Doctor No

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Paul Weiler’s Medical Malpractice on Trial† is a splendid little book. In 161 very readable pages (plus sixty-eight pages of endnotes), he describes and critiques the current regime of medical malpractice law, surveys and evaluates a range of reforms previously proposed (and sometimes enacted), and offers a bold improvement package of his own. His most inventive and promising ideas are to substitute organizational liability (such as hospital liability) for individual physician liability (pp 122-32) and to replace fault-based compensation with a no-fault scheme covering all medical accidents that lead to serious disability or death (pp 132-58). Weiler tempers the boldness of his vision with a sensitive appreciation of both the political and practical problems of promptly achieving it. This appreciation leads him to advocate the immediate adoption of more modest steps in the direction he favors, including substantial changes in the measure of damages in malpractice cases and experiments with elective no-fault compensation in lieu of litigation.

Although I am persuaded that Weiler’s recommendations would lead to a vast improvement over the current regime, he has not yet shown, as I will later explain, that his focused no-fault plan is the best long-range solution. Even so, I think this slim volume is a “must” for anyone who wants to understand contemporary issues surrounding medical malpractice. Medical Malpractice on Trial contains countless nuggets of information and analysis concerning

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† Paul C. Weiler, Medical Malpractice on Trial (Harvard, 1991). All parenthetical page numbers in the text and footnotes refer to this text.
a dazzling array of issues and contentions that have been featured in the debate over medical malpractice reform during the past twenty years. In the course of his presentation, Weiler pulls together nearly all of the best work by others who have written in this field.

Moreover, this book integrates the findings and analyses of two large and important projects for which Weiler has been centrally responsible. This information is otherwise only accessible in more awkward forms. While there is much to be gained from reading the more than 1,000-page final Reporters’ Study of Enterprise Liability for Personal Injury (1991) for the American Law Institute ("Reporters’ Study") (which covers many other topics besides malpractice) and Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990) ("Harvard Study") (the massive first report of the Harvard Medical Malpractice Study Group), Weiler’s book is the place to start for a well organized and compact examination of the medical malpractice field.

I. MEDICAL MALPRACTICE, MALPRACTICE LAW, AND MALPRACTICE INSURANCE TODAY

A. Patterns of Claiming and Collecting

Weiler paints a startling picture of current patterns of claiming and collecting which reveals the minor and idiosyncratic role malpractice law plays in the compensation of malpractice victims. Based on the Harvard Study, Weiler explains that of every 100,000 patients discharged from hospitals, nearly 4,000 suffered an “adverse event" from their medical treatment. About one-fourth of these are the result of medical malpractice (p 12). In short, hospital patients on average run about a four percent risk of an adverse event and about a one percent risk of medical malpractice.

These 100,000 patient discharges and 1,000 malpractice-caused injuries generate about 125 legal claims. About sixty of the 125 claimants actually receive compensation (p 13). The rest of the

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2 Reporters’ Study of Enterprise Liability for Personal Injury (ALI, 1991) ("Reporters’ Study").


4 In the Harvard Study, a hospital occurrence counted as an adverse event if it prolonged the patient’s stay in the hospital by at least one day or caused the patient’s death (p 18).
claims lose at trial or are dropped. Of those sixty successful claimants, about twenty receive payment before they have filed a lawsuit, about thirty-five after a suit is filed but before (or during) trial, and only about five win at trial (pp 53, 193 n 30).

According to neutral physicians reviewing the records, however, of every 125 claims that plaintiffs make, no malpractice occurred in about eighty-five cases. Based on Weiler's account and the Harvard study, I have calculated that most of the cases where malpractice occurred and a patient filed a claim lead to some award (thirty to thirty-five of forty); but some thirty percent of the claims where malpractice apparently did not occur also result in some payment (twenty-five to thirty of eighty-five), albeit a payment that is often substantially discounted from the amount of the claimant's likely recovery had liability been clear.

To put it in a somewhat different way, about thirty to thirty-five of every 1,000 malpractice victims use the legal system to obtain compensation for their losses, although only perhaps four out of every 1,000 obtain an award of individualized justice through a jury of their peers. At the same time, twenty-five to thirty people who were probably not victims of malpractice nevertheless receive payment from the system. In some cases these people probably have not even suffered any harm or a net detriment to health as a result of the medical treatment they complained about.

I've so far used the illustrative numbers of 1,000 tort victims out of every 100,000 hospital discharges in order to provide a ready feel for the data. In fact, we are talking about some forty million annual hospitalizations across America (p 71). These numbers translate into about a million and a half adverse events and 400,000 torts (one percent of 40 million) every year. Yet, the system's compensation shortfall is enormous: only 25,000 medical malpractice claimants, out of 50,000 who claim and 400,000 who are injured, are likely to receive some compensation, of whom only 12,500 to 15,000 were actually malpractice victims. Of course, many of those patients injured through medical malpractice suffer only minor injuries, about half incurring only minimal impairment and recovering completely within a month, and another substantial group fully recovering in less than six months (p 136). Still, in as

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8 Torts are also committed in doctors' offices—13% of malpractice claims arise out of conduct in doctors' offices as compared with 81% from hospitalizations and the rest from other locations such as nursing homes (pp 225-26 n 18). We know a lot less, however, about how often torts occur outside of hospitals and hence less about the proportion of those so injured who actually claim and recover.
many as twenty-five percent of the cases of medical negligence the patient dies—at least in part as a result of malpractice. In addition, about ten percent of the victims of medical malpractice suffer long-lasting disabilities. Projecting the findings nationally, the Harvard Study suggests that every year the approximately 1.5 million adverse events from medical treatment in hospitals seriously and permanently disable approximately 150,000 people and kill more than 150,000 people (many of whom, admittedly, are elderly and perhaps frail at the outset). Medical negligence accounts for greater than a quarter of those more than 300,000 substantial harms, only a small portion of which are actually compensated through the current tort system.

B. Administrative Costs, Insurance, and Other Burdens

Weiler also rightly emphasizes the enormous waste of the existing regime. In order to deliver $1 in net compensation into the hands of those medical malpractice claimants who receive something from the system, more than $1.35 is spent on claims processing costs. The legal expenses of both sides are the most significant costs. And these figures don’t even count the substantial additional transactions costs not directly attributable to claims processing, including commissions, marketing expenses, and taxes paid and profits earned by insurers, all of which probably amount to more than twenty percent of the cost of medical liability insurance (pp 192-93 n 28).

