Physicians have identified malpractice reform as their first priority during the recent flurry of national reform initiatives. Their focus on malpractice, however, tends to obscure the relationship between malpractice and the systemic problems wrecking our healthcare delivery system. Because malpractice has an impact on all three foci of comprehensive reform—quality, cost, and access—it is reasonable to expect healthcare reform to include some manner of tort reform. However, it is important to realize the tangential nature of the relationship and keep the focus of reform on the underlying issues of system reform. The authors define the areas of physician liability under tort law (both malpractice and product liability), point out the misperceptions that inform physician behavior, and review the individual reforms proposed. They identify the stakeholders and their positions on each proposal, while imploring a cooperative, systemwide approach to tort reform.

(Key words: Tort reform, medical liability, product liability, healthcare reform, malpractice)

Meaningful malpractice reform surfaced as the number 1 issue for many physicians as they awaited federal action on healthcare reform, and the reasons for their concern are readily evident. A quick review of some of the exorbitant jury verdicts awarded in medical-malpractice cases in Ohio adequately sets the scene. A $12.35 million verdict was awarded in March 1994, to a 36-year-old man, now paralyzed below the chest, whose physician failed to diagnose a spinal abscess in 1988. In Hiltz v Cincinnati Children's Hospital et al, a $17.05 million verdict—Ohio's largest malpractice verdict to date—was awarded in 1992 for a 9-year-old boy who was partially paralyzed in 1987 after suffering brain damage during a hospital stay for an infection. In 1991, Stelma v Jugullon, MD, Berman MD, and Parma Community General Hospital resulted in a $10.72 million verdict for a 36-year-old who suffered quadriplegia after undergoing in 1986 a test for which dye was injected into an artery.

Reversing a 2-year decline, the median malpractice award for 1993 reached the neighborhood of $500,000, raising it nearly $150,000 from the 1992 level of $350,000. The frequency with which malpractice awards topped $1 million was also on the rise. Malpractice data not only illustrate the increasing general litigiousness of the American public, but also specifically document the explosion of medical malpractice claims in the American legal system. According to data from St Paul Fire & Marine Insurance Co, which insures nearly 50,000 physicians nationwide, the frequency of medical malpractice claims against physicians continues to rise also. Actual medical malpractice awards, the proliferation of court actions involving medical-device product liability—cardiac pacemakers, artificial heart valves, intravenous devices—and the potential for malpractice claims serve as constant reminders to physicians of their increasing vulnerability.
Although both the median size of jury verdicts in medical-malpractice cases and the number of claims per 100 physicians is rising, a remarkably small percentage of malpractice claims actually proceed to trial. The vast majority of malpractice claims are resolved through early settlement between the parties, dismissal of cases by judges, or claims being dropped by the plaintiffs. In 1984, only 12% of the cases nationwide proceeded to trial, and of this number, another 12.5% of the cases were settled before the jury reached a verdict. In a study of nearly 12,000 claims brought against physicians which were closed between 1977 and 1992 in New Jersey, 67% of the claims closed before completion of the discovery process.6

In fact, research on 187 birth injury and emergency department malpractice claims produced consistent results and showed that among cases dropped by plaintiffs, an expert physician panel found defendants to be not liable three times as often as they were found liable.5 One reason that so few claims proceed to trial is that fault on the part of the physician must be established for a plaintiff to win in court. It is understandable that the number and size of malpractice verdicts bring malpractice to the forefront of the physicians' reform agenda. This focus, however, tends to obscure the relationship between malpractice and the systemic problems wracking our healthcare delivery system.

While malpractice stands as an issue of healthcare quality, implementation of reforms in the malpractice liability system would potentially have an impact on both the access to healthcare and the cost of healthcare. Reform has cost consequences beyond medical malpractice. There are direct and indirect costs of administering our medical liability system, and these costs are shifted to the cost of care. Access is restricted by the increasing costs of healthcare services, and the inability of many people to afford the more expensive care. Access to healthcare is further compromised when physicians refuse to offer particular services or refuse to see patients who are perceived to be at a higher litigiousness risk. Thus, all three of the major healthcare reform themes are inextricably linked to the question of medical liability and malpractice reform. And yet, for all three reform themes—cost, quality, and access—malpractice is a tangential concern and not the central reason for problems in the areas of healthcare costs and access.

