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An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries†

Jeffrey O'Connell*

The inadequacies of tort liability as it applies to personal injury have become commonplace knowledge in recent years. David Sandford's incisive summary of the present system's unwieldy mixture of insurance, law, technology, and emotion—largely leading to frustration—is as follows:

Newspapers in March [1975] reported the sad story of Gail Kalmowitz, a nearly blind college student, who had undertaken to sue for negligence two doctors and the hospital where she had been born prematurely. She asserted that the defendants' failure to provide her adequate care following her birth in 1953 had caused her loss of sight. While the jury in her case was deciding its verdict, she became anxious about the outcome and accepted a $165,000 settlement offered her by the defendants' insurance company. A few minutes later the jury returned and she learned that had she not settled she would have won $900,000. Was she a fool?

The insurance company evidently expected a big verdict in her favor, but Miss Kalmowitz was merely playing the odds. . . . [After all] the majority of plaintiffs in malpractice . . . suits end up with nothing. Moreover, even if Miss Kalmowitz had waited for the jury, the defendants could have appealed and might, after years and expense to her, have won a reversal. Miss Kalmowitz chose a sure thing and that may not have been a mistake,[1]

† This Article is part of a study by the author financed by the John Simon Guggenheim Memorial Foundation; Consumers Union; the Foundation for Insurance Research, Study and Training (FIRST) of the League Insurance Group, Southfield, Michigan; and the Center for Advanced Study, University of Illinois.

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1. For an excellent description of the frustrations to doctors from a case like Kalmowitz, see N.Y. Times, Apr. 27, 1975, at 1, cols. 2-3. They are summarized in the following letter to the editors of Newsweek:

[The case of] . . . Gail Kalmowitz . . . is a classic example of the malpractice malaise threatening the health professions. Two physicians, practicing medicine according to the then current standards of care, preserve the life of a premature infant, who later becomes blind as a consequence of the high oxygen concentration that made her very survival possible. Twenty-two years later, the physicians are held retroactively accountable to a different and changing standard.

When it was discovered that the eyes of some infants were more sensitive than others to high oxygen concentrations, there
Ideally, an inept or careless physician should be made to pay the costs of the damage he does; likewise the manufacturer of a faulty or dangerous consumer product. Guilt should be fixed and punished and the fellow who makes the shabby power tool that ends up putting out someone's eyes should have to pay for the doctors, for the loss of a career, and for the lifetime support of the blinded consumer. "Ideally" is the key word, of course, because retribution is an inexact science. Some products are inherently hazardous—a chain saw for example—and if the user saws off his arm is it because the machine was faulty and the user was not warned of the peril, or is it because the victim operated the saw carelessly and in flagrant disregard of its operating features and instructions?

Nor is this common ambiguity the only problem. Whatever the circumstances of an accident, the lawyers for the contending parties, in our adversary system of laws, will arrive in court prepared to present, as theatrically as a judge will tolerate, the "best" case for their clients. Extraneous matters are introduced into proceedings to sway jury verdicts. Indeed, lawyers try during the empaneling of juries to select persons who, by dint of certain stereotypes, are likely to be more—or less—inclined to find in favor of one party or the other. A plaintiff's lawyer might prefer jurors who are young, or Jewish, or black, or who work in blue-collar jobs, and who are presumed to be generous in their impulses toward the injured. The lawyer representing the doctor accused of malpractice is likely to want on the jury retired persons living on fixed incomes and "tight with a buck," middle-management types, or a highly diverse group liable to squabble and unlikely to grant a large award.

Once a trial is underway the plaintiff and the defendant, each in his own ways, will try to win the sympathies of jurors with irrelevancies. The blind plaintiff might be encouraged to come to court with his seeing-eye dog and to dab at his eyes with a handkerchief. The corporation's lawyer might dress shabbily and play the rube and sit in court next to a "goat"—[an] . . . official of the sued company who, it is heavily implied, will personally suffer an adverse verdict [whereas in fact an insurer will almost always pay any verdict]. On the defense side was a concerted effort to lower oxygen concentrations in incubators to what were then considered less toxic levels. Predictably, there was a drop in the incidence of retrolental fibroplasia. Ironically, however, recent evidence in the United States, England and elsewhere now indicates that lowering oxygen concentration to prevent the rare occurrence of blindness has been accomplished at the cost of an increase in mental retardation of oxygen-deprived premature infants. It could be argued that Miss Kalmowitz might have grown up retarded instead of blind—had she in fact survived at all without the extra oxygen. This is a hard dilemma, but one we must face daily in our imperfect world. We can't have it both ways, and the burdens of choice are not eased by having to second-guess what interpretations will be placed on our actions by an emotion-charged jury twenty years after the fact.


there will be expensive technical experts offering abstruse testimony that the product at issue was not unreasonably dangerous, that it was not the product but something else that caused the injury, that the product was not defective when sold, that the injured person had been negligent in the maintenance or use of the product, that the manufacturer had amply warned of the hazards involved, and so forth.

The injured plaintiff in these cases is allowed to sue not only to recover the actual expenses incurred as a result of his accident—medical bills, lost wages, etc.—but for intangible pain and suffering. Thus a judgment can run into the hundreds of thousands of dollars or more, and the lawyer for the plaintiff, working on a contingency-fee basis, will collect a percentage, usually a third, of the money won in court. Doctors, particularly, are quick to argue that one of the reasons there are so many malpractice suits is that aggrieved patients are egged on by attorneys hoping to get rich. A third of a million dollars is quite a . . . . fee. Product liability suits and malpractice cases do seem to reward lawyers generously . . .

Whatever the virtues of the fault system and of law suits, it remains true, according to . . . the National Product Safety Commission, that “most injuries to consumers go uncompensated.” . . . Trials are expensive, and it’s not worth a lawyer’s while to sue for damages of less than $5,000 or $10,000. Perhaps two-thirds of those injured never pursue a claim beyond writing an unacknowledged letter to the firm whose product was involved in an accident.

The problem is immense. The Product Safety Commission estimates that 20-million people in the United States are injured each year “as a result of accidents connected with consumer products.” These are, quite frequently, architectural glass, color television sets, fireworks, floor furnaces, glass bottles, bicycles, hot water vaporizers, household chemicals, infant furniture, ladders, power tools, lawnmowers, toys, gas heaters. There are perhaps 500,000 product liability cases in the courts each year.

Medical malpractice suits are even more of a problem, given the near impossibility of proving negligence and the reticence of doctors to testify against one another. Malpractice is a nightmare to doctors as well as to patient litigants: a doctor may resort to expensive and needless procedures (for instance, X-rays) only to establish later in court, if need be, that he had done everything he could to diagnose and treat illness. Insurance companies want to get out of the malpractice business; they say it isn’t profitable. Doctors are carping about malpractice insurance rates, now commonly as high as $12,000 or more a year for a physician . . . .

Some idea of the waste the tort liability insurance system generates is gained by examining just how much of the premium dollar ever reaches accident victims. While defenders of tort

liability seem always to be offended by appraisals of the system from this vantage, surely the thrust of even the common law has been to recognize increasingly the rights of accident victims to share in tort liability insurance proceeds.

Professor Robert Keeton of the Harvard Law School has compiled the following table:

| Where the Automobile Bodily Injury Liability Insurance Premium Dollar Goes |
|-------------------------------|---------|
| General Overhead[7]           | 33 cents|
| Claims Administration Cost    |         |
| Defense Side[8]               | 13 cents|
| Claimants' Side[9]            | 10 cents|


The principal sources of data relied upon in making this computation are the following: the American Insurance Association [AIA] Cost Study [AIA, SPECIAL COMM. TO STUDY AND EVALUATE THE KEETON-O'CONNELL BASIC PROTECTION PLAN AND AUTOMOBILE ACCIDENT REPARATIONS, REPORT 13-16 (1968)]...; the Michigan Study of Conard and his colleagues [A. CONARD, J. MORGAN, R. PRATT, C. VOLTZ, & R. BOMBAUGH, AUTOMOBILE ACCIDENT COSTS AND PAYMENTS—STUDIES IN THE ECONOMICS OF INJURY REPARATION (1964)]...; Harwayne, Automobile Basic Protection Costs Evaluated (1968); and Harwayne, Insurance Costs of Basic Protection Plan in Michigan, 1967 U. ILL. L. FORUM 479 (1967), also published in Crisis in Car Insurance 119 [(R. Keeton, J. O'Connell, & J. McCord eds. 1968)]. Harwayne is a Fellow of the Casualty Actuarial Society and an independent consulting actuary. His studies were conducted under the sponsorship of the Automobile Claims Study at Harvard Law School, in which the Basic Protection Plan was developed. The calculations presented here were published in a 1969 pamphlet, under the same title as this chapter. [Compensation Systems—The Search for a Viable Alternative to Negligence Law]. They were thereafter cited and independently confirmed in N.Y. Ins. Dept' Report 34-37 (1970).

Id. at 513 n.17.

7. General overhead, as used here, refers to all overhead other than claims administration costs. It includes agents' fees and other marketing costs (variously referred to in the insurance industry as production or acquisition costs), home office expenses, taxes, and profit. Harwayne's study sustains the estimate used in this chart, that actual general overhead comes to 33 cents of the premium dollar.

Id. at 514 n.18.

8. Harwayne observes that in recent years national stock company averages for defense claim costs have varied from 12.8 to 13.3 per cent and national mutual company averages from 16.2 to 16.6. The chart presented here uses a figure of 13 cents as a very conservative figure for the industry as a whole on a national basis.

Id. n.19.

9. Earlier field studies...—particularly studies by Professor
ELECTIVE NO-FAULT

**Total Claims Administration Cost**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Overheard</td>
<td>56 cents</td>
</tr>
<tr>
<td>Net Amount Paid to Victims Above Losses (in theory for Pain and Suffering)[10]</td>
<td>21.5 cents</td>
</tr>
<tr>
<td>Paid to Compensate for Losses Also Compensated from Other Sources (including income tax saving)[11]</td>
<td>8 cents</td>
</tr>
</tbody>
</table>

Conard and his colleagues at the University of Michigan—show these costs to be about 10 cents of the premium dollar. This figure is used in the chart. It is, of course, an average for all claimants—representing a mean between lower claims costs for those without attorneys and higher claims costs for those with attorneys, who also generally receive higher total payments.

These claims costs on the claimants' side are paid out of the gross sum the insurance companies pay to settle claims, whether paid before or after a trial. Under the AIA figures that amount is 55 cents; under the adjusted figures used in this chart, 54 cents.

*Id.* at 514-15 n.20.

10. The AIA study found that the total amount paid in settlement of a bodily injury claim under the tort liability system is on the average 2.4 times the amount of economic loss.

When we divide 2.4 into 54 cents of gross payment for claims, we find that 22.5 cents go to compensation for economic losses of those victims to whom payments are made. Deducting this 22.5 cents and the 10 cents for claimants' attorneys from the total of 54 cents, we find that 21.5 cents go to compensation above both economic loss and attorneys' fees.

In theory this is compensation for pain and suffering, though it is not all that is paid on this theory. That is, at least part of the amount that goes to pay claimants' attorneys' fees (the 10-cent figure) can also be said to have been awarded on the theory of damages for pain and suffering, since claimants are not entitled to recover compensation for their attorneys' fees as such.

*Id.* at 515 n.21.

11. The AIA report shows that other available sources of compensation such as Blue Cross, Blue Shield, accident and health coverage, and the like amount to at least 11 per cent of the total tort recoveries. That is, this is the amount they found in duplicated payments. This would amount to 6 cents of the premium dollar (11 per cent of 54 cents).

The Harwayne study calls attention to the fact that the AIA study obtained from claimants themselves the data reported as compensation from other sources than automobile liability insurance. It seems likely indeed that data collected in this way would not reflect the full extent of other payments. Moreover, such data do not reflect the overlapping of compensation that results from the fact that a claimant is excused from paying income tax on the compensation he receives for the amount of wages lost, on which he would have had to pay a tax if he had received that amount as wages.

A figure of 8 cents seems a very conservative estimate of overlapping compensation (including the income tax saving), and this figure is used in the chart.

For 1969, and even more so as to later years, this figure of 8 cents is a conservatively low estimate of overlapping compensation for another reason beyond those so far stated—payments of compensation from sources other than liability insur-
Genuine dollar losses are what most people want to insure against. Apart from tort liability insurance, there is no market for pain and suffering coverage in insurance that people buy on themselves. As Professor Alfred Conard of the University of Michigan Law School has put it:

Did you ever hear of anyone voluntarily buying insurance against pain and suffering? Everybody I know would rather keep his premium money and bear his suffering without balm. If no one in his right mind would voluntarily buy insurance against pain and suffering, it is silly to require everyone to buy it compulsorily.13

Yet only 14.5 cents of the automobile tort liability insurance dollar goes to meet that essential insurance need of payment for dollar losses not otherwise compensated.14

Similar inadequacy is found in compensating injury in at least two other situations—personal injury from medical malpractice and from defective products.

Extrapolating (conservatively) the auto liability and other figures16 to medical malpractice, we get the following figures:

<table>
<thead>
<tr>
<th>Hypothesis of Where the Medical Malpractice Liability Insurance Premium Dollar Goes</th>
<th>General Overhead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overhead</td>
<td>30 cents</td>
</tr>
</tbody>
</table>

...
Claims Administration Cost

Defense Side 24 cents
Claimants Side 18 cents

Total Claims Administration Cost 42 cents

response to written interrogatories from the Subcommittee. Washington Insurance Newsletter, Dec. 8, 1975, at 7 [hereinafter cited as Newsletter]. According to another estimate for medical malpractice insurance, “Approximately 25 percent of a physician’s malpractice insurance premium . . . is consumed by the . . . insurer [exclusive of legal fees].” Note, Comparative Approaches to Liability for Medical Maloccurrences, 84 YALE L.J. 1141, 1155 (1975) (citing Remarks of G. Parrella, Medical Malpractice Insurance, Connecticut Medical Society House of Delegates, Nov. 20, 1974; on file with the Yale Law Journal). But that same estimate is much higher for legal fees: “An additional estimated 50 percent of the premium is consumed by lawyers in the form of fees for services in medical litigation.” Id. For a similar estimate of “more than 50 cents” of the insurance dollar going to lawyers, “less than 25 cents” to patients, and the remainder to insurers’ expenses, see Physicians Crisis Committee [of Detroit], Court Docket Survey 2 (1975).

