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THE CASE FOR NO-FAULT MEDICAL LIABILITY

PAUL C. WEILER*

INTRODUCTION

For the last two decades, medical malpractice litigation has been the focal point of the tort reform debate. Fueled by the first malpractice insurance "crisis" of the mid-1970s, a number of state legislatures adopted a variety of constraints on the common-law tort system for negligent medical injuries: offsets of collateral source payments,\(^2\) caps on pain and suffering damages\(^3\) and contingent legal fees,\(^4\) panels to screen the merits of claims before suit or trial,\(^5\) and so on. After a lull in the late 1970s and early 1980s, doctors were again caught up in a broader spiral of tort liability claims and insurance premiums in the mid-1980s. Legislatures responded with


1. This Article restates an argument I first developed in my book, PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (1991) [hereinafter WEILER I]. That book, in turn, drew upon two projects that I had been working on for the previous five years. One project, the Harvard Medical Practice Study in New York, was an empirical investigation of all aspects of medical injury and malpractice litigation, a study for which I was the principal legal investigator. The nature and results of the Harvard Study are detailed in PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE (1993) [hereinafter WEILER II]. In addition to other sources of empirical data cited specifically in this Article, therefore, WEILER II should be consulted generally for the key findings of the Harvard Study. The second project was the American Law Institute's comprehensive study of tort litigation and tort reform, including medical malpractice law, for which I served as Chief Reporter (and on which three of my colleagues in this Symposium—Jeffrey O'Connell, Robert Rabin, and Gary Schwartz—played major roles). The analysis and proposals of the ALI Study are contained in a two-volume report to the ALI: See AMERICAN LAW INSTITUTE, REPORTERS' STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY (1991) [hereinafter ALI REPORT]. These three volumes contain detailed documentation of, and references for, the bulk of the claims I am making here. Needless to say, I am greatly indebted to my partners in both those projects for their help in shaping my thoughts on this topic.


3. See, e.g., CAL. CIV. CODE § 3333.2 (West Supp. 1990); S.D. CODIFIED LAWS ANN. § 21-3-11 (1987); see also WEILER I, supra note 1, at 55-56.

4. See, e.g., DEL. CODE ANN. tit. 18, § 6865 (1990); CAL. BUS. & PROF. CODE § 6146 (West 1990); see also WEILER I, supra note 1, at 62-64.

5. See MD. CODE ANN., CTS. & JUD. PROC. §§ 3-2A-01 to -09 (1989) (creating an arbitration procedure for the initial determination of health care malpractice claims); WEILER I, supra note 1, at 29 & nn. 41-42.
more of the same,\textsuperscript{6} this time often extending the benefit of such legal protections against litigation to other defendants such as product manufacturers. That second burst of state legislative activity was again followed by a plateauing of malpractice claims and premiums. In the early 1990s, however, the federal government, particularly the Bush administration and its supporters in Congress, took up the cause of medical malpractice reform, rather than focusing simply on products liability. Their stated mission was somewhat different—relieving the nation’s broader crisis of rising health care costs and premiums—but the means were the same: a host of constraints upon patients seeking to sue health care providers.\textsuperscript{7}

From a practical empirical perspective, this legislative preoccupation with medical malpractice seems curious. The total cost of malpractice insurance—the most generous estimate is about \$9 billion—is only a tiny fraction of the nation’s \$130 billion in tort liability expenditures (of which \$90 billion goes toward motor vehicle accident insurance alone), and of its \$190 billion total liability bill (when one adds the \$60 billion of annual workers’ compensation costs).\textsuperscript{8} And the idea that containing medical liability costs will make any appreciable dent in health care costs is absurd. A mere two months’ growth in our monstrous \$840 billion health care bill\textsuperscript{9} would exceed the savings made from total elimination of malpractice premiums.\textsuperscript{10}


\textsuperscript{7.} See e.g., William Winkenwerder, Health-Care Plans: Which One Will Work?, ATLANTA CONST., Oct. 25, 1992, at H4 (characterizing then-President Bush’s plan as an “aggressive” one, requiring caps on punitive damages and reducing incentives for trial lawyers to sue).

\textsuperscript{8.} For a compilation of tort-liability expenditures in 1991, see ROBERT W. STURGIS, TORT COST TRENDS: AN INTERNATIONAL PERSPECTIVE 1 (Tillinghast 1992). See also John F. Burton, Jr., Workers’ Compensation Costs in 1991, in 5 JOHN BURTON’S WORKERS’ COMPENSATION MONITOR 1 (1992) (documenting workers’ compensation expenditures in 1991). A recent study performed by the National Insurance Consumer organization reported that doctors and hospitals paid almost \$4.9 billion in insurance premiums in 1991, compared with \$2.7 billion in 1985. See Jonathan M. Moses, Malpractice Claims, WALL. ST. J., Mar. 25, 1993, at B5. To these premiums paid by providers one should add another \$2 to \$3 billion for the cost of self-insurance by larger health care organizations.

\textsuperscript{9.} See Moses, supra note 8, at B5.

\textsuperscript{10.} I realize that there is an additional cost of liability to the health care system—the expense of “defensive” medicine. The best estimate is that these additional costs of litigation are roughly twice the cost of direct insurance, bringing the total liability burden to about \$27 billion; that is still only 3\% or so of our total health care costs. For reasons I will detail later, it is fallacious to assume that, on balance, defensive medicine adds to, rather than reduces, the total health care bill. See infra text following note 101.
There is, of course, a political explanation for this legislative preoccupation. The principal targets of malpractice litigation are not faceless corporations, such as product manufacturers, but real, live doctors. And unlike motor vehicle litigation where the nominal defendants are also real people, a malpractice suit challenges the professional performance, reputation, and identity of a doctor or nurse or other health care provider. The emotional trauma of having to defend against what often turn out to be misguided malpractice claims, together with the financial trauma of occasional jumps in their malpractice premiums, periodically sends doctors to state capitals—and now the nation’s capital—for relief. Because both legislators and voters can more readily empathize with the plight of their family doctor than, for example, drug manufacturers or asbestos producers, such statutory relief has regularly been forthcoming.

There is an unhappy consequence of this political equation that lines family doctors up against trial lawyers: legislative relief is extended just to doctors, not to injured patients. Perhaps in a kinder, gentler America, we will “sue each other less and care for each other more” (to quote President Bush). Such exhortations by the former President, though, are of little consolation to a patient who has been crippled for life because a surgeon’s scalpel slipped at the operating table. These human tragedies are vividly displayed in the atmosphere of the courtroom, perhaps exerting too great an influence in that forum. But the reality of personal injury tends to get lost from view in the legislative chamber, with unfortunate consequences for the orientation of the typical tort-reform package.

Such a pattern is not inevitable. The response to the current refrain that we have too much misguided malpractice liability is not necessarily to produce less of the same kind of liability. It may be better to produce even more of a very different brand of liability—no-fault medical liability.

With no-fault workers’ compensation as a historical model, and with different versions of no-fault motor vehicle compensation emerging on the scene in the early 1970s, it was natural that the idea of no-fault medical compensation would also be floated in the debates about the malpractice crisis of the mid-1970s. This idea was

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11. Throughout his unsuccessful re-election campaign in 1992, President Bush reiterated a theme attacking our “crazy” legal system, and exhorting the public to “sue each other less and care for each other more.” See, e.g., Ruth Rendon, Lawyer-Bashing by Bush Gets Man a Second Shot at Lawsuit, HOUSTON CHRON., Oct. 27, 1992, at A1.

12. For early arguments in support of a no-fault medical malpractice insurance system, see Clark C. Havighurst & Laurence R. Tancredi, “Medical Adversity Insurance”—
quickly rejected,\textsuperscript{13} not so much because of opposition from trial lawyers as from fears of doctors that this system would be unworkable or, even if no-fault did work, that it would be far too expensive.

That initial rejection of no-fault was rendered at a time when malpractice claims were being filed at an annual rate of one per thirty-five doctors, and total premiums were $1 billion annually.\textsuperscript{14} Now that claims are being filed at an annual rate of more than one per ten doctors, and premiums have reached the $9 billion level, doctors and politicians are taking a serious second look at this concept, especially in the more litigious regions and specialties. Two states—Virginia and Florida—have already adopted narrow versions of no-fault liability for certain brain-damaged baby cases, and two other states—New York and North Carolina—are now considering broader programs for obstetrical injuries.\textsuperscript{16} Three countries—Sweden, Finland and New Zealand, the latter as part of its broader accident compensation plan\textsuperscript{17}—have already adopted across-the-board no-fault medical compensation programs,\textsuperscript{18} and a number of others—for example, Great Britain and Canada—are actively con-
sidering this same model. It is at least thinkable, then, that this country will embrace no-fault as a response to a third malpractice crisis that may well emerge in the mid-1990s.

I. HIGHLIGHTS AND LOWLIGHTS OF THE CURRENT MALPRACTICE REGIME

As I will explain in detail later in this Article, no-fault is not a magic wand that will usher in an idyllic realm of medical liability. The practical concerns that diverted political attention away from this model are real. Through careful program design, these concerns can be ameliorated, but not eliminated. Nevertheless, in choosing among programmatic alternatives, the issue is not whether one proposal is ideal, viewed just by itself. Rather, the concern is whether a particular proposal is better than the alternatives, especially the status quo. Not only has medical malpractice been the most reformed part of our tort litigation system, it has also been the most heavily researched. The most wide-ranging investigation was the Harvard Medical Practice Study in New York, of which I was the original architect. The following are among the key findings of the Harvard Study and other empirical research about the actual performance of malpractice litigation, for better or for worse.

Malpractice litigation has undergone an apparently explosive increase over the last three decades—from approximately one claim per 100 doctors a year in the late 1950s to more than ten claims per 100 doctors in the early 1990s. But the major reason why there are so many legal claims is that there are so many medical (or iatrogenic) injuries: one disabling injury for every 25 hospitalizations, with one in four injuries due to provider negligence. If one compares the current level of litigation, not to the rate thirty years ago, but to the risk of negligent injuries occurring right now, it turns out that there are many more torts occurring in the medical care system than tort claims being filed—let alone being paid—in the legal system. In New York, for example, a state with one of the highest malpractice litigation rates in the nation, we found that

20. See supra note 1.
22. An iatrogenic disorder is an unexpected or avoidable adverse event, as opposed to an inevitable or anticipated traumatic byproduct of necessary treatment.
23. Weiler II, supra note 1, at 137.
there was only one malpractice claim paid for every three serious, negligently inflicted, medical injuries that could be identified.  

A major source of this litigation gap is that most injured patients do not themselves realize that their current disability is due to provider negligence; rather, most attribute their illness to the condition that originally brought them to a doctor or a hospital. Indeed, in New York we found that both the most serious losses and the bulk of the uncompensated losses were suffered by patients who had been negligently injured, notwithstanding the formal promise of our fault-based tort system. The other side of the coin is that most of the malpractice claims are filed for the wrong cases: there was no negligence in the treatment—and sometimes not even an injury. The information gap faced by most patients, wondering whether their condition provides any reason even to consult a lawyer, also hampers lawyers when they have to decide whether to file a claim on the basis of what their clients have been able to tell them.

