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NO FAULT COMPENSATION FOR MEDICAL INJURIES

*Josephine Y. King**

INTRODUCTION

A nation that implements a reasonably adequate health insurance program spares its citizens some of the anxiety and deprivation accompanying the incidence of injury, disease, or other illness. With accessible, publicly supported health care, persons suffering such disabilities would not be concerned about proof of misconduct on the part of any actor as a prerequisite to economic recovery. Nonetheless, the question of misconduct or fault must be dealt with somewhere in the legal system, particularly if it rises above the level of ordinary negligence. These issues can be more effectively approached by licensing authorities, formulating standards of treatment, intelligently and courageously enforcing professional standards, and ultimately by application of the criminal law. In focusing on the victim's disability, this Essay urges a separation of the compensation goal from the putative deterrent function of tort law.¹

While the system of vindicating wrongs through tort litigation has historically served either as a substitute for or as an adjunct of more rigorous criminal penalties, the development of third party insurance, and the possibility or requirement of purchasing protection through indemnification has stunted, blunted, or obliterated a fear of personal liability on the part of the tortfeasor. Furthermore, if the disability is the result of an act of a manufacturer or other corporation or government, the cost of any judgment is passed on to the public through increased prices or taxes.

Although law students are taught that a judgment for the plaintiff in a tort action serves as compensation for the injury suffered by the victim and as an incentive to the tortfeasor to conform his conduct to the standards of the law, the reality is that a tort judgment accomplishes neither objective ade-

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1. See generally David S. Starr, *The No-Fault Alternative to Medical Malpractice Litigation: Compensation, Deterrence, and Viability Aspects of a Patient Compensation Scheme*, 20 TEX. TECH L. REV. 803 (1989) (suggesting that the tort system is inadequate to compensate the injured patient).

quately, if at all. In fact, many claims of injury based on tortious conduct—defendant's violation of a duty owed to the plaintiff—either never reach the courts² or, if litigated successfully, result in a recovery which is not rationally related to the nature and scope of the wrong.³ The latter proposition operates in both directions. Some victims are paid far more than the economic cost of their injury, usually by settling with insurers who are uncertain of the outcome of litigation or estimate the cost of defending the insured as exceeding the payoff of a nuisance claim by a moderate sum. Thus, even though that claim has little or no merit, an insurer may offer a settlement with the victim. In other cases, a few victims of injury, whether in the hospital or on the highway, obtain very substantial sums based not only on the nature and severity of the illness but also, and perhaps even more so, upon appeal to the sympathy of the jury and display of histrionic talents on the part of counsel.⁴

Advocating a no fault approach to personal injury is not new in the United States, as exemplified by a universal acceptance of a strict liability scheme of workers' compensation. Nevertheless, the movement in the late 1960s and 1970s for no fault reparations for motor vehicle accidents aroused fierce opposition from American negligence lawyers and, initially, the insurance industry.⁵ The insurance industry soon succumbed, however, realizing that Congress might legislate in the field and impose federal regulation. Because the insurance industry preferred to continue its symbiotic relationship with state insurance departments, it suggested various limited state-based no fault plans.⁶ After more than a decade of politics and proposals, approximately one-half of the states have implemented some form of first party no fault coverage for injuries due to vehicle accidents.⁷

2. HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK, chs 7, 10 (1990).

3. For data and commentary on the operation of the tort system in vehicle accident personal injury cases, see NEW YORK INS. DEP'T, AUTOMOBILE INSURANCE . . . FOR WHOSE BENEFIT? (1970); ALFRED F. CONARD ET AL., AUTOMOBILE ACCIDENT COSTS AND PAYMENTS: STUDIES IN THE ECONOMICS OF INJURY REPARATION (1964); ROBERT E. KEETON & JEFFREY O'CONNELL, BASIC PROTECTION FOR THE TRAFFIC VICTIM: A BLUEPRINT FOR REFORMING AUTOMOBILE INSURANCE (1965). See also INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, BEYOND MALPRACTICE: COMPENSATION FOR MEDICAL INJURIES 12-13 (1978); DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECY'S COMM'N ON MEDICAL MALPRACTICE 101 (1973), DHEW Pub. No. (05) 73-88.