Assessments of the extent to which malpractice is a barrier to containing the cost of healthcare and expanding access to healthcare is not always based on realistic and accurate data concerning insurance costs and the increased risk of litigation from high health-risk populations. Medical malpractice is the target of much political debate regarding its influence on the overall cost of healthcare. And yet, the direct costs of medical malpractice, measured by insurance premiums of physicians and other healthcare providers, plus the insurance costs of self-insured hospitals and producers of medical devices, account for less than 1% of the total healthcare budget. Although the indirect costs of defensive medicine are harder to quantify, defensive medicine is a reality in the proactive behavior of physicians. Indirect cost issues are consistent with the general physician lack of concern with the price of many of the services associated with the healthcare that they administer or prescribe.

Access, however, is a direct casualty of the increased costs of healthcare. As physicians' defensive behavior results in increased service utilization, the threshold of affordability is pushed ever higher. Access also falls prey to the misperceptions about which populations are most likely to sue, particularly in high-risk specialties such as obstetrics and pediatrics.

Given malpractice has an impact—albeit indirect—on all three foci of comprehensive reform, it is reasonable to expect healthcare reform to include some manner of tort reform—if only to increase equitability under the law. But the malpractice/tort reform strategies that have been proposed do not offer fundamental, comprehensive reform of the liability system.

While many reform proposals have been characterized as self-serving initiatives to limit litigation and jury awards by the medical and insurance industries, resistance to most efforts at tort reforms by lawyers can be equally decried as self-serving for members of the legal profession. Although malpractice reform is not the major culprit in our troubled healthcare system, fundamental reform must address the tort system to achieve the broad results desired by healthcare reformers and to approach a greater degree of justice and fairness for all injured persons. Many of the proposed tort reforms avoid fundamental changes and only represent procedural tinkering with the present liability system. All interested stakeholders in the bat-
tle over tort reform and comprehensive healthcare reform must begin to take a greater client/patient advocacy stance to ensure patients and clients actually benefit.

**Malpractice and the quality issue**

Medical liability functions as a means to hold physicians accountable for their professional conduct. Malpractice cases are brought under the theory of negligence and, in a medical context, are essentially an issue of medical quality. The most traditional definition of quality in medicine has been the prevention of untoward outcomes caused by medical care, so-called iatrogenic injuries. Thus, medical malpractice occurs when a patient, while under physician or hospital care, receives a substandard quality of care resulting in an injury. Although all malpractice begins with an injury to a patient, not all injuries are the result of malpractice. Precisely, medical malpractice occurs in a subset of injuries that directly result from a provider’s negligence. Negligence is defined as “conduct that falls below the standard established by the law for the protection of others against unreasonable risk of harm.”

One of the most comprehensive studies of the incidence of medical malpractice and its attendant implications for quality of healthcare in the United States was undertaken in 1984. Troyen A. Brennan, working with a team of investigators, evaluated a random sample of more than 30,000 medical cases from New York hospitals. From these data, he estimated the number of adverse events, and the percentage of all adverse events, caused by negligent or substandard care. Using the numbers from New York and applying them nationally, Brennan’s team extrapolated the adverse event-related death total for the United States at large to be 180,000 iatrogenic deaths annually, 90,000 due to negligence; in addition, approximately 35,000 permanent disabilities occurring on a national basis are caused by adverse events while under provider care annually.

Brennan’s team of investigators found that although large numbers of medical injuries occur in hospitals, surprisingly few of these—only one in seven—give rise to litigation. Based on these estimates and the direct measures of injuries caused by substandard care, the investigators concluded that poor quality care pervades the current healthcare system. It is easily concluded from the data that many legitimate cases in which patients suffer injuries while under provider care are never pursued, and thus many deserving victims are never compensated.

**Product liability** emerged from the concept of strict liability and its applicability to producers of goods. Strict liability differs from negligence in that it is not premised on fault. The crux of product liability looks to the nature of the product and not the behavior of the producer. If a product is found to be defective when placed in the stream of commerce, the producer may be liable for the harm that it causes regardless of fault. A product’s defect, failure, or contribution to a medical problem or illness results in a producer’s liability based on failure to warn of dangerous side effects or on production of a defectively designed product.