It is true that the process of litigation and discovery does a remarkably good job of sifting the good claims from the bad. It pays the vast majority of valid cases and rejects the vast majority of invalid cases by either paying no money, or paying only a fraction of the dollar amounts paid to good claims. But the price of this litigation process is the considerable distress inflicted on doctors whose professional care and competence are subjected to legal examination, and the indignation felt by many doctors when their opponents realize the charge was unfounded and simply drop the matter.

24. See id. at 139.
25. A recent RAND study surveyed a nationwide sample of families to determine the incidence and causes of, and reactions to, accidental injuries. Deborah R. Hensler et al., Compensation of Accidental Injuries in the United States (RAND Institute for Civil Justice 1991). Respondents only attributed 1% of their total reported injuries to medical treatment. Id. at 31. This ratio is far smaller than the population-wide estimates of medical injuries derived from direct reviews of medical records of hospitalized patients in New York and California. See Weiler II, supra note 1, at 69-70.
26. See Weiler II, supra note 1, at 72-73.
27. Id. at 71.
28. See generally Frederick W. Cheney et al., Standard of Care and Anesthesia Liability, 261 JAMA 1599 (1989) (finding that, for anesthesia-related injuries, there is a high probability of recovery if care was substandard, but still a moderate probability if care was appropriate); Henry S. Farber & Michelle J. White, Medical Malpractice: An Empirical Examination of the Litigation Process, 22 RAND J. Econ. 199 (1991) (concluding that, in a single hospital study, quality of care is an extremely important determinant of liability); Mark I. Taragin et al., The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims, 117 Annals Internal Med. 780 (1992) (finding that defensibility of the case, rather than severity of the injury, predominantly influences whether any payment is made).
Contrary to the usual lament of tort defendants, though, doctors do fare quite well in the ten percent or so of cases in which a patient does press the matter on to trial. Patients win only one-third of jury verdicts, a much lower percentage than plaintiffs in products liability or motor vehicle cases.29 Indeed, the one in-depth study of this issue found that doctors rarely lose a case they should win, but win a significantly high proportion of cases their own insurers think they should lose, because juries often bend over backwards to make sure they are not unfairly stigmatizing a doctor with a malpractice verdict.30

Nevertheless, if a jury is convinced that there was negligent treatment, it tends to render very large damage awards. The average malpractice verdict is three times the size of motor vehicle verdicts, and twice the size of products and governmental liability verdicts, after adjusting for the age of the victim and severity of injury.31 With the ability to use subjective damage categories such as pain and suffering—not to mention explicitly punitive damages—juries can register their moral condemnation of truly substandard care with truly breathtaking awards, in some cases $50 million or more.32

The problem with juries who react emotionally to a doctor's malfeasance is that the doctor does not actually pay this penalty. To the extent that money eventually is paid, it comes from the doctor's malpractice insurer—whose policy premiums have almost no individual experience rating. There are good, actuarial reasons for that feature of malpractice insurance. The experience of being successfully sued is a sufficiently random event in doctors' lives that it provides little credible evidence of comparative levels of medical

29. See Brian Ostrom et al., What Are Tort Awards Really Like? The Untold Story from State Courts, 14 Law & Pol'y 77, 83-85 (1992) (finding that plaintiffs in a broad sample of state courts won just 29% of medical malpractice verdicts, versus the 64% victory rate in motor vehicle accident verdicts, and the 46% rate in products liability verdicts).

30. For various estimates of plaintiff malpractice victory rates, see Thomas B. Metzloff, Resolving Malpractice Disputes: Imaging the Jury's Shadow, 54 Law & Contemp. Probs. 43, 64 (1991). Metzloff discussed the sharp divergence in appraisals of the merits of patients' cases by North Carolina malpractice insurers and juries and concluded that the divergence was highly unfavorable to malpractice plaintiffs. Id. at 82-83.


competence and litigation risk. That means that the burden of malpractice awards rendered against a few doctors is borne equally by all doctors practicing in that specialty and region who are being insured against future suits. Because the size of the insurance pool is typically quite small in the malpractice area, the price of malpractice insurance for high-risk specialties in high-risk cities can skyrocket—ranging up to $200,000 a year for necessary levels of coverage for surgeons and obstetricians in cities like New York and Miami.

Sudden hikes in malpractice insurance rates by risk-averse insurers, as occurred in both the mid-1970s and mid-1980s, produce understandable outrage among doctors facing an immediate drop in their take-home earnings, and send them to their state legislatures for—often misguided—statutory responses. In the longer run, though, doctors do not personally pay the cost of malpractice insurance, no more than they pay the malpractice awards. These liability costs are passed along to patients as part of the price of medical services. In turn, most patients do not personally pay for their medical treatment. These costs are borne by the health insurance system, public or private, that now covers roughly eighty-five percent of the care being delivered in this country. Therefore, it is the American worker and taxpayer who ultimately pays the bill for our malpractice system—buying a special form of insurance, in effect, against the cost of negligently inflicted medical injury.

Viewed as a form of insurance, the malpractice regime has major flaws. As noted above, tort benefits are doled out in a rather arbitrary manner to some—but not most—deserving victims, and also to those persons who are not even "deserving" within tort law's fault-based frame of reference. Even worse, to make payment to the relative handful of patients who do surmount the natural and legal barriers to demonstrating legal entitlement to damages, the malpractice system must spend an inordinate amount of both time—three years, on average, for all claims and five years for the more serious claims—and money—nearly sixty cents of the malpractice insurance dollar—litigating whether the doctor was at fault so that the victim can be compensated.

33. See John E. Rolph, Merit Rating for Physicians' Malpractice Premiums: Only a Modest Deterrent, 54 LAW & CONTEMP. PROBS. 65 (1991) (discussing whether liability insurance premiums should be based on a physician's malpractice record).
34. Weiler I, supra note 1, at 4.
35. For a discussion of the time it takes to resolve malpractice claims, see U.S. General Accounting Office, Medical Malpractice: Characteristics of Claims Closed.
The fact that the target of malpractice claims is an individual doctor, who has strong personal and professional incentives to fight these cases, means that malpractice claims are more expensive to litigate and more likely to go to a full trial. The fact that there are numerous health care providers who may be involved in the treatment of a particular patient—a family practitioner, internist, surgeon, and anesthetist, as well as the hospital—means that additional litigation time and money is spent on infighting among the defendants regarding who was truly to blame for the patient’s injury.

From the point of view of defenders of the tort system, these expenditures are warranted not because tort law is an efficient mode of compensating patients for past injuries, but because it is an effective deterrent mechanism to motivate doctors to try to avoid injuries to future patients. From the point of view of critics, however, this behavioral reaction to the malpractice system is a major part of the problem, rather than of the solution.

Doctors do sharply overestimate the threat of litigation, and have a strong aversion to being sued, because they cannot insure against the emotional trauma of a malpractice action. Doctors thus adopt a variety of defensive measures to avoid suit whenever possible, often ordering extra laboratory tests, performing more elaborate procedures (for example, Caesarean-section deliveries), keeping more detailed medical records, and spending more time with their patients.36 Defensive medicine has been estimated to cost roughly twice the amount of direct malpractice premiums, thus elevating the total expense of malpractice litigation to $27 billion,

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36. In addition to the Harvard Study’s broader evidence of physician reaction to malpractice litigation, see generally WEILER I, supra note 1, ch. 6, a recently published byproduct of the study documents the increased rates of Caesarean-section deliveries associated with higher levels of malpractice litigation. See A. Russell Localio et al., Relationship Between Malpractice Claims and Caesarean Deliveries, 269 JAMA 366 (1993).
rather than $9 billion.\textsuperscript{37}

Nevertheless, defensive medicine just as easily can be viewed as a compliment to, rather than an epithet against, the legal system. Consider our reaction if it could be proved that motor vehicle litigation induces defensive driving and thereby saves lives and limbs.\textsuperscript{38}

As I explained earlier, hospitals can be quite dangerous to our health. To the extent, then, that the prospect of being sued induces greater levels of care from providers, malpractice litigation is a social benefit, not a social cost. Indeed, imposing more rigorous medical liability might actually save health care dollars because one of the principal expenditures generated by medical injuries, as by any injury, is the need for more treatment. In the Harvard Study, we found that the additional health care expenditure required for treatment of iatrogenic injuries was twice the cost of malpractice insurance.\textsuperscript{39}

But this finding ignores the much greater cost of lost earnings, household production, and enjoyment of life by patients who were disabled or killed in medical accidents.

There are, however, a number of features of malpractice litigation that make it a less-than-ideal injury prevention mechanism. I noted earlier the erratic manner in which the costs of litigation are visited upon doctors, careful and negligent alike.\textsuperscript{40} Equally troubling is tort law's emphasis on the individual fault of doctors or other providers whose momentary inadvertence or mistake may have been the immediate cause of an injury—though such legal fault takes place within the context of a broader health care system that is not doing all it can to reduce the occasions for, or consequences of, the human error that is inevitable in our increasingly ambitious health care system.\textsuperscript{41}

In the face of daunting statistical obstacles, my colleagues and I were able to discern some injury prevention benefit from malpractice litigation in New York.\textsuperscript{42} Thus, if faced with a choice between

\begin{itemize}
  \item[37.] The best study of the overall financial costs of malpractice litigation concluded that the cost of "defensive medicine" in 1983-1984 was approximately twice the cost of physician malpractice premiums ($3 billion) that year. Roger A. Reynolds et al., The Cost of Medical Professional Liability, 257 JAMA 2776 (1987).
  \item[38.] Actually, this has been proved. See 1 ALI REPORT, supra note 1, at 357-60.
  \item[39.] Weiler I, supra note 1, at 85 & n.42.
  \item[40.] See supra text accompanying notes 33-34.
  \item[41.] See generally Weiler II, supra note 1, at 138.
  \item[42.] In one part of our analysis, we compared on an aggregate hospital basis the rates of negligent medical injuries to the rates of malpractice claims. While we found a negative relationship between the two—that is, more tort claims were associated with a smaller proportion of negligent injury—this estimate was not statistically significant given the limited size of the hospital-level data. Id. at 139. On the other hand, when we
current fault-based liability and no liability at all, I would unhesitatingly choose the former. When the range of policy choices is expanded to encompass a very different, much broader brand of no-fault liability, however, there is good reason to entertain the no-fault model on the grounds of injury prevention as well as injury compensation.

In sum, serious empirical research on medical malpractice litigation presents a picture that does not square with the stereotypes of either the doctors or the lawyers who operate within that system. Contrary to doctors' impressions, injured patients do not sue at the drop of a hat, encouraged by juries who bend over backwards to dip into the deep pockets of malpractice insurers in order to do something for needy victims. There are far fewer suits than serious injuries; when claims are made, juries tend to sympathize more with doctors than with patients; and even successful plaintiffs obtain, on average, lower awards than they are supposedly entitled to receive.

It is hardly a testimonial to the litigation system favored by trial lawyers, though, that most deserving complainants are not able to collect any of the redress the law has promised them. Most of the claims brought are the wrong ones, inflicting a good deal of stress on innocent doctors and expense on the rest of the community.

looked at the patient data, it revealed that those patients who were least likely to bring tort claims—the elderly and the uninsured—were also those most likely to suffer from negligent injury—a relationship that did prove to be statistically significant. See id. at 129-34.

