cedure is devoid of legal technicalities. The forum may be anywhere: the office of the physician or of one of the attorneys; the patient's home; a hospital room. As in a court trial, attorneys for the disputants present their cases. Witnesses are heard, documents reviewed, and then a decision is rendered. A court reporter need not be present unless one of the parties requests it.

Hearsay evidence is admissible. This is a great help to the plaintiff's attorney in a malpractice case; it permits him to introduce textbook evidence.

Arbitration can only arise if the parties have specifically provided for it by contract. This contract could be signed after the particular dispute occurs, but usually it will be signed in anticipation of some possible conflict arising in the future. For the physician and patient the contract ordinarily would be signed when the physician first accepts the case.

A lot of people have a deep-down feeling that when the doctor says, "Here, sign this," and they sign it, they don't really appreciate every aspect or implication of this binding contract. But the California Supreme Court has favored these contracts in a number of recent decisions. To one plaintiff who wanted the contract declared invalid on the ground that he had a right to a court trial, the court just pushed the whole issue of due process out of the way and said, in effect, "Arbitration doesn't affect rights. It is simply a change of forum. You were going to go to the Superior Court. Now you go to the arbitrator."

Of course, if a patient is sick and goes to a doctor and signs the arbitration contract because he is afraid the doctor will not treat him otherwise, that would be an adhesion contract. That is one which is forced upon an inferior party by a superior party, and adhesion contracts are invalid at law. But in a nine-hospital experiment in Southern California in which arbitration contracts have been sought since 1969 from all patients upon admission except those acutely ill, the patients have a thirty-day period from the time of hospital discharge to void the contract. The nine hospitals hope to get around the adhesion-contract problem that way. Incidentally, less than ten patients have taken advantage of that release provision.

Arbitration has also been in effect since 1932 at the Ross-Loos Medical Group which has 150 physicians and an active patient list of about ninety thousand. And arbitration was recently adopted by the Southern California Kaiser Foundation Health Plan, which has seven hospitals and twenty outpatient clinics and a total membership of about one million people. Within two or three years, if the value of the arbitration method is demonstrated, the Northern California Kaiser Health Plan may adopt it. And if the method continues to prove valuable, I think California physicians generally will adopt it. In that case, the California experience may be useful to the rest of the country.

An arbitration case begins when the defendant is notified that a claim is being made against him. The usual contract may provide for a period of thirty days in which the claimant and defendant each must select an arbitrator; there is another thirty-day period for these two arbitrators to select a third, neutral person. If they cannot agree on a third person, the Superior Court judge selects him. There is also a brief period between the selection of the panel and the start of the hearing. So you can be in arbitration within ninety days after initial notification of the defendant. The time limits are even shorter in the Ross-Loos contract, about seven weeks. In practice, time extensions are often requested and granted.

The advantages for both physician and patient are the short period of time before the proceeding starts as well as the brevity of the proceeding itself. Ross-Loos has had only one case that took longer than four days. The clinic had only one case that took three days. A number have taken two and a half days. Many of them have taken only one day.

For the physician there is comparative privacy and an absence of excoriating, public cross-examination. No transcript is required unless one party requests it, and the arbitrators' decisions are not published.

A big advantage for the patient is the admissibility of textbook evidence; he does not have to present the expert testimony of physician witnesses. The California arbitration law has no rules about hearsay evidence. It specifically says that the arbitrator can accept evidence which he himself acquires outside of the hearing room. But if he uses such evidence he must present the substance of it in the hearing and give those in the room a chance to rebut it. I know this is a frightening prospect to most attorneys. But that procedure is consistent with the informality of arbitration and with its presumption that people will be honest and fair. The law repeatedly builds into the arbitration system the requirement that all cards be face up on the table.

Another great advantage for many patients is that whereas the majority now get nothing for a medical injury because their damages are not substantial

enough to make it worthwhile to go to court, arbitration makes it possible to get some compensation. That is, with textbook evidence, the general-practice attorney can have a reasonable shot at winning. And the brevity of the hearing makes the case economically feasible for him. From the physician's point of view — and this is somewhat speculative — it is felt that huge verdicts of the kind juries sometimes return will not be returned by arbitrators.

One of the advantages or disadvantages, depending on whether you win or lose in arbitration, is the finality of the decision. The arbitrator's decision cannot be appealed except within an extremely narrow scope: if he is guilty of fraud, or refused to hear one or another of the parties, or held a hearing when one of them could not attend, or refused to receive some evidence.

Will the economy and ease of arbitration open physicians up to numerous malpractice claims? The Ross-Loos experience is that it does not. But their experience is colored by an administrative policy which anticipates trouble before it really starts. Any Ross-Loos patient who suffers a medical injury, regardless of whether or not negligence seems likely, may be considered a candidate for a small financial settlement. So the vast majority of cases which proceed to arbitration are those which Ross-Loos feels quite certain it can win. Over the years, there has been only one substantial verdict against Ross-Loos. This was for seventy thousand dollars in 1968.

The nine-hospital experiment has been going for only two years so it is too early to tell, but those hospitals have had no more claims than they would have had in a courtroom situation. In fact they have not had a case go through arbitration yet.

Kaiser's experience may give us the final information on the real value of arbitration. Kaiser has a very heavy case load of malpractice cases due, I think, to the comparatively impersonal management at most Kaiser facilities. That creates enough ambivalence in the patient so that he does not hesitate to sue Kaiser.

Finally, a question we must face is this: How do you achieve quality control of health care within the context of arbitration? The whole procedure is private. You do not have the newspaper headlines of malpractice litigation. You do not even have the reporting in the jury-verdict reporting sheets. Does this carry privacy too far? The obvious answer is that there are many other stimuli to quality control. However, I think you could establish a reporting function within the arbitration system. I do not know whether arbitration falls within the state law which requires that all settlements or verdicts of more than three thousand dollars be reported to the state board of medical examiners.

**RICHARD S. L. RODDIS:** Arbitration developed in this country in the area of commercial contracts and labor relations. I am wondering what our attitude would be if it does expand broadly into consumer areas. What would we think would be the result if all auto manufacturers were to put arbitration clauses in their warranties? And what would be the result if the major medical malpractice insurer in an area were to require that each of its insured physicians had to exact a binding arbitration agreement from every prospective patient? Would that be as attractive-sounding to us as the Ross-Loos or Kaiser arrangements? What is it that distinguishes among these situations?

**RUBSAMEN:** The courts will not permit adhesion contracts, as I said earlier. Where the patient is acutely ill or has a complicated problem and there is a rather narrow field of selection among specialists who can take care of him, making the patient sign an arbitration agreement would be an adhesion contract.

What about a usurpation of the field? It has been all right for Ross-Loos, and I think it is all right for Kaiser in Southern California, to say to their patients and members, "Either you sign this arbitration contract or we will not treat you." This is permitted because the patient can go to a private doctor. But if the sole malpractice insurance carrier in an area simply co-opted the field, the patient would not have the option of refusing to sign the contract under such a circumstance, and I think that that would be an adhesion contract.

**MARK BLUMBERG:** Essentially members of the Kaiser Foundation Health Plan have a dual choice. Each year, they have the choice of continuing with Kaiser. If they decide not to re-enroll, their employer or whoever picks up the Kaiser premium will pay for another health benefits plan that offers indemnity for service-type benefits with a similar employer contribution. So it isn't a case of their signing an agreement on the occasion of some illness. They make a choice on the occasion of an annual enrollment period, and if they don't prefer Kaiser they can switch to Blue Cross or some other program at a subsequent enrollment period.

**MARKUS:** I have no reticence about accepting the arbitration procedure in cases where the damages are relatively small and the monetary claims are slight. This is sensible for both sides, and you do get a kind of rough justice in those cases. On larger claims, where both sides feel it is important enough and critical enough, they should not be forced to arbitrate in lieu of litigation.

**RUBSAMEN:** What you said earlier about juries favoring doctors is probably true, at least outside the large urban areas. So if the medical facts of a case are really complex, and it promises to be a tough one, an attorney probably would do better in arbitration with textbook evidence. And this will apply in a big case, even if his recovery will be less, because his risk of getting nothing is less.

**MARKUS:** I am not saying that we should do only what is good for the plaintiff. I happen more commonly to represent the claimant, but my sense of justice says that if either party to a serious dispute feels he wants the full-dress, long, more complicated, more expensive procedure of a court trial, he should have it.

**RUBSAMEN:** You know, there are a couple of curious things about the way arbitration has been accepted in California. The Casualty Indemnity Exchange has about 1,500 to 1,700 private-practice physicians under insurance contract. These doctors are pledged to sign up ninety per cent of their patients to arbitration. If they can't do that, they do not get the fifteen-per-cent reduction in their insurance premium.

Now these doctors have found two things. First, patients do not object to signing. Second, these doctors have had fewer malpractice claims made against them than has a parallel group of physicians who have not had the arbitration clause. Maybe that is because doctors who are willing to sign up arbitration contracts are kind of open, loose guys who have good patient relationships. Patients are often smart. They really want to have a feeling that the doctor is squaring with them. When the doctor says to them, "This is a clause which says I am not going to put the entire state of California's legal system between you and me if we have a disagreement," I think the patients respond.

**BUSH:** I hope that somebody is studying in detail the circumstances under which patients are signing these arbitration contracts. Every study done in medical care about what patients know in these matters is contrary to what you are saying. Studies show they are almost totally ignorant of what is going on. They do trust the doctor. They will sign. But they are signing without knowing what issue may come up. They are signing away their constitutional right to a trial by jury.

**RUBSAMEN:** The federal Constitution does not guarantee the right to a jury trial in a state civil case, although the California constitution does. However, the patient can waive this right by contract, which is what he does when he signs an arbitration agreement.

**BUSH:** Perhaps, but it is a right that presently exists and that arbitration would take away. The patient does not even know what the problems might be in his case. It is like signing a blanket consent to everything that is going to happen when you walk into the hospital. That is not informed consent in any general understanding of that term. And I do not see how you can make it give any feedback to affect the quality of the care in the health system. If you begin keeping records of negligence and if you start publicizing the results of arbitration proceedings, and if you still identify fault, then there is surely no advantage for the provider of health care.

**RUBSAMEN:** The advantage is the shorter trial, the lack of cross-examination, and the finality of the decision. But the physician certainly wants to avoid publicity. I think your criticism is well-founded and points to a significant problem.

**ROBERT E. KEETON:** One of the tests of the extent to which a patient is really giving an informed consent when he signs these contracts is to put the question this way: What difference in the incidence of signing would there be if you asked the patient if he would like to sign the arbitration agreement *after* the medical injury or unexpected result has arisen which may be the basis of a claim? I think we would all agree that the number of patients who would sign at that point would be very much lower than the number who sign in advance.

I agree entirely with Dr. Bush's statement. People who sign these forms do not really understand the significance of what they are doing. They do not understand the terms of the choice being offered to them. They do not understand the terms of the legal

consequences of that choice. And I am very uncomfortable with a legal doctrine that depends on this ritual — and I use that term "ritual" designedly — this ritual of signature of a theoretically informed consent, especially in the context in which the person is given this choice, "You sign this form or you do not get treated in this system."

**ELI P. BERNZWEIG:** One of the problems with the thirty-day period within which a patient can void the arbitration contract is that often a medical injury may not show up in that short a time. A person can leave one of these nine hospitals and thirty days later be in what he thinks is a perfectly reasonable medical condition. Then six months later he will develop severe abdominal distress, go to another physician and be told upon X-ray examination that there is a sponge still inside him. However, his thirty-day opportunity to void the arbitration contract has long since passed. But if he has the option to rescind that contract he most likely would exercise that right and try to get some monetary as well as physical relief. I am concerned about abrogating these rights through arbitration agreements. I am inclined to view arbitration with a jaundiced eye in general if there are no appellate rights.

**KEETON:** One of the things that impresses me about the arbitration development in California is that the impetus for it comes from the providers of the medical services. It comes for reasons of cost control and adverse publicity control. And when I see that combination of motivations I am extremely skeptical about the argument that the development of arbitration is serving the best interests of the patients. If it does serve the best interests of the patients it is pure coincidence.

If we take a look at arbitration in the light of the patients' special interests, what we should do if we want to provide for the large number of small malpractice claims that are never pursued in the present fault-and-liability system is to write a statute that would say the patient shall always have the right of arbitration at his option after the medical injury occurs. At that point, the patient may choose arbitration and, with the advice of a lawyer, he undoubtedly would choose it in the small cases, while often preferring court trial in the larger cases.