17. The figure of 24 cents for costs of administering defense claims is the response of the insurance industry to one of the Kennedy Subcommittee questions. Newsletter, supra note 16, at 7.

Medical malpractice cases (like product liability cases) are much more difficult to prepare and try for both plaintiff and defense lawyers, so that it is safe to assume more is spent on legal fees by both sides for medical malpractice claims than for automobile liability claims. J. O’Connell, Ending Insult to Injury: No-Fault Insurance for Products and Services 29-30, 41 (1975) [hereinafter cited as J. O’Connell]. Also given their complexity, it is much more likely that a claimant in a medical malpractice or product liability case will retain a lawyer. Admittedly, estimates vary widely:

One insurance company told the subcommittee [of the Senate Committee on Government Operations] that of the total [loss] costs from its malpractice business, only 30 percent of these funds actually go to the patient; 15 percent goes to the plaintiff’s attorney; and 55 percent is taken by defense attorney fees and defense investigation costs.

Another said that 38 percent of each claims loss goes to the patient; 35 percent goes to the plaintiff’s attorney; and 27 percent is taken by defense attorney fees and defense investigation costs.

It is readily apparent, then, that the amount of claims and judgments paid represent only a portion of the costs generated by malpractice actions. Furthermore, the lion’s share of the expense goes to the legal community.


Without certainty about whether plaintiff’s or defendant’s counsel ends up with a different ratio of the total money going to counsel fees in medical malpractice liability insurance as opposed to automobile liability insurance, I have assumed the same ratio (13:23 = 24:42; 10:23 = 18:42). See text accompanying notes 8-9 supra. Actually, given the greater resistance to medical malpractice claims compared to automobile liability claims, see J. O’Connell, supra at 29-30, it might be safe to assume defense lawyers receive even more of the premium dollar
vis-à-vis plaintiff's lawyers. Note that the total figure of 42 cents roughly corresponds with the estimate in a generally astute appraisal of medical malpractice insurance by journalists Stephen Cain and Clark Hallas: "For every dollar collected by a patient who successfully sues a doctor or hospital for medical malpractice, the attorneys representing both sides of the suit collect an estimated $2." Cain & Hallas, Possibility of Fraud Is Probed in Medical Malpractice Suits, Detroit News, Oct. 10, 1974, at 1, cols. 2-4 (which, for the purposes of this Article, involved a comparison of the figures for claims administration cost for both the defense side and the claimants' side and for the net paid to victims altogether).

Representatives of the insurance industry, in response to a Subcommittee question, stated: "A . . . breakdown between plaintiff's attorney fees and benefits to the claimant is not available from insurance statistical data. However, if the commonly quoted estimate of one-third of the settlement as the fee for the plaintiff's attorney is assumed, then $1.153 [of the premium dollar] would go to the attorney and $.305 to the claimant." Newsletter, supra note 16, at 7.

18. According to other estimates, this figure understates total overhead (including claimants' administration costs) and, as a corollary, overstates the net amount paid to claimants. For example, in a preview of a study by the Institute of Interdisciplinary Studies in Minneapolis, Minnesota, under a research grant from the National Institute of Health, it has been indicated that "only sixteen to twenty-seven cents [of the present medical malpractice premium dollar] reaches the patient whereas of the automobile liability insurance dollar, forty-four cents reaches the victim and in Workmen's Compensation sixty-four to ninety-three cents reaches the injured workman." Morris, Medical Report: Malpractice Crisis—A View of Malpractice in the 1970's, 1971 Ins. Couns. J. 521, 523. Subsequently, Rick Carlson of the Institute opined that only "between sixteen and seventeen cents of the premium dollar ends up as benefits to victims of medical injuries." Medical Malpractice: A Discussion of Alternative Compensation and Quality Control Systems 5 (D. McDonald ed. 1971) (Center for the Study of Democratic Institutions Occasional Paper). According to still another study, 16 to 25 per cent of the premium dollar is eventually paid to patients. Cal. Assembly Select Comm. on Medical Malpractice, Preliminary Report 5–6 (1974), cited in Note, supra note 16, at 1155 n.75. Apparently relying on Physicians Crisis Committee [of Detroit], supra note 16, consumer columnist Sylvia Porter has reported that in Michigan 23 cents goes to the patient, with 55 cents being spent on lawyers and litigation expenses and the remaining 22 cents on insurance overhead. Sylvia Porter's column, December 8, 1975. According to Ms. Porter, the situation is "even worse in some other states." Id. On the other hand, the insurance industry estimate, in reply to a Subcommittee question, was 31 cents as net payment to victims and 69 cents to total overhead. Newsletter, supra note 16, at 7.

19. The ratio, under tort liability, of pain and suffering payment (including plaintiffs' attorneys' fees) to out-of-pocket losses (including those compensated from other sources) is about 1.4:1. See P. Keeton & R. Keeton, supra note 6, at 515 n.31 (reporting that "the total amount paid in settlement of a bodily injury claim under the tort liability system [for auto accidents] is on the average 2.4 times the amount
Paid to Compensate for Losses
Also Compensated from Other
Sources (including income
tax saving)\(^{20}\)

\begin{align*}
6.7 \text{ cents} \\
\end{align*}

Paid to Compensate for Losses
Not Compensated from Other
Sources\(^{21}\)

\begin{align*}
12.5 \text{ cents} \\
\end{align*}

Net Paid to Victims Altogether\(^{22}\)

\begin{align*}
28 \text{ cents} \\
\frac{100}{100} \text{ cents} \\
\end{align*}

Here, then, for all the agony caused by the medical malpractice tort system, we find that it returns at the most only 28 cents of the premium dollar to injured patients, and, of that, only 12.5 cents reimburses the patient for dollar losses not otherwise compensated.

In this regard, Phillip Corboy, a prominent personal injury lawyer, has recently referred to the testimony of a nurse in a case involving severe burns caused one Jake Crouch when a transformer on which he was working exploded and spewed burning

\begin{itemize}
\item \textit{of economic loss}, which is another way of saying that the ratio is 1.4:1.
\item It might be argued that—given stouter resistance to claims and especially fewer nuisance claims under medical malpractice insurance, see J. O'Connell, supra note 17, at 29, 38-41—less is paid for pain and suffering arising from medical malpractice liability than from auto bodily injury liability. But for indication that most medical malpractice claims are for relatively minor injuries and for small amounts ($2000 or less in one-half of all paid claims), thus justifying an inference that insurance companies prefer a nominal settlement rather than the expense of defending its insureds, see King, \textit{A Commentary on the Report of the Malpractice Commission}, 29 Record of N.Y.C.B.A. 294, 295 (1974) (based on, but not specifically citing, Rudov, Myers, & Mirabella, \textit{Medical Malpractice Insurance Claims Files Closed in 1970}, in \textit{Appendix, Report of Secretary's Commission on Medical Malpractice} 1 (U.S. Dep't of Health, Education, and Welfare Pub. No. (OS) 73-59, 1973). According to one estimate, over half of medical malpractice cost is related to awards for “pain and suffering.” Address by Steven Resnick, conference entitled “The Medical Malpractice Crisis: Managing the Costs,” University of Maryland School of Law, Nov. 21, 1975 [hereinafter cited as Conference]. Also it is the low limits of automobile liability insurance (often only $20,000) that often cause little to be paid for pain and suffering in severe cases. Medical malpractice limits would often be $300,000 higher. Thus I have used Professor Keeton's ratio to arrive at the figure of 8.8 cents (28 + 18 = 46 + 2.4 = 19.2 + 18 = 37.2; 46 - 37.2 = 8.8). See note 10 supra.
\item I have calculated this figure on the basis of the Keeton formula explained in note 11 supra: \[(11 \text{ percent of 46 cents} = 5 \text{ cents}) + [(\frac{1}{2} \times 5 \text{ cents}) = 1.7 \text{ cents to account for income tax savings}] = 6.7 \text{ cents. The result, as in the Keeton calculation, is no doubt a very conservative estimate.}
\item \textit{After accounting for other purposes to which all the rest of the premium dollar is committed, we find that only} [12.5] \text{ cents go to compensating for losses not otherwise compensated.}” Note 12 supra.
\item See note 18 supra.
\end{itemize}
oil on him. Corboy’s purpose apparently is to illustrate the reality of pain and to justify the law’s attention to compensating for it. The nurse describes in detail the extensive (and, one gathers, hugely expensive) treatment of the patient, including the careful professional application of Sulfamylon cream plus extensive and professionally supervised administration of whirlpool treatments. She then testifies:

[Jake] very soon after he was admitted [to the hospital] became aware of the fact that the treatment would be a long one. . . . He would look to the future and getting out of the hospital and the possibility of getting back to work. . . . [H]e liked to be out in his job and he felt this wasn’t going to be possible and this was a factor in his depression, that his lifestyle would have to change. He often discussed with me what would happen to his family. He worried about how they were making out . . . as far as financial arrangements . . . and I would say a great deal of time he was severely depressed . . . .

The patient in this case was awarded $650,000 after, as Corboy indicates, a lengthy trial (he does not tell us the length of time between injury and trial). But Jake Crouch was one of the lucky ones in being paid at all from the tort liability system. As the nurse’s testimony poignantly indicates, what he needed was treatment—both physical and psychiatric (for his depression)—and assurances that his family would be cared for. In short—as with most of us if seriously injured—he was primarily concerned with payment for his out-of-pocket losses, not for his pain and suffering.

Discussion of a products liability case raises the point that the figures for products liability insurance have not been developed with even the precision of those available for medical malpractice insurance, not to speak of the relatively exhaustive figures available for automobile liability insurance. But products liability cases share characteristics with medical malpractice cases. In both, liability turns on very complicated fact situations with concomitantly extraordinary expense and delay, and the defendants take offense to attacks on their professional or entrepreneurial pride and therefore are inclined to resist settlement more strongly than, say, the insured motorist-defendant.


Extrapolating (once again, conservatively) from both the auto liability and medical malpractice figures, we get the following figures:

<table>
<thead>
<tr>
<th>Hypothesis of Where the Bodily Injury Product Liability Insurance Premium Dollar Goes</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Overheard(^{25})</td>
</tr>
<tr>
<td>Claims Administration Cost(^{26})</td>
</tr>
<tr>
<td>Defense Side</td>
</tr>
<tr>
<td>Claimants' Side</td>
</tr>
<tr>
<td>Total Claims Administration Cost</td>
</tr>
<tr>
<td>Total Overheard(^{27})</td>
</tr>
<tr>
<td>Net Amount Paid to Victims Above Losses (in theory for Pain and Suffering)(^{28})</td>
</tr>
<tr>
<td>Paid to Compensate for Losses Also Compensated from Other Sources (including income tax saving)(^{29})</td>
</tr>
<tr>
<td>Paid to Compensate for Losses Not Compensated from Other Sources(^{30})</td>
</tr>
<tr>
<td>Net Paid to Victims Altogether(^{31})</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

25. I have used the medical malpractice figure on the ground that such coverage, in its complexity and marketing, more closely resembles that for malpractice liability than for auto liability.

26. I have assumed that the amounts spent for both defendants' and claimants' legal expenses for products liability lie halfway between the amounts spent on auto liability and medical malpractice claims. Therefore, for the defense side 24 cents (medical malpractice) minus 13 cents (auto liability) = 11; 11 ÷ 2 = 5.5; 24 - 5.5 = 18.5. On the claimants' side, 18 cents minus 10 cents = 8 cents; 8 ÷ 2 = 4; 18 - 4 = 14.

27. Cf. note 18 supra.

28. As with medical malpractice, see note 19 supra, I have used the Keeton formula to determine the amount spent to compensate for pain and suffering: (37.5 + 14 = 51.5 ÷ 2.4 = 21.5 + 14 = 35.5; 51.5 - 35.5 = 16). See note 10 supra.

29. Here also I have used the Keeton formula explained in note 11 supra: [(11 percent of 51.5 cents) = 5.7 cents] + [((1/2 x 5.67 cents) = 1.69 cents to account for income tax savings] = approximately 7.5 cents. As with the earlier calculation, this is probably a very conservative estimate. In fact, since so many product liability cases are also covered by workers' compensation (with its unlimited medical benefits and substantial wage loss payments), the figure is probably even more conservative for products liability than for medical malpractice or auto liability.

30. "After accounting for other purposes to which all the rest of the premium dollar is committed, we find that only [14] cents go to compensating for losses not otherwise compensated." Notes 12 and 21 supra.

31. Cf. note 18 supra.
Here, too, for all the expense and agony caused by the tort system we find it returns only 37.5 cents of the premium dollar to injured victims and, of that, only 14 cents reimburses victims of malfunctioning products for dollar losses not otherwise compensated.

I. HOW VALUABLE IS COMMON-LAW TORT LIABILITY?

Perhaps the most distressing aspect of the common law’s system of personal injury insurance is that it compounds the problem by, in effect, requiring everyone to buy such largely worthless but horrendously expensive insurance.

Suppose, instead, that one were given the choice when one buys a power tool or undergoes an operation:

“Do you wish to buy tort liability insurance?”

“What’s that?”