43. Weiler I, supra note 1, at 13.
44. Weiler II, supra note 1, at 139. See supra text accompanying notes 24-26.
45. 2 ALI Report, supra note 1, at 111-14 & n.4; supra text accompanying notes 29-30.
46. On the other hand, see supra note 31 and accompanying text for an estimate that average malpractice awards are larger than those for comparable injuries caused by other torts.

In a review of my book, Medical Malpractice on Trial, Professor Stephen Sugarman used population-wide extrapolations from the Harvard Study findings to encapsulate the true state of affairs. See Stephen D. Sugarman, Doctor No, 58 U. CHI. L. REV. 1499, 1500-02 (1991). Of nearly 40 million patients hospitalized every year, 1.5 million patients suffer some disabling injuries, 400,000 of them negligently inflicted. Id. at 1501. Although many more than 100,000 of these medical torts involved fatal or serious permanent disabilities, only 50,000 malpractice claims are made and 25,000 paid—of which approximately 10,000 cases were paid in modest amounts because there was likely no merit to the claims. Id. In his recent article, Michael Saks relied heavily upon the Harvard Study—but corroborated it by a variety of other research findings—to present a comparable picture of the broader personal injury-tort litigation relationship. See Michael J. Saks, Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?, 140 U. PA. L. REV. 1147 (1992).

47. Weiler I, supra note 1, at 15.
Furthermore, tort damages are distributed in a highly erratic fashion, with a few lucky plaintiffs collecting huge awards, while most of the seriously injured receive much less than their actual economic losses.

II. NO-FAULT MEDICAL LIABILITY

We have to find a better way, then, to give injured patients the redress they need and, at the same time, enhance the benefits and reduce the burdens of legal liability upon our health care system. I have argued elsewhere for major reforms that can be made within the current tort-fault regime—in particular, legal rationalization of tort damages—which does not include the doctors' pet reform of a damages cap. Here, however, I will spell out the case for a very different model of no-fault medical liability.

The traditional malpractice system assumes that if, and only if, a patient has been injured by the fault of the physician or other health care provider, the physician should pay the patient's losses, both financial and nonfinancial. The culpable defendant must be legally responsible for all these patient losses, irrespective of whether they are also covered by alternative forms of insurance. Judgments about both the doctor's fault and the patient's damages—awarded in a single lump sum—are ultimately made by a lay jury at the end of an elaborate litigation process. While ninety percent of malpractice claims are settled voluntarily by the parties at some stage of the lawsuit, these negotiations take place within the shadow of the governing legal rules and prospective jury determinations.

Under my no-fault liability proposal, patients would be entitled to compensation whenever they suffer a significant disability

48. See Sugarman, supra note 46, at 1502-04; see also Weiler I, supra note 1, at 2-7.
49. For my argument about why a cap, particularly one that is expressed in fixed nominal dollars, is a highly regressive "reform" device that imposes almost the entire burden of malpractice relief for doctors upon the most severely injured patients—who are already the least generously compensated tort victims—see Weiler I, supra note 1, at 44-69 (chapter 3). Chapter 3 also develops the case for more fundamental and equitable reforms in the principles of malpractice damages—if we choose to preserve the existing tort-fault model of medical liability.
50. Id. at 15.
51. Id. at 53-54.
52. The proposal has also been endorsed by my colleagues in both the Harvard Study, see Weiler II, supra note 1, at 151-52, and the American Law Institute Study. See 2 ALI REPORT, supra note 1, at 487-516.

At present, I am working with Senator Robert Graham of Florida and his staff to develop a detailed statutory version of this proposal, which Senator Graham is contemplating introducing in Congress in 1993.
caused by their medical treatment—irrespective of whether the treatment was negligent. Compensation would be paid periodically for the actual financial losses—health care costs and lost earnings—that are not covered by either private or public insurance, and modest additional amounts would be paid to severely injured patients to help them adjust to their loss of enjoyment of life. The principal target of liability would be not the individual doctor but the hospital or other health care organization under whose auspices the patient had been treated; such enterprise-based liability would extend to all care rendered by doctors affiliated with the hospitals. Administration of this program would reside in a specialized and accessible tribunal that would utilize explicit criteria and schedules to decide what events are compensable and what payments are appropriate for nonmeasurable losses.

As I consider the pros and cons of the several components of this no-fault model, I will elaborate further on the details of the proposal. Before so doing, I shall spell out my criteria for comparative appraisal of the status quo and this fundamental alternative.

The traditional justification for the tort-fault model is corrective justice: the principle that the burden of personal injury should be shifted from innocent victim to culpable actor. While corrective justice may still be the best explanation for the key ingredients of our tort system as they are vividly displayed in medical malpractice, it no longer provides a persuasive moral justification for that regime. The kind of legal negligence that tort litigation tends to fasten upon in our increasingly ambitious health care system—momentary mistakes and slip-ups by busy doctors and nurses that inflict irreversible injuries upon patients—is at best an attenuated form of personal fault. And even if one grants that it seems fairer—as between a doctor who is slightly at fault and a patient who is entirely innocent—to hold the doctor responsible for the injury to the patient, the fact is that in our present system the legally negligent doctor does not pay. Instead, the injured patient's losses incorporated in the tort award are distributed to the broader community through the combination of doctors' liability insurance and patients' health insurance. Moreover, because tort law is a mandatory feature of the patient-health provider contract, we are all, in effect, re-

53. The most important contemporary exponent of this view is Professor Ernest Weinrib. See Ernest J. Weinrib, Understanding Tort Law, 23 VAL. U. L. REV. 485 (1989).
54. Causality, fault, and quantum of damages are, of course, the core features. Weil er 1, supra note 1, at 45.
55. See id. at 46-47.
quired to purchase such disability insurance against the risk of negligent medical injury.\textsuperscript{56} Liability law and its administration, therefore, actually serve as a port of entry to these disability benefits.

Once we recognize the complex interplay of medicine, law, and insurance, more utilitarian judgments are required about how to make this disability insurance system socially optimal. How sensibly do the legal rules select which patient-victims and what types of losses will be given compensation? How effective is the allocation of liability among providers in the prevention of future injuries and losses? How economical is the administration of such an insurance program in the money, time, and emotional outlays required to make decisions about rational prevention and compensation of medical injury?\textsuperscript{57}

III. Sensible Compensation

In terms of compensation for past medical injuries, the single biggest difference in the no-fault model is that insurance coverage for patient losses will not turn on the fortuitous question whether the injury can be proved to be the result of the negligence of a doctor or other provider—proof that requires more monetary expenditures than does payment to the few patients who successfully litigate

\textsuperscript{56} \textit{Id.} at 47.

\textsuperscript{57} My views about how we should appraise alternative liability models are most heavily influenced by GUIDO CALABRESI, \textit{The Costs of Accidents: A Legal and Economic Analysis} (1970), whose approach was more rigorously developed by STEVEN SHAVELL, \textit{Economic Analysis of Accident Law} (1987), and applied to the malpractice setting by PATRICIA M. DANZON, \textit{Medical Malpractice: Theory, Evidence, and Public Policy} (1985). Professor Mark Grady, in his review of my 1991 book, mistakenly imputed to me the strange position that a combination of corrective justice and social insurance now serves as the justification for medical liability. \textit{See} Mark F. Grady, \textit{Better Medicine Causes More Lawsuits, and New Administrative Courts Will Not Solve the Problem}, 86 \textit{Nw. U. L. Rev.} 1068, 1081-86 (1992). As I stated above, \textit{see supra} text accompanying notes 49-57, and equally clearly in \textit{Medical Malpractice on Trial}, \textit{see WEILER I}, \textit{supra} note 1, at 45-47, while I believe that corrective justice is the most coherent historical explanation for the core features of the tort-fault model, it cannot serve as a justification for contemporary tort law because the latter actually functions as a vehicle for mandatory disability insurance. In deciding how to make this disability insurance socially optimal—or “efficient,” as I phrased it in \textit{Medical Malpractice on Trial}—the most important criterion, though not the only one, is prevention of medical injury. \textit{Id.} at 47. It is precisely for that reason that I rejected the social-insurance model in favor of a liability-insurance model for handling medical injuries. \textit{Id.} at 18. \textit{See also} Sugarman, \textit{supra} note 46, at 1522-24 (recognizing and criticizing my position). I have used this footnote to clarify this point lest anyone else beside Professor Grady misread what I am saying about this crucial starting point for the policy inquiry.
that issue.\textsuperscript{58}

Unquestionably, no-fault is a more sensible legal channel into the disability insurance fund than is fault-based liability (though not as good on that score as pure loss insurance). Such an expansion of the legal reach of the program naturally evokes a major concern: If it is now costing us so much malpractice money to compensate just a tiny handful of medical accident victims, how could we possibly afford to compensate the much larger number of victims who would not only be eligible for, but also have readier access to, a no-fault administrative compensation system?

At the level of fundamental principle, it must be noted initially, the assertion that we cannot afford to pay for the cost of patient injuries is simply wrong. If patients are injured as a result of medical accidents, the resulting costs will be "afforded" somehow—if not by the broader community, then by the immediate victim and family. Indeed, a good deal of the cost of medical accidents—the expense of additional treatment and rehabilitation—is actually generated by and handled within the health care system. The only issue is whether these costs will be funneled through liability insurance or handled directly by health insurance. Compensating the additional cost of medical accidents would add only a small fraction to our already huge $840 billion health care budget.

Whatever the merits of the last argument as a matter of principle, it is not likely to fare particularly well in the political arena where everyone is now concerned about how to pare, rather than add to, our spiraling health care costs. Fortunately, there is also a practical response to the affordability argument. While eligibility of injured patients would not be conditioned on proof of provider fault, coverage of particular patient losses—and therefore overall system costs—would be contained in a variety of ways not addressed by traditional tort law.

Under the common law of tort damages, the few victims who are injured as a result of demonstrably careless treatment get full compensation for all their losses—whether these losses are modest or grave, financial or nonfinancial, covered by collateral sources or entirely uninsured. Juries have broad discretion to settle on a single, lump-sum award. The awards are occasionally in amounts that seem inflated by tens of millions of dollars because of jury outrage at the course of medical treatment painted in the courtroom.\textsuperscript{59}

\textsuperscript{58} See generally \textsc{Weiler II}, supra note 1, at 24.

\textsuperscript{59} For a discussion of this general phenomenon, see \textsc{Weiler I}, supra note 1, at 3-4.
In a no-fault compensation system, by contrast, the principal target of the available funds would be the tangible financial needs of significantly disabled victims. Money would be provided to pay the bills for medical treatment and physical or vocational rehabilitation. Income would be made available on a periodic basis to replace the patient's lost earnings or ability to perform valuable services in the household. Some redress also would be provided for the nonfinancial loss of enjoyment of life, but only for those suffering significant long-term disabilities, and only in moderate amounts specified in an age-adjusted schedule of physical impairments. Finally, patients who need an attorney to successfully establish a contested claim would be reimbursed for this legal cost of their injury. Ideally, such costs would be reimbursed through a modest percentage formula that provides reasonable returns for lawyers operating in this less formal, less complex administrative process.\textsuperscript{60}

The premise of this benefit design is that disability insurance should be concentrated on the large financial losses of the smaller number of accident victims who suffer substantial injuries, rather than on the modest losses suffered by a much larger number of slightly injured patients. If we are to mandate what still would be a costly form of insurance, we should assume that people can absorb small financial setbacks out of their own resources, and make the object of our social concern those patients and families who suffer severe losses.

