A CONSUMER PERSPECTIVE ON MEDICAL MALPRACTICE

SYLVIA A. LAW*

I
INTRODUCTION

In 1975, and now again in 1985, there has arisen a public perception of a "malpractice crisis." The crisis, then and now, principally troubles physicians, who believe that liability insurance premiums are too high. A crisis seen through the eyes of doctors and measured in premium dollars naturally generates responses evaluated in terms of effect on premiums. The needs of patients and consumers never even enter the debate.

Many Americans confront enormous difficulty obtaining affordable medical care of decent quality. This article describes these main consumer problems, traces the complex relationships between them and legal actions for medical malpractice, and briefly critiques current proposals for malpractice reform. The thesis of the article is that even in the best of circumstances legal claims for medical malpractice seldom provide effective

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* Professor of Law, New York University School of Law.

Two NYU law students, David Rawson and Karen Treiger, helped with this article.

1. The malpractice crisis of 1985 differs from that of 1975 in only two important ways. First, in 1975 it seemed that not all physicians in some states could purchase any malpractice insurance, regardless of price. In 1975, private malpractice insurers threatened to leave the market in several states unless they were given large premium increases, and no other insurers appeared willing to step in and provide coverage. Since 1975, availability of coverage has improved. For example, 31 states have created joint underwriting associations, mandated consortiums of private insurance companies that can, if necessary, be forced to write medical malpractice insurance at state-set rates, without risk of loss or opportunity for profit. See, e.g., R. Pierce, What Legislators Need to Know about Medical Malpractice 5 (1985).

Second, the capacity to understand the financial situation of malpractice insurers has improved in the past decade. Prior to 1985, neither insurance rating organizations nor regulators collected data on medical malpractice as a line of insurance separate from general liability. Without rigorous information, policymakers relied on anecdote and political argument. For instance, the 1975 "crisis" was precipitated when one multinational conglomerate, the Teledyne Corporation, pulled its subsidiary, the Argonaut Company, out of the malpractice business. Argonaut had been the primary provider of medical malpractice insurance in several states. Argonaut had at first demanded massive rate increases, but neither the insurance industry nor the state regulators had sufficient data to understand that Argonaut's demands were not dictated by their risk experience. Ignorance generated panic. See S. Law & S. Polan, Pain and Profit: The Politics of Malpractice 161-95 (1978).

The National Association of Insurance Commissioners subsequently discovered that 1975, the year of crisis, was profitable for the malpractice insurance industry. In 1975 operating profit for all lines of insurance was one percent, while for malpractice insurance it was nine percent. National Assoc. of Ins. Comm'rs, Report on Profitability by Line and by State for the Year 1976 (Aug. 12, 1977) (unpublished draft). In 1985, there is little reason to believe that malpractice insurers as a class face acute financial distress. See R. Pierce, supra, at 4-7.
means to address patients' real problems. Although society could and should develop stronger means to deal with these problems, malpractice "reforms" adopted solely to reduce premiums generally make things worse for consumers.

II

LEGAL CLAIMS FOR MEDICAL MALPRACTICE DO LITTLE TO ADDRESS THE REAL PROBLEMS OF HEALTH CARE CONSUMERS

Americans seeking medical care face three major problems: (1) many cannot obtain necessary services, (2) costs are unreasonably high, and (3) the quality of care provided is often not as good as it should be and the human relationships often are not healing. Legal actions for medical malpractice have some relevance to these central issues, but not much.

A. Access to Service

In 1984, fifteen percent of the American people had no public or private medical insurance, and many more had only very thin coverage. Over a quarter of women in the prime child-bearing years (eighteen to twenty-four) have no form of health insurance to help pay the $3,200 average expense of a normal delivery. The uninsured population has grown in recent years. Lacking coverage, the uninsured must pay out of his or her own pocket or seek reduced-price or charity care.

Even as the need for charity service from doctors and hospitals becomes more urgent, an increased ethic of competition in medical care and reduced government payments for services for the poor have encouraged hospitals to

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2. Swartz, People Without Health Insurance, (Mar. 12, 1985) (presentation at American Health Planning Association annual conference, Washington, D.C.) (based on Dep't of Commerce Current Population Survey data on coverage states in March of that year; a lower percentage was uncovered during the entire year).


Several factors explain the growing numbers of people without insurance. Cuts in federal domestic spending and states' fiscal stringency have generated sharp restrictions in the state-federal Medicaid programs that insure many of the poorest of the poor. R. Bovbjerg & J. Holahan, Medicaid in the Reagan Era: Federal Policy and State Choices 12-16 (1982). Changes in employment patterns—high unemployment, declining unionization, and shifts from manufacturing to service work—have reduced medical insurance provided through employment related groups. Adams, Changing Employment Patterns of Organized Workers, Monthly Lab. Rev., Feb. 1985, at 25, 26; Serrin, U.S. Cites Continued Drop in Union Membership, N.Y. Times, Feb. 8, 1985, at B5, col. 1; Swartz, supra note 2, at 5. Intensified insurance price competition, including much self-insurance by large firms, has discouraged health insurers from community rating. Healthy groups of workers pay lower rates based on their experience, and individuals and smaller or less healthy groups are often priced out of the market.
intensify efforts to limit charity care.6 While many doctors and hospitals voluntarily provide care to people who are unable to pay, the law can also encourage such behavior.

