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Contracting for No-fault Liability Insurance Covering Doctors and Hospitals

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CONTRACTING FOR NO-FAULT LIABILITY INSURANCE COVERING DOCTORS AND HOSPITALS*

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Chancellor Allen Wallis of the University of Rochester told the 1974 graduating class of his university's medical school:

> You who are receiving degrees in medicine . . . undoubtedly realize that throughout the country at this season thousands of others are receiving similar degrees in token of their preparation, like yours, for devoting the best parts of their lives to improving the health of their fellow men.
>
> Most of you are vaguely aware, also, that all over the country even larger numbers are emerging from professional schools of another sort, namely schools of law. Probably few of you realize, however, that before your careers have run their courses those lawyers may have more influence than you have over what you do, how you do it, and how you are rewarded.
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> You may find lawyers defining the range of treatments that you are allowed to use in specified circumstances. Lawyers may prescribe the criteria by which you are to choose among the allowable treatments. Lawyers may specify the priorities you must assign to different patients. Lawyers may require you to keep detailed records to establish at all times that you are in full compliance. Lawyers may punish you unless you can refute . . . their presumption that your failures result from not following all of their rules, regulations, and requirements. And lawyers may decide what incomes you deserve.
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> . . . .
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> The lawyers have you outnumbered, but on the average they are no match for you in intelligence, industry or dedication. Just don't let them ambush you while you are absorbed in caring for the sick.[1]

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1. Address by Allen Wallis, Commencement Exercises, School of Medicine and Dentistry, University of Rochester, May 26, 1974.

In the New York Times of February 25, 1975, Harry Schwartz, a member of the Times' Editorial Board in an article entitled "Will Medicine Be Strangled in the Law," commented on Chancellor Wallis' remarks:

> It is less than a year since Chancellor Wallis made that forecast, but the passage of time has only strengthened the probability that he is right . . . .

As a lawyer and a law professor, perhaps I am disqualified from contesting Chancellor Wallis' comparative appraisal of these two learned professions. But I admit we lawyers have hardly acquitted ourselves favorably in structuring the law of medical malpractice. We have created a legal-insurance mechanism for dealing with adverse results from medical care that is mired in delay, waste, cruelty, hardship and acrimony. What can be done about it? One possible approach might be a medical malpractice insurance system based on the concept of no-fault.

Consider, for instance, the recent trends in automobile liability. Under the old tort system, when Smith and Jones collide in their cars, Jones' insurance company pays Smith only if Smith proves Jones guilty, and himself guiltless, of faulty driving. As an "innocent" party claiming against a "wrongdoer," Smith, if successful in his claim, is compensated not only for his out-of-pocket loss (principally wage loss and medical expenses) but also for the pecuniary value of his pain and suffering. But ordinarily it is difficult to establish fault and to assign a pecuniary value to the amount of pain suffered. Furthermore, in the relatively rare case in which there is recovery, payment is usually long delayed. The pool of insurance money is largely consumed, not by payment for losses, but by administrative expenses — insurance overhead and expensive experts negotiating and fighting over who and what is to be paid.[2]

> More laws involving medicine have been passed this last decade than in all of the rest of the United States history before 1965. Through Medicare, Medicaid and other programs, the Government pays for an ever-increasing portion of all medical care in this country, and it is increasingly demanding the right to control what it is paying for. Simultaneously, however, Government is increasing the stringency of its controls over all branches of medical care, regardless of who pays for it.

N.Y. Times, Feb. 25, 1975, at 35, cols. 1–3.

2. For a discussion for the layman of both common law tort liability and no-fault auto insurance, see J. O'CONNELL, THE INJURY INDUSTRY: AND THE REMEDY OF NO-FAULT INSURANCE (1971) [hereinafter cited as O'CONNELL, THE INJURY INDUSTRY].

For auto accidents the solution that has been increasingly adopted across the country is no-fault insurance. Sixteen states have enacted reasonably effective no-fault laws to cover automobile accidents.[3] Under such laws, after the collision between Smith and Jones, each is paid by his own insurance company regardless of anyone's fault. Payment is made to each victim periodically as his out-of-pocket losses accrue, this being an easier and more practical system than one which pays a lump sum that includes the monetary value of pain. Since each victim is paid by his own insurance company, each is required to abandon his tort claim, based on fault, against the other party. With the resultant savings in legal fees — no-fault insurance has been called "no lawyer" insurance — and the abandonment of claims for non-pecuniary losses, more people receive payments from the insurance pool and the pool requires fewer dollars.