In the case of medical accident insurance, the preferred "deductible" format should be the duration of disability, rather than the dollar amount of losses. Requiring proof that the patient was disabled for a specified period of time makes it easier to disentangle the medical costs and lost earnings that are attributable to the injury from the losses that would normally be expected to flow from the underlying illness and its treatment. The Harvard Study demonstrates that a modest, two-month dividing line serves this purpose quite well.\textsuperscript{61}

\textsuperscript{60.} Awarding successful no-fault claimants reasonable attorney fees (reduced considerably from the judicial level) is a feature of a number of workers' compensation systems, and one that flows naturally from the underlying premise that the focus of such compensation should be on the tangible financial needs of disabled victims. Stated in somewhat simplistic terms, just as we pay the bills for doctors needed by claimants to treat the physical aspects of their injuries, we must pay the bills for lawyers needed by claimants to resolve legal-economic disputes occasioned by their injuries. See Weiler I, \textit{supra} note 1, at 61-69, for necessary refinements in, and qualifications to, this proposal.

\textsuperscript{61.} See Weiler II, \textit{supra} note 1, at 101-03. \textit{See also infra} note 77.
A much bigger cost-saving comes from the fact that mandatory patient compensation should reimburse only those losses not covered by other sources of public and private loss insurance. The reason for such an offset is that loss insurance is a considerably more accessible and efficient conduit for injury redress than is a no-fault liability regime that requires judgment about the cause of—if not the fault for—the injuries for which benefits are sought. Particularly for health care, but also for much of lost earnings, these alternative forms of insurance are available for the bulk of the injury costs that fall within the two-month deductible period spelled out above.

Finally, while it probably is fair to provide unlimited coverage for long-term medical and rehabilitation costs, only a designated proportion of net lost wages should be replaced. If we follow the example of no-fault workers' compensation, we would reimburse two-thirds of gross earnings (or eighty percent of net earnings) up to a ceiling set at approximately 200 percent of the average wage in the jurisdiction.

This last benefit constraint has two policy justifications. One is to secure more equitable distribution of the benefits and burdens of medical liability insurance. In the current tort system—which replaces all lost earnings, however high they may be—damages awards paid to persons with high incomes are much larger than awards paid to those persons with smaller incomes. In addition, the prospect of such higher awards makes the wealthier group's claims much more attractive to litigators who are paid on a contingent, percentage-fee basis. The financial burden of malpractice insurance, however, ultimately falls on the people who pay the bills for medical services or premiums for health insurance. Worse, the prices and premiums charged do not vary according to the incomes of the consumers forced to buy this form of disability insurance as one component of their health care bills. Eliminating this regressive income redistribution of traditional tort liability is one reason for limiting the scope of income replacement to a reasonable range approximating the community average. Those with higher incomes can—and most do—voluntarily purchase the additional disability protection they need to protect their higher income levels.

The second justification for shifting from full compensation to some degree of cost-sharing is that the latter will reduce the risk of moral hazard on the part of victims who might otherwise alter their behavior patterns when they realize that all their financial losses are going to be made up from such an external source. I doubt that this is a significant factor in inducing careless behavior by potential vic-
tims prior to their injuries—particularly in the medical context, where most serious iatrogenic injuries are inflicted on patients who are comparatively passive recipients of treatment. A more substantial problem arises in the aftermath of the medical accident. At that point the patient's decisions about how strenuous a rehabilitation regime to undertake, and whether and when to return to work, are important determinants of the total economic loss that will flow from the original injury. From that can be seen the virtue of a coinsurance component under which individual victims bear some share of their lost earnings in order to maintain their incentive to return to work and reduce total earnings losses.

The Harvard Study undertook an in-depth investigation of whether a no-fault medical liability model as described above would be "affordable" as compared with the present costs of malpractice insurance. We were pleasantly surprised to finish our inquiry with an affirmative answer. Admittedly, New York is one of the nation's leaders in malpractice litigation and insurance costs. But in that state—and likely also in Florida, Michigan, Illinois, and a few others—citizens can purchase this more comprehensive and better-tailored form of no-fault insurance for roughly the same amount of money they are now spending on the existing malpractice insurance system. Furthermore, that cost equation does not take account of either the substantial emotional stress experienced by doctors—and patients—who become embroiled in litigation, or the sizable financial expenditures generated by unnecessary and excessive defensive medicine.

IV. ECONOMICAL ADMINISTRATION

As I noted earlier, the single biggest cost-saving feature of no-fault medical insurance would be the deduction of amounts paid by collateral sources of insurance, principally health insurance but also sick leave or disability insurance benefits. Implementation of this rule requires not only alteration of state common law that traditionally has ignored collateral source payments—a step that a number of states have already taken for medical malpractice—but also requires changes in federal legislation—specifically, Medicare, Medicaid, and ERISA—that now precludes states from removing the

62. See id. at 105-09.
63. See WEILER I, supra note 1, at 85 (discussing the costs of defensive medicine).
64. See supra note 2 and accompanying text.
subrogation rights of these key loss insurers.65 The justification for such legislative action cannot simply be to save costs: the direct payments have merely been shifted from one insurance account to another. The justification, instead, is that making liability insurance secondary to loss insurance produces savings in overall insurance costs. Whereas no-fault workers' compensation, for example, spends roughly twenty cents of each claims dollar on administration, public and private health insurance spends between five and ten cents of each claims dollar for this purpose.66

Because malpractice litigation uses up approximately fifty-five to sixty percent of the claims dollar—not even counting the business costs incurred by all forms of private insurance to accumulate insurance funds by selling coverage, and collecting and investing premiums67—the same argument of cost savings can be made for substituting no-fault for fault-based liability.68 These administrative savings help make it possible to compensate more victims for roughly the same amount of money.69

Medical malpractice is an especially costly form of litigation for several reasons. First, it is hard for patients to detect and document provider fault.70 This process often requires extensive discovery before the essential facts are uncovered and the claim can then be either paid or dropped. Second, doctors have strong personal and professional incentives to fight hard against any such admission or finding of carelessness on their part. This is one reason why malpractice cases take far longer to dispose of than motor vehicle cases,


67. See Weiler II, supra note 1, at 139.

68. Professor Sugarman provided a synopsis of the current use of the malpractice liability insurance dollar, excluding the 11 cents that goes for business costs. Sugarman, supra note 46, at 1502-03. Of the claims dollar, 57 cents is spent on processing costs and 43 cents is paid to victims, of which 20 cents goes for pain and suffering and 23 cents for financial loss. See Weiler I, supra note 1, at 53 & n.28. Of the financial compensation, 11 cents is expended for items already covered by collateral insurance sources, leaving just 12 cents spent on the actual financial losses of injured victims. Id.

69. Weiler II, supra note 1, at 139.

70. See id. at 13.
for example, with a much higher proportion going on to a full jury trial.\textsuperscript{71} Finally, by contrast with products liability suits, where the defendant is a single corporate organization, malpractice suits often involve multiple actors, each of whom spend duplicate resources in protracted disputes involving not only the patient-plaintiff, but also each other.\textsuperscript{72}

The shift to no-fault liability—borne by the health care enterprise rather than individual doctors—will eliminate much of the expense and trauma of that legal struggle. Indeed, if the experience in Sweden is any indication, some doctors will often help their patients secure disability benefits for treatment-related injuries, rather than fight tooth-and-nail against such an outcome. Moreover, once entitlement is established, benefits are paid on a periodic basis. This allows patients to collect the needed funds early in the recuperation period, rather than waiting until their disability is fully stabilized so that lawyers and juries can project total lump sum damages, predictions that rarely are on the mark in any case.

In addition to these alterations in substantive rules, there would be a major change in forum and procedure. Once the common law's focus on fault and its overtones of corrective justice have been dispensed with,\textsuperscript{73} it is easier to shift medical injury cases out of the elaborate and expensive civil-litigation system and into an informal, streamlined, administrative process. Rather than relying on the verdicts of lay juries assembled ad hoc for each contested case, awards would be made by experienced adjudicators acting in accordance with guidelines established by a specialized administrative tribunal. One byproduct of the shift in forum is that states could dispense with medical screening panels, which were created and funded in an attempt to produce more accurate malpractice decisions.\textsuperscript{74}

These apparent administrative values of no-fault, however, encounter a serious objection in the medical context. Critics believe that finding the true cause of a patient's disability would typically be as difficult as determining the doctor's fault under the current mal-

\textsuperscript{71} In state courts in 1988, 5\% of all tort cases were resolved by a trial verdict, as compared to 11\% of all malpractice cases. Saks, supra note 46, at 1228; see also Metzloff, supra note 30, at 49-50 (finding that 13\% of North Carolina's malpractice suits proceeded to trial and 11\% were tried to verdict).

\textsuperscript{72} A typical malpractice suit might name as codefendants the patient's family physician, internist, surgeon, anesthesiologist, radiologist, and other members of the hospital's staff, all of whom are vitally interested in shifting liability away from themselves.

\textsuperscript{73} See Saks, supra note 46, at 44-47 (discussing the concept of corrective justice and its influence on tort litigation); supra notes 53-54 and accompanying text.

\textsuperscript{74} Saks, supra note 46, at 29.
practice system.\textsuperscript{75} If that be the case, adoption of a more accessible no-fault system might generate even higher administrative expenditures because a larger number of patients would be lodging equally contentious claims.

Unquestionably it is harder to prove that medical treatment caused a patient's injury than to prove that a car caused injury to a driver or pedestrian, or that employment caused injury to a worker. Unlike the driver who gets into a car or the employee who goes to work, a patient who enters a hospital may already be suffering from an underlying illness which itself may be the cause of the eventual disability. If someone breaks a leg from a fall at work or in a car crash, that person enters the hospital for treatment but may emerge with a permanent limp. The consequences of this disability are properly chargeable to the health care system only if the disability was caused by the treatment received in the hospital, rather than by the original accident. Indeed, it is evident that some of an injured patient's medical expenses and lost earnings must be attributable to her initial unhealthy condition and its treatment and expected recuperation. Determining whether medical treatment worsened the original condition—and estimating any corresponding financial loss—requires delicate judgments about what transpired inside the hospital, and how that treatment altered the path that the patient's condition would otherwise have been expected to follow.

The problem is more complex than simply identifying, factually, which losses—for example, which episodes of lost work and earnings—were caused by medical treatment. Equally difficult are the conceptual issues concerning which losses are properly attributable to a specialized program of liability for health care injuries. Doctors often undertake such traumatic medical procedures, for example, radical chemotherapy for cancer, because intervention is necessary to arrest and cure a disease that is even more life-threatening than the treatment. Consequently, in assessing liability it is not enough to decide that a particular disability episode was the consequence of—that it arose out of and in the course of—medical

\textsuperscript{75} This was the principal reason why some of the leading scholarly exponents of no-fault in other contexts, such as motor vehicle accidents, had grave reservations about the viability of this concept in the medical sphere. See Robert E. Keeton, \textit{Compensation for Medical Accidents}, 121 U. PA. L. REV. 590, 594 (1973); Guido Calabresi, \textit{The Problem of Malpractice: Trying to Round Out the Circle}, 27 U. TORONTO L.J. 131, 137 (1977); Richard A. Epstein, \textit{Medical Malpractice: Its Cause and Cure}, in \textit{The Economics of Medical Malpractice} 245, 257-58, 262 (Simon Rottenberg ed., 1978).
treatment. The disability must fall outside the range of intended or expected consequences of the treatment.

