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MEDICAL MALPRACTICE LITIGATION (U.S.)— MEDICAL MISHAP COMPENSATION (N.Z.)

Walter Gellhorn†

Ours is an era of rising expectations concerning health care. Miracle drugs, death-defying surgical procedures, and demystification of the genes have become the almost daily diet of newspaper readers. Nowadays, successful outcomes of what in days past would have been lost causes have aroused in many laypersons a perhaps excessively fervid faith in the efficacy of medico-surgical efforts.

As in most other human affairs, the hopes of the faithful are often disappointed. Medico-surgical realities do not measure up to expectations. What then?

This paper considers two approaches to coping with the consequences of medico-surgical failure. In the United States, law seeks to provide monetary solace if it can trace the failure's cause to a blameworthy person or organization. In New Zealand, blame is irrelevant. A social insurance plan provides compensation for all personal injuries arising out of accidents, including medical mishaps, whatever may have been their cause.

The discussion that follows does not advocate one or another of the two approaches. The purpose is, rather, to underscore problems that require close attention, whichever be the approach taken.

I

MALPRACTICE LITIGATION IN THE UNITED STATES

In the United States, medical malpractice litigation has become epidemic rather than episodic. It reflects all manner of dissatisfactions on the part of patients (or their survivors) with the performance or nonperformance of medical, hospital, or staff personnel—venality or venery, incompetence or inattentiveness, negligence or neglectfulness, faulty diagnosis or faulty equipment. The range of alleged failures on the part of presumably well trained persons is indeed impressive.

Even so, the claims made are far fewer than they might be. Some years ago a rather limited survey of the records of reasonably representative hospitals suggested that seven and one-half percent

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of the persons who had been discharged after having received medical treatment had apparently been injured by it. Twenty-nine percent of these injuries, according to the survey, stemmed from negligence on the part of a health care provider.¹ Only a few persons who had suffered from this negligence, however, sought redress; the others accepted their fate because ignorant of having cause to complain or because the time and trouble and tension a contest would involve outweighed the possible satisfaction of gaining compensation.² Still, the claims that were formally expressed were numerous.

Claims, outcomes, and costs. During 1984 (the latest year for which comprehensive statistics are readily at hand) the American insurance industry closed approximately 73,500 malpractice claims against 103,300 health care providers.³ Fewer than half—forty-three percent—of the settled claims led to compensatory payments. The median payment was \$18,000; the nine percent of the paid claims closed by payment of indemnities of \$250,000 or more raised the average to \$80,741. The largest single payment in 1984 was \$2.5 million; the lowest was \$1. The total for the year was \$2.6 billion—to which must be added the more than \$800 million the insurance companies expended in investigating and defending against the claims closed.⁴

According to some estimates, somewhat less than half of the

¹ See Pocincki, Dogger & Schwartz, *The Incidence of Iatrogenic Injuries*, in U.S. DEP'T OF HEALTH, EDUC. AND WELFARE, REPORT OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE'S COMMISSION ON MEDICAL MALPRACTICE app. 50, 55, 62, 63 (DHEW Pub. No. (OS) 73-89, 1973). A California study commissioned a few years later by that state's medical and hospital associations put the figures a bit lower—adverse medical outcomes were noted in 4.65 percent of hospital discharges, and negligence had at least arguably occurred in 17 percent of those cases. MEDICAL INSURANCE FEASIBILITY STUDY 50-51, 103-05 (D. Mills ed. 1977). This study has been summarized in Mills, *Medical Insurance Feasibility Study—A Technical Summary*, 128 WESTERN J. MED. 360 (1978).

² Data evidencing underlitigation are explained in W. SCHWARTZ & N. KOMESAR, DOCTORS, DAMAGES AND DETERRENCE: AN ECONOMIC VIEW OF MEDICAL MALPRACTICE 11-12 (Rand, R-2340NIH/RC, 1978). A sampling that concentrated on persons injured while undergoing "high risk" medical treatments in hospitals showed that 61.2 percent of "adverse events" were of a "minor temporary nature." Only 1.1 percent were of a "major permanent total" or "grave permanent total" nature. HARVARD MEDICAL PRACTICE STUDY GROUP, MEDICAL CARE AND MEDICAL INJURIES IN THE STATE OF NEW YORK: A PILOT STUDY 66 (1987) [hereinafter N.Y. PILOT STUDY].

³ U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984, at 2 (GAO/HRD-87-55, Apr. 1987) [hereinafter APR. 1987 GAO REPORT]. Eighty percent of the claims closed by insurance companies in 1984 related to injuries that had occurred in hospitals; approximately 13 percent had occurred in doctors' offices. *Id.* at 25 table 2.8.

⁴ *Id.* at 2. The median and average costs of investigating and defending against claims closed in 1984 were \$2,390 and \$10,985, respectively. *Id.* at 2, 21, 22. Defense attorneys received almost 83 percent of the companies' costs (about \$668 million out of a total of \$807 million). *Id.* at 21.

total amount of the liability insurance premiums that health care providers pay reaches the pockets of claimants after insurance providers have made expenditures for claims administration and other corporate purposes.⁵ Of the portion of the medical malpractice insurance dollar that does reach the claimant after litigation, moreover, barely half, according to data analyzed a decade ago, remains in the claimant's pocket after he has paid all expenses, which include attorneys' and expert witnesses' fees.⁶ Apart from the immediate parties' expenditures, account must still be taken of the direct outlay of public dollars for judicial and administrative services to litigants, wholly distinct from additional long-term social costs resulting from under-compensation in some instances⁷ and, in others, spectacular over-compensation that may stimulate excessive combativeness in pursuit of a grand lottery prize.⁸

Claims settling is not a speedy process in most instances. In

⁵ Sugarman, *Doing Away with Tort Law*, 73 CALIF. L. REV. 555, 596 (1985). Estimates of what claimants actually received vary greatly, ranging from as low as 18 percent to a high of 54 percent of the premium dollar. U.S. DEP'T OF HEALTH & HUMAN SERVICES, REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE 16 (Aug. 1987) [hereinafter HHS TASK FORCE REPORT].

⁶ See J. KAKALICK & N. PACE, COSTS AND COMPENSATION PAID IN TORT LITIGATION 68-76 (1986).

⁷ Fifty-seven percent of the 73,500 medical malpractice claims that were closed in 1984 produced no payments at all, and many of the payments made in the remaining cases were for petty amounts. APR. 1987 GAO REPORT, *supra* note 3, at 2. Malpractice claimants whose demonstrable economic losses exceeded \$100,000 received from the insurers less than the amounts lost, while those whose losses ranged from zero to \$49,999 often received payments substantially greater than the actual economic loss. *Id.* at 44-45. Some years ago an analyst of recoveries by plaintiffs in automobile accident cases remarked, in terms that may be pertinent to medical malpractice cases as well, that "the fault system tends toward over-compensation in the small cases, while in big damage cases very few victims get as much as twenty-five per cent of their real economic loss." Franklin, *Replacing the Negligence Lottery: Compensation and Selective Reimbursement*, 53 VA. L. REV. 774, 780 (1967).

⁸ Until 1985 the largest malpractice award in North Carolina had been \$200,000. In March 1985 a jury awarded \$6.5 million. A medical mutual insurance company official reportedly feared this might "set a benchmark for future cases. The official attributed the larger awards and settlements to an increasing public awareness of the benefits of pursuing a claim [and] more aggressive plaintiff attorneys . . ." U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: 6 STATE CASE STUDIES SHOW CLAIMS AND COSTS STILL RISE DESPITE REFORMS 39 (GAO/HRD-87-21, Dec. 1986) [hereinafter DEC. 1986 GAO REPORT]. The unpredictability of jury verdicts is said also to be an element of the lottery. The "lottery" figure of speech reflects reality. In the period 1980-1984 the average jury award in malpractice cases in Cook County, Illinois, was \$1,179,000 (in 1984 dollars), when juries awarded anything at all. The big verdicts in 67 cases during those four years accounted for 85 percent of the total amount that Cook County juries awarded in 1980-1984; all the other successful suitors had to divide a small pot rather than gain a grand prize; and, plainly, the unsuccessful suitors won nothing at all. M. PETERSON, CIVIL JURIES IN THE 1980S: TRENDS IN JURY TRIALS AND VERDICTS IN CALIFORNIA AND COOK COUNTY, ILLINOIS 21, 32-34 (RAND R-3466-ICJ, 1987). Many jury awards are substantially pared by later court orders or by negotiations before any payments are actually made. The dollar amounts just stated do not consider subsequent reductions.

1984 a few cases were disposed of within a month, but the median time from filing to closing was twenty-three months, and the time elapse for those cases closed with an indemnity payment was often greater. Moreover, the cases that were generated by the more serious injuries and that led to the largest compensatory payments lingered even longer, some of them more than ten years.⁹

Efforts to curb costs. During recent years the federal and state governments have made strong efforts to curb costs associated with alleged medical malpractice, to expedite and improve decisions when contests arise, and to assure continuation of health services that had seemed jeopardized by mounting insurance costs borne by prudent health care providers. That problems existed was indisputable. What to do about them was uncertain.

Medical malpractice insurance rates rose to levels that led some doctors to retire or to avoid practicing in high-risk fields.¹⁰ In a number of states in 1986 the annual premium for obstetricians exceeded \$30,000, a discouragingly high figure for medically trained personnel who were considering a career choice; the cost of insurance for neurosurgeons, orthopedists, and others was not far behind, and sometimes was ahead.¹¹ In 1985 obstetricians and gynecologists in parts of Florida paid annual premiums of \$185,460; the national average for that group was \$23,300.¹²

Some legislatures were persuaded that insurance costs could and should be reduced by imposing a limit upon the amount recov-

⁹ APR. 1987 GAO REPORT, *supra* note 3, at 4; *see also* U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OR SOLUTIONS 4 (GAO/HRD-86-50, Feb. 1986) [hereinafter FEB. 1986 GAO REPORT] (organization of health care providers stated that "some patients were delaying their recovery, at the encouragement of their attorneys, to maximize damages").

¹⁰ *See infra* note 94.

¹¹ *See* DEC. 1986 GAO REPORT, *supra* note 8, at 16 table 2.2. The Association of Trial Lawyers of America, however, reportedly regarded medical malpractice liability insurance as not overly expensive, when considered in light of what the Association said was the average gross income of physicians (\$200,000). *See* FEB. 1986 GAO REPORT, *supra* note 9, at 26. Other inquiries have shown that the cost of insurance is a minor though still substantial element of the physician's total overhead expenses. In 1984, the average for all self-employed physicians was 9 percent of the "cost of doing business," but was greater for those in the "high-risk specialties." Obstetricians and gynecologists expended 8 percent of their gross income for insurance. *See* U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: INSURANCE COSTS INCREASED BUT VARIED AMONG PHYSICIANS AND HOSPITALS 3-4 (GAO/HRD-86-112, Sept. 1986) [hereinafter SEPT. 1986 GAO REPORT].

¹² HHS TASK FORCE REPORT, *supra* note 5, at 14. The most elaborate presentation of material related to the "rapidly expanding crisis" appears in U.S. TORT POLICY WORKING GROUP, REPORT OF THE TORT POLICY WORKING GROUP ON THE CAUSES, EXTENT AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY (Feb. 1986) [hereinafter TORT POLICY WORKING GROUP REPORT]. The Tort Policy Working Group was established by the Attorney General in 1985; its members are drawn from ten agencies and the White House.

erable by an injured person. This pleased the insurers and the insured, but gave rise to constitutional controversies (with diverse outcomes)¹³ as well as under-compensation for some of those who had been severely injured.

Because submitting complex medical issues to technically ill-equipped jurors seemed to many persons unwise, even though most state constitutions enshrine the "right to trial by jury," various states required that contested claims be initially scrutinized by panels whose members included health professionals. The judgment of a panel, the legislators thought, would influence the parties to settle disagreements. Thus far that hope has not been fulfilled. In some states lawyers contend that the panel proceeding has become simply a time-consuming step that delays final disposition of cases without improving the end result.

In yet other states, moves have been made to limit attorneys' fees, shorten the statutory period within which a suit for damages must be commenced, provide for periodic payments in place of large lump sums, require reduction of awards for payments a claimant has received from other sources (such as private insurance or workers' compensation), and eliminate the *ad damnum* segment of a formal complaint.¹⁴ The efficacy of these various "reforms" has not

¹³ See Note, *The Constitutionality of Medical Malpractice Legislative Reform: A National Survey*, 18 LOY. U. CHI. L.J. 1053 (1987) (authored by Larry Stephen Milner); Note, *Judicial Review of Medical Malpractice Legislation*, 20 SUFFOLK U.L. REV. 523 (1986) (authored by William N. Erickson). Compare *Carson v. Maurer*, 120 N.H. 925, 941-43, 424 A.2d 825, 836-38 (1985) (invalidating statutory limitation on amount recoverable for noneconomic consequences of medical malpractice) with *Fein v. Permanente Medical Group*, 38 Cal. 3d 137, 695 P.2d 665 (upholding cap on awards for pain and suffering), *appeal dismissed*, 474 U.S. 892 (1985). According to Huber, *Injury Litigation and Liability Insurance Dynamics*, 238 SCI., Oct. 2, 1987, at 31, 35, "Capping liability payouts has had some demonstrable impact in the few instances where strict rules have been put in place"—20 percent decrease or more. HHS TASK FORCE REPORT, *supra* note 5, at 121-35, provides an excellent overview of changes in state laws and court decisions bearing on malpractice claims.

