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# MEDICAL MALPRACTICE DAMAGE AWARDS: THE NEED FOR A DUAL APPROACH

## I. Introduction

Damage awards in medical malpractice<sup>1</sup> actions brought in New York State courts have increased steadily<sup>2</sup> in the past ten years.<sup>3</sup> This

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1. Many of the modern definitions of medical malpractice derive from the standard enunciated in *Pike v. Honsinger*, 155 N.Y. 201, 209-10, 49 N.E. 760, 762 (1898):

The law relating to malpractice is simple and well settled, although not always easy of application. . . . Upon consenting to treat a patient, it becomes [a physician's or surgeon's] duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgment in exercising his skill and applying his knowledge. The law holds him liable for an injury to his patient resulting from want of the requisite knowledge and skill, or the omission to exercise reasonable care, or the failure to use his best judgment. . . . The rule of reasonable care and diligence does not require the exercise of the highest possible degree of care, and, to render a physician and surgeon liable, it is not enough that there has been a less degree of care than some other medical man might have shown, or less than even he himself might have bestowed, but there must be a want of ordinary and reasonable care, leading to a bad result. . . . The rule requiring him to use his best judgment does not hold him liable for a mere error of judgment, provided he does what he thinks is best after careful examination. . . .

For a discussion of the genesis of medical malpractice law and lawsuits in the United States, see generally Sandor, *The History of Professional Liability Suits in the United States*, 163 J. AMER. MED. A. 459 (1957); 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 8.01 (1960).

2. In New York, annual losses incurred by insured parties, which include damage awards and attorney's costs for prior claims, reflect a steady increase: for 1971, \$7.1 million; 1972, \$11.2 million; 1973, \$17.4 million; 1974, \$21.7 million; 1975, \$27.6 million; 1976, \$23.5 million; 1977, \$31.2 million; 1978, \$47.3 million; 1979, \$64.2 million; 1980, \$81.9 million; and 1981, \$91.7 million. 1970-1975 figures reflect the amounts paid by Employers Insurance of Wausau. Letter from George A. Wright, Jr., Vice-president, Medical Liability Mutual Insurance Co. (March 30, 1983) (listing amounts paid by his company's predecessor). 1976-1981 figures reflect the amounts paid by all carriers as compiled by the New York State Insurance Department and reflect a similar data base to the previous years. Telephone interview with Mark Presser, Chief of the Property & Casualty Division, New York State Insurance Department (Sept. 29, 1982) [hereinafter cited as Presser]. Even more significantly, the value of average claims paid has also increased dramatically: 1976, \$39,858; 1977, \$44,209; 1978, \$54,033; 1979, \$62,963; 1980, \$76,469; and 1981, \$89,351. Presser. The New York State Insurance Department calculates that the continuing rate of increase from 1976 to 1981 averages out to 18% a year and that if the current exponential rate of increase continues, the average medical malpractice claim made in 1982 will be paid out in 1989 at \$700,000. *Id.*

3. Actions against physicians have been known since early times and were frequently expressed in contract terms. 1 D. LOUISELL & H. WILLIAMS, *supra* note 1,

trend surpasses the general increase in awards granted in other types of litigation involving insured losses brought in the same period.<sup>4</sup> The tremendous growth in malpractice liability has resulted in higher premiums<sup>5</sup> which insured physicians pass along in higher prices to health care consumers.<sup>6</sup> Attempts to break this spiral by legislative reforms have met with little success.<sup>7</sup>

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¶ 8.01, at 188. Sandor, *supra* note 1, reports early English cases appearing from 1374 and notes that by 1518 the College of Physicians of London provided for a fine or 14 days imprisonment for any member who committed malpractice. *Id.* at 459. Sandor notes that the first American case was *Cross v. Guthrey*, 2 Root 90 (Conn. 1794), decided upon pleadings of breach of contract. Sandor, *supra* note 1, at 460. But the American law of malpractice as it evolved in the last century embraced the principles of negligence. *Id.* The author's study of appellate decisions reveals few cases reported in each state before 1900; however, malpractice actions appear in significant numbers after the turn of the century. *Id.* at 460 (graph), 461-63 (Table 1). Although malpractice actions usually are based upon theories of negligence, modern courts have also recognized a contract theory. *Hawkins v. McGee*, 84 N.H. 114, 146 A. 641 (1929) (breach of promise to achieve a specific result); *Robins v. Finestone*, 308 N.Y. 543, 547, 127 N.E.2d 330, 332 (1955) (breach of promise to use a specific method of treatment).

4. The average rate of increase in medical malpractice awards, *see* note 2 *supra*, is considered by State Insurance Department analysts to be the highest rate of increase of all insured loss categories. Presser, *supra* note 2. Trends for casualty losses are calculated from the average rate at which individual claims are paid and thus do not reflect an increase in the number of claims paid. Telephone interview with Don Yazey, Chief Information Officer, Insurance Services Office (Jan. 10, 1983). The Insurance Services Office, an industry-supported actuarial and statistical research organization, calculates that the trend in New York State for "completed operations"—all liabilities associated with the production of products and services and thus the most nearly similar area to medical liability—increased at 13.5% per year for the years 1973 through 1980. *Id.*

5. Premium rates for physicians in New York are set according to medical specialty and county of practice. Specialties are grouped into 13 "classes." 1982 NEW YORK STATE INSURANCE DEPARTMENT RATE MANUAL Exhibit 1 [hereinafter cited as RATE MANUAL]. The least expensive category includes psychiatrists and pathologists; the most expensive is for neurosurgeons. For example, a general practitioner, placed in the third lowest class, paid between \$1,200 to \$2,400 annually for coverage in 1977. T. LOMBARDI, MEDICAL MALPRACTICE INSURANCE 48 (1978). Today, the same coverage ranges from \$2,720 (premium class 11 in all upstate counties) to \$6,013 (premium class 11 in Nassau, Suffolk and Sullivan Counties). RATE MANUAL, *supra*, at 1. High risk specialties pay higher premiums. Neurosurgeons (premium class 1) pay in a range of \$20,830 (all upstate counties) to \$46,044 (Nassau, Suffolk and Sullivan Counties); followed closely by \$40,187 (Bronx, Kings, Queens, Richmond and Rockland Counties) and \$35,915 (New York County). *Id.* Rates for obstetricians (premium class 3) range similarly: from a low of \$17,011 (in all upstate counties) to \$37,603 (Nassau, Suffolk and Sullivan Counties) to \$32,819 (Bronx, Kings, Queens, Richmond and Rockland Counties) and \$29,331 (New York County). *Id.*

6. *See* notes 31 & 78 *infra* and accompanying text.

7. This trend appears unabated despite a 1975 legislative enactment designed to control these costs. For a complete discussion of the 1975 enactment *see* notes 43-51 *infra* and accompanying text.

Controversy surrounds the question of what caused this growth in malpractice awards. Plaintiffs' attorneys contend that increases in malpractice awards have evolved from widespread physician carelessness which is best deterred by bringing suit.<sup>8</sup> Defendants counter that large monetary awards are often the result of legal arguments which appeal more to a jury's sense of sympathy for an injured patient than to any clear negligence.<sup>9</sup>

Some commentators have argued that little provable malpractice occurs and that too many cases of non-negligent injury result in awards.<sup>10</sup> The present system, it is contended, treats some physicians unfairly when awards are levied without regard to fault.<sup>11</sup> Others argue that large numbers of injured patients are unable to gain any compensation at all.<sup>12</sup> In any event, the present tort/litigation insur-

8. See C. KRAMER, *THE NEGLIGENT DOCTOR* 15-18 (1968). The author theorizes that a high percentage of medical treatments, especially surgical operations, are undertaken by poorly-trained and unsupervised persons and that the current levels of malpractice actions represents only a portion of those which could be brought. *Id.* In addition, he posits the theory that litigation is necessary to hold the medical profession accountable. *Id.* at 17.

9. D. HAVENER, *OBSERVATIONS REGARDING INVESTIGATION AND PREPARATION OF MEDICAL MALPRACTICE LITIGATION* 7 (Defense Research Institute No. 4, 1977).

One indispensable prerequisite to a recovery should be a physician's professional negligence producing patient injury. Some doctors *are* negligent and cause patient injury. However, that factor is often lacking in claims asserted and suits filed. Many claims arise only from the fact of a bad result—sometimes a catastrophic patient result. Even without clear and undisputed medical negligence, if there is *some* evidence of possible physician fault, before a jury such an instance can produce catastrophic results for the physician as well as for the patient.

*Id.*

10. The contention has been stated this way:

The first tier and the root cause of the medical malpractice problem as identified by a massive government study commissioned by the Department of Health, Education, and Welfare is that adverse results inevitably occur during the course of medical treatment. These iatrogenic injuries [those induced during treatment] may or may not be caused by the negligence of someone in the health-care hierarchy, but arise regularly because medical technology, though highly sophisticated, has yet to overcome all untoward effects of drugs and surgical procedures.

*Recent Medical Malpractice Legislation—A First Checkup*, 50 TUL. L. REV. 655, 655-65 (1976) [hereinafter cited as *Recent Medical Malpractice Legislation*].

11. T. LOMBARDI, *supra* note 5, at 21-22. "The complexities of modern medicine, doctors maintain, make it very difficult for a lay jury to judge the merits of medical malpractice cases. . . . 'The members of the jury don't know who is telling the truth but they can see a crippled man in a chair.'" *Id.*

12. See Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, in *MEDICAL MALPRACTICE* 1-2 (1977). "[M]edical malpractice suits are at best a capricious and inequitable means of compensation. While some claimants obtain very large awards, others suffering from equally serious injuries receive no compensation

ance system has resulted in increased fees to health care consumers<sup>13</sup> and uncertainty of compensation for many injured patients.<sup>14</sup>

This Note will examine the evolution of increased malpractice costs in New York and their distribution throughout the health care system. The current litigation system and several recently proposed methods of equitable compensation will be analyzed. Discussion will then focus on the extent to which these proposals satisfy the twin criteria of deterring the negligent physician and compensating injured patients. In addition, the constitutional issues raised by alternative compensation systems and limitations on damage awards will be addressed. This Note concludes by offering alternative proposals for compensating certain non-negligent injuries with limited compensation awards, a separate funding mechanism and an alternative verdict for the jury.