4. JEFFREY O'CONNELL, THE LAWSUIT LOTTERY: ONLY THE LAWYERS WIN 8 (1979).

5. See KEETON & O'CONNELL, *supra* note 3, at 133-34; Josephine Y. King, *Accident Reparation: Reappraisal and Reform*, 3 CONN. L. REV. 268, 293 nn.143, 144 (1970-71).

6. See Josephine Y. King, *The Insurance Industry and Compensation Plans*, 43 N.Y.U. L. REV. 1137, 1152-1164 (1968) (presenting five different proposals by the industry in 1968).

7. JOSEPHINE Y. KING, NO FAULT AUTOMOBILE ACCIDENT LAW §§ 2.1-2.32 (1987).

VARIATIONS OF NO FAULT

No fault is not a monolithic concept. In its purest form, which could be designated type A, no fault is a first party insurance system which compensates only for net economic loss. Specifically, net economic loss includes medical and rehabilitative expenses, wage loss, and substitute services uncompensated from any other source. Therefore, collateral payments such as health, accident, and employers' sick leave compensation would be primary. However, no provision for pain and suffering reparations exists. Through the first party insurance mechanism, the insured looks to his or her own insurer to recover out-of-pocket loss, regardless of who was at fault in causing the injury. The insured files a claim against his or her insurer; only when there is a controversy over coverage or the amount of payment which cannot be settled by negotiation or arbitration will the matter reach the courts.

In the United States, no fault automobile compensation is a variation of type A, although it falls notably short of conforming to the pure scheme since states permit tort actions for noneconomic loss if a very serious injury has occurred and the victim can prove fault.⁸ In the absence of serious injury, economic loss is covered up to a specified amount regardless of fault.

A type B scheme, which is surfacing in malpractice reform, is a third party insurance system which requires health care providers to purchase insurance to indemnify them for recoveries awarded to injured patients.⁹ No fault entitles patients to recover if they can show the requisite injury and causation. However, proof of negligence on the part of the health care provider is not a condition precedent to recovery. Type B plans generally allow recovery for some noneconomic loss. The right to judicial review in cases of serious injuries with provable fault is not clearly delineated. Nonetheless, it would be difficult to justify a compensation system which would refuse to allow litigation in a case involving the intentional commission of an injurious act.

A variable which might appear in either type A or type B depends on whether purchase of the first party or the third party insurance is compulsory. Permitting participation on a voluntary basis weakens the system, reveals doubts in the feasibility of no fault, or simply reflects a political compromise to pursue an incremental rather than a total commitment to radical change.

8. See, e.g., MICH. COMP. LAWS ANN. §§ 500.3101-.3179 (West 1983 & Supp. 1991); N.Y. INS. LAW §§ 5101-5108 (McKinney 1985 & Supp. 1992).

9. For a description of various statutory schemes for insuring health care providers, see Ronald S. Latz, *No-Fault Liability and Medical Malpractice: A Viability Analysis*, 10 J. LEGAL MED. 479, 493-97 (1989).

MEDICAL ADVERSITY INSURANCE AND DESIGNATED
COMPENSABLE EVENTS

Professor Clark Havighurst and Dr. Lawrence Tancredi advanced a challenging and complex compensation scheme in the early 1970s.¹⁰ This type B no fault scheme, which is similar to workers' compensation, requires institutional and individual health care providers to purchase "medical adversity insurance" covering their patients.¹¹ A patient experiencing injury as a result of a "compensable event" would be entitled to indemnification for medical and hospital bills and lost wages up to a specified maximum. Compensation is not strictly confined to pure economic loss, however, since the authors permit inclusion of payments for pain and suffering if such suffering is long lasting or closely associated with the medical procedure.¹²

The plan requires that health care providers pay premiums based on their experience rating, which evaluates physicians and hospitals according to their prior malpractice claims.¹³ It is suggested that this experience rating improves the quality of care by operating as an incentive to avoid adverse outcomes in malpractice litigation. Furthermore, the plan dictates that providers would be personally liable if they are aware that a patient has a claim, but fail to inform that patient.