In states still following the common law rules as to tort damages, forty to fifty percent of the compensation paid is for pain and suffering (pp 51, 55), the lion’s share of which is concentrated on the five percent of successful claimants with the most serious injuries (who represent perhaps two or three of every 1,000 victims of

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6 Harvard Study at 6-21, table 6.5 (cited in note 3).
7 Id at 6-25, table 6.5.
8 I define the seriously disabled category more broadly than Weiler does. Weiler mentions 30,000 seriously disabled people (p 12), but based on the report of the Harvard Study Group this figure must refer to people in the most severe disability category. The Harvard Study found that 9% of those suffering adverse events were disabled for more than six months and 14% died. Harvard Study at 6-1 (cited in note 3). Between 2% and 3% were permanently disabled with a disability rating of more than 50%. Id at 6-21, table 6.5. This puts the number killed in excess of 150,000, the number disabled for more than six months in the range of 150,000, and those in the most seriously disabled category at about 40,000 annually. Weiler notes that those not able to return to work within six months approached a quarter, numbering around 375,000, of the total annual number of adverse events (p 136).
9 See James S. Kakalik and Nicholas M. Pace, Costs and Compensation Paid in Tort Litigation (Rand Institute for Civil Justice, 1986).
malpractice) (p 48). Moreover, of the remaining compensation paid through the legal system, perhaps as much as sixty percent is already covered by public and private insurance programs like Blue Cross and other forms of private health insurance, Medicare, Medicaid, Social Security, disability insurance, sick leave, and so on (p 51).

A little arithmetic, then, shows that for every one dollar that is collected in malpractice insurance premiums, ten to fifteen cents has traditionally gone to reimburse claimants’ actual out-of-pocket economic losses. Furthermore, delays of several years between the time of claim filing and receipt of compensation are not at all uncommon (p 52).

Physicians, hospitals, and others paid a total of about $7 billion in medical liability insurance premiums in 1988. Weiler’s data illustrates that around $1 billion of that amount will finally go to reimburse otherwise uncompensated economic losses. Claimants will actually probably receive a net cash total of between $2 and $3 billion (p 99), depending upon how successful “collateral” sources (private and social insurance funds) are in recouping what otherwise would amount to double recovery by claimants.

The financial impact of the system on certain classes of physicians is enormous. For example, high-risk specialists like neurosurgeons and obstetricians in high-risk states like New York and Florida pay annual medical malpractice insurance premiums of between $100,000 and $200,000 (p 4). Still, as Weiler makes clear, the insurance burdens should not be over-dramatized since the national average malpractice insurance cost per doctor was only about $16,000 in 1988; the $7 billion in malpractice premiums paid in 1988 represented not much more than one percent of total annual expenditures for health care nationwide that year (p 4).

To this cost, however, one must add at least some of the $9 or $10 billion spent annually by physicians on “defensive” medicine, in the form of extra record-keeping, extra tests given to patients, extra time with patients and the like (p 85). Of course, some of those dollars might actually have benefitted patients and are cost-justified in an economic sense. But it is widely believed that many of these defensive measures do not help patients (and sometimes are even risky to patients); they serve primarily to help the doctor ward off malpractice claims (and, frequently, to increase the doctor’s income as well) (p 87).

Additional social costs of the existing legal system include (1) the psychological burden on those doctors who feel they are caught up in a Kafkaesque legal system (p 81), (2) the refusal of compe-
tent physicians to enter or continue practice in certain high-risk specialties or to perform certain desirable but higher risk treatments (p 85), and (3) the lost services of and earnings by doctors who must devote up to an average of five uncompensated days to defend against a typical malpractice claim (p 81). So, while the “costs” generated by legal liability for medical malpractice do not loom large in the overall national health care budget, they are plainly not chicken feed.

In sum, from the viewpoint of compensating victims, whether we focus only on victims of malpractice or on all victims of adverse events from medical treatment, Weiler’s analysis demonstrates that the current system is a disaster and a disgrace. The few are lucky lottery winners, so to speak, only about half of whom should even have been given lottery tickets. The many are ignored. Although it may not be fair to say that “only the lawyers win,” it can hardly be said that, from the compensation perspective, patients as a class win.

C. Individualized Justice?

The system, overall, also fails to serve well the ideal of individual justice. As Weiler demonstrates, on the patient side, most “deserving” victims, those who have been wronged, get nothing, and only a trivial proportion of wronged victims have the satisfaction (if it turns out to be that) of winning in court. At the same time, many successful claimants are not “deserving” in the sense of having been wronged.

On the defendant side, physicians generally do not pay higher malpractice insurance premiums because of successful malpractice claims against them. Rather, rates turn far more importantly on the number and size of claims against other doctors practicing the same specialty and in the same region (p 76).

Because nearly all the claims are either settled or dropped, “blame” as assigned by the current system is both highly selective and often misapplied. Insurance companies settle many undeserving claims for their nuisance value, often irritating the physicians involved (p 15). And while doctors are actually vindicated about half of the time in court (p 168 n 8), victory in litigation is hardly the sort of justice they crave. (At the same time, some of those doctors who win at trial probably did commit malpractice, but win because of a lack of evidence, or a jury that is overly sympathetic to or awed by them.)

Meanwhile, most “malpractice” in the legal system turns out to be the sort of momentary slip of the hand that most people fre-
quently display (p 14). Unfortunately, in risky medical treatment settings those momentary errors can be extremely harmful. While we might agree that people victimized by these sorts of errors are in some sense "entitled" to better care, an error of this sort hardly makes someone a bad person, let alone a bad doctor. Contrary to widespread belief, repeat offenders are actually responsible for a small share of the malpractice that occurs (p 79). A truer picture is that a large number of doctors regularly commit errors that are in theory avoidable, and only some of these doctors are unlucky enough to have those errors lead to significant patient harm.

D. Prevention

Weiler concludes, and I agree, that if the current legal system covering medical malpractice can be justified at all, it must be because of its role in preventing medical accidents by deterring acts of malpractice that would otherwise occur (p 71). Of course, even if the present scheme had some positive impact on physician conduct, that would hardly end the inquiry. Alternative deterrence strategies would also have to be considered.

Weiler addresses the prevention issue in his marvelously helpful Chapter 4. Weiler believes that the existing malpractice regime does aid patient safety (p 91). But he concludes that certain reforms would do better not only on this dimension, but also on other dimensions (such as better victim compensation, lower administrative costs, and less harm to physicians and medical practice) (p 132). However, the goal of accident prevention remains central to Weiler's victim compensation reforms.