¹⁴ In an *ad damnum* clause, the plaintiff specifies the relief he seeks. One presumes that the elimination of this clause is designed to discourage dull-witted jurors or newspaper readers from taking seriously a statement that a podiatrist who negligently removed an ingrown toenail should pay \$20,000,000 to compensate for having caused the plaintiff physical and emotional distress and lastingly impaired his ability to race in the Boston Marathon. At least 31 states prohibit any statement of the amount of damages claimed. HHS TASK FORCE REPORT, *supra* note 5, at 125. For a report of recent legislative responses to the liability insurance crisis, see NAT'L CONFERENCE OF STATE LEGISLATURES, *RESOLVING THE LIABILITY INSURANCE CRISIS: STATE LEGISLATIVE ACTIVITIES IN 1986* (July 1986). For a useful discussion of earlier legislative modifications of pre-existing tort law, see Kemper, Selby & Simmons, *Reform Revisited: A Review of the Indiana Malpractice Act Ten Years Later*, 19 IND. L. REV. 1129 (1986) [hereinafter Kemper]; Trebilcock, *The Social Insurance-Deterrence Dilemma of Modern North American Tort Law: A Canadian Perspective on the Liability Insurance Crisis*, 24 SAN DIEGO L. REV. 929 (1987); see also APR. 1987 GAO REPORT, *supra* note 3, at 3, 38; Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 5, 18-26.

yet been thoroughly confirmed by empirical data.¹⁵

Social purposes of malpractice actions. Why does a system survive, despite being extremely costly in dollars-and-cents and yet far from demonstrably efficient in fairly or fully recompensing those who have been injured by a health care provider's asserted fault? Why is persuading an inexperienced jury that some identifiable fault in the course of medical treatment caused a claimant's injury deemed to be an essential element of any plan to deal financially with the consequences of the injury?

A cynic might remark, by way of answer, that lawyers and insurance companies benefit financially from things as they are, and therefore resist change.¹⁶ That explanation has substance, but is a gross oversimplification. Most of those who favor (or at least accept without demur) the present system of malpractice litigation sincerely ascribe to its benign effects and principled purposes; their belief in those effects and purposes should not be summarily dismissed.

¹⁵ See Danzon, *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims*, 48 OHIO ST. L.J. 413 (1987). Compare P. DANZON, *THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS* (1982) (dollar caps and offset by collateral sources reduced severity of malpractice claims, but evidence shows no connection between reforms and decline in frequency of claims) and Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 57 [hereinafter Danzon, *New Evidence*] (concluding that some changes, such as offsetting collateral benefits, shortening statute of limitations, and capping awards, had in fact reduced claim frequency or claim severity, but that pre-trial screening panels had been ineffective) with Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J. HEALTH POL. POL'Y & LAW 629, 640 (1985) (showing that of all the "reforms" only the mandatory use of screening panels could be said to have had a statistically significant impact on malpractice insurance premiums) and DEC. 1986 GAO REPORT, *supra* note 8, at 18 (reporting that "[w]ith few exceptions, the reforms were perceived by the organizations surveyed as having no major impact on the number of claims filed or the size of awards and settlements."). Grad, *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, 36 CASE W. RES. L. REV. 1058, 1076-85 (1986), is an especially insightful description and appraisal of the various "crisis" enactments. At present a not yet successful attempt to transfer malpractice claims from the realm of tort law to the realm of contract law is discernible. See, e.g., Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 287; Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 261; Ginsburg, Kahn, Thornhill & Gambardella, *Contractual Revisions to Medical Malpractice Liability*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 253.

¹⁶ See, e.g., Pierce, *Institutional Aspects of Tort Reform*, 73 CALIF. L. REV. 917, 918 (1985) (referring to "the existence of powerful vested interests opposing change").

No consensus is likely to develop because neither potential accident victims nor society at large has an effective voice in the lawmaking process. Two groups that have much greater ability to affect that process—trial lawyers and insurance companies—perceive significant advantages in the present system and oppose most reforms vigorously. Any attempt to reform tort law must recognize and deal with these obstacles.

Id. (footnotes omitted).

An able American Bar Association committee, whose commentaries were written by one of this country's outstanding professors of tort law, suggested as recently as 1984 that "the right of citizens to bring suit for private wrongs, reinforced by widespread knowledge of that right, provides an important outlet for conflict that otherwise would break into violence."¹⁷ The development of liability for fault in the mid-nineteenth century¹⁸ reflected a moral sentiment, by no means now extinct, that *justice* (however it be defined) demands that the doer of an injurious act compensate an innocent person who has suffered as a direct consequence of that act.¹⁹

As the ABA committee acknowledged, the rise of liability insurance and the development of social mechanisms for dealing with the immediate economic and medical impacts of personal injury have attenuated the "raw emotions" of times long past. Yet the contention that tort law, "as an interstitial resolver" of individual controversies, serves "both as a grievance mechanism at a level of advanced social development and as a brake on the overt conflict that may break through the crust of civilization when injury victims have reason to believe that society is not responding justly to their plight" is still plausible.²⁰

Many thoughtful analysts now reject the conventional hypothesis that systematically affixing individual liability for a fault injurious to another serves these two great social purposes—avoidance of

¹⁷ ABA SPECIAL COMM. ON THE TORT LIABILITY SYSTEM, TOWARDS A JURISPRUDENCE OF INJURY: THE CONTINUING CREATION OF A SYSTEM OF SUBSTANTIVE JUSTICE IN AMERICAN TORT LAW 3-16 (with commentaries by Marshall S. Shapo, Nov. 1984) [hereinafter ABA REPORT].

¹⁸ See, e.g., *Brown v. Kendall*, 60 Mass. 292 (1850); Fletcher, *Fairness and Utility in Tort Theory*, 85 HARV. L. REV. 537, 561 (1972).

¹⁹ But see G. CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 301 (1970): "It strikes critic and community as unfair if a person injured by someone who has violated a moral code is not compensated, or if someone who violates a moral code and is hurt is compensated, at the expense of an innocent party." The author does not, however, believe that "rather undifferentiated notions of justice" do in reality support "the fault system," based as it purports to be on "a simplistic bilateral view of the accident problem." He concludes that

the moment one accepts the notion that justice does not require that an individual injurer compensate his individual victim—and the allowance of insurance for faulty parties is clear indication that this notion is accepted—and the moment one realizes that wrongdoers can be punished for wrongful acts quite apart from whether they must compensate victims, it becomes very hard to see how the fault system can be supported on grounds of justice.

Id. at 302-03. Compare Gregory, *Trespass to Negligence to Absolute Liability*, 37 VA. L. REV. 359, 396, 397 (1951) ("growth of insurance with its possibilities of risk-spreading and loss absorption, has changed our social context as much as any other single development"). But cf. TORT POLICY WORKING GROUP REPORT, *supra* note 10, at 30-33 (extolling the concept of fault).

²⁰ ABA REPORT, *supra* note 17, at 3-18.

vengeful violence and fulfillment of the community's sense of right and wrong. Guido Calabresi, dean of the Yale law faculty, for example, believes that American society has long been wholly ready "to abandon the view that justice requires individual injurers to pay their victims on the basis of fault and . . . , moreover, wherever an adequate alternative has been presented, people have tended to prefer it to the traditional fault system,"²¹ as shown, for example, by the general acceptance of workers' compensation laws that provide limited but assured compensation for employment-related injuries regardless of fault. The prevalence and acceptability of insurance, Calabresi adds, "strongly suggests that we do not worry too much about whether the individual faulty party pays his victim, so long as the victim is paid."²² In Dean Calabresi's view,

justice will support the fault system only if there is no sensible alternative system presented, only if the choice is solely between crushing one relatively wrongful and one relatively innocent party. . . . [T]he moral aims of our society, and even our undifferentiated sense of justice, can be better met through systems that concentrate on the deterrence and compensation we want than through an archaic system of liability that presumes an organization of society in which the best that can be done is to treat each accident . . . as a universe unto itself.²³

Tort law as a necessary deterrent. A third justification of the tort system's approach to adverse effects of medical attention (or inattention) is the widespread belief, shared by the American Bar Association's special committee, that it "provides a significant, and necessary, deterrent against incompetent and careless rendition of medical services."²⁴

The soundness of that view has been increasingly challenged in recent decades. Insurance forestalls the individualized impact of a jury's conclusion that a health care provider has been at fault. Individual defendants may suffer costs in terms of lost time and, as is often said, emotional wounds; but payment of a damage award against an identified defendant is made from a pooled fund of insurance premiums, rather than from the funds of the asserted wrongdoer. Hence the possibility that gigantic personal liability will bring financial ruin is negated in this context. That possibility may once have been a true threat, but it is no longer likely to be wholly effective as a deterrent in the real world of today.²⁵

²¹ G. CALABRESI, *supra* note 19, at 304.

²² *Id.* at 305.

²³ *Id.* at 307.

²⁴ ABA REPORT, *supra* note 17, at 11-32.

²⁵ See Fleming, *The Role of Negligence in Modern Tort Law*, 53 VA. L. REV. 815, 823-24

Nevertheless, the desire to avoid involvement in litigation remains even without the threat of large financial losses. This, according to some, has induced many physicians to engage in costly "defensive medicine," characterized by excessive tests and superfluous procedures, to preclude any possibility of later being accused of having neglected measures that just conceivably might have been helpful to the patient.²⁶ Other medical personnel have abandoned practice altogether in order to lessen their own exposure to litigation.²⁷

(1967) ("The deterrent function of the law of torts was severely, perhaps fatally, undermined by the advent of liability insurance."). *But see* P. DANZON, *MEDICAL MALPRACTICE* ch. 7 (1985); *cf.* S. SHAVELL, *ECONOMIC ANALYSIS OF ACCIDENT LAW* 292 (1987) (though acknowledging "the relative lack of statistical study" of extent to which prospect of liability really deters, and need to "rely mainly on intuition" in considering that matter, author concludes that a person's being protected by liability insurance does not altogether undo deterrent effect of liability on behavior).

By and large, malpractice insurance rates are fixed for a class rather than for an individual. "Merit rating" of individuals, which leads to differentials in rates or other aspects of the insurance policy, is practiced by some though by no means all insurers. A recent Massachusetts statute has mandated merit rating for the bulk of the insured health care providers in that state. *See* MASS. GEN. LAWS ANN. ch. 175A, § 5A (West 1987). The underlying theory is that this will personalize insurance costs sufficiently to stimulate greater care. Information concerning insurance rates, practices, and claims costs is excellently summarized in HHS TASK FORCE REPORT, *supra* note 5, at 145-78; *see also* SEPT. 1986 GAO REPORT, *supra* note 11, at 14-15 (brief summary of factors influencing rates and type of policies).

²⁶ *See* SEPT. 1986 GAO REPORT, *supra* note 11, at 13. Defensive medicine has included not only additional diagnostic tests and treatment procedures, but also more elaborate patient records, more frequent follow-up visits by patients to their doctors, and more time spent with each patient. The American Medical Association stated that these steps were not being dictated by medical considerations, and were of marginal benefit to patients and unjustifiably costly. The Association of Trial Lawyers of America, on the other hand, regarded all of this as simply "careful medicine," not "defensive medicine." *Id.* The GAO remarked: "The cost of defensive medicine is impossible to quantify with any degree of confidence because of the difficulty in developing a sound methodology to isolate 'defensive' practices from medical care provided for good clinical reasons." *Id.* A recent study estimated that the cost came to \$10.6 billion in 1984, accounting for 18 percent of what was spent for all physicians' services in that year. *See* Reynolds, Rizzo & Gonzalez, *The Cost of Medical Professional Liability*, 257 J. A.M.A. 2776, 2778 (1987). For skeptical appraisal of the problem of defensive medicine, *see* Robinson, *Rethinking the Allocation of Medical Malpractice Risks between Patients and Providers*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 172, 176-78. For a far more cynical analysis, *see* Fine & Sunshine, *Malpractice Reform Through Consumer Choice and Consumer Education: Are New Concepts Marketable?*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 213, 215-217. *See also* *MEDICAL MALPRACTICE* 22, 27-28, 32-33 (D. Yaggy & P. Hodgson eds. 1987).

²⁷ The Massachusetts chapter of the American College of Obstetricians and Gynecologists asserted recently that since 1984 nearly one-fifth of the 428 Massachusetts obstetricians who had responded to a survey sent to 635 Fellows had ceased practicing obstetrics because of burdensome insurance costs and litigation. *N.Y. Times*, Jan. 17, 1988, § 1, at 38, col. 1. Compare *N.Y. PILOT STUDY*, *supra* note 2, at 11. *See also id.* at 121-122, noting that though an adverse verdict in a malpractice proceeding may have "some impact upon professional reputation and practice" and may perhaps even cause

Other deterrents. Though the efficacy of malpractice suits as producers of care and competence may be debated, nobody doubts that carelessness and incompetence must be deterred. If the fault system, involving nonexpert jurors' judgments concerning responsibility for particular occurrences (often in the distant past), does not adequately fulfill the need for deterrence, what should take its place?

Years ago critics of the existing pattern of litigation argued that imprisonment or civil monetary fines beyond the protection of a liability insurance policy would be more effective than tort law in shaping behavior.²⁸ Professional disciplinary action against health care providers whose conduct had not measured up to expected standards would be yet more effective as a warning signal. It would deliver a message not only to those who were themselves being disciplined and were thus being told to mend their ways, but would

an insurer to increase a physician's future insurance costs, doubt remains concerning the efficacy of tort proceedings as "incentives to doctors and other providers to be more careful in their course of treatment"

First, an ideal prevention system needs to make accurate judgments about who really was at fault in particular incidents, and then to tailor its sanctions to the degree of carelessness involved in different accidents. Under the tort system, though, the initiation of a suit and the assessment of damages are dependent on the nature and level of the patient's injury rather than upon the gravity of the doctor's negligence, and the judgments about the latter are made by lay juries who may be prone to mistakes in appraising complicated forms of treatment with the benefit of hindsight.

Id.

²⁸ See, e.g., G. CALABRESI, *supra* note 19, at 269-70, 272:

whenever normal individuals can choose whether or not to engage in wrongful conduct before an accident, an appropriate noninsurable penalty is necessarily a more effective deterrent than an already paid insurance premium.

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. . . . Because the fault system, like the market system, must work primarily through raising the costs to categories of individuals rather than affecting the individual at the time of decision, it is necessarily as ineffective as the market system in dealing with such acts, and considerably less effective than a system of penalties.

For a sophisticated analysis of the efficacy of the fault-liability system as a deterrent and safety enhancer, see Pierce, *Encouraging Safety: The Limits of Tort Law and Government Regulation*, 33 VAND. L. REV. 1281 (1980). Pierce argues that modern tort law ineffectively deters accidents and poorly compensates victims, compensating only some of those who are deserving, frequently undercompensating, and seldom compensating promptly.