To illustrate, suppose that a person arrived at a hospital with a broken leg complicated by serious infection, and that—prior to admission—gangrene had set in. Imagine further that, in the doctor’s medical judgment, amputation of the leg was necessary to save the patient’s life, and that the patient consented to the operation. Although it is true that the amputation directly caused the loss of the leg, one would certainly not conclude—from the standpoint of liability policy—that medical treatment was the relevant cause of the loss. The patient’s initial unhealthy condition required this radical intervention, and thus the underlying condition must be deemed the true cause of the loss of the leg. If the medical treatment had caused the infection and subsequent amputation, however, the loss properly would be the responsibility of a no-fault patient compensation scheme.

In fact, not even in this hypothetical case of an identifiable iatrogenic injury should all the costs of the disability be compensable. The initial condition of a broken leg would itself normally have produced some hospital and medical expenses and lost earnings during the period of treatment and recuperation. Only the additional injuries resulting from infection and amputation would be attributable to the health care system. In practice, it would likely be too costly and burdensome to have a patient-compensation program always try to isolate precisely which of the immediate economic consequences were attributable to the original, unhealthy condition and which to the iatrogenic injury, even after determining that such an injury had occurred. For this reason, the program would feature the across-the-board rule mentioned earlier, that no-fault insurance is available only after a two-month period of disability had run. Such a threshold not only fineses this particularly troublesome aspect of the causal inquiry, but it also concentrates the program’s resources on longer-term disability, which is the proper focus of mandatory insurance under either fault-based or no-fault liability criteria.

76. See supra note 61 and accompanying text.

77. The Harvard Study found that a two-month deductible would exclude only 10% of total net losses suffered by injured patients in New York, but would cut to one-half the number of potential claimants for medical benefits, to one-quarter the number for wage-loss benefits, and to one-tenth the number for household-production benefits. WEILER II, supra note 1, at 101-03. The last benefit would likely be the most difficult to administer in practice. Id.
The target of a patient-compensation program, therefore, is the unintended or unexpected adverse consequence of medical care, not the inevitable or regular consequence of treatment that would have been undertaken even if one had known, \textit{ex ante}, of the harmful consequences that would flow from the medical intervention. Even so, drawing the line between unintended and inevitable consequences is not tantamount to conducting an inquiry about the doctor's fault. Let us consider three cases to illustrate the difference.

In the first case, a patient has a breast lump that a biopsy indicates is malignant. On the recommendation of her doctor, the patient agrees to a mastectomy. Once a more complete examination of the tissue becomes possible after surgery, however, the earlier diagnosis is revised: the lump is benign. In the second case, a patient is diagnosed with a condition that is best treated with a particular drug. When the patient uses the prescribed drug, however, it becomes evident for the first time that he is susceptible to a reaction to the drug that is even worse than the original illness, which might instead have been addressed with a different, although less effective, treatment. In the third case, a coronary catheterization required by the patient's condition unfortunately precipitates a blood clot that travels to the patient's foot and cuts off the flow of blood. This rare, but not unheard-of, event requires amputation.

Under the fault-based system, the doctors' behavior would be scrutinized from the perspective of the situations as they appeared at the time the treatment decisions were made. Therefore, negligence would not be found in any of these cases because the medical judgments were perfectly reasonable in light of the information available about the risks and benefits of the courses of treatment. Under the no-fault patient-compensation scheme, however, in which the situation would be considered \textit{with} the aid of hindsight, it is evident that the harmful events—amputation of the foot, severe drug reaction, and removal of a normal breast—were not inevitable results of treatment required to cure the patients' condition, unlike the removal of a gangrenous leg. If any of the resulting disabilities fit within the benefit structure of the program, they would be compensable.

Ultimately, though, it is not possible to design a program for pure no-fault patient compensation. All of my examples to this point consisted of positive, although harmful, consequences of medical intervention—acts of commission. The particularly difficult cases in the medical setting are instances of omission, in which the
A harmful consequence is attributable to a failure to properly diagnose and treat the patient’s condition in the first place.

Consider the example of a patient undergoing treatment for cancer who dies in the hospital as a result of the malignancy. The death is caused by the original condition, not the treatment. Contrast this with a case in which the patient dies as the result of an inadvertent overdose of chemotherapy, a positive medical intervention. The matter becomes more complicated, however, if the cancer in the first example was a curable one, such as an early Hodgkin’s lymphoma that was not properly diagnosed or treated in the hospital. In that instance, even though it may be descriptively accurate to conclude that cancer was the factual cause of death, legal policy would judge the significant cause to be the doctor’s failure to interrupt the natural development of the tumor—an act of omission.

Our notion of causation must be broadened, therefore, to include what might be called policy causation—what should have happened—as opposed to purely factual causation—what did or might have happened. If causation is so broad, however, we must ensure that a self-contained patient-compensation program does not eventually become a general social insurance for every disability or fatality that medical care did not prevent or cure. To prevent this, one must establish criteria specifying what should have happened, thereby distinguishing the properly compensable cases from the noncompensable ones. The easy cases are those in which treatment was impossible. If a disease cannot be cured, it should be the responsibility of broad-based social insurance, public or private, to pay for the victim’s losses from such diseases. This role should not be assigned to a patient-compensation program, which is supposed to saddle the health care system with only those costs of disabling injuries that are attributable to its own operations.

Suppose, however, that the disease could have been cured if it had been treated by the top practitioner in one of the major teaching hospitals of the world. Under that optimal care standard, compensation should be available for any disability that could probably have been avoided by some doctor, somewhere. That would likely be a very expensive compensation program. To avoid going that far—by choosing to compensate only disabilities that would have been cured by the reasonable care expected from the average doctor in an actual practice setting—it is necessary to reinstate the fault principle as the basis for compensating at least this category of iatrogenic injuries.
The foregoing cases illustrate the admitted conceptual and practical difficulties that confront efforts to transplant the no-fault model into the medical setting. But the fact that there are real difficulties in designing such a liability alternative is not a sufficient reason for rigid adherence to the tort status quo. Indeed, tort law itself must grapple with the same, knotty, causal questions. Once a court decides that a doctor was at fault in the standard of care provided, it must then make a second determination of whether the medical negligence was actually the cause of harm to the patient for which damages are sought. Such harm would of course include the failure to cure a disease that should have been manageable. In a series of cases over the last decade dealing with this issue, known as "loss of a chance," courts have grappled more and more frankly with the problem of what to do about a patient who went to a doctor with an existing cancer or heart disease, but who now argues that the doctor's failure to properly diagnose or treat the condition deprived her of a real, though perhaps less than an even, chance of survival.78

In any event, even though questions of causation can be conundrums in either the tort or the no-fault setting, the evidence is that the causal inquiry—the sole question in the no-fault scheme—is generally far less difficult than the fault determination that must be made—in addition to the causal inquiry—in the tort-fault system. Only a small fraction—five percent—of the Harvard Study reviewers' causal judgments were "close calls," a mere quarter of the proportion of difficult standard-of-care judgments the doctors had to make.79 Moreover, the results of the academic investigation in New York are corroborated by experience in Sweden and New Zealand, two countries that have provided no-fault compensation for medical injuries for nearly two decades. While administrators in both countries have regularly encountered individual cases that pose knotty

78. See, e.g., Fennell v. Southern Md. Hosp. Ctr., 320 Md. 776, 780-94, 580 A.2d 206, 208-15 (1990) (analyzing in depth the question whether loss of a chance of survival could be compensable under either a relaxed standard of causation or as a new element of damages); McKellips v. Saint Francis Hosp., Inc., 741 P.2d 467, 477 (Okla. 1987) (holding that in medical malpractice cases involving the loss of less than an even chance of recovery or survival, the question of proximate cause is for the jury if the plaintiff shows that the defendant's conduct caused a substantial reduction of the patient's chance of recovery or survival, irrespective of statistical evidence); Herskovits v. Group Health Coop., 664 P.2d 474, 479 (Wash. 1983) ("[M]edical testimony of a reduction of chance of survival from 39 to 25 percent is sufficient evidence to send the issue of proximate cause to the jury."); see also Joseph H. King, Jr., Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, 90 YALE L.J. 1353 (1981).

79. Weiler I, supra note 1, at 144.
legal problems, they have been able, as a general matter, to draw the causal dividing line without any pronounced burden on the no-fault programs as a whole.

Still, I am under no illusion that foreign administrative experience, let alone a single academic investigation, can be readily duplicated in the American legal system. Such a system supplies able and aggressive lawyers to parties with a real incentive to do battle in the administrative, as well as in the judicial, setting. That is why it is crucial that no-fault medical liability, if it is to be successful, make use of a legal-medical device known as "designated compensable events" (DCEs).80

DCEs are formulas that spell out that if a patient undergoes a certain medical procedure (for example, hernia repair) and later displays a particular outcome (for example, infarction of the bowel), the latter injury would automatically be compensable to the extent it produces the kinds of disabling loss that are covered by the plan's benefit schedule.81 These DCE formulas would be (as they have been) developed by teams of doctors and lawyers to address recurring problems of medical injury causation by identifying those treatment-outcome relationships that typically meet (or do not meet) the concept of compensable iatrogenic injury stated earlier—an unexpected or avoidable adverse event, as opposed to the inevitable or anticipated traumatic byproduct of necessary treatments. Plan administrators would then be able to use any such formulas that apply to particular cases coming before them, saving them from having to conduct a full-scale inquiry about medical causation in each individual case.

Tentative lists of DCEs have already been devised for such medical-litigation settings as general surgery, orthopedic surgery, and obstetrics.82 Investigations have shown that these lists cover a high proportion of the more serious cases that are now litigated and

80. The notion of designated compensable events was first developed and advocated in the mid-1970s by Clark Havighurst and Laurence Tancredi as an offshoot of their proposal for "medical adversity insurance," which proposed experimentation with this idea. See ABA COMM'N ON MEDICAL PROFESSIONAL LIABILITY, DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY 8 (1990). More recently, Professor Tancredi, in conjunction with Randall Bovbjerg, has been refining and testing this concept under the nomenclature of "accelerated-compensable events." See Laurence R. Tancredi & Randall R. Bovbjerg, Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test, 54 LAW & CONTEMP. PROBS. 147, 148 (Spring 1991) (arguing that reforms based on accelerated-compensation events would lead to more equitable compensation).

81. WEILER II, supra note 1, at 149.

82. Id. at 151.
the potentially compensable events identified by the Harvard Study.\textsuperscript{83} There is no doubt that implementation of such no-fault medical-accident criteria would be far more predictable and economical than current inquiries about provider negligence.\textsuperscript{84} The question, though, is whether DCEs should be employed as a form of selective no-fault compensation with fault-based malpractice law in the background, as some DCE proponents advocate,\textsuperscript{85} or used only if incorporated into a comprehensive no-fault program that bases compensation for events not covered by a DCE upon individualized judgments about medical causation rather than provider fault.