**BUSH:** There is gathering support in professional circles and insurance companies for arbitration, but the thing that concerns me most is that, as it is now developing, it provides almost zero feedback to the long-term quality of medical care. It settles the compensation problem in a very brief, efficient, final way. But it speaks not at all to the question of the improvement of medical care. And that is the major issue. And as soon as arbitration becomes universal, the patient will not have any choice but to sign because there will be no other providers of health care to whom he can go.

**KEETON:** I am not, as you may gather, a great advocate of arbitration, but I do not see why there has to be less feedback in the arbitration private remedy than in the court private remedy. Whatever reporting back to medical authorities you require in court litigation you can require in arbitration proceedings. It seems to me that the only difference would be in the degree of publicity that attaches to arbitration proceedings.

**RUBSAMEN:** A defense attorney recently told me, "I think courtroom litigation is an excellent barrier for the defense of many doctors who can win in court but not in arbitration, or who would never get into court because the claims are too small." So that is another facet of the feedback issue.

Further, if a plethora of cases went through arbitrators' offices and if these had to be reported, and if repeatedly one found injuries — perhaps small ones with implications for bigger injuries — arising from one doctor or perhaps a medical group, maybe such data, accumulated over a period of just a few years, would enable the arbitrators' offices to serve as way stations for channeling that information, but without general publicity as occurs in civil trial. That could lead to reform of a specific physician, a group of physicians, a community of physicians, or a hospital. Reform might come much more quickly from that kind of feedback than it does now from waiting out and analyzing courtroom litigation.

Finally, don't forget that medical malpractice cases in California have struck good doctors as often as, or even more often than, bad ones. This is especially true in the last five or ten years when rare medical accidents have resulted in fierce litigation because of the serious injuries involved, but where the physicians who treated these people have been competent practitioners. Putting the burden on the good doctor is not going to make him a better doctor. Arbitration has a real advantage for that reason.

**RODDIS:** I have no inherent opposition to the arbi-

tration model. We should recognize, though, that it yields results so different from those of the fault-and-liability trial court system that the decision as to which method should be used ought to be made at a public lawmaking level. I am always hesitant about private lawmaking by contract, at least when it is between disparate parties. A lot of that is going on in the country today. I call it the folklore of contractualism. Professor Keeton has referred to it as the ritual of contractual lawmaking.

## No-Fault as a Middle Ground

Mr. Carlson disavowed formal advocacy of a no-fault compensation system as *the* alternative to the present fault-and-liability tort system. His own preference, he said, was for "a kind of social insurance approach." But he presented an outline of a no-fault program which he thought promised distinct advantages over the present system in its effects on the quality of health care.

He described no-fault medical insurance as a "middle ground" between the present system and a social insurance system. Its premise would be that "compensation for medical injury should be tied to the degree that a given result from a medical procedure or treatment deviates from a set of expected results for like medical procedures." It would thus differ from the current malpractice approach in which a claimant must prove the negligence of the physician or hospital. And it would differ from a social insurance approach which would compensate all victims of medical injuries regardless of the origin or cause of the injuries.

He emphasized that "compensation under a no-fault system would not be paid for all disability states resulting from the provision of health care services, even if those services produced an optimal recovery. Rather, compensation would be paid for the degree of deviation of a patient's outcome from a range of expected outcomes for like procedures."

On the question of how a no-fault compensation system could be expected to exert any ameliorating or regulatory influence upon health care providers, Mr. Carlson said: "Assessment of compensations would be made without reference to the behavior of the providers. [But] once compensation issues have been resolved, process reviews of provider behavior (and other disciplinary mechanisms) to correct sub-performance ostensibly contributing to, if not proximately causing, the claim in question can and should be made."

He acknowledged that the present state of the technology would make it difficult to measure patient outcomes objectively, or even to measure the quality of medical care in general. He questioned the dominant assumption that the "conservative medicine" now held up as "standard" inside and outside malpractice court trials is "good medicine." And he was hopeful that a no-fault system would have four ameliorative effects on medical care.

**CARLSON:** *First, it should encourage innovation.*

Of course, to assume that innovation is desirable may beg the question unless it can be demonstrated that innovation will improve the quality of health care or give the same quality at lower cost. However, innovation is likely to be advantageous in a nearly moribund system, and there are safeguards that can be installed in the interest of quality.

*Second, it should enlist the cooperation of health care providers.*

No-fault should encourage health care providers to set up a continuing education system and cooperate in the forming of a data system to review processes and install disciplinary procedures based on the compensation claims experience (patient outcomes) of the over-all health care system. Admittedly this would tend to compromise the purity of the no-fault concept, and health care providers would inevitably try to traduce the data-collection effort if the findings can be subsequently used against them. But this is a risk that may have to be taken if the no-fault approach is to accomplish the goals of both compensation and regulation.

*Third, it should facilitate the large-unit organizational method of health care.*

Although it is still accurate to describe the health care system as a "cottage industry" made up of solo providers who, often as not, function in a fragmented, unintegrated way, still the unit for delivery of care is gradually becoming larger. Providers are forming group practices on both a multi-specialty

and one-specialty basis. Larger organizations, such as Kaiser-Permanente, have integrated health care with other attributes and phenomena such as marketing, capital formation, branching. Now the federal government is capping this development through proposed amendments to the federal health care financing program which will facilitate prepayment to these larger organizations.

The means by which financial responsibility for the quality of health care is assured will probably be expanded so that it will include not only the individual practitioner but also the large health care organization or institution. A shift in the law to accommodate organizational responsibility for the patient's health can be expected and, if desired, fostered through legal procedural innovation.

If this kind of shift takes place (and elements are now discernible in recent tort case law affecting the malpractice liability of hospitals), it can be argued that a no-fault system would be more effective than tort law both in affixing responsibility for compensation and in controlling the quality of care delivered by such organizations for two reasons:

For one, even a no-fault system must identify providers associated with claims in order to obtain diagnostic and prognostic data to determine disability levels. In the case of individual and smaller units of providers, identification of the actual practitioners involved may be difficult because more than one unit may have been involved (e g., referrals to specialists, consultations, etc.). However, with a large organization which is contractually obligated to furnish all necessary care to a given patient only one provider unit — the organization — is involved. Thus the task of procuring data is eased, especially in view of the chaotic state of medical-record technology (e.g., lack of comparability between the records of one provider unit and another).

Two, it is more likely that effective regulation by health care providers will take place in the environment of a large organization based upon hard information which can be furnished by the compensation system than if such data is fed to individual providers or to external provider self-regulatory systems. An organization which is itself the legally responsible party in a claim for compensation possesses the incentives to monitor internally the processes of care to insure that quality will be achieved; and to sanction practitioners (either employed by or affiliated with the organization) whose conduct leads to an inordinate number of claims.

**Internalizing the Cost of Malpractice**

I have reservations about too rigid an application of the concept of the internalization of cost. Putting the burden of losses on those who cause the losses has certain quality control advantages. But too close an attribution of loss cost to loss production may have disadvantages. Some of these disadvantages have already been mentioned: physicians refraining from certain kinds of medical procedures and avoiding or leaving certain medical specialties because they present a high malpractice risk. And what about the doctors who serve poor areas and are overworked and practicing under less than optimal conditions? Are we to attribute the loss costs heavily to them? If we do, that may not improve the quality of medical care; perhaps all that would happen is that we would simply impose a heavy cost burden on the particular segment of society they are trying to serve. The whole problem of how to allocate loss cost is very complex. It is possible to become so enthusiastic over the idea of attributing loss cost to loss production and to think that that is a good way to get some quality control in medicine that we may overlook the complexities and some of the collateral consequences of applying that concept.

*Richard S. L. Roddis*

*Fourth, it should liberate the concept of what constitutes quality health care, a concept narrowly restricted by the present tort system of liability.*

No-fault would free us from a system of reparations which focuses on discrete human acts regardless of the degree of relationship between those acts and the actual outcomes of health care. To insure that quality care is being achieved we must think through what we as a society mean by quality. And we must develop the technology to measure objectively whether we are getting it.

A no-fault system offers the opportunity to achieve: (1) a reconceptualization of quality; (2) a retooling of the praxis of the system free from the constraints and imperatives of tort-based reparations; and (3) the design and installation of an outcomes-monitoring system to measure the quality of care and fix the compensation for medical injuries when warranted.

**MARKUS:** Although you describe that system as no-fault, when you discuss the ground for compensation for medical injuries you seem to me to be describing what we are actually doing now in malpractice litigation in our fault system. If you tie compensation to the "degree to which the outcome of medical care deviates from a set of expected re-

sults from like medical procedures," that is nothing more than a rather sophisticated statement of the rule of *res ipsa loquitur*. That rule says that if the results of medical care are not those which we could anticipate under ordinary circumstances, there is a legal presumption of negligence. Of course, that presumption is subject to rebuttal if one can show that the result really came from some other cause.

I also think that in providing compensation for damages, we should not feel we must be bound to one exclusive system. We could have a national health insurance system to provide a basic minimum of protection for medical injuries, and we would still need a tort system to provide remedies for compensation beyond that basic minimum.

Finally, I cannot agree that the present tort liability system is not effective in dissuading physicians from undesirable medical procedures. It is my experience that when a physician is found legally responsible, whether by verdict or settlement, it very quickly gets around the medical community, and effort is made to avoid the situation that got him into trouble.

**CARLSON:** I don't want to get into a semantic tangle about what is or is not no-fault. The system I have outlined is no-fault on the ground that, for purposes of compensation, no inquiry is made into whether or not there was fault attendant on the medical procedure. It is true that, once the compensation question has been resolved, the information would be used to correct the behavior of the provider. Then you initiate a fault-like inquiry. However, the system rests not on a finding of negligence, but only on whether a medical injury occurred: That is, did the result deviate from an expected set of results from like procedures?

Also I did not suggest that one kind of compensation system excludes the possibility of others, nor did I suggest that there is no deterrent in the current tort liability system. But I do raise this question: If in fact the current system is deterring certain kinds of behavior by providers, do we really know whether or not that is always poor quality behavior and therefore whether it should be deterred? I don't think we will ever know the answer to that until we have a means of assessing and measuring the outcomes of medical care.

**KEETON:** A combination of fault and no-fault systems can be worked out in several ways. One is through staging in which both systems are used to determine what compensation the victim will receive. He receives the first level of compensation on a no-fault, straight insurance basis. Then if he thinks he is entitled to more, he seeks that on the fault basis. Along with that, you can also have the insurance company, which makes payment on the first level of compensation, proceed in tort on a fault basis against the person allegedly at fault, say, the physician, to try to get back what it has paid and thereby reduce the cost of the no-fault system by recouping part of the costs on a fault basis. There is an infinite variety of combinations you can arrange for the two systems corresponding to the different purposes you have in mind.

With regard to the no-fault system's effect on the quality of care, we could have an exclusively no-fault compensation and still have some kind of adjudication within the medical society or through independent procedures, which would also involve other people in the medical societies, to determine whether the care was what it should have been, whether the doctor was at fault in some respect, whether his behavior ought to be regulated, or deterred, or influenced. The fault-finding, then, is used not to determine compensation but to influence the quality of care in the future.

Perhaps we ought to talk a little bit, too, about the idea of *res ipsa loquitur*. It is derived from an old English case in which a man was walking along the street and was hit on the head with a barrel of flour that had fallen out of an upstairs window. One of the judges remarked, *"Res ipsa loquitur."* Obviously there was some fault involved; "the thing speaks for itself." Barrels of flour do not fall out of a second-story window and hit pedestrians unless somebody was at fault in handling the flour. So *res ipsa loquitur* is a doctrine used in law to show not only that something unexpectable happened but also that we should not expect it to happen unless somebody was at fault. Therefore, even though we have no proof of what he did wrong, or how this happened, we have a compelling inference on circumstantial evidence that the person who is picked as the defendant — by excluding all the others who showed they had nothing to do with the thing — was at fault.

Now, we draw that inference in *res ipsa loquitur* cases because, in addition to proving that something unexpected happened, we also require proof that various other possible explanations were not the explanation of this accident. We do that by proving that the defendant was in exclusive control of the instrumentality that caused harm just before the

harm was caused. Second, we say that this is not the kind of unanticipated incident that ordinarily occurs without somebody being at fault. Then we have a third requirement: the plaintiff must prove that *he* was not in any way at fault. Put these three things together and by circumstantial evidence you have excluded all the possibilities in the universe except that the defendant was at fault.