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3. The following is a list of such states and their no-fault statutes. The first sections cited are the provisions defining no-fault benefits, and the second sections cited are the provisions concerning the extent to which tort rights are abolished.

Colorado: COLO. REV. STAT. ANN. §§ 10-4-706, 10-4-705(2); § 10-4-714 (1973).

Connecticut: CONN. GEN. STAT. ANN. §§ 38-320, 38-319(b), 38-338, 38-321 (a); § 38-323(a) (Supp. 1976).

Florida: FLA. STAT. ANN. §§ 627.736, 627.733(4); § 627.737 (1972).

Georgia: GA. CODE ANN. §§ 56-3403b, 56-3408b, 56-3407b; § 56-3410b (Supp. 1976).

Hawaii: HAWAII REV. STAT. §§ 294-2(10), 294-3; §§ 294-6(a), 294-10(b) (Supp. 1974).

Kansas: KAN. STAT. ANN. §§ 40-3103, 40-3109(a)(4), 40-3116(c); § 40-3117 (Supp. 1974).

Kentucky: KY. REV. STAT. ANN. §§ 304.39-020(2), -020(5), -130, -160, -030; § 304.39-060 (Supp. 1974).

Massachusetts: MASS. GEN. LAWS ANN. ch. 90, §§ 34A, 34N; ch. 231, § 6D, ch. 90, § 34M (Supp. 1975).

Michigan: MICH. COMP. LAWS ANN. §§ 500.3107, 500.3108, 500.3113, 500.3115, 500.3171, 500.3172; § 500.3135 (Supp. 1975-1976).

Minnesota: MINN. STAT. ANN. §§ 65B.44, 65B.63, 65B.64, 65B.46; § 65B.51 (Supp. 1975-1976).

Nevada: NEV. REV. STAT. §§ 698.070, 698.230, 698.380; 698.280(h) (1973).

New Jersey: N.J. REV. STAT. § 39:6A-4; §§ 39:6A-8, 39:6A-12 (1973).

New York: N.Y. INS. LAW §§ 671.1, 672.1; §§ 673(1), 671(2)(b) (McKinney Supp. 1975-1976).

North Dakota: N.D. CENT. CODE § 26-41-03(2); §§ 26-41-03(18), 26-41-12 (Supp. 1975).

Pennsylvania: PA. STAT. ANN. tit. 40, §§ 1009.103, .108, .201, .202; tit. 40, § 1009.301 (Supp. 1976-1977).

Utah: UTAH CODE ANN. §§ 31-41-6, 31-41-7; § 31-41-9(1) (1974).

For a discussion of the distinction between a genuine no-fault law and a "spurious" or so-called add-on law, see N.Y. Times, Nov. 27, 1972, at 55, cols. 1-2. Under a genuine no-fault law, no-fault benefits are accompanied to some extent by

Under the old tort system, those who suffer losses from events other than auto accidents face an even bleaker prospect. Prior to reform, many people injured in traffic accidents were at least paid a large total sum. But for other types of accidents the prospect of being paid and the delays in receiving any payment are much more discouraging. The medical malpractice situation is particularly bad. Here the issues are extremely complex, with an even greater portion of the insurance premium dollar being consumed by insurance overhead and legal fees. Although the insurance premiums of doctors in some specialties currently reach $20,000 or more, the victims of medical misadventure are not likely to see any of that money. According to a United States Senate study, "The lion's share of the total cost to the insurance companies of malpractice suits and claims goes to the legal community."[4] One expert estimates that "[only] between 16 and 17 cents of the premium dollar ends up as benefits to victims of medical injuries,"[5] in contrast to 93 cents for Blue Cross, 83 cents for much health insurance, and 44 cents for the deservedly maligned tort liability auto insurance system.[6]

Some visionaries perceive national health insurance as a solution to the problems plaguing the compensation of medical malpractice victims. But if and when national health insurance is enacted, it will cover only a relatively small portion of the personal injury losses suffered by accident victims. In the case of medical malpractice claims, wage losses make up 74 percent of total injury losses while only 24 percent are medical losses (with two percent for "other expenses").[7]

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an abolition of the right to sue based on who is at fault in causing the accident. Under an "add-on" no-fault law no-fault benefits are provided with no abolition of the right to sue for pain and suffering based on fault.