## II. The Phenomenon of Medical Malpractice

### A. Recent Causes and Effects

The past decade has witnessed an acute increase in the number of medical malpractice suits.<sup>15</sup> Beyond the problem that there always will be a small number of poorly-trained, overworked or simply care-

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at all." *Id.*; J.B. SPENCE, *MEDICAL MALPRACTICE* 279, 283-84 (Practicing Law Instit. No. 68, 1974) (practicing attorney cautions colleagues that because of the time and expense of litigating malpractice cases only the most substantial cases should be accepted); Havighurst & Tancredi, "Medical Adversity Insurance"—A *No-Fault Approach to Medical Malpractice and Quality Assurance*, 613 *INS. L.J.* 69, 89 (1974) (suggests that many patients do not even consider bringing suit because they are unaware of any treatment injury, "lack a litigious spirit," or regard the physician as "nonculpable").

13. See notes 31 & 78 *infra* and accompanying text.

14. Because of the factors cited in note 12 *supra*, the ability of an injured patient to receive monetary damages depends upon a variety of events occurring in succession: He must be aware of the injury, he must suspect that malpractice occurred, he must find an attorney willing to take the case on a contingency, and he must be willing to wait until the end of all proceedings to learn if his efforts have resulted in any compensation. See also Law, *Improve the Medicine, Not the Law*, *EMPIRE ST. REP.* 41, 42 (Sept. 1982) ("[i]n most cases this heavy burden [of proving professional negligence] cannot be met").

15. See *Recent Medical Malpractice Legislation*, *supra* note 10, at 656. In New York, the number of malpractice actions filed has followed this trend: 1976, 1,421; 1977, 1,667. THE ADMINISTRATIVE BOARD OF THE JUDICIAL CONFERENCE AND THE OFFICE OF COURT ADMINISTRATION, *ANNUAL REPORTS*, 1976 (Table 29); 1977 (Table 30). In 1978, 1,647; 1979, 1,862; 1980, 1,793; 1981, 2,129. CHIEF ADMINISTRATOR OF THE COURTS, NEW YORK STATE OFFICE OF COURT ADMINISTRATION, *ANNUAL REPORTS*, 1978 (Table 29); 1979 (Table 29); 1980 (Table 29); 1981 (Table 3-21).

less physicians,<sup>16</sup> there have been significant changes in the patient-doctor relationship.<sup>17</sup> Patients, with increasing expectations that modern medicine will cure their ailments,<sup>18</sup> have a greater willingness to bring suit.<sup>19</sup> Often, these medical malpractice claims are raised

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16. See C. KRAMER, *supra* note 8. "Violating fundamental principles of good treatment has become . . . alarmingly widespread. . . ." *Id.* at 15. See also Law, *supra* note 14, at 41 ("[this] is a crisis resulting from the number of patients who suffer injury as the result of substandard, sometimes wholly unnecessary, medical care"). The contention is not wholly polemic. The current state of American medicine was explored in SECRETARY'S COMM'N ON MEDICAL MALPRACTICE, DEP'T OF HEALTH, EDUC. AND WELFARE, 1973 REPORT. That report recommended:

*Injury Prevention*—The Commission recommends the development of intensified medical injury prevention programs for every health-care institution in the nation, such programs to be predicated on the following:

1. investigation and analysis of the frequency and causes of the general categories and specific types of adverse incidents causing injuries to patients;
2. development of appropriate measures to minimize the risk of injuries and adverse incidents to patients through the cooperative efforts of all persons involved in the providing of patient care in such institutions.

*Id.*, quoted in W. CURRAN & E. SHAPIRO, *Law, Medicine and Forensic Science* 519-20 (3d ed. 1982).

17. See *Recent Medical Malpractice Legislation*, *supra* note 10, at 657.

18.

Forty years ago, a physician's only treatment of a patient's illness might be to sit at the side of the bed and comfort his patient and the family while the patient died. The same patient today may be treated by very complex methods, such as open heart surgery, from which he is more likely than not to recover, but in which the incidence of untoward result is high. The patient forgets that 40 years ago he would have died without medical intervention. Now he expects perfection from the surgeon and files suit for the untoward result.

A. HOLDER, *MEDICAL MALPRACTICE LAW* 401 (2d ed. 1978). See also *Recent Medical Malpractice Legislation*, *supra* note 10, at 657 (patients have "unrealistic expectations" of a treatment's outcome, a frame of mind fostered by media attention on modern medical care).

19. In a national survey, physicians were categorized according to medical specialty and geographical setting. Langwell & Werner, *Regional Variations in the Determinants of Professional Liability Claims*, 5 J. HEALTH POL. POL'Y & L. 498 (1980-81). The researchers attempted to calculate the statistical likelihood of a malpractice suit being brought against the average physician in each category. *Id.* at 504-07. The survey showed a markedly higher probability of a malpractice suit being brought against a physician if he practiced in an urban area. *Id.* at 509, 510 (Table 5). The authors conclude: "[T]he analysis suggests that there are systematic differences in the likelihood of a claim for physicians located in different regions. These differences may be associated with variations in demographic characteristics of the population, availability of medical resources, or in legal environment." *Id.* at 512. Specifically, the authors argue that the number of "malpractice incidents . . . was

against a physician the patient hardly knows.<sup>20</sup> As one commentator has pointed out, "when this is coupled with the frustration of having no effective channel for complaint, a patient may file a malpractice claim because he has little reason for restraint."<sup>21</sup> Indeed, if he is seriously injured and has lost the ability to earn a living, he may have no choice but to do so.

The proliferation of malpractice litigation is exacerbated by the phenomenon of modern science itself. Medicine, as it embraces technological advances, offers new hope through innovative yet risky techniques to those previously considered untreatable.<sup>22</sup> This results in a situation where these patients sometimes emerge from hospitals with legal claims against their physicians for less than perfect outcomes.<sup>23</sup> Such claims may arise because a physician performed the procedure

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significantly related to [such variables as] per capita income, availability of medical facilities and legal services. . . . Educational levels may be associated with differences in the ability of patients to identify actual violations of medical standards, while higher income levels may imply easier access to the legal system." *Id.* at 499.

20. One commentator has warned that urbanization and specialization have depersonalized the doctor-patient relationship to the point that it has become easy for a patient to blame the doctor when results are less than he had hoped for. *See Recent Medical Malpractice Legislation, supra* note 10, at 657. The physician is likely today to be a specialist to whom the patient has been referred on a one-time basis. This is because medical advances have increased the number of recognized specialties and subspecialties. W. CURRAN & E. SHAPIRO, *supra* note 16, at 346-47.

21. *Recent Medical Malpractice Legislation, supra* note 10, at 657.

22. *See* A. HOLDER, *supra* note 18, at 401. *See also* Mechanic, *supra* note 12, at 3. "Increasingly, physicians have available a more powerful technology for evaluating and treating disease, but a technology that also can cause havoc when incorrectly applied. The traditional practitioner, with his little black bag, was able to affect a disease in only a modest way, but his possibilities of doing harm were also more limited than at present." *Id.*

23. "Physicians who are innovative in their medical or surgical treatments and who have an unavoidably poor result are often penalized in malpractice litigation because their methods differ from the average care or norm in their areas." T. LOMBARDI, *supra* note 5, at 23-24 (quoting George Himler, former President of New York State Medical Society). The development of procedures and medications which allow for the transplantation of human organs, especially the kidneys, heart, skin, or cornea, have raised a plethora of legal questions, including the issues of what constitutes acceptable transplant procedures. Annot., 76 A.L.R.3d 890, 893 (1977). For a survey of how the courts have viewed the liability of those who perform such procedures, see *id.* at 901-04. In a recent case, *Colton v. New York Hosp.*, 918 Misc.2d 957, 414 N.Y.S.2d 866 (Sup. Ct. N.Y. County 1979), the supreme court considered the effect of a covenant not to sue signed by a kidney donor prior to the operation. Noting the "experimental and inherently dangerous" nature of the procedure, the court said that such a procedure "foreseeably" contains certain "untoward consequences" which may be covered by the agreement. *Id.* at 969-70, 414 N.Y.S. 2d at 876. But negligent acts and their causation to the injuries was outside the scope of the agreement and the court remanded these issues for trial. *Id.*

improperly.<sup>24</sup> However, adverse effects often result from an unavoidable and necessary risk of a new or difficult procedure.<sup>25</sup>

The increasing number of lawsuits has intensified the need for physicians to obtain insurance to protect themselves from losses. Medical malpractice insurance policies indemnify physicians<sup>26</sup> from "all risks encountered."<sup>27</sup> Such insurance is generally perceived by the medical profession as a shield that need only be raised against "damages suffered as the result of malpractice."<sup>28</sup> Some commentators, however, suggest that the now ubiquitous insurance serves as a convenient monetary pool for juries to compensate those who suffer the adverse results of a medical procedure when no malpractice in fact occurred.<sup>29</sup> In any event, the rising number of successful lawsuits and the increasing monetary values of the awards has caused a parallel increase in medical malpractice insurance premiums.<sup>30</sup> The increased premiums generally are passed on to patients in the form of higher fees,<sup>31</sup> particularly to patients in urban areas.<sup>32</sup>

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24. For a discussion of malpractice definitions and what constitutes a proper standard of care, see D. HARNEY, *MEDICAL MALPRACTICE* § 3.1 (1973).