Mr. Carlson's standard does not have anything in it about excluding these other possibilities, so it is neutral on the question of whether there is fault or no fault in this unexpected deviation from a set of expected results from a like medical procedure. When we talk about unexpected results and deviation from expected results, we are really talking about an area of human ignorance. If we knew and understood all the influences on human behavior we would be able to explain how a certain thing came about. We would not have any "unexpected results." So when we talk about deviations we are saying that we do not know whether this result is explained by fault or not.

**MARKUS:** But Mr. Carlson's presumption is that standards can be derived which will yield a high degree of predictability and reliability as to what the expected results will be from any given medical treatment. As soon as you say that these standards are reliable and acceptable as indicators of anticipated results, then you do draw the inference that there was fault when those results do not occur.

**CARLSON:** Admittedly the technology has not yet been developed which would enable this no-fault system simply to look at the outcome of a medical treatment, plot the result, and determine whether compensation should be afforded. But it is that kind of objective plotting that would be vital in the system.

**RUBSAMEN:** What we are asking, when we look for a deviation from an expected result, is: Will we compensate rare accidents? In 1955, in California, the State Supreme Court, in *Seneris v. Haas,* said, in effect, "Yes, we are going to compensate rare accidents. We don't care if it is rare for a patient to get a paraplegia following a spinal anesthetic without anybody being negligent. We are going to require a plaintiff's verdict unless the doctor can explain." And there are other cases. In one, the patient died following tonsilar anesthetic — open-drop ether. That was so excessively rare that the California Supreme Court applied *res ipsa loquitur* and perhaps still would. But the Supreme Court has vacillated on this "rarity principle." The newer law on the subject is very complex.

But see how this translates right over into the no-fault area? Take the case of the patient who comes into the hospital with a little chest pain. An alert resident does an electrocardiogram and finds depression of the S.T. segments across the chest. He puts him into a coronary-care unit and gets the enzyme studies and finds they are moderately raised. He makes the diagnosis of a presumptive myocardial infarction, although it may just be changes incident to an acute coronary insufficiency. The patient is on the electronic monitors and all of a sudden he has a ventricular fibrillation. Assume the staff is on it instantly. Everything is done. They treat him beautifully. There is no "untoward" anything here. This is just one of those complications that occur in treating coronaries. And the patient dies.

So, in the hearing we get this, "Doctor, how often, when you get a thirty-eight-year-old man with these changes, do you have him drop dead?" "That is not uncommon." "Then, if you put him in the coronary-care unit and have him monitored and all is going well, how often does he drop dead?" "That is rather rare." "Well, because it is rare, we are going to look to the deviation from the expected result" (to quote your language, Mr. Carlson) "and we are going to pay off."

Now whether we should or shouldn't pay is a social policy question. But I think this points to the complexity of the problem. Our experience with *res ipsa loquitur* in California shows how intellectually unsatisfying these sorts of resolutions are when one looks to the "deviation from expected results" for the answer.

**KEETON:** Wouldn't you agree that in all the cases, the California court is saying this unexpected result is proof of fault? Presumed fault, maybe, but nevertheless fault? It may be fault proved circumstantially by excluding other possibilities, but nevertheless their theory of liability here was fault and not simply compensating on the ground that these were rare occurrences.

**RUBSAMEN:** The court translated the rarity of the paraplegia in *Seneris* into the probability of fault. The fact that this was an accident that rarely happens, absent negligence, was ignored, and the court in effect said, "From the seat of our pants we are deciding that if you identify something sufficiently

rare we are going to pay you." So it's true, they just translated rarity into negligence.

KEETON: The thing about *res ipsa loquitur* is that we brand it fault when we draw this presumed inference of fault, and that may have some psychological impact on the way doctors and the community react to it. And this does things to the doctor's reputation and his further practice.

What would happen if we applied the concept of strict liability in health care the way we have developed over the past twenty-five years its application to injuries resulting from defects of products? Strict liability is virtually identical with no-fault: it simply says that you are liable for anything that you cause, whether or not your behavior has been negligent.

If you applied that to doctors, if you imposed on doctors strict liability for all of the deviational results of their treatment, and also required doctors, as a prerequisite for their license to practice medicine, to have liability insurance to cover this strict liability, then we would have the equivalent of a no-fault system. Under both systems the same people would get paid the same benefits and doctors would pay the same insurance premiums. But under both strict liability and no-fault insurance, we are not saying the doctor is at fault. We are simply saying that this was an accident for which the system ought to compensate.

MARKUS: I don't think the notion of strict liability as applied in the consumer-products field is the standard we should apply in medicine. Strict liability in manufactured goods means that a manufacturer is liable if he caused dissemination of a product that was unreasonably hazardous to potential users because of a defect in the product at the time it left his control. So the notion of defect is a fault concept. It is true you do not have to show that the defect resulted from negligence, but you do have to show that it was defective. So I do not see a good comparison of this kind of strict liability to a no-fault liability as you have hypothesized it here.

CARLSON: The whole process of injury is very complex, no matter what system we use. Dr. Rubsamen has given a pretty good description of the almost Byzantine nature of trying to find fault in malpractice litigation in California. There is complexity, too, in the no-fault approach, but it lies in the technology that has to be developed in order to generate scales by which you can plot medical results in an objective manner.

RUBSAMEN: I am just trying to picture the whole thing working, because at clinical pathological conferences I have listened to people who have the whole autopsy in front of them — the whole thing is laid out — and they still cannot agree as to the cause of death. And they've got no axes to grind.

BLUMBERG: Medicine is both probabilistic and stochastic rather than mechanistic. A doctor must know the odds of an outcome in a given condition. It is as if he threw darts at a dart board — ninety-nine per cent go in the bull's eye under some conditions and thirty per cent go in the bull's-eye under other conditions. He cannot foresee or predict where the dart will go in any one individual case. A doctor who cures thirty per cent of some cancer cases is doing extraordinarily well. Should suit be brought for the seventy per cent who die? You would say that is absurd. All right, what about the ten per cent who die, or the five per cent, or the one per cent in those rare instances we have been talking about where the courts have paid damages and where the doctor, who has followed procedure, nevertheless gets an adverse outcome?

BUSH: Since medicine is probabilistic, the problem is how to determine the proximate cause of a medical injury in the particular case. We can answer fairly easily the questions of whether damages occurred and whether standard practice was followed. The hard question to answer is, are *these* damages connected with *these* deviations from acceptable medical practice? In those cases where the bad result comes out, even when good care is given, to agonize over whether fault occurred is to agonize over an unanswerable question.

If we could work out scales that measured patient outcomes objectively, and if the findings were divorced from the concept of individual guilt, then that would provide a feedback mechanism to improve the quality of medical care, compensate the victims, get the individual doctor off the hook, and get people who are in key positions in medicine to become aware that there ought to be some changes in practices to improve the number of good patient outcomes in the long run.

But I don't think the proximate-cause problem in medical injuries is separable from the question of nonstandard care, and from the question of fault or negligence in some sense. I do not believe it makes sense, however, to apply the concept of fault in the individual case.

**BERNZWEIG:** Defining the compensable event is nearly impossible. We know that many people who have suffered medical injuries are going uncompensated today. Now if we hypothesize a system simply to compensate maloccurrences arising out of blameless medical treatment, then I can foresee the economic costs of such a system trebling and quadrupling to the point of impossibility. There isn't an administrative mechanism large enough to settle all the compensability issues that would arise under such a system. We'd have to have new systems of courts throughout the country. I am wondering if all of this is feasible.

I ask the question, who is pressuring for no-fault? Are consumers writing letters to their congressmen complaining about not getting equal justice in the courthouse for medical injuries they have sustained? No. The pressure is coming from providers who do not want to sustain the stigma of being served with a summons and a complaint in a malpractice suit.

# What Is "Standard Medical Practice"?

The most persistent and baffling problem throughout the conference was what distinguishes standard medical practice from malpractice. This issue cut across all discussion of the relative merits of the tort liability system, a no-fault system, and a social insurance system. For, in the end, whatever compensation system or combination of systems is established, if it is to have an ameliorative impact on the quality of health care and keep costs to a manageable figure, it must be able to identify and sort out the causes of medical injuries to patients. This exchange was repeated, with variations, during the discussion:

**BLUMBERG:** For a good surgeon, the top one in the country, in ten per cent of his appendectomies, the appendix will be healthy because he wants to "fail safe." For another surgeon, twenty per cent of the appendices may be healthy. But what do you do with the doctor when eighty per cent of the appendices he takes out are healthy? Where do you draw the line between good and bad practice? And how do you determine in any one particular case whether the appendectomy was unnecessary? The tissue committee at the hospital is supposed to make this determination, but it cannot do it except on a collection of cases. It can reprimand a physician who has a bad batting average. But in any one case it is very difficult to ascertain whether the operation was unnecessary.

**ROGER EGEBERG:** I am surprised that anyone still does tonsillectomies. The tonsils are a couple of pretty good lymph glands that help us except when they are terribly overwhelmed and then they should be removed. And yet, tonsillectomy is the most common operation in the United States.

**BLUMBERG:** Maybe this is a solution to the appendectomy problem: Since taking out a diseased appendix is more complicated than taking out a normal one, it may be appropriate to change the fee schedule so that the doctor would get twenty-five dollars for removing a normal appendix, and, say, three hundred dollars for taking out a diseased appendix.

**RUBSAMEN:** This is a complex issue. I want to put in a word for the physician who takes out normal appendices. Here are two examples. A fellow is out on the golf course. He had had a good dinner the night before but did not feel much like eating breakfast, yet felt good enough to play golf. He is on the fifth hole, hits the ball, gets a pain in the right lower quadrant. He plays five more holes, feels sick, goes to the hospital. An alert surgeon sees him, feels a mass — not much else — and operates on the ruptured appendix. He ruptured that appendix, we both thought, on that fifth hole when he hit that ball. His symptoms of appendicitis consisted of anorexia that morning.

A second case. In my first year in practice I consulted with a small group that did a lot of merchant seaman work. If you are a doctor to a shipping agent, you soon learn that if you pull a man off a freighter because he may have appendicitis (perhaps the freighter is going on a twenty-two-day trip to Australia), you had better have the appendix taken out because repeated episodes may prove a liability to the company and the patient, as well, if he's at sea. That means the surgeon will be taking out a lot of normal appendices. But it also means that one learns a lot about appendicitis that "isn't" appendicitis. We spent two hours one day evaluating a

patient, deciding whether to do an appendectomy. Finally the surgeon said, "Take it out. This fellow will be out on the boat for twenty-two days. It's too big a risk. I'll bet ten to one he does not have appendicitis, but take it out." He had a gangrenous appendix.

So, this is why an old surgeon who is now dead, who was my professor at Stanford and who had practiced medicine during the pre-antibiotic days, said to our class in 1945, "If you boys go into surgery and you are not taking out half as many normals as you are pathologicals you are not doing enough appendectomies." Probably many surgeons would not agree, but he said it because a ruptured appendix, even today, is a catastrophe. And most appendectomies are awfully simple.

I relate these experiences to show how the medical facts are often far more complex than envisaged by those who postulate a system which must deal with them.

**EGEBERG:** If the pathologist in the hospital doesn't find a certain percentage of normal appendices in the appendectomies — maybe it's ten per cent, or twenty per cent now — I would say that that hospital is running the risk of ruptured appendices. And that is a catastrophe, as you say. Of course, if all the normals are from one doctor then you look at that retrospectively and make some judgment.

**BLUMBERG:** Is this cause for malpractice: a woman has her uterus taken out with her prior consent, and the uterus is normal?

**MARKUS:** If the exercise of reasonable care would not have called for that surgery, it is malpractice.

**RUBSAMEN:** But you would have a tough time getting expert medical testimony that that was malpractice where she had troublesome bleeding.

**MARKUS:** We had a case involving thoracic surgery. The child was suspected of having a mass which might be a tumor. Just before the surgery was to be done, the usual tuberculin test was performed and it was determined that the child had tuberculosis. It is my understanding that in those circumstances one does not perform surgery but treats for the tuberculosis. The surgeon went ahead anyway without any particular reason except that he had planned to do the surgery and he did it. In that case the total damage we can assert is that this child went through an unnecessary, purposeless operation. He is no worse off than he was before. There was some medical expense involved but no serious permanent consequential damage. That is a case which is legally meritorious but practically unsatisfactory. I think that the solution for that kind for case is a different remedy than a court trial — perhaps arbitration or mediation to produce an early settlement. Otherwise such cases will just not be pursued.

**RODDIS:** Think of the dilemma you put the doctor in when you say that the unnecessary operation is a form of malpractice. There is very strong pressure on doctors to operate in virtually every case on women who have masses in the breast, even though a large number turn out to be benign tumors. They are under tremendous pressure to operate.