4. SUBCOM. ON EXECUTIVE REORGANIZATION OF THE SENATE COMM. ON GOVERNMENT OPERATIONS, MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN, 91st Cong., 1st Sess., 2 (Comm. Print 1969).

5. CENTER FOR THE STUDY OF DEMOCRATIC INSTITUTIONS, MEDICAL MALPRACTICE: A DISCUSSION OF ALTERNATIVE COMPENSATION AND QUALITY CONTROL SYSTEMS, A CENTER OCCASIONAL PAPER 5, (D. McDonald, ed., 1971). *See also* O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries,* 60 MINN. L. REV. 501, 506–09 (1976) [hereinafter cited as O'Connell, *An Alternative*].

6. Warne, *Let's Hear from the Insurance Consumer,* 36 INS. COUNS. J. 494, 496 (1969). For a general discussion of the inadequacies of the common law medical malpractice liability system, see O'CONNELL, *supra* note 5, at 501–12.

7. INSURANCE SERVICES OFFICE, REPORT TO THE ALL-INDUSTRY COMMITTEE, SPECIAL MALPRACTICE REVIEW: 1974 CLOSED-CLAIMS SURVEY, PRELIMINARY ANALYSIS OF SURVEY RESULTS 35 (Dec. 1, 1975). These figures closely replicate those for serious automobile accidents for which 74 percent of injury losses is for wage loss, 22 percent for medical losses, and four percent for other expenses. U.S. DEP'T OF TRANSPORTATION, MOTOR VEHICLE CRASH LOSSES AND THEIR COMPENSATION IN THE UNITED

No one seriously suggests that social security will be extended in the foreseeable future to cover middle class wage loss. Thus, horrendous losses from personal injuries — uncompensated by any social insurance scheme — will unquestionably continue for the indefinite future.[8]

No-fault auto insurance has been much easier to implement than will be no-fault insurance for many other kinds of accidents. In the case of automobile insurance, there already existed a widespread system of fault liability insurance, mutually applicable to both parties involved in the accident, that could be readily transferred into a no-fault loss insurance system. There was also little fear that the transformation would impose new and frightening burdens on either party. Furthermore, the activity of driving an automobile involved a sufficiently known danger; thus a no-fault statute could manageably and predictably define who was to be required to pay for what loss. These factors do not apply to many of the other kinds of accidents. When an individual goes to a doctor, the doctor may have liability insurance that may pay the patient in the event of a malpractice suit, but the patient has no similar liability insurance to pay the doctor. Nor can the physician readily agree to substitute no-fault insurance, through which payments are made regardless of how any adverse result were caused, for his fault liability insurance. Surely a doctor who treats a patient with a heart condition would resist a requirement that he cover any further medical expense and wage loss whenever such a patient takes a turn for the worse.[9]

But there is a way to apply no-fault insurance to many types of accidents. Businesses or professionals could select all, or just certain, risks of personal injury that their activities typically create and agree to pay for out-of-pocket losses when injury results from those risks.[10] The incentive to elect no-fault insurance would be that to the extent — and only to the extent — that a guarantee of no-fault insurance payment exists at the time of the accident, no claim based on fault (or,

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STATES: A REPORT TO THE CONGRESS AND THE PRESIDENT 6 (March 1971). (These figures were computed using the losses listed in Table 2 for Medical Expenses, Wage Loss, and Other Expenses.)

8. J. O'CONNELL, ENDING INSULT TO INJURY: NO-FAULT INSURANCE FOR PRODUCTS AND SERVICES 75–79 (1975) [hereinafter cited as O'CONNELL, ENDING INSULT TO INJURY].

9. *Id.* at 72–73.