25. See *Recent Medical Malpractice Legislation*, *supra* note 10, at 655-56. Whether these adverse results are due to negligent or non-negligent causes is a dividing line issue for those who have shaped the public debate over this matter. Some writers argue that the patient often is injured as a result of a series of unavoidable medical events unrelated to negligence by medical personnel. See *Mechanic*, *supra* note 12, at 16. Cf. *Havighurst & Tancredi*, *supra* note 12, at 75. Others place the blame for most injuries on physicians who delay treatment or are careless. See C. KRAMER, *supra* note 8, at 249. The theory that the increased number of medical injuries is due mainly to negligence was recently stated this way: "The enormous quantity of research . . . generated by the debate over malpractice in 1975 did not produce one shred of evidence suggesting . . . that the injuries of successful claimants result from anything other than avoidable medical negligence." *Law*, *supra* note 14, at 41.

The issue of what caused an injury is often made more difficult for a jury because the plaintiff initially comes to the defendant suffering from some symptom or ailment; the effects of this ailment must be distinguished from the result of the alleged malpractice.

26. The scope of this Note will be limited to the impact of malpractice awards and settlements upon physicians and their patients. Insurance plans which indemnify hospitals are not discussed.

27. 11 G. COUCH, *COUCH ON INSURANCE* 2D § 44.372-.373 (rev. ed. 1982).

28. T. LOMBARDI, *supra* note 5, at xv.

29. *Id.* See generally *Recent Medical Malpractice Legislation*, *supra* note 10, at 655-60 (large monetary awards for malpractice claimants, whether in fact they were injured through an act of negligence or not, invariably are paid by insurance).

30. See notes 2 & 5 *supra*.

31. Schwartz & Komesar, *Doctors, Damages and Deterrence*, 1978 *NEW ENG. J. OF MED.* 1282, 1287 (patients bear most of the burden of higher malpractice insurance premiums through higher health insurance premiums). See also Langwell & Werner, *supra* note 19, at 498-99 (higher premiums and increased likelihood of claims result in "increased costs of care as physicians pass premium increases on to



## B. The Unfulfilled Goals of Malpractice Litigation

Ideally, a negligently injured patient should receive adequate compensation for his losses. This compensation award should deter any potential tortfeasor from acting in a similarly negligent fashion.<sup>33</sup> Unfortunately, however, the current system of malpractice litigation and insurance coverage obscures society's goals in affixing damages.<sup>34</sup>

First, many injured patients have claims that are too modest or difficult to prove, and thus not worth the time and expense of lengthy litigation.<sup>35</sup> These patients, therefore, may receive no compensation at all.<sup>36</sup> Second, the system of malpractice insurance insulates both actual and potential tortfeasors from the "deterrence signal"<sup>37</sup> of damage awards.<sup>38</sup> The potential tortfeasor is insulated because premium

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consumers in the form of higher fees"). Because premiums are raised evenly within each medical specialty and geographical subdivision, no physician need fear setting a rate grossly inconsistent to those of his colleagues in a locality. *See* note 78 *infra* and accompanying text.

32. In general, premium rates for all physicians practicing in urban areas are higher and must be absorbed in the local fee structure. *See* notes 66-70 *infra* and accompanying text.

33. Schwartz & Komesar, *supra* note 31, at 1284-85.

34. *See* note 31 *supra* and accompanying text and notes 38 & 42 *infra* and accompanying text.

35. Mechanic, *supra* note 12, at 10.

36. *See* note 12 *supra*.

37. Schwartz & Komesar, *supra* note 31, at 1282.

38. *Id.* at 1287. Malpractice insurance premiums are set only by specialty and geographical area. *See* notes 39-40 *infra* and accompanying text. As Prosser has stated, deterrence is an important factor in awarding damages. W. PROSSER, *THE LAW OF TORTS* § 5, at 23 (4th ed. 1971).

The "prophylactic" factor of preventing future harm has been quite important in the field of torts. The courts are concerned not only with compensation of the victim, but with admonition of the wrongdoer. When the decisions of the courts become known, and defendants realize that they may be held liable, there is of course a strong incentive to prevent the occurrence of the harm. Not infrequently one reason for imposing liability is the deliberate purpose of providing that incentive.

*Id.* However, physicians whose insurance is influenced only by specialty and locality—but not history of wrongdoing—are "virtually insulated" from being punished through premium increases. Schwartz & Komesar, *supra* note 31, at 1287. This is because surcharges reflecting such a history are often only set by peer review boards. Havighurst, *Medical Adversity Insurance—Has Its Time Come?*, in *MEDICAL MALPRACTICE* 57 n.7 (1977). The peer review system of premium surcharges has been developed because of the medical profession's perception that (1) malpractice claims are often randomly incurred, (2) they are not equitably related to acts of negligence and (3) these physicians should not be shielded. *Id.* Thus, verdicts of liability often do not have the desired effect upon past or potential tortfeasors. *Id.* at 72 n.52. For a discussion of peer review systems in New York State see note 42 *infra*. "Virtually the only penalty currently paid by the negligent physician is the value of his time spent in

increases, uniformly rated by geographical location<sup>39</sup> and specialty "group,"<sup>40</sup> may be hidden in fees.<sup>41</sup> Moreover, the vast majority of actual tortfeasors insured in New York State pay little if any surcharge on their insurance premiums.<sup>42</sup> Thus, the prudent physician often pays the same premium as the reckless one.

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defending a suit and the costs of his embarrassment." Schwartz & Komesar, *supra* note 31, at 1287.

39. Premium rates for New York physicians are grouped according to five geographical territories. The first four territories include New York City and the suburban counties of Nassau, Suffolk, Westchester, Rockland, Orange, Sullivan and Ulster. The fifth category is composed of the remainder of the state. Premium rates in the latter, depending upon medical specialty, are approximately one-half or one-third of those for the physicians serving the more populated area. RATE MANUAL, *supra* note 5.

40. Premium rates in New York also are determined according to membership in certain specialty groupings. It has been suggested that this system leads to insulation of the tortfeasor:

Malpractice insurance, as it is currently administered, virtually insulates the negligent physician from the damages award and, thus, from the malpractice [deterrence] signal. The reason is simple: the malpractice premiums of individual physicians are rarely influenced by their record of claims, settlements and verdicts. Rather, premiums are usually set for an entire specialty group in a given region. Thus, the physician with a record of frequent negligence bears no larger share of the burden than his colleagues with excellent records. No individual physician has more than a slight pecuniary incentive to reduce the expected losses resulting from his own behavior.

Schwartz & Komesar, *supra* note 31, at 1287.

41. However, this system may not totally insulate physicians. Some commentators have suggested, for example, that fear of malpractice suits exists and is socially beneficial in that it encourages the practice of defensive medicine, particularly the use of all available diagnostic tests. See Havighurst, *supra* note 38, at 57 n.8; Law, *supra* note 14, at 41.

42. Physician/tortfeasors in New York may have their individual premiums adjusted according to one of two systems. Physicians covered under the Medical Liability Mutual Insurance Company who experience claims or awards against them may appear before the Medical Liability Defense Board to protest a surcharge or cancellation of their policies. The review is subjective and designed to allow the physician to explain his use of proper procedures in the matter. Exact statistics on the numbers surcharged are not kept, but are believed to be minimal. Presser, *supra* note 2. Physicians covered under the Medical Malpractice Insurance Association, including those who have had policies cancelled elsewhere, are subject to a system of automatic surcharges. Policies may not be cancelled. The surcharge system provides for a 25 to 200% surcharge on the individual's premium rates depending upon the number of points accumulated. The first surcharge, 25%, is levied when three points have accumulated. Payment of any claim against a policy accumulates two points. Filing of any claim for which a cash reserve of more than \$250,000 must be kept, based upon the nature and likely success of the claim, results in the accumulation of one point. Presser, *supra* note 2.

### C. Previous Legislative "Reforms"

Legislative concern with the system of malpractice litigation and its insurance nexus has rarely focused on solving the broad policy problems underlying malpractice suits. Rather, the emphasis has been placed on making malpractice insurance available to physicians at an affordable price.

The New York Legislature's first major attempt at adjusting medical malpractice premiums came during the 1975 legislative session<sup>43</sup> after two large medical malpractice carriers refused to cover members of the New York State Medical Society.<sup>44</sup> The carriers claimed that it was unprofitable to insure New York State physicians due to escalating awards to malpractice victims.<sup>45</sup> Their refusal to insure the state's physicians left no major malpractice carrier. As the legislature met to solve the problem, physicians threatened that increased premiums would force them to give up their practices en masse.<sup>46</sup>

After a five-month debate,<sup>47</sup> the legislature passed a seven-point package<sup>48</sup> specifically designed to lower malpractice insurance premi-

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43. [1975] NEW YORK LEGIS. ANN. 419. In 1974, the legislature responded to rising premiums by establishing mandatory screening panels for malpractice cases. T. LOMBARDI, *supra* note 5, at 85. Procedures for the panels are codified in N.Y. JUD. LAW § 148-a.1 (McKinney 1983). The panels are designed to relieve the congestion on civil court calendars by requiring each plaintiff to first present his case before a volunteer panel composed of a supreme court justice, an attorney and a physician for a determination of liability. The plaintiff may accept the finding or go to trial, but the panel's finding will be presented to the court. INSTITUTE OF JUDICIAL ADMINISTRATION, *MEDICAL MALPRACTICE PANELS IN FOUR STATES* 3-5 (1977).

44. For a discussion of the loss of the Employers Insurance of Wausau and Argonaut Insurance companies, see T. LOMBARDI, *supra* note 5, at 85-87. See also *Rx for New York's Medical Malpractice Crisis*, 11 COLUM. J.L. & SOC. PROBS. 467, 468 (1975).