Legal obligations to provide charity care are very limited, however. Doctors have no duty to provide any at all, even in an emergency.7 Some states require hospitals to treat people who need acute, emergency care, but not to provide the ordinary, primary care that many people need.8 Even such limited duties are difficult to enforce.9 The possibility that someone injured when care is denied may sue for malpractice often provides the most persistent pressure for hospital compliance.

Charity care obligations enforced by malpractice threats are a disgracefully inadequate response to patient needs for medical care. Generally, malpractice remedies arise only after an individual patient has been turned away and thereby injured and cannot practically be enforced unless the injury is severe. In a society as wealthy as ours, minimal decency demands more than malpractice threats promoting haphazard charity. Public programs such as Medicaid could be expanded, or payment formulae could be implemented that reimburse hospitals for the care they provide to the uninsured.10 Another alternative would be to do what every other developed nation and even many developing ones have done and create a national health insurance or service program.

But programs to spread the cost of medical services for the poor and sick are as politically vulnerable as these people are politically weak. Hospitals, particularly those in areas of high unemployment and poverty, are caught between tightening reimbursement schedules and growing requests for charity care. Charity enforced by malpractice risk helps enfranchise the poor by inspiring hospitals to articulate the needs of both the hospitals and the people that they serve.11

6. See, e.g., Two More Tragic Examples of Patient Dumping Come to Light, 144 Health Advoc. 3 (1985); Wilensky, Solving Uncompensated Hospital Care, Health Aff., Winter 1984, at 50.
10. See Wilensky, supra note 6, at 55-58; see also Staff of Senate Special Comm. on Aging, 98th Cong., 1st Sess., Current Developments in Prospective Reimbursement Systems for Financing Hospital Care 5-9 (Comm. Print 1983); Demkovitch, Verdict is Still Out on Prototype of New Hospital Cost-Cutting Plan, 15 Nat'L J. 2573 (1983).
11. For an excellent collection of articles addressing the problems of the uninsured and the hospitals that serve them, see Hospitals and the Uninsured Poor: Measuring and Paying for Uncompensated Care (S. Rogers, A. Rousseau & S. Nesbitt eds. 1984).
B. Costs

The high and rising price of medical care and insurance to cover it pose another major, not unrelated, problem for consumers and patients in America today. Medical care spending is a major item in state and federal budgets, and now constitutes a burden for employers as well as consumers.

While such high costs create very serious problems, malpractice premiums contribute little to them. Malpractice insurance premiums account for only about one percent of the nation's 350 billion dollar bill for personal health care services. Between 1976 and 1983 the proportion of gross income that the average physician paid for malpractice insurance actually decreased from 4.40% to 3.69%.

Many doctors sincerely believe that the risk of malpractice increases medical costs by requiring them to do unnecessary tests and procedures solely to avoid liability. However, the nature, extent, and cost of such "defensive medicine" are unclear. Iatrogenic injuries, that is, those caused by medical intervention, generate enormous human suffering and financial cost. If, as seems likely, the threat of medical malpractice liability prevents even a small portion of these treatment-induced injuries, then, even in purely financial terms, malpractice liability saves more than it costs.

The troubling phenomenon of rising medical costs must be addressed directly. After a decade of effort, hospital costs have been somewhat
restrained by administrative action under Medicare and Medicaid,\(^\text{20}\) regulation for all payers in several states,\(^\text{21}\) and consumer and business resistance.\(^\text{22}\) Physician costs continue to rise steeply.\(^\text{23}\) Insurers can cut their costs most easily by shifting them to patients, through increased deductibles and coinsurance, as well as through increased premiums. In recent years the out-of-pocket obligations that insured patients face at time of illness have increased dramatically.\(^\text{24}\) Doctors take home more income than any other class of workers in this society, an average of $106,300 in 1983.\(^\text{25}\) Yet, society has not developed ways to pay doctors that both assure them fair compensation and constrain soaring medical costs.\(^\text{26}\) Those who view the problem of medical costs through the prism of alleged excesses in malpractice premiums blind themselves to a social problem of great importance to both doctors and patients.

General data thus demonstrate plainly that malpractice premiums neither drive medical cost increases nor significantly impede access. Aggregate information obviously does not describe every particular situation. Some health care workers—nurse midwives serving low income people or obstetricians in rural areas, for example—may provide essential services for prices that do not allow them to absorb large increases in malpractice premiums. Organized medicine uses such cases to advocate relief for all doctors from “onerous” premiums. Perhaps a subsidy is needed for premiums for some particular medical providers who meet essential needs at earning levels that cannot sustain rising malpractice premiums. While aggregate data do not disclose everything about the impact of malpractice premiums, they do indicate one thing: major legal reforms cannot sensibly be addressed to idiosyncratic problems.

