SCHOOL OF LAW
CASE WESTERN RESERVE UNIVERSITY

Case Western Reserve Law Review

Volume 36 | Issue 4 Article 18

1986

Commentary

James F. Blumstein

COMMENTARY

*James F. Blumstein**

INTRODUCTION

PROFESSOR GRAD has written an article concerning what he describes as the "so-called medical malpractice crisis, in reality a crisis of insurance availability . . . ." Professor Grad recommends the elimination of the tort liability system as applied to medical care and calls for a no-fault system of victim compensation that strictly limits individual recoveries and disregards the tort system's traditional concern for quality assurance.

As the title he has chosen for his paper reflects, he views the current situation with some not inconsiderable degree of pessimism. There is, in Professor Grad's judgment, "The Waning [of] Options." Of all the conclusions that Professor Grad reaches, I find that particular one to be the most troublesome and puzzling because it does not give adequate due to the exciting competitive marketplace developments that have occurred in the last decade. As a result, the thrust of the discussion was, for me at least, somewhat sterile, particularly in light of the stimulating and lively discussion of a vast array of options that occurred a few years ago at a conference on medical malpractice sponsored by the Urban Institute in Washington.[1]

Professor Grad's article contains a certain assertiveness concerning the propriety of a single proposed "solution" to the "crisis." Yet for many of us, I suspect, the one thing that we have come to believe is that a single, monolithic approach is not really going to provide a satisfactory solution. We now approach these issues with a heavy dose of dubiety concerning the one-right-way strategy of legislating a permanent, long-run solution. This is particularly the case when there are major disagreements about values in this highly sensitive field, as well as controversy concerning the critical elements of diagnosis of and prescription for the problem. I therefore

* Professor of Law, Vanderbilt Law School. B.A. (1966), M.A. (1970), LL.B. (1970), Yale University.

1. The papers from that conference are published in 49 *Law and Contemporary Problems* (Spr. 1986).

view Professor Grad's article as contributing to the dialogue concerning malpractice from a particular perspective, but I feel uncomfortable in recognizing it as a comprehensive analysis of the full array of options that might well be pursued in the public policy arena.

In this brief Commentary, I propose to examine Professor Grad's diagnosis of the problem, his prescription, and his proposed course of treatment.

I. DIAGNOSIS AND PRESCRIPTION

Professor Grad views the present malpractice system as "very expensive and absurdly ineffective." And Professor Grad does not mince words when he proceeds to assert that "[t]his absurdly inefficient system has few justifications." For Professor Grad, the problem is far-reaching and irremediable without a fundamental restructuring of the entire system of tort liability as it relates to the area of medical malpractice. The current system of tort liability achieves neither of its primary goals effectively, Professor Grad argues. It fails to compensate victims of medical maloccurrences fairly, and it does not contribute to the promotion of quality care (or, to look at the other side of the coin, it does not deter suboptimal levels of quality). In addition, from a philosophical viewpoint, Professor Grad views the system of tort law liability as "an outmoded theory of law and liability." To perpetuate such an unwarranted system—"to achieve its inadequate results"—is to add intellectual insult to the very practical injury suffered by unfairly compensated victims of untoward medical outcomes. Accordingly, Professor Grad recommends the abandonment of a system of tort liability with regard to medical injuries, replacing it with a scheme not unlike the workers' compensation approach that strictly limits recoveries and entirely disregards issues of quality assurance. Although some no-fault plans are sensitive to deterrence concerns,[2] Professor Grad's proposal seems bent on ignoring quality issues entirely.

Even those who are not prepared to endorse the full sweep of Professor Grad's condemnation of the tort liability system must concede that the system cannot be satisfactorily defended solely as a

2. *See, e.g.*, Havighurst & Tancredi, *Medical Adversity Insurance—A No-fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK MEMORIAL FUND Q. 125 (1985).

system of victim compensation.[3] But then the system of tort liability is not designed to serve merely a single value. Its very rationale is to strike a balance between the goals of compensation and quality assurance. The issue upon which Professor Grad's analysis must rest, consequently, is his pessimistic view of the impact of the tort liability system on deterring inappropriate, suboptimal levels of quality of medical care.

Again, Professor Grad is characteristically straightforward. He does not believe that the system of medical malpractice law makes any significant contribution to deterring poor quality care. "The scant evidence available leads to some negative conclusions: . . . the assertion that the tort law and lawsuits against physicians for medical malpractice exert a deterrent effect is not demonstrated by existing evidence although time and again the trial bar and patient advocates have claimed such an effect."