I want to ask Dr. Blumberg a question about Kaiser. A few years ago a study showed that Kaiser had a dramatically lower incidence of surgery among the subscribers than there was in the general patient population outside the group. I wondered whether that might be due in part to a favorable selection in the Kaiser subscriber group, and in part due to some control mechanism within the Kaiser medical group. Is a Kaiser surgeon's decision to operate reviewed preoperatively?

**BLUMBERG:** There isn't any financial incentive for unwarranted surgery in our program. I think that is the major reason for the lower incidence of surgery. Furthermore, the physician groups are only staffed by as many surgeons as the physicians feel are necessary. The supervisorial control is arranged pretty much like a university teaching service, with the chief of service of each clinic or hospital supervising the men working under him. However, there is no over-all "manual." The standards for one hospital in a region may be quite different from the standards of another hospital in the same region. But the principal reason for the lower incidence of surgery is the elimination of the financial incentive. We do very few tonsillectomies, for example. The physicians are paid on a capitation basis rather than on a fee-for-service basis.

**RODDIS:** That is a very disturbing answer, not from Kaiser's standpoint, but because we have been talking until now as if the overuse of surgery was some form of medical misjudgment. If the differential in the incidence of surgery is not due to different systems of peer review or internal control within the

health community, but rather is due simply to the presence or absence of financial incentives, the implication is that overuse of surgery throughout the medical community is a pure form of exploitation.

**EGEBERG:** I went to medical school back in the nineteen-twenties. We were told then that tonsillectomy had been greatly overrated. It was done to reduce rheumatic heart disease or to treat rheumatoid arthritis. As I said, I was shocked to find out in Washington that tonsillectomy is the most frequent operation that Medicare and Medicaid have to pay for. And if tonsillectomy is a common practice, a standard practice, in a certain hospital or a particular community, but not generally warranted, what can you do about it?

**BUSH:** I believe that if a few cases were taken through court, you wouldn't need a revision of the present procedure. A few landmark cases would do it. If you did away with unnecessary hysterectomies, unnecessary tonsillectomies, and a half-dozen other "bread-and-butter" things like that, you would have a precedent, and that alone would make a marked, dramatic difference in the quality of surgical care in this country.

I just disagree that some of these operations involve terribly complex medical judgments. The problems we have been talking about are not unusual or advanced malignancies where only the real expert can feel it and say whether you should or should not operate, and know what the percentages are. But in hysterectomies the criteria are so much easier, and tonsils aren't all that hard to see. If there is a general understanding that you do not do these things, then the medical judgment that is involved is not all that complicated.

**BLUMBERG:** The question of whether what is standard medical practice is also good medical practice — and therefore a useful criterion in malpractice suits — is not always easy to answer. We are getting some very interesting statistics about smallpox vaccination. We now know how many die from the smallpox vaccination each year; over the past twenty years more have died from the vaccination than have died from smallpox.

**KEETON:** I don't think we can expect either arbitration or tort liability to be able to do anything substantial about the unnecessary medical procedure. When there is available to the plaintiff and the defendant's attorneys competing medical testimony about whether a particular treatment was appropriate, then almost certainly there would not be a submissible issue to the jury. To get a submissible issue you have to have testimony that the medical procedure is one that is not approved by any respected segment of the medical community. If ten per cent of the medical profession say this is the right thing to do, you have not got a submissible issue.

**CARLSON:** What you have just said illustrates one

**The "Physician's Assistant"**

The Physician's Assistant can be an answer to some very real problems that exist for the practitioner, especially in the rural areas. His problems of how to keep up with medical progress cannot be overstated. For example, the problem of treating hemorrhagic shock, shock associated with certain types of infection (so-called gram-negative shock), the problems associated with a loss of kidney function, the problems associated with sudden and acute loss of liver function — twenty or so years ago, the best doctor was no better than an average one on most such problems. And thirty-five years ago, there was little a doctor could do about any of them.

But in recent years, medical progress has just left a lot of doctors ignorant who used not to be ignorant.

For example, take the problem of one blood transfusion. A couple of years ago a study showed that infectious hepatitis, a serum hepatitis, which is associated with blood transfusions, was attributable, in forty-two per cent of the instances, to a single transfusion. A rough rule of thumb is that one blood transfusion is never indicated. One is never enough to do good; all you do is expose the patient to serum hepatitis. Yet in the rural counties that sort of thing goes on all the time.

All right, how do you push that rural physician who may not have contact with continuing medical education? How are you going to push him if he is impervious to the circuit riders from the San Francisco Medical Center and from the California Medical Association, the best university continuing medical education system and the best state medical society education program in the country? One thing you can do is publicly identify his errors through malpractice litigation. A much more constructive way is to involve the physician himself in a teaching situation, make him be the teacher. When a doctor assumes responsibility for teaching interns and residents, the truth is that half the time they are teaching him. No matter how specialized your practice, a sharp resident will usually give you as much as you give him.

Picture, then, the busy rural practitioner with two or three thousand persons whom he serves. He is over-

loaded. He needs a Physician's Assistant trained, say, at Stanford for two years, and who is on a continuing program at Stanford for several additional years. During these years, perhaps the Physician's Assistant could go back to Stanford for a three-day weekend once a month, and for a six-week period once a year. His education could be continued in that way.

This Physician's Assistant could have a constant stream of material coming from Stanford to his office in that little rural community, material he must study and be examined on in his educational program. Perhaps as the law in this area develops, he will be looking forward to a three-year residency at the end of that six-year period which will lead to an M.D. degree. Such a prospect has been discussed at high levels in medical circles.

Now the communication between that rural physician and that Physician's Assistant and the patient will be crucial, because it doesn't matter how bullheaded that physician may be, he has to look at the patient and what is transpiring there. So perhaps the Physician's Assistant says, "Doctor, I notice you ordered iron for Mr. Jones because he has an anemia. I looked at his blood count and, you know, in a man an iron-deficiency anemia is significant. It's not just an anemia problem. It may mean he has a cancer. This may be causing the blood loss from his body. We have got to look for that. I learned that last month at school."

Well, all right, they start with a barium enema, and lo and behold! the cancer of the cecum is identified.

So this doctor has learned something. He has learned it from his Physician's Assistant through the patient. What I have related is partly speculative, but this teamwork may be ultimately the solution to the problem of how the small-town and rural doctor can keep up.

The insurance companies don't quite know how to handle the P.A.'s. They are a hot potato right now in California. I understand they will be insured through American Mutual as though they were nurses. However, I wonder if their potential liability is not the same as that of the average doctor.

*David Rubsamen, M.D.*

of the gravest flaws in the tort-based compensation system. To the extent that you have medical procedures which are not necessarily warranted but on which you can adduce testimony that they reflect common practice in the health care system, then those procedures become the standard of medical care which the law embraces. Under such circumstances, the tort-based system does not provide very good feedback to improve the quality of health care.

**RUBSAMEN:** I don't agree. We should not assume that we lack redress for removal of normal organs. The expert for the defense gets up and says. "This procedure was indicated." You say to him, "Doctor, you are not trying to tell me that in this community it is standard practice to remove normal uteri." "No, I am not saying that." "Then, doctor, if I can prove that this uterus was not only normal but that there was no clinical basis for making the decision to remove it, you would agree that that was substandard, wouldn't you?" "I'd agree to that."

You would then proceed to show through your expert that the clinical evidence did not justify the removal of this uterus, plus the fact that it was indeed normal. That is no problem, if you can find your expert. *That* is the crucial point, not the fact that it is O.K. to go around removing normal organs without good clinical indications.

**BLUMBERG:** Whenever we discuss standards, I am impressed by the striking regional differences in medical practices. Doctors generally conform to the standards followed where they practice, not where they went to school. They can't practice medicine their own way.

If a doctor from New England, where the average length of stay for maternity cases is five and a half days, ends up in San Diego, he will be down to three days because that is the community custom there. That example is probably a taste difference rather than a difference in medical judgment. But the same regional differences exist in the care of coronary heart disease. In some places, the patient is up and walking in a week. In others, he is flat on his back for a month. It appears to me that one of those standards is wrong. I'll make it that simple. There is not room for both of those to be the right way to treat similar coronary cases.

**BUSH:** I think there is legitimate professional disagreement about how long a coronary ought to stay in bed. When there is legitimate medical opinion on both sides of something like that, one side should not be dogmatized into any manual. Professionals should have their options left open. A premature judgment on innovation should not be made rigorous. If various standards are acceptable in current medical judgment and current medical ignorance, then leave them acceptable.

What I am concerned about is how to stimulate legitimate medical innovation and how to distinguish what is clearly nonstandard and then label it as such so that it doesn't persist in health care just

because fifty per cent of the doctors are still doing it. To accomplish that, we need a body that would have time to investigate the thing, and it would have to be a body that physicians would recognize as authoritative, convincing, and thorough. It is not something that can be done ad hoc or overnight.

RUBSAMEN: I second that statement about standards. That is an important point.

EGEBERG: When a person graduated from medical school in 1920 he did not have to worry about attending any continuing courses in medical education. He could count on practicing good medicine for the next thirty years by reading an occasional paper. When he graduated in 1940, it was quite different. He could keep abreast of changes for about ten years based on what he learned in school. A man who graduates today has to begin studying very hard from the moment he graduates, and he has to keep on studying just to keep up.

So we say, "What is standard in the community is the norm." But as I said earlier there are some communities where tonsillectomies are standard. I think the weakest argument for what constitutes malpractice is that it "deviates from the standard."

MARKUS: The rule of law varies a bit from jurisdiction to jurisdiction, but many of the jurisdictions state that negligence is the failure to exercise reasonable care, whether or not most of the physicians in that community exercise that same care. In other words, one can be negligent even though he does what substantially everybody else does in his community. It is true that there are legal communities that do not accept that rule and say, instead, that the only guiding principle is what is done by others, or whether a responsible school of medicine accepts it. But a significant number of legal jurisdictions say that the mere fact that a large number of people do something does not necessarily answer the question as to whether or not that is good health care.

## A Mathematical Model to Tie Compensation to Causation

The question of standard versus nonstandard health care rose again with Dr. Bush's presentation of a mathematical model, using the analytical tools of operations research and systems analysis, to identify on some objective statistical ground the predictable and proportionate causative factors in specific medical injuries.

The model, he said, was designed to clarify, perhaps diminish, some of the ambiguities in the present tort liability system. It would seek to compensate all victims of medical injuries traceable to nonstandard health care treatment. The determination of whether a particular treatment is standard or nonstandard, and what the group outcome probabilities are, and whether the treatment is the proximate cause of the damages in question, would be made by authoritative medical panels composed of several practitioners and specialists in the field.

The model would take into consideration the stochastic nature of disease (i.e., that over time a person can be in multiple states or conditions of health). The system would also be sensitive to and systematically assimilate proven innovations in health care which would affect the determination of what is standard and what is nonstandard and also the ratio of good and bad outcomes in patient treatment.

If the judgment is made in a given case that a compensable event had occurred, the model would then yield a calculation of that compensation based on a "coefficient of causality." The coefficient of causality would be derived from previous experience with long series of defined groups of patients under different treatment regimens. If a patient had suffered an injury, and if he had received an unacceptable treatment, then, based on the different probabilities of the injury following an acceptable treatment, the probability of causal relation between the treatment and the injury can be determined. If the probability that the injury was attributable to the treatment was sixty per cent, the patient could be compensated at the rate of sixty per cent of what would be predetermined as "full compensation."

"The net effect in the long run," Dr. Bush said, "is that all patients who are injured — under circumstances in which unacceptable medical treatment contributed to the proximate cause — would be awarded something, and the awards would add up to the total amount of disability imposed on the

population by health care providers. I believe most physicians and hospitals would find this fair if they accept the responsibility for paying for the disability caused by the health care system."

Dr. Bush added that an institutionalized administrative mechanism would have to be developed to collect the data and give continuity to the hearings. It should be made up not only of medical experts, but also of public representatives and consumers of medical care, he said, "because I am well aware that administrative bureaus can come under the control of interest groups who know how to fix a system so that it operates to their advantage.

"We need some sort of administrative agency to operate this and, among other things, to equalize the amounts of awards made for similar events. It could also restore the faith of the medical profession in the court system. Today awards are being made for which physicians simply cannot feel they are responsible. Patients are being given awards for things that would have occurred anyway. I think this is one of the reasons why doctors are so reluctant to testify in court. They are convinced that the decision-making rules are just not consistent with what the disease process is."