The critical element in this alternative to the tort litigation system is the identification of "compensable events" which would allow indemnification for economic loss. The principal criterion determining which outcomes of medical intervention merit compensation without a finding of negligence is relative avoidability.¹⁴ In satisfying this standard, it must be determined how frequently an adverse outcome occurs due to unavoidable consequences of treating the patient's condition and whether it is unexpected or preventable. Some compensable events include postoperative infections, allergic reactions to drugs, hospital accidents, and foreign objects left in the body. A second criterion in identifying compensable events is the effect that selecting a particular treatment with potential adverse effects will have on efforts to avoid the ultimate adverse result.¹⁵ The purpose is improvement in the quality of care. Another consideration is determining who the appropriate risk

10. For an analysis of this no fault compensation scheme, see Clark C. Havighurst, "Medical Adversity Insurance"—*Has Its Time Come?*, 1975 DUKE L.J. 1233; Clark C. Havighurst & Lawrence R. Tancredi, "Medical Adversity Insurance": *A No-Fault Approach to Medical Malpractice and Quality Assurance*, 613 INS. L.J. 69 (1974); Lawrence R. Tancredi, *Designing a No-Fault Alternative*, 49 LAW & CONTEMP. PROBS. 277 (1986).

11. Havighurst & Tancredi, *supra* note 10, at 71.

12. *Id.* at 72.

13. *Id.* at 72-73.

14. *Id.* at 77-79.

15. *Id.* at 79-83.

bearer is, specifically who should bear the costs of the injury.¹⁶

A system which provides compensation for the sequelae of iatrogenic injury must demonstrate medical intervention, most often an affirmative act but also including omitted acts resulting in injury. A causal link must exist between the medical intervention and the adverse outcome. Since alleviating the effects of the patient's disability is the primary goal, this compensable events approach does not demand proof of medical misconduct. Instead, negligent or willful departure from the appropriate professional standard of care must be dealt with elsewhere. The system would operate more economically if adverse outcomes of minimal economic consequence, such as minor disability resulting in negligible medical expenses and wage loss were excluded as a threshold matter.

O'CONNELL PROPOSALS

A system that adopts the proposal of Professor Jeffrey O'Connell would enable professionals, manufacturers, and corporations to elect to indemnify those they injure.¹⁷ The scheme requires the enactment of a statute allowing a defendant to foreclose a claim by promising within a fixed period of time to pay the plaintiff periodically for economic loss. Such payments would cover medical expenses, net wage loss, and reasonable attorney's fees.¹⁸ The statute may also provide a cap on the average weekly or monthly income loss payments. Furthermore, the claimant would be disqualified from seeking a recovery in tort.

Professor O'Connell offers an additional recommendation that does not require the enactment of a statute. Under a "Neo-No Fault" system, a provider of services or products often would be obligated to pay a victim's net economic loss within a specific period of time, regardless of fault.¹⁹ Economic loss would include medical expenses and lost wages above the amounts available from the victim's own health and accident insurance or sick leave granted by the employer.²⁰ Thus, in this elective system, the providers agree to be bound to pay net economic loss and give victims the option to accept the tender or pursue their claims in court.

Legislation embodying some of the ideas of the O'Connell statutory plan was introduced in the 98th Congress, although it did not succeed in winning

16. *Id.* at 82.

17. Jeffrey O'Connell, *An Elective No-Fault Liability Statute*, 628 INS. L.J. 261, 264 (1975).

18. *Id.* at 267-90.

19. Jeffrey O'Connell, *A "Neo No-Fault" Contract in Lieu of Tort: Preaccident Guarantees of Postaccident Settlement Offers*, 73 CAL. L. REV. 898, 907 (1985).