Any decent truth-in-insurance bill would then require the buyer to be told:

Your chances of being paid any benefits under the insurance are extremely small. Most people who are injured (by this procedure/by this product) are not paid from this insurance. In point of fact about (75/65)\(^{32}\) percent of the premium is used up by insurance overhead and legal expenses on both sides. And even if you are one of the rare ones who ever collects under this insurance, you would only be paid after about two years or more has elapsed after you had put in your claim. Also there is a strong chance that before you are paid you would have to appear in court (at least in a lawyer’s office for pretrial proceedings under oath) not only to tell your story but to be sharply cross-examined by the insurance company’s lawyer who, frankly, will often be out to cast doubt on your credibility and reliability. That can be a very humiliating experience. In addition even if you go to trial and win, it is very likely that there will be an appeal—or several appeals—which can take from an additional year or two before you would be paid, assuming you win the appeal.

Of course, we lawyers have seen to it that no one is forced to explain the dubious value of insurance covering tort liability. And, in a measure, there is no point in telling the consumer/patient of the relatively worthless nature of such insurance inasmuch as he is not allowed to reject it even if he discovers its worthlessness. On the contrary, because tort liability is imposed by common law, tort liability insurance must be bought by everyone who buys a product or undergoes medical treatment since any reputable manufacturer, retailer, or health care provider will

32. See text accompanying notes 16-18, 25-27 supra.
buy such insurance and add the cost of it to the overall cost of the product or service. The cases are replete with pronouncements from judges that any manufacturer, retailer, or health care provider who tries to dispense with tort liability in the sale of a product or service will not be allowed to do so.33

A. PATCHWORK REFORM

What to do about all of this? One could in essence maintain the present system for lack of any other alternative. Such maintenance could, it is true, probably be accompanied by some window dressing changes. But none of those so far suggested would likely change things except in the slightest way—and possibly for the worse.

One reform often advanced as a solution is arbitration of medical malpractice claims. As a practical matter, however, the problem of the present system is not who is hearing these claims but what is being heard. Replacing a judge or juries with lawyers and other panelists dressed in business suits will help only marginally at best. As two insurance executives have put it: “Arbitration cases appear to require the same preparation and negotiating processes of other claims and may thereby increase the actual preparation cost of claims by the addition of arbitration fees to the other legal fees.”34

A second proposal frequently offered is the so-called “claims made” system. In the words of Dean Richard Rosett of the Graduate School of Business of the University of Chicago, however:

A change from policies that insure the physician forever against claims arising from treatment given this year to a [claims made] policy that insures him against claims that arise this year from treatments ever given is not fundamental. It eliminates—or at least reduces—the forecasting problems unpredictable inflation poses, but in a reasonably predictable economy, steady-state cost of insurance will be the same either way. Under the present system, for example, the insurance company charges the physician now for claims that will arise 15 years from now and that premium is part of the physician's expense and is reflected in what he charges for treatment. Under the suggested change he would know that insurance would be needed 15 years hence to protect him against claims arising from treatment given now. A proper counting of his expense now will include provision for that future premium. It does not matter whether the insurance company must set something aside

Thus, in addition to generating no cost savings, by requiring a
doctor to forecast his future cost to cover his costs after he retires
(or the costs to his estate after he dies), a claims made policy
shifts the most unpredictable risks to those far less able to pre-
dict and prepare for those risks than insurance companies. What
this probably would mean as a practical matter is that the typical
doctor, far from setting aside reserves this year to pay for future
claims arising from this year's services, would be paying in future
years (and then forcing his patients to pay) for the liability aris-
ing from his services rendered this year—a sort of deficit financ-
ing, if you will, with the greater problems this would present
to doctors and their families on retirement or death.

A third suggestion is that limits be placed on contingent fees
that can be charged by plaintiff's lawyers. Curiously enough,
nothing is concomitantly said about curbing defense lawyers' fees. Since the problem of medical malpractice stems from litiga-
tion between two sides, why is an equitable solution to limit what
one side can spend on litigation while ignoring the other? As
long as we keep a system—like the fault system—that depends
on litigation, how much sense does it make to limit by statute
either side's (or both sides') access to litigation?

B. ABANDONMENT OF TORT LIABILITY

An alternative to maintaining, with minor adjustments, the
present tort liability system for medical malpractice and products
liability litigation would simply be to abolish the tort liability
system as it applies to such areas and let anyone who so desires
buy his own coverage for his own loss. At first blush, the solu-
tion seems too extreme to be seriously proffered or considered.
But weigh the following exchange between Congressman Bob
Eckhardt, Democrat from Texas, and former Dean Erwin N. Gris-
wold of the Harvard Law School, certainly a conservative, care-
ful legal scholar, concerning a no-fault law that would similarly
simply abolish tort liability and leave anyone who so desires free
to buy his own coverage for his own loss:

Mr. ECKHARDT. . . . In H.R. 10 [a federal no-fault automo-
ble insurance bill], there is a provision [eliminating] tort lia-
ibility with respect to property losses altogether. Then H.R. 10
provides for optional coverage under no-fault [for] property

The result would be that an individual would either have to elect to accept no-fault liability by buying no-fault insurance, which must be offered to him but which is not mandatory, or not be covered at all since H.R. 10 broadly limits tort liability in any event.

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It seems to me that when the statute merely gives a person the opportunity to elect coverage by insurance, thus not establishing a complete system of reparation, and at the same time broadly wipes out tort liability, there may be a serious constitutional question.

Mr. Griswold. . . . I don't, myself, find that question very difficult. I would think that Congress, under the commerce power, if it chooses to do so, for whatever reasons that appear to warrant it, could entirely eliminate property damage liability. That is, in effect, what H.R. 10 does.

If that were done, then persons who own automobiles or other property may well want to consider the question of whether they should obtain insurance for that. As I understand it, that is the effect of H.R. 10.

Mr. Eckhardt. Well, Dean, suppose we did not pass any no-fault statute, but the United States Congress decided that all tort liability was too burdensome and too costly and simply provided that tort liability for . . . property damages . . . shall henceforward be wiped out in the Union[,] could you do that constitutionally?[7]

Mr. Griswold. Congressman Eckhardt, in my opinion, Congress could do that if it chooses to do so.6

Of course, Dean Griswold was discussing the abolition of tort liability for property damage. One can make the case, however, that if a legislature could abolish tort liability for property damage, a fortiori, it could do the same for tort liability for personal injury arising out of the use of manufactured products or medical treatment. It is not without significance that a lower Michigan court has found the Michigan no-fault auto law abolishing tort liability for property damage invalid on the ground that the old common-law tort system, coupled with the availability of collision insurance, had been working sufficiently well that such abolition of tort liability was unconstitutional.37 Perhaps, then,

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a tort system working as poorly as does that for product liability and medical malpractice should be viewed as more subject to such legislative abolition.

Thus it is that several states have recently put “caps” or limits on what can be obtained in medical malpractice actions. For example, in California, the limit is $250,000 (for pain and suffering); in Idaho, $150,000; in Indiana, $500,000; in Illinois $500,000; in Ohio, $200,000 (for pain and suffering). Two trial courts—one in Idaho and the other in Illinois—have recently ruled these statutes unconstitutional. Admittedly, therefore, there is grave doubt about how courts will view a simple abolition of the tort remedy for medical malpractice or products liability, given doubts about the lesser step of limiting the amount of tort liability. In a measure, however, the courts’ willingness to strike down such limitations as unconstitutional, while never questioning the constitutionality of limits of, say, $5000, $10,000, or $20,000 uniformly prevailing in the United States for tort liability insurance for auto accidents, demonstrates how totally unrealistic are the courts in their attitudes toward insurance and torts. Limitations on the amount of insurance that motorists must carry have a pervasively devastating effect on how much is in fact available for accidents involving negligence in that jurisdiction (especially since a claimant may be unable to discover the limits of insurance carried by any motorist). A limit of $500,000 on medical malpractice verdicts, on the other hand, in a jurisdiction like Indiana will probably affect no claimant for years, if ever, and indeed, will rarely affect any claimant in any jurisdiction. Yet the latter is quickly struck down and the former goes unquestioned for generations! Constitutions may no longer be color-blind, but their eyesight still seems woefully weak.
Thus, given the relatively worthless nature of tort liability insurance as an insurance mechanism, one forced to choose between retaining the present system and simply abolishing it, (at least as applied to personal injury for products liability and medical malpractice), would probably more sensibly abolish it than retain it. In addition to all the money spent on overhead costs and legal fees, one must take account of the substantial amounts of money and energy spent by the medical profession trying to avoid tort liability in a manner that, far from helping the patient, hurts him. Dr. James Potchen, head of the Michigan State University Radiology Department and chairman of the Committee on Radiology of the American Medical Association, tells us that around one billion dollars a year is being spent nationally for largely unnecessary X-rays that physicians now order to protect themselves from potential malpractice claims:

Potchen . . . said that in many cases doctors ordering the X-rays know that they will be of little medical value in making a diagnosis.

However, Dr. Potchen . . . said doctors are “beginning to feel that if they don’t perform these tests they’ll get sued for malpractice.”

He cited as an example a skull X-ray which is almost always ordered for youngsters when they are brought to emergency rooms for head injuries even though studies have shown the X-rays are all but useless.

Even though this is widely known, Dr. Potchen said, the skull X-ray has become standardized in the law as a medical practice and therefore doctors are afraid to do away with it.

Overall, about 11 per cent of all X-rays given patients are a result of so-called defensive medicine—medicine that may in itself have no value other than to forestall the possible lawsuit, he said.

He estimated that the cost to consumers could be between $200 million and $1 billion yearly, with the higher figure more likely.

Not only are the services superfluous, but—given the dangers of exposure to radiation—they lead to needlessly added injuries!

Admittedly, however, many will be concerned about the occasional claimant who, after tort liability for medical malpractice and products liability has been abolished, has no major medical or other catastrophic insurance coverage but who nonetheless would have had a valid tort claim against a health care provider or product manufacturer. Perhaps the only answer to this di-

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43. See notes 16-18 supra and accompanying text.
44. Baltimore Sun, Nov. 22, 1975, § B, at 1-2, cols. 4-5. See also Remarks of James Potchen, Conference, supra note 19.
lemma is to keep in mind how few and fortuitous are such claims; and if, as is likely, it is the poor who are most likely to be without their own coverage against catastrophe, keep in mind, too, that it is the poor who seem least likely to pursue a tort remedy and who certainly derive the least benefit from the tort system. In the words of H. Laurence Ross, a sociologist who has studied the tort liability system:

[T]ort law in action may . . . be termed inequitable. It is responsive to a wide variety of influences that are not defined as legitimate by common standards of equity. The interviews and observations I conducted convinced me that the negotiated settlement rewards the sophisticated claimant and penalizes the inexperienced, the naïve, the simple, and the indifferent. Translating these terms into social statuses, I believe that the settlement produces relatively more for the affluent, the educated, the white, and the city-dweller. It penalizes the poor, the uneducated, the Negro and the countryman.45

Others will be concerned about the effect on deterrence if tort liability is simply abolished for products liability and medical malpractice. This worry, too, probably fails to stand up. Despite exhaustive attempts to identify them, little, if any, deterrent effects of the present product liability system could be discovered by the National Commission on Product Safety.46 And while medical malpractice liability may lead to defensive and even unsafe medicine, no one seems able to point to any evidence of the present system acting as a deterrent and thereby leading

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45. H. Ross, SETTLED OUT OF COURT: THE SOCIAL PROCESS OF INSURANCE CLAIMS ADJUSTMENTS 241–42 (1970). Consider the following table:

<table>
<thead>
<tr>
<th>Family income (1)</th>
<th>Percent retaining counsel (2)</th>
<th>Ratio of net reparations to economic loss (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $5,000</td>
<td>30.0</td>
<td>0.38</td>
</tr>
<tr>
<td>$5,000–9,999</td>
<td>36.7</td>
<td>0.52</td>
</tr>
<tr>
<td>$10,000 and over</td>
<td>41.9</td>
<td>0.61</td>
</tr>
<tr>
<td>Total</td>
<td>35.0</td>
<td>0.49</td>
</tr>
</tbody>
</table>

1 U.S. DEP’T OF TRANSPORTATION, ECONOMIC CONSEQUENCES OF AUTOMOBILE ACCIDENT INJURIES 54 (1970) (Automobile Insurance and Compensation Study). The reparations received figures include both tort and nontort sources, with “‘[a]bout one-third’ of recovery [for bodily injury and property damage] from tort.” Id. at 2.

to safer medicine. Even Guido Calabresi, perhaps the leading advocate of imaginative use of the tort and insurance systems to achieve deterrence, recently concluded that there is no basis for believing that the present tort liability system promotes quality medical care.\(^\text{47}\) In short, when a system is as highly wasteful and arbitrary as is the present tort system, the burden rests heavily on those who would maintain it to demonstrate its effectiveness as a deterrent, not on those who would abolish it to prove that such abolition would have no unsalutary effect on deterrence. That is a burden that defenders of the status quo manifestly have been unable to meet, except by intuition and anecdote.\(^\text{48}\)

Even granted the failings of tort liability, however, one must admit that for political, practical, and constitutional reasons the revolutionary solution of simply abolishing it without any substitute should be avoided, if possible. Bear in mind it has been assumed by many courts—state and federal (arguably erroneously in light of Dean Griswold's testimony, for example)\(^\text{49}\)—that a substituted remedy, such as mandated no-fault benefits, must be provided if common-law tort rights are to be abolished.\(^\text{50}\)

There are similar political, practical, and constitutional obstacles to a proposal advanced by Professor Richard Epstein of the University of Chicago, urging much greater tolerance by the courts for contractual arrangements to abandon or limit tort liability. Under Professor Epstein's proposal, health care providers would be allowed to impose all or most of the risks of medical procedures on patients under the doctrine of assumption of risk; they would be allowed, for example, to limit their liability to, say, gross negligence, or to put tight limits on the dollar amount of their tort liability. "Private agreements of free individuals," he

\(^{47}\) Remarks of Guido Calabresi, Conference, supra note 19.


\(^{49}\) See text accompanying note 36 supra.