As to compensation, distinct from deterrence, see D. HARRIS, M. MACLEAN, H. GENN, S. LLOYD-BOSTOCK, P. FENN, P. CORFIELD & Y. BRITAN, *COMPENSATION AND SUPPORT FOR ILLNESS AND INJURY* (1984) [hereinafter D. HARRIS], ably (and discordantly) reviewed by Abel, Book Review, 73 CALIF. L. REV. 1003 (1985); Kornhauser, Book Review, 73 CALIF. L. REV. 1024 (1985); see also P. MUNCH [DANZON], *COSTS AND BENEFITS OF THE TORT SYSTEM IF VIEWED AS A COMPENSATION SYSTEM* 71-90 (1977).

also remind others of the professional discrediting that substandard performances might bring.

Typically, hospitals maintain self-administered "quality assurance programs" that provide opportunity to review the work of the staff (including independent physicians who have been accorded the privilege of admitting their patients). These programs have been slackly administered in many institutions and have therefore been of variable worth. Their mere existence has given no assurance that the quality of attending physicians' work will be closely examined.²⁹

The medical profession itself and state governments' administrative organs have sweeping power to restrict or even halt a miscreant physician's career; but inadequate funding for staff and investigatory resources, often coupled with indecisive leadership, has made for scant use of the power. Still, judgments rendered by bodies like these impress health professionals more profoundly than do the verdicts of jurors who, when asked to determine whether faulty conduct occurred in an event long past, may sometimes be impressed by the sad state of the plaintiff in the case now before them, without fully grasping the medical subtleties of the case that was actually before the physician long ago. Moreover, an adverse determination by a professional tribunal cannot be shrugged off; the offender cannot simply pass it along to his insurance company.

A real question nevertheless arises about the efficacy of existing disciplinary processes because, plainly, they do not commence of themselves and those who are responsible for putting them into motion have sometimes themselves apparently been slow to move. As a recent report to the New York State Commissioner of Health declared:

Whatever its other deficiencies, the tort system does stimulate patients who have been injured by careless treatment to call to account the doctor or hospital in open court. The patient's lawyer has a professional and financial incentive to do the best job possible of documenting the case against such negligent treatment.³⁰

²⁹ The American Association of Retired Persons has asserted that "the existence of only 'paper' quality assurance programs has contributed significantly to the incidences of malpractice." FEB. 1986 GAO REPORT, *supra* note 9, at 28.

³⁰ N.Y. PILOT STUDY, *supra* note 2, at 124, 125. A research aim of the study is to provide empirical testing of the view that external or internal systems for appraising the work of medical personnel are dominated by fellow professionals who lack incentive to initiate and conduct vigorous proceedings against allegedly negligent physicians "and then to impose the types of sanctions or preventive measures which the pattern of behavior exhibited in the case might seem to demand." *Id.* at 124-25. In late 1985 the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services studied state medical licensing boards. The OIG found that budgetary and personnel inadequacies had resulted in large backlogs of undecided cases and consequent lack of enthusiasm for initiating yet more disciplinary proceedings. The OIG recommended

Safety enhancement as the goal sought. In this area of human concern, the goal to which law aspires (or, at any rate, should aspire) is enhancing safety. That is to say, law should seek primarily to help diminish the occurrence of injuries related to health care, rather than be content with simply assigning blame, administering discipline after the event, or providing compensation for accidents that have already occurred. If fault-based tort remedies are, at best, only spottily effective as enhancers of patients' safety and if noninsurable penalties upon physicians and other providers of health services have been mildly applied in the past,³¹ can administration of professional discipline be invigorated to accomplish its declared purpose of injury prevention? Real possibility of an affirmative answer to that question now exists.

Identification of unworthy physicians. The licensing and disciplining of physicians are state functions. As in so many other areas of state affairs, however, the national government can and does heavily influence the content and administration of state laws by financial inducements, technical assistance, and educational programs.³² The federal role has been enlarged by enactment of the Health Care Quality Improvement Act of 1986,³³ which, among other things, comprehensively requires hospitals, state licensing boards, peer review organizations, and other bodies involved in granting privileges

increased physician licensing fees to support expanded and improved disciplinary activities. HHS TASK FORCE REPORT, *supra* note 5, at 63.

³¹ See HHS TASK FORCE REPORT, *supra* note 5, at 65-66: Licensed physicians in 1985 numbered 552,716. In that year the licensing boards of the fifty states took 2,108 disciplinary actions (37 percent more than in 1984). They revoked 406 licenses and suspended 235, they placed 491 physicians on probation, and they otherwise disciplined 976 for unacceptable behavior. The state boards proceeded informally in perhaps three times as many cases; the informal actions included directing a licensee to "avoid performing certain procedures which are beyond his competence, or to obtain further training." *Id.* at 65. Approximately half of the disciplinary actions formally taken related to improper prescription of drugs, and a physician's personal drug or alcohol abuse accounted for roughly a quarter of the total. The relatively small number of disciplinary actions for incompetence may not fully reflect the number of proceedings launched on that account "since boards may be using more easily proven violations such as drug use or over-prescribing, which often coexist with incompetence, as the basis for their actions" when legally adequate evidence to prove incompetence is not readily at hand or when lengthy proceedings can be avoided by relying on other issues. *Id.* at 66.

The legal profession's record in dealing with discreditable attorneys is not so glittering as to warrant lawyers' casting the first stone. See, e.g., Weber, "Still in Good Standing": *The Crisis in Attorney Discipline*, A.B.A. J., Nov. 1, 1987, at 58.

³² One of the national government's informational undertakings that many regard as having improved health care and lessened the occurrence of iatrogenic injuries (i.e., injuries caused by physician or surgeon) is the National Second Surgical Opinion Program, which informs persons who may be facing elective surgery and encourages steps to guard against improvident procedures.

³³ Pub. L. No. 99-660, §§ 401-432, 100 Stat. 3743, 3784-94 (codified at 42 U.S.C.A. §§ 52, 11101-111 (West Supp. 1987)).

to or imposing discipline upon physicians to report at least monthly every adverse action taken. Further, every insurance provider (whether a commercial enterprise or a mutual protection society) must now report every settlement or judgment paid on a malpractice claim, with the name of the affected practitioner, the name of any hospital with which he may be linked, a description of the alleged acts or omissions, and the consequent injuries.³⁴

The Department of Health and Human Services, which receives these multitudinous reports and deposits them in a National Data Bank, will be in a position to provide timely information about a physician or other licensed health care practitioner upon the request of state licensing boards, hospitals, and other health care entities that "have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner or to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff."³⁵ If suitable use is made of the National Data Bank, this single step will greatly strengthen existing means of preventing an individual who is under disciplinary restraint in one area from simply moving to another; licensure can become better informed and more confident, and hospitals will be far better able to avoid employing or having other professional relationships with physicians of questionable reliability.³⁶

³⁴ *Id.* §§ 421-25, 42 U.S.C.A. §§ 11131-11135. Federal agencies themselves employ 21,500 full-time physicians and contract with several times that number. HHS TASK FORCE REPORT, *supra* note 5, at 78. The reporting requirements just described do not apply to the federal government, but presumably the employing and contracting agencies will voluntarily report to the National Data Bank (as most had to the Disciplinary Data Bank, described below) concerning actions affecting their personnel individually; and presumably, too, when they are considering candidates for employment, they will draw on others' deposits of information in the data bank.

The Federation of State Medical Boards has long maintained a Physician Disciplinary Data Bank (DDB), which has been a useful tool. The DDB, however, was not so comprehensive as the new national data bank; reports to it were voluntary, and hospitals and insurance carriers were under no obligation to convey to the DDB the information they possessed.

³⁵ Health Care Quality Improvement Act § 427(a), 42 U.S.C.A. § 11137(a).

³⁶ Section 425(a)(1), 42 U.S.C.A. § 11135(a), imposes a duty on each hospital to request information from the National Data Bank whenever a practitioner applies for hospital staff privileges (courtesy or otherwise). Section 425(a)(2), 42 U.S.C.A. § 11135(b), requires each hospital biennially to request a report concerning all of its staff members as well as any practitioners granted clinical privileges.

A 1985 Pennsylvania study revealed that one percent of the physicians in that state had been responsible for 25 percent of paid claims. HHS TASK FORCE REPORT, *supra* note 5, at 58. Of course this did not conclusively establish that each and every member of that small group should be shunned ever afterward; still, were the past record known, the need of close examination in the future would be clear. *See also* U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION 14 (GAO/HRD-87-73, May 1987) [hereinafter MAY 1987 GAO REPORT] (of 71,930 physicians involved in malpractice claims closed in 1984, at least 42 percent had previously been the objects of

Another admirable step toward weeding out the unsuitable practitioners—or, in some instances, simply constricting the professional activities in which they may engage—has been taken altogether nongovernmentally by the American Medical Association (AMA). The AMA's Physician Masterfile now contains verified data concerning the education and specialty board certification (if any) of every physician in the country. Disciplinary action reported to the Federation of State Medical Boards' data bank is noted in the Physician Masterfile. Indeed, if a physician is known to have been disciplined in one state, the AMA takes it upon itself to inform the appropriate authorities in every other state in which that individual may also have been licensed. The AMA also notifies states of physicians' deaths, because impostors have sometimes used the credentials of deceased practitioners to gain entry into medical practice.³⁷

The easier availability of relevant information concerning medical personnel will be of diminished value if the pertinent state agencies and other review organizations are inadequately financed and unsuitably staffed to utilize it.³⁸ As to that, variations among the states are likely, as has been true in respect of allocation of public resources for many other socially desirable programs. Yet one may reasonably hope and believe that the more populous states, those with the largest corps of medical personnel and probably the largest volume of controversy concerning the quality of medical performance, will be energetic in seeking to deter objectionable practices.

The New York experience. New York is an example. There, a newly invigorated Office of Professional Medical Conduct (OPMC) is responsible for investigating all complaints of medical misconduct and, when warranted, for filing formal charges that lead to a hearing before a committee of the Board for Professional Medical Conduct or, in urgent situations, to summary license suspension by the State Commissioner of Health.³⁹ The OPMC's investigation unit has as

claims). As FEB. 1986 GAO REPORT, *supra* note 9, at 60-61, stresses, however, a health care provider's competence cannot be determined by simply counting the number of lawsuits that named her as defendant.

³⁷ The above information is drawn from HHS TASK FORCE REPORT, *supra* note 5, at 68, and from sources there cited.

³⁸ A 1985 study found that although the powers of state medical licensing boards had been enlarged in recent years, "budgetary, personnel, and productivity increases have not kept pace with expanding workloads, and as a result large backlogs and extensive caseloads have become commonplace," contributing to tardy disciplinary action in some instances. HHS TASK FORCE REPORT, *supra* note 5, at 63; see also OFFICE OF INSPECTOR GENERAL, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, MEDICAL LICENSURE AND DISCIPLINE, AN OVERVIEW ii, 12-18 (1986).

³⁹ "Medical misconduct" is embracively defined by N.Y. EDUC. LAW § 6509 (McKinney 1985) and by N.Y. COMP. CODES R. & REGS., tit. 8, §§ 29.1, 29.2, 29.4 (1987). The Board for Professional Medical Conduct is established pursuant to N.Y. PUB. HEALTH LAW § 230 (McKinney 1987). That same section provides the Health Commissioner's

its objective the completion of investigation within six months of receiving a complaint.

During 1986 the Office of Professional Medical Conduct acted on its own initiative thirty-seven times and responded to approximately 2,500 complaints. Of these, 1,360 came from members of the public or the news media, eighty-four were anonymous, and the rest came from diverse sources including physicians and insurance companies.⁴⁰ The volume of complaints exceeded that of the immediately preceding years by almost one-third, presumably not because the occasions to complain had increased so dramatically, but because public awareness of and confidence in the available administrative process had mounted. The OPMC completed 2,740 investigations in 1986, approximately twice as many as in 1985 and eight times as many as in 1982. It sent 301 cases, six times as many as in 1984 and more than double those in 1985, forward for formal proceedings. Of these, the board rendered decisions in 206 of 242 cases that came before it. Final revocations or surrenders of licenses were ordered in ninety-two cases, triple the number in 1982 and double the number in 1985; less severe sanctions such as suspensions for stated periods, censure and reprimand, and critical findings noted on the licensee's record occurred in ninety-seven instances, far above the levels of the years before. In addition, the Health Commissioner summarily suspended fifteen licenses in 1986, as against four in 1985 and two in 1984.⁴¹

Inquiry into the circumstances of the individual cases, however, reveals again that seeking to eliminate the unfit among the mass of licensees may involve issues other than the performance of medical responsibilities alone. Of the 206 cases that were decided on the basis of formal charges filed by the OPMC, eighty-three related to

power to suspend a license summarily. The Board, whose members are appointed by the Health Commissioner with the Governor's approval, consisted of 124 physician members and 32 lay members in 1987. "Hearing committees" have two physician members and one lay member. *Id.* § 230(6).

⁴⁰ Insurance companies in New York are required by N.Y. Ins. Law § 315 (McKinney 1985) to report incidents of possible malpractice of which they are informed. In 1986, New York inaugurated an improved reporting and data recording system to further facilitate OPMC's inquiries. Only 40 of the complaints received in 1986, however, came from insurance companies, so the improved system had slight use.

In addition to complaints that may generate investigations, the OPMC has at hand a mass of required quarterly reports from insurance companies concerning malpractice claims against New York doctors, their disposition by judgment or settlement, and any cancellation of medical liability insurance for reasons other than nonpayment of premiums. These reports go to OPMC's Medical Malpractice Unit for analysis and aggregation, to be used mainly for future legislative or administrative policymaking rather than for indications of need to investigate individuals.

⁴¹ The numbers given in the text and in the discussion that follows were provided to the author by the New York State Department of Health.

improper dispensation of drugs, twenty-six to Medicaid/Medicare/insurance fraud, one to dealing in counterfeit currency, three to falsification of records, three to income tax evasion, and still others to variegated criminal offenses. Some of these—such as drug dispensation, falsifying records, and participating in fraudulent practices—in all likelihood touched upon the performance of professional duties as well as upon personal morality. The specific charges, however, related to criminal behavior rather than to medical responsibilities.