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\(^{22}\) See Demkovich, supra note 14.

\(^{23}\) See, e.g., 1984 Senate Comm. Print, supra note 13, at 8.

\(^{24}\) One study of the health insurance policies offered by 1,185 large corporations between 1982 and 1984 shows that the proportion requiring a front-end deductible for surgical fees increased from 34% to 59%, and the proportion paying the full balance of the surgeon's fees decreased from 42% to 26%. Goldsmith, Death of a Paradigm: The Challenge of Competition, Health Aff., Fall 1984, at 5 (citing Hewitt Associates, Company Practices in Health Care Cost Management—1984 (survey)). For general information on out-of-pocket costs for individuals eligible for Medicare, see Davis & Rowland, Reforming Medicare: A New Approach to Financing, in 1983 House Conference, supra note 20, at 98 (in 1981 the average person eligible for Medicare paid $1,154 in out-of-pocket medical costs).

\(^{25}\) Net Income Averaged $106,300 in '83, Am. Med. News, Oct. 5, 1984, at 2, col. 2. Heads of Fortune 500 companies, of course, earn more than doctors, but do not constitute a recognizable professional class: most aspirants to that status fail, whereas almost all medical school graduates succeed.

\(^{26}\) See generally 1984 Senate Comm. Print, supra note 13.
C. Quality of Care and Relationships

Even people who can afford medical care too often suffer unnecessary injury and anxiety. Some patients are injured by chronically incompetent physicians. Others are hurt by doctors who, while generally competent, sometimes fail to take reasonable care. Many patients find it difficult to learn about their conditions and to participate in making treatment choices. Others are hurt by a lack of coordination and communication among the people involved in taking care of them. These problems relate to medical malpractice actions, albeit in a complex way.

Most doctors and nurses are competent, conscientious, concerned, hard working, honest, and are rarely, if ever, sued for medical malpractice. However, significant numbers of doctors regularly practice medicine that is inadequate by any standard. Some are senile. Some are addicted to drugs, including alcohol, that impair their skill and judgment. Others are poorly trained. Whatever the reason, the most basic function of the malpractice law is to deter medical practice that falls below any reasonable line of minimal adequacy, and to compensate patients injured by such practice.

Unfortunately, malpractice claims do not provide strong deterrence for doctors who are chronically incompetent. A doctor who is unable or unwilling to confront his or her own impairment is unlikely to be restrained by the threat of a legal or insurance claim. Doctors can do unreasonably dangerous things for a considerable period of time without being sued.

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27. U.S. DEP’T OF HEALTH, EDUC., AND WELFARE, REPORT OF THE SECRETARY’S COMMISSION ON MEDICAL MALPRACTICE & APPENDIX 12 (1973) (most American physicians “have never had a medical malpractice suit filed against them and those who have, have rarely been sued more than once”).


28. “Every physician knows some colleague who has to be watched carefully, an old friend or even teacher for whom he hesitates to ring [sic] down the curtain even though he knows that the man or woman has advanced beyond his or her competence.” Spiro & Mandell, Visceral Viewpoints: Leaders and the Swan—Who Should Do Family Practice, 295 NEW ENG. J. MED. 90 (1976). The extent of senility is obviously difficult to quantify.

29. Physicians are the occupational category with the highest use of illicit drugs. Stout-Wiegand & Trent, Physician Drug Use: Availability or Occupational Stress?, 16 Int’l J. Addictions 317 (1981). The AMA concedes that “the greater accessibility of drugs to physicians (than to others) may cause physicians to be somewhat more susceptible to this problem,” but that “alcoholism most likely represents the greater problem in terms of number of physicians affected.” Effect of Alcohol and Drug Abuse on Productivity: Joint Hearing Before the Subcomm. on Alcoholism and Drug Abuse and the Subcomm. on Employment and Productivity of the Comm. on Labor and Human Resources, 97th Cong., 1st Sess. 64-116 (1982) (testimony of AMA representatives William Y. Rial and LeClair Bissell).