The extremely popular Rely tampon, when implicated in an outbreak of toxic shock syndrome, was removed from the market under a barrage of product liability claims. The Bjork-Shiley Convexo-Concave heart valve, the A. H. Robbins Dalkon Shield intrauterine device, and numerous pacemakers and their producers are examples of products and companies that continue to face malpractice lawsuits due to product liability. These products differ from the Rely example because they are all implant-ed devices and require the involvement of a physician in prescribing and inserting the product. In the implant examples, claims against a physician can be based on failure to inform a patient of risks associated with a particular product, failure to perform a thorough examination, failure to perform a thorough screening for any and all medications being taken, negligent implantation, insertion—or removal in the case of intrauterine devices—and failure to monitor the patient for adverse reactions.

In general, courts have held that a showing of a defect that caused injury is sufficient to justify strict liability. Both pharmaceutical manufacturers and medical device producers can be sued under strict liability—although drugs and vaccines may be exempt from design defect claims. Because many medical devices and virtually all drugs must be prescribed by a physician, malpractice and product liability cases are often filed simultaneously. Consequently, device manufacturers have replaced physicians as the most frequently named defendants in cases involving medical device use and product liability.
The law governing medical and product liability is a type of tort law. Tort law offers citizens a private, judicially enforced remedy for certain injuries. The remedy in both medical malpractice and product liability cases is generally a monetary award intended to compensate victims for their losses. Tort law is presumed to stand as a deterrent, and it is anticipated that the threat of having one's professional or corporate reputation damaged by malpractice litigation (reinforced by establishment of the National Practitioner Data Bank) and the threat of having to pay potentially large damages should significantly deter negligent behavior and promote a high quality of medical care and reliable and safe products. Unfortunately, the number of malpractice claims, product liability actions, iatrogenic injuries, and iatrogenic deaths do not support an assumption of high-quality healthcare or product safety in the United States.

Strategies, processes, and procedures integral to the functioning of the health profession exist to ensure high-quality care for patients. Physicians set forth ethical standards in medical training which call for an altruistic attention to the patient's medical needs, and physicians form specialty credentialing committees in their hospitals and professional organizations to maintain established levels of competency. Professional standard review organizations and peer review organizations attempt to retroactively monitor physician performance. However, the final responsibility for medical quality control, usually in response to an adverse event, falls to the legal system, the liability system in particular. The system through which healthcare providers are held accountable for their actions stands outside the medical profession and is presided over by lawyers who make their living in adversarial confrontation pursuing victims' rights under the law—their specialty. In a very real sense, providers, by their reluctance to take collective responsibility for greater accountability and quality control on themselves for the good of standardized patient outcomes, have by their own reluctance and inaction created the nemesis that they now face.

**Malpractice and the cost issue**

Malpractice law influences healthcare costs in two distinct ways: directly through the costs of administering the malpractice system; and indirectly, through the effects of the malpractice system on provider behavior. The direct costs of administering the malpractice system are borne by healthcare providers, and they include the payment of malpractice insurance premiums—which reflect the amounts paid out to compensate injured parties—out-of-pocket expenses, and the time providers spend defending themselves against malpractice suits. The direct costs of medical malpractice, measured by the premiums paid for malpractice insurance, are calculated to be less than 1% of total national healthcare expenditures. This being the case, it is argued that massive tort reform will ultimately do little to reduce this cost of healthcare.

However, the larger, hidden indirect costs of the malpractice system result from the signals it sends to providers to alter their behavior. Indirect costs stem from a major goal of the malpractice system: to deter physicians and other healthcare providers from putting patients at excessive risk of adverse outcomes. Many physicians claim that the current malpractice system encourages the practice of defensive medicine. Defensive medicine is used to describe medical practice decisions that are predicated on the desire to avoid malpractice liability rather than a consideration of medical cost-benefit analysis. They report that the law promotes not extra carefulness, but extra care. Positive defensive medicine is defined in this context as the ordering of more tests and procedures than are necessary or useful as a precautionary measure to guard against any future malpractice claim. Although the patient receives more care, the extra care may not contribute to improved outcomes and therefore may represent pure waste, greater patient risk, and overutilization within the system.