45. T. LOMBARDI, *supra* note 5, at 85-86. From 1958 to 1975, malpractice awards for medical society members rose from \$1.3 million to \$28 million. *Id.* at 87-88 (citing Medical Society statistics). By 1981, this figure had reached \$90 million. See note 2 *supra*. Critics of the companies charged that the unprofitability in malpractice insurance lines in the 1970's was also due to bad financial investments pursued by the carriers. See Law, *supra* note 14, at 42; Sansweet, *Teledyne Takes Drastic Steps in an Effort to Salvage Its Argonaut Insurance Unit*, Wall St. J., Jan. 30, 1975, at 26, col. 6; Herman, *Damage Insurers Hit by Losses on Stocks, Rise in Claim Amounts*, Wall St. J., Jan. 20, 1975, at 1, col. 6. Today, several companies continue to write a small number of policies, largely as a courtesy to some physicians or as a part of a package of larger policies for the insured. Presser, *supra* note 2.

46. See T. LOMBARDI, *supra* note 5, at 91.

47. For a detailed account of the various lobbying efforts, hearings and studies which preceded passage of the legislative package, see generally T. LOMBARDI, *supra* note 5, at 83-107.

48. This seven-point package was embodied in the following eight statutory changes. N.Y. PUB. HEALTH LAW § 2805-d (McKinney 1983) (limited medical mal-

ums by decreasing claim loss.<sup>49</sup> The package shortened the statute of limitations in malpractice suits to two and one-half years or ten years for minors or others acting under disability; permitted consideration of payments from collateral sources; limited the cause of action based on a lack of informed consent to non-emergency situations; and made the findings of pre-trial screening panels admissible at trial.<sup>50</sup> Availability of coverage was guaranteed by requiring all remaining carriers to provide an insurance pool through a Joint Underwriting Association.<sup>51</sup> Despite the substantive nature of the new statutes, many physicians felt these measures would be insufficient in lowering premiums and a scattered work stoppage occurred.<sup>52</sup> Persons who observed the so-called "crisis" later said that the legislative package would not solve the problem.<sup>53</sup> Additionally, it was predicted that physicians would be forced to leave the state if the premium spiral continued.<sup>54</sup>

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practice actions based on a lack of informed consent); N.Y. INS. LAW § 335 (McKinney Supp. 1982-1983) (mandated reporting of medical malpractice claims); N.Y. CIV. PRAC. LAW § 214-a (McKinney Supp. 1982-1983) (limited commencement of medical malpractice actions to two and a half years after termination of treatment); *id.* § 208 (limited commencement of medical malpractice actions for persons under a disability of infancy to a period of ten years after accrual of the action); *id.* § 4010 (McKinney Supp. 1982-1983) (extended admissibility of collateral source payments to medical malpractice trials; was amended in 1981 to mandate the reduction of such payments from awards); N.Y. INS. LAW §§ 5501-5515 (McKinney Supp. 1982-1983) (established a joint underwriting association to provide medical malpractice insurance); N.Y. JUD. LAW § 148-a.8 (McKinney 1983) (allowed the finding of malpractice screening panels to be admissible at trial); N.Y. PUB. HEALTH LAW § 230 (McKinney Supp. 1982-1983) (established an Office of Professional Medical Conduct).

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The Primary purpose of the new malpractice bill is to minimize claim loss experience so that medical malpractice insurance premiums will be kept within acceptable reach. To accomplish this objective many rational considerations fell by the wayside as a politically expedient solution acceptable to everyone caught up in the malpractice maelstrom evolved. CPLR 214-a represents that compromise, and virtually every sentence contained therein is troublesome.

N.Y. CIV. PRAC. LAW § 214-a Practice Commentary (McKinney Supp. 1982-83).

50. See note 48 *supra*.

51. N.Y. INS. LAW §§ 5501-5515 (McKinney Supp. 1982-1983), discussed in note 48 *supra*. This entity is now known as the Medical Malpractice Insurance Association (MMIA). In 1978, the New York State Medical Society formed a separate nonprofit carrier, the Medical Liability Mutual Insurance Company (MLMIC). N.Y. Times, Nov. 24, 1978, at A2, col. 3. Today, the MMIA insures approximately 3,000 New York State physicians and MLMIC approximately 22,000. Presser, *supra* note 2.

52. T. LOMBARDI, *supra* note 5, at 98-99.

53. See *id.* at 95. See also Special Advisory Panel on Medical Malpractice, New York State Legislature, Recommendation No. 1 [hereinafter cited as Special Advisory Panel], (cited in T. LOMBARDI, *supra* note 5, at 177 ("the overriding concern should be to create a system of compensation for adverse medical outcomes resulting from medical treatment, whether or not caused by negligence.")). *Id.*

54. T. LOMBARDI, *supra* note 5, at 95.

The statistics gathered since enactment of the legislation by the New York State Insurance Department show that the legislative package has had "no significant effect" in reversing the upward spiral in damage awards.<sup>55</sup> Thus, despite the legislature's express goal of stabilizing insurance premiums,<sup>56</sup> premiums have increased. Rather than relocate or refuse to work, physicians have passed the continued increases to patients in higher medical fees.<sup>57</sup> Moreover, the broader issues of deterrence and proper compensation remain unaddressed.

### III. New Attempts at Controlling Costs

#### A. The 1981-1982 Premium Increases

During the past two years, the continued growth in malpractice awards has forced the State Insurance Department to allow substantive premium increases for physicians. In 1981, the Medical Malpractice Insurance Association (MMIA), the joint underwriting association, and the Medical Liability Mutual Insurance Company (MLMIC), the private carrier set up by the state medical society to serve its members, requested premiums of 367.8 and 71%, respectively.<sup>58</sup> Because of the disparity in the rate requests, a private actuarial service was retained by the department to make an independent determination of a justified rate increase.<sup>59</sup> This report was ultimately rejected by the insurance superintendent for a variety of reasons.<sup>60</sup>

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55. Presser, *supra* note 2.

56. [1975] NEW YORK LEGIS. ANN. 419; N.Y. CIV. PRAC. LAW § 214-a Practice Commentary (McKinney Supp. 1982-1983).

57. See note 8 *infra* and accompanying text.

58. The MLMIC request was reduced to 52% after the legislature amended the Civil Practice Law and Rules to provide for mandatory abrogation of the collateral source rule in medical malpractice cases. See note 48 *supra*. The MMIA request was reduced to 210% after further adjustments. New York State Insurance Dep't News Release, Oct. 31, 1981.

59. The decision by then Insurance Superintendent Albert Lewis to retain the private service, Presley and Associates, Inc., was unprecedented within the department. The firm recommended an across the board increase for both companies of 107%. New York State Insurance Dep't News Release, Oct. 31, 1981.

60. *In re* Medical Malpractice Insurance Association and Medical Liability Mutual Insurance Company, New York State Insurance Dep't, Opinion and Decision (Oct. 30, 1981). In his opinion, Superintendent Lewis cited several reasons for rejecting the Presley recommendations. These included judgmental differences in actuarial methods, *id.* at 7-8; inadequate consideration given to investment income, *id.* at 10; reduction in the statute of limitations, *id.*; and the continuously declining birthrate in New York State, *id.* at 6.

Rate increases of 26.6% for MLMIC<sup>61</sup> and 27.8% for MMIA for 1981 were approved.<sup>62</sup>

In 1982, the two insurers filed for rate increases of 243% (MMIA) and 73% (MLMIC).<sup>63</sup> MLMIC received an increase of 15%;<sup>64</sup> MMIA has challenged this rate and is seeking a higher increase in proceedings before a departmental law judge.<sup>65</sup>

For physicians with maximum coverage of \$1 million per person/\$3 million per occurrence, these rate increases raise annual premiums to rates ranging from \$1,494 for psychiatrists and pathologists in the upstate counties to \$46,044 for neurosurgeons in Nassau, Suffolk and Sullivan Counties. Illustrative of rate differentials by specialty are the premiums paid by an internist (\$5,776) and a general surgeon (\$20,794) in the same area for the same coverage.<sup>66</sup>

In addition to classification by specialty, the rates reflect a strict geographical breakdown.<sup>67</sup> The highest premiums are paid by physicians in the five boroughs of New York City, Nassau, Suffolk, Rockland, and Sullivan Counties.<sup>68</sup> The same neurosurgeon, internist and general surgeon practicing in an upstate county would pay annual premiums of \$20,830, \$3,350 and \$12,060 respectively.<sup>69</sup> On average, rates for urban physicians are roughly twice those paid by physicians in more rural areas.<sup>70</sup>

## B. The Proposed Patient Compensation Fund

The 1981-1982 rate increases were accompanied by debate among legal, medical and insurance interests over how high an increase, if any, was justified.<sup>71</sup> In addition, substantive legislative reform was

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61. This included a 5.3% one-time surcharge as an addition to MLMIC's surplus account. *Id.* at 11.

62. *Id.* at 11-12.

63. Presser, *supra* note 2.

64. RATE MANUAL, *supra* note 5.

65. This matter is still pending before a departmental law judge.

66. These rates are for the Borough of Manhattan. RATE MANUAL, *supra* note 5.

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.* This calculation is based on a comparison between rates charged in New York City, Nassau, Suffolk, Westchester, Rockland, Sullivan, Ulster, and Orange Counties and the remaining counties in New York State.