30. In recent years, thousands of U.S. citizens unable to gain admission to a U.S. medical school have studied in newly established schools in the Caribbean and Mexico. Imperato, An Overview of New York State and the Offshore Medical Schools, 84 N.Y.S.J. MED. 337 (1984). These schools are not licensed by anyone and commonly lack clinical facilities; there is substantial basis for concern about the quality of education they provide. Ass’n of Am. Med. Colleges, Quality of Preparation for the Practice of Medicine in Certain Foreign-Chartered Medical Schools, 56 J. Med. Educ. 963 (1981); Woodruffe, Offshore Medical Schools, 2 LANCET 546 (1982). Yet many of these schools’ graduates finish their training in the United States, often in the weakest, least sought-after residency programs, then practice in this country. A. Gellhorn, Report of the New York State Commission on Graduate Medical Education 50-74 (1985); see also Mick & Worobey, Foreign Medical Graduates in the 1980’s: Trends in Specialization, 74 Am. J. Pub. Health 698 (1984).
particularly if the physician has congenial personal relationships with patients, colleagues, and hospital administrators.31

Even if a malpractice claim is filed and succeeds, liability often imposes little personal burden on the doctor because almost all doctors are insured. Furthermore, insurers very seldom charge higher premiums to doctors who are repeatedly held liable for medical malpractice, although they may eventually restrict or drop coverage.32 Nor do the responsible state agencies do much to deter malpractice. In many states, malpractice claims are not even reported to the state agency that licenses physicians.33 In any case, those agencies lack the resources even to investigate the complaints they do receive.34 Moreover, neither the state licensing agencies nor the medical societies commonly provide strong grievance mechanisms as an alternative to malpractice claims. A protective medical ethic deters conscientious doctors from doing all they could to safeguard patients from colleagues whom they perceive to be practicing beyond their competence. Thus, society does not do all that reasonably could be done to limit the damage caused by chronically incompetent doctors. Rising malpractice premiums should inspire greater efforts, particularly on the part of physicians, to restrain doctors who practice substandard medicine.35

Further, patients often have difficulty obtaining even rudimentary information about their condition, the treatment options available to them, and the record and qualifications of those who care for them. Again, society does not do all that could be done to help patients make informed, intelligent decisions about medical care. For example, the federally supported Professional Review Organizations gather a tremendous amount of statistical data about doctors and hospitals for Medicare payment purposes. They then systematically deny patients access to that information.36

31. Doctors involved in some of the most egregious cases of long-term damage to patients are often described as warm and personable. See, e.g., How Well Does Medicine Police Itself?, 15 MED. WORLD NEWS 62 (1974); Rensberger, Death of Two Doctors Poses a Fitness Issue, N.Y. Times, Aug. 15, 1975, at A1, col. 5.


33. S. LAW & S. POLAN, supra note 1, at 257. In response to the 1975 crisis, a number of states required malpractice insurers to report such information to the licensing board.

34. 1984 data of the Federation of State Medical Boards shows that 16 states reported fewer than two disciplinary actions per 1,000 doctors. Twenty-one states showed between two and five disciplinary actions per 1,000 physicians. Only four states had more than nine disciplinary actions per 1,000 doctors. Brinkley, Rules on Disciplining Incompetent U.S. Doctors Are Marked by Confusion, N.Y. Times, Sept. 3, 1985, at A1, col. 1 [hereinafter cited as Brinkley, Rules]; see also Brinkley, U.S. Industry and Physicians Attack Medical Malpractice, N.Y. Times, Sept. 2, 1985, at A1, col. 1.


36. See, e.g., Public Citizen v. Department of HEW, 668 F.2d 537 (D.C. Cir. 1981) (denying consumers access to aggregate data prepared by the Professional Standards Review Organizations,
One malpractice doctrine—the law of informed consent—has somewhat encouraged doctors to communicate better with patients and help patients participate in treatment decisions. In the mid-1970's several malpractice decisions rejected the prior notions that doctors' duty to communicate was limited by customary professional practice and required that physicians provide any information that would affect a reasonable person's judgment about medical treatment—but even this apparent legal right to informed consent falls well short of requiring the respectful sharing that many patients want. Additionally, in response to the 1975 malpractice "crisis," many states reinstituted the traditional principle that doctors are only required to communicate as much information as other physicians in the community commonly provide.

Apart from changing malpractice standards, other cultural developments have also promoted communication and patient participation in medical decisionmaking. Feminist transformation of consciousness and more general self-health movements have generated millions of transactions of heightened consumer awareness, if not outright rebellion against traditional doctor-knows-best paternalism. These shifts in turn produce profound changes in doctor/patient relationships. Although broadened legal doctrines of informed consent have been modified to reaffirm doctors' traditional authority, changes in consciousness are not so easily rolled back.

Many physicians find it difficult to share uncertainty with patients. Much more could be done to improve communication, especially with regard to

the Medicare predecessor of today's PRO's). The American Medical Association has successfully blocked a bill to require the Secretary of Health and Human Services to study ways of making available information accessible to consumers. See Brinkley, Doctors' Lobby Facing Unsolicited 2d Opinions, N.Y. Times, July 17, 1984, at B6, col. 3.


38. See Lidz & Meisel, Informed Consent and the Structure of Medical Care, in 2 President's Comm. for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 317 (1982) [hereinafter cited as Making Health Care Decisions].