Clinical practice guidelines have been proposed as one way to establish a standard criterion for administering appropriate care—with considerations for the variability between individual cases—to ensure that necessary care was provided and to guard against overutilization of services. Although many physicians look on practice guidelines as "cookbook" medicine, practice guidelines could have an impact on the tort process by providing independent and impartial exculpatory or inculpatory evidence about the standard of care. Guidelines would increase the validity and reliability of negligence determination and improve the litigation process because the determination of
fault would be less complex with relevant reference guidelines. Theoretically, a system of guidelines for general and specialty care would address the issue of requisite care. However the variation among practitioners has made the development of guidelines a ponderous and difficult task. It is estimated that less than 20% of medical injuries would be addressed by presently existing parameters.

**Malpractice and the access issue**

Negative defensive medicine refers to the practice of avoiding high-risk patients or procedures for fear of increased potential of malpractice litigation. The effect of this type of defensive medicine results in restricted access to medical care. It promotes a type of discrimination based on the healthcare needs for certain populations and creates a mistaken impression that certain populations are more likely to sue. This type of restriction of access is especially evident among obstetricians and gynecologists. As a specialty, obstetrics and gynecology suffered the most costly claims between January and June in 1993, with total indemnity reaching $899 million, an average payment of $184,720 per claim, and topping all specialties with 15% of all claims. Also, a recent judicial ruling directs that a mother-to-be and her unborn child with congenital anomalies has the right to sue his/her physicians, presumably the mother's consultants, the pediatricians, neonatologists, neurosurgeons, and other specialists on the healthcare team who were involved in either prenatal or postnatal care (or both) of the baby.

A 1992 survey of 4100 of the 20,986 members of the American College of Obstetricians and Gynecologists found that during 1990–1991, 53.9% of all claims involved obstetric care. Other data indicate that 79.4% of the obstetricians surveyed had been sued at least once during their careers, and a quarter of those had been sued four or more times. Thus, for obstetricians, a negative defensive posture taken by many has been to restrict the services offered, to refer patients to other physicians who will deliver babies, and to refuse Medicaid, uninsured, and second- or third-trimester patients.

The long-held perception among physicians, especially obstetricians, that poor and minority patients are more likely to sue continues to create barriers to access that add to the poor health demographics of these populations. Thus, malpractice reform has special importance in the arena of healthcare for minority and poor populations.

We should all be reminded that although it is illegal to discriminate against people on the basis of gender, age, race, ethnicity, religion, and national origin, it is not illegal to discriminate based on economic status. The carefully documented study published in *JAMA* in October 1993 should herald the ending of a stereotypic perception that has had such a profound impact on human healthcare. By starting with hospital records of patients injured while under hospital care and working back to suits filed, Burstin and associates were able to demonstrate that poor and uninsured patients were significantly less likely to file malpractice claims. The risk of claims was lower among Medicaid recipients in the sample, and no significant differences were found by patient race or gender among injured patients.

One of the most important conclusions that can be drawn from this study is that proposed legislation to shield physicians who serve the poor from malpractice suits should be reconsidered. Such legislation would probably have the effect of further perpetuating the myth and depriving the poor of the accountability processes afforded to all other Americans.

One factor resulting in fewer malpractice suits filed by the poor, even when injuries exist, is that these cases are less economically attractive to a lawyer than those of wealthy persons. Average payouts for Medicaid plaintiffs were $25,000, compared with $250,000 for the privately insured. In addition, legal services lawyers who serve poor neighborhoods can only take on malpractice cases if two private attorneys have turned them away.

Burstin and coworkers conclude:

> Our results suggest that rather than suing more frequently, poor and near-poor patients are far less likely to sue, taking into account the fact of injury. Underclaiming by poor patients occurs in the full case-control sample, as well as the injured patient group. The effect is very strong, and the relationship between income and claiming is similar to a dose-response effect. Furthermore, we found that the poor were also less likely to file inappropriate malpractice claims when they were not medically injured.

Access to care is also compromised as the costs of healthcare continue to rise. As the price of healthcare moves past certain levels, impov—
Upheld populations and populations barely achieving a minimal existence are made ineligible for care on the basis of their economic position.