By contrast, I believe that the right strategy is to move toward the separation of the behavioral control and compensation functions—which, as I will explain, would take us away from both the current malpractice scheme and Weiler's favored alternative.

II. Track One Reforms: Substantial Changes in the Traditional Legal Regime

Weiler calls for reform along two tracks. Track two involves moving to what he calls "no-fault liability" for medical accidents. I will discuss this approach in the next section. Track one, my focus here, involves what he terms "serious reform" of the traditional system.

Weiler generally eschews doctrinal reform concerning the standard of care that physicians owe their patients. He quickly dismisses alternative dispute resolution procedures, like screening
panels (p 42). Instead, he concentrates on damages law. In Weiler's prescription, successful medical malpractice plaintiffs should not receive compensation for losses covered by "collateral sources" (pp 47-54) and should have reduced recovery for pain and suffering (pp 54-61). In return, they should receive compensation for their attorney's fees (pp 61-69).

In favoring such a trade, Weiler basically endorses the solution that Professor Jeffrey O'Connell and I have recommended previously for personal injury cases generally—although, in the details, there are perhaps some important differences among us.\textsuperscript{10}

A. Reversing the "Collateral Sources" Rule

Weiler, O'Connell, and I all favor a general reversal of the common law rule that ignores other "collateral" sources of compensation for the same loss when determining the amount of a victim's award in a tort case (pp 50-52). Weiler does not pay much attention, however, to the details of just which collateral sources should count in reducing what otherwise would be the victim's malpractice award.

I assume Weiler would agree with me that a plaintiff should not recover in a lawsuit for losses already covered by social insurance or public assistance benefits or by basic work-related employee benefits, like health insurance. I also assume that Weiler

\textsuperscript{10} O'Connell's proposed trades came in two sequential proposals that I have combined into a single recommendation for the purposes of this review. See Jeffrey O'Connell, A Proposal to Abolish Contributory and Comparative Fault, with Compensatory Savings by Also Abolishing the Collateral Source Rule, 1979 U Ill L F 591; Jeffrey O'Connell, A Proposal to Abolish Defendants' Payment for Pain and Suffering in Return for Payment of Claimants' Attorneys' Fees, 1981 U Ill L Rev 333; Stephen D. Sugarman, Doing Away With Personal Injury Law 167 (Quorum, 1989); and Stephen D. Sugarman, Serious Tort Law Reform, 24 San Diego L Rev 795 (1987).

Apart from issues discussed in the text, O'Connell and I both proposed that, as part of the trade, plaintiffs should gain an additional advantage through the elimination of the defense of plaintiff fault. Victim fault would constitute neither a complete bar to recovery, as in the common law regime, nor grounds for a reduced recovery, as is the case under modern comparative fault systems now in place in most states. Weiler does not include this change in his package. Of course, in medical malpractice cases, plaintiff fault is rarely an issue anyway, so this difference among us has little consequence in the malpractice context.

I would also have plaintiffs give up some access to punitive damages by making their availability and amount a matter for the judge, rather than the jury, to decide. This rule would bring punitive damages law in personal injury cases closer to the practice in civil rights law where a judge will often award large attorneys' fees in class action cases which expose and bring to justice especially bad conduct by the defendants. Weiler does not address the issue of punitive damages in his book, perhaps for the sensible reason that it has played relatively little role in the medical malpractice field. The Reporters' Study calls for restraints on the award of punitive damages. Reporters' Study at 231-65 (cited in note 2).
would agree that malpractice law should continue to ignore the victim's savings and personally-purchased, permanent life insurance, even though they too are available to replace the losses incurred. After all, reversing the collateral sources rule isn't really meant to turn tort law into a means-tested compensation scheme.

Rather, the justification for the proposal is to channel the responsibility for the compensation into broadly applicable and far more cheaply administered first party loss insurance schemes and away from third party liability insurance which is so costly to administer. Yet, even given this general rationale, it is rather difficult to decide what to do about things such as disability insurance, especially when individually purchased by the victim outside the job context; and term life insurance, especially when automatically provided to all employees by the victim's employer. These are close questions that several state legislatures have already recognized in their attempts to turn the general pronouncements of law professors (and others) about the collateral sources rule into specific statutory provisions.\(^1\)

Weiler contrasts the reversal of the collateral sources rule with the imposition of an overall ceiling on malpractice awards (p 51), an approach, he notes, that has been followed in a few states (p 49). He opposes the latter, and I agree, because it bites most in the relatively few cases with the greatest loss (p 50). Reversing the collateral sources rule, by contrast, concentrates malpractice payments on cases of greater need.

B. Limiting and Standardizing Recovery for Pain and Suffering

Weiler, O'Connell, and I have somewhat divergent views with respect to tort compensation for pain and suffering. O'Connell's favored solution is to eliminate it altogether.\(^2\) I do not favor that solution, at least for now, partly because it may be thought to represent too sharp a break with tradition, partly because of my empathy with the outrage that may be felt by those very seriously harmed through the fault of another, and partly because even workers' compensation law tends to pay some arbitrarily selected amounts to those who suffer serious permanent impairments.

Therefore, I propose retaining tort recovery for pain and suffering, also called "general damages," but in a quite restricted

\(^{11}\) More attention is given to the details of reversing the collateral sources rule in 2 Reporters' Study at 161-82 (cited in note 2).

form. First, no one could recover general damages who had not suffered a serious injury, defined as involving either a disability that prevents one from returning to one’s normal activities for more than six months, or a significant and permanent impairment or disfigurement. The idea is to eliminate payments to those claimants who now milk the defendant for the nuisance value of their claim, those claimants who feign or exaggerate soft tissue injuries, and, candidly, those who may well have suffered immediately following their injury, but who, by the time of trial, no longer have significant residual suffering from the accident.

This threshold is broadly based on the threshold employed by the Michigan auto no-fault scheme. It is intended, if applied to all torts cases, to bar the general damages claims of more than three-quarters of those now receiving some compensation for pain and suffering. In the medical malpractice context, however, one would expect proportionately fewer pain and suffering claims to be barred. This result is expected because the difficulties and expense of medical malpractice litigation already serve to exclude from the system a fairly large proportion of small injury cases.