40. Feminists have produced self-help books that enable women to understand their own problems and empower them to deal with experts. For example, over two billion copies of Boston Women's Health Book Collective, Our Bodies Our Selves (3d ed. 1984) have been sold (and an additional 30,000 in Spanish). Beckwith, Boston Women's Health Book Collective: Women Empowering Women, 10 Women and Health 1, 1 (1985). Feminists have also analyzed the medical profession's treatment of women. See, e.g., S. Armes, Immaculate Deception: A New Look at Women and Childbirth in America (1975); B. Ehrenreich, For Her Own Good: 150 Years of the Experts' Advice to Women (1979).

41. See generally J. Katz, supra note 37 (especially ch. VII). The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research supported extensive surveys of patients and doctors and concluded, "Often patients were not told what treatment or procedure had been ordered for them, much less asked to decide whether or not to accept it. The purpose of the procedure was frequently obscure and the risks commonly went unmentioned. Presentation of alternatives was extraordinarily rare." 1 Making Health Care Decisions, supra note 38, at 47 (quoting Appelbaum & Roth, Treatment Refusal in Medical Hospitals, in 2 Making Health Care Decisions, supra note 38, at app. D, 411).
risks and financial options. While many doctors are obsessed with the dangers of malpractice liability, their beliefs and actions seem more based on apocryphal stories shared in the cafeteria or locker room than on an objective assessment of malpractice experience or the value of communication with patients. Few medical schools require that doctors study even basic principles of malpractice law in any systematic way.

Perhaps the most serious quality problems for patients arise because the people responsible for care communicate poorly with one another and fail to coordinate their work. The most extensive examination to date of the care provided in an American teaching hospital concluded: "The central purpose of the hospital—the care of patients, especially the personal aspects of that care—was not controlled directly or effectively by the hospital or by anyone." Although this classic study is now almost twenty years old, the problems of fragmentation have grown worse in recent years as medical practice has become more specialized.

All of these problems—the chronically incompetent doctor, the need for communication with patients and for coordination among care givers—demand collective response. Patients cannot address these issues effectively through atomized individual actions, whether in the form of malpractice suits or individual contracts with providers. Medical coworkers, rather than patients, are in the best position to identify the chronically incompetent physician and to take action to limit the damage done. Even if more information were available to individual patients, it would often be quite difficult for them to evaluate the quality of their medical care and to take steps to improve it, particularly when acute illness strikes suddenly. People who work in hospitals have the greatest capacity to improve patterns of coordination and communication. Patients, particularly organized patients working through community groups, senior citizen organizations, or groups formed to aid people suffering from particular conditions, could also play an important role in such collective efforts.

Malpractice law has had some limited success in encouraging such collective responses. For example, some courts have held hospitals liable when patients were injured by chronically incompetent physicians. These cases apply ordinary negligence principles to make hospitals responsible for minimal monitoring structures to protect patients against the foreseeable, preventable risks of injury by such doctors. Such cases have prompted

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42. Doctors rarely discuss the costs of treatment alternatives with their patients. Physicians often do not even know how various choices affect their patients financially, including nonphysician care and variations in insurance coverage. The President’s Commission found that 70% of the public believed that doctors should initiate discussion of the financial costs of treatment, but only 38% of the doctors reported that they do so. 1 MAKING HEALTH CARE DECISIONS, supra note 38, at 78-79.

43. 1 MAKING HEALTH CARE DECISIONS, supra note 38, at 141.


hospital accreditation organizations to incorporate similar principles into their standards.\(^4\)

Many barriers inhibit cooperative, collective efforts to promote communication and coordination of medical care and to limit the damage done by chronic incompetents. Doctors are divided by specialization and a tradition of departmental organization, particularly in hospitals. Doctors, nurses, and other health care workers, who must cooperate to care for patients, are divided by hierarchial organizational structures.\(^4\) It is difficult to develop relationships of mutual respect, sharing, and criticism between physicians who are generally white, male, and affluent, and the people, often nonwhite women, who provide most "hands-on" patient care in the hospital.

The law also discourages cooperative work. For example, basic legal and cultural concepts of work conceive of employment solely as an exchange in which the worker gets a salary in return for doing a job, the content of which is determined by the employer.\(^4\) Under this view, nurses, and even salaried doctors, have no legitimate interest in the content of the work that they do, but only in their wages and working conditions.\(^4\) Of course, salaried doctors and nurses do actually care about their patients and the content of their work, as do their corporate employers. Nonetheless, our dominant concepts of work subtly undermine cooperation. For a second example, the antitrust law condemns many forms of cooperative actions among active or potential competitors. The antitrust principles applicable in this area are sufficiently unsettled that doctors who take collective action to deal with a chronically