Malpractice reform: Turfs
As was stated earlier, all parties in the battle over malpractice/tort reform—physicians, lawyers, insurers—have their own objectives and agendas that they jealously pursue. Physicians want reforms that limit their liability, limit damages, limit litigation in general, and lower their malpractice insurance premiums. Insurers want reforms that limit damages and allow for periodic payments of awards, both of which help their profitability position. The American Trial Lawyers Association (ATLA) opposes most tort reform proposals unless they strengthen patients’ rights, and calls many of the reform proposals a direct assault on the Constitution and the Seventh Amendment’s guarantee that every American has the right to trial by jury. Opponents to tort reform have their own views of the changes that could improve quality, cost, and access in the healthcare delivery system. Their proposals focus on changes that will protect patients’ rights and they advocate the following measures:

- Improved quality and safety of medical care—It is argued that the cause of medical malpractice is malpractice. Those opposed to tort reform believe that lawsuits would be greatly reduced if physicians would improve quality in the medical profession and if drug companies would stop putting profits ahead of patient safety. It is also suggested that state medical boards be strengthened, and performance audits and recertification for physicians, together with stronger regulation of hospitals be required.

- Elimination of physician self-dealing—Opponents point to the practice of self-referral as the real culprit of runaway costs in the medical profession. In 1991, the Consumer Federation of America (CFA) reported that the most significant change in physicians’ practices during the 1980s was the dramatic increase in self-dealing for ancillary medical service. The CFA report found that physicians with a financial interest in a laboratory ordered 34% to 96% more tests and, as a result, their prices were 2% to 38% higher and total bills were 26% to 125% more than those of independent laboratories.

- Streamlining the medical liability system—At present, medical defendants can obtain a decided advantage by delaying case resolution. Two changes at the state level would promote expeditious case resolution:

1. Apply prejudgment interest in all medical liability cases. This would provide an incentive for liability insurers to seek early resolution as opposed to dragging out cases.

2. Develop a simplified system for handling small cases at the state level. Many cases currently are not filed because, given the medical and insurance industries’ resources, litigation is simply too expensive. A simplified system for small cases would fill that void. It should, at a minimum, have strict time limits to ensure speedy resolution of claims, and simplified rules of proof and processes, such as limits on experts and bans on costly discovery.

- Reforming malpractice insurance—Necessary insurance reforms include compressed rate classifications and mandated experience ratings. Compressed rate classifications would pool physicians into a few groups with physicians placed into high-, medium-, or low-risk classifications; each pool would have sufficient numbers of physicians to allow the risk to be spread among many insureds to permit affordable premiums. Mandated experience ratings would reward “good” physicians with lower premiums, while penalizing “bad” physicians with higher premiums. Insurers also should not be allowed to either “skim” the risk by insuring only the least risky physicians, or overreserve and thus hold reserves as liabilities while investing these funds.

Malpractice reform proposals
The proponents of tort reform have put forward a number of proposals to “fix” parts of the problem. Each of these has been incorporated into various unsuccessful national healthcare reform proposals over the past year. Some have been tried in various state reform initiatives with mixed results.

Alternative dispute resolution
Although most malpractice cases do not reach trial, the civil litigation system is often criticized for being slow, expensive, and unpredictable. Therefore, many critics of the medical liability system advocate other methods of resolving malpractice claims. These methods range from pretrial screening and early settlement
offers to formal arbitration or mediation panels. Supporters of malpractice reform—the American Medical Association, specialty societies, hospitals, and the insurance industry—think that because it is easier and less costly to initiate, alternative dispute resolution (ADR) will open the malpractice system to thousands of victims who do not file legitimate claims because they are intimidated by the courts, unable to finance a lawsuit, or have claims too small to attract an attorney.