10. For a draft statute implementing this proposal, see O'Connell, *An Elective No-Fault Liability Statute*, 1975 INS. L.J. 261 [hereinafter cited as O'Connell, *No-Fault Statute*]. Although the statute is drafted for enactment by a state legislature, the bill could be adapted easily to enactment by Congress. For a discussion of federal jurisdiction over such matters, see O'CONNELL, ENDING INSULT TO INJURY, *supra* note 8, at 161–62.

in the case of products liability, a defect) would be allowed. As a result, the elector would be allowed to avoid paying for (1) lawyers on both sides arguing over the question of fault or product defect, (2) a victim's pain and suffering, and (3) losses already paid by some other source such as Blue Cross. In other words, the payor would stand ready to pay more victims but to pay each victim much less. Under such a scheme, the stigma of liability would be substantially, and often totally, avoided. Payment would be made on the morally neutral ground that the accident was just that — an "accident" — rather than being made on the basis of defective manufacture or professional malpractice. Two examples will perhaps illustrate how elective no-fault liability would work for health care providers and allied endeavors.

A pharmaceutical house, knowing of the possibility of side effects from a new drug, could agree to pay the cost of those side effects in the few persons affected whenever they occur. This automatic payment would avoid lengthy, bitter, and expensive litigation over such things as the adequacy of warnings and the nature of the idiosyncratic condition of the person suffering loss.[11]

A doctor, realizing the inevitable risks of certain neurological complications from spinal anesthesia, could agree to pay automatically any further medical expenses or wage loss stemming from those complications when they occur. This method would obviate the lengthy, bitter, and expensive litigation over the extent to which the complications were caused by medical error, or the patient's preexisting condition.[12]

In each case the prior agreement to make such no-fault payments would supplant any claim based on fault, just as happens under no-fault

11. Elective no-fault insurance, as the above example indicates, might apply not only to medical services but to products of all kinds. It could also apply to such matters as owners' and occupiers' liability. *See* O'CONNELL, ENDING INSULT TO INJURY, *supra* note 8, chs. 2 and 4.

12. In a 1974 article, Havighurst and Tancredi listed some compensable events, compiled in a meeting with a group of orthopedists, that arise from adverse consequences of surgical treatment. They included, for example, postoperative infections, thrombophlebitis and embolism, catheter infections, allergic and toxic reactions to antibiotic and other drugs, blood transfusion reactions, foreign bodies, growth deformity secondary to bone injury, Volkmann's contracture and other consequences from casts, and failure of healing of fractures (including malunion, nonunion and delayed union). Havighurst and Tancredi, *Medical Adversity Insurance — A No-Fault Approach to Medical Malpractice and Quality Assurance,* 1974 INS. L.J. 69, 76, originally appearing in the Spring 1973 issue of THE MILBANK MEMORIAL FUND QUARTERLY. For a more comprehensive list of compensable events and discussion thereof, see Havighurst, *"Medical Adversity Insurance" — Has Its Time Come?,* 1975 DUKE L.J. 1233, 1256–63, *quoted in* O'Connell, *An Alternative, supra* note 5, at 525–28.

auto insurance. Furthermore, businesses or professionals could be allowed to limit the amount of no-fault benefits for which they are liable to multiples of, for example, $10,000;[13] enabling legislation would grant a corresponding exemption from tort suits. The exemption would equal the no-fault benefits, but would be applied separately against damages for economic loss and against damages for pain and suffering. For example, with no-fault benefits of $20,000, there would be an exemption of $20,000 against any finding of out-of-pocket loss under a tort claim and a further exemption of $20,000 against damages for pain and suffering.[14] Certainly astute businesses or professionals, concerned about skyrocketing liability premiums under present law, would be inclined to study the costs of elective no-fault liability in comparison to regular tort liability. For at least some

13. Concerning the fear of the costs of unlimited benefits, see O'CONNELL, ENDING INSULT TO INJURY, *supra* note 8, at 73–75, 79–80. Some studies have indicated that at least in the matter of gross costs, the cost of paying for unlimited *medical* expenses (as opposed to wage losses, as well) under an insurance mechanism need not be too forbidding. (On the unmanageability of wage losses, see note 7 and accompanying text *supra*.) According to a statement submitted to the U.S. House Subcommittee on Consumer Protection and Finance by the National Association of Casualty and Surety agents, "Regarding the cost to the consumer of unlimited medical benefits coverage, a 1974 report on the subject pointed out that the frequency of large medical hospital and rehabilitation expenses in auto accident cases is so low that unlimited medical benefits can be provided for 0.1% more than the premium for $50,000 of such coverage." NATIONAL UNDERWRITER (Property & Cas. ed.) Sept. 5, 1975, at 13. On the other hand underestimations of the costs of unlimited insurance under Medicare and Medicaid have made many wary of the unpredictable costs of new and explosively more inclusive health coverage. O'CONNELL, ENDING INSULT TO INJURY, *supra* note 8, at 74. Even if the costs are manageable, some smaller insurers insist that they would be vulnerable to being wiped out by several large claims. This is disputed in the above-mentioned report to the U.S. House Subcommittee:

> Further, there is no evidence to our knowledge to show that the requirement of unlimited medical, hospital and rehabilitation benefits will so increase reinsurance costs for smaller insurance companies that it may put some of them out of business. This has certainly not been the case with workers' compensation laws in the 47 states which place no limit on workmen's compensation medical benefits.

NATIONAL UNDERWRITER (Property & Cas. ed.) Sept. 5, 1975, at 13.

14. The reason for a separate tort exemption for pain and suffering, in addition to one for out-of-pocket loss, is discussed in R. KEETON & J. O'CONNELL, BASIC PROTECTION FOR THE TRAFFIC VICTIM 442 (1965). Unless there were a tort exemption for pain and suffering, an accident victim would still be able profitably to assert a tort claim. Although the claim for out-of-pocket loss would be reduced by the out-of-pocket exemption, the fact that pain and suffering is often reckoned as a multiple of economic loss means that the victim would still benefit from hiring a lawyer, paid on a contingent fee, to assert his tort claim for pain and suffering. This would reduce any advantage of the tort exemption.

Why, though, is this separate tort exemption defined in terms of a common law finding of pain and suffering rather than under some of the more objective tests such

categories of injuries, they might find it advantageous to pay on a no-fault basis only for out-of-pocket loss. The limitation of liability to pecuniary losses that exceed amounts already paid from other sources[15] would eliminate payments in most cases of lesser injuries and would substantially reduce payments in cases of greater injuries. In addition, as suggested earlier, all parties would save the huge amounts now spent on attorneys and expert witnesses in attempting to resolve the intractable question of whether fault or a product defect caused the accident.

The normal tort system is so wasteful that the availability of such a no-fault option would encourage many businesses and professionals at least to develop data and to evaluate which system of compensation would better suit their needs. Even for those whose costs would not be significantly lower, freedom from the animosity of the tort liability system would make elective no-fault insurance an attractive alternative. One senses that many health care providers — even surgeons — can accept their presently high malpractice premiums. But the uncertainty over whether the frequency and average cost of claims will become stable, coupled with the *indignity* of the present accusatory system, makes them frantic. No-fault insurance provides more certain criteria for determining both claims frequency and claims cost by substituting objective data for actuarial predictions of future jury reactions and by eliminating the unpredictable "pain and suffering" factor. No-fault also eliminates the stigma in being responsible for losses. But if the costs of applying elective no-fault to certain risks and procedures are too large, then health care providers can simply refuse to elect coverage for those risks. *Forbes* magazine in an article on elective no-fault insurance stated: "It can be applied where it works and ignored where it doesn't. An accurate check on costs and benefits can be kept at each step of the way."[16] The experience under Michigan's no-fault auto insurance law illustrates the range of savings available under no-fault insurance as opposed to traditional tort liability. Coverage under no-fault provides unlimited medical benefits, $36,000 of wage loss, and residual tort liability of $20,000 (beyond no-fault's tort exemption) in return for premiums that are no higher

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as the amount of medical bills or the number of days of disability? The answer is that unlike such a more objective test, a pain and suffering yardstick does not present a precise target at which a plaintiff's lawyer and his client can aim, confident that if only the client amasses a few more medical bills or stays out of work a little longer, the tort threshold will be surpassed. *See* O'Connell, *No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others,* 1975 INS. L.J. 531, 535 n.8.