Professor Grad points out that the existence of liability insurance tends to undermine the deterrent impact of malpractice judgments from an economic point of view. By protecting a provider's assets, liability insurance offsets the financial *in terrorem* effect otherwise associated with the financial risk of liability for a negligent diagnosis, treatment decision, or act. Professor Grad argues that liability insurance premiums can be passed along to third party payors of medical care, including governmental payors. This practice serves not only to undermine the goal of deterrence, he argues, it also demonstrates the unhealthy beggar-thy-neighbor flavor in our system of tort liability.

Professor Grad acknowledges that there are nonpecuniary costs associated with medical malpractice liability, including loss of reputation. In an increasingly competitive environment, purchasers are shopping for bundles of services, and providers are grouping themselves into collective entities to be better able to bid for patient accounts. In that type of a competitive milieu,[4] where information is actively being sought in the lively economic marketplace, reputation is an extraordinarily valuable economic asset. The stigma associated with malpractice is likely to come to light more frequently in a competitive environment, and likely to have significant consequences as patient-provider and payor-provider relationships increasingly take on more of an arm's-length marketplace character.

3. *See* P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 3 (1985).

4. *See generally* Blumstein & Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849 (1981).

Professor Grad is undoubtedly correct when he asserts that convincing evidence with respect to the deterrence issue is lacking. But experts now estimate that the existing medical malpractice system could be justified if it reduces the number of negligent medical injuries by twenty percent.[5] The incidents of malpractice and injuries caused by malpractice are estimated to far exceed the cost of malpractice claims.[6] Thus, the cost of injuries due to malpractice is several times the cost of malpractice claims. That fact suggests an appropriate role for deterrence and the impropriety of just throwing up one's hands in favor of an approach that candidly places no emphasis whatsoever on deterrence.

Dissatisfaction with the present level of deterrence may or may not be justified. For those who are not satisfied, however, it would appear that the challenge is to design an institutional system of liability and liability insurance that more nearly accommodates the quality assurance interest. Particularly in view of the current pressures for cost containment that Professor Grad mentions, one would think that this is hardly the time to propose broad-based, comprehensive, and mandatory legislation that would expressly disregard the traditional tort concern with optimal deterrence. Even if the case for deterrence has not yet been satisfactorily proven, it would seem that steps short of abandoning the field altogether might be appropriately considered. Fortunately, the public policy debate now seems to recognize the need to address an appropriate mix of approaches that include deterrence as well as compensation.

One other element of Professor Grad's diagnosis is worthy of consideration. He notes the expense and unfairness associated with the present medical malpractice system. Although he cites the low end of a range of estimates, Professor Grad is correct that the proportion of malpractice insurance premium dollars winding up in patient/victim hands is relatively low. He uses the figure twenty-five percent. Others have estimated a range of twenty-eight to forty percent.[7] In any event, Professor Grad does successfully make the case that there are substantial costs associated with the adjudication of fault, the administration of claims, the negotiation of settlements, etc., inherent in the present system. Yet, preventable medical injuries are also very expensive, in some ways easily calculable and in other ways difficult to compute. The mere assertion of the present

5. *See* P. DANZON, *supra* note 3, at 226.

6. *See* Bovbjerg & Havighurst, *Medical Malpractice: An Update for Noncombatants*, BUS. & HEALTH, Sept. 1985, at 38.

7. *Id.* at 40.

system's expense is insufficient to answer the question whether the expense involved offsets an equal or higher expense attributable to medical injuries. That is why the deterrence issue is so critical and must be confronted, both analytically and institutionally.

Professor Grad's critique of the current system with regard to compensation also focuses on the existence of variable awards, especially where juries are involved, and on the relatively small number of claims that are actually litigated. But some have argued that out-of-court settlements correlate well with economic damages, such as loss of wages and medical expenses.[8] This synchrony suggests that sophisticated negotiators know what a malpractice claim is "worth" and can reach an accommodation, accordingly. Yet, the availability of an alternative—litigation—is probably necessary to create the proper climate for serious negotiations to take place.

Finally, the rhetoric of crisis that Professor Grad adopts may or may not be appropriate. The partisans in the political arena surely adopt that heated vocabulary, but one wonders whether, for purposes of analysis of alternative options, such charged language facilitates the type of serious discussion that is now occurring among economists, lawyers, physicians, and insurance industry representatives. For example, a more sober assessment reveals the following:

1) malpractice insurance premiums averaged $7100 in 1983;
2) fewer than twenty-five percent of physicians paid over $10,000 in malpractice insurance premiums in 1983;
3) total physicians' premiums accounted for only 3.8% of physicians' gross revenues in 1983, a relatively stable proportion over the past decade;
4) total malpractice premiums, excluding self-insurance programs, totaled about $2 billion in 1983 and estimates are that self-insurance funding probably cost less than $2 billion for that period;
5) malpractice expenses accounted for about one percent of national health care spending in 1983 (although the proportion varied widely across states) and have not grown much in the past decade.