I strongly favor the latter setting for use of the DCE model, for reasons of both individual equity and institutional politics. Suppose, instead, that DCEs were used to carve out a limited no-fault preserve within the broader malpractice terrain. The consequence would be that the victim of any surgical injury that was covered by a DCE formula would collect only the limited benefits considered appropriate under no-fault. However, the victim of another surgical mishap not yet covered by a DCE would be free to try to prove provider-fault to collect one of the huge awards that juries may render under the common-law standards of tort recovery. The trouble is that the first patient may well have been the victim of more egregiously negligent treatment than the second patient, perhaps rendered in the very same hospital operating room, but the relative size of recovery would turn on the fact that a DCE had been devised for one kind of case but not for the other.

That unfair disparity in treatment of prior patient-victims would, in turn, produce pitched political battles about development of future DCE formulas. Doctors and defense attorneys would naturally want DCEs devised for all of the cases that were most likely to

\textsuperscript{83} See Randall R. Bovbjerg et al., Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System, 265 JAMA 2836, 2838 (1991) (concluding that accelerated-compensation events would resolve cases more efficiently than the current system). In their study, the authors applied their initial list of obstetrical DCEs to a sample of more than 300 obstetrical claims filed over a six-year period, and found that the DCE list covered half the obstetrical claims, two-thirds of claims involving serious permanent injuries, and three-quarters of the tort indemnities actually paid on claims. Id. Initial results from application of lists of both obstetrical and surgical DCEs to the broader sample of patient injuries, which was not as limited as the Harvard Study's focus on tort claims, also found that these formulas covered substantial proportions of potentially compensable surgical and obstetrical events. Tancredi & Bovbjerg, supra note 80, at 159-61.

\textsuperscript{84} See, e.g., Tancredi & Bovbjerg, supra note 80, at 2842 (concluding that accelerated-compensation events would resolve cases more efficiently and with greater regularity than the current system).

\textsuperscript{85} Professors Tancredi and Bovbjerg, in particular, advocate this. See generally id.
produce viable malpractice claims, but would prefer to leave uncovered those cases that were least likely to surface in viable litigation. Patients and plaintiff attorneys would be inclined in precisely the opposite direction, and the resulting tug-of-war would hardly constitute a reasoned inquiry into the appropriate scope and context of DCEs or health care in general.

Instead, we should decide as a matter of fundamental principle whether, all things considered, no-fault is a better liability model for patients and doctors than tort-fault. If we do opt for a broad no-fault program, DCEs can be a valuable administrative device within that program. However, availability of such a formula for attributing a particular type of injury to a specified form of medical treatment should not be the litmus test of whether the injury is to be governed by one or the other of these radically different liability regimes.

Assuming we were to adopt some version of medical no-fault, a key component of this program would be a DCE panel—comprised of medical scientists and practitioners who are knowledgeable about the usual connection between treatments and outcomes, and plan administrators and lawyers who are knowledgeable about the difficulties in identifying the true causes of patient disability when individual claims are lodged. DCE formulas would be regularly devised and revised on the basis of both new claims experience and scholarly research. And because all that would ride on the decision to adopt a proposed DCE standard would be whether to use this somewhat cruder, but much less contentious, mode of no-fault claims administration for a particular injury, the DCE inquiry is likely to generate a good deal more light and less heat.

V. Effective Prevention

With the help of DCEs, no-fault patient compensation will be administratively feasible, just as it will be financially affordable. But while elimination of the fault inquiry would slash the present administrative share of the claims dollar from nearly sixty percent to less than thirty percent, that share could be reduced by yet another two-thirds—to ten percent or less—if we also eliminate the inquiry into the cause of a patient's injury, and provide compensation simply on the basis of the type and magnitude of losses suffered.86

86. Weiler II, supra note 1, at 106; see also Priest, supra note 66, at 1560. Professor Priest estimated that "Blue Cross-Blue Shield first-party health insurance administrative costs are 10% of benefits; SSI disability insurance administrative costs are 8% of bene-
Consider, for example, the no-fault schemes recently adopted in Virginia and Florida for babies who suffer neurological injuries during delivery. These programs provide generous compensation for the resulting medical and rehabilitation expenses, as well as modest replacement of future lost earnings and an allowance for nonfinancial harm. However, only a small fraction of infants born with cerebral palsy or other birth defects sustain these injuries as a result of medical treatment. Experience in both states demonstrates that it is extremely difficult for infants and their families to show that they had iatrogenic injury cases, because the symptoms of this condition often do not manifest themselves until years later. Thus, the most recent "bad baby" proposal in North Carolina would extend insurance coverage to all cerebral palsy cases, except for cases of genetic inheritance or maternal substance abuse that clearly were not attributable to the birthing process.

From the vantage point of the disabled child, however, even that last exclusion seems arbitrary—granting compensation for the present losses of some infants but not others simply because of the way in which their respective injuries appear to have occurred years earlier. More generally, why should one advocate a program that requires health care organizations to guarantee patients redress for medical-care costs that stem from disabling injuries suffered inside the hospital, when there is no social guarantee of health-insurance coverage for the injuries or illnesses that brought the patients into the hospital in the first place? From a compensation perspective, there is no doubt that, if we leave the tort-fault regime in search of more sensible compensation and economical administration, a categorical program of no-fault medical liability based only on the cause fits; Workers' Compensation disability insurance administrative costs are (a much-criticized) 21% of benefits." Id.


88. Va. Code Ann. §§ 38.2-5009.3 to -5009.4. The Florida Act does not compensate for lost wages as does the Virginia Act, but it does allow for a non-economic damage award of up to $100,000 to the infant's parents or legal guardians. Fla. Stat. Ann. § 766.301(1)(6).

89. Bobbitt et al., supra note 16, at 842 (noting that most current studies have failed to establish a causal relationship between medical mismanagement and cerebral palsy).

90. As of mid-1991, three and one-half years after the Virginia Act came into effect and two and one-half years after the Florida Act came into effect, only two compensation claims had been filed in Virginia, both initially rejected and under appeal, and twelve had been filed in Florida, eight accepted and four still under investigation. Id. at 854 n.114.

91. Id. at 859 n.137.
of the injury should be a way-station on the road to broader social insurance for all victims against especially catastrophic losses.

The reason why we should stop at no-fault is that such a program can play a significant deterrent role in preventing medical injuries before the fact, rather than simply concentrating on compensation for victims after the fact. The distinctive virtue of no-fault liability is that such a regime imposes responsibility for disabling injuries upon the enterprise whose activities caused the injury, and thereby creates a financial incentive for the enterprise to take steps that will reduce the risk of such injuries in the future.

The no-fault program I endorse, then, is very different from the standard version of medical no-fault, whether exhibited by the narrow, brain-damaged-baby plans in Virginia and Florida or by the comprehensive medical accident plans in Sweden and New Zealand. Each of these programs diffuses responsibility for compensating medical injuries among all those required to contribute to the insurance fund in question. The preferred model for enterprise medical liability instead is workers' compensation, which makes individual employers, including hospitals, legally responsible for injuries that occur to their employees as a result of working in the employers' operations. While insurance against such no-fault liability is available to organizations not large enough to shoulder the risk on their own, such insurance can be experience-rated in an actuarially credible way to maintain a potent incentive for the enterprise to prevent injuries, both occupational and medical, and so avoid its legal and financial liability.

From this perspective, no-fault and tort-fault liability are both members of the broader family of liability regimes. Retention of some version of legal liability for medical accidents is crucial to those who, like myself, are uncomfortable with the idea of relying solely on ethical, market, or regulatory incentives to ensure the necessary levels of safety and quality in modern-day medicine.

It is clear that the prospect of malpractice liability does induce substantial changes in the behavior of medical providers trying to avoid the threat of suit. In the face of major statistical obstacles posed by our limited data base, the Harvard Study found some positive evidence that such altered provider behavior also reduces the

92. I ALI REPORT, supra note 1, at 105-27 (describing a no-fault workers' compensation model). This chapter of the ALI Report drew on a larger background paper that the author wrote in 1986 for the ALI Study.

93. See generally WEILER I, supra note 1, at 70-105 (explaining the reasons for the author's discomfort).
likelihood of negligent injury to patients. In the motor vehicle area, with much broader data sets, scholars have shown that dispensing with tort liability and substituting the loss insurance model of typical auto no-fault plans raises the incidence of motor vehicle injuries that require such compensation. On the other hand, the workers' compensation model of no-fault liability imposed on the employer in whose enterprise occupational injuries occur can be credited with reducing the rate of worker deaths by somewhere between twenty-five and forty-five percent. The key difference is that workers’ compensation imposes on an organization—the employer—a direct financial incentive to take the measures necessary to reduce unwarranted hazards in its operations, including the human errors of employees and contractors.

As a matter of general principle, one would expect the model of strict institutional liability for medical injury to be considerably more effective than present, fault-based personal liability. Whatever tort law may say, the financial burden of defending against and paying for malpractice suits is borne not by the individual negligent doctor, but by all of the physicians in that specialty and region who must pay premiums for malpractice insurance coverage, under policies that make almost no adjustment in premiums charged to take account of differences in the number of meritorious claims against

94. The best such evidence comes from Quebec which, unlike American states with no-fault auto plans, totally replaced the tort system with a no-fault compensation scheme in the late 1970s. See Jeffrey O'Connell & Charles Tenser, North America's Most Ambitious No-Fault Law: Quebec's Auto Insurance Act, 24 San Diego L. Rev. 917 (1987). Research done about the effect of the Quebec plan indicated that the province’s shift in liability policy did increase hazards on its highways. Mark Gaudry, The Effects on Road Safety of the Compulsory Insurance, Flat Premium Rating and No-Fault Features of the 1978 Quebec Automobile Act, in 2 Report of Enquiry Into Motor Vehicle Accident Compensation in Ontario (1988). Gaudry attributes the 7% increase in motor vehicle fatalities entirely to the Quebec plan’s flat-rate premium system for motor vehicle insurance, which attracted larger numbers of high-risk drivers onto Quebec highways. Id. In another study, Rose Anne Devlin estimated that the impact of no-fault on fatality rates was even higher—14%—and concluded that a substantial proportion of this increase was due to a reduction in driving precautions induced by the no-fault model. Rose Anne Devlin, Liability Versus No-Fault Automobile Insurance Regimes: An Analysis of the Experience in Quebec 212 (1988) (unpublished Ph.D. dissertation, University of Toronto).

individual insureds. The no-fault program I have in mind would impose legal responsibility on hospitals or other health care organizations that often are large enough to be self-insured (perhaps with "catastrophic" insurance for awards over $10 million). Even if smaller hospitals become part of an insurance pool, they are likely to generate sufficient claims-experience to warrant sizable variations in premiums charged, depending on the institution's comparative success in reducing its rates of compensable patient injuries.

Under a no-fault regime, the defendant hospital would still be responsible for all negligent injuries suffered by patients—that is, for all cases in which the incident would have been avoided had the individual doctor, nurse, or technician taken the necessary precaution. With respect to this subset of patient injuries, the no-fault program would not only retain, but even accentuate, present legal incentives for reasonable medical care. As observed above, a no-fault liability program avoids most of the financial dilution produced by insurance against fault-based medical liability. In addition, the program's greater accessibility would increase the number of patient claims lodged for negligent medical injuries that are now too difficult to bring, irrespective of tort law's formal doctrines.