\(^{50}\) See, e.g., Pinnick v. Cleary, 360 Mass. 1, 21-23, 271 N.E.2d 592, 605-06 (1971). Although the requirement that an adequate and reasonable substitute for the abrogated tort recovery must be provided was enunciated by the Supreme Court in New York Cent. R.R. v. White, 243 U.S. 188, 201 (1917), "it is doubtful that the Court would find the test necessary today. Nonetheless, the dictum has given the reasonable substitute test considerable impetus in state courts. All cases examining the constitutionality of no-fault legislation on due process grounds have applied this test." Note, Due Process Problems of Property Damage No-Fault Insurance, 8 U. Mich. J.L. Reformer 646, 649 & n.25 (1975). But see Montgomery v. Daniels, 81 Misc. 2d 373, 367 N.Y.S.2d 419 (Sup. Ct. 1975).
argues, "promise the best solution to the problems of medical malpractice in a world in which no perfect solution is possible."

If then, there is little sense in retaining with minor adjustments the tort system of compensation for personal injuries arising from malfunctioning products or medical services, and if it is not practical to abolish that system, what can be done?

II. ELECTIVE NO-FAULT REFORM FOR MEDICAL MALPRACTICE AND PRODUCTS LIABILITY

A. APPLICABILITY OF WORKERS' COMPENSATION AND AUTOMOBILE LIABILITY REFORMS

The basic difficulty with present medical malpractice and products liability insurance is fundamentally a replication of the difficulties that plagued industrial accident insurance before workers' compensation and automobile liability insurance before no-fault auto insurance. In each case, traditional tort liability demanded (as it still does) answers to the intractable questions of (1) who is at fault (or whose product is defective) in causing the accident, and (2) what is the monetary value of something essentially untranslatable into dollars and cents—pain and suffering.

The solution for industrial and auto accidents has long been seen as relatively simple: Structure the insurance system so that it pays (1) for losses regardless of fault and (2) only for out-of-pocket losses (essentially, medical expenses and wage loss, which are readily reducible to dollars and cents, and not pain and suffering, which are not). Thereby, in one simple stroke these two questions that plague the system are eliminated, with payment for more claims financed by the savings from simplifying the insured event (by not having to pay either (1) for determination of fault and the monetary value of pain and suffering.

51. In a way, the proposals examined in this Article can be arranged in the following spectrum:

(1) Legislative abolition or limitation of tort liability.
(2) Epstein's proposal for contractual abolition or limitation of tort liability.
(3) My proposal for elective no-fault insurance as a substitute for tort liability, relatively loosely supervised by the courts and insurance commissioners. See notes 55-56 infra and accompanying text.
(4) Professor Clark Havighurst's proposal for no-fault insurance as a substitute for tort liability, pursuant to tightly structured governmentally mandated standards to protect patients. See notes 57-58, 126 infra and accompanying text.

52. See J. O'CONNELL, supra note 17, chs. 2, 4, 10.
or (2) for pain and suffering itself. Applying this solution to medical malpractice insurance is somewhat more complex because it is more difficult to define the no-fault insured event for medical maloccurrences than for industrial or auto accidents. Under a no-fault system the employer pays an employee-victim injured in an accident "arising out of or in the course of employment,"53 regardless of anyone’s fault; the motorist pays any motor vehicle injured in an accident "arising out of the ownership, maintenance or use of a motor vehicle,"54 regardless of anyone’s fault. But it is not feasible simply to force the health care provider similarly to pay any patient “injured in the course of medical treatment,” regardless of anyone’s fault. The problem is how to define whether the patient was injured in the course of medical treatment, as opposed to suffering injury due to his own prior condition that sent him to a health care provider in the first place (his so-called presenting complaint). Assume that a patient goes to a doctor with a thyroid condition: the doctor treats him (perhaps by an operation)—the patient gets worse. A health care provider could not realistically be asked to pay for any worsened condition after treatment; but determining which worsened conditions are due to the doctor’s intervention and which to the patient’s presenting complaint would be as intractable as determining the criteria for payment under the present negligence criterion. As indicated in the report of the [HEW] Secretary’s Commission on Medical Malpractice:

At the outset, the Commission members wrestled with the virtually impossible task of defining the “compensable event” which results from a “medical injury”. Every effort to date on this subject has met with the same lack of success. Although we have a reasonable understanding of the terms “work injury” and "automobile accident injury", we have no real mental picture that covers the field of medical injuries. Does a “medical injury” occur when a physician fails to heal his patient or fails to heal him quickly, in the face of the joint hopes by the physician and the patient that an early recovery can be obtained? Illness and accidental injury become inextricably intertwined when fault issues are ignored.55

To be sure, other similar problems attend defining the compensable event for products liability. Ladder manufacturers

53. This language appears in a typical workers’ compensation statute. 1 A. Larson, Workmen’s Compensation Law § 6.00 et seq. (1972).
would undoubtedly find it overwhelming to be asked to pay for all injuries resulting from falls from ladders regardless of the users' negligence or a lack of any defect in the ladder; similarly, stove manufacturers would find absurd a demand for compensation for all injuries resulting from burns from stoves.

While for this reason no-fault insurance cannot be applied across the board to all adverse results of medical treatment and manufacturing (the way in which it can be applied across the board to all industrial or auto accidents), this is not to say that it could not be applied to many such adverse effects of both. Health care providers and manufacturers can probably identify hundreds of malocurrences that can be readily isolated and for which it would be feasible to apply the no-fault bargain: prompt payment for out-of-pocket losses in return for waiver of the right to sue based on alleged fault for possible, but by no means certain, payment for out-of-pocket loss plus pain and suffering. For such identifiable injuries, the savings realized from eliminating payment for (1) insurance overhead and legal fees and (2) pain and suffering could be used to finance prompt and expeditious payment regardless of fault. Moreover, the bargain should include no payment under no-fault insurance that would duplicate payment already made from other sources, such as Blue Cross and employer-paid sick leave. The advantages to insureds and their insurers thus would be (1) potentially lower premiums; (2) greater certainty of the extent of potential liability, in that liability would no longer turn on the vicissitudes of unpredictable common-law liability but rather on defined, predictable compensable events; (3) avoidance of stigmatization or paying a windfall gain solely because of fortuitous injury; (4) use of insurance dollars to pay genuine losses, as opposed to devoting large amounts to payment of legal fees and company overhead; and (5) good will arising from prompt payment to customers/patients versus ill will stemming from resistance to claims for injuries attributable to the use of products or services.

As examples of the way elective no-fault liability would work, a manufacturer of a power tool could elect to take out a no-fault policy to pay for out-of-pocket losses—medical expense and wage loss—whenever an amputation results from use of the power tool. Just as no-fault auto insurance pays without regard to anyone's negligence, so payment would be made in this instance without regard to the victim's possible carelessness or the lack of any defect in the tool. Similarly, a doctor who knows the inevitable risks of, say, cardiac arrest occurring in even nor-
mal patients in the course of a given surgical procedure could agree to pay for out-of-pocket losses stemming from such an adverse result of an operation regardless of anyone's fault. In both cases, the prior agreement to make such no-fault payments would wipe out any claim based on fault, just as happens under no-fault auto insurance.56

B. DEFINING COMPENSABLE EVENTS

In a 1974 article, Clark Havighurst and Lawrence Tancredi listed some examples of likely adverse results arising from surgical treatment that might be selected as compensable events under a no-fault plan: They included, for example, postoperative infections, thrombophlebitis and embolism, catheter infections, allergic and toxic reactions to antibiotic and other drugs, blood transfusion reactions, foreign bodies, growth deformity secondary to bone injury, Volkmann's contracture and other consequences from casts, and failure of healing of fractures (including malunion, nonunion, and delayed union).57 This list was compiled

56. Note, too, the flexibility possible under elective no-fault liability. For example, electors might be allowed to experiment with no-fault liability for products produced during a given period. In addition, the elector might be allowed to limit the amount of no-fault benefits for which he is liable to multiples of $10,000, assuming the enabling legislation authorized a corresponding tort exemption measured against both out-of-pocket loss and pain and suffering. For example, if no-fault benefits of $20,000 are provided, no tort suit could be maintained for out-of-pocket loss less than $20,000, nor for pain and suffering less than $20,000. See J. O'Connell, supra note 17, at 104-06. For more extensive discussions of elective no-fault insurance generally, see J. O'Connell, supra note 17. For a precis of the book, see O'Connell, Elective No-Fault Liability Insurance for All Kinds of Accidents: A Proposal, 1973 Ins. L.J. 495; for a draft statute, with commentary, implementing the proposal, see O'Connell, An Elective No-Fault Liability Statute, 1975 Ins. L.J. 261; for a discussion of implementing the proposal by contract, with or without an enabling statute, see O'Connell, Elective No-Fault Liability by Contract—With or Without an Enabling Statute, 1975 U. Ill. L.F. 59, printed in slightly different form in O'Connell, No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others, 1975 Ins. L.J. 531.

after informal consultation with a group of orthopedists. Other specialties could compile similar lists—and all would be much more extensive than the exemplars listed above.

Indeed, Professor Havighurst has himself more recently compiled a more technically ambitious list of adverse results of general surgery and anesthesiology that might be candidates for compensable events under no-fault insurance. He indicated that the list for general surgery “was compiled by reviewing the most common surgical complications and considering them in light of the following questions:”

1. To what extent is the incidence of this complication related to the technical skill, judgment, or attentiveness of the surgeon?
2. Is this complication a clinically distinct entity? Can its existence be readily substantiated?
3. How early in the postoperative period is this complication detectable?
4. How costly are the sequelae of this complication?
5. Would an incentive to minimize the occurrence of this complication bias the choice of treatment in unfortunate ways?

It is clear that Professor Havighurst focuses in item 1 on compensating for adverse results most likely to have been caused by physician error—to adverse results relatively avoidable, in the aggregate, by a health care provider. But items 2 through 5 do not necessarily thus limit compensable events. Even unavoidable events may meet the criteria of items 2 through 5 and might thus be included as compensable events under elective no-fault insurance. In other words, both avoidable and unavoidable re-

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The suggested compensable events in the original [Havighurst-Tancredi no-fault] ... proposal [see notes 57-58 supra and accompanying text] were merely illustrative of possibilities. The only set of events carefully considered at that time was blood transfusion reactions [... which were deemed appropriate for compensation under a hospital-purchased [no-fault] ... policy even in the case of certain hepatitis reactions which were neither clearly avoidable nor clearly caused by the transfusion]. Although the [Havighurst-Tancredi] ... proposal contemplated extensive professional investigation of numerous events which were candidates for the list, no professional groups have taken up the project, and it has not been possible to involve physicians extensively in subsequent investigations. The results of further specification efforts are therefore still highly tentative.

Our recent efforts toward compiling a definitive list of compensable events have concentrated on anesthesiology and general surgery.

Id., 1975 Duke L.J. at 1256.
ELECTIVE NO-FAULT

suits might be subject to no-fault compensation.\textsuperscript{59} Indeed, to otherwise limit no-fault compensation (with its lower pay-out) would be to undercut the bargain of no-fault insurance: less payment to more people in return for abandoning the fault criterion. After all, we did not institute no-fault insurance for industrial or auto accidents only for those injuries most likely avoidable through the exercise of due care by the employer or motorist. Nor need we do so for medical maloccurrences. The bargain, then, of no-fault insurance is that the insurer agrees to pay for both avoidable and unavoidable injuries instead of only for avoidable injuries; the savings from (1) not having to distinguish between the two and (2) not paying as much per case (by, for example, eliminating payment for pain and suffering) serve to finance payment for unavoidable as well as avoidable injuries.

What follows, then, is Professor Havighurst's more extensive list of compensable events. The only caveat one must keep in mind in perusing it is that although it is limited to events that, in the aggregate, are relatively avoidable, an ultimate list would not have to be thus limited. That aside, the list illustrates the flavor of what at least some items on such a list would be.

1. \textit{General Surgery}\textsuperscript{60}
   
   \begin{itemize}
   \item General
   \begin{itemize}
   \item 1. Foreign bodies acquired intraoperatively
   \item 2. Burns acquired intraoperatively
   \item 3. Injury resulting from severance of an indwelling plastic catheter\textsuperscript{61}
   \item 4. Neurological deficit resulting from intramuscular injection
   \item 5. Injury resulting from mistaken identity
   \item 6. Injury resulting from inadvertent intravascular injection of local anesthetic
   \end{itemize}
   \end{itemize}

\textsuperscript{59} See id., 1975 DUKE L.J. at 1273-77.
\textsuperscript{60} List from Id. n. 71, 1975 DUKE L.J. at 1257-60.

The primary source consulted [for the general surgery list] was C. P. Artz & J. B. Hardy, eds., \textit{MANAGEMENT OF SURGICAL COMPLICATIONS} (3d ed., 1975).

\textsuperscript{61} The relative avoidability of this complication is illustrated by the striking diminution of its incidence as practitioners have become more aware of the technical mistake which creates the difficulty. "Such occurrences can be minimized by careful attention to the management of the catheter and the catheter site as well as the utilization of radiopaque catheters and the careful measurement of the length of the catheter before insertion and after removal." Moncrief, \textit{Complications of Parenteral Fluid Therapy}, in \textit{MANAGEMENT OF SURGICAL COMPLICATIONS}, supra note \textsuperscript{60}, at 68, 75.

\textsuperscript{62} Id. n.72, 1975 DUKE L.J. at 1257 n.72.
7. Postoperative wound dehiscence in noncarcinomatous patient under age forty-five

8. Tetanus infection subsequent to treatment of wound

9. Severe reaction to administration of tetanus antitoxin [On irreversible neurological damage or death following intraoperative cardiac arrest or spinal anesthesia, see Anesthesiology below.]

Procedure-specific

Parathyroid surgery or thyroidectomy

10. Permanent recurrent laryngeal nerve damage

11. Postoperative hypoparathyroidism exceeding two weeks' duration

Thyroidectomy or tonsillectomy

12. Death in the immediate postoperative period

Cholecystectomy

62. “Studies have shown that a few surgeons will have many wounds with dehiscence and others will have extremely few. Surgical technique is important.” Hunt, Wound Complication, in MANAGEMENT OF SURGICAL COMPLICATIONS, supra note [60], at 21, 25. A number of technical errors are known to increase the likelihood of dehiscence. Other variables, such as age and condition of the patient and the type of operation performed, also affect the incidence of this complication. Restricting compensability to patients under forty-five would help to screen out the effects of the principal variables that lie beyond the surgeon’s control.