71. During the 1981 departmental hearings, actuaries using identical data produced widely varying projections for the amount of required premium increase. By contrast, the New York State Trial Lawyers Association advocated a reduction in premiums. See *Trial Bar Hits Bid to Raise Medical Malpractice Costs*, N.Y.L.J., June 12, 1981, at 1, col. 2; *107% Malpractice Insurance Rate Rise Urged*, N.Y. Times, Sept. 13, 1981, at 61, col. 1.

proposed by Governor Hugh Carey.<sup>72</sup> The proposed bill called for a patient compensation fund for payment of certain large medical malpractice awards.<sup>73</sup> The fund, created through a surcharge on health insurance premiums,<sup>74</sup> was offered as a way of lessening the financial burden on health care consumers<sup>75</sup> and responsible physicians.<sup>76</sup> As a practical matter, the bill would lower the pressure on malpractice carriers by having the fund reimburse them for ninety percent of awards between \$250,000 and \$1 million.<sup>77</sup>

It was hoped the bill would ameliorate two perceived problems. First, that sufficient monies to pay increasing malpractice awards could no longer be raised through the traditional method of increasing premiums. Second, that increased premiums (as well as existing premiums) would be routinely passed into medical fees.<sup>78</sup> The problem of

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72. Program Bill. No. 387/82, proposed April 6, 1982 [hereinafter cited as Program Bill]. A program bill is prepared by the governor's staff to reflect the governor's suggested reform and is circulated in hopes of attracting a legislative sponsor. *See also Carey is Seeking Major Changes on Malpractice*, N.Y. Times, April 7, 1982, at B1, col. 6.

73. Section 710 of the proposed bill provided for reimbursement to medical malpractice insurance carriers of 90% of awards between \$250,000 and \$1 million from a health insurance supported fund.

74. The fund would have provided for direct payment into the fund by most health insurers on a percentage basis. This funding method is unique to patient compensation funds established in other states, which require payments by health care providers. *See Schrero, Patient Compensation Funds: Legislative Responses to the Medical Malpractice Crisis*, 5 AM. J. OF L. & MED. 175, 178-79 (1979).

75. *See* N.Y. Times, April 7, 1982, at B1, col. 6. Dr. Jeffrey Sachs, health advisor to Gov. Carey, was quoted as saying: "[T]he consumer pays no matter what." *Id.*

76. Memorandum accompanying Program Bill No. 387/82, at 5.

77. Program Bill, *supra* note 72, § 710.

78. The governor's staff confirmed the practice of passing on the cost of medical malpractice insurance premiums to patients in the form of increased medical fees. Data gathered in preparation of the bill showed that increases in premium rates directly resulted in medical fee increases. In some cases, the percentage of the premium increase was reported to patients as the reason for identical percentage fee increases. But the actual dollar increase paid by the physician was actually a smaller component of his total costs. The existence of the "pass-along" was the major impetus for the drafting of the bill. Telephone interview with Kevin McAnaney, Ass't Counsel to Gov. Carey (Oct. 1, 1982) [hereinafter cited as McAnaney interview]. These findings were embodied in the bill:

1. The escalation of medical malpractice premium rates constitutes a critical threat to the health care delivery system in this state.
2. The availability of medical malpractice insurance coverage at affordable rates is essential to assure that patients are properly compensated for injuries caused by medical malpractice.
3. In order to assure that injured patients are properly compensated and to maintain the integrity of the state's health care delivery system, which is affected with the public purpose of providing quality treatment to the citizens of this state, it is necessary that health care insurers

the "pass-along" was addressed by establishing a standard rate of payment into the fund by health insurance carriers<sup>79</sup> and then requiring these carriers to monitor the medical fees they reimburse for any unjustified increase.<sup>80</sup> Thus, a major portion of the state's malpractice payment, evidenced by uneven rates and borne by health-care consumers and their insurance carriers, would be paid more "precisely"<sup>81</sup> and evenly by those who pay medical fees. Opponents of the bill<sup>82</sup> argued that the pass-along of premiums might not be routine.<sup>83</sup> The bill's ultimate demise resulted from opposition to patients being forced to pay for the negligence of physicians.<sup>84</sup>

If the public policy adopted *sub rosa* by the failure of the Carey administration bill is that the tortfeasor should continue to pay for his negligent acts, then it is useful to ask: Is the tortfeasor paying for his negligence under the present system? If a patient compensation fund should not be used to pay for negligently caused injuries, might it then

and self-insurers assume a portion of the costs of medical malpractice insurance directly rather than indirectly.

4. The risk of medical liability and the costs of medical malpractice are, in significant part, a component of the aggregate cost of our health care delivery system. Such costs are currently borne by the public in the form of higher hospital and medical fees and increases in health insurance premiums which do not precisely reflect increases in medical malpractice insurance rates.

Program Bill, *supra* note 72, § 702, Statement of Legislative Findings and Declaration. The bill never attracted a sponsor and thus never generated a formal legislative bill number. McAnaney interview, *supra*.

79. Program Bill, *supra* note 72, § 706.

80. *Id.* §§ 702.5, 711.1.

81. *Id.* § 702.4.

82. Lobbyists for unions and businesses which pay for the bulk of health insurance premiums in the state applied pressure in the legislature which defeated the bill. Major health carriers also told legislative leaders they did not believe that malpractice insurance premiums were being routinely passed on to patients as a hidden cost of medical care. Telephone interview with legislative aide, July 10, 1982 (anonymous by request). Several commentators also attacked the bill and its theoretical basis. See *Multi-fault Plan for Malpractice*, Rochester Times-Union, May 6, 1982, at 12A, col. 1; Law, *supra* note 14.

83. Law, *supra* note 14. But the practice has been documented in other studies. See Roddis & Stewart, *The Insurance of Medical Losses*, in MEDICAL MALPRACTICE, *supra* note 12, at 109-10; Schwartz & Komesar, *supra* note 31.

84. One legislative aide stated the argument this way: "Many people objected to the idea of the victim paying for the tort." Telephone interview with legislative aide, July 10, 1982 (anonymous by request). See also Law, *supra* note 14, at 42 ("It makes no sense to devote substantial resources to the determination of fault, and then to allow the financial consequences of these proven wrongs to be shifted directly to the patients and the public."). *Id.*



be used to solve the nagging issue of paying for those who cannot prove negligence?<sup>85</sup>

### C. The 1983 Proposal

During the 1983 legislative session, a new reform proposal was introduced<sup>86</sup> which adds several procedural steps for malpractice litigants<sup>87</sup> and limits awards for non-economic losses to \$100,000.<sup>88</sup> In addition, it calls for an amendment to the New York State Constitution which would enable the legislature to provide for an alternative forum for adjudication of malpractice claims.<sup>89</sup> The proposal, which is now being studied by the Committees on Health and Insurance, has been attacked as "immuniz[ing] the medical profession from responsibility for tortious acts" and "a thinly veiled attempt to wipe out malpractice actions."<sup>90</sup> The proposal, however, does recognize the continued upward spiral of malpractice awards and their adverse impact on health care costs.<sup>91</sup> But because it continues to provide for a

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85. See Special Advisory Panel, *supra* note 53, at 177. This panel report, never adopted by the legislature, briefly discussed the idea of devising some system of compensating victims of "adverse outcomes," but did not suggest specifically how the system should work or how it should be funded. *Id.*

86. S.2122, A.2497 (1983), was introduced on Feb. 1 by State Sen. Tarky Lombardi, Jr. and several co-sponsors.

87. The principal features of the proposal are: a requirement that the plaintiff post a bond to cover defendant's costs at trial if the plaintiff decides to proceed after a finding of no liability by the medical malpractice screening panel. S.2122, A.2497 § 5 (1983) (although a waiver is allowed for certain indigents), *id.*; reduction of attorneys contingent fees, *id.* § 6; requirement that qualified experts certify the meritousness of claims when they are filed, *id.* § 8; and sets additional requirements for the pedigree of expert witnesses, *id.* In addition, the proposal sets up a system of regional offices of professional conduct. *Id.* § 1.

88. Damages for compensation of pain and suffering are limited to \$100,000. *Id.* § 9.

89. S.Res. 2121 (1983) proposes a constitutional amendment which would authorize the legislature to establish alternative methods of adjudication of medical malpractice claims, "with or without trial by jury."

90. N.Y.L.J., Feb. 21, 1983, at 1, col. 1.

91. Introductory Memorandum accompanying S.2122-83 (Statement in Support):

The size of medical malpractice insurance premiums has risen dramatically since the medical liability crisis of 1975 when the commercial insurance industry ceased writing this type of coverage. Malpractice premiums have more than doubled in the intervening seven years as a result of dramatic increases in the frequency of medical liability suits and the severity of the awards granted by juries [sic] in such suits . . . . The bill's provisions will assure the continued availability of high quality medical care to all New Yorkers and will positively impact our overall effort to control rapidly escalating health care costs.

uniformity in treatment of all physicians and all patients, it fails to bring an adequate "deterrence signal"<sup>92</sup> into the system. It also fails to address the problems of those who are adversely injured but are unable to prove negligence.<sup>93</sup> Moreover, the bill places severe procedural and remedial burdens on all injured parties, even those who may be the victims of the worst kinds of malpractice.

#### IV. Compensation for Medical Victims: A Proposed Modification

##### A. Malpractice Reformers

Since the difficulties in the current system of compensating malpractice victims became apparent more than a decade ago,<sup>94</sup> several commentators have forwarded detailed proposals for reform. In general, most of these proposals seek to change the orientation of the adjudicatory process. Instead of asking if negligence occurred and who was at fault, the proposals focus on whether the injury occurred and how much compensation should be offered. The proposals emphasize the goal of providing a quick, but moderate, measure of compensation instead of forcing victims to engage in the difficult procedure of litigating the fault of the physician. In this respect, such schemes closely resemble the rationale for establishment of the worker's compensation system.<sup>95</sup>

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92. See notes 37-42 *supra* and accompanying text.

93. See note 12 *supra* and accompanying text & notes 94-104 *infra* and accompanying text.

94. Best known in this area are the works of Professors Havighurst, Keeton, O'Connell and Tancredi. See generally Havighurst, *supra* note 38; Havighurst and Tancredi, *supra* note 12; Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590 (1972-73); O'Connell, *Expanding No-Fault Beyond Auto Insurance: Some Proposals*, 59 VA. L. REV. 749 (1973).