No-fault also casts its net much farther to encompass legally blameless accidents that are larger in number than those due to the identifiable fault of some provider. One might ask what preventive—as opposed to compensatory—value is achieved by imposing liability for a medical injury that could not have been avoided by currently reasonable precautions. The answer is that no-fault liability assumes a dynamic perspective on the medical accident problem, whereas malpractice law focuses only on procedures and precautions that the medical profession has already adopted, given the current state of the art. The practice of medicine is constantly evolving under the impetus of newly developed diagnostic and treatment techniques. Many iatrogenic injuries that were accepted as inevitable just a decade or two ago—heart-block during cardiac surgery, for example—are now considered avoidable as a matter of course. The vital preventive role of a no-fault system is to add a legal spur to existing incentives to undertake research and innovation in safer, more advanced medical techniques in these settings. And in the meantime, incorporating the cost of medical accidents in the price charged for particular modes of treatment will permit a more in-

96. See generally SLOAN ET AL., supra note 35, at ch. 8 (discussing "Risk Classification").
formed judgment by the health care system of the net value of this treatment as compared with others that, while less promising, are also less hazardous.

There is a subtle but important difference in the way that no-fault and fault-based liability motivate medical-care providers to deliver safe and high quality care. A no-fault program leaves it to hospitals and other health care organizations to decide whether it is worthwhile to invest in particular safety precautions, or whether instead to bear the financial cost of risks that are currently judged not reasonably preventable. Because the health care provider must pay for unavoidable injuries that still do occur, it faces a continuing financial incentive to seek and adopt safer modes of treatment as these become feasible. By contrast, under the fault system, a jury scrutinizes the specific quality of treatment that happened to be rendered by the individual doctor involved in the case, and decides whether to issue a verdict of poor professional performance. Critics of no-fault worry that by jettisoning the public stigma of malpractice litigation, with its significant and noninsurable reputational losses, that doctors no longer will have a legal motivation to avoid substandard patient care.

After spending five years absorbed in an empirical study of medical negligence and medical injury that documented the fact that there is one tort for every 100 hospitalizations, I am convinced that we would be better off without the dramatic morality play of tort litigation. The tort-fault model fuels the popular but mistaken impression that the solution to the medical injury problem consists of finding and holding accountable a few bad apples in the medical profession. To the contrary, most of the negligence identified in hospital records, and most of the negligence that surfaces in the tort system, consists of momentary inattention and inadvertent slip-ups, rather than deliberate scrimping on the quality of patient care to serve the personal interests of doctors or nurses.97

The deeper source of medical hazard is modern medicine's ambitious efforts to cure the even greater hazards of modern life. Many of today's procedures are risky precisely because they are so complex and so invasive. Imagine that doctors can now perform surgery upon fetuses in utero to prevent what would otherwise be severe and untreatable defects after birth. But no matter how sophisticated medical procedures and technologies may become, patients ultimately must rely on the care and attention of human

97. Weiler II, supra note 1, at 138.
As we all know from our experience in driving cars, human beings are prone to let their minds wander, to make mistakes, and to fail to notice dangers. So, too, in medicine, we can never program out all human frailty from even the most highly trained doctors, nurses, and technicians. Unlike the comparatively safe environment of the highway or the workplace, the hospital—especially in its operating room—is a hazardous and unforgiving environment. Even surgeons and obstetricians, who concentrate on their work far more rigorously than most people, including lawyers, occasionally will have a momentary lapse of attention. That mistake—which may constitute negligence in the eyes of the law—can have tragic consequences (including stressful litigation) when it occurs during a delicate surgical procedure, such as the removal of a tumor from inside the patient's brain or beside his spinal cord.

Recognition of these facts should make us more understanding of the situation of those charged with negligence in the world of modern medicine. Nevertheless, empathy is no reason to relax the pressure that legal liability exerts for necessary levels of concentration and care. It does suggest, however, that a better mode of liability is one that obligates the health care organization to pay for patients' injuries, however they occur, and thereby gives the organization a continuing opportunity and incentive to learn how such injuries occur and how best to avoid them. Institutional memory can help piece together patterns displayed in a host of apparently idiosyncratic incidents. If the record discloses a tendency towards erratic behavior on the part of doctors, nurses, and other hospital staff involved in these cases, a hospital can take the steps necessary to improve these providers' performance—or terminate their roles in the institution. (And, unlike a tort award, the suspension of a doctor's valuable hospital admitting privileges is a financial loss against which a doctor cannot insure.) Alternatively, the sequence of injuries may turn out to be primarily attributable to the normal routines or facilities of the institution—the absence of systems that monitor oxygen levels for patients under anesthesia; diagnostic and treatment mistakes made in the emergency room by residents near the end of continuous, thirty-six-hour shifts; or the failure of hospi-
tal records or communication systems to transmit crucial information to the various providers involved in treatment of the same patients. To the extent such systemic failures are the major causes of medical accidents—as I believe they are—the role of a no-fault organizational liability is to prod hospitals to pool their collective staff wisdom in devising procedures and technologies that minimize the ever-present risk of occasional human failure, rather than simply to single out for blame those individuals whose mistakes happen to inflict the serious patient injuries that are likely to surface in the courtroom.

This shift in the focus of legal liability from the personal fault of the individual doctor to the collective responsibility of the health care association has a clear affinity with important institutional changes that are now taking place within the health care system itself—"total quality management" as the vehicle for enhancing the quality of medical treatment, and "managed competition" among institutional providers to try to control the nation's spiraling health care costs. A favored cost-control target of physicians, pundits, and politicians is the excessive defensive medicine supposedly induced by spiraling malpractice litigation.

I noted earlier that such preoccupation with defensive medicine is somewhat misguided. Careful research on this topic indicates that while the cost of defensive medicine—totaling perhaps $20 billion a year—may be twice the cost of direct malpractice insurance, this is still only a tiny fraction of our more than $840 billion health care bill. In addition, some of the defensive precautions induced by the threat of suit likely reduce the incidence of medical injuries, thereby saving not only the lives and well-being of patients and their families, but also saving the health care system the sizable extra cost of treating medically injured patients. On the other hand, I am satisfied that a considerable proportion of the extra tests, records, and time used by doctors fearful of litigation is unproductive; indeed, some of the additional procedures—for example, Caesarean-section rather than normal deliveries—may actually pose greater medical risks to patients, even if they reduce the legal risks of physicians.

99. For the best example of the preventive value of organizational liability, see John H. Eichhorn et al., Standards for Patient Monitoring During Anesthesia at Harvard Medical School, 256 JAMA 1017 (1986) (reporting on the process used to balance doctors' autonomy with the goals of improving patient care by mandating detailed standards for minimal patient-monitoring during anesthesia).

100. See WEILER II, supra note 1, at 174 n.14.

101. See supra notes 10, 37 and accompanying text.
Some of the key features of the tort-fault liability model—those that would be altered in the no-fault liability model—are especially conducive to wasteful defensive medicine. The focus of malpractice litigation is whether, in an individual case, the doctor failed to follow the steps and procedures that are accepted within the profession, not whether the doctor's mode of practice produces better or worse outcomes for patients over the general run of cases. Doctors feel strong psychological aversion to being sued and having cases come to trial where their professional reputations may be publicly blackened. They have a strong personal incentive, then, to utilize the full catalogue of medical precautions to create a dossier designed to protect providers from suit, irrespective of whether these steps protect patients from harm. Because doctors make the vast bulk of treatment decisions on behalf of those patients whose extensive health care insurance leaves little room for consumer resistance against unnecessary but expensive tests and procedures, the cumulative result is likely to be sizable social expenditures upon unproductive medical precautions.

No-fault medical liability would substantially alleviate these misplaced legal incentives. The fact that the target of liability is the health care institution, rather than the individual practitioner, would remove much of the emotion and risk-aversion felt by doctors deciding what treatment steps to take with their patients. In addition, the fact that the basis of liability for the organization is the outcome, not the process, of treatment—that is, whether the patient actually suffered a medical injury, not whether the injury was produced by documented provider mistakes—means that there would be no legal payoff from adopting treatment measures that only reduce the odds of doctors being sued without reducing the odds of patients being hurt.

I do not mean to overplay the ability of liability reform to reduce medical costs. As stated earlier, determining whether a particular patient outcome was caused by an omission in medical treatment—for example, a failure to detect breast cancer in time—implicitly rests on a judgment of physician fault, thereby creating some incentive to perform unnecessary diagnostic tests and procedures. Reinforcing that physician incentive is the fact that such practices not only reduce lawsuits, they also increase physician incomes. (More tests and elaborate procedures mean higher billings.) Nevertheless, if one includes organizational no-fault liability within new models of health care cost-containment, the bulk of unjustified medical expenditures generated by fears of litigation should be
weeded out in the long run. That prospect reinforces the observation I made earlier—that no-fault liability not only delivers better compensation and prevention to patients, but is affordable by the public that now pays for the existing malpractice system.

VI. Elective No-Fault

In this Article, I have not considered a radically different approach to medical injuries: a scheme that would assign responsibility for compensating past injuries to first-party loss insurance and leave prevention of future injuries to administrative safety and health regulation. Whatever may be the prospects for health insurance, it will be decades, at least, before this country ever adopts comprehensive social insurance for earnings lost as a result of disability, and I am dubious about the injury-prevention potential of external regulation of the competence and performance of health care providers. For the foreseeable future, then, we will need to employ a liability model that supplies a measure of both compensation and prevention to fill the gaps left by these other programs. And for the reasons I have developed at some length, the no-fault version of medical liability should be taken seriously in the ongoing debate about this topic.

This is not to imply that we should sweep away the existing malpractice system and mandate full-blown no-fault liability across the board. There is enough force to the various concerns I have addressed about medical no-fault liability to make policymakers understandably reluctant to take such a fateful leap in the dark. Fortunately, there is an intermediate step: enacting legislation that would facilitate adoption of the no-fault model on an elective basis. Indeed, precisely that same path was followed early in this

102. The major scholarly figure who advocates this approach is Stephen Sugarman. For his broader analysis, see Stephen D. Sugarman, Doing Away with Personal Injury Law (1989). For his thoughts about medical injuries in particular, see Sugarman, supra note 46, at 1521-24.

103. See Weiler I, supra note 1, at 107-13 (addressing various reasons why regulation will not ensure physician competence).

104. See Jeffrey O'Connell, An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries, 60 Minn. L. Rev. 501 (1976) (advocating, as early as 1976, elective medical no-fault insurance). See also Richard A. Epstein, The Historical Origins and Economic Structure of Workers' Compensation Law, 16 Ga. L. Rev. 775 (1982) (recounting the early years of workers' compensation). Interestingly, the Swedish no-fault program was adopted voluntarily by its health care system, and still rests on a contractual basis. This has afforded the program the flexibility to adopt a variety of decision-making rules applied in difficult, recurring cases, for example, rules for deciding when infections should be treated as iatrogenic. See sources cited supra note 18.
century during the gradual emergence of no-fault workers’ compensation liability for occupational injuries.

The ideal scenario involves federal legislation containing the following ingredients:

* Hospitals and other health care organizations would be explicitly empowered to offer their patients administrative compensation for medical injuries in return for patient waiver of the common-law tort liability of the hospital and its affiliated providers.