Thirty-two additional cases dealt with impairment, and nine with fraudulently obtaining a medical diploma. State proceedings in these instances undoubtedly reflected a desire to lessen the risk of patients suffering injuries in the course of medical treatment.⁴²

As for cases of types that might directly generate malpractice claims by patients, twenty-seven related to negligent, incompetent, or fraudulent practice, one to abetting an unlicensed person, one to patient abandonment, and sixteen to sexual abuse.

The tone and energy of New York's activism may reflect the personal qualities of the present Health Commissioner, Dr. David Axelrod. He has indeed spurred improved administration and the development of enlightened policy in many areas. Without reference to personalities, however, New York with its roughly 55,000 licensed doctors has begun doing what other states with smaller medical populations can do also, if they choose.

Many states have enacted "shield laws" that, like New York's,

⁴² The New York State Medical Society has created a Physicians Committee to work with the state authorities in seeking to rehabilitate a physician whose license has been suspended (or voluntarily surrendered) because of alcohol, drug, or mental health problems. After a treatment program has met with apparent success and a physician's license has been restored, a monitoring program and probation continue for at least two years. Monitoring involves not merely random testing, but also close supervision of the licensee's medical practice as revealed by case records and direct observation. N.Y. PUB. HEALTH LAW § 230(17)-(18) (McKinney 1987). And note HHS TASK FORCE REPORT, *supra* note 5, at 70-71, remarking that "objectionable practices" may reflect impairment rather than technical lacks:

Impairment, defined as 'the inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness, including alcoholism or drug dependence,' can be a cause of substandard performance and avoidable medical injury.

...

Whatever the exact number of impaired physicians, even a small number is sufficient to warrant strong programs addressing the situation, in view of their role as providers of care where less than full awareness and good judgment may result in injury or death to the patient.

The close linkage between physicians' impairment and medical malpractice has been effectively shown in an October 1987 report to New Jersey's governor and legislature, REPORT AND RECOMMENDATIONS OF THE STATE OF NEW JERSEY COMMISSION OF INVESTIGATION ON IMPAIRED AND INCOMPETENT PHYSICIANS 8, 10-12, 33 (Oct. 1987).

should encourage utilization of the state's disciplinary processes by safeguarding informants against reprisals in the form of lawsuits for defamation, conspiracy to restrain competition,⁴³ and other unpleasantries.⁴⁴ No longer should fear impede the flow of pertinent information about unworthy practitioners. On the contrary, the flow should increase when stimulated by mounting awareness that information will in fact be put to sophisticated use rather than smothered by "professional courtesy" or administrative lethargy.⁴⁵ Even so, the "brotherhood of silence" within the medical profession itself has not yet been overcome.

New moves toward safety enhancement. Two other developments can possibly advance the cause of patient safety more significantly than can the threat of either tort actions or disciplinary proceedings after harm has been done.

First, organizations of accredited specialists have progressively developed guidelines and standards to enhance the quality of care their members provide.⁴⁶

⁴³ See Curran, *Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws*, 316 NEW ENG. J. MED. 597 (1987).

⁴⁴ Lawyers for doctors charged with misconduct are said occasionally to have silenced complainants in the past by threatening to sue them. That kind of threat seems empty now. N.Y. PUB. HEALTH LAW § 230(11)(a) (McKinney 1987) imposes a duty on medical societies and institutional officials to report "any information . . . which reasonably appears to show that a physician is guilty of professional misconduct," and "any other person" may report confidentially and with assurance of immunity from lawsuits if acting in good faith. The federal Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, §§ 401-432, 100 Stat. 3743, 3784 (codified at 42 U.S.C.A. §§ 11101-11152-94 (West Supp. 1987)) provides a nationwide shield, in order to encourage freer resort to professional review actions. Section 411(a)(2), 42 U.S.C.A. 11111, provides in part that "no person . . . providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law . . ." unless the informant knew the information to be false. Protection of peer review processes by hospitals and medical societies has also been much strengthened by the new statute. §§ 411-415, 431, 42 U.S.C.A. §§ 11111-11115, 11151.

⁴⁵ Energetic investigation of complaints must, however, be accompanied by prudent awareness that the filing of a malpractice claim, settlement by payment of money, or, even, evidence of a doctor's involvement in an isolated lamentable occurrence is not in itself compelling evidence of professional unworthiness. See HHS TASK FORCE REPORT, *supra* note 5, at 83. According to a 1986 survey, at least one malpractice claim had been pressed against 64 percent of obstetricians/gynecologists, 50 percent of surgeons, 39 percent of radiologists, and 36 percent of anesthesiologists. MAY 1987 GAO REPORT, *supra* note 36, at 16. For a discussion of advances in some fields from "relatively simple procedures" to "complex procedures" with an "evolving technology" that may lead to "a higher complication rate and many uncertain outcomes," see *id.* at 18. See also FEB. 1986 GAO REPORT, *supra* note 9, at 60-61 (recounting cautionary statements concerning the inferences to be drawn from the fact that a physician has been the target of professional liability lawsuits).

⁴⁶ The work of the American Society of Anesthesiologists, through its Committee on Patient Safety and Risk Management, will serve as an example. Anesthetic mishaps are not of high frequency, but when they do occur, the consequences may be grave. The

Second, state licensing bodies have shown mounting interest in periodically reexamining a physician's qualifications, instead of simply bestowing a lifetime license whose renewal at stated intervals is an occasion for collecting a fee rather than for considering the licensee's merit. In 1987 a number of states required licensees to earn "continuing medical education credits" in order to qualify for renewal of licensure;⁴⁷ Massachusetts required its physicians to participate in risk management programs and Florida required every physician to complete at least five hours of risk management training every two years.⁴⁸ A few states even delved into records (such as reports by hospitals concerning adverse privileging actions) before a license could be extended.⁴⁹ Breaking new ground, New York in mid-1987 resolved to be the first state to undertake a substantial reexamination of a medical licensee's competence at stated intervals.⁵⁰

In sum, lawsuits that seek to fix blame for adverse events related to medical treatment are not now, if ever they were, the sole means available in the United States for deterring misconduct and encouraging conscientious, effective discharge of professional responsibilities.

Society has forced its members to become aware of technical advances, equipment developments, protective devices, and monitoring procedures in their field of work, inside and outside the operating room itself. In 1986 the Society adopted Minimal Standards for Anesthesia, based on those prepared by the anesthesiologists in the several Harvard hospitals. See Eichhorn, Cooper & Cullen, *Standards for Patient Monitoring During Anesthesia at Harvard Medical School*, 256 J. A.M.A. 1017 (1986). The Society's related Anesthesia Patient Safety Foundation is devoted to developing information concerning causes and prevention of anesthetic injuries. Anesthesiologists are still engaged in a risky activity, but the preventive campaigns have made considerable headway in lessening the risks. This is evidenced in part by claims statistics. The frequency of claims against anesthesiologists in 1979 had been 39 percent higher than the average for all physicians. By 1985 that figure had declined to 4.7 percent. Wood, *Anesthesia Claim Decrease: Number Rises More Slowly But Severity Remains High*, 1 ANESTHESIA PATIENT SAFETY FOUND. NEWSL. 21 (1986).

⁴⁷ HHS TASK FORCE REPORT, *supra* note 5, at 61-62.

⁴⁸ MAY 1987 GAO REPORT, *supra* note 36, at 17.

⁴⁹ HHS TASK FORCE REPORT, *supra* note 5, at 61-62; MAY 1987 GAO REPORT, *supra* note 36, at 17.

⁵⁰ N.Y. Times, June 28, 1987, at A29, col. 1. The New York review would extend to all licensees, whether or not they have hospital affiliations. The state's reexamination of professional fitness would supplement the activities of the national specialty boards (fifteen of the twenty-three now in existence) that already require certified specialists to undergo some measure of periodic review of competence in order to retain their board certification. The New York State Advisory Committee on Physician Credentialing, created at the Governor's request and chaired by designees of the Health Commissioner and the Chancellor of the Board of Regents, suggested in a February 1988 report that physicians should have to renew their licenses every nine years by taking an examination, undergoing review by other physicians, or by an evaluation of patient records. N.Y. Times, Feb. 26, 1988, at A1, col. 1.

II

MEDICAL MISADVENTURE IN NEW ZEALAND

In 1974 New Zealand, a country that shares "the common law tradition," ceased relying on medical malpractice litigation as a means of achieving social well-being. Instead it provided by law for compensating "*persons who suffer personal injury by accident*" (and some of their dependents if death results); it also provided that "no proceedings for damages arising directly or indirectly out of the injury or death shall be brought in any court in New Zealand independently of this Act, . . . whether under any rule of law or any enactment."⁵¹ "Personal injury by accident" includes:

- (i) The physical and mental consequences of any such injury or of the accident;
- (ii) Medical, surgical, dental, or first aid misadventure.⁵²

A brief examination of the operation of the New Zealand no-fault system may be useful for the United States despite great disparities between the two countries. New Zealand's 3.3 million population and its land mass are approximately those of Colorado. These objective facts argue against supposing that what works well in New Zealand will assuredly be successful also in the much larger and more populous United States. They do not, however, argue against being closely observant of New Zealand's having replaced long accepted legal concepts and methods. Mr. Justice Brandeis, commenting fifty-five years ago on state governments' experiments in remolding existing economic practices to meet changing societal needs, remarked: "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."⁵³ So, too, the outcome of an experiment courageously launched by a single small nation, whose traditions and policies are closely akin to this country's, may substantially affect American policy choices for the future.

The meaning of "medical misadventure." A medical (or other health care) "misadventure" is not itself defined in the Accident Compensation Act. The Act simply includes it as a species of the accidental injuries for which the Act provides relief. In general, a "personal injury by accident" occurs when a human being's system is damaged

⁵¹ Accident Compensation Act §§ 26-27, [1982] 3 N.Z. Stat. 1552, 1577-79. The 1982 statute is in the main a codification of the initial Accident Compensation Law of 1972 (which came into force in 1974) and numerous later amendments that affected details and administration, without modifying the underlying philosophy.

⁵² *Id.* § 2, [1982] 3 N.Z. Stat. at 1560.

⁵³ *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

unexpectedly, without design by the person injured, by a cause other than disease or the aging process. The element of unexpectedness connotes, as a generality, a certain measure of suddenness, a specific event as distinct from the consequences of a general deterioration of the body over a long period of time. Thus, a person who, while at work, experienced a fatal heart attack because of high blood pressure would not have suffered injury by accident *unless* the cardiovascular episode were shown to be immediately related to an identifiable and, for that person, an unusual stress or strain.⁵⁴

As the years have passed, the term "medical misadventure" has gained meaning through repeated application. Plainly enough, it includes negligent or otherwise wrongful conduct. It goes farther, however, for it also connotes mishaps that come about with no element of fault.⁵⁵ The question the system asks is not whether a person is suffering the consequences of blameworthy medical conduct, but, rather, whether medical causation of a person's injury is established.

Initial judicial hesitancy to read "misadventure" expansively aroused vigorous criticism in informed quarters.⁵⁶ Until fairly recently New Zealand courts tended to think of a mishap as a traumatic event. They were wary of regarding diagnostic inadequacies as misadventures. Some of the judges deemed patients in those situations not to have suffered a mishap, but simply to have suffered the consequences of an underlying disease or bodily condition that had been neither caused nor altered by medical activity. Some judges at first did not consider unsatisfactory outcomes of medical treatment to be misadventures. For example, when prudently prescribed and faultlessly performed surgical procedures, anesthetic methods, or drug administrations were known to entail a risk (though it be slim) of adverse results, a patient unfortunate enough to leave the operating room in far less happy condition than when

⁵⁴ Definitional discussion is found in J. FAHY, ACCIDENT COMPENSATION COVERAGE 20-28 (8th ed. 1984); and compare T. ISON, ACCIDENT COMPENSATION 23-29 (1980). Interestingly, the New Zealand statute was criticized in some American quarters for not having gone far enough, rather than for being revolutionary. See, e.g., Henderson, *The New Zealand Accident Compensation Reform*, 48 U. CHI. L. REV. 781, 792 (1981) ("there is no reason why victims of misfortunes other than accidents should not have equally valid claims to compensation as accident victims").

⁵⁵ See J. FAHY, *supra* note 54, at 22-24, in part referring to the case *Application for Review by E*, [1983] N.Z.A.C.R. 650, a High Court decision that "medical misadventure" occurs when a person who is receiving medical care or attention suffers bodily or mental injury or damage "caused by mischance or accident, unexpected and undesigned, in the nature of medical error or medical mishap." J. FAHY, *supra*, note 54, at 23 (emphasis added).

⁵⁶ See, e.g., Palmer, *Accident Compensation in New Zealand: The First Two Years*, 25 AM. J. COMP. L. 1, 38-39 (1977).

she had entered might be regarded not as the victim of a mischance, but only as the loser of a gamble that a particular result would be happily achieved in her case as in the generality.

More recently, the current has run toward recognizing that the person whose bodily condition is worsened rather than bettered by medical treatment has indeed suffered an injury caused by an unexpected, undesigned mischance even when medical science had foretold the possibility of worsening. Some of the decisions have somewhat timidly tiptoed into the "informed consent" area; a patient who was not told or was misinformed about the element of risk might be said to have encountered an unexpected accident if the risk became a reality.⁵⁷ Other cases have regarded the remoteness of the risk of a grave, undesired result as a factor to be weighed, whether or not the existence of risk had been disclosed before treatment was undertaken. A patient who, after being told that an operation to relieve back pain entailed a one-in-a-hundred chance of her becoming a paraplegic, nevertheless submits to the operation and, alas, then discovers she is *the one*, is indeed suffering from bad fortune, that is, "misadventure."⁵⁸

As yet, no clear measurement of "remoteness" has been provided by the New Zealand courts. Plainly enough the judges are aware that all medical treatment, no matter how well considered and executed, is inherently risky in that it may not succeed in producing the desired result, but they wish, as a critic has said, "to avoid slid-

⁵⁷ See, e.g., *Knox v. Accident Compensation Corp.*, No. 149/86 (Accident Compensation Appeal Auth. Oct. 21, 1986) (a surgical procedure to sterilize claimant was properly performed, but unsuccessful; claimant, who had not been warned to avoid sexual intercourse until later tests showed successful outcome, became pregnant; *held*, claim for medical misadventure had been established); see also Mahoney, *Informed Consent and Breach of the Medical Contract to Achieve a Particular Result: Opportunities for New Zealand's Latent Personal Injury Litigators to Peek Out of the Accident Compensation Closet*, 6 OTAGO L. REV. 103 (1985); Osborne, *Informed Consent to Medical Treatment and the Accident Compensation Act 1972*, 1979 N.Z.L.J. 198. *But cf. Re Priestly*, [1984] N.Z.A.C.R. 787 (doctor under no duty to inform patient of risks of failure sterilization unless patient asked).

