractice claims were decided following arbitration. See U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984, at 37 tbl. 2.20 (1987); U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: FEW CLAIMS RESOLVED THROUGH MICHIGAN'S VOLUNTARY ARBITRATION PROGRAM 3-4, 7 (1990) [hereinafter GAO MICHIGAN ARBITRATION STUDY] (finding that legislation meant to encourage voluntary binding arbitration resulted in only 247 actual arbitrations out of a pool of approximately 20,000 malpractice claims in 13 years).

⁷⁴ See Irving Ladimer, Joel C. Solomon & Michael Mulvihill, *Experience in Medical Malpractice Arbitration*, 2 J. LEGAL MED. 433, 455-69 (1981); Stephen Zuckerman, Christopher F. Koller & Randall R. Bovbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 85, 103-06 (summarizing existing empirical information on malpractice arbitration programs).

⁷⁵ Weiler's view on this point contrasts sharply with other commentators who assume, with no empirical proof, that arbitration will inevitably disadvantage malpractice plaintiffs. See, e.g., Nicolas P. Terry, *The Technical and Conceptual Flaws of Medical Malpractice Arbitration*, 30 ST. LOUIS U. L.J. 571, 574-75 (1986) (suggesting that "for conceptual and technical reasons, malpractice arbitration as currently envisioned is a dangerously inappropriate solution to the real or perceived malpractice crisis").

⁷⁶ See, e.g., *Roberts v. McNamara-Warren Community Hosp.*, 360 N.W.2d 279, 281 (Mich. App. 1984); *Obstetrics & Gynecologists Ltd. v. Pepper*, 693 P.2d 1259, 1260-61 (Nev. 1985).

⁷⁷ See, e.g., GA. CODE ANN. § 9-9-62 (Supp. 1992) (limiting enforcement of arbitrations to situations in which the claimant's agreement to arbitrate post-dates the alleged act of physician negligence and is made after consultation with an attorney). One commentator has gone as far as to suggest that advising clients to arbitrate could subject attorneys to legal malpractice claims. See Terry, *supra* note 75, at 605. In fact, existing empirical evidence suggests that plaintiffs are at least as likely to prevail in arbitration as in traditional litigation. See GAO MICHIGAN ARBITRATION STUDY, *supra* note 73, at 8 (noting that plaintiffs prevailed in 22% of arbitration cases as compared to 18% of traditional litigation); see also Kevin M. Clermont & Theodore Eisenberg, *Trial by Jury or Judge: Transcending Empiricism*, 77 CORNELL L. REV. 1124, 1137 tbl. 3 (1992) (finding that malpractice plaintiffs prevailed more often in federal court cases tried by a judge than in cases presented to a jury).

Weiler follows these observations with an argument that the arbitration process is not well suited to the malpractice context. He first describes the supposed paradigmatic example of labor arbitration, which is supported by the employer's and employee's mutual interest in maintaining a working long-term relationship, and then notes that the doctor-patient relationship, by contrast, does not generate the same shared interests. For example, although a hospital may desire the long-run benefits offered by arbitration, an individual with but a single claim may be loath to entrust the dispute to arbitration. Moreover, plaintiffs' attorneys will be "suspicious of arbitration and willing to fight for a chance to get to a jury if that seems advantageous to the case" (p. 217 n.25). As a result, plaintiffs are likely to challenge arbitration agreements vigorously, and such challenges would defeat a central benefit of arbitration, namely, expedited resolution on the merits. The combined message of text and notes is that, although arbitration may be an initially attractive alternative on both conceptual and practical grounds, the promised benefits are largely unattainable.