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\(^4\) Gonzales v. Nork, No. 228566 (Cal. App. Dep't Super. Ct., Co. of Sacramento) (reported in S. LAW & S. POLAN, supra note 1, at app. 241-46), rev'd on other grounds, 33 Cal. App. 3d 997, 109 Cal. Rptr. 428 (1973), aff'd, 29 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978), which influenced the change in Joint Commission on Accreditation of Hospitals (JCAH) policy, involved a doctor who performed dozens of unnecessary operations over several years. His incompetence left many patients dead or seriously injured. The JCAH sent a representative to testify that the hospital had complied with all quality of care standards and norms. The court found that the hospital at which he practiced had conformed to all accreditation, licensing, and customary standards for quality care. Yet, the hospital had no mechanism to collect and evaluate relevant information about the chronically incompetent, or even fraudulent, doctor. The court held this failure was unreasonable, saying, "This may amount to holding the whole 'health care industry' . . . negligent. And if it does, so be it. Precedent is not wanting for such a holding." Id. at app. 244. In response to this lower court decision, the JCAH amended its standards to require ongoing oversight of physicians. See S. LAW & S. POLAN, supra note 1, at 54-69.

\(^4\) See generally Levitt, Men and Women As Providers of Health Care, 11 SOC. SCI. & MED. 395 (1977).


\(^4\) For example, New York City bargains collectively with the interns and residents in its public hospitals. The doctors can negotiate about the standard hours of their own shift, but they cannot bargain about the staffing levels necessary to avoid the need for regular "emergency" 24-hour service. City of New York v. Committee of Interns and Residents, No. B-10-81 (Office of Collective Bargaining, City of New York 1981).
incompetent colleague have legitimate basis for concern about antitrust liability.

In brief, medical malpractice law is largely irrelevant to the problems confronting consumers of medical care. It has some modest beneficial effects in promoting emergency services to all, developing ways to monitor basic physician competence, and fostering communication with patients. Malpractice law may be a poor and inefficient means of promoting quality care and healing relationships, but its very inadequacy helps to maintain pressure to develop alternative social mechanisms to address these problems.
In the past ten years, state legislatures have adopted many measures to restrain malpractice premium rates. The most common reforms limit patient rights that had grown over time. Popular changes include limits on the compensation that seriously injured patients can receive, tighter restrictions on the time in which suit must be filed, limits on fees of patients' lawyers, restrictions on the proof patients can use to establish medical malpractice, and restrictions on the grounds upon which patients can establish fault. Other contributors to this symposium advocate two approaches, as yet little tried, that deserve special scrutiny: (1) private contracting about malpractice rules or process, and (2) federal legislation to induce prompt payment of victims' actual economic loss resulting from medical care, whether or not the patient can establish fault.

A. Contracting

Clark Havighurst and others urge that medical providers offer patients contracts creating a different set of rules to govern what happens when a patient is injured by medical treatment. Contracts could limit the circumstances in which the provider could be held liable for the patient's injury or could alter the process by which disputes were resolved.

Proposals to address the "crisis" through contracts altering the substantive standard of care misconceive the nature of medical malpractice. Malpractice claims often involve patients who have been seriously injured by actions that no reasonable practitioner would approve. Informed patients who are free to choose will not absolve doctors of responsibility for such conduct. Nor are contracts needed to protect providers from pressure to provide overelaborate or unnecessary care. Malpractice standards are not monolithic or rigid, but rather are tailored to circumstances. Informed consent law already allows doctors and patients to shape specific treatments to

52. R. Pierce, supra note 1, at 18-19. See generally Comment, An Analysis of State Legislative Responses to the Medical Malpractice Crisis, 1975 Duke L.J. 1417.


56. The black-letter law is that [i]n the absence of . . . [an unusual] express agreement, the doctor does not warrant or insure either a correct diagnosis or a successful course of treatment, and the doctor will not be liable for an honest mistake of judgment, where the proper course is open to reasonable doubt . . . . [T]he doctor must have and use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing . . . . Where there are different schools of medical thought, and alternative methods of acceptable treatment, it is held that the dispute cannot be settled by the law, and the doctor is entitled to be judged according to the tenets of the school the doctor professes to follow.
meet patients' preferences. Doctors can avoid inefficient, costly treatment by informing patients of the alternatives and allowing patient choice.

Proposals to encourage contracting—for specific services or for general standards—also misconceive the market for medical services. Patients have little capacity to make informed judgments about cost and quality trade-offs prior to illness or to shop at time of serious illness. Courts must carefully evaluate contracts offered by doctors, especially those prepared by professional associations for widespread use, lest they be merely adhesive agreements. The contracts should be judged reasonable only if they benefit both parties. As a practical matter, moreover, informed patients who are free to choose are unlikely to accept any significant reduction in the standards of care. Patients generally want high quality at reduced costs, not cut rates with fewer protections. The main competition to traditional medical practice comes from HMO's, which are at the high end of the quality spectrum in terms of comprehensive benefits and physician credentials. Few patients will sacrifice quality in exchange for the trivial cost savings that can accurately be attributed to the full cost of malpractice premiums.