95. In examining the needs for a non-judicial system of compensating workplace injuries, the Supreme Court noted:

[I]n the highly organized and hazardous industries of the present day the causes of accident are often so obscure and complex that in a material proportion of cases it is impossible by any method correctly to ascertain the facts necessary to form an accurate judgment, and in a still larger proportion the expense and delay required for such ascertainment amount in effect to a defeat of justice; that, under the present system, the injured workman is left to bear the greater part of industrial accident loss, which because of his limited income, he is unable to sustain, so that he and those dependent upon him are overcome by poverty and frequently become a burden upon public or private charity; and that litigation is unduly costly and tedious, encouraging corrupt practices and arousing antagonisms between employers and employees.

N.Y. Central R.R. Co. v. White, 243 U.S. 188, 197 (1917).

As an example, the proposal for "Medical Adversity Insurance" (MAI)<sup>96</sup> suggests an extra-judicial (but legislatively mandatory) system of insurance compensation of any medical "result" which appears on a pre-selected list.<sup>97</sup> These results, or adverse outcomes, would include the products of ordinary negligence as well as non-negligent but iatrogenic<sup>98</sup> injuries.<sup>99</sup> Left to judicial consideration are only cases of "failure to obtain informed consent, abandonment of the patient, gross negligence, intentional misconduct, and illegal behavior."<sup>100</sup> As a practical matter, the system sought to emulate the "no-fault" insurance concept by "dispensing with the expensive process of assigning blame in each case."<sup>101</sup> But it parts company with the traditional no-fault scheme by "retain[ing] an element of [health care] provider responsibility for adverse outcomes as a means of maintaining desirable incentives"<sup>102</sup> through the use of an "experience rating"<sup>103</sup> on the provider's adversity insurance premiums. Thus, the scheme sought to compensate all injuries on a pre-selected list—without any direct assignment of blame. Those within the plan include the patients who were unavoidably injured, as well as those who could prove malpractice.

Perhaps the most significant element of the MAI proposal lies in its recognition that many patients injured as they pass through the health care system are not compensated for their losses. Among the uncompensated are those patients whose injuries were *not caused by* negligence or who *could not prove* negligence.<sup>104</sup> It is clear that any system

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96. See Havighurst & Tancredi, *supra* note 12.

97. "Compensable events" included such injuries as foreign bodies or burns acquired during surgery, perforation of the uterus during dilation and curettage, or bacterial sepsis following a blood transfusion. Havighurst, *supra* note 38, at 79-81.

98. Iatrogenic injuries are those "[d]enoting an unfavorable response to therapy, induced by the therapeutic effort itself." *STEDMAN'S MEDICAL DICTIONARY* 688 (illus. 24th ed. 1982).

99. Havighurst & Tancredi, *supra* note 12, at 75-77.

100. *Id.* at 76.

101. *Id.* at 70.

102. *Id.*

103. *Id.* at 72.

104. For examples of New York cases in which patients sustained severe injuries but were unable to prove negligence and thus received no compensation, see *De Falco v. Long Island College Hosp.*, 90 Misc. 2d 164, 393 N.Y.S.2d 859 (Sup. Ct. Kings County 1977). In *De Falco*, a patient underwent cataract surgery and developed a drop of blood and an infection in his eye, which necessitated its removal. The patient was unable to prove negligence by either surgeon or hospital despite testimony that a nurse had retrieved an eye patch from the floor and placed it over the patient's eye. The court said this act "bespeaks improper treatment and malpractice" but declined to find liability against defendants in the absence of expert testimony proving that germs from the floor had caused the infection. *Id.* at 167, 393 N.Y.S.2d

which broadens its definitions to include such persons would allow a greater number of injured persons to gain compensation.<sup>105</sup> An expansive definition of patients who suffer "adverse injury" might encompass patients who would otherwise have obtained large awards—whether due to jury confusion or sympathy for the plaintiff if the matter had gone to trial.<sup>106</sup>

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at 862; *see also* *Henry v. Bronx Lebanon Medical Center*, 53 A.D.2d 476, 385 N.Y.S.2d 772 (1st Dep't 1976). In *Henry*, a child was delivered with fractures of the skull and collarbone, and injuries to the upper and lower arm despite a lack of physical abnormalities in the mother which might have precluded a normal birth. The delivery was complicated by the unusual position of the child prior to delivery which required the use of forceps to complete the delivery. The court found that the use of forceps, the method of application and the failure to choose an additional x-ray test or perform a surgical delivery did not constitute malpractice. *Id.* at 480-81, 385 N.Y.S.2d at 775. "Presence of an injury does not mean that there is negligence," the court said. *Id.* at 480, 385 N.Y.S.2d at 775. *See also* *Charlton v. Montefiore Hosp.*, 45 Misc. 2d 153, 256 N.Y.S.2d 219 (Sup. Ct. Queens County 1965). In *Charlton*, a patient who underwent surgery for removal of a growth on her left eye emerged from surgery with a drooping eyelid, possibly the result of an injection of anesthesia there. "Before there can be a recovery here," the court said, "it is necessary for plaintiff to establish that there has been a deviation from the proper surgical and operative methods. In a case like this, the mere fact of an unexpected result does not give rise to the presumption of negligence, and to permit a trier of fact to indulge in such an inference would in reality permit speculation as to the basic cause of the injury." *Id.* at 156-57, 256 N.Y.S.2d at 223.

105. *Havighurst & Tancredi*, *supra* note 12, at 89.

106. The difficulty some courts have in separating underlying physical condition from malpractice or in placing the blame for an injury on a physician in a close case is as often resolved in favor of the patient as it is against him. *See* note 104 *supra*. The problem was stated succinctly in *Monahan v. Weichert*, 82 A.D.2d 102, 442 N.Y.S.2d 295 (4th Dep't 1981), in which a patient suffering from severe rheumatoid arthritis of the knee joints underwent surgery for knee joint replacement which resulted in the loss of mobility of the joints. The court noted: "In this medical malpractice case we consider primarily the problem of distinguishing the effect of [defendant's] alleged negligence from the natural results of [plaintiff's] disease. . . ." *Id.* at 103, 442 N.Y.S.2d at 296. "Here we are concerned with the operation of two independent forces, one being the course of plaintiff's illness. To establish a prima facie case plaintiff need not eliminate entirely all possibility that defendant's conduct was not a cause, but only offer sufficient evidence from which reasonable men may conclude that it is more probable that the injury was caused by the defendant than that it was not." *Id.* at 108, 442 N.Y.S.2d at 299. *See also* *Spadaccini v. Dolan*, 63 A.D.2d 110, 407 N.Y.S.2d 840 (1st Dep't 1978). In *Spadaccini*, the plaintiff, who underwent surgery to relieve a severe infection in his chin and mouth, suddenly turned blue and began choking in the post-operative period. *Id.* at 113-15, 442 N.Y.S.2d at 842-43. This choking caused a lack of oxygen which in turn resulted in brain damage and eventual death. *Id.* at 115, 407 N.Y.S.2d at 843. The plaintiff alleged negligence in an alleged 15-minute delay in providing ameliorative treatment to him. *Id.* The defendants contended that the brain damage was irreversible after one minute and failure to perform a tracheotomy as a preventative measure immediately after surgery was a mere error in judgment. *Id.* The court dismissed this contention. *Id.*

The MAI concept suffers from an unduly narrow list of compensable injuries; resolution of the question of whether a given injury falls within a category of "adverse injury" as set forth by MAI would be by a bureaucratic determination. Moreover, MAI swallows up the concept of ordinary negligence and its usefulness as a deterrent. Tort litigation and injury compensation need not be warring concepts. Elements of both could, and should, be retained in a dual system of compensation.

### B. The Proposal

An alternative approach would allow the jury to reach one of three possible verdicts: no injury, adverse injury or medical malpractice. The middle-level adverse injury verdict would be available to those unable to show negligence. The size of the award would be restricted by limiting damages awarded for such non-economic losses as "pain and suffering."<sup>107</sup>

As the adverse injury plaintiff might be said to have suffered only the inherent risk of the treatment he had undergone, a logical source for the funds to satisfy such restricted awards would be a surcharge on health insurance premiums, as was contemplated in the Carey proposal.<sup>108</sup> Use of the fund would be restricted to non-negligently injured patients. By contrast, a fund drawn from the contributions of patients to satisfy awards arising from medical malpractice is less desirable.<sup>109</sup>

A finding of medical malpractice with a full range of damages would still be available to the jury in a proper case. Such damages would be assessed against the physician/tortfeasor and ultimately his medical malpractice insurance carrier. The inherent deterrence value in a verdict of negligence would have greater impact as such verdicts would become less frequent. The malpractice award would then be closely tied to the negligent physician and his colleagues through a

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The difficulty juries often have with reaching a fair verdict in a malpractice case is illustrated by those cases in which courts have been forced to reduce awards as "excessive" or "grossly excessive." See, e.g., *Burton v. Brooklyn Doctors Hosp.*, 88 A.D.2d 217, 452 N.Y.S.2d 875 (1st Dep't 1982); *Ramsey v. Jewish Hosp.*, 67 A.D.2d 680, 412 N.Y.S.2d 173 (2d Dep't 1979); *Roman v. Bronx Lebanon Hosp.*, 51 A.D.2d 529, 379 N.Y.S.2d 81 (1st Dep't 1976).

107. *Havighurst & Tancredi*, *supra* note 12, at 101; Special Advisory Panel, *supra* note 53, at 180.