15. *See* text following note 10 *supra.*

16. FORBES, Sept. 1, 1975, at 64.

(and often significantly less) than what formerly provided a total of $20,000 tort liability coverage![17]

Many people will ask why a doctor who may be guilty of gross negligence in injuring his patients should escape with paying his patient little or no damages. Such an outcome might occur under elective no-fault liability when a patient's out-of-pocket losses are largely or completely compensated by his own collateral sources. The answer is that tort liability should not be the principal device for punishing egregiously negligent conduct. It is grossly inefficient for such purposes because it requires the expenditure of huge sums of money, yet "punishes" relatively few wrongful acts. And finally, even when those few wrongful acts lead to civil sanctions, the perpetrators are not punished, but serve only as a conduit to a large insurance pool made up of contributions from all health care providers and, ultimately, their patients. (Note that the elective no-fault liability act does preserve common law tort liability for intentional wrongs in order to cover the relatively few cases of criminal neglect.)[18]

The fear that a change to no-fault insurance for injuries arising from medical treatment will lessen deterrence of unsafe medical procedures and conduct is also groundless. That has not been the experience with the system of no-fault workers' compensation.[19] Furthermore the present system itself is not very effective as a deterrent.[20] There are

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17. On the relative success of auto no-fault in providing more certain and expeditious payment to traffic victims, see Bovbjerg, *The Impact of No-Fault Auto Insurance on Massachusetts Courts,* 11 NEW ENGLAND L. REV. 325 (1976); Clark & Waterson, *"No-Fault" in Delaware,* 6 RUTGERS-CAMDEN L.J. 225 (1974); Little, *No-Fault Auto Reparation in Florida: An Empirical Examination of Some of Its effects,* 9 MICH. J.L. REFORM 1 (1975); O'Connell, *Operation of No-Fault Auto Laws: A Survey of the Surveys,* 56 NEB. L. REV. 23 (1977); Widiss, Massachusetts *No-Fault Automobile Insurance: Its Impact on the Legal Profession,* 56 BOSTON U.L. REV. 323 (1976); Widiss, *Accident Victims Under No-Fault Automobile Insurance: A Massachusetts Survey,* 61 IOWA L. REV. 1 (1975). *See also* HENDERSON, *Report on the Status and Effect of No-Fault Insurance Schemes for Automobile Accidents in the United States* (submitted to the Special Committee on the Uniform Motor Vehicle Accident Reparations Act of the National Conference of Commissioners on Uniform State Laws, June 26, 1976).

In sum, the general consensus of the literature is that no-fault has been largely successful, though hampered by such factors as inflation and tort thresholds that eliminate too few claims based on fault. *See* Wall Street J., Jan. 21, 1976, at 1, col. 6.

18. *See* O'Connell, *No-Fault Statute, supra* note 10, at 280 n.69.

19. *See* 2 F. HARPER & F. JAMES, TORTS § 12.4 at 757 (1956).

20. As to lack of deterrence achieved by the present common law medical malpractice system, see U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 14–18 (1973) [hereinafter cited as HEW REPORT]. For a summary see O'Connell, ENDING INSULT TO INJURY, *supra* note 8, at 42–44.

indications that malpractice claims work a greater hardship against the safest doctors and hospitals, which employ the most innovative and advanced procedures, rather than on the doctors and hospitals that are the least safe.[21] In addition it appears that malpractice cases figure very little in accreditation or disciplinary proceedings for and by doctors and hospitals.[22] Such litigation is rightly viewed as often being a private fight carried on in a circus atmosphere that is utterly unreliable for purposes of professional review and discipline.

There is precedent for such an elective approach to no-fault accident law in the workers' compensation laws enacted early in this century. These statutes were passed in order to obviate certain constitutional objections, no longer seen as valid, to *compulsory* workers' compensation laws.[23] They allowed employers to elect coverage under no-fault workers' compensation for employee injuries, thereby avoiding traditional common law liability based on fault. It is not without significance that no-fault workers' compensation laws reflected the enlightened and compassionate concern of many employers for employee injuries.[24] Elective no-fault liability insurance for medical services would thus allow health care providers to extend to their patients the much more humane system of no-fault payment that has long been applicable to industrial and commercial employees.

My initial proposal for elective no-fault insurance envisioned some form of enabling legislation similar to that adopted for elective workers' compensation statutes.[25] But I now propose, pending enactment of legislation authorizing elective no-fault liability, that health

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21. *See* STATE OF NEW YORK, SPECIAL ADVISORY PANEL ON MEDICAL MALPRACTICE, REPORT 169 (1976) [hereinafter cited as REPORT].