* Legislation would require that benefits payable meet certain standards of generosity, including full coverage of out-of-pocket medical expenses (that is, those expenses not covered by direct insurance), eighty percent of net lost earnings up to 200 percent of the state’s average earnings level, plus a specified payments schedule for loss of enjoyment of life associated with certain physical impairments.

* Federal legislation is required to permit such medical no-fault liability to operate as second payor to first-party loss insurance by removing existing indemnity rights of loss insurers such as Medicare, Medicaid, and private carriers or self-insured employers.\(^\text{105}\)

* The claims administration procedure would meet acceptable standards of accessibility, neutrality, and due process, and would authorize a designated-compensable-events panel to develop DCE criteria that specify many of

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105. There are legal roadblocks to state legislatures removing indemnity rights of either federally-funded health insurance under Medicare or Medicaid, or private health and disability insurance provided by self-insured employees covered by ERISA law. See cases cited supra note 65. But see Bobbitt et al., supra note 16, at 866-88 (describing how a state no-fault statute might be worded to finesse the obstacles posed at least by Medicare and Medicaid).

Removing the indemnity right of public and private insurers is indispensable if we are going to make medical liability insurance a secondary payor. A patient’s no-fault entitlement could not be reduced by the amount payable under first-party health or disability insurance if carriers providing the latter coverage retain their rights to recover these loss payments from the patient’s liability award. This secondary-carrier feature of medical no-fault is essential for two reasons. First, the program is made affordable within the financial and political envelope provided by current malpractice expenditures. Second, it eliminates the need to expend a considerable amount of administrative resources on determining the causal link between the medical injury and disability—a task that would be especially troublesome in the case of elderly patients whose principal financial losses are medical costs already covered by Medicare. It is hard to imagine any principled objection that can be lodged by health insurers against removal of their indemnity rights. It is the health-insurance system that ultimately pays the cost of the more-expensive-to-administer medical liability system—whether as present-day fault-based liability or proposed no-fault liability.
the medical injuries that would—or would not—be
covered.
* The program would cover all medical injuries in-
flicted on the hospital’s patients, even those caused by non-
employee doctors with admitting privileges, and even those
caused by diagnostic or treatment decisions made in the
doctors’ offices. Doctors with admitting privileges in more
than one hospital would designate one such institution as
their principal practice site for purposes of liability for in-
jury to patients who were never admitted to any hospital.
* Appropriate adjustments would be made in the rev-
enues received for their services by all participants, both in
fees paid to the hospitals shouldering this new, no-fault lia-
ibility, and to the doctors being relieved of personal tort
liability. Until and unless revisions are made in the reim-
bursement schedules of the variety of health insurers, these
cost adjustments would take the form of direct agreements
between the hospital and its medical staff about how to re-
allocate the payments received by each for risky procedures
such as obstetrical deliveries.
* The health care facility would have to operate an ef-
fective quality-assurance program that would include internal
measures to hold accountable those providers responsible for undue numbers of medical injuries that
surface through this claims process. Federal legislation
would address the question whether immunity from anti-
trust liability would cover the doctor-members of hospital
peer-review committees that recommend suspension of
practice privileges of accident-prone colleagues.106
* Before patients are invited to decide whether to ac-
cept medical care under no-fault auspices—or to choose in-
stitutions and doctors still governed by the existing
malpractice regime—the patients would have to be fully in-
formed in easily comprehensible terms of both the tort
rights they were surrendering and the no-fault benefits
they would be eligible to receive.
* Providers would have full immunity against tort
claims lodged not only by patients who choose to accept
treatment within this no-fault regime, but also by third par-
ties—such as the patients’ family members suing for loss of
consortium or drug manufacturers seeking contribution for
tort suits brought by patients against them. Health care

106. Peer-review is currently immune from antitrust scrutiny only if a state has
adopted peer-review conduct as “state action,” thus exempt from antitrust liability. See
providers, in turn, would have no right to recover no-fault benefits paid to injured patients through subrogation claims lodged against outside parties who may have contributed to the patients' disabilities.\textsuperscript{107}

This scenario for reform offers several important advantages. Obviously it is much easier to offer doctors and their patients a choice about no-fault, a choice made under carefully tailored protection, than to convince the general public—including the medical and legal communities—to mandate no-fault for everyone. Next, elective no-fault affords us the chance to learn from the experience of pioneer institutions blazing this trail: to observe, for example, whether these institutions specify one kind of designated event as a compensable injury, or treat a certain type of fringe benefit (for example, lost employer-contributions to a pension plan) as compensable earnings. Finally, careful scientific study of such demonstration no-fault projects, monitored as they operate side-by-side with the tort-fault system, would enable everyone to gain a realistic appreciation of the comparative advantages and disadvantages of each, before government is asked to decide that one regime is so far superior that it should be established as public policy for everyone. Judge-made and judge-mandated malpractice law has never had to pass such a test of how well it satisfies the needs of either patients or doctors.

\textbf{Conclusion}

No-fault is \textit{not} an easy and ideal cure for all the ailments of legal liability.\textsuperscript{108} No such cure-all is possible, precisely because of the va-

\textsuperscript{107} For an extended analysis of the problem of overlapping no-fault liability of health care providers and continued fault-based liability of the manufacturers of prescription drugs, suppliers of medical equipment, or other third parties that may be involved in patient injuries, see Weiler I, supra note 1, at 145. In addition to the list of huge malpractice awards referred to in note 32, supra, the largest jury verdict in 1991 was a $127 million verdict rendered in a Chicago suit by a patient who was blinded in one eye when injected with a manufacturer's drug by his ophthalmologist. See Charles Mount, \textit{Injured Man Awarded $127 Million from Upjohn}, CHI. TRIB., Oct. 19, 1991, at B1. Essentially the same problem has been faced for many decades in the occupational injury area, which is covered by both employer-provided workers' compensation and tort liability of third-party manufacturers of workplace products. The proposal in the text—which would make tort liability the tertiary insurer of medical injuries, standing behind no-fault liability and first-party loss insurance—is the one I have also advocated for occupational injury. See Paul C. Weiler, \textit{Workers' Compensation and Product Liability: The Interaction of a Tort and Non-Tort Regime}, 50 OHIO ST. L.J. 825 (1989).

\textsuperscript{108} Indeed, workers' compensation, our principal example of no-fault liability, has itself become the object of business concern and legislative reaction in numerous states, with total employer costs doubling since the mid-1980s. See Burton, supra note 8, at 1-2.
riety of constituencies whose needs and concerns must be accommodated. Such a divergence of interests exists even if one is inclined—as I am—to downplay the interests of doctors and lawyers in redesigning medical liability, and to concentrate principally on the needs of patients. The "patient" constituency is itself divided into three distinct groups. One is made up of patients who have already been injured as a result of past medical treatment and who want adequate and accessible compensation for their losses. A second consists of patients who are about to have treatment for their illnesses and want effective prevention of avoidable injuries. A third is comprised of people who, knowing they will be patients at some time in the future, are paying now for health insurance that funds the overall medical-care system—and who thus want these compensation and prevention functions of medical disability insurance provided with as much economy and as little waste as possible. There is no easy way to blend these competing values into a single liability system. But when one compares the promise of medical no-fault with the performance of malpractice litigation, the no-fault alternative has more than enough merit to justify its availability as a legal option. Hopefully the necessary legislation will be in place to facilitate design and use of this option by the time the nation is enveloped in yet another malpractice crisis—likely in the mid-1990s.109

**Addendum**

After this Article was written, Professor Jennifer Arlen authored an extended commentary on the pieces prepared for this symposium.

The article by Professor Gary Schwartz in this Symposium reinforces in my mind the need to use the elective approach to allow individual health care institutions to work out the crucial details of benefit eligibility and administration before a legislature presumes to mandate such no-fault coverage across the board. See Gary T. Schwartz, *Waste, Fraud, and Abuse in Workers' Compensation: The Recent California Experience*, 52 Md. L. Rev. 983 (1993). Ironically, the largest factor in rising workers' compensation costs is soaring expenditures by the health care system in treating injured employees—now constituting more than 40% of workers' compensation payments. For a revealing study that helps explain why, see Alex Swedlow et al., *Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians*, 327 New Eng. J. Med. 1502 (1992). I should also note that in executive sessions I have helped organize at Harvard over the workers' compensation crisis, the one point agreed upon by all parties—employers, unions, insurers, doctors, and lawyers—is that they did not want to dispense with the administrative no-fault model, and revive litigation about employer (and employee) fault for workplace injuries.

I have not altered my text to address the numerous thoughtful suggestions that Professor Arlen makes regarding the proper design of no-fault medical liability. However, I shall use this addendum to state my reactions to one of her key critiques. (The reader may wish to postpone reading this until after reading Professor Arlen's article.)

Professor Arlen and I share the view that the law's objective here is to secure an optimal blend of medical injury prevention and patient compensation while containing the costs of administering the liability program (including defensive and wasteful reactions by both doctors and patients to the presence of such a program). Within the existing tort regime, a key source of tension among these objectives is its treatment of payments made by collateral insurance sources. From the point of view of patient compensation, the most sensible step is to offset these first-party payments against any third-party liability award. However, Professor Arlen is legitimately concerned that the resulting diminution in hospitals' expected liability will reduce their incentive to prevent medical injuries happening in the first place. Thus, she sketches an elaborate scheme under which hospitals would bear all the costs of patient injury, but patients would collect only their actual pecuniary losses.

The simplest reason why in this context I favor, instead, collateral source offset is that this programmatic feature is the only basis upon which medical no-fault could possibly be entertained in the political arena. The Harvard Study found that if one made no-fault liability pay for the already-insured-against losses from all iatrogenic injuries, the program's costs would exceed those of present-day malpractice litigation by an order of magnitude—a step that in the current environment is simply unthinkable. Thus, those who agree (as I think Professor Arlen does) that medical no-fault is preferable to present-day tort-fault will have to accept this collateral source offset feature as well.

There are a number of practical reasons why we should not consider that political reality to be intolerable from the point of view of public policy. One reason is that the collateral source offset rule has been adopted by a growing number of legislatures to contain the size of malpractice recovery in individual cases, without expanding the range of this liability program at all. A second reason is the fact that the costs borne by the hospital from administering this

more accessible no-fault system—paying not just their own, but also their patients' legal bills—itself offsets some of the savings derived from the fact that most of the patient's direct injury costs are covered by first-party (largely health) insurance. Finally, if there were to be a sharp increase in the magnitude of hospitals' expected liability, so also would there be an increase in the tendency of hospitals to obtain liability insurance against that risk—thereby deflecting much of the incentive effect that might be derived from Professor Arlen's suggested expansion in legal liability.

Theoretical analysis is valuable in identifying the key issues that must be addressed in any legal reform. But the goal of liability reform is not to achieve a perfectly precise allocation of accident costs to responsible actors. That is a goal that can only be achieved in theoretical analysis. In the real world of medical liability, the law's aim should be to send out a meaningful enough signal to get the attention of those parties who are in a position to accomplish tangible improvements in the safety and quality of medical care. On that score, I believe that hospital-based, no-fault liability fares quite well, especially by comparison with the existing doctor-based, fault-oriented malpractice regime.