Weiler's weak backing of arbitration stands in sharp contrast to his overly complimentary estimation of the AMA's controversial administrative plan to transfer all malpractice disputes from the courts to a specialized administrative tribunal (pp. 114-22).⁷⁸ The AMA's proposal includes elaborate procedural steps such as an initial review and investigation by a claims processor; referral to a neutral expert; assignment of a "court-appointed" attorney; mandatory settlement offers; submission of the dispute to a hearing examiner; and review of substantive decisions by an overseeing board.⁷⁹

Although a few commentators have expressed cautious interest in the AMA's proposal,⁸⁰ others have been decidedly negative, viewing it as yet another piece of medical-profession propaganda.⁸¹ Weiler's assessment is that the AMA plan deserves a "serious appraisal" and

⁷⁸ See AMERICAN MEDICAL ASS'N/NAT'L MEDICAL SPECIALTY SOC'Y COORDINATION PROJECT ON PROFESSIONAL LIABILITY, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED, ADMINISTRATIVE SYSTEM (1988).

⁷⁹ For a fuller description, see Kirk B. Johnson, Carter G. Phillips, David Orentlicher & Martin S. Hatlie, *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1379-84 (1989).

⁸⁰ See, e.g., Randall R. Bovbjerg, *Reforming a Proposed Tort Reform: Improving on the American Medical Association's Proposed Administrative Tribunal for Medical Malpractice*, 1 CTS., HEALTH SCI. & L. 19, 20 (1990).

⁸¹ See, e.g., J. Douglas Peters, *Critique of the American Medical Association's Model Medical Liability and Practices Reform Act*, 1 CTS., HEALTH SCI. & L. 51, 56 (1990) (suggesting that "to replace a system that has worked to resolve civil disputes for hundreds of years with an untried system that is radically alien to the citizenry is more than legally unsound. It defies common sense"). To date, no state has adopted the AMA's plan.

that the "AMA's ingeniously designed proposal would likely fare quite well in any open-minded comparison" with traditional litigation (p. 117). Weiler, despite his general reluctance to endorse alternatives to litigation, has, curiously enough, cast his vote for the most elaborate and untested of all ADR options.

One would expect that Weiler's position on the merits of arbitration vis-a-vis the AMA plan would, at the very least, be one of neutrality. For many of the same reasons that Weiler finds the AMA's administrative alternative intriguing, a pro-arbitration policy offers advantages over the current litigation system. The primary virtues of the AMA's proposal are its promise for improving access for plaintiffs and ensuring the quality of decisions through adjudication by experienced decisionmakers. Both these goals can be promoted by a properly designed arbitration system.⁸² If selected according to appropriate criteria, arbitrators could generate as reliable and consistent results as an administrative decisionmaker.⁸³

Private arbitration has several clear advantages over the AMA's plan; it would potentially solve much of what Weiler thinks is wrong with traditional litigation. Arbitration offers plaintiffs improved access by potentially lowering the costs of seeking compensation. For the medical profession, it offers three significant advantages: First, the replacement of the lay jury with a more specialized decisionmaker; second, greater privacy that, combined with an expert decisionmaker, might help to lower the emotional trauma associated with malpractice litigation; and third, potentially lower costs. Permitting wide-scale arbitration of malpractice claims would certainly be less disruptive of the existing system than would Weiler's public-law reform proposals or the AMA's plan. A market already exists for private ADR providers interested in establishing malpractice programs; similarly, the arbitration process would continue to permit the participants in the existing settlement process — the insurance claims adjusters, defense attorneys, and plaintiffs' attorneys — to continue to play their roles. The AMA plan, by contrast, requires the creation of a new bureaucracy that would consist of claims reviewers, hearing examiners, expert witness panels, attorneys, and board members, which would raise serious questions as to whether the appropriate expertise

⁸² See Havighurst & Metzloff, *supra* note 3, at 184–85.

⁸³ One possible difference is that the AMA's proposal calls for extensive written decisions (p. 116), whereas, in most private arbitrations, no written decisions are issued. In my opinion, however, the benefits of the AMA written-decision policy are likely to be minimal. Malpractice cases tend to be very fact-specific; even an extensive written decision will have little direct application to other cases. Although a written decision would, of course, more easily permit appellate review on the merits of the liability issue (which adds delay and expense), its impact on developing specific standards of care over the entire range of medical issues would be negligible.

could be garnered in a public institution without the massive expenditure of public funds.⁸⁴ Private arbitration, well ensconced in other litigation contexts, also minimizes the serious Seventh Amendment problems inherent in the AMA plan. Finally, arbitration, with its informal procedures and minimal discovery, would almost certainly result in quicker and less expensive decisions. Again, this contrasts with the extensive procedural trappings of the AMA proposal.