⁵⁸ See, e.g., *MacDonald v. Accident Compensation Corp.*, [1985] 5 N.Z.A.R. 276. In that case a properly performed abdominal operation led to the patient's suffering a leaky bowel. The possibility of this consequence was known, but the risk was considered to be a bit less than one percent. The disproportion between the predictable danger and the operation's actual results heavily influenced the conclusion that things had "turned out badly" for the patient and that this constituted misadventure. See also *Viggars v. Accident Compensation Corp.*, [1986] 6 N.Z.A.R. 235: A patient suffered a stroke while a carotid arteriogram was being performed to assess the condition of his arteries. This was known to be a possible though highly unlikely outcome of this type of operation. The unhappy consequence of the operation in this instance "was so unusual and unlikely that it could properly be described as mischance or bad fortune," *id.* at 239, and "clearly not within the normal range of medical or surgical failure attendant upon an arteriogram," *id.* at 240—and "it accords with the natural and ordinary meaning of the words" that the sufferer had indeed experienced a "medical misadventure." *Id.*

ing down the slippery slope and compensating illness or death every time medical treatment fails.'⁵⁹

A treatment's failure to improve the patient's health is far different, however, from a treatment's creating a new distress. As to the latter kind of post-treatment misfortune, why should it matter that a form of medical treatment is known to have a tiny or, even, a substantial element of risk that the patient may suffer a new distress (rather than a betterment or a continuation of the status quo)? If the misfortune does occur, the patient has in fact been injured. What is more, the injury, though known to be possible, was unexpected, for nobody would direct and nobody would submit to a treatment that was actually expected to accomplish a distressing result. The injury was undesigned, that is to say, not planned to happen; it was the outcome of an identifiable event, the treatment.

Most nonmedical accidents that give rise to compensation for personal injuries in New Zealand, as in the United States, undoubtedly stem from activities in which risk of injury inheres. One indignant legal scholar writes:

Merely because there is a known chance that can be quantified in statistical terms that a daily automobile commuter will suffer a personal injury through a motor vehicle collision does not make the disaster, when it occurs, any less of an "accident" or a "misadventure". That a known risk has the effect of turning an accident into some undefined "something else" solely in the medical field is anomalous and unfair.⁶⁰

In all probability courts will perceive the soundness of this view. If they do not, or if the parliament does not then strengthen the present protection against injuries occasioned by medical treatment, one may predict a partial revival of personal injury litigation with heavy reliance on the doctrine of informed consent or a spate of contractual disputes concerning a medical practitioner's failure to produce

⁵⁹ REPORT OF THE ROYAL COMMISSION ON CIVIL LIABILITY AND COMPENSATION FOR PERSONAL INJURY 288 (1978) (testimony of Geoffrey Palmer), *quoted in Mahoney, supra* note 57, at 109; *see also* Accident Compensation Auckland Hospital Bd., [1986] 2 N.Z.L.R. 748, 751: "All treatment, whether medical or surgical, has a chance of being unsuccessful. There is an expected failure rate in all these matters and such failure may be because no matter how correct the treatment, nature does not always respond in the desired way. It would be quite beyond the intention or wording of the Accident Compensation Act that cover should be granted on the basis of personal injury by accident because medical treatment was not 100% effective. Certainty cannot be underwritten."

In the United States, as in New Zealand, an unsuccessful outcome does not in itself show that a patient suffered at the hands of her doctor. If the patient seeks compensation, she must show that her physician's act or failure to act deprived her of an opportunity to recover or significantly enlarged the risk of an undesired outcome. *See* Annotation, *Medical Malpractice—"Loss of Chance" Causality*, 54 A.L.R.4th 10, 17 (1987).

⁶⁰ Mahoney, *supra* note 57, at 108.

the results of which he had assured the patient.⁶¹

From the standpoint of New Zealand's medical profession, loosely interpreting and liberally applying "medical misadventure" are advantageous because the Accident Compensation Act bars lawsuits for damages "arising directly or indirectly" from a personal injury by accident—and the Accident Compensation Corporation's decision as to whether a person has in fact "suffered personal injury by accident" is conclusive.⁶² Hence New Zealand physicians will be protected rather than harmed if the courts unequivocally conclude that an injurious outcome of treatment, even though lying within the known range of risk and not at all the product of anybody's fault, is within the statutory scope of "medical misadventure."

The issue is perhaps not of major moment because, without reference to misadventure, section 2(1) of the Act defines "personal injury by accident" as including, among other things, "[t]he physical and mental consequences of any such injury or of the accident."⁶³ Where a person sought medical attention because he was injured by what is indisputably an accident (for example, an automobile collision or a machinery malfunction in a factory), the effect of the medical treatment upon the already injured person is assuredly among "the physical and mental consequences" of the accident or the injury. Whether or not the outcome of a physician's efforts might have been deemed to be "medical misadventure" had the claimant-patient been previously uninjured, the medical treatment's results (be they benign or adverse) in a case of this nature must be taken fully into account when the Accident Compensation Corporation determines entitlement to compensation. Hence cases explicitly turning on the occurrence of medical misadventure are numerically

⁶¹ Mahoney reports that "a few of such claims" were actually in "various stages of litigation" in early 1985, though the present writer found no awareness of them in early 1987. *Id.* at 124 n.21; see also Osborne, *The Duty to Disclose Risks of Medical Treatment in New Zealand*, 12 N.Z. RECENT LAW (n.s.) 66, 71 (1986) (asserting that "the common law action for failure to disclose risks of medical treatment is at least in some form alive in New Zealand and it promises to be an important and interesting addendum to the Accident Compensation Scheme"); cf. Bowden & Hodson, *The Search for the Middle Ground: Medical Misadventure and Surgical Risk*, 99 N.Z. MED. J. 628 (1986) (advising doctors before undertaking to render a medical service of uncertain efficacy to obtain their patient's informed consent).

Compare Hellner, *Compensation for Personal Injury: The Swedish Alternative*, 34 AM. J. COMP. L. 613, 629 (1986):

A special question . . . is whether lack of information and informed consent should be considered a sufficient ground for protection. In my opinion it is not. It is probably rare that information about risks will in fact influence a patient's decision about the treatment that he will accept; he will rely on the advice given to him, whether or not he knows of the risks.

⁶² Accident Compensation Act § 27(1) & (3), [1982] 3 N.Z. Stat. 1552, 1578.

⁶³ *Id.* § 2(1)(a)(i), [1982] 3 N.Z. Stat. at 1560.

insignificant. What might otherwise have been contested episodes have more often than not become inconspicuous elements of plainly compensable injuries.⁶⁴

Financing, cost, and benefits. The social insurance system just sketched is financed by levies on employers, self-employed persons, and owners of motor vehicles, and also by public monies.⁶⁵ The total expenditure is considerable for a small country. Yet, despite greatly broadened assurance that injured persons will be compensated without having to prove somebody else's fault, the costs seem bearable.⁶⁶ Motorists no longer need insure against liability for causing personal injuries, employers no longer need pay for workers' compensation insurance, self-employed persons no longer need pay for protection against total interruption of earnings because of incapacitating injury, and at least the more affluent among the country's taxpayers, including medical personnel, no longer need buy as much liability insurance as once they did. Moreover, and most significant of all, only about ten percent of the Accident Compensation Corporation's funds are expended for administrative purposes, the balance being paid out to or on behalf of persons injured by accidents.⁶⁷ Because the Accident Compensation Corporation has re-

⁶⁴ Table 2 of 4 ACCIDENT COMPENSATION CORP., ACC STATISTICS 4 (1985) shows that of the 117,436 accidental injuries in 1983 which led to compensation by the ACC, 2,035 happened in hospitals. In that same year only 91 injuries resulting from accidents explicitly characterized as medical misadventures were compensated. *Id.* at 19 table 5.

⁶⁵ T. ISON, *supra* note 54, at 122-27.

⁶⁶ The Accident Compensation Corporation's compensation payments to claimants have grown markedly during the past several years, apparently reflecting mounting public awareness of the availability of compensation for even short term, minor injuries. The Law Commission proposed that the present waiting period of one week before compensation become payable be extended to a two-week waiting period; this "would remove a large number of minor injuries from the scheme, removing some financial pressure from the funding, and enabling the Corporation to concentrate on major disabilities and simplifying its administration." NEW ZEALAND LAW COMMISSION, THE ACCIDENT COMPENSATION SCHEME 13 (Rep. No. 3, 1987).

⁶⁷ REPORT OF THE ACCIDENT COMPENSATION CORPORATION 11 (1987) shows the following:

1983/84 89 cents/\$1.00 to injured person
 1984/85 90 cents/\$1.00 to injured person
 1985/86 91 cents/\$1.00 to injured person
 1986/87 93 cents/\$1.00 to injured person

The Corporation's operating costs include the expenditures for rehabilitation of injured persons, as well as the costs of accident prevention. (Here as elsewhere in this paper dollar amounts refer to New Zealand dollars rather than to the American variety. When this was written, a \$N.Z. could be bought by 60-odd cents U.S. In terms of purchasing power within New Zealand, however, a \$N.Z. seemed to this writer in 1987 to be fully the equivalent of a \$U.S.)

The actuality appears to be far different from what was predicted some years ago. In 1976 a scholar asserted that treating medical causation rather than medical negligence as the central issue would probably have a disappointing administrative effect upon "transaction costs." Epstein, *Medical Malpractice: The Case for Contract*, 76 AM. B.

jected only a tiny percentage of the approximately 150,000 compensation claims received annually, judicial review proceedings have been few.⁶⁸

The level of benefits in New Zealand is far lower than the more exuberant jury awards in American malpractice litigation. An injured person who receives earnings related compensation (i.e., an individual who is self-employed or employed by another) is paid for loss of earnings while disabled equal to eighty percent of normal earnings (including overtime), periodically adjusted to reflect cost-of-living increases.⁶⁹ An injured nonearner, having lost no earnings, clearly is unentitled to compensation on that account. Whether or not an earner, however, every person injured by accident does receive the cost of medical attention, rehabilitation and related equipment, expenses of remodeling the dwelling place or motor vehicle if the injury has necessitated structural changes, and payment for necessary care in the home or elsewhere if the injured person requires constant personal attention because of the injury.⁷⁰ Moreover, to a person whose accidental injury involves the permanent loss or impairment of any bodily function (for example, loss of an arm or a toe, total blindness, or deafness in one ear), a lump sum payment not to exceed \$17,000 is made without reference to the sufferer's status as earner or nonearner.⁷¹ Finally, again without differentiating between earners and nonearners, the statute provides that the Accident Compensation Corporation may pay the injured person "a lump sum of such amount (if any) as the Corporation thinks fit but not exceeding \$10,000 in respect of

- (a) The loss . . . of amenities or capacity for enjoying life, including loss from disfigurement; and
- (b) Pain and mental suffering, including nervous shock and neurosis.⁷²

The statute adjures the Corporation to "have regard to the person's

FOUND. RES. J. 87, 148 (1976). Professor Epstein avowed the opinion that "we need in the context of medical malpractice less government, and not more government; we need greater respect for private initiative and control . . ." *Id.* at 95; see also P. DANZON, *supra* note 25, at 216-17: "The program costs of a comprehensive no-fault system of compensation for iatrogenic injury could indeed be staggering. . . . The proponents of no-fault plans hope to offset these additional costs by savings from three sources: reduced litigation per case, scheduled awards in place of unlimited, individualized tort awards, and offset of collateral benefits." The author doubted that the hoped for savings would be realized; but, at least thus far, they have in fact been substantial in New Zealand.

⁶⁸ T. ISON, *supra* note 54, at 122.

⁶⁹ Accident Compensation Act § 52, [1982] 3 N.Z. Stat. 1552, 1606-10.

⁷⁰ *Id.* §§ 72, 75, 78, 80, [1982] 3 N.Z. Stat. at 1642-44, 1645-49, 1650-52, 1654-56.

⁷¹ *Id.* § 78, [1982] 3 N.Z. Stat. at 1650-52.

⁷² *Id.* § 79, [1982] 3 N.Z. Stat. at 1652-54.

knowledge and awareness of his injury and loss.”⁷³

In short, the financial aspect of New Zealand's substitute for medical malpractice litigation precludes anyone's hoping to “hit the jackpot” or to “win the lottery” as in the United States. A New Zealander who has suffered a medical mishap cannot, as can an American, commence a lengthy contest that may or may not lead to recovering substantial sums (from which, in any event, lawyers' fees and other expenses must be deducted). *At the most* a New Zealander can expect an easily accessible administrative process with right of appeal to the courts if the outcome is unsatisfactory (and in most instances the claimant is paid his costs, regardless of outcome), a fairly speedy award of a steady income related to past earnings, a payment of no more than \$10,000 for pain and suffering and loss of amenities, another payment not to exceed \$17,000 for bodily impairment that may not relate at all to past or future earnings, medical attention as needed, and financial help in adjusting to changed circumstances.

The other big difference between America's fault-based system and New Zealand's social insurance system is that fewer than half of those who seek compensation in the United States for injuries they attribute to malpractice receive any compensation whatever, and most persons who might be regarded as potential claimants do not even begin the contest. In New Zealand, by contrast, persons injured by accident can and do file claims freely without becoming entangled in expense or in the heat-engendering issue of blameworthiness, and most of the claims are acted upon favorably.

In New Zealand, assurance of compensation in a reasonably predictable amount seems to be preferred to taking one's chances on recovery of unexpected riches in an amount determined by subjective sentiment.⁷⁴ Avoidance of the adversary atmosphere that in-

⁷³ *Id.*, [1982] 3 N.Z. Stat. at 1652-54.