W. Keeton, supra note 7, at 186-87.

Even as courts have abandoned the locality rule to hold physicians, particularly specialists, to national standards, they have held that the resources available in a particular community can be considered in determining what is reasonable: "It is permissible to consider the medical resources available to the physician as one circumstance in determining the skill and care required. Under [the national] standard, some allowance is made for the type of community in which the physician carries on his practice . . . ." Brune v. Belinkoff, 354 Mass. 102, 107, 235 N.E.2d 793, 798 (1968) (emphasis in original). Note that practice varies considerably between communities. See infra note 71 and accompanying text.

When there is more than one accepted method of treatment for the patient's disease or injury, a physician will not be liable for choosing any acceptable mode of treatment. See, e.g., Harwell v. Pitman, 428 So. 2d 1049, 1053 (La. Ct. App.), reh'g denied, 434 So. 2d 1092 (La. 1983) ("Whether or not to operate is a matter of clinical judgment for the treating surgeon after weighing all the facts before him."); Roberts v. Tardif, 417 A.2d 444, 448-49 (Me. 1980) ("A doctor is not liable for injury resulting when he pursues one of several acceptable courses of treatment meeting the applicable standard of care in the circumstance, even though an alternative procedure might also meet that standard that might have avoided the injury."); Kinning v. Nelson, 281 N.W.2d 849, 852 (Minn. 1979) (physician not responsible for an honest error in judgment in choosing between accepted methods of diagnosis); Furey v. Thomas Jefferson Univ. Hosp., 325 Pa. Super. 212, 224-26, 472 A.2d 1083, 1090 (1984) (medical authorities were so split on whether surgery or antibiotic therapy was proper that each side characterized the other's treatment as malpractice: in these circumstances, there is no liability, even if the alternative accepted treatment would have avoided the injury).

See supra notes 37-39 and accompanying text. The doctrine by implication also shows that malpractice law already allows flexible practice. If malpractice standards were monolithic, there would be no purpose in informing patients about alternative treatment options available to them.


58. See Ginsburg, Kahn, Thornhill & Gambardella, Contractual Revisions to Medical Malpractice Liability, LAW & CONTEMP. PROBS., Spring 1986, at 253, 255.

59. See generally Blendon & Altman, Public Attitudes About Health-Care Costs: A Lesson in National Schizophrenia, 311 NEW ENGL. J. MED. 613 (1984) (53% of Americans favor more social spending for health care, but at the same time, and not inconsistently, express concern about rising prices of health care and out-of-pocket costs).


62. See supra text accompanying notes 15-16.
Contracts that alter the forum in which malpractice claims are decided have greater potential to serve the interests of both physicians and patients. Adversary litigation is not always the best means of resolving human conflict. Today, many people find it cheaper, faster, and less traumatic to resolve disputes through arbitration rather than through more formal, adversary litigation.

The dilemma in substituting arbitration for litigation is that streamlining reforms may sacrifice some element of fairness to one party or the other. Those very characteristics which make the judicial process cumbersome and inefficient—the rights to discovery, cross examination, appeal, and principled decisionmaking—also help to assure fairness to each side. To achieve economies of cost, time, and formality, arbitration procedures must be different from judicial proceedings. Conversely, maintaining judicial-style protections in arbitration burdens it with similar delays and complexities. People's tastes for formalized adversary processes vary, however. Particularly for relatively small claims—for which courtroom resolution is not financially feasible—arbitration may provide a sensible means to resolve malpractice disputes, one that meets the needs of both doctors and patients.

Binding agreements to arbitrate should only be upheld if they are informed and voluntary. Under present law, doctors and patients can always agree to arbitrate after a dispute arises. When such agreements are signed prior to treatment, however, they are usually constructed by doctors and their lawyers and often offered to patients at the point they seek medical care. Doctors seem to find arbitration attractive because they believe it will reduce premiums, but it is difficult to devise a program that is both less costly and attractive to informed consumers. Arbitration cannot fairly be sold to patients by emphasizing only its positive aspects, without providing the balanced information necessary to allow informed choice. There is an inherent tension between providers' desire to lower premiums and patients' desire for an arbitration program that offers them real benefits.

B. Federally Mandated Solutions

The most radical proposals for addressing the malpractice crisis would impose uniform federal answers to the vexing questions that malpractice raises. The Moore-Gephardt bill is the best developed proposal. It would virtually require states to adopt one specific reform—to allow providers to foreclose patients' claims for pain and suffering by tendering payment for net

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64. See, e.g., Lash, Arbitration of Medical Malpractice Disputes as a Response to the Medical Malpractice Crisis: Panacea or Pandora's Box for Insurers?, 46 INS. COUNS. J. 102, 102 (1979); see also Note, Medical Malpractice Arbitration: A Patient's Perspective, 61 WASH. U.L.Q 123 (1983).
65. Note, supra note 64, at 144-50.
66. Id. at 155-56.
out-of-pocket economic loss within 180 days of an adverse medical "incident." 68

This interesting proposal raises many questions. When a patient is blinded or loses a limb because a doctor did something that no reasonable physician would have done, is it fair to say that the only legitimate losses the doctor should be required to pay are damages to the patient's established earning capacity and actual medical expenses (reduced by whatever amount the patient's other insurance policies will pay)? When a person is blinded or loses a limb, that injury is only "pain and suffering" in legal terms, except to the extent that the patient's earning capacity is diminished. Under the proposed law, people would be worth only what they can earn, or what they cost in terms of net medical expense. 69 Loss of the ability to enjoy life or rear children, freedom and joy of movement and perception, are compensable, if at all, as an item of "pain and suffering" that the bill would abolish.