**RUBSAMEN:** Let me comment on your idea of a panel of experts responsible for issuing statements concerning rare accidents. Let us say that vesical vaginal fistula resulting from a hysterectomy in a woman who does not have substantially disturbed architecture in the pelvis is negligently caused ninety-five per cent of the time. Ergo, by your formula, this should be compensated at the rate of ninety-five per cent as though it were negligence. Or, osteomyelitis following a clean bone operation is negligently caused $x$ per cent, therefore that should be compensated $x$ per cent.

In the rarity cases I cited earlier, this is precisely what the California Supreme Court has struggled with. For example, the court was perfectly aware that tonsillectomy might be associated with an anesthetic death without somebody being negligent. But it was such an excessively rare prospect that they were willing to take the chance that they were wrong in saying the defendant was negligent.

If medicine adopted the rule you propose, two safeguards should be built into it. First, the hearing should not take place in a courtroom. This forum imposes a very unfair psychological penalty on the doctor who happens to be one of those who is not negligent. There may be a penalty in terms of lost practice too. Second, I would like to see the legal action called something other than negligence.

Now, as I understand your proposal you do not charge negligence, you just say that this or that medical accident comes within the ambit of our social policy rule. The rule says, "Go ahead and do these hysterectomies, but if you have trouble the ax falls." This may be all you need to bring about your desired feedback and exert one more pressure to improve medical procedures. It isn't unreasonable to anticipate fewer hysterectomies if every complication of a hysterectomy, whether the operation was necessary or unnecessary, was reimbursed as a matter of policy.

**KEETON:** I would like to try to identify two themes in Dr. Bush's presentation and this discussion. The first theme is concerned with methods of adjudication. Dr. Bush has expressed a strong preference for what we might call a committee method of adjudication over the adversary method. That is a debatable proposition; there are advantages in both systems. Let us put that one aside.

The second theme is concerned with a proposal for proportionate compensation as a way of dealing with what I would call our problem of ignorance; i.e., we do not know whether a particular course of treatment caused the result, so we cannot answer the question of causation of a medical injury. We will always have incomplete information, and Dr. Bush is suggesting that a preferable way to deal with that is to use a system of proportionate compensation rather than an all-or-nothing compensation.

But the same kind of logical and scientific problems that are present in your proposal are present in all other adjudication, including criminal law. How would you feel about a system that says, "If on the evidence it appears to the jury (the fact-finder) sixty per cent probable that this man is guilty, we will put him in jail for sixty per cent of the time that we would have put him in jail if we knew a hundred per cent that he was guilty"? You would react terribly adversely to that.

You said that proportionate compensation would be fair to the providers of health care. Yes, but it doesn't look the same way to the victim who would not feel fairly treated if he were given only sixty-per-cent compensation.

**BUSH:** I am well aware that many victims of medical injuries would protest violently that they have not been adequately compensated. Likewise, it is not

clear to me that in many cases it is just to compensate them from malpractice insurance funds at all. I am not so sure that a system of proportionate compensation is socially desirable; it was just an idea. But I am convinced, on the basis of logic, rationality, and statistics, that you cannot ever say that one case was caused by one act.

**KEETON:** You cannot say that in the scientific sense. But you are not saying, are you, that it is irrational or necessarily an unwise policy choice for us to say, in effect, to the jury, "It is your job to determine whether this event was caused by this act"?

**BUSH:** That is a waste of time. There is no answer. If the statistics are as close as the cases we are now discussing, we are in a coin-flipping situation. Even if they are not that close, in medical cases the jury's judgment of causality depends on the expert testimony. We could deal with that testimony directly and systematically.

**KEETON:** If the statistics are sixty-forty, one thing that can be said for the present jury system is that it is more often right than wrong, whereas if we use proportionate compensation we give up being right in most cases in order to be less wrong in all cases.

**BUSH:** I think that what has happened in our current system is that, because the rule is all or nothing, and because of the probability of being wrong in such a large proportion of cases — between fifty-one and ninety per cent of the cases — juries hesitate to find a physician liable, and so the system ends up by not compensating, even at the fifty-one-per-cent level.

**KEETON:** The certainty of your quantification of risk is illusory. When you classify a particular case as belonging to a particular risk group, you must determine what the characteristics of that individual case are; I emphasize *that individual case*. If you put that into an adjudicatory system, which involves individual advocacy, you will have that classification challenged. Are you going to treat all appendectomies alike? Or are you going to say that lots of different classes of patients come in with different sets of symptoms that may or may not be appendicitis? Any classification system you devise is rougher than real life. So the fifty-one-per-cent precision that you come out with in your formula for a given medical procedure for a given condition is illusory. Real life is not that way.

**BUSH:** The point you bring up is a profound one because, as Savage demonstrated, all statistics are ultimately dependent on subjective classifications. But if there were appropriate committees to handle this, they could consider the variations in each case and they would make the classification for the causality of the medical injury specific to that case. The medical specialists can make the classification as refined — objective, if you will — as current knowledge permits. Once the classification is made objective, the counting of the people who go from one classification to the other is objective, too. This is what expert testimony now does in a cursory way.

**KEETON:** I think our main point of interest is this: your model works out very nicely when you are dealing with masses of cases. And looking at it from the point of view of health care providers it may be fair. But from the point of view of the injured person and his one case of injury it does not look quite as fair to him. As far as he is concerned, the system is perversely objective when it decides how it will classify his injury for purposes of compensation.

## The Role of the Insurance Companies

Professional liability insurance companies, as the "third parties" in the health care services, are generally viewed as necessary but, in important ways, imperfect. Predictably, Professor Ehrenzweig's criticism of the concept and effect of liability insurance in general was the most pointed and the most uncompromising:

"Being 'born in sin,' owing its existence to the misuse of tort law to non-tort, [liability insurance] suffers from congenital flaws. [It] does, of course, not only protect 'innocent' enterprise. It also permits potential wrongdoers to insure themselves against the consequences of their wrong, and thus defeats whatever may have been left of the admonitory

character of the fault rule. . . . Being a mere escape hatch from the worst consequences of a fundamentally inappropriate scheme of distributing losses, liability insurance continues to fail both parties as well as the public. The entrepreneur, on the one hand, remains exposed to incalculable potential liabilities in excess of his insurance. His victim, on the other hand, remains unprotected against an uninsured indigent enterprise as well as against accidental losses as to which he cannot prove 'negligence,' however broadly that concept be applied."

Mr. Markus expressed "serious doubt" as to whether the insurers are operating in a rational fashion in the health care services. "Their rates seem to have no relationship to the risks, no relationship to the payments of benefits, and no relationship to their reserves," Mr. Markus said. "Much of the dissatisfaction with the tort liability and insurance approach to malpractice centers on the premium rates being charged. If the rates are insanely high, maybe we should start looking at the insurers for a more dispositive explanation of what they are doing."

His indictment was not limited to the fiscal activities of the carriers. "From the viewpoint of the claimants' counsel, I have seen some very peculiar practices by the liability insurers. We have a one-year statute of limitation in Ohio and we have had a number of cases in which our clients have come to us eleven months after the alleged malpractice. In some instances it is virtually impossible, in that one month that remains for us, to make an intelligent decision as to whether or not there is a meritorious case. We must assemble and evaluate records, obtain consulting assistance, do some investigation.

"On several such occasions we have contacted the potential defendant and said, 'Doctor, your patient has come to us. We don't know whether there is a meritorious claim against you. If it is meritorious we would certainly like to investigate the possibility of negotiation and the accomplishment of a settlement without filing a lawsuit. If it is not, we certainly would not like to file a suit which would be embarrassing, annoying, and perturbing to you. We suggest that by voluntary agreement, as the law permits, the two sides agree to a postponement of the statute of limitation for two months, or six months, or whatever a sensible period of time would be.'

"The doctors are uniformly favorable to this idea. They think it is reasonable, sensible, and decent of us to suggest it. But they say that they will have to get permission from their insurer. And without exception the insurer says, 'No. Let 'em sue us.'

"Now we think that that is clearly acting against the interest of the physician. That puts us in a position in which we are forced to file a lawsuit. And it may be that we later determine there was no basis for filing a suit and we have to quit, all of which is to our disadvantage as well as to the physician's. In this area there is almost no regulation of the insurers. The superintendents of insurance in the various states have little or no knowledge about what the professional liability insurers are doing. They let the insurers do almost anything they want."

A more mutually satisfying relationship between physicians and insurers was described by Dr. Rubsamen: "In California we have a precedent for cooperation. American Mutual has perhaps eight thousand doctors under contract in twenty-six Northern California counties. In each of those counties there is a medical society committee with whom the local attorney for the insurance carrier cooperates. If this medical committee says, 'fight,' American Mutual is obligated to fight; if the committee says, 'settle,' the carrier is not obligated to settle, but usually will.

"They even go so far as to honor the committee's request, though they are not required to, if it says, 'Insure this doctor. Even though his track record is mediocre, we want you to insure him.' The company does not have varying insurance rates for different doctors.

"American Mutual has found, over a period of twenty-five years, that this very close liaison with the medical committees is invaluable."

Relying on the insurance liability mechanism for quality control in the health care field is to rely on an imperfect, unsatisfying, and friction-producing method, Dean Roddis said. "Because of physician pressures, the carriers often refrain from brandishing the one formidable quality-control weapon they have: merit rating of their customers. When better quality-control methods are generated by the health care providers themselves, we can expect more stability in the insurance mechanism."

Insurance economics need not be mysterious, and the problem of setting realistic premium rates need not be as difficult as some people make it out to be, Dean Roddis added.

"I think that insurers and insureds have been playing hide and seek. The effect of overreserving on rates should be controllable. It is a technical problem. There is no insurmountable technical bar-

rier to the excluding of the effect of overreserving from the rate picture."

Complicating the setting of rating and reserving policies for medical malpractice is the fact that premiums are charged in one year while many claims incurred from medical activity that policy year will not mature or be resolved until three, four, or five years later. As a margin against an unexpectedly large volume of claims some years hence, the insurance companies set what some critics allege are excessively high premium rates and maintain excessive reserve funds which, of course, are invested and return income to the carriers during the interval between the time claims are incurred and when they are resolved.

It was Dean Roddis' contention that a five-year "workout" of claims experience, premium rates, and reserves, in which all three elements are related to each other and carefully allocated to the correct policy year, would yield an accurate loss-cost analysis and an objective basis for a realistic rate structure.

But the ability of the insurance companies to attract investment capital in order to write insurance contracts, particularly in the medical malpractice field, is often beset, Dean Roddis pointed out, by uncertainties and frequently imponderable variables: "It doesn't take very long for investment money to flow into a particular insurance market or to flow away from it. The term 'capacity of the insurance market' is used a lot. 'Capacity' tends to be a function of the perceptions of managers and investors as to the rate of return in relation to investment risk. I am not talking about 'risk' in the actuarial insurance sense now, but in the sense of the typical investment risk, that is, the degree to which actual financial results of operations may vary from the predicted results. When investors look at the insurance business, they look at its rate of return from all sources. Those include not only the underwriting yield but also the yield from the banking function, that is, from the investment of the insurance companies' money.

"There has been a long fight between regulators and insurers over the consideration of investment yield in establishing premium rates, with the insurers seeking to exclude from consideration by the regulators the income from investments. In any event, given an aggregate yield concept, the insurer naturally will expect more in the way of a net return on those lines of coverage where it faces a greater risk that results will vary substantially from those anticipated, such as the malpractice insurance line.

"It is a fact," Dean Roddis continued, "that the uncertainties of malpractice underwriting have been very acute in the last fifteen years for a number of reasons. One is the high degree of what is known as juridical hazard, that is, the constant expansion of judicial concepts which tend to facilitate prosecution of claims and liberalize the outcomes from the plaintiffs' point of view. Another is a sociological factor, an enhanced claims consciousness. A third is the great growth in the complexity of health care services. All these have affected the risk environment to the point where it is very difficult to evaluate the future, and then rating becomes almost a pure judgment proposition.

"Complicating the picture is that there comes a time when the uncertainties in underwriting just cannot be compensated for by ever-higher premium rates. There is no rate for some types of risks. Then the 'capacity of the insurance market' is really limited. Indeed, you then see companies begin to withdraw from those lines of business."

## Cost Considerations in Policy Decisions

"The only kind of no-fault compensation system I would be interested in, whether for automobile accidents, medical accidents, or whatever, is one that would do a cost-accounting job; that is, it would identify the kinds of compensation needs that arise from a certain source and impose on that source the costs for taking care of those needs," Professor Keeton said in a presentation of some of the cost and administrative implications of the three major compensation methods: a fault-and-liability insurance system; a no-fault system; and a Social Security insurance system.