Thus, as Bovbjerg and Havighurst state, "[w]hether the one percent is viewed as too much [or] too little of the health care budget to spend on compensating for malpractice, the total dollar amount poses no immediate fiscal threat to the health care system."[9] Those data suggest that a cooling of the rhetoric might be a prudent course, particularly for "noncombatants."

8. *See* P. DANZON, *supra* note 3, at 50.
9. Bovbjerg & Havighurst, *supra* note 6, at 39.

II. TREATMENT

Professor Grad recommends adoption of a no-fault system of compensation for medical injuries. He views no-fault compensation as equitable socially and economically, as well as affordable. It can provide "decent compensation to all persons injured in medical accidents, rather than outsized recoveries to a few." Moreover, Professor Grad views this comprehensive medical no-fault approach as the "only option which holds out the hope of a long-term resolution of the problem." Professor Grad draws that conclusion after a rather cursory examination of tort law reform alternatives and no examination of contract or other voluntary, negotiated approaches that would be consistent with the emerging decentralized, pluralistic, and competitive health care marketplace.

For Professor Grad, elimination of the issue of negligence simplifies the costly process of adjudication. Some critics of the no-fault approach wonder whether other thorny elements of litigation won't emerge, such as the issue of causation, in a system limited to injuries caused by medical treatment. The very attempt to draw a boundary around this partial social insurance scheme—limiting it to medical injuries—is likely to spur new areas of dispute and litigation.

Indeed, the broadest criticism of a no-fault system for medical injuries is typically the concern with causation, of determining compensable events.[10] The most reasonable no-fault proposals acknowledge these concerns and do not purport to be complete substitutes for the tort liability system. The comprehensive nature of Professor Grad's proposal results in the loss of some of the strengths of more limited no-fault plans. Professor Grad recognizes that "[e]ven proponents of such plans have sometimes found it difficult to define medical injury, the iatrogenic, treatment-related injury, adequately." Yet, he can only assure us that the "substantial [problem] may well yield a workable solution following more intensive study." That is not much solace, unfortunately, for such a wide ranging, wholesale substitution for the existing tort liability system.

Professor Grad would use a schedule of recoveries for injury. This schedule would not be fine-tuned to specific situations or to specific needs of beneficiaries. Thus, the victim is not likely to be made whole, since the scope of recovery would be tightly limited. This plan conforms, therefore, to a social insurance model, which, if

10. *See, e.g.*, Havighurst, *Medical Adversity Insurance—Has Its Time Come?*, 1975 DUKE L.J. 1233, 1252-56.

truth be known, seems to implement a not-so-hidden agenda. Recovery for pain and suffering would be barred. Loss of income for persons with high incomes would not be recompensed. Those persons would need to insure for those risks of loss independently. There is a heavy overlay of ideology—a leveling approach—that warrants fuller ferreting out and more forthright explication.[11] Indeed, with widespread medical insurance already in place for the vast majority of Americans, it is not clear why the compensation system Professor Grad envisions is necessary at all. Would it not create new areas of duplication and overlap while it is purporting to alleviate others?

Finally, I cannot conclude without a comment about the failure of Professor Grad to come to grips with the dramatically different health care landscape of the 1980's with the emergence of a competitive marketplace in the health care industry.[12] In this sense, Professor Grad's article suffers from a bit of a time warp.

Professor Clark Havighurst has observed that "active competition in the health care sector is what makes it possible now to contemplate private solutions to the problems posed by tort law for medical care providers and their patients."[13] The competitive environment also suggests a rethinking of regulatory, mandatory, comprehensive solutions to the malpractice issue. Private choice and pluralism may be more worthwhile alternatives, with legislative efforts aimed at perfecting the functioning of the market, assuring access to information, preventing collusion or boycotts, and enforcing private agreements within broad parameters of fairness. As part of that type of pluralistic system—which could incorporate agreements regarding arbitration, differing standards of care, recovery constraints, and varying rules on informed consent—a no-fault alternative surely has a place. But the legislative adoption of a no-fault system as the sole, preclusive alternative is probably not appropriate at this time. Rather, it is time to let one hundred flowers bloom in the health marketplace. It is too soon to lock into place a single, monolithic, preclusive option. Having just broken loose from a health system whose arteries were hardened by excessive

11. *See generally* Blumstein, *Distinguishing Government's Responsibility in Rationing Public and Private Medical Resources*, 60 TEX. L. REV. 899 (1982); Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345 (1981); Blumstein & Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL., POL'Y & L. 382 (1979).

12. *See, e.g.*, Blumstein & Sloan, *supra* note 4.

13. Havighurst, *Reforming Malpractice Law Through Consumer Choice*, 3 HEALTH AFF., Winter 1984, at 63, 65.

regulation, we must be careful not to walk all the way through a revolving door.