Id. n.73, 1975 DUKE L.J. at 1257 n.73.

63. “In the hands of competent surgeons experienced in exposing the recurrent laryngeal nerves, permanent nerve injury occurs in less than 1 per cent of cases.” Hardy, Complications of Thyroid and Parathyroid Surgery, in MANAGEMENT OF SURGICAL COMPLICATIONS, supra note [60], at 291, 300. Technical skill and attentiveness are probably the key variables determining the incidence of the complication. Permanent abnormal phonation and serious respiratory obstruction are the sequelae involved.

Id. n.74, 1975 DUKE L.J. at 1257-58 n.74.

64. If all four parathyroid glands are inadvertently removed during surgery, hypocalcemic tetany will result, and lifelong drug therapy will be necessary to compensate for the activity of the removed glands. “In a review of 600 cases of thyroid surgery . . . 17 (2.8 per cent) cases of transient postoperative hypocalcemic tetany and nine (1.5 per cent) cases of permanent hypoparathyroidism [were found].” [Hardy, supra note 63, at 300.] Preserving the parathyroids during total thyroidectomies for thyroid malignancy is a difficult technical feat; for this reason some may suggest that compensability be restricted to patients without thyroid malignancy. Others may argue that precisely because of the difficulty of the procedure, the adverse outcome should be made compensable to deter less technically competent surgeons from attempting the operation.

Id. n.75, 1975 DUKE L.J. at 1258 n.75.

65. Careful observations in the postoperative period will prevent the fatal consequence of uncontrolled hemorrhage. “The most distressing fact is that, though this hazard and possible sequelae are well known on all active surgical services, every 3 or 4 years in most general hospitals some patient loses his life from this cause.” [Hardy, note 65, at 296.] Designating “death”
13. Injury to common bile duct

Venous stripping

14. Injury from inadvertent stripping of femoral artery

Gastrointestinal procedures

15. Inadvertent gastrostomy

16. Duodenal stump leakage following gastric resection

17. Instrumental perforation of esophagus

Gynecology

18. Perforation of uterus during dilatation and curettage

19. Vesicovaginal, ureterovaginal, rectovaginal, or enterovaginal fistula following gynecological procedure on noncarcinomatous patient

20. Permanent damage to ureter

Prostatectomy

21. Rectal injury

22. Permanent urinary incontinence

Treatment of fracture

23. Nerve paralysis following treatment with straps, splints, or casts

as the compensable event rather than “postoperative hemorrhage” serves three goals: (1) Death is obviously not subject to the definitional problems inherent in a term like “hemorrhage.” (2) Hemorrhage promptly noticed and controlled will not result in injury significant enough to compensate. (3) While the hemorrhage itself is of questionable avoidability, the surgeon can affect the consequences of hemorrhage by careful postoperative monitoring.

Id. n.76, 1975 Duke L.J. 1258 n.76.

66. Careless dissection and blind clamping of bleeding vessels can produce an injury to the common bile duct. “Perhaps less than half of those who sustain a stricture due to operative injury survive for 10 years.” Glenn, Complications Following Operations Upon the Biliary Tract, in MANAGEMENT OF SURGICAL COMPLICATIONS, supra note [60], at 501, 521.

Id. n.77, 1975 Duke L.J. 1258 n.77.

67. This technical error can be avoided by careful identification of anatomical structures. Its occurrence necessitates reoperation.

Id. n.78, 1975 Duke L.J. 1258 n.78.

68. Duodenal stump leakage is the most serious common complication and the main source of mortality in gastric resections. Surgical judgment, technical skill, and postoperative management are among the variables affecting its incidence.

Id. n.79, 1975 Duke L.J. 1258 n.79.

69. As the use of instrumentation in the treatment of GI conditions has increased, instrumental perforation of the esophagus has emerged as a serious complication. This outcome is relatively avoidable.

Id. n.80, 1975 Duke L.J. 1258 n.80.

70. These complications are highly avoidable.

Id. n.81, 1975 Duke L.J. 1259 n.81.

71. “Delayed nerve paralysis is practically always secondary to faulty treatment.” Hampton, Complications of Common Frac-
24. Function-impairing deformity from malunion of fracture\textsuperscript{72}

\textit{Blood transfusion}

25. Hemolytic reaction\textsuperscript{78}

26. Bacterial sepsis

27. Serum hepatitis\textsuperscript{74}

\textit{Nephrectomy}

28. Nephrectomy in the absence of a normally functioning contralateral kidney

2. \textit{Anesthesiology}

In anesthesiology, highly detailed specification of events compensable under [no-fault insurance] . . . such as has been attempted for general surgery, is appropriate for dental and peripheral nerve injuries occurring under anesthesia, and such injuries should be included on the list covered by the anesthesiologist's [no-fault] . . . policy. This piecemeal approach seems inadequate, however, to manage the most serious adverse consequences of anesthesia, namely death or irreversible central nervous system damage occurring in a wide variety of surgical circumstances. . . .

. . . Thus, it is tentatively proposed to make compensable any death or irreversible central nervous system injury under anesthesia occurring in a patient between six months and sixty years of age undergoing any of the following procedures: tonsillectomy, cholecystectomy, hysterectomy, dilatation and curettage, repair of inguinal or hiatal hernia, abortion, sterilization, uterine suspension, venous stripping, thyroidectomy, mastectomy, and gastrectomy.

The task of defining compensable events would be even easier for manufacturers of many products—especially those that tend to inflict simple, traumatic, easily identifiable injuries (such as those from power tools).\textsuperscript{75}

\textsuperscript{72} The term 'malunion' really implies union of a fracture in a function-impairing deformity which could have been prevented by more skillful management of the fracture." [Hampton, supra note 71, at 709-10.]

\textsuperscript{73} See Havighurst & Tancredi, supra note 57, at 83.

\textsuperscript{74} See id. at 83-88.

\textsuperscript{75} On a point beyond the scope of this Article, perhaps the most promising area for elective no-fault liability is owners' and occupiers' liability insurance since smaller, nuisance claims are most likely to arise from injuries occurring in one's house or apartment or business establishment, and the automobile universe has shown that it is where such claims abound that no-fault can be implemented most easily. The reason this is so is that where nuisance claims abound the tort liability system is most wasteful: more is paid for pain and suffering and more is paid for amounts already paid from collateral sources. Both of these excess pay-outs can be eliminated by no-fault insurance. But except for lessors
III. NO-FAULT REFORM AS UNCONSTITUTIONAL OR UNCONSCIONABLE?

No-fault reform for medical and product injuries could be instituted by legislation authorizing substitution of no-fault for traditional tort liability in the case of given injuries, or it could be instituted without enabling legislation by contract between patients and health care providers, signed before treatment, or between consumers and product manufacturers or retailers, signed before purchase. Already hospitals contract with patients to resort to arbitration, rather than common-law litigation, to resolve disputes arising from hospital treatment; no-fault agreements could readily be added to such arbitration contracts. Of course, treatment should not be refused if a patient chooses not to sign a no-fault agreement; nor should such agreements be used for emergency cases, lacking statutory authorization.

To be sure, the argument will be made that such contracts by health care providers, manufacturers, or retailers would be unconstitutional if authorized by legislation, or unconscionable dealing with lessees, it will be impossible to impose such liability by contract without enabling legislation since there is no contract in which to incorporate the no-fault agreement. For this reason, though, elective no-fault liability for slips and falls and other injuries should be implemented in leases.

76. For draft legislation, see O'Connell, An Elective No-Fault Liability Statute, 1975 Ins. L.J. 261.

77. For a discussion of the enforceability of such contracts, see O'Connell, Elective No-Fault Liability by Contract—With or Without an Enabling Statute, 1975 U. Ill. L.F. 59, printed in slightly different form in O'Connell, No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others, 1975 Ins. L.J. 53.

78. See note 34 supra.

79. For extensive discussion of the constitutionality of such legislation, see O'Connell & Souk, Is It Constitutional?, in J. O'Connell, supra note 17, at 294. Basically, the arguments against the constitutionality of an elective no-fault statute are: (1) due process is denied when common-law rights are thus abrogated, especially at the option of a potential tortfeasor or who substitutes for common-law liability a right to elective no-fault benefits, see id. at 205-14; and (2) equal protection is similarly denied because of different treatment of similarly situated accident victims depending once again on private elections, albeit pursuant to statute, by potential tortfeasors. See id. at 214-23. Problems may also arise under other constitutional provisions, such as section 54 of the Kentucky Constitution: “The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property.” See J. O'Connell, supra note 17, at 223-27. For discussion of the particular circumstances under which these problems may arise and the reaction at the trial court level, see notes 38-40 supra and accompanying text.
if implemented without enabling legislation. Since the contracts would probably have a greater chance of being upheld by the courts if instituted under the aegis of legislative authorization, let us examine whether such contracts are unconscionable as a sort of ultimate test of their validity.

In the words of Professor Arthur Leff of the Yale Law School:

What is the function of [the] ... unconscionability concept ...? Briefly, it appears to be one technique for controlling the quality of a transaction when free market control is considered ineffective. It is one method for substituting government regulation for regulation by the parties. The theory of classical contract, paralleling classical economics, was that ordinarily the market mechanism should maximize the welfare of the parties.

... [But] no market is perfect. ... First, there may be monopolistic or oligopolistic powers in that market, either "natural," conspiratorial, or government sanctioned [as in the case of health care providers]. Second, the information necessary for market choice may not be available at reasonable cost with respect to any particular consumer product [or service], especially when a consumer [or patient] has to process information about a vast array of goods [or services]; consumers [or patients] notably lack the expertise that comes from buyer specialization. Third, with respect to consumer "contracts," most of the boiler plate is about contingencies, things that will become important only if the product or deal breaks down [such as the product or service resulting in unexpected personal injury]. It is hard to focus attention on what should not ordinarily happen, or at least to focus as carefully as upon what will happen for sure; i.e., the price and the nature of the goods [or services]. In any event, for these and other reasons, it has been persuasively argued that the market bargaining process will not protect consumers from a large variety of injuries in a huge array of transactions. And if not, some other device to supply that protection may have to be designed. The natural step is to look to government intervention; i.e., to invoke the political "market" instead of the economic one to correct the latter's alleged imperfections.

... Even having made that decision, however, one has barely begun the intellectual struggle such an apparent insight should set off. If the government is to intervene, what form should that intervention take? Should it be legislative and administrative, legislative and judicial?

So, one can regulate insurance contracts by administrative rulings (through an insurance commissioner), through legislation (witness New York State's rigorously precise statutory delineation).

80. See note 77 supra.

tion of insurance contract terms),\textsuperscript{82} or "by the government via the judicial bureaucracy, on an ad hoc case-by-case basis, essentially unrestrained by legislative or administrative guidance"\textsuperscript{83} (this, of course, is what courts do when they decide which contract clauses are unconscionable). The premise of the market, however, is that parties to a contract know what is best for them; the premise of governmental intervention, including that by the courts in ruling contracts unconscionable, is that a governmental bureaucracy, whether administrative, legislative, or judicial, rather than the parties, knows what is best for them.

If the courts were to strike down all elective no-fault insurance contracts, they would in effect be saying that the purchase of tort liability insurance is so much in the interest of consumers as a class that they will not be allowed to buy any other form of insurance. But how much sense does it really make to say that tort liability insurance is so valuable to potential accident victims that the market will not be allowed to substitute any other form of insurance? Especially dubious is this position when one takes account of how much the public seems to favor no-fault insurance over fault insurance. The consumer movement seems almost unanimous in its support of no-fault insurance.\textsuperscript{84} Keep in mind that the effect of common-law tort decisions is that all buyers of goods and services must automatically buy from manufacturers or service providers insurance policies that cover personal injury caused by faulty or defective products or services. Theoretically, that may well make sense, but also keep in mind that the effect of such an insurance policy is that (1) expenses already paid for are paid all over again and (2) payment is based on fault or defect, with additional amounts being paid for pain and suffering, so that the premium is primarily used for legal expenses and insurance overhead—payment is thus usually nonexistent and, even if made, often nonutilitarian and always long delayed.\textsuperscript{85} Why, then, should providers of goods or services be precluded from experimenting with other forms of insurance, arguably more efficient?

At least under elective no-fault insurance some providers of goods and services would be offering an alternative to the tort system. If it were protested that all providers of goods and serv-

\textsuperscript{82} See, e.g., N.Y. Ins. Law §§ 140-74 (McKinney 1966).
\textsuperscript{83} Leff, supra note 81, at 353.
\textsuperscript{85} See notes 1-23 supra and accompanying text.
ices would elect no-fault and thus leave no choice to the consumer, that is no different from the present system where all are forced into offering (or buying) insurance based on fault. Unanimous election of no-fault would also be an indication that the new system is universally seen by providers of goods and services as better for them (and presumably their customers) than liability based on fault. If it were further protested that providers of goods and services are likely to make a decision inimical to the interests of their customers, at least in this instance, such a criticism seems unfounded in light of the inadequacies of the system based on tort. Should a court insist that such marketing and professional decisions are unconstitutional (if made pursuant to a statute allowing provider choice) or unconscionable (if made without statutory authorization)?