In the no-fault scheme, he said, cost accounting for compensating medical injuries would be difficult and expensive because of the inherent difficulty of determining the cause of the injuries. "One must

sort out and distinguish in an alleged medical injury situation those conditions in the patient that are traceable to his initial need for treatment and those which can be traced to the treatment itself. That is an administratively expensive issue to deal with in any kind of compensation system. It calls for expert testimony. It may call for expert advocates.

"But if you come to the conclusion that that is too expensive, then you are pushed either in the direction of our present fault system or toward a Social Security system. You escape most of the causation issues and their attendant administrative expenses in a very broad Social Security system which simply undertakes to provide, without any cost accounting, the medical services that patients need for whatever reason they need them."

In any system of compensation, Professor Keeton said, an insurance provision, with all its imperfections, is indispensable for an equitable distribution of the risk. "In the case of a fault system," he said "we ought not to follow the fault theory to its ultimate end, that is, that the loss must be borne by one of two individuals: the innocent victim, or the doctor who was negligent. I am not saying that we should not merit-rate and charge the negligent doctor a different premium. But I do not think we would favor compelling the individual doctor to bear the full cost of a mistake that turns out to be several hundred thousand dollars."

While he felt adoption of a no-fault private insurance system for automobile accidents was desirable, Professor Keeton said he had strong doubts about adopting a similar system for medical accidents. For one thing, he said, a much larger percentage of the no-fault auto insurance premium dollar would be paid back to victims of automobile accidents than would be true of no-fault medical insurance premiums in the case of medical accidents.

Also, virtually all economic losses can be compensated in a no-fault auto insurance program for less than what drivers are now paying in liability insurance premiums. "The same cannot be said for no-fault medical accident insurance. Such insurance will not be a viable replacement for our present malpractice claims unless it not only provides the additional medical services needed but also reimburses the patient for wage or income loss and other out-of-pocket expenses connected with his injury. If no-fault insurance will not do at least that much — and that is an expensive undertaking — then it will be hard to accept it as a replacement for our present system in which it is at least theoretically possible for a person to be reimbursed for his full economic loss plus general damages for pain and suffering if he is able to hurdle all the legal obstacles and win a judgment."

Professor Keeton's remarks were followed by this exchange:

**BUSH:** The fact that the costs of no-fault medical accident insurance would be markedly higher than present costs does not favor one system or another. No matter what system is adopted, it is ultimately the patient — the public — who pays the expenses. If we had national health insurance, for example, the public would pay for it in higher taxes. I think we would agree that all victims of medical malpractice should be compensated. If we presume that they are not being fairly compensated now, then any new system would probably cost more than the present one. I think that the choice between these systems depends on at least these three questions: Does it compensate everybody who deserves it and no others? Does it give feedback to the medical profession? Is it administratively simpler and more efficient, particularly in the determination of the proximate cause of each medical injury?

**KEETON:** It has been suggested several times in this meeting that the impetus for moving to a no-fault scheme is coming primarily from health care providers because they resent being accused of fault in the present system. I suggest an additional motivation, an economic one. Health care providers look at the automobile insurance system and note that a no-fault auto insurance scheme achieves a reduction in costs. They draw the conclusion that if they switch from a malpractice insurance program to a no-fault insurance program they will achieve a similar reduction in costs. If they realized that they cannot reduce costs by going to a no-fault system, there might be some changes in the lineup of those who are supporting no-fault in the health care field.

**RUBSAMEN:** When a patient enters the hospital with a headache, is treated for a day or two, and then develops his paralysis, his stroke, I take it that under a social insurance system he would be compensated without any questions about whether or not the treatment caused the stroke.

**KEETON:** It depends. You have a choice to make. In your social insurance systems do you want to separate the needs arising from accidental medical injuries

from those arising from congenital conditions, disease, and so on?

**RUBSAMEN:** In a social insurance scheme, would you ask the question whether the stroke came from a deviation from an expected result?

**KEETON:** You would not be concerned with the causation issue in social insurance because you would not be making any effort at cost accounting in order to determine compensation. You still have to define entitlement to benefits, and decide how broad you want to make that entitlement under social insurance.

**RUBSAMEN:** Let us assume that in this situation the patient who went to the hospital and got this stroke qualified for compensation under a social insurance system. But suppose that fellow had not gone to the hospital when he had his headache. He stayed at home and was treated by a favorite maiden aunt who used to do a little work in the hospital when she was a young woman. He gets his stroke at home. In either case he winds up incapacitated, loses his wages, and so on. But in the first instance, because he was fortunate enough to have gone to the hospital, he is compensated; in the latter instance, because he got no medical treatment, he is not compensated. Wouldn't this be a grave injustice?

**KEETON:** You have the problem of the injustice of treating one group of victims better than another, and you have the problem of costs. You can minimize the problem of administrative expenses and solve the problem of equity among different kinds of victims by adopting a very broad Social Security system similar to our present Social Security system which now compensates for permanent disability regardless of its cause.

**MARKUS:** I reach a somewhat different conclusion than you do about the efficiency of no-fault auto insurance. If no-fault compensates all people hurt in accidents, it will be compensating not only the victims of the accidents but also those who are causing the accidents. So while forty-four cents of the auto insurance premium dollar now gets back in benefits to victims, under no-fault they will get a much smaller amount since they will have to share the benefits with those who caused the accidents in the first place.

In any event, I would opt for the most efficient system, and that is the social insurance approach which would distribute the most dollars with the least administrative expenses. Social insurance eliminates not only most of the causation issues which require administrative decisions, it also does away with the profits the private insurer has been obtaining from the transaction.

**BLUMBERG:** If under social insurance you have to determine whether the medical injury was caused by a physician or other health care component, you will still have a difficult decision process. But if you simply assumed that the health services are responsible for the patient who has a medical injury after treatment, you would do away with ninety per cent of the decision problem. After all, patients don't go out and irradiate themselves.

**KEETON:** I think I would disagree sharply with you if you think that ninety per cent of the problem would be avoided if we simply asked what is done to the patient, not who did it. Your irradiation example is atypical. The more typical illustration would be one in which the patient now has a condition and it is debatable whether his condition is a natural delopment from the condition for which he came to be treated or whether, instead, it is the consequence of the combination of that prior condition plus a mistake or an accident that occurred in the process of treatment.

**BLUMBERG:** I don't necessarily like my ninety-per cent estimate, but I feel that the majority of the decision problems would be eliminated if we did not ask how much of the trouble was caused by the doctor but simply asked, did he cause any of it, and if he did, we compensate.

**KEETON:** For a fully informed decision on this issue we would have to look at a body of potential cases. If we did and came to the conclusion that in the majority of the cases in which we today have litigation over negligence, there is not a difficult causation issue — that is, the physician clearly is at least partially responsible for the injury — then that would indicate that a no-fault private insurance system would be preferable to our present malpractice system. On the other hand, if we came to the conclusion that in most instances you would not escape the causation issue, then that seems to me to suggest that under a no-fault approach we would find the same heavy overhead we now have in the medical malpractice system.

A CENTER REPORT

# MEDICAL MALPRACTICE

*A discussion of alternative compensation and quality control systems*

In 1971, the Center, in cooperation with the Secretary's Commission on Medical Malpractice of the Department of Health, Education and Welfare, sponsored a three-day conference on medical malpractice. The report of this conference was widely distributed by H.E.W.'s commission to physicians, attorneys, and insurers. It is published here as a service to all Center members because of the growing gravity and complexity of the medical malpractice problem.

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The question tackled at the Center's conference on medical malpractice concerned the effectiveness of the present tort liability system of compensating persons who sustain injuries arising out of medical treatment, and the advantages and disadvantages of alternative systems such as arbitration, no-fault insurance, and Social Security insurance.

Both the question and the conference were prompted by disturbing developments in American medicine. Some of these developments were documented in 1969 by Senator Abraham Ribicoff's Subcommittee on Executive Reorganization in a 1,060-page report entitled "Medical Malpractice: The Patient Versus the Physician."

Based on replies to questions he had put to physicians, lawyers, insurance executives, and the Department of Health, Education and Welfare, Senator Ribicoff came to these conclusions:

☐ "The number of malpractice suits and claims is rising sharply in certain regions of the country. The size of the judgments and settlements is increasing rapidly.

☐ "Most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. . . . These suits are the indirect result of a deterioration of the traditional physician-patient relationship.

☐ "The publicity given to higher malpractice judgments and settlements, based frequently on new legal precedents, is likely to trigger increasing litigation in other states. The situation threatens to become a national crisis.

☐ "Already, higher judgments and settlements are having the following direct results:

Companies providing malpractice insurance are increasing the cost of coverage.

These costs — in the form of higher charges — are being passed on to patients, their health care insurance companies, and federal health care programs.

☐ "The rising number of malpractice suits is forcing physicians to practice what they call defensive medicine, viewing each patient as a potential malpractice claimant. Physicians often order excessive diagnostic procedures for patients, thereby increasing the cost of care. Moreover, they are declining to perform other procedures which in themselves may entail some risk of patient injury.

☐ "At present, it appears that no one affected by the rise in malpractice suits and claims has been able to deal with this problem in a manner that promises to alleviate this situation.

☐ "The lion's share of the total cost to the insurance companies of malpractice suits and claims goes to the legal community.

☐ "There is a definite federal role in the malpractice problem."

Senator Ribicoff said he hoped his findings would be the "starting point for a public debate on this very important issue."

For the Center conference, the staff was joined by six lawyers, a hospital administrator, and four physicians (one of whom is also a lawyer). None questioned the need for such a meeting, and three points were tacitly stipulated: medical malpractice exists; self-regulation by the medical profession is not adequate; and an increase in malpractice litigation does not necessarily mean that the incidence of malpractice is increasing or that the over-all quality of medical care is declining.

Indeed, on the last point Dr. Roger Egeberg noted that, while modern medicine is curing more, the patients are enjoying it less. "Until about fifty years ago," Dr. Egeberg said, "when people went to their doctor, more of them died, or became crippled, or their illness lasted longer than if they had gone to their Aunt Amy. There wasn't an awful lot a doctor could do except support and sympathize with the patient, show a community of feeling. But that was terribly important.

"Since 1940, however, medicine has advanced more than it had in all the previous history of mankind. Now the doctor can do a lot of things for his patient. He has also come into a considerable amount of money. And he feels a different kind of responsibility. All too often his attitude is that if you cannot cure a patient, there is nothing you can do for him.

At the bedside in the presence of a problem he is less apt to stay and comfort family and patient and more apt to go to the library to see if there is a recent paper that might help with the diagnosis or treatment. I am sure that the old-fashioned physician, who could not cure in more than an infinitesimal number of instances, did something that was at least as important for the patient as what is done for him by today's doctor who can cure but who finds himself too busy to do these other things.

"So the whole relationship between physician and patient has changed, partly as a result of advances in medicine, partly because those advances have produced changes in the physician himself. That is a big reason why the patients' attitude has changed. So many see their doctor as a rich businessman and medicine as a business."

Eli Bernzweig noted, however, that sometimes the capabilities of modern medicine are "ballyhooed to the point at which patients expect miracles from their physicians. Then when something goes wrong, when there is a maloccurrence or a therapeutic misadventure, the public tends to assume negligence is involved and some compensation is due."

## Tort Law Criticized and Defended

Few kind words were heard for the manner in which victims of medical injury are compensated today. The fault-and-liability insurance system forces the victims to bring civil suit against the physician or hospital and to prove that there was negligence in the treatment. (In a few but significantly large and growing pockets of the population arbitration is being substituted for a court trial.)

Tort law, as it has been shaped in modern times, was described as irrational and an "insult to common sense" by Albert Ehrenzweig. (Although he was not able to attend the conference, Professor Ehrenzweig's paper, "Liability for Fault — Today's Unreason," was distributed to the participants.)

The *raison d'être* for the independence of tort law, or civil liability, from criminal liability, Ehrenzweig wrote, is that it offered "a tool capable of compensating harm rather than punishing wrong." Yet civil liability has preserved its punitive function as well as the requirement and presumption of fault because, Ehrenzweig is convinced, we have an "unconscious urge to find a wish and will behind all causation," and because of our "animistic, irrational belief in the ubiquity of guilt."

According to Ehrenzweig, since it is the only tool we have to procure minimum protection, fault liability is stretched in tort law to include many kinds of innocent conduct and the causation of unavoidable loss. What this amounts to, he wrote, is "negligence without fault." (During the conference, Dr. David Rubsamen furnished a couple of illustrations of negligence without fault, drawn from California malpractice lawsuits, in which large judgments were awarded to plaintiffs despite the fact that specific derelictions on the part of the physician defendants could not be identified. The mere rarity of the bad results of medical treatment invoked a legal doctrine which let juries compensate the victims by finding the physicians guilty of malpractice.)