Second, I propose a ceiling on pain and suffering recovery. It would be set at $150,000 (in 1988 dollars) and would grow with inflation.\textsuperscript{13} Weiler rejects a ceiling of the sort I’ve proposed on the ground that it arbitrarily imposes reduced recovery only on those who have been most seriously injured (pp 55-56). Yet, in practice, as I will shortly explain, I would hope that my proposal could work very much like the considerably more sophisticated regime that Weiler offers.

Weiler favors the creation of a “scale” (pp 58-61). A scale is not the same as a schedule which would attempt to establish in advance a certain dollar sum for every sort of injury. Instead, the scale would assign so many dollars for each of a selected array of injuries. The top of the scale would be reserved for the most serious non-fatal injuries—such as an infant blinded or made quadriplegic at birth (p 59). Other representative and less serious injuries would also appear on the scale, to which lesser dollar amounts of recovery would attach. In addition, the scale would take into account the age of the victim and hence the number of years of suffering ahead (id). The parties (in settlement negotiations) and juries and judges (in cases that go to trial) would be told

\textsuperscript{13} O’Connell’s fallback position is less restrictive than mine. Were the legislature not to abolish pain and suffering awards altogether, his alternative statutory language would impose a threshold similar to mine, but no ceiling. Id at 350.
about the scale and would seek to locate their claims at an appropriate place along it (pp 59-60).

As Weiler well recognizes, a scale (as well as a schedule) would in fact contain its own ceiling. But Weiler says that the way existing ceilings work is that juries, unaware of the ceiling, decide on the amount of common law damages to which the victim is entitled. Afterwards, the judge simply applies the cap (p 59). This process results in a range of injuries of quite different degrees of severity being treated alike at the top (p 59).

Caps need not work that way, however. Suppose instead, judges, juries and litigators were told that the purpose of the cap is to serve as the highest point on Weiler's scale—as a sum reserved for the most serious and long-lasting harms only—with lesser injuries to receive appropriately lower amounts. With that understanding, the two schemes might well function much alike, although I concede that Weiler's proposal holds the promise of greater consistency among cases falling along the scale. The real dispute between us here is the comparative advantage, if any, of rule-making over individual adjudication. In this context, the English common law judges seem to have developed a de facto scale, without formally adopting one through the rule-making process Weiler proposes.¹⁴ In any event, Weiler and I seem close here in principle, if not in administrative detail.

Another key point of agreement is that in order to reach even the bottom of Weiler's scale, the plaintiff would have to suffer at least the sort of serious injury I described in discussing my proposed threshold (pp 59-60).

A possibly important difference between us is the current dollar value to be awarded for pain and suffering in the most serious injury cases and, in turn, the amount to be awarded along the scale to all seriously injured victims with valid claims. That is, Weiler might find my inflation-adjusted $150,000 rather too low as the top of his scale, although he is a bit coy on this question.

My idea is to provide enough money so that the most seriously injured victims could invest the award and comfortably earn the arbitrary sum of $1,000 a month in 1988 dollars—an amount that would significantly benefit most Americans, but would not make anyone rich. Given modest inflation and lowered interest rates since 1988, the $150,000 figure might be raised to $200,000 today.

Weiler first argues that the point of the pain and suffering award should be to allow the person to adjust socially and psycho-

¹⁴ But, of course, English personal injury cases generally do not use juries.
logically to his or her condition, just as the other damages awarded address medical and vocational adjustment (p 58). He emphasizes the importance of inquiring whether the award really can be used to pay for things that would further those social and psychological goals (id). Yet, it is not clear that he favors individualized inquiries along these lines. He gives an example of a hobbyist piano player and a hobbyist chess player each losing a hand, suggesting that, other things being equal, the piano player should get a larger payment (pp 60-61). But this illustration seems primarily to emphasize differences in lost enjoyment from similar injuries, not so much a difference in what each person needs to adjust, unless he has in mind the pianist taking lessons to learn how to play pieces written for one hand. So, too, when he suggests that a blind or quadriplegic child should be at the top of his scale (p 59), he really doesn’t justify this suggestion in terms of appropriate spending for social and psychological adjustment, but rather, it seems, in terms of the enormity of these injuries.

As a result, Weiler’s analysis, like mine, provides no real basis for determining the range of the scale, and, like mine, his solution would involve a certain arbitrariness. At one point Weiler says that under his plan the amount paid at the ceiling “would likely fall well within the range of the statutory damage caps recently adopted by the state legislatures” (p 58). I find this statement ambiguous. Does he have in mind as the range Maryland’s $350,000 limit and New Hampshire’s $875,000?15 Is California’s $250,000 cap in medical malpractice cases, adopted in the 1970s, “recent” enough? While Weiler’s discussion leaves me thinking that the top of his scale might approach $500,000, I note that he also favorably cites the Canadian approach in which the scale tops out at about $200,000 Canadian (close to my recommendation) (pp 58, 195-96 n 45).

C. Paying Successful Plaintiffs’ Legal Fees

Weiler, O’Connell, and I all agree that successful claimants should be entitled to reasonable legal fees as part of their damage award, and that losing claimants should not be obligated to pay the legal fees of defendants (pp 66-67). Frivolous claims aside,

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bringing a lawsuit is not a tort, and, given the current tort system, the cost of defending against non-frivolous claims seems fairly a part of the cost of the practice of medicine. By contrast, requiring the defendant to pay for those real costs incurred by winning plaintiffs seems just. This sense of justice is especially clear because the proposed changes would reduce recovery for pain and suffering and collateral sources—damages that are well understood, as a practical matter, to provide the money to pay for the plaintiff’s lawyer.

I propose that plaintiffs who win at trial normally be awarded legal fees calculated as a declining percentage of the rest of their award, starting with forty percent of the first $50,000 awarded and decreasing to a sum equal to fifteen percent of the award above $600,000.\textsuperscript{17} In a small proportion of cases involving special difficulty or ease, trial judges would be permitted to award higher or lower sums for the lawyers. For cases that settle reasonably early in the litigation process, I propose that a lower proportion of the award should be added on for legal fees. Although O’Connell’s proposed statute provides for the payment of “reasonable attorney’s fees” by defendants to successful plaintiffs, it does not address how to determine that sum.\textsuperscript{18}

Weiler falls somewhere between O’Connell and me in terms of specificity. Although he does not take a firm stand, his tentatively favored solution seems to be one in which, like mine, the legal fees would be set as a percentage of the overall award (pp 68-69). The specific percentage would not vary based on the amount of the award; instead, it would vary based on the point in the process at which the case is resolved (for example, fifteen percent if settled early and thirty-five percent if tried) (p 64). Weiler appears to endorse part, but not all, of my proposal.\textsuperscript{19}

We disagree over whether the attorney’s percentage should be lower the higher the total amount of the award. The disagreement turns in large part on our different views of the current market for plaintiffs’ legal services, which I believe is quite imperfect and Weiler does not. As I see it, most claimants do not shop for lawyers; they see only one, by referral or otherwise, and do not bargain

\textsuperscript{17} This percentage schedule is based on the California rule now in place that limits how much the plaintiff’s lawyer may take out of the plaintiff’s award. \textit{Cal Bus & Prof Code} § 6146 (West, Supp 1990).