⁷⁴ Damages for pain and suffering and punitive damages are particularly susceptible to determination by “subjective sentiment.” Physical or emotional pain and suffering “have no measurable dimensions, mathematical or financial. Courts [in the United States] have . . . , therefore, relied upon the collective judgment of juries to quantify such injuries.” Ingber, *Rethinking Intangible Injuries: A Focus on Remedy*, 73 CALIF. L. REV. 772, 778 (1985); see also P. CANE, *ATIYAH'S ACCIDENTS, COMPENSATION AND THE LAW* 183-87 (4th ed. 1987) (discussing difficulties and inconsistencies in assessing intangible injuries). Sometimes what is found to be acceptable as a jury's “collective judgment” seems rather extreme. See, e.g., *Tetuan v. A.H. Robins Co.*, 241 Kan. 441, 738 P.2d 1210 (1987) (upholding, after seven years of litigation, an award of \$9.2 million to a woman who suffered an infection caused by an intrauterine device and as a consequence underwent a total hysterectomy).

But cf. Johnston, *Punitive Liability: A New Paradigm of Efficiency in Tort Law*, 87 COLUM. L. REV. 1385 (1987) (advocating the notion of “optimal punitive liability” as a more efficient principle of liability than those currently used in tort law). Statutory curbs on punitive damage awards have tended to be related to specific types of cases, rather than

evitably accompanies litigation concerning malpractice or other torts involving allegations of highly personalized fault seems to be widely regarded as a social gain. During three months of intensive (though not scientifically structured) interviewing throughout New Zealand in 1987, this writer found no hint of desire, in any element of the population, to return to the good old days of the fault system and malpractice lawsuits. Nobody voiced concern about a diminution of retributive justice or about disregarding the "fairness" or "morality" of making injurers pay the bills—supposedly among the chief justifications of continued malpractice litigation in the United States. The right to be compensated seems to have been accepted as fulfilling emotional as well as economic needs.⁷⁵ These impressions were confirmed in mid-1987 by a careful nationwide opinion poll of 2,500 persons, eighty percent of whom supported the present accident compensation scheme, though some favored redistribution of some of its costs.⁷⁶

Injury prevention. The New Zealand Accident Compensation Act states as its purposes: (1) promoting safety, (2) advancing the rehabilitation of persons who, despite efforts to increase safety, are nev-

comprehensive. See, e.g., Act of July 22, 1987, ch. 197, § 5, 1987 N.J. Sess. Law Serv. 188, 191 (West) (limiting punitive damages in products liability actions to only those cases where claimant receives compensatory damages and proves by preponderance of evidence that harm was caused with actual malice or willful disregard); Labaton, *Cut in Punitive Awards Sought*, N.Y. Times, Oct. 12, 1987, § D, at 2, col. 1 (discussing isolated cases of punitive damages awards and attempts by some state legislatures to limit them). But see M. SHANLEY & M. PETERSON, POSTTRIAL ADJUSTMENTS TO JURY AWARDS (RAND R-3511-1CJ, 1987) (showing that original jury awards have been substantially reduced by judges or by the parties' agreement, and that reductions are particularly marked when juries have awarded large sums as punitive damages); see also M. PETERSON, S. SARMA & M. SHANLEY, PUNITIVE DAMAGES (1987) (surveying the results of 68 punitive damages awards in California and Illinois and finding that plaintiffs received only about half the amount of the juries' awards). As to conscientious jurors' difficulty in dealing with complex medical testimony and in following judges' instructions, see *Juries on Trial: Are They "Out of Control"?*, 11 RAND RES. REV. 1 (1987), and M. SELVIN & L. PICUS, THE DEBATE OVER JURY PERFORMANCE 61 (1987).

⁷⁵ Cf. Keeton, *Is There a Place for Negligence in Modern Tort Law?*, 53 VA. L. REV. 886, 889 (1967):

To what extent is appeasement accomplished because rights to compensation are based on negligence rather than merely because they are recognized as enforceable rights? For example, would appeasement of the innocent victim of a negligent driver be any less effective if the victim were entitled to the same compensation but on a basis of strict liability, or on a basis of loss insurance? As with the question whether a community sense of justice demands that negligent actors compensate innocent victims, here again no answer can be proved correct. Instead we must speculate, and perhaps the more persuasive speculation is that merely recognizing a right to compensation does far more to appease the offended than basing that right on negligence

⁷⁶ See NEW ZEALAND LAW COMMISSION, THE ACCIDENT COMPENSATION SCHEME 3 (Prelim. Paper No. 2, 1987).

ertheless injured by accident, and (3) providing for compensation of those who do suffer the consequences of accidental injuries to the person.⁷⁷ The emphasis has been reversed in administrative reality. Attention is given primarily to the compensatory aspects of the statutory scheme; rehabilitation is chiefly of interest because, when successful, it terminates or at least reduces payments to persons who have been injured; and preventive activities, looking toward enhanced safety, are less vigorously pursued than the Accident Compensation Corporation's other major tasks.

The Corporation's safety officers have not, let it be said, been idle or altogether ineffective. On the contrary, their efforts to educate the public about hazards have often been notably successful; a visitor is struck by the extent to which workers, householders, athletes, and children have become accustomed to using protective devices such as headgear, breathing filters in dusty or fume-laden environments, and "ear muffs" to reduce the impact of noise. Sometimes successful, too, have been gentle proddings of employers whose businesses have been marked by high accident rates. The Corporation has made efforts to persuade managers that an injury to a worker is often coupled with injury to a machine or to costly interference with production work. As a general policy, however, the Corporation has sought to avoid confrontations and disciplinary measures as means of driving home the lessons safety officers have tried to teach.⁷⁸

Proceedings against doctors. This no doubt carefully considered disinclination to "get tough" is especially manifest in relation to health care providers. Medical practitioners, who are not in abundant supply in many parts of New Zealand, are integral elements of the administrative machinery that makes the Accident Compensation Act operable. The Accident Compensation Corporation needs

⁷⁷ Accident Compensation Act, § 26, [1982] 3 N.Z. Stat. 1552, 1577-78.

⁷⁸ Section 40(2)(a), [1982] 3 N.Z. Stat. at 1594, authorizes the ACC to impose "a penalty of such amount as it thinks fit" (up to 100 percent of the annual levy) on an employer or self-employed person whose "accident experience" is disquieting when compared with that of others in the same type of business. Section 49(d), [1982] 3 N.Z. Stat. at 1604, permits the ACC to impose "penalty rates of annual levies to be paid by drivers and classes of drivers whose driving or accident record is significantly worse than average." Neither section has thus far played a role in administration of the compensation system. For comparative purposes, the following sampling of information culled from official United States sources is provided concerning the Occupational Safety and Health Administration's exercise of power to levy penalties for record-keeping and other safety violations: 9/16/86 Union Carbide \$1,377,700; 12/23/86 Shell Oil \$244,000; 1/30/87 Chrysler Corp. \$295,332; 4/25/87 John Morrell \$690,000. Obviously, these are among the more dramatic examples; but many other cases involved sums substantial enough to assure their being noticed by top management. In late 1987 the ACC began considering whether it should seek a similar capability to penalize disregard of safety measures.

them as aides, not as adversaries. In some parts of the country, disqualifying one or two doctors might impair the Corporation's functioning.⁷⁹

A claim for accidental injury must at the very outset be supported by a certificate from a general practitioner concerning the nature of the injury.⁸⁰ The claimant's general practitioner also certifies the extent and duration of disability.⁸¹ The general practitioner's prescription of pharmaceuticals or of nonmedical or quasi-medical treatments—physiotherapy, acupuncture, chiropractic, and whatnot—is a precondition of the Corporation's paying the bills.⁸² Referral of the patient to a specialist is initially in the general practitioner's discretion, and the general practitioner chooses which specialist is most likely to fit the patient's needs and tastes.

As for the specialists, they do more than merely render their specialized services to the patients who come to them through the general practitioner channel. They also expertly appraise the present and future condition of claimants whom the Accident Compensation Corporation has referred to them. This occurs when doubts have arisen concerning, for example, continuing entitlement to compensation or the precise extent to which bodily malfunctioning is likely to be permanent.

Relations between the Accident Compensation Corporation and the medical profession and related health care providers have not been constantly amiable. The Corporation pays doctors' bills, but only to the extent it "considers that the amount to be paid by it is reasonable by New Zealand standards."⁸³ Predictably, wrangling has occurred concerning what is "reasonable" and which of various "New Zealand standards" should be used as measurements.⁸⁴

⁷⁹ In mid-1987, registered medical practitioners in New Zealand totaled over 8,000—1,886 "specialists" and 6,406 "general practitioners"—in widely scattered localities. Uneven distribution of medical resources gives rise to problems in the United States as well as in New Zealand. *See, e.g.*, N.Y. Times, June 20, 1987, at 33, col. 1: A statewide quality assurance committee, designated by the federal government to monitor medical care given to Medicare patients in Texas, disqualified some small town doctors for having "grossly and flagrantly" violated professional standards of care, citing five elderly Texans who had died as a result. Far from earning tumultuous applause, this led to widespread complaints, echoed in Congress, that elderly persons in rural areas were being deprived of their doctors by overzealous review panels.

⁸⁰ Accident Compensation Act § 75, [1982] 3 N.Z. Stat. 1552, 1645-49.

⁸¹ *Id.* §§ 78, 80, [1982] 3 N.Z. Stat. at 1650-52, 1654-56.

⁸² *Id.*, [1982] 3 N.Z. Stat. at 1650-52, 1654-56.

⁸³ *Id.* § 75(b), [1982] 3 N.Z. Stat. at 1645.

⁸⁴ The Corporation has recently been sued in the High Court for not fulfilling its statutory duty when, instead of paying fees of health care providers and hospitals almost unquestioningly, it fixed "annotation lines" whereby fees up to a certain amount were paid readily, but any fee above the line had to be specially justified. *See* The Dominion (Wellington), Dec. 1, 1987, at 10, col. 7.

Apart from economic friction, the "guild spirit" within the medical profession appears to an outsider to be even stronger in New Zealand than in the United States, where sometimes extensive public regulation of the practice of medicine has become familiar (though not always greeted with cheers). Hostile reactions have discouraged the Corporation's attempts to apply sanctions against physicians whose reports have rather blatantly distorted the reality of claimants' medical conditions. Medical societies have seemingly regarded discipline as their province. Other would-be disciplinarians have sometimes been viewed as "doctor bashers" rather than as protectors of the public (and of the medical profession itself) against incompetence, impairment, carelessness, or dishonesty.⁸⁵

A senior official, agreeing in principle that professional protectionism has made for a certain flabbiness in dealing with complaints against providers of health care, has expressed belief that the Accident Compensation Corporation's proposing more efficient and perhaps sterner measures would probably worsen the Corporation's "already shaky relationship" with the medical community. When conferring throughout New Zealand, this writer was struck by the frequency of officials' conversational references to doctors whose honesty or whose capability they strongly disparage. Yet the Corporation, so far as this writer could ascertain, applies little pressure on offenders or incompetents to improve their ways. Corporation officials have pictured medical organizations as unresponsive to complaints and requests to be stern. Persons within the organizations deny this characterization. They declare that complaints have actually been few and that those few have been ill documented; they add that scant use has been made of available means of stimulating better behavior on the part of possibly though not demonstrably delinquent doctors.⁸⁶

⁸⁵ This appears to be true whether the alleged misconduct has to do with medicine or, simply, money. Instances of doctors submitting bills to the ACC for services they never performed have been well authenticated, but have not led to criminal prosecutions. Knowingly false certification that a patient suffered an accidental injury or is still incapacitated after he has recovered is not a rarity. In 1980 a civil suit was brought by the ACC against a practitioner who had "negligently and in breach of contract" certified untruthfully that a patient had suffered incapacity as a result of personal injury by accident. Before discovering the falsity of the certification, the ACC had paid out \$10,000, which it now sought to recover. The case was settled by the doctor's paying damages in a substantial sum. Even this utilization of a conventional civil remedy to emphasize the importance of careful medical certification was ill regarded. The ACC has not since proceeded in this manner.

⁸⁶ Means do indeed exist. The Medical Practitioners Act creates a lofty Medical Council that has power to register and to de-register (permanently or for periods up to twelve months) medical practitioners, as well as to fine those who are found to have been "guilty of disgraceful conduct in a professional respect." [1968] 1 N.Z. Stat. 417. Anybody may complain in writing. All the members of the Medical Council, except pos-

Occasions for considering at least an admonition are not difficult to discover. A surgeon, instead of performing a simple curettage, removed a young woman's uterus; he had failed to read the notes that explicitly told him which operation he was to perform on this particular patient. A general practitioner billed the Accident Compensation Corporation for services rendered to the patients he purportedly served; at the dollar rate approved by the Corporation, his charges added up to an astonishing and unbelievable total—to have earned the amount sought he would have had to see patients at a phenomenally rapid rate throughout twelve hour days, six days a week. Another general practitioner in instance after instance certified that his patients who were motorcyclists suffered from a health condition which made wearing a protective helmet inadvisable. His certification suspended the need to comply with an otherwise applicable regulation about the use of protective headgear. By odd coincidence all the persons involved, without exception, proved to be members of a motorcycle gang ostentatiously committed to ruffianly bravado rather than prudence. Yet another physician, thrice consulted about changes in a patient's digestive comfort, neither examined the patient nor referred him to a physician who could and would examine him; the patient at last went elsewhere upon his own initiative and was then found to have an intestinal malignancy, fortunately still operable. "War stories" like these are told by personnel in Corporation offices in all parts of New Zealand. Some may perhaps come under the heading of good yarns, but many (like that involving the uterus-removing surgeon) are reflected in officially reported "medical misadventure" cases.

Deterrents. The threat of having to pay her injured patients large sums of money theoretically deters an American doctor from being careless. Even in theory, as well as in real life, that deterrent has been minuscule in New Zealand since 1974. No study has shown that, as a consequence, the quality of medical service has suffered.