108. See notes 72-85 *supra* and accompanying text.

109. Legislative opponents of the fund successfully used this point to defeat the concept. See notes 72-85 *supra* and accompanying text.

system of *mandatory* premium adjustments based on the risk he actually presents to his insurance carrier.<sup>110</sup> This risk would be predicated on previous malpractice awards against the physician. This type of system has been suggested as the most appropriate method of passing a deterrence signal<sup>111</sup> back to actual and potential tortfeasors.<sup>112</sup> Moreover, individualized premiums would be more difficult to pass back to patients in the form of increased fees.<sup>113</sup>

## V. Constitutional Issues

Attempts to limit monetary recovery generate strong constitutional challenges. Challenges to such reforms would most probably involve the equal protection and due process clauses of the fourteenth amendment. The Supreme Court, however, has noted that "statutes limiting liability are relatively commonplace and have consistently been enforced by the courts."<sup>114</sup> Indeed, statutes which limit recovery by injured parties have created a system of worker's compensation,<sup>115</sup> limited the liability of operators of nuclear power plants,<sup>116</sup> upheld international agreements which limit recovery for injuries suffered during international air travel,<sup>117</sup> provided special benefits for victims

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110. Under an experience rating, the insured party would have his future premiums mandatorily assessed based upon the individual risk he now presents to the insurer. Under a retroactive premium adjustment, he would be contractually bound to pay an adjustment on his previous premium rate for the year of the occurrence. For a brief description of how this would be adapted to medical liability insurance, see Roddis & Stewart, *supra* note 83, at 128-29. One study of 8000 physicians in Los Angeles over a four-year period showed that .6% (46 physicians) accounted for 10% of all claims and 30% of all awards paid under an insurance plan. Schwartz & Komesar, *supra* note 31, at 1289 n.32 (citing Phelps, Experience Rating in Medical Malpractice Insurance (Rand Corp. 1977)).

111. Schwartz & Komesar, *supra* note 31, at 1284-85.

112. See *id.* at 1287, Phelps, *supra* note 110.

113. A physician who alone in his area received a sharp premium increase and passed this increase in fees would then be charging rates disproportionate to his colleagues and not within the health insurance reimbursement rates.

114. *Duke Power Co. v. Carolina Env'tl. Study Group*, 438 U.S. 59, 88 n.32 (1978).

115. *N.Y. Central R.R. v. White*, 243 U.S. 188 (1917) (upheld compensation payment to widow of railroad night watchman killed while on duty); *Mountain Timber Co. v. Washington*, 243 U.S. 219 (1917) (logging company required to contribute to workman's compensation fund).

116. *Duke*, 438 U.S. 59 (1978) (limited liability from accidents at private nuclear power plants to \$560 million in an indemnification fund).

117. *Indemnity Ins. Co. of N. Am. v. Pan Am. Airways*, 58 F. Supp. 338 (S.D.N.Y. 1944) (limited liability of international airplane travelers to limits established under the Warsaw Convention). Cf. *Franklin Mint v. TWA*, 690 F.2d 303 (2d Cir. 1982) (held unenforceable cargo liability limitation in the United States).

of "black lung disease,"<sup>118</sup> and limited the recovery of certain auto accident victims under no-fault insurance.<sup>119</sup>

### A. Equal Protection Challenges

Legislative efforts in the 1970's to insure the availability of malpractice insurance by altering the litigation and compensation of malpractice claims invariably met with constitutional challenges. Such measures were viewed as interfering with patients' equal protection rights.<sup>120</sup> State courts construing these statutes failed to agree on their constitutionality.<sup>121</sup> Much of this disagreement, it has been suggested, evolved from judicial uncertainty over which equal protection standard should be applied.<sup>122</sup>

Under the minimal "rational basis" test, medical malpractice legislation gained easy judicial approval.<sup>123</sup> Equal protection challenges to new malpractice legislation, at least in New York, would likely follow the "rational basis"<sup>124</sup> analysis used by the New York Appellate Divi-

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118. 30 U.S.C. § 901 (1976).

119. *Montgomery v. Daniels*, 38 N.Y.2d 41, 340 N.E.2d 444, 378 N.Y.S.2d 1 (1975) (upheld application of state no-fault insurance law in case involving automobile accident).

120. Victims of medical malpractice have argued that the creation of such devices as pre-trial screening panels, stringent statutes of limitation, or absolute limits on awards amounted to impermissible discrimination based solely on their status as patients. See generally M. REDISH, *LEGISLATIVE RESPONSE TO THE MEDICAL MALPRACTICE CRISIS: CONSTITUTIONAL IMPLICATIONS* (Am. Hosp. Ass'n 1977); Harper, *Which Equal Protection Standard for Medical Malpractice Legislation?*, 8 HASTINGS CONST. L.Q. 125; White & McKenna, *Constitutionality of Recent Malpractice Legislation*, 13 FORUM 312 (1977-78). For a recent example see also *Fein v. Permanente Medical Group*, 121 Cal. App. 3d 135, 148, 175 Cal. Rptr. 177, 183-84 (Ct. App. 1981).

121. Harper, *supra* note 120, at 126.

122. M. REDISH, *supra* note 120, at 20-21. Under the traditional two-tiered approach, the right of a potential plaintiff to sue was not deemed fundamental, thus allowing a state to impinge on this right on a showing of a rational relationship of the measure to a valid state goal. L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 16-2 (1973). However, the two-tiered approach was thought to have been supplemented by a "means scrutiny" test which required examination of the methods asserted by the state in attaining its goals. "[U]nder the means scrutiny test the courts would probably ask: 1) Is there in fact such a crisis? 2) If there is, will the legislation in question substantially tend to alleviate the problem?" M. REDISH, *supra* note 120, at 21 n.78. For an example of one state court's use of this test, see *Jones v. State Bd. of Medicine*, 97 Idaho 859, 555 P.2d 399, (1976), *cert. denied*, 431 U.S. 914 (1977).

123. M. REDISH, *supra* note 120, at 18. The strict scrutiny test is historically reserved for statutes which limit either a fundamental right or a right enjoyed by a "suspect class," L. TRIBE, *supra* note 120, at § 16-6. But the Supreme Court appeared, for a brief time, to be evolving a middle level "means scrutiny" test. The court has since abandoned this test. M. REDISH, *supra* note 120, at 23-25.

124. "In the area of economics and social welfare, a state does not violate the Equal Protection Clause merely because the classification made by its laws are

sion in *Comiskey v. Arlen*.<sup>125</sup> In *Comiskey*, the court upheld the admissibility at trial of the findings of the state's medical malpractice screening panels.<sup>126</sup> The panels had been established by statute.<sup>127</sup>

The effect of the court's ruling, which rested on the reasoning of the New York Court of Appeals in upholding the New York "no-fault" automobile insurance statute,<sup>128</sup> was to give the legislature broad powers to legislate in the event of increasing medical malpractice insurance rates.<sup>129</sup> The court stated that the pre-trial screening panels did not deny fundamental access to the courts.<sup>130</sup> Rather, the panels bore a rational relationship to the "urgent necessity to find a reasonable procedure for dealing with the crisis situation of increasing medical malpractice insurance rates."<sup>131</sup>

Attempts to limit recovery by malpractice plaintiffs also have had a checkered history. The malpractice insurance statutes which included this feature in the 1970's at first fared poorly in the era of the state courts' equal protection uncertainty.<sup>132</sup>

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imperfect. If the classification has some 'reasonable basis' it does not offend the Constitution simply because the classification 'is not made with mathematical nicety or because in practice it results in some inequity.'" *Comiskey v. Arlen*, 55 A.D.2d 304, 314, 390 N.Y.S.2d 122, 129 (2d Dep't 1976) (quoting *Dandridge v. Williams*, 397 U.S. 371, 485 (1970)).

125. 55 A.D.2d 304, 390 N.Y.S.2d 122 (2d Dep't 1976).

126. *Id.* at 306, 390 N.Y.S.2d at 124.

127. The screening panels were established under N.Y. JUD. LAW § 148-a.1 (McKinney Supp. 1982-1983). See note 43 *supra*.

128. "More importantly, a finding of unconstitutionality herein is precluded by the decision of our Court of Appeals in *Montgomery v. Daniels*. . . ." *Comiskey v. Arlen*, 55 A.D.2d 304, 307, 390 N.Y.S.2d 122, 125 (2d Dep't 1976) (citing *Montgomery v. Daniels*, 38 N.Y.2d 41, 340 N.E.2d 444 (1975)).

129. *Id.* at 304, 314, 390 N.Y.S.2d 122, 129-30 (2d Dep't 1976).

130. *Comiskey v. Arlen*, 55 A.D.2d at 315, 390 N.Y.S.2d 122, 130 (2d Dep't 1976).

131. *Id.* at 129-30, 390 N.Y.S.2d at 314.

132. In *Pendegast v. Nelson*, 199 Neb. 97, 256 N.W.2d 657 (1977), the Nebraska Supreme Court applied a "rational basis" test and cited *Dandridge v. Williams*, 397 U.S. 471, 485 (1970) for the proposition that legislatures should be given broad discretion in matters of economics and social welfare. 199 Neb. at 113, 256 N.W.2d at 668. In *Wright v. Central DuPage Hosp. Ass'n*, 63 Ill. 2d 313, 329-30, 347 N.E.2d 736, 743 (1976), the Illinois Supreme Court did not deal with federal constitutional principles and instead overturned a \$500,000 recovery limitation statute, ILL. REV. STAT. ch. 70, § 101 (1975), based upon the Illinois Constitution. In *Jones v. State Bd. of Medicine*, 97 Idaho 859, 555 P.2d 399 (1976), the Idaho Supreme Court refused to decide the merits of a similar statute, IDAHO CODE § 39-4201 (1975), chose the "means scrutiny test" as the appropriate test, and remanded the matter for further findings. 97 Idaho 859, 871, 555 P.2d 399, 411 (1976).