\textsuperscript{18} O’Connell, 1981 U Ill L Rev at 352 (cited in note 10).

\textsuperscript{19} He also proposes several nice additional wrinkles to deal with both baseless suits and frivolous defenses, as well as unreasonable unwillingness by either side to settle during the process once an offer is made (p 68).
over price. Of course, even if a small proportion of claimants
shopped well, they might effectively police the market for everyone
else. But I don’t think that happens either.

Even when claimants shop among lawyers, frequently through
referrals, I believe that malpractice attorneys try to convince
claimants to employ them through non-price-cutting strategies. If
nothing else, offering a lower price might inadvertently signal to
the would-be client that the lawyer is less qualified. That danger is
especially great in those cases where the plaintiff is highly risk-
averse and unable to evaluate either how good the lawyer is or just
what sort of lawyer is needed. Rather, the claimant generally wants
the best lawyer possible, fearing that otherwise the case might be
lost entirely. If I am right that claimants typically select their law-
yer on the basis of reputation, the result, in a socially perverse
way, is that the lawyers with the best reputations will tend to get
the easiest and most lucrative cases. Conversely, those with lesser
reputations will handle the harder cases. The best strategy for am-
bitious and talented lawyers lower down in the pecking order,
then, seems to be to work exceptionally hard in an effort to build a
reputation in the legal community, not to charge a lower fee.

Were there to be negotiations among sophisticated parties for
legal services in malpractice cases, I believe that contracts would
provide for a lower percentage the more recovered, as is apparently
true for real estate agent commissions on sales of homes. This re-
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nor terribly original. The areas Weiler addresses are exactly the ones that legislatures, scholars, and commissions have been working to reform.

The most important quality of Weiler's proposal, in my judgment, is that it is balanced. This balance is in sharp contrast to the one-sided proposals from the Reagan and Bush Administrations\(^2\) and, as Weiler points out, to the generally one-sided legislation that states have so far enacted. And Weiler's particular balance, it must be re-emphasized, would mesh the damages awarded in malpractice cases with malpractice claimants' actual losses far more sensibly than does the current system.

Given the wide array of legislation enacted by different states during the past twenty years, Weiler's package would have quite different meanings from state to state. For example, in those states that have already reversed the collateral sources rule and capped pain and suffering awards, or capped total awards (pp 31-32), the total cost of the system to defendants might actually go up under Weiler's plan. By contrast, in a regime still embodying the basic common law rules, Weiler's package should reduce overall costs to defendants, as well as significantly altering who gets what.

Creating more predictability in awards by imposing a threshold on, and precluding extravagant awards for, pain and suffering is likely to lead to somewhat reduced administrative costs and to the elimination of a fair number of weak, modest-injury liability cases. On the other hand, there is little reason to think that this sort of package will either end the payment of invalid claims where there are serious injuries but no malpractice, or increase legitimate serious injury malpractice claims. And, of course, this package does not broaden coverage to seriously injured victims of adverse events in the absence of malpractice.

In sum, Weiler's package deserves support because, although it would not likely have a dramatic impact on malpractice insurance premiums, it would distribute money among plaintiffs in what I consider to be a far more socially desirable way than does the current system and is not easily labeled pro-plaintiff or pro-defendant.23

E. A Further Idea—Organizational Liability

Although it appears elsewhere in his book, Weiler recommends yet another change that I think should be included as part of his track one reform. He calls it “organizational liability” (pp 122-32). Breathtakingly simple, and exceedingly inventive, organizational liability means that, for injuries incurred inside health care institutions, mainly hospitals, the institution—not the physician—would be liable for the physician’s malpractice. Victims could not sue their surgeons or anesthesiologists, for example, but could sue the hospital instead. The proposal would treat doctors as employees of hospitals, even when they are, for other legal purposes, only independent contractors.

The direct consequences of organizational liability would be that doctors could no longer be named as individual defendants, except in cases concerning malpractice they might commit in their offices, and they would no longer purchase individual malpractice insurance to cover torts they commit in hospitals. As Weiler explains, this reform would largely conform medical practice to the prevailing situation in health maintenance organizations, some university and public hospitals, and other settings where the doctors are in fact employees of the institution and do not buy their own malpractice insurance (pp 124-25). While doctors in those other settings today may actually be named as defendants, everyone involved soon appreciates that any damage or settlement awards will be paid by the employer or its insurer.

Thus, although the formal common law rule is that employers who are held vicariously liable for the torts of their employees have a right of indemnity from their employees, this right simply is not asserted against negligent employees who impose costs on the organization. The upshot, as Weiler notes, is that doctors would basically be treated the way airline pilots are in cases arising out of plane crashes (p 125). Pilots are not expected to carry individual

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23 Subject to the reservations I have already noted as to some of the details.
insurance and, whatever the technical legal rights of their employer airlines, airlines simply do not seek indemnity from negligent pilots.

I agree with Weiler that two strong advantages of organizational liability would be that: (1) hospitals could better build medical malpractice costs into the overall cost of patient care than could doctors (p 127), and (2) physicians would no longer labor under the fear of an individual judgment against them that they perceive to be unjust (p 131). For those reasons, I applaud and support this recommendation.

Weiler's own main reservation about his proposal concerns whether it might lead to more careless conduct by doctors (p 129). But he concludes that, to the contrary, organizational liability should actually lead to fewer patient injuries as compared with the current rule (pp 129-31). Weiler is keenly aware that, although airline pilots don't individually pay tort damages when their carelessness brings about passenger harm, airline liability, at least in theory, translates into the retraining, discipline, or even firing of negligent employees. Likewise, he envisions that hospitals would respond to the threatened imposition of organizational liability with new and more effective behavioral controls over their physicians. As a result, in Weiler's view, organizational liability would also prove beneficial in preventing accidents.