What, if anything, would motivate a doctor or hospital to tender payment of actual economic loss in cases where lost earning capacity and medical expenses were large, and the "pain and suffering" damages were relatively small? 70 Would this proposal increase or reduce premium costs? Would it give doctors, or patients, a sense that the malpractice law operated in a fairer and more efficient way? The answers to all of these questions are unclear.

In this country there is tremendous local and regional variation in customary medical practice 71 as well as in the organization and financing of medical care. 72 Further, there is a deep tradition of state, rather than federal responsibility for the key issues of malpractice: development of common law principles of negligence; 73 licensing and regulation of hospitals, physicians, and other health care workers; 74 provision of medical care to the unin-

68. The bill would also preempt state malpractice laws in cases arising from services financed by Medicare, Medicaid, and other federally funded programs. States would have several years to establish an alternative medical liability system conforming to the bill's requirements to avoid this preemption.


70. Supporters argue that hospitals will tender payment to injured patients to avoid the cost of litigation. Since only a small portion of injured patients ever sue, however, and most of those never recover damages, it is unlikely that hospitals will be motivated to tender payments voluntarily.

71. See Wilensky, supra note 6. The seminal research was Wennberg & Gittelsohn, Small Area Variations in Health Care Delivery, 182 Science 102 (1973). Variations are particularly likely where there is professional uncertainty concerning diagnosis or treatment. See generally Wennberg, Barnes & Zubkoff, Professional Uncertainty and the Problem of Supplier-Induced Demand, 16 Soc. Sci. Med. 811 (1982).


73. "There is no federal general common law." Erie R.R. Co. v. Tompkins, 304 U.S. 64, 80 (1938).

74. See generally R. Derbyshire, supra note 34.
sured; and regulation of insurance. States accordingly have much greater experience than the federal government with these issues. Moreover, any "solution" will have different effects when introduced in divergent contexts.

The federal government could play an important role addressing some discrete, well-defined problems. For one example, state-by-state licensing of physicians sometimes allows a doctor disciplined in one state to move to a new area where it is difficult to find reliable information about his or her history. A federal clearinghouse of information about state disciplinary actions could ameliorate this problem. For a second example, state insurance regulators must rely on industry sources and self-reporting for information about liability insurers that operate in national markets. Further, determination of reasonable liability insurance rates and reserves is an exceedingly complex matter. A federal clearinghouse of information and ideas could provide valuable aid to state regulators.

More generally, however, for decades states have grappled with the problems surrounding malpractice and have tried divergent approaches. Justice Brandeis once observed, "It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory and try novel social and economic experiments without risk to the rest of the country." States are trying new approaches to malpractice, now more than ever. If they prove beneficial, other states can and will adopt them.

If in the experience of several states, some approaches clearly help, history suggests that other states will follow suit. If they do not, then Congress can impose changes on everyone. Today, however, there are few tested responses to the many problems of medical malpractice that are so plainly correct that they should be imposed by federal fiat. For Congress to dictate a federal no-fault system or any other untried proposal, without first testing it in even a single state, would be sheer hubris and folly.

75. See supra note 6 and accompanying text, on reimbursement for charity care. Public hospital services are also traditionally local and state responsibilities. See Brown, Public Hospitals on the Brink: Their Problems and Their Options, 7 J. Health Pol., Pol'y & L. 927, 929 (1983).

Under both Medicaid and the Hill-Burton construction program, see supra note 9, federal funds are provided to support state-administered programs. Medicare is the only significant financing program for health services to the public that is not shaped and administered by the states.

76. See generally S. Law, Blue Cross: What Went Wrong? (2d ed. 1976). For a discussion of divergent state laws mandating that insurance include particular forms of benefits and protections, see Metropolitan Life Ins. v. Massachusetts, —U.S.—, 105 S. Ct. 2380, 2383-84 (1985); see also McGuire & Montgomery, Mandated Mental Health Benefits in Private Health Insurance, 7 J. Health Pol., Pol'y & L. 380 (1982).

77. See Brinkley, Rules, supra note 34, at A1, col. 1.

78. S. Law & S. Polan, supra note 1, at 188-94 (need for federal action to supplement state insurance regulation).


80. See supra note 1.