A thorough investigation of automotive accidents during the

sibly the Director-General of Health, are themselves medical practitioners; most of them are nominees of various professional associations. The Act also provides for the Medical Practitioners Disciplinary Committee, four of whose five members are directly appointed by the Medical Association. The Disciplinary Committee deals with charges from any source that a registered medical practitioner has engaged in "professional misconduct," which is something less than "disgraceful conduct." A finding of guilt may lead to a moderate fine and to censure, with a right of appeal to the Medical Council *Id.*

In addition to these statutory mechanisms, medical societies say that they are ready, able, and willing to join with the ACC in having an informal and confidential face-to-face discussion with a practitioner about whose dutifulness the ACC has misgivings. This kind of off-the-record discussion will, some doctors believe, favorably influence the practitioner's future behavior.

first seven years of operations under the Accident Compensation Act concluded that

the removal of tort liability for personal injury in New Zealand has apparently had no adverse effect on driving habits. In fact, statistics show a decline in accident and fatality rates. . . . [C]learly the removal of tort rights for personal injury cases did not produce the increase in accident-producing behavior predicted by the traditional theory of tort deterrence.⁸⁷

In respect of automotive mishaps, however, sometimes active enforcement of laws and regulations aimed at driving while intoxicated or in a reckless manner are external deterrents. Moreover, new safety measures (for example, requiring motorcyclists to use helmets and motorists to fasten seat belts) no doubt help reduce the severity of accidents that do still occur.

In respect of accidental personal injury related to medical treatment, no before-and-after statistics are available to demonstrate that medical mishaps do or do not occur more frequently now that lawsuits for medical malpractice have been barred. External deterrents, akin to police officers' enforcement of automotive traffic laws and regulations, do exist, but are too rarely used to be regarded as significant controls of medical doctors' behavior. During a fairly rigorous inquiry in 1987, this writer heard no expression of opinion in New Zealand that instances of malpractice had risen after the Accident Compensation Act became operative. Since external controls have been so little used, one must conclude that New Zealand relies upon a sense of professional responsibility, with its central core of self-esteem coupled with self-discipline, to be the most potent deterrent of medical misbehavior.⁸⁸

Still, an occasional publicized scolding of those few whose conduct has discernibly not measured up to acceptable standards might

⁸⁷ Brown, *Deterrence and No-Fault: The New Zealand Experience*, 73 CALIF. L. REV. 976, 1002 (1985).

⁸⁸ The thought has been expressed in the United States, too, that "the non-monetary costs of an accusation," rather than the possibility of adverse financial consequences, are what really cause a doctor to practice medicine in a way that will minimize the possibility of later accusations. See Kemper, *supra* note 14, at 1146; see also Bell, *Legislative Intrusion Into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939, 985 (1984) (commenting that malpractice lawsuit serves as "a negative sanction" because it consumes "the doctor's limited time and energy" and threatens "his relations with his patients"). Bell doubts that the economic aspect of malpractice liability has the deterrent effect others ascribe to it; he documents his belief that "the psychological approach" provides "a more fruitful guide to judgments about the deterrent effects of liability rules." *Id.* The author refers to physicians' belief, whether or not well founded, that an adverse judgment in a malpractice lawsuit results in "social stigma, loss of prestige, embarrassment, time, anxiety and the like." *Id.* at 992.

usefully remind others what those standards are.⁸⁹ Expression of either professional or official disapprobation is a rarity in New Zealand. Occasionally one hears discussion about creating new mechanisms for receiving and acting upon complaints concerning the functioning of medical doctors and diverse health care providers. Thus far little has been done to strengthen processes that might serve as external deterrents of shortcomings. In fact, so far as this writer learned, no means now exist for computerized storage of complaints and other bits of information that might, as they accumulate, point the need for investigation of a particular hospital, procedure, or individual. New Zealanders seemingly maintain an extraordinarily strong confidence in the medical profession and all it touches.⁹⁰

III

A FEW QUESTIONS AND TENTATIVE CONCLUSIONS

Doubts about the malpractice system. During recent decades medical malpractice proceedings in the United States have increased in number, though not to the ungovernable dimensions insurance and medical spokesmen sometimes suggest.⁹¹ The number of physicians has grown, too, as has the population in general. Hence, upward movement in the volume of claims is not in itself surprising. More significant than population figures in influencing the number

⁸⁹ Cf. Colimore, *Doctor Cut from Medicare; Led Review Panel*, Phila. Inquirer, April 25, 1987, at 1, col. 1: "[A doctor] was barred from the program after the state determined that he had charged it for 269 'medically unnecessary' office visits. Dr. [name stated] also was cited for billing the state for 'inferior services' involving 16 patients who received electrocardiograms that state officials said were of 'little or no therapeutic or diagnostic value.'" Full details of these shortcomings were included in the news story, which presumably appeared in other cities' newspapers and thus probably came to the notice of most Pennsylvania practitioners.

⁹⁰ What appears to be confidence may in actuality simply be awareness that in some parts of New Zealand one's choices as a patient are somewhat limited. In December 1986 an internal ACC document indicated that when, for example, the Accident Compensation Corporation itself sought to refer a patient to any one of the four orthopedic surgeons in Palmerston North, a delay of twelve to eighteen months occurred before an appointment could be had; then another six to eight weeks passed before the ACC received a report concerning the patient's condition. In Gisborne, the scheduling of appointments with one of the four specialists (undifferentiated) required waits of two to six months; reports of the specialists' findings came "up to 3 months" later. In New Plymouth the appointment delays with specialists other than general surgeons ranged from two to three and one-half months; the reports in most instances arrived two to four weeks afterward. "General Surgeons," unlike other specialists in that area, were apparently very prompt in arranging appointments and rendering reports. These examples suggest that specialized medical service may be in such short supply and heavy demand that at least some patients may be inclined to take whatever they get without grumbling loudly or often.

⁹¹ For effective statistical analysis, see Danzon, *New Evidence*, *supra* note 15, at 57, and P. DANZON, *supra* note 25, at 58-83.

of malpractice actions, however, is the increasing urbanization of America. Utilization of medical services tends to be more general in cities than in the countryside. In addition, exposure to novel, complex surgical procedures is more likely to be experienced in urban than in rural hospitals. City dwellers may therefore face greater risk of injuries than do their country cousins. This is, as it were, the price they pay for greater possibility of overcoming ill health. The mere fact that malpractice cases abound is not in itself reason to halt or to diminish them.

On the other hand, preserving them simply because they have become a familiar feature of the landscape is imprudent. If litigation concerning injuries allegedly caused by improper medical practices has been an effective means of deterring the delivery of substandard care, then evidence of effectiveness should by now be readily available. Seemingly it is not.⁹²

Cause does exist, however, for believing that the malpractice system has had undesired consequences. Earlier discussion has touched upon the expense of insurance,⁹³ the withdrawal of medical services in connection with high risk activities,⁹⁴ and the apparently mounting tendency to engage in "defensive medicine" that enables

⁹² Objective analysts have concluded that "almost no systematic investigation exists on how malpractice experience affects medical quality or vice versa." Zuckerman, Koller & Bovbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 85, 87 [hereinafter Zuckerman].

⁹³ See *supra* text accompanying notes 11-12. *But cf.* Zuckerman, *supra* note 92, at 92 (doubting that the problem of "affordability of malpractice premiums" was as widespread as often asserted, "even though the burden for certain specialists (for example, obstetricians) and physicians in certain areas or states (such as New York) is well above national averages"). The Zuckerman study drew mainly upon data that do not reflect the massive increases in insurance premiums since 1980. See also Grad, *supra* note 15, at 1071-75 (reporting that it is "now generally agreed that [the medical malpractice crisis] was a crisis not of medical malpractice but of insurance availability").

⁹⁴ See *supra* notes 11 & 27 and accompanying text. S. LAW & S. POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE 116-17 (1978) reported that forty-three states had enacted "Good Samaritan Statutes" to protect a medical person against malpractice suits if he seeks to help in an emergency situation encountered outside the office or hospital. Even after the statutes' enactment, about half the doctors surveyed some years ago expressed doubt about stopping to render aid to persons injured in a traffic accident. See also Zuckerman, *supra* note 92, at 109, which refers to a 1985 survey by the American College of Obstetricians and Gynecologists that showed 23 percent of obstetricians had reduced the number of high risk pregnancies they would agree to treat, and 12 percent had given up obstetrics altogether because of the malpractice risk. The American Medical Association found in 1983 that over one-third of the then practicing physicians had begun refusing certain types of cases they had previously accepted. Compare MEDICAL MALPRACTICE, *supra* note 26, at 43, asserting that 40 percent of the 47,000 members of the American College of Surgeons had given up "admittedly vulnerable parts" of their practice, while an equally large segment of the American College of Obstetrics and Gynecology had "altered their practice in some way." See also *Woman in Florida, Shot in Back, Waits 13 Hours for Surgery*, N.Y. Times, Aug. 9, 1987, at A21, col. 4: Edwina Haynes, who had been shot in the back and had no health insur-

a doctor to assert he left no stone unturned, without in fact benefiting a patient whose well-being depends on clues not buried beneath stones.⁹⁵

Viewed simply as a system of compensation—that is, a system of making whole the person who has suffered loss as a result of another's fault—medical malpractice litigation seems also to fall far short of its goal. Many “potentially compensable events,” as reviewers of hospital records characterize the seemingly negligent treatments provided patients,⁹⁶ do not result in litigation because the injuries are minor⁹⁷ or for other reasons (including the individual patient's ignorance). As for all medical injuries, suffered in hospitals or elsewhere, for which a claim for compensation had been filed, fifty-seven percent of the claims were rejected without any payment at all. The payments that were made have been analyzed and re-analyzed by well qualified (and sometimes wholly objective) persons without arriving at a clear consensus concerning their adequacy. Some evidence exists that successful claimants whose economic losses were toward the lower end of the scale “tended to be overcompensated, while those with higher losses were undercom-

ance, waited for 13 hours before doctors could find a hospital that would accept her for surgery, a hospital official has charged.

.....

“We called 14 neurosurgeons and six hospitals, and some just simply said ‘I’m not interested in her because I’m not interested in a lawsuit,’” said Dr. Richard Thomas, director of emergency services at Glades General Hospital here.

Glades General has never had a neurosurgeon and had to transfer Ms. Haynes . . . The bullet damaged her spinal cord and pierced her liver.

.....

On the hospital's 20th call, Tampa General agreed to accept Ms. Haynes, and she was flown 150 miles Thursday afternoon to the Gulf Coast hospital. . . .

But the task of finding a suitable hospital was complicated by recent moves by hundreds of South Florida physicians to cut back or quit practice in the face of record malpractice insurance rates. Malpractice premiums for Dade and Broward County neurosurgeons average \$192,420 a year. The statewide average is \$102,339.

⁹⁵ See *supra* note 26 and accompanying text; see also S. LAW & S. POLAN, *supra* note 94, at 115 (reporting that 70% of doctors responding to an AMA poll believe they are practicing defensive medicine although empirical studies cast doubt on this self-appraisal); Bell, *supra* note 88, at 971 (doubting that the dividing line between defensive medicine and simply thoroughgoing medicine is clear, but remarking: “. . . [S]urveys indicate that 50 to 70% of doctors say they practice defensive medicine. It is reasonable to assume that where there is so much smoke, there must be some fire.”); Zuckerman, *supra* note 92, at 108, and sources cited (authors have no doubt about the increased costs attributable to defensive medicine, such as superfluous tests and x-rays, but are skeptical of attempts to compute the precise dollar amount of the cost, as the American Medical Association had done in 1984: \$15.1 billion).

⁹⁶ See *supra* note 1 and accompanying text.

⁹⁷ See *supra* note 2.

pensated";⁹⁸ one study, indeed, concluded that undercompensation was the norm, whatever be the actual level of economic loss.⁹⁹ On the other hand, some evidence shows that the more severe injuries do lead to higher compensation; if severity of *injury* does in fact largely determine the extent of the victim's *economic* loss (a debatable proposition), one can argue that the distribution of compensation is fairer than many have thought.¹⁰⁰

In any event, malpractice proceedings leave fifty-seven percent of claimants uncompensated, though injured, and many who have never become claimants have also suffered injuries without being indemnified. On the basis of data compiled in the mid-1970s, moreover, analysts were able to conclude that only one of 150 persons injured while in California hospitals received any compensation whatever.¹⁰¹ Even if, as seems to be true, the filing of claims has become somewhat more frequent in the 1980s, one is left with the sense that the balm of money is not being liberally applied to wounds incurred during medical treatment.

Accomplishments of the New Zealand plan. Concentrating as it does on the fact of injury rather than on the issue of culpability, New Zealand has not encountered precisely the same problems that have beset the American malpractice system. In New Zealand people are compensated for medically caused injuries that "arose out of and in the course of" treatment, just as is true in America in the now familiar field of workers' compensation for persons who have suffered injuries arising out of and in the course of employment.

When first introduced in this country in the early twentieth century, some years later than in New Zealand, many regarded the idea of developing a workers' compensation system as heretical. Now the notion of providing compensation for injured employees, without inquiry into blameworthiness, is accepted without demur. Like New Zealand's accidental injury law, American workers' compensation laws measure compensation by formulas and schedules that exclude the possibility of extravagantly large awards while assuring somewhat equal treatment of like cases.

⁹⁸ Zuckerman, *supra* note 92, at 99-100.

⁹⁹ *Id.* at 100. *But cf.* HHS TASK FORCE REPORT, *supra* note 5, at 16: A study of claims closed by indemnity payments in 1984 "found that 62 percent of patients compensated received payments greater than their economic loss, 8 percent received a payment equal to their loss, and 30 percent received a payment less than their loss. However, these figures represent compensation paid before the claimants' attorneys' fees were subtracted."

¹⁰⁰ This is the view taken by P. DANZON & L. LILLARD, *THE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS* 23-24, 31 (1982). For further analysis of payments made as a consequence of malpractice litigation, compared with other types of tort cases, see J. KAKALICK & N. PACE, *supra* note 6.

¹⁰¹ Zuckerman, *supra* note 92, at 99.

The workers' compensation system has gained acceptance also because its simplified administration does truly reduce costs of operation. In the United States the bulk of employers' insurance premiums is actually expended for those who are the intended beneficiaries of the workers' compensation law, injured workers.¹⁰² That is true as well in New Zealand, where the Accident Compensation Act has absorbed the preexisting industrial injury law and gone beyond it into new territory. The payments experience in New Zealand in respect of medical injuries is markedly different from that of the United States, where only a minor fraction of the malpractice insurance dollar reaches injured persons' pockets.¹⁰³

Doubts persist, nonetheless, about whether New Zealand's thus far successful effort to provide ready compensation for accidental injuries is significant for the United States. New Zealand's compensation for noneconomic consequences of injury (such as "loss of amenities of life" or "pain and suffering") is far, far smaller than the exciting prizes Americans have become accustomed to reading about in their newspapers.¹⁰⁴ To bring under control unrealistically heightened expectations stirred by the present malpractice lottery will be a political feat of substantial difficulty.