I am skeptical about these projected safety gains; at the same time, I am not worried that organizational liability would lead to more patient injuries. But I want to reserve my discussion of the question until I take up Weiler's track two no-fault reform proposal, which also contains organizational liability as a component and depends importantly for its intellectual justification upon the same alleged safety-promoting features.

III. Track Two Reforms: Toward a No-fault System for Medical Accidents

A. The Plan

Most exciting of Weiler's recommendations is his call for a no-fault compensation scheme covering all seriously injured victims of medical treatment. Although he admits that he has not yet worked out the full details of his proposal, its main features are clear. Any hospital patient injured by medical treatment who is disabled for

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24 Of course, malpractice litigation would still focus on whether the doctor acted carelessly.
six months or more would be entitled to compensation from the hospital, regardless of fault (p 136). That compensation would cover economic losses (such as lost income, lost household production, and medical and rehabilitation expenses) not otherwise covered through broad-based social and first party insurance schemes (id). It would also include modest payments for non-economic loss to the severely and permanently disabled, based upon a schedule that takes into account the victim's age at the time of injury and the nature of the impairment (p 135).

Weiler is not the first to recommend a no-fault approach to medical accidents. O'Connell proposed an "elective" no-fault remedy for malpractice problems nearly twenty years ago. Clark Havighurst and Laurence Tancredi, separately and together, have been promoting various medical no-fault plans for just as long. Weiler's analysis, however, is the first to claim that it is both affordable and administratively feasible for no-fault to cover the full range of patient harms from medical treatment, provided that coverage is restricted to the most seriously injured.

Previously, it was generally believed (or feared) that it would too often be too hard or too expensive to tell whether medical treatment caused the injury. After all, many people leave the hospital worse off than when they entered, not because of something done to them by their doctor or by hospital employees, but because their ailment has simply taken a turn for the worse. None of the advocates of medical no-fault plans believes that a no-fault program should cover those situations. People who die or decline from the disease or condition from which they suffer on entry are not the responsibility of the medical establishment. No-fault is meant to pay only for those patients the system accidentally harms, whether through malpractice or not. In addition to the causation problem, it has been feared that it would be much more expensive than in the current system to compensate all patients who are accidentally injured in the course of medical treatment.

Faced with these causal and fiscal conundrums, medical no-fault advocates have tended to favor creating a list of typical injuries that are generally caused by medical accidents and have reasonably well understood financial consequences. The no-fault plan

would then cover only those things on the list (often called the "designated compensatory events"). This list might be generated legislatively to cover all hospitals, or it might be the product of decentralized market transactions in which individual hospitals and patients contractually agree that the no-fault plan and not malpractice law would cover specified injuries.

Weiler argues, however, that the Harvard study reveals two startling facts that go against the conventional wisdom. First, determining whether a patient is suffering from a medical accident or not was, in the Harvard study, not so difficult after all. Based upon expert reviews of medical files, only five percent of the cases were "close calls" (p 144). So, while there will be hard cases, those situations evidently do not arise very often. Second, even though nearly fifty times as many patients suffer from medical accidents as recover on malpractice claims (p 134), restricting the no-fault plan to the less than one-fourth of those victims who are seriously injured and then compensating them only for their net losses appears to make the scheme affordable (pp 135-36).

Notice that this "same-cost" assertion assumes that the no-fault plan would substitute completely for the tort system, at least for injuries suffered in a hospital. The implication, then, is that Weiler's track one proposals are best seen as first step reforms of the traditional system.

It remains to be seen whether the ease of administration and affordable cost conclusions would stand up in practice, and the Harvard study has already run into criticism along these lines. But I believe that Weiler has made a strong enough showing of his proposal's potential practicality that the proposal plainly deserves the more careful study and evaluation that Weiler seeks.

B. The Likely Impact of Weiler's No-Fault Plan

In order to decide what difference Weiler's no-fault plan would make, we must compare it to something. The most important comparison, I believe, is to the malpractice system altered by Weiler's track one reforms discussed above.

Consider, first, the seriously injured who would otherwise have valid malpractice claims. Because track one reforms would already restrict them to net economic losses and curtail payments for pain

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and suffering, in most cases their benefit package would not be terribly different under the no-fault plan. First, hospitals would be liable for pretty much the same net out-of-pocket losses under both schemes. To be sure, Weiler's no-fault plan would restrict lost wages to no more than 150 percent of the state average wage (p 137), so that the relatively few no-fault claimants who earn more would be denied full recovery if they had failed to arrange for disability or life insurance on their own. But, of course, those higher earners are exactly the people who are most likely to have such private first party protection anyway.

In addition, the no-fault plan would probably cut back pain and suffering awards even further. Weiler doesn't acknowledge this directly, but the language he uses in describing those benefits (p 135) and the workers' compensation analogy he draws upon (p 132) suggest that would be the case. Whether this result would lower claimant recoveries to the range I have proposed for tort law, or even lower, remains to be seen.

In return for these reductions, claimants would be spared the burden of having to prove malpractice. Assuming the Harvard Study's findings about the eligibility determination under no-fault hold up, recovery would become enormously easier for those who now eventually show enough evidence of malpractice to win a settlement or verdict.

And, of course, no-fault would bring in a large new group of previously uncompensated claimants who suffer from adverse events not caused by malpractice. Unfortunately, Weiler does not make clear just how many new beneficiaries we are talking about, but it has to be many times the number who are currently compensated for serious injury caused by malpractice.

Most seriously disabled, elderly victims of medical accidents, now covered by Medicare and Social Security, would likely be eligible for little more than the no-fault plan's pain and suffering payment, because their uncovered economic losses are likely to be small. Some, however, would exhaust their Medicare coverage, or have special needs that no-fault, but not Medicare, would cover, and would substantially benefit from the plan. Most middle and professional class people with steady jobs would be largely restricted to recovering the pain and suffering component, because other insurance would already cover most of their economic losses. However, some people in those groups do not have adequate health insurance, rehabilitation coverage, or disability income protection, and could benefit considerably. If a member of one of these groups were killed in a medical accident, her heirs might qualify for sub-
stantial income replacement benefits under the plan, depending on the extent to which the plan allows duplication of the victim’s own pension and life insurance benefits.