Weiler's reticence on the subject of arbitration (and private ordering in general) is surprising. He is certainly correct that a serious question about the utility of importing arbitration into the medical malpractice context is raised by its current neglect, for which he provides two explanations: active judicial scrutiny and legislative restrictions. However, Weiler probably understates the degree to which existing malpractice statutes limit the use of arbitration. Arbitration has not "caught on" in the malpractice context in large part because the existing statutes ostensibly designed to promote arbitration do nothing of the sort. In Michigan, for example, the statute details the specific form that arbitration hearings must follow, thus defeating one of the essential purposes of arbitration — party control over a flexible procedure.⁸⁵ Such legislative restrictions unduly prohibit physicians from selecting an ADR method that is now routinely forced on potential litigants in a variety of other contexts by stock brokers, ticket sales agents, contractors, and corporations.⁸⁶ The fact that medical malpractice plaintiffs may have less of a motivation to seek arbitration as plaintiffs in other areas should be legally irrelevant. Assuming an arbitration process that comports with due process guarantees, there is no reason to restrict its use in malpractice.⁸⁷

Weiler thus fails to follow through on the logic of his own observations: if, as he maintains, arbitration is desirable but underutilized as a result of excessive judicial scrutiny and legislative restrictions, it seems apparent that we should move towards less scrutiny and fewer restrictions. This strongly suggests the development of new statutory approaches to facilitate malpractice arbitration, such as by more freely

⁸⁴ See Bovbjerg, *supra* note 80, at 24–25.

⁸⁵ See MICH. COMP. LAWS § 600.5044(2) (1987) (requiring the use of three arbitrators, one of whom must be a physician).

⁸⁶ See, e.g., *Gilmer v. Interstate/Johnson Lane Corp.*, 111 S. Ct. 1647, 1652–57 (1991) (upholding enforcement of an arbitration agreement in the context of an age discrimination suit); *Shearson/American Express v. McMahon*, 482 U.S. 220, 225–26 (1987) (identifying a general public policy in favor of arbitration and holding that this policy applies even in the context of disputes between consumers and securities dealers).

⁸⁷ More important than consumer protection provisions that restrict the freedom of physicians to insist upon arbitration would be certification requirements designed to ensure the neutrality and quality of the arbitration process. For discussion of appropriate certification requirements, see Havighurst & Metzloff, cited above in note 3, at 187–88.

permitting physicians to insist upon arbitration in their dealings with patients.

B. Exploring Uncharted Waters: No-Fault Compensation

Weiler's concluding section consists of an examination of the potential application of a no-fault scheme to medical malpractice cases. Numerous malpractice commentators have in the past explored the no-fault option.⁸⁸ Weiler's major contributions here are his specific suggestions for how a no-fault scheme would work and his assessment — the first to rely on empirical findings — that such an approach would be affordable.

In the past, the most common concern with a no-fault approach was its cost (p. 134). Affordability concerns raise two distinct questions. The first issue is whether a no-fault scheme can properly differentiate between injuries caused by medical treatment and injuries caused by the patient's underlying illness. Unlike other statutorily governed contexts in which the individual's injuries are a direct function of the action that triggers the right to compensation (injury on the job in the case of worker's compensation or an automobile accident in the case of a no-fault automobile program), there is no such clarity in medicine.⁸⁹ Second, there is the question of whether the system can afford to compensate all iatrogenic injuries.