If rationalizations for the negligence rule in tort law have been, as Ehrenzweig claimed, "spare and poor," the conference's practical and operational objections to tort liability in health care were numerous and pointed, although not all of the comments were negative. Greatest attention was paid to these aspects of the present compensation system:

### (1) Its Effect on the Quality of Health Care

Rick Carlson said that physicians with whom he has discussed the matter repudiate the fault-and-liability system. "They do not believe it says anything useful about the way in which medical care should be provided. Also, professional liability insurance coverage tends to thin out whatever deterrence the fault system might have for physicians. Nor are high insurance premium rates a deterrent because physician income is so high." Finally, Carlson said, findings of malpractice are seldom used to regulate formally the way in which health care is provided. "I am not aware of a single instance in which the findings of malpractice are fed systematically to disciplinary boards at the state level for action against health care providers."

Mr. Bernzweig noted, however, that the California legislature had recently passed a statute

making it mandatory for all insurance carriers to report to the state licensing body any settlements or awards of three thousand dollars or more in malpractice cases. In turn, the state licensing body must report these annually to the legislature and make recommendations for amelioration. "So we are beginning to get some feedback from the tort system into health care. But, of course, it is too early to tell what California will do with this and whether other states will adopt a similar procedure."

Dr. J. W. Bush stated flatly, "However much feedback there is now, it is miniscule compared to what is needed and to what should occur after a long, detailed, expensive investigation of a case with a bad outcome."

Dr. Mark Blumberg said he thought that malpractice litigation "tended to reduce medical misdeeds," and that to the extent it did so it was a "definite benefit to society." But he also said that, in effect, court decisions in malpractice cases "are writing a manual for medical practice," and he made it clear that such a "manual" does not necessarily make for sound medicine.

In order to forestall potential malpractice litigation or to have a strong defense in case a suit is filed, physicians are requiring more X-rays and other diagnostic tests, consulting more with specialists, ordering lengthier hospitalization and more nursing care.

The general view is that much of this "defensive medicine" is unnecessary, expensive, and potentially harmful. Mr. Bernzweig cited a medical post-audit of 1,200 children who had undergone skull X-rays for head trauma. That audit showed that the X-rays were necessary in only two or three of those cases. "A lot of children were subjected to unnecessary radiation because the doctors were protecting themselves against the possibility of a malpractice suit," Mr. Bernzweig said.

Dr. Blumberg pointed out that a new Public Health Service book "recommends drastic reduction in the number of X-rays being taken in this country. The principal harm from radiation is injury to the germ plasm in the male and female gonads which will show up as congential anomalies several generations from now. By insisting on a lot of X-rays, often simply for the legal protection of the doctor, you can reap some short-term benefits, but you are also causing unknown but almost certain long-term adverse consequences to society. And how do you sue for that?"

He added that some patients are punished because physicians avoid certain procedures that may be indicated but are risky. Also, physicians tend to avoid those subspecialities in medicine which are particularly prone to malpractice litigation. "And the current fault system certainly does not encourage a physician to say to his patient, 'Look, we've had a little trouble in your case. I want you to know about it, so that whenever you have to see a doctor you can tell him about it.' "

Skepticism about the extent to which physicians order unnecessary procedures was expressed by Richard Markus. "I am not saying those practices do not exist," he said, "but I would like to see some objective evidence as to their extent.

"This I do know: if a patient is told there is only one chance in a hundred that these X-rays will be of substantial help and save him a lot of grief, that patient will ask for the X-rays. It's easy to say that these things are done only to avoid professional liability. But often what the doctor is really saying is that there is a remote chance, not a totally insignificant chance, that this X-ray or this test may be extremely useful. At the same time he may feel that if he does not order the test or X-ray he will be vulnerable to litigation. And maybe that is a good thing."

The strongest claim of benefits from the present system came from Dr. Rubsamen, who said there have been striking improvements in certain areas of medical care in California as a direct result of the malpractice threat. "Anesthesia done by the general practitioner has not disappeared, but it is now a very small percentage of the total anesthesia in the state," Dr. Rubsamen said. "The general practitioner knows that his professional liability insurance premium will be as high as that of an anesthesiologist if he performs any part of the practice of anesthesia. But, more importantly, hospitals are requiring that the anesthesia be given by specialists, not general practitioners. Hospitals have been nailed in the past when there have been anesthetic accidents.

"I also think that the malpractice threat has stimulated the willingness of physicians to obtain consultation, and that is good. Many physicians are growing more cautious; one gets the impression they feel they had better not try some of the big surgery when they can refer it to the best-qualified surgeons. After all, the general practitioner who tries to do a gastrectomy will find that his talents in that operation will be compared to those of a specialist, not to another general practitioner doing gastrectomies.

"After reviewing several thousand medical records

in the last ten years, I have the impression that it would be a good thing if there were more consultation in medical practice."

### (2) Who Gets Compensated

Although the number of malpractice lawsuits and claims is increasing and the publicity attached to large awards or settlements may give the impression that a fair and just compensation system is flourishing, the consensus at the conference was that most people who sustain medical injuries, either through negligence or unavoidable accidents, do not get into the claims system. They receive no compensation.

Mr. Bernzweig cited an American Medical Association professional liability survey which indicated that for every patient who files a malpractice suit "there are probably ten times as many who never become aware of the fact that they have legitimate fault claims under our system."

And when patients are aware that they may have a claim many find they can do nothing about it.

"A considerable number of patients who have a medical injury, even though probably negligently caused, and who go to see a first-class malpractice attorney, will not be accepted by him," Dr. Rubsamen said.

"A patient may have lost a month's work and be out of pocket a thousand dollars for medical expenses because of the doctor's negligence. Assume he is now completely recovered and feels fine. That month of work and the thousand dollars for medical expenses is a heavy burden for a man making five hundred dollars a month. But no first-class attorney in California will take that case because the malpractice insurance carriers will not settle, and it just costs too much money for the plaintiff's attorney to try them.

"There is an excellent plaintiff's attorney in Northern California who will not accept a case of probable liability that will bring in less than twenty-five thousand dollars. He will not accept a case of absolutely certain, clear-cut liability if it is worth less than ten thousand."

### (3) The Cost of Administration

Robert Keeton said that of every dollar paid in insurance premiums for automobile accident insurance, forty-four cents is returned in the form of payments to victims of accidents. And of that forty-four cents "only a very small percentage compensates victims for out-of-pocket economic losses. The greatest part of that forty-four cents goes to what I would call the overcompensating of some of the victims."

But payout on the insurance premium dollar in medical malpractice judgments and settlements is even less. According to Mr. Carlson, between sixteen and seventeen cents of the premium dollar ends up as benefits to victims of medical injuries.

Although figures for the breakdown of the non-compensation part of the malpractice insurance premium dollar were not available, Professor Keeton said that in the automobile insurance business, of the fifty-six cents of the premium dollar absorbed by overhead, twenty-three cents is for claims administrative costs, and thirty-three cents is for general overhead. The claims administration costs include plaintiffs' attorneys' fees, defense attorneys' fees, adjuster costs, investigation costs, and a fraction of a cent for fees for expert witnesses. The thirty-three cents for general overhead includes about nineteen cents in marketing costs (mostly commissions) for agents who sell the insurance, and five cents for profits.

### (4) Inducement to Venality

The prospect of acquiring or paying out a huge amount of money in a court judgment or settlement is a strong inducement to litigants to compromise, or at least bend, their integrity. Lawyers, physicians, judges, and insurance officials all attest to the fact that principals in malpractice lawsuits, if they do not perjure themselves, often bring something less than candor with them to the witness stand when the stakes are high.

"When we compel litigants in negligence cases to prove or disprove guilt and innocence as causes of what in truth are largely inevitable incidents of our hazardous society," Professor Ehrenzweig wrote, "we promote perjury and repeat a procedure not greatly superior to the trial by battle or the ordeal by water or fire."

### (5) The Effect on Innocent Physicians

To the extent that juries return verdicts for the plaintiff in malpractice lawsuits under circumstances described by Dr. Rubsamen (i.e., to compensate the victim of the rare medical accident), grave injustice is done to the non-negligent physician. Dr. Blumberg said it is "malicious" to pin a malpractice verdict on an innocent doctor.

# The Anatomy of Compensation, and a Plea for Preserving the Private Remedy

The argument for keeping the tort liability system, or private remedy, to deal with alleged incidents of medical malpractice was made by Mr. Markus. He saw tort liability as a necessary remedy for at least some medical injuries, but not necessarily sufficient to cover all compensable incidents. His argument was made within the context of an outline of seven major elements that are found in medical accident compensation.

**RICHARD M. MARKUS:** The first element is *defining the compensable incident*. There are at least four possible methods of doing that. One is the fault system we now have; another is the unexpected adverse result; a third is the less-expected adverse result; and the fourth is a no-fault system in which any adverse result is compensated whether or not one can demonstrate either the typical causative or typical fault characteristics. The first three are simply different aspects of the same standard to determine compensation: that is, a patient, following medical treatment, suffers results contrary to what is expected from that treatment. But under the fourth system, no-fault, we say we do not care what caused the patient's problem, he has a problem and because of our social concern we should do something about it.

The second element is the *decision mechanism*. Who decides whether there was a compensable event? Under our present system, with the exception of arbitration panels in some areas, we use a court to make that decision, which means a trial by a judge alone or by a judge with a jury. There is a common misunderstanding among physicians that juries tend to be very liberal to the claimant and adverse to the physician. My experience as a plaintiff's attorney is that juries rather tend to identify with the physician than with the claimant. As a claimant's representative I have frequently offered to waive the jury and try the case with the court, only to be refused by defense counsel representing the insurance company's interest.

Certainly the court procedure is the longest, most complicated, and most expensive of all possible alternative methods. At the same time it is very precisely reflective of changing community attitudes and standards with respect to medical injuries and compensation.

On smaller, less serious medical injury claims, I would favor use of the arbitration method in which both sides would have an early opportunity to present their positions and get a preliminary decision as to whether there is physician or claimant merit, thus encouraging either settlement or abandonment of the claim.

I am the least receptive to the idea of an administrative agency to decide what is a compensable event. Agencies have a built-in rigidity which makes it difficult for them to adjust to changing values in our society. Also, the rules of law are more flexible and responsive to change through the courts than they would be through administrative agencies.

The third element is the *insurance mechanism*. There are four possibilities:

☐ A prohibition of all insurance.

☐ Private insurance to protect either or both the person suffering the loss and the person against whom the claim is being made.

☐ Private insurance closely regulated by the government.

☐ Public insurance which is, in effect, Social Security.

The kind of insurance we should have depends upon the breadth of compensation we want to provide. If we want to compensate only those who have suffered unexpected injury after medical treatment, that is, where we can show medical causation of that injury (whether the causation was due to negligence or not), then I would favor the use of private insurance, but much more regulated than it is now. The inadequate regulation of the insurance industry is a very serious problem. There are almost no available data showing what the insurance companies are doing, how they use their money, what role they play in the over-all health care system, what effect they are having on the quality of health care.

If the society decides that it wants to go in the direction of compensating everybody who has suffered an unpleasant result, regardless of whether its cause can be identified, then the remedy would have to be public insurance, or Social Security, which would eliminate private profit and thus reduce, if

not eliminate, the costs associated with profit in the private insurance business.

So before we can choose the insurance plan we must raise the substantive social policy question: How broadly do we want to cover people who have a health problem?

The fourth element is *rules of liability and evidence*. Very small changes in the rules can have a radical impact on the whole system of health care and compensation. If these rules are liberalized in favor of the plaintiff or claimant, for example, then we may be said to be moving in the direction of a no-fault concept, but we are also broadening the remedy and compensation of the claimant.

If we expand or contract the rules of *res ipsa loquitur* ("the thing speaks for itself," that is, the medical injury is such that it could not have occurred unless someone had been negligent); informed consent; who can testify (e.g., doctors from the same or other localities, from the same or related specialties), that will have profound effect on the system.

The fifth element in the system is the *level of compensation*. There are three kinds of levels of compensation: (1) special damages (medical expenses, wage losses, and other out-of-pocket expenses); (2) general damages, or human loss; and (3) comparative causality compensation [described later by Dr. Bush] in which the degree of compensation is proportionate to the degree of causality arising out of the health care system itself.