20. *Id.*

sufficient support.²¹ Basically, the bill would have permitted health care providers to make a commitment to compensate injured patients in exchange for relinquishing their right to sue for noneconomic damages. Patients would be entitled to full reimbursement for out-of-pocket expenses, including wages, medical costs less any payment from third parties, and treatment for pain. Because compensation would be on a periodic basis as losses accrued, health care providers would not know the extent of their liability at the time of making the commitment to pay.

BRITISH PROPOSALS

Both the Royal College of Physicians and the British Medical Association (BMA) have recently advocated a form of no fault compensation. Although the full reports are not yet available, it has been suggested that the Royal College has proposed reparations for economic loss with a limitation on lost earnings and has included some noneconomic damages as well.²² According to these proposals, plaintiffs must forego a negligence action if they choose no fault compensation.

The BMA reprinted a study of 19 district health authorities covering almost 300 claims in 1988.²³ Of these claims, forty-five percent were ineligible for compensation, thirty-six percent suffered minor injury and no lost income, seven percent experienced loss of earnings for a certain period of disability and thirteen percent were permanently disabled or died leaving dependents.²⁴ The BMA's proposal consisted of three levels of compensation: 1) 500 to 5,000 pounds when there is no lasting disability; 2) 1000 pounds to 25,000 pounds if a person experiences not only pain, but a loss of wages, and 3) up to 10,000 pounds each year for a person who requires continuous support, such as a brain damaged baby.²⁵ The BMA also proposed a separate emergency fund to compensate special cases, such as hemophiliacs afflicted with AIDS as a consequence of blood transfusions.²⁶ The BMA

21. For a legal commentary on the proposed bill, see W. Henson Moore & John S. Hoff, *H.R. 3084: A More Rational Compensation System for Medical Malpractice*, 49 *LAW & CONTEMP. PROBS.* 117 (1986). Similarly, the 102d Congress proposed a system of alternative dispute resolution for medical injury claims whereby recovery is limited to economic loss. See H.R. 1004, 102d Cong., 1st Sess. (1991).

22. David Bolt, *Compensating for Medical Mishaps: A Model "No Fault" Scheme*, *NEW L.J.*, Jan. 27, 1989, at 109, 109-10.

23. *Support for No Fault Liability*, World Insurance Report, Jan. 18, 1991, available in LEXIS, Banking Library, FINTIME File.

24. *Id.*

25. *BMA Puts Cost on "No Fault" Compensation*, *THE DAILY TELEGRAPH*, Jan. 11, 1991, at 4.

26. Liz Hunt, *No Fault Medical Plan "Would Cost \$ 1000m,"* *THE INDEPENDENT*, Jan. 11, 1991, at 6.

estimated that this compensation scheme would cost more than 100 million pounds per year.²⁷

Among the factors motivating British physicians to initiate a no fault proposal were the high costs associated with the current system of litigation and compensation, the long delays in recovery, and the failure to restore many who are physically injured, while excessively compensating others. After estimating that expenditures on legal and administrative fees consume seventy percent of a patient's award, the report concluded that the present system is unfair to patients.²⁸

THE NATIONAL CHILDHOOD VACCINE INJURY ACT

The first national no fault reparation system approved by Congress is the National Childhood Vaccine Injury Act of 1986²⁹ (The Vaccine Act) covering injury or death due to the administration of compulsory childhood vaccinations. The impetus for such legislation came from a number of sources, including parents' organizations, vaccine manufacturers, and public health authorities.³⁰ In fact, some vaccine manufacturers had withdrawn their products from the market because of liability exposure and the difficulty in maintaining adequate insurance. At the same time, public health authorities sought to maintain the availability of certain vaccines despite the unavoidable risk of adverse effects.