It is interesting to note that when the government intervenes in overruling or displacing market decisions,

[It is more active in situations where the failure of self-protection through market mechanisms might have serious and irreversible consequences for the buyer. For instance, where the failure to shop carefully and intelligently might lead to death, sickness or serious bodily injury, the government is more likely to intervene to stipulate at least minimum standards for the goods. ... [E.g., ... auto-safety standards. ... Only rarely does the government intervene, except through information-generating devices like expanded notions of fraud, or through devices like the Prospectus requirement of the Securities Act of 1933 ... when the danger is merely that the buyer will get less than he might otherwise have received. In other words, government is most likely to intervene directly when the risk to the buyer goes beyond the value of the thing bargained for [; in other words, beyond just being bilked by worthless or shoddy goods such as a power lawn mower that won't start, one stands to lose a foot when the mower does work. Obviously, that loss of a foot is beyond the value of the thing bargained for (the lawn mower).] When one looks at the cases ... it appears, though dimly, that the court's “using” [unconscionability] ... may already have started, though not very consciously, implementing some such criterion as “risk beyond the value of the bargain” as an unacknowledged touchstone for those contract clauses needing for their validation (if ever validatable) some form of super-assent [from a court]. The clearest instance is with respect to warranty disclaimers, where elimination by “contract” of recourse against the seller or manufacturer means not only that one may get defective or worthless goods, but that one may also sustain uncompensated personal injuries.86

Note that crucial word “uncompensated.” The law should not just stop after asserting that the loss of the foot exceeds the value of the bargain, and, therefore, the manufacturer will

86. Leff, supra note 81, at 353 n.19.
not be allowed to bargain away his tort liability for the loss of that foot. In effect, as we have seen, decisions such as *Henning-sen v. Bloomfield Motors, Inc.*\(^\text{87}\) require the manufacturer to sell—and the purchaser to buy—insurance for personal injury stemming from a defect in the product.\(^\text{88}\) But if we are focusing on bargains we have to ask, do we not, how good is that bargain mandated by the judicial bureaucracy? How likely is it that the injury will be compensated under the insurance mandated by the courts? Is the bargain of getting tort liability insurance so good—and the assurance of compensation so great—that the courts should allow no other remedy or insurance to be substituted for it? Looked at that way, the answer would clearly seem to be negative. The National Commission on Product Safety,\(^\text{89}\) after exhaustively examining the current product liability system, opined that “[t]o advise a battered consumer to sue may simply add insult to injury.”\(^\text{90}\)

Another argument in favor of permitting elective no-fault insurance contracts is derived from history: compensation for personal injury stemming from products, at least, has been for a century and a half a fascinating minuet between tort and contract.\(^\text{91}\) First, in 1842, in order to limit payment for personal injury, contract (specifically, the doctrine of privity) was used in a product liability case to get around the inadequacies of tort (specifically, the almost unlimited liability in tort to almost anyone);\(^\text{92}\) then, in 1916, in order to ensure more ready payment for personal injury, tort (specifically, liability for negligence regardless of the lack of privity) was used to get around the inadequacies of contract (namely privity);\(^\text{93}\) then, once again in order to ensure more ready payment for personal injury, contract (specifically, the doctrine of warranty) was used increasingly in products liability cases to get around the inadequacies of tort (specifically, such requirements as proof of negligence and the

\[\text{87.} 32\text{ N.J. 358, 161 A.2d 69 (1960).}\]
\[\text{88.} \text{See text accompanying note 33 supra.}\]
\[\text{89.} \text{The chairman of the Commission was Arnold Elkind of the New York City Bar, a prominent personal injury lawyer.}\]
\[\text{90.} \text{NATIONAL COMM’N ON PRODUCT SAFETY, FINAL REPORT 74 (1970).}\]
\[\text{91.} \text{See Franklin, When Worlds Collide: Liability Theories and Disclaimers in Defective-Product Cases, 18 STAN. L. REV. 974 (1966). As to the mixture of tort and contract in the origins of health care provider liability, see 1 D. LOUISELL & H. WILLIAMIS, MEDICAL MALPRACTICE § 8.03, at 194-200 (1973).}\]
\[\text{92.} \text{Winterbottom v. Wright, 10 M. & W. 109, 152 Eng. Rep. 402 (Ex. 1842).}\]
absence of contributory negligence); then, in order to ensure still readier payment, tort (specifically, the doctrine of strict liability) was used to get around the inadequacies of contract (specifically, such requirements as privity and notice under the doctrine of warranty); so now, in turn, to ensure readier payment still, contract (specifically, elective no-fault liability as a warranty) should be used to get around the inadequacies of tort (specifically, such requirements as proof of defect under the doctrine of strict liability).

Bear in mind that the proposal for elective no-fault insurance follows closely the provisions of the Uniform Motor Vehicle Accident Reparations Act (UMVARA), the no-fault auto law drafted at the behest of and endorsed by the Commissioners on Uniform State Laws. Elective no-fault allows those liable in tort for personal injuries to substitute to the maximum extent possible no-fault benefits for out-of-pocket losses. Concerning this trade-off, consider the following remarks of Professor Robert E. Keeton:

(1) Under the existing [auto tort] system, the package is $25,000 per person/$50,000 per accident liability insurance coverage, with the assurance (by uninsured motorist coverage) of the collectibility of one's valid claims against other drivers up to at least that same amount. This package . . . [provides] each person with the right to recover for both economic loss and [pain and suffering] when there is a valid claim based on negligence, but no right to recover either kind of damages in other cases. . . .

(2) The other package is UMVARA, with guaranteed lifetime coverage, no overall limit and relatively liberal internal

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95. See id. § 98.
96. See O'Connell, No-Fault Liability by Contract for Doctors, Manufacturers, Retailers and Others, 1975 INS. L.J. 531, 541.
97. NATIONAL CONF. OF COMMISS'RS ON UNIFORM STATE LAWS, UNIFORM MOTOR VEHICLE ACCIDENT REPARATIONS ACT (Nov. 1, 1972 ed.).
98. See note 76 supra. Even if contracts are used without enabling legislation, the provisions of the no-fault draft bill should be the basis on which insurers draft elective no-fault provisions. In addition, approval of elective no-fault insurance contracts by an insurance commissioner might well be viewed as necessary under the law of some states. R. KEETON, INSURANCE LAW—BASIC TEXT 71-72, 543-45, 550-53 (1971). A regulator might well use the terms of the draft bill as a basis for prescribing, proscribing, or permitting specific policy provisions. Note that approval of elective no-fault insurance contracts by an insurance commissioner would probably enhance the likelihood of a contract being upheld by the courts, in that approval by a public official is arguably inconsistent with unconscionability. For more on safeguards against unfair contracts being imposed on the public, see J. O'CONNELL, supra note 17, at 155-56.
limits ($200 per week for wage loss and a semi-private rather than a private room when hospitalization is needed). Subject to these internal limits, this package provides total coverage for economic losses sustained in automobile accidents regardless of negligence, but no chance of recovering general damages for noneconomic detriment (such as pain and suffering) unless the injury is severe.

Which package would you choose?59

To further illustrate the huge amounts now being misspent under traditional tort liability that could be shifted to prompt payment of out-of-pocket losses under no-fault insurance, consider the following figures from Michigan: Coverage under Michigan's no-fault auto laws pay unlimited medical expenses, plus $36,000 of wage losses, and residual tort liability (beyond the tort exemption under the no-fault law) of $20,000, all for a cost no greater—and substantially less for those willing to forego payment if already paid from Blue Cross or employer-financed sick leave, for example—than the costs of only $20,000 under traditional tort liability coverage.

As suggested earlier, because of the difficulty of identifying all insured events we cannot mandate the no-fault bargain across the board to all medical or product injuries.100 But since the advantages of no-fault protection are so dramatic compared to liability based on fault or defect, why not allow anyone potentially liable in tort to put the advantages of no-fault to work? Recently, the prestigious Special Advisory Panel on Medical Malpractice, appointed by Governor Carey of New York and chaired by President William McGill of Columbia University, stated as its first of 17 recommendations:

Inasmuch as the present tort law/liability insurance system for medical malpractice will eventually break down and costs have and will continue to rise to unacceptable levels, fundamental reform of the present tort law/liability insurance system should be undertaken. ... [T]he overriding concern should be to create a system of compensation for adverse medical outcomes resulting from medical treatment, whether or not caused by negligence.101

100. See text accompanying note 55 supra.
(The panel's report did not advert specifically to no-fault, but according to the New York Times:

Supporters of the Panel recommendation have shied away from the no-fault label because they feel it will frighten off the insurance companies and lawyers who fought no-fault automobile insurance....

There are at least two responses, however, to any attempt to shy away from the label "no-fault." First, if that term accurately describes the plan, there is little, if any, hope that this well-known term can be avoided. The press and the public will inevitably call the proposed reform by such a widely known label, if it fits. It is not without significance that the proponents of no-fault insurance did not invent the term; it was apparently coined by the press as a convenient term that would fit into headlines. Once introduced by the press, it took on a life of its own for both the press and the public, and no term could have supplanted it. Second, if one is urging reform, perhaps the greatest advantage

102. See N.Y. Times, Feb. 22, 1976, at 38, col. 3. The Times also reported that an additional fear of the no-fault label was that "people will feel that doctors guilty of negligence will not be penalized." Id. As to this objection, see notes 145-59 infra and accompanying text.

103. Perhaps the following exchange illustrates something of the problem. A letter from a very thoughtful and eminent law professor, long interested in automobile insurance reform, was received by proponents of no-fault automobile insurance in October of 1970:

Dear...:

Along with the continuing newspaper discussion of the advances and distortions of no-fault insurance, I saw a bumper sticker the other day! It said "No fault no pay." I surmise that is a production of the Trial Lawyers Association.

Anyway, it led me to reflect that "no-fault" is not a very positive kind of slogan, and that it may also have been captured and diluted. How about "self-protection insurance"? This phrase has obvious connotations of self-reliance and security. It can also easily be put in an active voice: "Insure to protect yourself."

I hereby give you... a free license to do what you will with this idea.

In answer:

Dear...:

Concerning your provocative note... on another name for reform than "no-fault" insurance, I have found that one does not control these things at all...

Rather, for reasons that are not at all clear, newspaper people and then the public latch on to a given name and one is stuck with it. The most important thing to my mind at this point is that reform is identified by a catch phrase that millions of people recognize. As you can probably appreciate, that is an inestimably important step. Once you've achieved it, almost no matter how disadvantageous you think the term to be, one is ill-advised to try to change the terminology because (a) you give away the big advantage of identification and (b) the chances are overwhelming you won't succeed in changing the name adopted anyway.

All I am trying to say is that if this were a rational process, I might go along with you in trying to steer the terminology
one can have, next to a valid idea, is widespread recognition of the substance of the proffered idea. In the commercial world, enterprises would gladly spend millions—perhaps hundreds of millions—to gain the kind of instant recognition that the term “no-fault” now excites in the United States, and indeed all over the world. To try to avoid its use for an idea of which it is descriptive seems both naive and wasteful.) Elective no-fault may be a controversial and somewhat complicated reform, but unconstitutional and unconscionable it is not.

IV. TORT COSTS AS THE BASE LINE FOR REFORM

One objection to elective no-fault insurance is that it uses the costs of the present tort system as a base line. In other words, it is the cost of the present system that sets the parameters for the operation of no-fault insurance in that it is expected that providers of goods and services will check their tort liability costs against the possible costs of no-fault insurance. Based on that comparison, they will decide whether it is “profitable” for them to elect no-fault insurance. In the words of Professor Havighurst:

[Elective no-fault, having its base line in the existing system and being designed by providers primarily for their own benefit, would be viable only to the extent that physicians perceive a benefit to themselves, in terms of cost and avoidance of unpleasantness, in establishing compensable categories.]

Professors Walter Blum and the late Harry Kalven of the University of Chicago Law School have more extensively criticized this common-law base line as a limitation of no-fault plans:

The upshot of a [no-fault] plan is to effect a shift from a redress perspective to an insurance perspective. As a result, one is liberated from being controlled by . . . common law [damages] . . . . and even from being much guided by them.

. . . Are the [new] award levels to be set on the assumption that there is a more or less fixed aggregate pool to be distributed as unconditional [no-fault] reparations to the victims, or on the assumption that the size of the pool is not a given, but is to be determined by notions of what the award levels ought to be? It is our impression that in almost all discussions [of no-fault] it is implicit that there is a more or less determined limit to the pool, and that this sense of limit is toward the kind of advantageous terminology you suggest. But it ain’t.

Cordially,
Jeffrey O’Connell

As a further illustration, the name Professor Keeton and I applied to our original plan, “Basic Protection,” was rarely used by others.

perhaps the controlling factor in determining the award structure.

One does not have to look far for an explanation. A chief point of rhetoric in the advocacy of plans has been that they will offer a better product, dollar for dollar, than the motorist is now buying; in brief, under a plan, a motorist's total insurance premiums will not increase, but will in all likelihood decrease. It follows that the maximum size of the pool to be distributed in unconditional [no-fault] awards has to be set by the size of the "pool" that is generated under the common law tort-insurance system. Whatever the need to acknowledge the political imperatives, an anomaly lurks here. The award potential under a plan is being largely determined by a factor which is irrelevant to the aspirations of a plan. The aggregate amount the common law "collects" for distribution to victims is crucially affected by the fact that the law is not intended to pay all victims, but only those who qualify under common law liability rules. A principle point of every plan in mandating unconditional [no-fault] reparations is to reject those common law criteria of eligibility for compensation. Yet in effect the outcome is to permit these rejected criteria to limit how much a plan will do for victims. This almost automatic acceptance of the size of the common law "pool" as a limitation may be a key clue in explaining why the discussion . . . under [no-fault] plans has been so little concerned with theory. Once it is assumed that the size of the pool is already determined, many genuine issues . . . are readily short-circuited.

... Throughout [this Article] we have recognized that the auto [no-fault] plan is a new institutional concept. Something new has been brought in to replace something old. At the heart of every plan is the replacement of conditional redress [based on fault] keyed to corrective justice, by unconditional [no-fault] reparations keyed to insurance. One might have thought that a change so conceived would have been able to break sharply with the common law and its legacy of traditions, expectations, and concepts. The most interesting impression with which we are left is that the common law, even in the case of the most ambitious plans, still makes its presence felt. Once again, Maitland's aphorism is corroborated: auto [no-fault] plans, too, might be said to be ruled from the grave.