The plan would be of the most help to those people currently without much first party insurance protection. These individuals typically include homemakers, children and older students, the temporarily unemployed, and modest earners employed in the secondary labor force or by small employers without good employee benefit plans. As Weiler notes, income replacement is especially important, since, as the Harvard study found, insurance typically protects only a small portion of lost earnings (pp 136-37).

By paying only after other basic compensation sources have been expended, Weiler’s no-fault medical accident plan would be far better aimed at real need than are existing auto no-fault and workers’ compensation schemes. Simplifying somewhat, those schemes, like the traditional tort system, are primary in the sense that if they and some type of first party insurance both cover the same loss, the loss falls on the compensation plan and not the insurance. By contrast, just as Weiler wants reformed malpractice law (in his track one reform) to pay only after “collateral sources” do, he also wants the medical no-fault plan to pay last.

C. How the Money Is Redirected

How are all those extra no-fault claims to be funded? There are three major sources of money. One portion would come from money saved as a result of lowered recoveries by those who are covered—lowered both from what Weiler’s reformed malpractice system would pay and from what the current tort system pays.

The second major source of funds would be reduced costs of claims processing. Weiler believes that, instead of society spending more than fifty percent of the malpractice premium dollar on administration as is done today, the no-fault plan would reduce spending to fifteen to twenty percent on claims administration, more like what is spent in workers’ compensation (pp 139, 229 n 38). This savings is to be achieved by employing an administrative compensation mechanism something like that which Social Security now uses in determining eligibility for disability benefits. Here Weiler writes somewhat approvingly of a recent proposal of the American Medical Association to shift medical malpractice claims to an expert administrative model and away from the current judi-
cial model (pp 114-22). But for Weiler the AMA proposal is much too timid, as it would retain the basic fault criteria as the entry point into the system (pp 117-18). Still, Weiler likes the AMA's idea of using specially trained hearing officers to decide doubtful cases (pp 115-16). In any event, the aspiration is that the administrative model would drastically reduce the use and cost of lawyers on both sides. Weiler is quite aware that workers' compensation in America has not eliminated claimants' lawyers; on the other hand, their compensation is typically a far lower share of the recovery than that paid in tort suits. So, whether compared with legal fees paid for by both sides (as today) or by defendants (as under Weiler's track one reforms), the legal fees under the no-fault plan are meant to be considerably less.

The third main source of funds to cover new claimants under the no-fault plan would come from the elimination of malpractice claims by those without serious injuries (p 136). Of course, many of those victims are de facto closed out of the current system because the costs of pursuing their cases, given the prospective recovery, make lawyers unwilling to take them. Even the payment of plaintiffs' legal fees by defendants under Weiler's reformed tort law is not likely to cause many more claims to be filed. The AMA's plan, by contrast, seeks to bring these lesser-injured victims into the system, by providing a lawyer for any claimant with a bona fide claim. Weiler's no-fault plan, however, not only excludes all the smaller-injury victims from coverage in the no-fault scheme, but also seemingly would deny them their tort rights. Weiler first disavows a position on the "exclusivity" issue (p 134), but then proceeds on a "same cost" assumption (p 135) which requires exclusivity if all the costs are to be used up by no-fault.

Weiler's approach to medical no-fault sharply departs from the American automobile no-fault practice. There, a few states like Michigan and New York aside, the plan is aimed almost entirely at small-injury cases, not the seriously injured. Automobile no-fault benefits are available with little or no deductible and no requirement of serious harm, and they have very low caps, such as $10,000. The seriously hurt are left to try their luck with tort law.29


29 Department of Transportation, Compensating Auto Victims (May 1985).
Weiler's medical no-fault is concentrated on the seriously injured. To keep costs under control, the plan would deny a tort remedy to anyone injured by a medical accident in a hospital.

I would be far more content to exclude those not seriously injured by medical accidents from both the tort and the medical no-fault plan were we to have a stronger social safety net for all Americans who are disabled for six months or less. That means reasonably assured first party health care benefits for lesser disabilities and well-designed, short term income replacement benefits. Having such programs in place, I believe, would also make Weiler's plan politically far more plausible.30

IV. TRACK THREE REFORMS: BROADENING THE SOCIAL INSURANCE NET AND DE-COUPLED PREVENTION AND COMPENSATION

A. The Comprehensive Compensation Alternative

As are his track one reforms, Weiler's no-fault plan is hospital based—doctors would not be individually responsible for compensating hospital patients who suffer an accidental injury while under their care. As before, Weiler's justification is that imposing the costs on sophisticated organizations like hospitals will promote safer and more cost-effective medical practice.

Otherwise, Weiler would surely agree that there is no principled basis for advantageously singling out victims of medical accidents for compensation. After all, once fault is abandoned as the criterion, one cannot very forcefully argue that someone who is injured through the course of medical treatment has a greater entitlement to receiving compensation for his or her losses than does one who suffers losses directly from illness or birth defect, or by an accident occurring outside of the hospital.

Indeed, because I believe that all Americans suffering from disabilities of virtually every cause should have access to a program that takes reasonable care of their medical and related expenses and reasonably replaces their lost wages, I much prefer a comprehensive compensation solution that does not distinguish among medical accidents, auto accidents, product injuries, work accidents and the like. For me, such a solution would rely upon a

broadened Social Security system and increased mandatory employee benefits.\textsuperscript{31}

B. Do We Need Medical No-fault for Accident Prevention?

But what of the claim that we need focused plans, such as Weiler's medical no-fault scheme, in order to force those who are in a position to reduce accidents to internalize costs so that the accident rate will decline? There are two responses to this claim. The first retort was given by Professor Marc Franklin more than twenty years ago and reiterated by Professor Richard Pierce more than ten years ago.\textsuperscript{32} As they pointed out, it is quite possible to imagine a comprehensive compensation scheme that makes no distinctions among causes of harm on the benefits side, but which is funded by contributions that vary with the number and severity of accidents caused by the scheme's funding sources, which, of course, could include hospitals.

The second retort frontally challenges the prevention claim. A reduction of medical accidents is better promoted through behavioral control mechanisms that do not depend upon the hospital having a financial interest in paying out lower no-fault benefits or making lesser contributions to the compensation fund.\textsuperscript{33}

For one thing, organizational no-fault liability also gives hospitals socially perverse incentives. For example, as is the case of employers under the existing workers' compensation scheme, hospitals will have a strong financial reason to fight claims by arguing that the claimant's injury was really caused by the condition that brought the patient to the hospital, and there will be pressure to organize the information collected at the hospital to lead to this conclusion. Hospitals are also likely to find it financially attractive to turn away patients whose health profiles make them most at risk of medical accidents, and to discourage or forbid the performance of medical treatment that most risks medical accidents—even when serving the patient and performing the riskier treatment are the socially desirable behaviors.