The Vaccine Act established the Office of Special Masters to resolve injury claims without requiring formal judicial action against the vaccine manufacturer.³¹ The proceedings are comparatively informal. The claimant must prove cause-in-fact, or "a logical sequence of cause and effect." It is not necessary to establish fault on the part of the manufacturer. Compensation awarded under the Vaccine Act includes past and future expenses, loss of earnings, and pain and suffering.³²

Commentators have applauded the Vaccine Act's procedure,³³ as well as its fair and efficient results, and urged its adoption as a model of tort reform. This program operates in a well-defined, highly specialized area where caus-

27. *Id.*

28. *BMA Puts Cost on "No Fault" Compensation*, *supra* note 25, at 4.

29. 42 U.S.C. §§ 300aa-1 to -34 (1988).

30. Denis J. Hauptly & Mary Mason, *The National Childhood Vaccine Injury Act: The Federal No-Fault Compensation Program That Gives a Booster for Tort Reform*, 37 *FED. B. NEWS & J.* 452, 452 (1990).

31. 42 U.S.C.A. § 300aa-12(c), (d) (West 1991).

32. 42 U.S.C.A. § 300aa-15(a)-(c) (West 1991).

33. *See, e.g.*, Sarah Glazer, *Vaccine Victims: No-Fault Federal Program Compensates for Injuries*, *WASH. POST*, Jan. 29, 1991, *Health Magazine*, at 9 (quoting Michael Hugo, Chairman of the Vaccine Litigation Group for the Association of Trial Lawyers of America).

ally related, adverse outcomes can be more easily identified. Nonetheless, it is more than simply a practical response to medical injury. As a matter of public policy, societal duty, and moral responsibility, a community should assist persons who are severely impaired through no act of their own as directly, expeditiously, and fully as is reasonably possible.

COMPENSATION FOR BIRTH-RELATED NEUROLOGICAL INJURIES

For reasons similar to Congress' objectives in passing the Vaccine Act, several states have recently enacted laws providing no fault reparations for birth-related neurological damage.³⁴ This type of legislation is necessary because life time care of a neurologically impaired infant, whether or not caused by the negligence of an obstetrician, involves an economic burden beyond the financial means of the average family. Furthermore, it is well known that obstetricians' malpractice premiums have climbed to extraordinary heights; to pay \$100,000 a year is not uncommon. As a consequence, shortages of obstetricians have developed in some states. State officials responsible for maintaining necessary health services in those states cannot ignore this trend.

The compensation provided by these acts is limited to actual medical expenses, a percentage of estimated lost earnings, and attorney's fees, all of which are paid on a periodic basis.³⁵ There is no award for pain and suffering. An administrative agency reviews the evidence and determines the validity of the claim and the appropriate amount of reparations.³⁶ Ultimately, there is the possibility of judicial review.

Funding for the compensation plan is based on assessments of physicians and hospitals. For example, obstetricians who wish to participate in the plan are assessed \$5000 per year;³⁷ hospitals are assessed \$50 for each live birth.³⁸ Additionally, all physicians licensed in the state are assessed \$250 per year.³⁹ This mandatory payment by all physicians has aroused opposition and is being challenged as unconstitutional.⁴⁰

34. See, e.g., FLA. STAT. ANN. §§ 766.301-.316 (West Supp. 1992); VA. CODE ANN. §§ 38.2-5000 to -5021 (Michie 1990 & Supp. 1991). For a thorough review of the Virginia Birth-Related Neurological Injury Compensation Program, see David G. Duff, *Compensation for Neurologically Impaired Infants: Medical No-Fault in Virginia*, 27 HARV. J. ON LEGIS. 391 (1990).

35. See, e.g., VA. CODE ANN. § 38.2-5009 (Michie 1990).

36. VA. CODE ANN. § 38.2-5008 (Michie 1990).

37. See FLA. STAT. ANN. § 766.314(4)(c) (West Supp. 1991).

38. See *id.* § 766.314(4)(a).

39. See *id.* § 766.314(4)(b)1.

40. See *McGibony v. Florida Birth-Related Neurological Injury Compensation Plan*, 564 So. 2d 177, 180 (Fla. Dist. Ct. App. 1990).