... The most obvious instance, made explicit in the public rhetoric, is tying the cost of the new arrangement to the cost of the old. Almost universally the base line for assessing the cost of a plan to the motorist is provided by the cost to him of the common law tort-insurance system. Use of the common law as a baseline is exemplified again in justifying . . . the limitations on reparations. This time the reference is not to what the common law costs, but to what the common law affords as redress. The justification may be seen in terms of a "bargain" in which old common law rights are traded for new unconditional [no-fault] reparation rights—a justification which would be without foundation in the absence of any common law rights.105

Of course the point is well taken; even more than with auto plans, elective no-fault insurance plans for medical malpractice and products liability use the present tort liability cost as a base line—but not necessarily for every compensable event. It might well be that providers of goods and services would, on occasion at least, decide to include no-fault benefits that would increase costs, on the ground that they and their customers/patients are better off with such expeditious compensation. A doctor might decide, for example, that automatic payment for additional costs attributable to complications arising from a thyroid operation merit at least offering the patient a higher cost option for insurance. A manufacturer might similarly consider that automatic payment of benefits for amputation resulting from the use of his power tool justifies a higher price. Admittedly, given strong beliefs that present liability insurance costs are too high, this may not happen too often. On the other hand, feelings that costs are too high under present common-law tort liability may well stem from the sense of how little anyone but lawyers benefits from those high costs; when a better insurance option is available providers of goods and services may well sense their customers/patients will be willing to pay more for better insurance protection.

Nevertheless, this question of tort liability costs as the base line for no-fault insurance is worthy of examination. There were many no-fault auto plans proposed between 1932 and 1965, but none really focused on what would be the costs vis-à-vis the tort system. Not surprisingly, it was only with the detailed structuring of auto no-fault in such a way that actuarial opinions could offer reassurance that costs would not rise and indeed would probably decline that the no-fault idea took hold. Without offering assurances as to cost, a reformer was in the position of going to a legislature and saying, "I can improve auto insur-

\[106\] Whether the higher price would be mentioned to—and bargained over with—the patient would probably, in practice, turn on whether the particular doctor now mentions—and bargains over—differences in expense for various modes of treatment. Doctors often don't do that—but dentists do.

\[107\] On the reluctance of merchants to publicize potential injuries from the use of their products, however, see J. O'Connell, supra note 17, at 100.


ance, but it will cost more,” to which a ready, if simplistic, reply might have been “Who couldn’t?” It was the offering of better insurance protection at the same or lower price that caught the public eye. Remember that auto insurance everywhere is, in effect, a compulsory purchase—as is, in effect, product liability and medical malpractice insurance. Thus changes in the insurance system that increase costs are seen as very offensive since all are required to pay more regardless of their desires. Thus, in turn, using present costs as the base line for reform does not seem so illogical.

Elective no-fault insurance seems to evoke essentially two main (inconsistent, but understandable) fears: first, insureds will elect compensable events in such a way that compensation to customers/patients will be drastically and unfairly reduced, compared to tort litigation; second, the costs of paying on a no-fault basis will be drastically increased, compared to tort litigation.

A. AN UNFAIR REDUCTION IN COMPENSATION?

As to the fear of reduced compensation, Professor Keeton and others have pointed to the enormously increased pay-outs possible under no-fault insurance compared to the tort system.\textsuperscript{110} Professors Blum and Kalven have analyzed it this way with reference to no-fault auto plans:

\begin{quote}
It is often argued that the internal savings in administering unconditional [no-fault] reparations, as measured against administering conditional [fault/defect] reparations, should be sufficient to pay for the additional coverage of victims ineligible for recovery at common law. The ratio of savings to pay-out declines as the amount of reparations goes up. It may be possible to locate a sort of optimal point for a ceiling—the point at which the internal savings just meet the pay-out on coverage of the additional victims. It is not clear, however, that this line of thinking has ever been [explicitly] used as a rationale for a [no-fault auto] . . . plan.\textsuperscript{111}
\end{quote}

But, of course, that is precisely the line of thinking undergirding elective no-fault liability—that providers of goods and services will be encouraged to find the optimal point “at which the internal savings just meet the pay-out on coverage of the additional victims.”\textsuperscript{112} Critics of elective no-fault, however, have pointed to the distinct possibility that insureds will not nec-

\textsuperscript{110} See note 143 infra.
\textsuperscript{111} Blum & Kalven, supra note 105, at 354 n.20.
\textsuperscript{112} Id.
Alternatively, insureds will be induced to carefully pick as compensable events those accidents likely to have already resulted in tort verdicts or settlements, thereby eliminating collateral payment and payment for pain and suffering while not greatly, if at all, increasing the pay-out to previously ineligible victims. In other words, they will be inclined to find an optimal point that eliminates tort pay-outs but fails to increase nontort pay-outs.

That costs may be cut too much at the price of eliminating valid tort claims raises a variant of what Professor Robert Keeton has spoken of in another context as the cost/equity dilemma. We cut costs at the price of doing equity. But keep in mind that the equity that is sacrificed is the "equity" of the tort system, which, in the aggregate, provides precious little equity. Nevertheless, Dean Richard Roddis of the University of Washington Law School has expressed the fear of a skewed cost/equity bargain as follows:

Uncontrolled experimentation by elective no-fault could be most unfortunate from a consumer standpoint. The providers will make a series of calculated economic choices about what to cover and their choices may not be the ones that I, as a health care consumer, would like to have made. At the least, I suggest that any elective no-fault system should subject the scope and terms of provider elections to external public control calculated to achieve reasonable uniformity, avoid confusion and conflicts among the elections of different providers in a particular treatment situation, and prevent unreasonable limitations in the elections.

Dean Roddis, then, would seem more comfortable if the legislature or insurance commissioner (presumably upon legislative delegation) defined compensable events under the no-fault system so that an optimal point more favorable to customers/patients would be ensured.

The question can be starkly posed: Given the admittedly difficult job of defining compensable events (which drives us to elective no-fault in the first place), whom do you trust more to do the job? A legislature and/or government agency on the one hand or providers of goods and services on the other? One can make a strong case for starting with the providers of goods and services since they are in a better position to decide what is best for them and their customers/patients than are the wisest gov-

ernment officials. Granted that there will be some overreaching, we will, on the whole, get a more flexible working arrangement through decentralization by letting the market for goods and services determine the optimal level of compensation for injuries from goods and services. 115

Admittedly there is already a great deal of distrust of the manner in which, for example, health care providers decide on appropriate treatment. This deep distrust has indeed led to the establishment of so-called Professional Standards Review Organizations (PSROs), ordained by congressional enactment. 116 Under the statute, regional review boards are being established, each "charged with defining acceptable norms of medical aid and insuring that individual physicians and hospitals meet specified standards of performance." 117 Each PSRO develops guidelines for a given illness, injury, or health condition, specifying, for instance, when hospitalization is necessary and the appropriate length of stay required in the course of proper care. 118 On the other hand, PSROs are the subject of bitter criticism by the medical profession on the ground that such massive bureaucratic intervention (once again, it will be noted, supposedly to correct the market between health care providers and their patients) 119 will not end up benefiting patients. 120 Professor Calabresi has recently commented that never before have


Similarly, United States Ambassador to the United Nations Daniel Patrick Moynihan, in a speech at about the same time, stated: "What is going on is a systematic effort to create an international society in which government is the one and only legitimate institution." Moynihan, A Diplomat's Rhetoric, Harper's, Jan. 1976, at 40, 41. See notes 166-75 infra and accompanying text.


118. For a good survey of PSROs, see A. Gosfield, PSRO's: THE LAW AND THE HEALTH CONSUMER (1975). 119. See text accompanying note 81 supra.

120. See A. Gosfield, supra note 118, at 2 n.9; Winsten, supra note 117.
such extensive result-oriented safety regulations of conduct as PSROs ended up working. “We end up,” he said, “with building codes.” In the case of PSROs selecting appropriate treatment—as with selecting compensable events when treatment goes awry—it is by no means clear that a governmental official ought necessarily to step between the doctor and his patient.

Of course, the choice is not simply a stark one between market or governmental determinations of compensable events. Arguably, an insurance commissioner's approval will be required before elective no-fault insurance policies are marketed. Indeed, I have also suggested that advisory committees of professional and business persons should be established to assist an insurance commissioner in approving given types of elective no-fault policies. Moreover, elective no-fault contracts will be subject not only to administrative scrutiny by insurance commissioners but to judicial scrutiny by courts as they apply the doctrine of unconscionability to identify particular instances of overreaching by providers of goods and services.

121. Remarks of Guido Calabresi, Conference, supra note 19. See notes 137-41 infra and accompanying text. For a detailed description, incidentally, of the corruption now thriving in New York City as a result of building codes and other safety regulations, see N.Y. Times, June 26, 1972, at 1, cols. 1-3; id., June 27, 1972, at 1, cols. 6-7.

122. A clear example of where we have resorted to governmental regulation, rather than physician discretion, in health care matters is in the prescription of new drugs. Under the Pure Food and Drug Act, 21 U.S.C. § 1 et seq. (1970), no drug can be prescribed by a physician until it has been tested and approved by the Food and Drug Administration (FDA). Id. § 355. With PSROs, we are, in effect, moving to arguably similarly governmental-imposed constraints on physician discretion. But there seems to be strong evidence that such governmental restraints on drug prescriptions have cost more in adverse effects than they have provided in benefits to the public. Studies by Sam Peltzman and Dr. William Wardell indicate that, on balance, we have suffered more in keeping beneficial drugs off (or delaying them from) the market than we have benefited in banning unsafe drugs. Indeed, for all the restraint "it is not at all clear that present regulations would prevent a thalidomide from being marketed." V. Fuchs, WHO SHALL LIVE? HEALTH, ECONOMICS AND SOCIAL CHOICE 115-19 (1974) (citing Peltzman, An Evaluation of Consumer Protection Legislation: The 1962 Drug Amendments, 81 J. POL. ECON. 1049 (1973) and Wardell, Introduction of New Therapeutic Drugs in the United States and Great Britain: An International Comparison, 14 CLIN. PHARM. & THERAP. 773 (1973)).

123. See note 98 supra.

124. J. O'Connell, supra note 17, at 155. Indeed, most of Professor Havighurst's criteria might be used. See notes 58-59 supra and accompanying text.

125. It will be essential for courts to weigh the fairness of the bargain as of a time before injury—and as it applies to consumers/patients as a group. J. O'Connell, supra note 17, at 118-19.
An additional fear related to overreaching by health care providers, in particular, is the fear (reflected in Professor Havighurst's fifth criterion—"Would an incentive to minimize the occurrence of this complication [as a compensable event] bias the choice of treatment in unfortunate ways?")\textsuperscript{126} that doctors might skew the treatment offered to lessen the likelihood of insurance payment being required. If, for example, no-fault benefits seem particularly likely to be paid to a given patient following a certain procedure, a different procedure might therefore be employed.

Here, too, however, participation of the insurance commissioner\textsuperscript{127} in applying a criterion such as that developed by Professor Havighurst would aid in avoiding allowance of manipulable compensable events that would entail such skewed treatment. Furthermore, skewed treatment itself might be the subject of a malpractice suit. Finally, query the degree to which we need be uniquely worried that doctors are going to improperly skew their treatment for the purposes of insurance any more than they will skew treatment for other improper purposes.\textsuperscript{128} In the case, then, of improper treatment to increase fees or to lessen insurance pay-out, there is cause for some fear of unethical behavior, but structuring bureaucratic remedies to prevent such behavior ought not to be lightly undertaken.

What operates here is the traditional tripartite spectrum for controlling improper behavior: Conscience/Market/Fiat. As economist James Buchanan has so succinctly put it: "The market economy's socio-political function is that of minimizing the necessity of resorting to internal ethical constraints on human behavior and/or external legal-governmental-political restrictions."\textsuperscript{129} To continue our focus on the health care provider,

\textsuperscript{126} Remarks of Clark Havighurst, Conference, supra note 19, at n.71, in Havighurst, note 58, 1975 DUKL J., at 1256.

\textsuperscript{127} See notes 123-24 supra and accompanying text.

\textsuperscript{128} Recently, for example, a prominent physician urged that surgeons be receiving salaries rather than charging fees that might tempt them to perform unnecessary operations. Dr. George Crile, Jr., emeritus consultant in surgery of the Cleveland Clinic, stated, "A surgeon deciding whether or not a patient should be operated on is acting as a judge. When he knows he will be paid $500 if he operates and nothing if he doesn't, the surgeon is faced with a conflict of interest." Chicago Sun-Times, Dec. 14, 1975, at 98, cols. 1-5. But what, for example, will be the effect of reimbursement only by salary on the availability of necessary surgery?

\textsuperscript{129} Buchanan, Good Economics—Bad Law, 60 VA. L. REV. 483, 486 (1975).

That the parties should be allowed to vary by contract the manner in which the law would otherwise impose loss is pivotal to the seminal
we find there exists already a great deal of ethical constraint on human behavior. In the words of Harvard economist Kenneth Arrow:

The medical profession's code of ethics may not be universally followed, but is practiced widely enough to create a popular presumption that each doctor acts with the patient's welfare in mind—that he will not, say, order unnecessary tests or operations. The code protects patients, to be sure, but it also benefits doctors by maintaining the public's trust in the entire profession.130

Similarly, according to Harvard sociologist Nathan Glazer: "In all systems, one must depend heavily on the professional ethic of the doctor to provide good and responsible care."131

In any case, of course, we do not depend on ethical constraints alone for anyone in our society. Even so, granted that the market for health care providers is very imperfect,132 I would nevertheless be cautious about deciding that the market, coupled with ethical constraints, is so inadequate that on the whole it

Theories of Professor Ronald Coase of the University of Chicago Law School. Coase, The Problem of Social Cost, 3 J. Law & Econ. 1 (1960). See also Demsetz, When Does the Rule of Liability Matter?, 1 J. Legal Studies 13 (1972). Under the Coase theorem, optimal allocation of resources need not depend on law-imposed rules (whether by court, legislature or administrative agency). Rather, regardless of the manner in which the law imposes liability for losses, if the parties are allowed to bargain over reshifting the loss, they will arrive at an optimum allocation of resources. Coase assumes no transaction costs—which include, for example, information costs, as well as the costs of lawyers or others in negotiating over the redistribution of losses between the parties. But that "fairly heroic" assumption of no transaction costs, see Gilmore, Products Liability: A Commentary, 38 U. Chi. L. Rev. 103, 105 (1970), does not alter the brilliance of Coase's insight. And, for our particular purpose, the transaction costs to producers of goods and services in bargaining over compensation rights with their customers/patients, with whom they are already in a contractual relationship, would be relatively low.