Lawyers and various consumer groups say that if ADR is not mandatory and binding, it will in effect be toothless, and the costs of resolution will double. If the defense wins under arbitration, the plaintiff appeals and the process begins all over again in court. However, to make arbitration binding and mandatory raises serious constitutional issues because federal and State constitutions grant plaintiffs a right to a jury trial. Lawyers believe that in its simplest form, ADR can expedite litigation by providing a process for earlier settlements while still allowing a case to proceed unfettered in court if a party is dissatisfied with the result. In that sense, increased use of ADR can be beneficial, but lawyers think that many ADR proposals are promoted as substitutes for trial by jury, contain coercive penalties designed to force settlements or postpone the right to proceed in court until ADR has been completed.14

Certificate of merit
An affidavit submitted within 90 days of the date the claim is filed, including a written report from a “qualified medical specialist,” certifying that there is “reasonable and meritorious cause” for filing the action. The great majority of cases are eventually found to be without merit, but as much time and money is spent defending those cases as is spent on legitimate claims. Plaintiffs’ lawyers, although not strongly opposed to this proposal, believe that it is unnecessary. Lawyers generally seek such confirmation of merit from medical experts to avoid wasting time on frivolous cases. But, defense attorneys complain that plaintiffs’ lawyers can usually find some “expert” willing to support almost any claim.14

Statute of limitations
Most reform proposals call for limits ranging from 2 to 7 years from the date the injury occurred or was discovered. Every state has some statute of limitations on malpractice claims, most allowing 1 to 3 years from the date of injury or discovery. Providers, physicians, and insurers argue that without reasonable time limits, memories fade, witnesses move, records are lost or destroyed, and cases become stale. Lawyers and consumer groups oppose limits of less than 3 years from discovery. Consumer groups view the statute of limitations as simply another form of protection for physicians. On the other hand, to protect victims from having their cases drag on indefinitely, the Center for Patient’s Rights would like to see the statute combined with a 3-year limit (from the date the claim is filed) for the disposition of all malpractice cases.14

Limits on attorneys’ fees
Plaintiffs’ lawyers typically charge contingency fees averaging a third of the settlement or award, although some collect 50% or more plus expenses. Providers, physicians, and insurers claim that plaintiffs’ lawyers’ fees are often far out of proportion to the work they put into a case; indeed, lawyers sometimes end up with more than their clients. These advocates of fee limits want even tougher limits than are proposed, and argue that the fee should be taken off the award or settlement after expenses—and not off the total award amount.

Lawyers and patient’s rights groups argue that limiting fees will discourage plaintiffs’ lawyers from taking on legitimate cases that promise only modest awards, and they argue that limiting plaintiffs’ attorney fees while permitting defendants to spend unlimited sums on legal representation is patently unfair to healthcare consumers.14

Caps on noneconomic damages
Providers, physicians, and insurers want limits on awards for noneconomic damages such as pain and suffering, loss of enjoyment, or loss of companionship. But they would not cap economic damages for lost income or medical expenses, or punitive damages for intentional or malicious conduct, which are rarely awarded in medical malpractice cases anyway. The medical lobby insists that such caps are an absolute necessity for effective reform. But plaintiffs’ lawyers are opposed because caps would sharply reduce awards—and their fees—for major cases involving pain and suffering. Lawyers main-
tain that arbitrarily capping damages is unjust and further injures those who have had the misfortune of being severely injured as their damages are most likely to exceed the cap. Further, damage caps permit a negligent wrongdoer to evade accountability for his or her acts.¹⁴

**Collateral source reduction**

Under traditional rules of evidence, defendants may not introduce information about a plaintiff’s other or collateral sources of recovery, such as health, life, or disability insurance. Some reform proposals call for malpractice awards or settlements to be reduced by any amount recovered from other sources. Defense lawyers contend that no patient deserves to collect twice for the same injury and that collateral reductions are perfectly fair if plaintiffs have other sources of recovery. Lawyers argue that this rule is unnecessary, because few plaintiffs actually receive double recovery. Most insurance policies include clauses requiring reimbursement if the policyholder receives an additional settlement or award for the same injury. This provision is called a “right of subrogation.” Patients’ rights groups argue that reducing awards because of other sources of recovery amounts to having the victim pay for his own injury.¹⁴

**Periodic payment of awards or settlements**

Periodic payment allows damages to be paid over an extended period or a lifetime, *according to the victim’s needs*. Malpractice carriers argue that periodic payment benefits plaintiffs by reducing the risk that funds intended to cover their future medical costs will be quickly depleted through poor investments or demands from other family members. Lawyers claim that periodic payment mainly benefits the insurers by reducing their immediate and net cost. Patients’ rights groups argue that victims deserve to obtain the entire award at once, and that courts have no right to limit the way they spend it. Defendants who have been adjudicated as negligent should not be permitted to keep plaintiffs’ compensation and dictate periodic payments. This mode of payment results in a windfall only for defendants, because they are able to invest and earn income on the unpaid balance of an award. The injured consumer should receive this benefit. Moreover, there should never be any delayed payment without full posting of security to ensure future payments.¹⁴