These legislative initiatives recognize the public's responsibility in providing economic assistance in cases of a particular kind of injury. The sense of ethical or moral duty to ease the catastrophic impact upon innocent victims is a beginning. Legislative bodies have not yet exhibited sufficient fortitude and resolve to create a system of universal health care paid for by a broad tax program. Nonetheless, the economic sustenance provided in cases of disastrous injuries or illnesses without proof of fault reveals some redeeming moral impulses.

CONCLUSION

Addressing the consequences of employment and motor vehicle related injuries has assumed some semblance of a public responsibility. A strict liability system of compensation is in effect for employment related injuries in all states, and a substantial number of states currently compensate motor vehicle related injuries. The rationale for these systems encompasses not only a public desire to avoid litigation costs and health care expenses, but also a concern for the personal welfare of injured individuals and their family. Additionally, the growing dissatisfaction with the uncertainty and irrationality of a tort remedy has fostered this public responsibility.

At least since the mid-1960s and the landmark works of Professors Conard, O'Connell, and Keeton, as well as other legal scholars, critics have exposed the real costs, abuses, and basic inequities of consigning injured persons to the traditional tort treadmill. The tort system has undergone numerous modifications during the past decade including caps on awards, abrogation of the collateral source rule, and periodic payments, among others.⁴¹ While some modifications may have observable effects on the frequency and size of malpractice claims, none is adequate to achieve major improvements in providing an ethical approach to necessary compensation.

The optimal system appears to be a pure type A mechanism based on social insurance. However, because this is not a realistic possibility in the United States at this time, a type B form which limits net economic loss recovery is the most fair, efficient, and politically palatable mechanism. Pain and suffering damages can rarely be justified on the basis of an accurate computation. Indeed, they have been characterized as irrational, illogical, the reservoir from which the attorneys will claim their fee, a generous and vicarious outpouring of jury sympathy, and the primary justification for insurers to charge high premiums.

A system with a net economic loss basis providing reasonable resources

41. See Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 *LAW & CONTEMP. PROBS.* 57, 76-78 (1986).

for an injured person to be treated, rehabilitated, and able to sustain dependents despite lost earnings, could gain public acceptance. Designing such a system is not an impossibility. Administrative boards or panels composed of three health care professionals, a health economist, a representative of social service agencies, and a member of both the legislative and executive branches could hear and decide medical injury claims both as to merit and compensation. Furthermore, judicial review may be provided after exhausting administrative remedies.

The problem of causation⁴² is an inhibiting factor in proposed no fault plans. It is difficult to penetrate a presenting illness plus treatment—a composite condition—in order to expose the true factual cause of the asserted injury and, therefore, one must anticipate that guidelines and principles will be developed by the appropriate administrative agency. In that case, the experience of the health professionals who serve on the panel of the administrative agency will be persuasive.

Beyond cause in fact, however, the real issue is proximate cause and the extent to which resources permit or the moral sensitivity of the public insists that medical injury or illness be compensated. More than sixty years ago, Judge Andrews in his dissent in the famous *Palsgraf* case remarked, "What we do mean by the word 'proximate' is that, because of convenience, of public policy, of a rough sense of justice, the law arbitrarily declines to trace a series of events beyond a certain point. This is not logic. It is practical politics."⁴³

42. For a variety of approaches to the theory of causation, see H.L.A. HART & TONY HONORE, *CAUSATION IN THE LAW* (2d ed. 1985); Glen O. Robinson, *Multiple Causation in Tort Law: Reflections on the DES Cases*, 68 VA. L. REV. 713 (1982); Richard W. Wright, *Causation, Responsibility, Risk, Probability, Naked Statistics, and Proof: Pruning the Bramble Bush by Clarifying the Concepts*, 73 IOWA L. REV. 1001 (1988).

43. *Palsgraf v. Long Island R.R.*, 162 N.E. 99, 103 (N.Y. 1926) (Andrews, J., dissenting).