22. *Cf. How State Medical Society Executives Size Up Professional Liability,* 164 J.A.M.A. 580–82 (1957).

23. For general discussion of the history of workmen's compensation and of the early constitutional objections to both elective and compulsory forms of workmen's compensation statutes, see 1 W. SCHNEIDER, WORKMEN'S COMPENSATION §§ 9–76 (1941); H. BRADBURY, WORKMEN'S COMPENSATION LAW 53–55 (1917). The Supreme Court settled most of these constitutional questions in a series of decisions handed down in 1917. *See* New York Central R.R. v. White, 243 U.S. 188 (1917) (holding that New York's compulsory workmen's compensation statute did not violate the due process provision of the fourteenth amendment in imposing liability on an employer without his consent and without his fault); *accord,* Mountain Timber Co. v. Washington, 243 U.S. 219 (1917); *see also* Hawkins v. Bleakley, 243 U.S. 210 (1917) (holding that Iowa's elective workmen's compensation statute did not violate the equal protection clause of the fourteenth amendment); O'CONNELL, ENDING INSULT TO INJURY, *supra* note 8, at 101.

24. NATIONAL COMMISSION ON STATE WORKMEN'S COMPENSATION LAWS, COMPENDIUM ON WORKMEN'S COMPENSATION 16–17 (1973).

25. *See* note 10 *supra.*

care providers go ahead and accomplish the same thing by contract without legislation.

Doctors are already required to impart extensive information to patients under the doctrine of informed consent. A 1973 report of the HEW Secretary's Commission on medical malpractice describes this doctrine as follows:

> Where a patient gives his express consent to a surgical procedure or particular course of therapy, the physician may nevertheless be held liable if the patient can show that he was not adequately informed of the risks and consequences of the operative procedure or course of therapy. In short, the law requires that the consent be an effective or "informed" one so that the patient can make an intelligent choice from among the various courses of possible treatment or to refuse treatment altogether.[26]

In view of the already extensive information required to be imparted by doctors to patients concerning proposed treatment, why could not doctors, even without the benefit of enabling legislation, offer to patients, before any treatment, the choice of being covered for certain or all adverse results by no-fault insurance? This compensation scheme would produce the same limitation on common law liability envisaged under an elective no-fault statute[27] as well as the elimination of claims based on negligence for designated "accidents" that may occur with actuarial predictability during a stay in a hospital. In many hospitals patients already sign an agreement, as part of admission, that requires any future dispute concerning injuries to be arbitrated.[28] Such an agreement could also provide for exclusive no-fault payment for designated injuries. But lacking a statute, as happens with arbitration agreements, the doctor or hospital should not refuse, nor be permitted to refuse, treatment if the patient declines the no-fault method of compensation. Such agreements should not be used at all for emergency treatments.[29]

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26. HEW REPORT, *supra* note 20, at 29.

27. *See* notes 10–12 and accompanying text *supra*.

28. *See* REPORT, *supra* note 21, at 45–47.

29. As one means of guaranteeing patient choice, an insurance commissioner — whose permission to offer elective no-fault liability contracts is arguably required (R. KEETON, INSURANCE LAW: BASIC TEXT 71–72, 543–45, 550–53 (1971); O'CONNELL, ENDING INSULT TO INJURY, *supra* note 8, at 155–56) — could require patient choice as a prerequisite to approval. Even without such safeguards, if a patient elects the proffered no-fault liability coverage under threat or refusal of treatment by a health care provider, a court might well void the election at the patient's option and thereby allow the patient's common law tort claim. If a doctor were simply to refuse to treat a person unless an elective no-fault agreement were signed, a person not receiving treatment might well have a cause of action against the doctor for such

Such no-fault agreements would probably be attacked in the courts as unconscionable.[30] An example of the way courts apply this doctrine of unconscionability is the 1963 California Supreme Court case of *Tunkl v. Regents of University of California.*[31] The UCLA Medical Center required as a condition of admission to its hospital that patients sign a release absolving the hospital "from any and all liability for the negligent or wrongful acts or omissions of its employees, if the hospital has used due care in selecting its employees."[32] This release contravened, of course, the normal common law rule of respondeat superior, which makes an employer liable for the negligent acts of its employees regardless of its care in selecting them. A patient sued, asserting the hospital's normal common law liability despite the agreement. The Supreme Court of California agreed and refused to enforce the agreement because it was basically unfair.