**Limiting joint and several liability**

Under traditional rules of indemnity, a plaintiff can sue multiple defendants “jointly” and recover from each one according to each one’s proportional liability. Or, if some of the defendants are either insolvent or have shielded their assets from judgment, the plaintiff can sue any one defendant “severally” for total damages, even if that defendant is only partially at fault. Providers, physicians, and insurers argue that the current system permits plaintiffs’ lawyers to seek judgment against the defendant with the “deepest pockets” regardless of the degree of liability. Lawyers and consumer groups oppose any change in the traditional rule on joint and several liability. They want plaintiffs’ lawyers to be able to seek damages from any or all defendants regardless of their degree of liability to improve the chances of collecting adequate damages.¹⁴

**Enterprise liability**

Enterprise liability would make regional health alliances, health maintenance organizations, hospitals, or other healthcare organizations assume liability for their physicians, who become immune from malpractice suits. In about two dozen states, courts have forced hospitals and health plans to assume some liability for malpractice committed by their physicians, even if they are not employees. Lawyers and physicians say that making health plans handle all liability claims would lower malpractice costs, reduce defensive medicine, and simplify the resolution of claims. Insurers fear that enterprise liability would increase the number of malpractice suits because patients would be more likely to file a claim against a “faceless” organization than they would against their own physician. Some physicians fear that giving up liability would result in a loss of autonomy: Physicians sued for malpractice would lose the opportunity to defend their reputations in court and would have to abide by any settlement their organization made. Some trial lawyers and patients’ rights groups object to enterprise liability because it would shield incompetent physicians, thereby weakening the current system’s deterrent against malpractice.¹⁴
Practice guidelines as a defense
One proposal would establish clinical practice guidelines as a legal standard of care and as protection against malpractice claims. Based on the response in Maine, which began a 5-year demonstration in 1991, this idea seems popular among physicians. Trial lawyers might also support this proposal, but only if departure from the guidelines would constitute proof of negligence. Physician opponents see this idea as further encroachment of cookbook medicine that leaves little room for clinical judgment.14

Public access to the National Practitioner Data Bank
Public access to the National Practitioner Data Bank (NPDB) is one of the major goals of the ATLA and patients' rights groups. The administration bill called for public access to the NPDB, which records malpractice judgments and disciplinary actions against physicians. The ATLA and consumer groups argue that patients should be able to check the NPDB to learn if a physician has been found liable in a malpractice suit or disciplined by any state medical board. Physicians call this proposal a breach of professional privacy. They contend that many arguable malpractice claims are settled by insurance carriers for the sake of expediency rather than legitimacy, and should not be used to damage physicians' reputations.14

Product liability reform
The rules covering product liability are derived from state court decisions and state legislative enactments resulting in varying product liability exposure levels among jurisdictions. The trend in virtually all states is to limit the expansion of product liability that occurred in the 1970s. As of 1990, 39 states had passed some form of liability reform, including more procedural hurdles for plaintiffs, limits on punitive damages, and narrower definitions of the concept of defect. All reforms are designed to provide more protection from liability for corporate defendants. The press for reform in the 1990s derives from the perception of an insurance crisis that prevented producers from acquiring adequate and affordable coverage. The perceived crisis arose because of the massive expansion of liability standards, an explosive growth in the number of lawsuits, and increases in the size of jury awards in the

1970s. The interest groups that are gathering on both sides of the reform battlefield are clearly defined. The device industry is allied with a broad coalition of manufacturers and insurers, all of whom exert considerable influence at both the state and federal levels.

Consumer groups and trial lawyers opposed to reform are joined on the other side. One tactic for opponents of reform has been to challenge the constitutionality of different product liability reforms in the courts. State imposed caps on damage awards have been challenged with mixed results, and the constitutionality of punitive damages was pending before the US Supreme Court in 1990.