I would be in favor of the social-insurance approach to cover the special damages. But I do not think our economy can possibly afford to provide social-insurance payment for general damages, or human loss, to everyone who has had an adverse medical result. That would be a stupendous sum of money. But we should not deprive people of the opportunity to obtain that compensation for general damages if they wish to pursue it through the private remedy of a lawsuit.

The sixth element is the *reporting system*. This is the system that should give us information about where the health services have failed and how we can improve them. There are two ways to accomplish that, and both should be used. One is economic: if we make someone compensate for medical negligence, then we will automatically get a report. The other is purely regulatory: it simply counts up the number of times that different adverse results occur and sends that information back to appropriate governmental authorities.

We should require all hospitals (which is where most of the serious problems occur) to make routine reports of adverse incidents observed in various treatment categories. Hospital personnel are understandably reluctant to do this because, in a sense, they would incriminate themselves and their friends. Their reluctance can be overcome by encouragement and by threat. The encouragement is that the information supplied by the hospitals would be absolutely privileged from any use in litigation, just as that kind of information is now privileged in aviation and motor carrier accidents. The threat is that failure to report would mean the appropriate government agency would undertake its own periodic investigation of the hospitals. If nothing else that would be an effective emotional threat to hospital personnel.

I do not want to impose an unrealistic burden on

**The Hospital-Physician Relationship**

A generation ago, the principal malpractice concerns of the hospital were anesthetic hazards, gross surgical errors in judgment and performance, and patient security. Today, in addition, we are concerned with electrical shock, drug reactions, errors of omission, patient abandonment, informed consent, cross-infections, optimal care, and a lot of other problems stemming from the increased complexity of medical technology, increased expectations of hospital performance, and increased awareness of the money awards for real and alleged malpractice.

The modern hospital administration must now devote enormous amounts of time to the recording of patient incidents, interrogatory responses, conferences with insurance claims adjusters, and courtroom appearances.

Hospitals are now safer places in which to be treated than ever before. Yet, medical practices are complex, sometimes hazardous; and modern drug therapy misapplied can be dangerous.

In the future, legal remedies may be too gross for the situations hospital people will find themselves in. Instead of the dramatic anesthetic incident or operating-room error, what is more typical now is that, in a long chain of events and actions in the hospital's health care treatment, seemingly insignificant choices can result in a poor outcome. This is because time and service pressures force choices that would not be made if hospitals could operate more reflectively.

Also there are many more people on the health delivery team today than there were twenty years ago. That creates a problem of communication between the different members of the team.

Another critical problem is that the hospital cannot control the medical manpower for optimal service. An

example: every hospital has a morning rush at nine o'clock when all the doctors make their rounds of the patients. This swamps the hospital organization. But apparently it is impossible for hospitals to regulate the flow of doctors, have them come through in an orderly fashion, so that their diagnosis and therapy needs can be decently accommodated.

Another example: while it is very common for a radiology group to be under contract to the hospital and to be present and responsible for the total operation of the X-ray department, there is in many hospitals no comparably contracted anesthesia group. Private anesthesiologists assume and take the same prerogatives as other men on the medical staff. This means the hospital does not have the authority to order the delivery of anesthesia when it is needed, but must instead rely on the willingness of the anesthesiologists to respond.

In many matters, the physician, acting and thinking of himself as an independent contractor, can be as willful as he pleases with respect to the hospital's needs. The private physician has the right to refuse to accept a patient for treatment. Yet our society believes that every patient has a right to medical treatment, and the hospital consequently is expected to have a physician present when that treatment is needed.

It is not unheard of that doctors who take their turn on surgical call for the emergency rooms of the hospital will go out to dinner, not leave word where they can be reached, and not notify their backup fellow doctor. As a result, when an emergency case comes in, the hospital is put in a terrible situation because it has the responsibility for having a doctor present but no authority to command his presence.

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the hospitals. Hospital personnel have enough to do to take care of their patients. But describing where they have problems and setting up internal quality-control procedures is also a part of taking care of patients. They could help each other as well as all health care facilities if they were systematically to report what they are doing in the way of internal control procedures.

The seventh, and last, element is *regulation of health care*. How do we control doctors and hospitals? What do we do to make sure that they give proper medical care? Licensing is one way to exercise some control. Regulation by a governmental administrative agency is another, though one can think of many objections to that. As for revocation of license, that is an extreme solution. Denying the license is a remedy for the totally incompetent physician. It obviously is not the remedy for the physician who has made an error but should not lose his license on that account.

A third way to exercise regulatory control is the private remedy. Any regulatory system that does not provide for this remedy is seriously deficient. The private remedy is the right and option of the individual to pursue what he believes to be the maltreatment that he has suffered. The private remedy is provided for the protection of individual interests. In the governmental area, for example, we provide for civil antitrust action and civil securities actions — these are methods by which the fellow who has been damaged can complain. He will not complain unless he has a financial incentive to complain, and, indeed, he will not be able to get counsel unless the counsel has some financial incentive.

The private remedy has important social consequences, too. When we make it possible for individuals to do something about damages they have suffered because of someone's negligence, we are furnishing society with, as it were, a private police force. It is an extra measure of protection for the society which it could never get by governmental agency alone.

When we consider the changes that might be made in the present health care and compensation system, we must distinguish between what can be done in the short range, the intermediate range, and the long range.

In the short range, small but significant changes can be made in such things as the decision machinery, the regulation of the insurance companies, the rules of liability and evidence, the system for reporting and analyzing medical accidents.

In the intermediate range, there is the prospect of a broader Social Security remedy in some form or other with the next ten years.

And in the long range, there is the possibility of achieving the technology to predict medical probabilities and to work out relative causation in medical accidents. There is also for the long range the question of how the conscience of the community may develop with respect to the scope of protection and compensation deemed desirable, or necessary.

**RICK CARLSON:** If we had a no-fault system of some kind, there would be equitable compensation of the victim of a medical injury. And there would also be built into the system regulatory feedback to improve the quality of health care. So why must we keep the private remedy?

**MARKUS:** A no-fault system, though regulatory and reporting aspects can be built in, would not highlight the particular errors or problems that occur in medical care. The private remedy does that. It is an extremely valuable method of bringing serious problems to the attention of responsible people.

Unquestionably in the matter of consumer protection in the use of manufactured products, the availability of the private remedy has been the single most powerful regulatory force. Indeed, most governmental regulations come only after repeated resort to the private remedy indicates that a serious general problem exists. And if the private remedy is to be a credible threat to wrongdoers, there must be enough financial incentive for individuals to use it. A revenge motive is not enough.

Really, the norm in almost every country except the United States is to have a broadly based Social Security compensation system for every person who has a disability or an illness; and, alongside that, there is provision for the private remedy. The need for the private remedy is not eliminated by an amelioration of the compensation system.

**MICHAEL TIGAR** (Visiting Fellow): The private remedy does not lend itself to the orderly development of sound medical practice. What you have is twelve people on a jury listening to two medical experts who give different opinions about whether a certain procedure was or was not negligent, did or did not amount to reasonable care. Then those twelve people, none of whom have ever been to a medical school, go into a room and decide whether it is 50.1 per cent probable that this particular procedure was or was not negligent. With that kind of a "remedy" you get one hell of a scatter of results about what is and what is not negligence, based on the peculiar chemistry of twelve people on a jury, on the persuasiveness of the trial lawyer, and on whether the experts looked properly distinguished and professorial on the witness stand.

**MARKUS:** Mr. Tigar, you are saying that human beings in general, not just jurors, should not make decisions, because all human beings are responsive to those influences.

**J. W. BUSH:** I would not agree with Mr. Markus' inference that all decisions made by humans are of the same general quality. Circumstances and contexts affect those decisions. Some systems produce better decisions than others. Nor would I take away the individual's right to appeal to a jury. But I think that a judgment about a particular medical procedure or practice that came from an expert body (which would include representatives of practitioners and claimants) that had time to take the testimony and opinions of various specialists, weigh the different views and the probabilities, and write it up carefully for discussion, would be respected in the medical community. And it would not amount to writing a medical manual which would say, "This is the only way to do it." It might simply say, "There are a number of acceptable ways to do it, but this particular procedure is no longer one of them."

**MARKUS:** One of the great advantages of the private remedy is that in the particular case it permits the decisional body, the court, to take a close look at the facts, to measure those facts by community standards, and to make a judgment whether a certain medical procedure is justifiable. If we abandon that method, if, say, we rely on the decision of some professional group, then we will take away from the community its power to regulate the medical profession, and I think that would be very sad.

## The Case for Arbitration

While acknowledging the deficiencies and procedural inequities of courtroom malpractice litigation, Dr. Rubsamen said that a no-fault liability system, if it sought to distinguish between compensable and non-compensable medical events, would require a vast bureaucratic hearing agency and countless hours of medical time to investigate claims. He proposed arbitration as a halfway point between courtroom litigation and no-fault liability: if arbitration does not prove to be an adequate remedy for the problems now perceived, the no-fault rule could then be adopted.

**DAVID RUBSAMEN:** In California, the arbitration pro-

cedure is devoid of legal technicalities. The forum may be anywhere: the office of the physician or of one of the attorneys; the patient's home; a hospital room. As in a court trial, attorneys for the disputants present their cases. Witnesses are heard, documents reviewed, and then a decision is rendered. A court reporter need not be present unless one of the parties requests it.

Hearsay evidence is admissible. This is a great help to the plaintiff's attorney in a malpractice case; it permits him to introduce textbook evidence.

Arbitration can only arise if the parties have specifically provided for it by contract. This contract could be signed after the particular dispute occurs, but usually it will be signed in anticipation of some possible conflict arising in the future. For the physician and patient the contract ordinarily would be signed when the physician first accepts the case.

A lot of people have a deep-down feeling that when the doctor says, "Here, sign this," and they sign it, they don't really appreciate every aspect or implication of this binding contract. But the California Supreme Court has favored these contracts in a number of recent decisions. To one plaintiff who wanted the contract declared invalid on the ground that he had a right to a court trial, the court just pushed the whole issue of due process out of the way and said, in effect, "Arbitration doesn't affect rights. It is simply a change of forum. You were going to go to the Superior Court. Now you go to the arbitrator."

Of course, if a patient is sick and goes to a doctor and signs the arbitration contract because he is afraid the doctor will not treat him otherwise, that would be an adhesion contract. That is one which is forced upon an inferior party by a superior party, and adhesion contracts are invalid at law. But in a nine-hospital experiment in Southern California in which arbitration contracts have been sought since 1969 from all patients upon admission except those acutely ill, the patients have a thirty-day period from the time of hospital discharge to void the contract. The nine hospitals hope to get around the adhesion-contract problem that way. Incidentally, less than ten patients have taken advantage of that release provision.

Arbitration has also been in effect since 1932 at the Ross-Loos Medical Group which has 150 physicians and an active patient list of about ninety thousand. And arbitration was recently adopted by the Southern California Kaiser Foundation Health Plan, which has seven hospitals and twenty outpatient clinics and a total membership of about one million people. Within two or three years, if the value of the arbitration method is demonstrated, the Northern California Kaiser Health Plan may adopt it. And if the method continues to prove valuable, I think California physicians generally will adopt it. In that case, the California experience may be useful to the rest of the country.

An arbitration case begins when the defendant is notified that a claim is being made against him. The usual contract may provide for a period of thirty days in which the claimant and defendant each must select an arbitrator; there is another thirty-day period for these two arbitrators to select a third, neutral person. If they cannot agree on a third person, the Superior Court judge selects him. There is also a brief period between the selection of the panel and the start of the hearing. So you can be in arbitration within ninety days after initial notification of the defendant. The time limits are even shorter in the Ross-Loos contract, about seven weeks. In practice, time extensions are often requested and granted.

The advantages for both physician and patient are the short period of time before the proceeding starts as well as the brevity of the proceeding itself. Ross-Loos has had only one case that took longer than four days. The clinic had only one case that took three days. A number have taken two and a half days. Many of them have taken only one day.

For the physician there is comparative privacy and an absence of excoriating, public cross-examination. No transcript is required unless one party requests it, and the arbitrators' decisions are not published.

A big advantage for the patient is the admissibility of textbook evidence; he does not have to present the expert testimony of physician witnesses. The California arbitration law has no rules about hearsay evidence. It specifically says that the arbitrator can accept evidence which he himself acquires outside of the hearing room. But if he uses such evidence he must present the substance of it in the hearing and give those in the room a chance to rebut it. I know this is a frightening prospect to most attorneys. But that procedure is consistent with the informality of arbitration and with its presumption that people will be honest and fair. The law repeatedly builds into the arbitration system the requirement that all cards be face up on the table.

Another great advantage for many patients is that whereas the majority now get nothing for a medical injury because their damages are not substantial