On the other hand, hospitals already have considerable incentives to police the conduct of independent contractor physicians, quite apart from any fear that courts might manipulate existing

\textsuperscript{31} Sugarman, \textit{Doing Away} at 127-52 (cited in note 10).


\textsuperscript{33} For my general arguments against tort law as an effective deterrent, see Sugarman, \textit{Doing Away} at 3-34 (cited in note 10).
tort doctrine to hold them legally liable for the malpractice of doctors working there. First, a hospital does not want to gain the reputation that its patients are more commonly victims of malpractice than patients elsewhere. Second, hospital administrators and boards are concerned about the care received by patients they tend; although hospital managers may increasingly think of themselves as running businesses, surely there is still a strong self-imposed moral commitment to good medical care. Anyway, to the extent that business considerations do dominate, I believe that the changes brought about by recent health care cost containment pressures also give hospitals an incentive to get their doctors to do it right the first time. Now if the doctor fouls up and the patient has to stay longer for more treatment, this longer stay may well not be paid for by the private or public insurer standing behind the patient.

This does not mean that all or even most hospitals today adequately supervise doctors practicing there, require retraining for doctors who need it, or deny privileges to incompetent physicians when that drastic solution is warranted. But many of the barriers to such actions would remain under Weiler's no-fault plan, or, alternatively, might be removed quite apart from his plan. For example, Weiler explains that the fear in the health care profession that a disciplined health professional will invoke antitrust laws may help explain some of the reluctance by hospitals to act more aggressively in policing those professionals (pp 111-12).

The Harvard Study sought to develop and analyze new evidence on the impact of tort law on physician behavior through an econometric study that relied on the fact that the likelihood of being sued for malpractice varies considerably from place to place within New York state. For reasons not worth trying to detail here, I am skeptical about this aspect of the Harvard study. Perhaps more importantly, Weiler himself expresses grave misgivings about whether the study really proves that malpractice law actually causes better medical care. Still, he does assert that it is his “judgment” that malpractice law has a “modest...preventive effect” (p 90).

Yet, if Weiler were right, we should expect to see lower malpractice rates in hospitals that are part of health maintenance organizations, other things being equal, as compared with hospitals in which independent physicians practice. After all, for the current malpractice system, HMOs face organizational liability of the sort Weiler is advocating. But I have seen nothing from the Harvard study or other research that demonstrates that HMOs or other
hospitals with employee-physicians in fact do respond with the
greater accident prevention efforts that Weiler's simple economic
model predicts. An important part of the explanation for this lack
of response, I believe, is the very point that Weiler himself empha-
sizes: a large amount of malpractice actually involves slips of the
hand or momentary inattention that are extremely difficult to
avoid (p 129).14

Moreover, Weiler himself points to new developments on the
regulatory front that hold considerable promise in terms of medi-
cal accident reduction quite apart from any cost internalizing
strategy. Simply put, state medical boards are probably better ad-
vised to spend more of their resources on requiring hospital risk
management and physician peer review rather than directly inves-
tigating and prosecuting doctors themselves (pp 110-11).

To be sure, these boards may not currently have sufficient re-
sources available to them to carry out their regulatory functions as
effectively as we might like. But it would surely seem right to redi-
rect toward regulatory enforcement some of the money that could
be saved by eliminating the administrative costs of determining
causation, as would occur were a comprehensive accident or disa-
ability compensation plan substituted for medical no-fault and
other focused plans.

C. Medical No-fault as a Step

Nevertheless, I can support Weiler's medical no-fault plan, not
as the best long-range solution, but instead as a step toward a
more comprehensive system for compensating the seriously dis-
abled. Taking political reality into account, we would expect to
achieve Weiler's track one reforms sooner than his medical no-
fault reform. Indeed, medical no-fault might be preliminarily tried
on an elective basis or in a few experimental states, as Weiler sug-
gests, before being applied universally (p 151).

If, however, concurrent with the track one reforms an ex-
panded temporary disability insurance scheme were adopted and
combined with a strong national health insurance system, then

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14 For very recent analyses of the impact of medical malpractice law on the promotion
of safety and the slowing of innovation, see the following essays in The Liability Maze,
Peter W. Huber and Robert E. Litan, eds (Brookings Institution, 1991): Gary T. Schwartz,
Product Liability and Medical Malpractice in Comparative Context 28; Stanley Joel Rei-
sier, Malpractice, Patient Safety, and the Ethical and Scientific Foundations of Medicine
227; and Laurence Tancredi and Dorothy Nelkin, Medical Malpractice and Its Effect on
Innovation 251.
people would realize that neither tort law, nor workers' compensation, nor auto no-fault or other no-fault plans such as Weiler's would need concern themselves with other than the most seriously injured.

Perhaps in the next stage, then, we might enact a series of such schemes focusing on the seriously injured—say, for victims of medical accidents, airplane accidents, prescription drug and vaccine side-effects, organized recreational sporting accidents and the like, as well as auto and workplace accidents. At that point, however, rather than continuing to add plans covering more and more specified groups, many might conclude that it would be wiser to consolidate this proliferation of schemes into a single compensation plan.

Whether we should define that overall plan in terms of accidents as New Zealand has, or even more broadly in terms of the seriously disabled generally, as I have proposed, could then be debated. By then we should also know more about whether organizational no-fault liability for medical accidents had indeed contributed to patient safety (as Weiler predicts), in which case the funding of the comprehensive plan might well wish to target those hospitals experiencing relatively more accidents for larger contributions toward the funding of the comprehensive plan. Or, if, as I anticipate, we conclude (as New Zealand has so far) that fine tuning on the pay-in side is not really worthwhile, then the comprehensive plan would likely be funded by much broader-based revenue sources.

In sum, viewing both Weiler's track one and track two proposals as steps rather than ends, I find them highly attractive, and, as such, I very much hope that the prescriptions offered in Medical Malpractice on Trial gain the support they deserve.

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For discussions and evaluations of the New Zealand plan, see Terence G. Ison, Accident Compensation (Croom Helm, 1980), and Geoffrey Palmer, Compensation for Incapacity (Oxford, 1979).