Comment
Malpractice/tort reform pits physicians, lawyers, and insurers against one another as each group lobbies for changes to enhance its own position and maneuvers to preserve the status quo where it suits its individual agenda. As the battle rages on, the obvious prisoner caught in the middle is the patient/client. Because no reform proposal goes unchallenged by at least one of the groups, each group in the fray should step back from its myopic focus and view the problem with distinct attention to the flow of populations through the system. Quality in the healthcare industry still often falls below a reasonable standard, resulting in numerous injuries and deaths each year. Justice for all under the present system of medical and product liability exists only for those persons with the most lucrative claims potential. Equitable standards of insurance rates for physicians are nonexistent, with considerations for performance and experience being wholly ignored.

To achieve quality, justice, and equality, collaboration and compromise must be the new rules of engagement, with patient/client advocacy the objective.

The healthcare system has undeniably done a poor job of monitoring its own performance and has allowed the law to stand as the primary source of accountability for resolving claims of substandard medical care. The medical profession need not "give up the store" but must be willing to bend for the benefit of substantial change throughout the entire system. Strengthened systems of accountability control must be integrated into the evolving systematization of healthcare to better serve and protect the public. Thus, as the medical community accepts,
under care systems, more of the responsibility for policing its own, the legal community must also embrace change in order to better serve the consumer in the resolution of those claims that find their way into the court system.

The legal and medical communities must collaborate to devise alternative means of resolving those claims that now go unresolved for lack of representation or process. Engaging in combative, adversarial processes, whether it is the physician's desire to "beat the rap" in a malpractice lawsuit or the lawyer’s wish to secure the largest possible damages for a client, creates a perverse shift of priorities. We all lose sight of the goal of our service—the rights and well-being of the consumer/patient.

Although the malpractice process should be an avenue of relief for those persons with a valid claim, the process has become a battleground. This process-oriented posturing by both the legal and medical professions serves no one but the combatants. The establishing of guilt and the leveling of blame have often superseded the immediate needs of the injured patient/client. This shift in priorities is why it is crucial at this juncture to set aside individual agendas and work as a committed, focused coalition for patient and consumer advocacy.

Where physicians are guilty of restricting access to their practices because of a patient's inability to pay, lawyers, too, must plead guilty to accepting only those malpractice suits that promise great rewards. Both groups have been guilty of following the incentives inherent in each profession toward elevating costs to the level of what the market will bear. At that level, however, some vulnerable populations go without healthcare and many meritorious claims go unresolved.

Malpractice law has assumed gargantuan responsibilities in healthcare—partly by default. Because healthcare has been provided, for the most part, by a loose collaboration among independent and autonomous providers, there is no consistent internal system of accountability present. The result has been a patchwork, adversarial approach to accountability through the courts. This has created an emotional and misinformed provider group who has further limited access for the poor or minority patient.

Physicians are licensed by the state, and membership in professional societies is voluntary. Thus, professional sanctioning of negligent physicians under current policies and structure is nearly impossible. However, new checks and balances can and should be built into a managed, reformed healthcare system.

We are finally reaching a point where the market will bear no more of the excesses in either profession. Only from a detached perspective, with the objective of consumer rights and patient well-being firmly in mind, can this country proceed to build an equitable system where justice, equality of access, and high-quality care for all are the standards. As studies have revealed, the current healthcare delivery system is anything but equitable. Vulnerable populations have difficulty gaining access to the delivery system because of economic discrimination, and once in the loop, they often tend to receive a poorer quality of care. Of the legal profession, the same is true and many deserving claims go unrepresented because of economic discrimination.

Where healthcare reform seeks to level the field on which all persons move in search of access to healthcare, malpractice reform should strive to provide access to the process of resolving all medical malpractice claims—not merely the most lucrative. If, through reform efforts, a system can be structured where the responsibility for any injury sustained through the course of treatment is accepted by the attending physician, healthcare organization, or the medical product industry—for example, silicone breast implants—then a collaborative effort to secure just compensation can proceed in a less adversarial atmosphere and in a less costly manner. This type of arrangement will allow all parties concerned to move past the painful accountability process of establishing guilt or negligence and move forward with the best interests of the patient/consumer in mind.

Unless we all step out of the process and look toward correcting the larger systemic problems, we will continue to be locked into a vicious cycle tinkering with small parts of the process while the system hurtles on blindly.

References
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