In a more recent case, *Fein v. Permanente Medical Group*,<sup>133</sup> the California Court of Appeals held that only the two-tier approach is now available and that the limited recovery statute at issue, involving neither a suspect classification nor a fundamental interest, should be analyzed by the rational basis test.<sup>134</sup> The *Fein* court did not use any specific Supreme Court decision to support its use of the "rational basis" test as the correct analytical tool and relied solely on California case law.<sup>135</sup> Another appellate court decision, however,<sup>136</sup> relied upon the Supreme Court's holding in *Duke Power Co. v. Carolina Environmental Study Group, Inc.*<sup>137</sup> in determining that standards of rationality<sup>138</sup> are to be used in analyzing constitutional challenges to state medical malpractice legislation.<sup>139</sup>

*Duke* concerned a challenge to the Price-Anderson Act,<sup>140</sup> which limited the liability of power companies from a nuclear accident to an aggregate of \$560 million.<sup>141</sup> Congress enacted the limitation on the theory that the "potentially vast liability in the event of a nuclear accident"<sup>142</sup> could not be absorbed by the nuclear energy industry and private insurance carriers; thus it was an obstacle to the development of this new source of energy.<sup>143</sup>

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133. *Fein v. Permanente Medical Group*, 121 Cal. App. 3d 135, 175 Cal. Rptr. 177 (Ct. App. 1981). In *Fein*, the plaintiff had challenged the California Medical Injury Compensation Reform Act, CAL. CIV. CODE § 3333.2 (West Supp. 1982-1983) Supp.), which provided, in part, that recovery for non-economic losses be limited to \$250,000. Plaintiff, an attorney employed by the California legislature, had won \$500,000 at trial for losses resulting from the failure of defendants to test for and prevent a debilitating heart attack he suffered after complaining of symptoms during three emergency room visits for a week prior to the attack. 121 Cal. App. 3d at 143-46, 175 Cal. Rptr. at 181-82. The court in *Fein* found that the "significantly increasing numbers of suits . . . increasing settlements and awards . . . projected losses related to malpractice insurances . . . decreased number of companies willing to provide malpractice insurance and skyrocketing costs of such insurance" provided a sufficient basis for the legislature's choice and thus was not arbitrary. 121 Cal. App. 3d at 151, 175 Cal. Rptr. at 186.

134. 121 Cal. App. 3d at 149, 175 Cal. Rptr. at 184.

135. 121 Cal. App. 3d at 149-50, 175 Cal. Rptr. at 184-85.

136. *Barme v. Wood*, 122 Cal. App. 3d 395, 176 Cal. Rptr. 42 (1981). In *Barme*, the plaintiff in intervention challenged a companion section of the Medical Injury Compensation Reform Act, CAL. CIV. CODE § 3333.1, (West Supp. 1982-1983), which barred recovery of funds by collateral sources from the tortfeasor.

137. 438 U.S. 59 (1978).

138. *Id.* at 93-94.

139. *Barme v. Wood*, 122 Cal. App. 3d 395, at 399, 176 Cal. Rptr. 42, at 47-48.

140. 71 Stat. 576, 42 U.S.C. § 2210 (1976 & Supp. V 1981).

141. *Id.*

142. *Duke*, 438 U.S. at 64.

143. *Id.* "As we read the Act and its Legislative history, it is clear that Congress' purpose was to remove the economic impediments in order to stimulate the private

The *Duke* court dismissed the appellees' claim that an equal protection violation ensued from setting up different legal treatment for victims of nuclear accidents, as compared to those injured by other causes.<sup>144</sup> The Court applied a standard of "rationality" and found that "the important congressional purpose of encouraging private participation in the exploitation of nuclear energy . . . is ample justification"<sup>145</sup> for setting up the special treatment. The *Duke* decision is indicative of the judicial support for statutes which "rationally" impose on jury awards in malpractice cases.

## B. Due Process Challenges

The due process right to sue under a particular legal theory and win damages is generally held to be subject to legislative change.<sup>146</sup> But the standard for substituting a common law remedy was not discussed until the 1917 decision in *N.Y. Central R.R. Co. v. White*<sup>147</sup> upholding the New York workmen's compensation statute. The language in *White* suggests, but does not require, the standard of a "reasonable substitute"<sup>148</sup> for replacement by a legislatively enacted compensation scheme. Sixty-two years later, the Supreme Court, in *Duke*, declined to resolve the issue of what force should be given this language.<sup>149</sup>

The *Duke* decision provides new strong support for legislative enactments which limit the liability of injured persons in deference to a

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development of electric energy by nuclear power while simultaneously providing the public compensation in the event of a catastrophic nuclear incident." *Id.* at 83.

144. *Id.* at 93-94.

145. *Id.* at 93.

146. This derives from the rule stated in *Munn v. Illinois*, 94 U.S. 113, 134 (1876):

A person has no property, no vested interest, in any rule of the common law. . . . Rights of property which have been created by the common law cannot be taken away without due process; but the law itself, as a rule of conduct, may be changed at the will, or even the whim, of the legislature, unless prevented by constitutional limitations.

147. 243 U.S. 188 (1917).

148. *Id.*

Nor is it necessary, for the purposes of the present case, to say that a state might, without violence to the constitutional guaranty of "due process of law," suddenly set aside all common-law rules respecting liability as between employer and employee, without providing a reasonably just substitute. . . . No such question is here presented, and we intimate no opinion upon it.

*Id.* at 201.

149. *Duke*, 438 U.S. at 88.

broader societal goal<sup>150</sup>—only if the substitution is “reasonably just.”<sup>151</sup> In setting this standard of review, the court said that the liability-limitation provision thus emerges as “a classic example of an economic regulation”<sup>152</sup> which “‘come[s] to the Court with a presumption of constitutionality, and that the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way.’”<sup>153</sup>

Appellees in *Duke* rested their due process claims on three arguments: first, “[t]he amount of recovery is not rationally related to the potential losses”; second, because “[t]he Act tends to encourage irresponsibility in matters of safety and environmental protection . . .” and finally because “[t]here is no *quid pro quo*’ for the liability limitations.”<sup>154</sup> The Court found the monetary figure within permissible limits<sup>155</sup> and noted that safety requirements were covered adequately in the federal licensing procedures.<sup>156</sup>

In deciding the *quid pro quo* issue, the Court cast its answer in the context of the *White* decision upholding worker’s compensation statutes:<sup>157</sup> that a “panoply of remedies and guarantees is at the least a reasonably just substitute for the common-law rights replaced by the

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The record before us fully supports the need for the imposition of a statutory limit on liability to encourage private industry participation and hence bears a rational relationship to Congress’ concern for stimulating the involvement of private enterprise in the production of electric energy through the use of atomic power. . . .

*Id.* at 84.

151. *Id.* at 88. For a discussion of the view that medical malpractice compensation schemes fail the “reasonably just substitute” test where applied to victims of negligence, see Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional “Quid Pro Quo” Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981). Learner considers the reasoning in *Duke* inapplicable to uphold limited liability of medical tortfeasors on the assumption that medical negligence might be preventable and that a private tort action forms the only method of deterring irresponsible conduct, *id.* at 179-80, whereas other factors are available which deter nuclear accidents, automobile accidents and workplace accidents. *Id.* at 181. However, this Note proceeds from the premise that many medical accidents are unavoidable, see notes 22-25 *supra* and accompanying text, and that private tort actions are, in the present system, an inadequate method of deterring tortfeasors. See notes 37-42 *supra* and accompanying text.

152. *Duke*, 438 U.S. at 83.

153. *Id.* (citing *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976)).

154. *Duke*, 438 U.S. at 82 (citing *Carolina Env’tl. Study Group v. U.S. Atomic Energy Comm’n*, 431 F. Supp. 203 (W.D.N.C. 1977)).

155. *Duke*, 438 U.S. at 87.

156. *Id.*

157. *Id.* at 92-93.

. . . [a]ct. Nothing more is required by the Due Process Clause."<sup>158</sup> The Court noted that under the worker's compensation program an injured worker is "entitled to moderate compensation in all cases of injury, and has a certain and speedy remedy without the difficulty and expense of establishing negligence or proving the amount of the damages."<sup>159</sup> These factors were analagous to the compensation scheme under the Price-Anderson Act.<sup>160</sup> Again, *Duke* evidences judicial support for the statutes restricting malpractice awards.

## VI. Conclusion

The litigation process involving those injured during medical treatment presents inequities for injured patients, physicians and health care consumers. Many patients recover disproportionately large awards. Others, unable to prove negligence, receive no compensation or are unable to enter the system at all. In addition, physicians have become insulated from the deterrence value of tort awards, as all share equally for the negligence of a few. Consumers pay high fees reflecting increasing insurance premiums. New York's first attempts at reforming this system amounted to ineffectual tinkering. The cost spiral and inherent inequities appear to be endemic. Further attempts to eliminate these inequities must address the problems of all groups if any measure of success is to be made.

Reforms in the present tort/litigation/insurance system are necessary. Any changes must contain these components: A mechanism for compensating all injured victims; a new source of funding such compensation; an effective means of deterring actual and potential tortfeasors; and a flexible method of separating negligent injuries from adverse medical results.

A patient compensation fund, evenly funded through all health insurance premiums, is the logical mechanism for compensating adverse results. It would provide a moderate level of compensation without requiring proof of negligence. However, the right to prove malpractice and win regular damages would still be made available in a proper case. As society still has a vital interest in deterring tort-

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158. *Id.* at 93. For a discussion of the ensuing confusion over whether the court in *White* had required a quid pro quo, see M. REDISH, *supra* note 120, at 39.

159. *Duke*, 438 U.S. at 93, (citing *N.Y. Central R.R. Co. v. White*, 243 U.S. 188, 201).

160. *Id.*

feasors, these damage awards should result in mandatory insurance surcharges.

Society needs to compensate injured persons and to deter tortfeasors. Under this system, the burden of all injuries would fall precisely on those who could, and should, pay for them.

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