Weiler does not claim to possess positive proof that a no-fault approach would be affordable. Instead, within the parameters established by the Harvard Study, he is able to discuss these obviously thorny questions with at least some informed basis for reaching an approximation of the magnitude of compensable injuries and for speculating on the practical problems that would be encountered. In this regard, recent work by Weiler and his colleagues further this analysis considerably; those seriously interested in grappling with the numbers are best referred to their most recent discussions.⁹⁰

However, even the most ardent defender of the litigation system must contemplate how well a no-fault scheme might function. Although the practical problems in implementing a comprehensive no-

⁸⁸ See, e.g., Jeffrey O'Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 34-37 (1975); Clark C. Havighurst & Laurence R. Tancredi, "Medical Adversity Insurance" — *A No-Fault Approach to Medical Malpractice and Quality Assurance*, 613 INS. L.J. 69, 69-71 (1974).

⁸⁹ Other skeptics, even if believing that the line can be drawn, are less sanguine about whether the system over time will be willing to draw the line. See, e.g., OLSON, *supra* note 30, at 311 ("An official malpractice board or compensation fund would come under inevitable pressure to pay claims based on guesswork about medical negligence that could not be absolutely ruled out as probably unfounded. That would lead down the slope to compensation for bad results in medicine generally, at untold expense.")

⁹⁰ See A MEASURE OF MALPRACTICE, *supra* note 7, at 77-109.

fault scheme⁹¹ seem at first blush enormous, Weiler carefully describes the different elements that such a scheme would likely entail. His goal is to demonstrate that a workable system can function as an appropriate compensation "backstop" without increasing the overall cost to physicians. Central to his argument is the assertion that major cost savings can be accomplished in the administration of a no-fault regime (pp. 139-44). To this end, he proposes to impose significant limits on patient recovery, and draws heavily on his earlier discussions of collateral source offsets and limitations on noneconomic damages (pp. 134-39).

It is not possible to compare directly the litigation system with Weiler's proposal — they are too different in purpose and scope, and the no-fault approach is too untested to provide any specific grounds for comparison. Being less critical of the litigation system than Weiler, or perhaps simply more optimistic that meaningful reform within the system is possible, I am less inclined to endorse such a radical approach. Yet Weiler's analysis moved me to take his suggestion far more seriously than I had in the past. The simple answer that no-fault is unaffordable or impractical no longer suffices; Weiler has inalterably changed the terms of the debate by forcing consideration of the no-fault option.

III. CONCLUSION

Commentators have long been interested in medical malpractice; we have long assumed that malpractice represented a fair test case for how well the litigation system functions. In part, our interest has stemmed from the cases themselves, many of which involve serious issues of life and death. In part, our curiosity has also been a function of the energy and concern devoted to the subject by the medical profession.

Weiler's book serves to justify and, indeed, to expand our understanding of the importance of malpractice in the continuing debate over the merits of our litigation system. As he explains, "[u]nderstanding the arguments and the experience in the medical context is indispensable . . . for developing sound policy for dealing with all disabling injuries, not simply those caused by medical treatment" (p. 2). This is undoubtedly correct. Our interest in malpractice, although perhaps initially fueled by the outbreak of hostilities in the mid-1970s amid an atmosphere of crisis, has been replaced by some-

⁹¹ A no-fault approach need not apply to all iatrogenic injuries. In Florida and Virginia, as Weiler notes (p. 228 n. 31), recent legislation enacted a limited no-fault scheme to compensate children who suffered serious neurological injuries during the birth process. *See* FLA. STAT. ANN. §§ 766.301-316 (West Supp. 1992); VA. CODE §§ 38.2-5000 to -5020 (Michie 1990 & Supp. 1992).

thing more fundamental: the realization that malpractice represents perhaps *the* perfect test case for addressing the workings of the tort system. Involving tens of thousands of claims per year, consuming billions of dollars in payments and costs, the malpractice context starkly presents the most salient issues that concern the quality of our litigation system.

Whether one accepts fully Weiler's criticisms or prescriptions for change, the richness of the debate and issues that Weiler so powerfully presents is impressive. He adeptly describes the complex interrelationships of the regimes of insurance, law, and medicine; he recounts a lengthy history of a wide variety of malpractice reforms; he interprets the new-found wealth of empirical information on an ever-expanding number of issues; and finally, he sketches out boldly different approaches for future reform. In furthering our understanding and assessment of that system and in conceptualizing the policy choices available, Weiler makes an extraordinary contribution.