As this case illustrates, judicial abhorrence of disclaimers of common law personal injury liability is likely to be encountered where disclaimers or limitations attempt to absolve the defendant totally or partially from normal liability for personal injuries. But such condemnations should not be applied to obstruct those modifications in liability that would net patients as a group more money more expeditiously than the common law tort system by eliminating, among other things, cumbersome criteria for payment.[33]

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refusal to treat — especially (but perhaps not necessarily only) when he or she had previously been a patient of the doctor. McCoid, *The Care Required of Medical Practitioners,* 12 VAND. L. REV. 549, 553–57 (1959).

30. For an extended discussion of the issue of elective no-fault contracts as "unconscionable," and a defense of them as not being so, see O'Connell, *Elective No-Fault Liability by Contract With or Without an Enabling Statute,* 1975 U. ILL. L.F. 59; O'Connell, *No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others,* 1975 INS. L.J. 531; O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries,* 60 MINN. L. REV. 501 (1976).

31. 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963).

32. *Id.* at 94, 383 P.2d at 442, 32 Cal. Rptr. at 34.

That an exculpatory agreement allowing a more favorable bargain between health care provider and patient might well be upheld is indicated by the court's emphasis that the agreement in *Tunkl* "makes no provision whereby a purchaser may pay additional reasonable fees and obtain protection against negligence." *Id.* at 100–01, 383 P.2d at 446, 32 Cal. Rptr. at 38.

33. Professor Marc Franklin has summarized the objections of the courts that lead them to strike down as unconscionable disclaimers of liability for personal injury:

> In personal injury situations, apart from a vague uneasiness about bargaining inequality and the evidentiary problem of notice to the buyer, there are other tangible concerns. These include the danger of a decrease in care by the seller [of goods or services]; the buyer's inability to discover the nature and quantum of the risk; the seller's ability to acquire insurance more efficiently; the buyer's

In sum, contracts that incorporate elective no-fault liability for personal injury are far from being unconscionable. They would, where feasible, bestow on victims of injuries incurred in the course of medical treatment or product use the same benefits and bargains of compensation that have long been recognized in the area of industrial accidents (and, more recently automobile accidents) to be fairer than common law remedies. And so, businesses or health care providers need not wait for an enabling statute in order to institute elective no-fault liability insurance. They should proceed to assume such liability now — by contract, with or without a statute.

There is one final caution. Given the timidity of the insurance industry's response to no-fault auto insurance (it took several generations for even a portion of the industry to see the obvious merit of the idea, and many in the industry are still either indifferent or hostile to the notion), the impetus for reform of the tort system as it applies to health care providers will have to come from them, as insureds, rather than from their insurers. As suggested earlier,[34] the example of the history of workers' compensation is a reminder: it was enlightened employer-insureds who led the way in achieving that early and lasting reform against the opposition of insurers, lawyers, and many in industry. Elective no-fault liability for product and service-related injuries will probably have to follow the same pattern.

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inability to protect himself to the same extent the law would protect him; and the likelihood that the buyer's misfortune will have serious repercussions on his family and ultimately on the community. I consider this a massive indictment of the disclaimer device.

Franklin, *When Worlds Collide: Liability Theories and Disclaimers in Defective-Product Cases,* 18 STAN. L. REV. 974, 1019 (1973).

But apart from unequal bargaining power, which alone is no basis for striking down a fair deal [*Id.* at 996; UNIFORM COMMERCIAL CODE § 2-320, Comment 1; Leff, *Unconscionability and the Code — The Emperor's New Clause,* 115 U. PA. L. REV. 485, 508 (1976)], none of these objections would seem to apply to elective no-fault liability. Notice can certainly be supplied to the patient prior to surgery or other medical procedures; no-fault liability actually provides a patient with better protection than he has under the capricious common law tort system; elective no-fault, in providing prompt and effective reparation eases the burdens on a victim, his family and the community; elective no-fault maintains the economic advantages of allocating the burden of obtaining insurance on the health care providers; in imposing absolute liability on the health care provider, elective no-fault should not result in any decrease in care by the provider. *See* note 19 and accompanying text *supra.*

34. *See* note 23 and accompanying text *supra.*