Then, too, New Zealand's system works without any great friction between the Accident Compensation Corporation and the mass of its "clients" (that is, the claimants) because the Corporation has avoided creating an adversary atmosphere. It does not act as though it were, say, an insurance company whose profitability would be enlarged if payment of claims were minimized. Rather, it administers a social insurance system that involves no contests between opposed interests, but only an inquiry to establish that the claimants have met the conditions of entitlement. Even when judgments about the precise cause of a discernible injury are difficult to make with utter confidence (as they often are), the Corporation approaches the task without a predisposition to oppose the claim, but, rather, with a readiness to act upon presumably disinterested medical advice.

Are state governments in this country prepared (a) to adopt a method of financing that excludes the need of buying insurance from private companies and (b) to develop an administrative style that eliminates the need for many services lawyers now profitably render defendants and plaintiffs? When New Zealand inaugurated its accident compensation scheme in the early 1970s, medical malpractice did not bulk large in the affairs of either the insurance busi-

¹⁰² See HHS TASK FORCE REPORT, *supra* note 5, at 16.

¹⁰³ See *supra* note 6 and accompanying text; *supra* note 67.

¹⁰⁴ See *supra* note 8 and accompanying text; see also Tancredi, *Designing a No-Fault Alternative*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 277.

ness or the legal profession. The situation in America today is different. One may anticipate that "socialization" would be sturdily resisted here; self-interest and ideology would commingle in opposition. This does not mean that the New Zealand approach should be ignored. It means only that transferability would not be easily achieved.

Lessening the risk of substandard medical care. The risk of substandard medical care remains large in both countries because neither of them has vigorously sought to call to account those whose patients have suffered. Note must be taken, however, of occasional awakenings from lethargy.¹⁰⁵ More awakenings are needed.

In the United States some experience has been had with maintaining rosters of physicians who are deemed qualified to render services in connection with the functioning of a particular administrative agency. This is true, for example, in the workers' compensation systems of a number of states. A doctor whose level of probity or performance is found to be objectionably low in that context may be removed from the particular roster without infringing upon the authority of other governmental or professional bodies concerned with licensing and disciplining physicians. Even when an administrative body possesses this power to act in self-defense, the power has thus far been diffidently exercised in the United States.¹⁰⁶ The

¹⁰⁵ See *supra* text accompanying notes 69-74; see also Brinkley, *State Medical Boards Disciplined Record Number of Doctors in '85*, N.Y. Times, Nov. 9, 1986, at 1, col. 1 (reporting that state agencies had disciplined a "record number of doctors in 1985," almost 60 percent more than in 1984).

¹⁰⁶ N.Y. WORK. COMP. LAW § 13-d(2) (McKinney 1965), for example, authorizes the chairman of the compensation board to revoke the authorization of a physician to receive fees for rendering medical services in matters within that board's authority, if the physician has been found (after suitable procedures) to have been "guilty of professional or other misconduct or incompetency" in that kind of activity. A quarter of a century ago this power was used only nine times in three years, during which 28,439 physicians were on the board's roster. Gellhorn & Lauer, *Administration of the New York Workmen's Compensation Law* (pt. 3), 37 N.Y.U. L. REV. 564, 587-88 (1962). "A sanction so infrequently used despite freely expressed dissatisfaction with licensees' behavior, is unlikely to influence the adequacy of medical treatment or the moderation of charges for professional services." *Id.* During the years 1984 through 1987, the power seems to have been used only once, so far as could be recalled by seemingly knowledgeable officials.

A 1982 statute, 42 U.S.C. § 1320c-5(b) (1982), authorizes the Federal Health Care Financing Administration, acting on a recommendation by a local peer review organization, to disqualify a doctor from receiving payments under Medicare if she "grossly and flagrantly" violates standards of care or if she commits a "substantial [violation] in a substantial number of cases." Examples of utilization of the new process appear *supra* notes 79 & 89. But see *Medicare Panels Accused of Laxity—Nader Aide Asserts Statistics Show that Physicians Fail to Police Their Peers*, N.Y. Times, Oct. 27, 1987, at A25, col. 4.

See also False Claims Amendments Act of 1986, 31 U.S.C.A. § 3729 (West Supp. 1987) (providing financial incentives for reporting overcharges in federal programs). N.Y. Times, Sept. 10, 1987, at 25, col. 1, reports a proceeding initiated by a doctor

power does not exist even on paper in New Zealand. Neither New Zealand nor the United States has developed a firm resolve to deal administratively (rather than by civil litigation or prosecutions for violation of penal statutes) with recurrently deficient behavior by a physician.

A doctor who has made a mistake in his professional work, as most doctors (like most other people) probably have done, may be sued in America, but the outcome of an isolated lawsuit does not show him to be a menace to future patients. So, too, an erroneous report or an exaggerated claim for money not actually owed is of course deplorable and is cause for censure; but an isolated misdeed, not shown to be an element of a pattern that suggests grave moral laxity, is scarcely sufficient cause to bring the heavy artillery into play. The case is different, however, when an official body responsible for administering a program of social insurance or health protection can fairly find that a physician who shares in this responsibility is persistently undercutting the administration. This occurs when evidence exists that the doctor has been repeatedly inept, repeatedly uninformed, or repeatedly given to the use of unsafe methods of practice, thus endangering those meant to be served; it occurs, too, when a doctor is shown to have exploited his position of trust by frequently making misleading statements in furtherance of

against a former colleague who had accused him of defrauding Medicare by billing for unnecessary or unperformed surgery.

See also N.Y. Times, Oct. 13, 1987, at 1, col. 6:

The Administration is drafting a major proposal to use price incentives and lists of selected doctors to help control the volume of physician services provided to 31 million elderly and disabled people through the Medicare program.

Dr. William L. Roper, head of the Medicare agency, said today that under the proposal, the Government would "steer Medicare patients toward certain doctors who practice a conservative style of medicine, who have a proven track record of providing appropriate medical care without unnecessary utilization of services."

....

Under the proposal, . . . Medicare would pay more of patients' bills if they went to doctors who made special efforts to eliminate unnecessary services. But beneficiaries would get no discount and might have to pay more of the bill themselves if they went to doctors with a history of ordering what the Government considers excessive tests, office visits or medical procedures.

The Government would publicize the names of "preferred providers." . . .

....

Dr. Roper said that the proposal would, to some extent, "impinge on doctors' ability to make decisions with respect to their patients."

....

Dr. Roper said the Government could monitor a doctor's "practice pattern" by measuring, for example, the number and frequency of office visits, X-rays, electrocardiograms, laboratory tests and other procedures.

his or others' interests at the expense of the program he ostensibly serves. When instances of these kinds come to light, self-protective measures should be available and should be used.

An uncomplicated measure to lessen the hazard of poor medical judgment has been encouraged, though not as yet widely required, in the United States. This is, very simply, obtaining a second opinion concerning need, feasibility, and procedure before surgery is undertaken.¹⁰⁷ Medico-legal lore is full of anecdotal references to unnecessary or bungled surgery, some instances of which attracted judicial attention.

After a lengthy trial that had converted his courtroom into "a *Grand Guignol* of medical horrors," a California judge found that the defendant who stood before him was a persistent bungler who had

abused the confidence reposed in him by inflicting his incompetence on the unsuspecting and defenseless public. [He] for nine years made a practice of performing unnecessary surgery, and performing it badly, simply to line his pockets. . . .

. . . .

. . . .Evidence was adduced as to 38 patients and, since several underwent multiple surgeries, something in excess of 50 operations. . . .

[The defendant] made a practice of operating not only on the basis of inadequate preoperative findings, but also on the basis of false findings. . . .

Another practice [he followed] was to operate on patients without giving them a period of conservative treatment within the hospital. . . .¹⁰⁸

The case was undoubtedly aberrational, both as to the extent of the harm done and as to the doctor's motivation. The sordid tale nevertheless points up the desirability of double checking more routinely than has been commonplace in some areas.

A number of American insurance companies do today actively encourage all patients who face elective surgery to obtain second opinions at the companies' expense. Many hospitals as well as public authorities call for second opinions or for various other means of monitoring surgical plans and performances.¹⁰⁹ Similar measures

¹⁰⁷ See *supra* note 32.

¹⁰⁸ S. LAW & S. POLAN, *supra* note 94, at 215, 217, 225. The entire sad story of the surgeon's misdeeds and of a hospital's negligence in failing to detect them is set forth *id.* in at 215-45.

¹⁰⁹ See, e.g., N.Y. PUB. HEALTH LAW § 2803(1)(e) (McKinney 1985). For a critical evaluation of the second opinion system, see Grad, *supra* note 15, at 1070-71 (discussing assertions that "thousands of deaths occur each year as a result of unnecessary surgery").

may not be feasible in a country (or in a portion of a country) that has only a small medico-surgical population.

Better records systems. Those who concentrate on preventing mishaps rather than on worrying chiefly about their consequences have recently sought improved systems for recording and using information about hospitalized patients. Patient care has come to be more a group enterprise than a solo performance. Jottings on pieces of paper are regarded in some hospitals as inadequately enlightening about a patient's status, needs, and prospects. A clinical observation, a test report, a notation of steps taken or proposed to be taken, and the like can be recorded for computerization and ready retrieval, to be used by all the team members whose judgments and actions may have a bearing on the patient's progress toward good health. In both New Zealand and the United States improved information management might well lead to avoiding some of the problems that now beget demands for redress.¹¹⁰

Specialization as affecting patients' attitudes. The prevalence of teamwork in many branches of patient care bears also on the general public's changing perceptions of the medical profession. Not many generations ago the medical profession's image in the public's mind was that of "the old family doctor," full of wisdom and sympathy and seemingly with time to spare for a bedside visit to a patient for what might today be regarded as a session of psychotherapy. Confidence in the family doctor's wizardry reflected belief that medical science was far more comprehensive and precise than in fact it has proved to be; the patient's unquestioning reliance on the supposed expert's judgment concerning diagnosis and treatment of medical problems was the norm.

Medicine's increased specialization in the present day has changed all that. When, as is now frequent in the United States, several physicians may be occupied in delivering various portions of a patient's care, the patient has no single authority figure to whom he entrusts his fate. In New Zealand, as soon as the need for a specialist has been perceived, the doctor whom the patient does know (the general practitioner) refers him to one with whom he has had no relationship. The new master of his fate functions in a hospital often located far from the patient's home and other emotional supports.

Whether in New Zealand or in the United States, the old-fashioned doctor-patient relationship is unlikely to develop as once it

¹¹⁰ The important part played by hospital and medical records in American malpractice litigation is explained in a leading treatise, D. HARNEY, *MEDICAL MALPRACTICE* §§ 20.1-20.4 (2d ed. 1987).

readily did.¹¹¹ Discussing that relationship, the American Association of Retired Persons, purportedly speaking for a membership of 25 million, asserted that American physicians in general had done little to improve their rapport with patients and that

the problem has been exacerbated by increasing numbers of specialists. These specialists or surgeons are often brought in by the primary care physician. Frequently, they never even have a conversation with the patient. When something goes wrong, since there has been so little contact, the patient is left with his/her own perceptions as to what should have occurred.¹¹²

Statistical evidence supports the hypothesis that lack of communication between the providers and the recipients of medical treatment has heightened disappointed patients' readiness to sue doctors. Those medical specialists who managed to spend a bit of time with patients incurred fewer claims than did their more impersonal colleagues.¹¹³

Possibly more important in the long term than anything having to do directly with malpractice or compensation systems is conscious consideration of the need for a collaborative relationship between doctors and patients as an element of successful health care

¹¹¹ See MAY 1987 GAO REPORT, *supra* note 36, at 19:

Deteriorating patient-physician relationships are also a result of the increasing specialization in medicine. Today, several physicians may be involved in delivering medical care to the patient. This increases the (1) likelihood that breakdowns in communication may occur between the patient and physician, increasing the degree of disappointment and dissatisfaction when the outcomes of medical care fall short of what was expected, and (2) need for improved patient-physician communication and better education of patients about the potential risks and outcomes associated with various medical treatments.

¹¹² FEB. 1986 GAO REPORT, *supra* note 9, at 35. The deterioration in relationship cuts both ways, according to Bell, *supra* note 88, at 985, who asserts that "[t]he malpractice process" has adversely affected an important aspect of the physician's work, namely, his relations with his patients.

The faith of patients in the physician and their gratitude for the care given them are attractive elements of practice for those interested and desirous of caring for others. The threat of malpractice litigation, however, turns every patient into a potential adversary. That potential adversariness is likely to interfere with the positive relationships with patients that make medical practice more enjoyable.

Id. (footnote omitted).

¹¹³ Zuckerman, *supra* note 92, at 97; *cf.* Epstein, *supra* note 67, at 89: "Others will have to determine if the sharp increase in malpractice actions is attributable to the increasing depersonalization of modern medical care—itsself the apparent by-product of the ever more technical, ever more specialized nature of modern medical practice." *But cf. Law, A Consumer Perspective on Medical Malpractice*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 310-11 ("Doctors can do unreasonably dangerous things for a considerable period of time without being sued, particularly if the physician has congenial personal relationships with patients, colleagues, and hospital administrators.").

programs.¹¹⁴ A paper concerning problems of law and its administration is not an appropriate setting for extended discussion of this topic. The topic nevertheless deserves mention here because the debilitation or the development of sound relationships between patients and their health care providers may sharply affect the shaping and functioning of legal systems that deal with unsatisfactory medical outcomes.

¹¹⁴ Dr. Jay Katz (physician, psychoanalyst, and Yale law professor) has written eloquently and persuasively about the worth of patient participation in decisionmaking and about the difficulty of overcoming physicians' concern that their more generously sharing decisional authority may beget fresh difficulties. See J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984) (especially ch. IV, "Sharing Authority: The Willingness to Trust"); see also HHS TASK FORCE REPORT, *supra* note 5, at 102-03.