Thus, to the extent the courts refuse to allow bargaining to reshift losses imposed by law, the more they blunt the parties' attempts to arrive at a more sensible solution and allocation of resources than may have been arrived at by merely relying on the law. To be sure, there is the danger that the parties will then arrive at a grossly inequitable bargain. The crucial question thus becomes which does one trust more—governmental fiat or private bargaining? It is the thesis of this Article, of course, that the imposition of personal injury liability under the tort system has proved to be so socially counterproductive that the Coase theorem must be applied: the courts should be receptive to more efficient arrangements worked out by the parties themselves.


132. See V. Fuchs, supra note 122, at 62, 102.
need be overbalanced by further tight, restrictive governmental controls either prescribing or proscribing norms for (1) treatment or (2) payment for injury arising from treatment.

In significant measure, then, rejection of elective no-fault insurance or a corresponding insistence that compensable events initially be defined by a legislature or insurance commissioner might replicate the fallacy of the courts if they were to strike down any and all elective no-fault contracts as contracts of adhesion or, if authorized by statute, as unconstitutional. In both cases, resort would be had to governmental fiat rather than the market to define compensable events. In each instance, a governmental agency (the courts or the legislature or an insurance commissioner) would be insisting that the line protecting the consumer/patient be drawn at a certain place—and, more specifically, at a point other than where providers of goods and services (who, in the aggregate, have to think about pleasing the consumer/patient) might have drawn it. All I'm suggesting is that—at least to start with—it might be best to rely primarily on providers of goods and services to draw that line at an appropriate place (with some relatively loose—and tolerant—supervision from courts and insurance commissioners), even though they will make some mistakes (and probably in their own favor). In the words of economist Harold Demsetz, speaking at a conference on the economics of products liability:

We would like to go on the premise that freedom of action is something that is good. We would like to have it produced, but it is not producible without costs. One of the costs of producing freedom is that people are going to make mistakes in using their freedom. Even from their own viewpoint they are going to make mistakes.

...It is not [, however,] a question of no mistakes versus some mistakes[,] it is a question of having mistakes of one kind versus mistakes of another kind. Obviously, no one has perfect knowledge. Somehow you must decide when you are going to stop trying to rectify the mistakes that arise from people's exercise of freedom. And maybe the line is not drawn in the right place. Maybe you want to shove it one way or another, but merely citing the fact that some people [make]... mistakes

133. See notes 81-100 supra and accompanying text.
134. Economist George Stigler has observed: "We [talk]... about how the market acquires information and how people react to it, but on the other hand, [one cannot]... presume that the legislature gets free, accurate, and immediate information on new developments and that it has an efficient bureaucracy to enforce its policies." Remarks of George Stigler, AAS-AEA Conference on Products Liability, in Manne, Edited Transcript of AAS-AEA Conference on Products Liability, 38 U. Chi. L. Rev. 117, 134 (1970).
that...hurt third parties is not in itself a convincing argument to me that we ought to draw the line someplace else.\textsuperscript{135}

In thus relying on the marketplace, one echoes the sentiments of many economists—and others—who question ever more regulation of the marketplace. At the same products liability conference, Melvin Reder, a Stanford University economist, argued as follows:

Part of what the economists have been saying is in fact what the students have been saying. No "\textit{in loco parentis.}" What we are saying is that, given the way people get information, they are going to do as good a job, as far as they are concerned, as some other person or agency can do for them. However poor this may be, the alternative to having individuals make their own individual decisions is to have them made by some other mechanism, and, in general, what we [economists] are saying is that in practice most people will indicate that...this is inferior.\textsuperscript{136}

As to mistakes stemming from governmental fiat, especially in the area of insurance, Dean Spencer Kimball of the University of Wisconsin, the country's leading authority on insurance regulation, has characterized the "typical American insurance code [of laws as] a rubbish heap without parallel in the law-making of modern man."\textsuperscript{137} And Professor Robert Keeton has been quick to point out that insurance terms dictated by public fiat are by no means necessarily framed in the public interest:

To say that a policy form is prescribed by statute or by administrative regulation is not to say that the initiative for modification...is...with the legislature or administrator. In fact the initiative is more often elsewhere.

[With respect to forms prescribed by administrative regulation [for example] it appears that proposals for change more often come from insurers than from any other source, including the office of the administrator...[T]he administrator gets most of his information about new needs through insurers, and in most instances his action on proposed forms is based to a large extent on information presented by them in support of proposed changes.\textsuperscript{138}

A good example of the public interest in insurance matters being perverted by governmental fiat lies in legislative and administrative prohibitions across the country against the writing of group auto insurance—insurance that normally would be provided automatically as a part of one's employment, with the premiums paid in whole or in part by the employer. Despite the fact that the greatest percentage of health insurance in the United States is sold under such group policies—with similarly

\textsuperscript{135} Remarks of Harold Demsetz, id. at 138-39.
\textsuperscript{136} Id. at 138.
\textsuperscript{138} R. KEETON, INSURANCE LAW—BASIC TEXT 71 (1971).
huge amounts of life insurance being sold in the same manner—
“[g]roup merchandising of automobile insurance is almost un-
known in the United States.” 149 Supposedly, prohibitions against


group auto insurance are designed to protect the public, but, in

fact, they are a naked example of featherbedding by insurance

agents (fearful of losing commissions) and small, local auto in-
surance companies (fearful of losing business to large multi-line

national companies who already write group life and health). Dean Kimball and his colleague, Herbert Denenberg, have la-
abeled the theoretical underpinning of these restrictive rules,

which are supposedly in the public interest, as “silly” 140 and

“absurd” 141—the rules nevertheless were universally adopted. 142

The point is, if doctors and insurance companies are intent on

ripping off the public, insurance regulations may be a thin shield

of protection.

B. AN UNMANAGEABLE INCREASE IN COSTS?

Some fear exists that, far from costing too little (with con-

comitant unfairness to those who should be paid), elective no-
fault insurance will cost too much. Again, in the words of Dean

Roddis:

I doubt that an adequate no-fault program for medical

“malocurrence” compensation will cost providers or their insur-

ers less . . . . [I]Indeed, it probably will cost more than the pres-

ent system . . . .

. . . If the elections result in an acceptably broad net of no-
fault coverage, then I surmise that the total dollars paid in

claims will be as much as and probably even greater than at

present. I do not dislike such a result for I suspect that there

are a great many people now who experienced an adverse result

from the treatment process and should have been accorded com-

pensation for economic loss but did not receive it. 143

139. Hearings on S. Res. 233 Before the Subcomm. on Antitrust and

Monopoly of the Senate Comm. on the Judiciary, 90th Cong., 2d Sess.,


140. S. KIMBALL & H. DENENBERG, MASS MARKETING OF PROPERTY

AND LIABILITY INSURANCE 62 (1970) (U.S. Dep't of Transportation Auto-

mobile Insurance and Compensation Study).


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142. See note 140 supra passim.

143. Roddis, supra note 114. For another pessimistic view of the
costs of no-fault medical malocurrence insurance compared to present
medical malpractice premiums, see R. Keeton, Compensation for Medical

Accidents, 121 U. Pa. L. Rev. 590 (1973). But, of course, as medical mal-

practice premiums skyrocket, the attraction of elective no-fault insurance
also increases dramatically, in that more and more funds are available
to be shifted from fault to no-fault payment.
But this, of course, is precisely the virtue of the elective feature of no-fault insurance. As Forbes magazine has reported, “[Elective no-fault] . . . can be applied where it works and ignored where it doesn’t. An accurate check on costs and benefits can be kept at each step of the way.” Indeed, since by definition there is no compulsion to offer such coverage, it lends itself perfectly to the so-called “stop loss” device under which, once insurers have committed a given amount of loss reserves to no-fault payment, they need not offer any further no-fault contracts. That way insurers and insureds need not fear the uncertainties normally accompanying novel and untried coverages, especially those mandated by statute or regulation.

V. THE EFFECT OF ELECTIVE NO-FAULT ON DETERRENCE

While recognizing that the present system of tort liability ill serves deterrence of unsafe medicine, for example, many will nonetheless insist that any substitute system must clearly lead to deterrence. Here, too, is an issue of real bite. Since several observers have already expressed fears that unless a no-fault compensation system as applied to medical injuries can be seen as a quality control device, it will either not get off the ground or fail to function properly, the following analysis will focus on medical malpractice. But most of the points are applicable to products liability as well. Those who fear the effect of no-fault insurance on deterrence have no illusions that the present tort system is effective in encouraging quality control. Nevertheless, they fear that if other quality-assurance incentives are not substituted for the loss of the in terrorem feature of malpractice law, elimination or significant weakening of the common-law fault system may prove difficult despite the clear benefits to be derived. Such fears are often expressed at conferences and hearings on medical malpractice when a switch from fault to no-fault insurance is proposed. Professor Havighurst’s original proposal for Medical Adversity No-Fault Medical Maloccurrence Insurance (written with Lawrence Tancredi) had as its primary emphasis forcing the compensation scheme to function as an incentive to encourage quality control. His subsequent approach, reflected in his conference remarks, is significantly less theoretical and more practically oriented, but is still focused on quality control. And, in the words of Dr. John Ball of the Department of Health, Education, and Welfare:

144. Sue! Sue!, Forbes, Sept. 1, 1975, at 63, 64.
145. See notes 57-60 supra and accompanying text.
In its most basic sense, liability for medical malpractice . . . acts as a control on the quality of medical care in that the patient, unsatisfied with a medical care outcome, can sue the provider of care. Thus, malpractice is a mechanism of control on the quality of outcomes of care, perhaps the only such control. It is, of course, generally accepted that it is not a good control, and it may owe its existence as a control in that it is the only such mechanism at that end of the spectrum of care with which the consumer is most concerned.

Aside from its historical background in tort laws, [the] malpractice [claims system] may exist in medical care in a sense because it is the only game in town. That is, it is the only control on the outcome of medical care, it is one method of physician discipline, and it is the primary mechanism of patient compensation. While it may be inefficient, unjust, or inadequate in all these uses, it exists at least in part because of the absence of alternatives. It exists also because it is the only present mechanism which takes into account the interest of the consumer. Any alternative to the malpractice system must therefore also speak to those interests.

Bear in mind, however, that no one can demonstrate that a no-fault system necessarily serves as a deterrent less well than does a fault system. In the case of workers' compensation, for example, it is not thought that turning to no-fault payment by employers to injured employees encouraged carelessness on the part of employers. Indeed, the converse has been postulated. In the words of perhaps the leading treatise on tort law by Professors Fowler Harper and Fleming James of Yale Law School: "The question is whether the tendency to [promote safety and reduce accidents] will be greater if the fault principle is retained, or if the principle of [no-fault] . . . liability is substituted for it. We believe that the tendency would be stronger under a system of [no-fault] . . . liability." In support of this conclusion, the authors argue that forcing someone to pay for accidents regardless of fault encourages safer conduct in that, as Professor Warren Seavey has written, "If the law requires a perfect score in result, the actor is more likely to strive for that than if the law requires only the ordinary precautions to be taken."
Nor should the allegedly large amount of incompetent medicine being practiced by incompetent doctors be seen as an argument against no-fault insurance. After all, it has never been the case that only safer employers have been allowed coverage under no-fault workers’ compensation. Indeed, the less safe is a provider of goods or services or jobs, the more the need to guarantee payment for injuries stemming from his actions. Also, the less skillful or prudent is a provider of goods or services or jobs, the less we probably need fear his ability to control or manipulate his accident risks so as to unfairly arrange lesser payment under his insurance.

On the other hand, notwithstanding the optimism expressed by Harper and James, confidence that no-fault insurance will not lessen deterrence is probably about as far as we can go—at least for the present. Blum and Kalven suggest:

Economists have urged that the chief function of [an insurance payment] . . . system is to provide incentives that will serve to alter behavior so as to optimize accident costs in the society. . . . The argument over the degree to which the deterrence objective offers criteria for designing [insurance-payment] . . . systems has not been resolved. . . . [W]e are disposed to hazard the guess that deterrence strategies cannot, for both practical and political reasons, be executed through . . . highly differentiated insurance [mechanisms]. . . .

its elimination of payment for pain and suffering, stated: “It sounds like the only people we’re going to preserve pain and suffering for are the doctors.” Remarks of Dr. Torrey C. Brown of the Johns Hopkins University Medical School faculty, Conference, supra note 19, in the Baltimore Sun, Nov. 22, 1975, § B, at 2, col. 8. This view seems mistaken, but it nevertheless indicates that payment under no-fault insurance will still entail some emotional as well as financial penalty. Indeed, Professor Robert Keeton suggested at the University of Maryland Conference, supra note 19, that one means of avoiding any stigma attaching to no-fault payment is to place all the patients of a health care provider (whether doctor, hospital, or clinic) under a (floating) group insurance contract so that payment takes on a “first party” aspect and does not come directly from the health care provider or its insurer. Even so, the nexus between the provision of health care services and ultimate payment will probably furnish as much deterrence as we realistically can hope for, at least at the outset of elective no-fault insurance.

150. Especially given the haphazard, episodic, and dilatory way malpractice is discovered and proven. See notes 1-3, 145-46 supra and accompanying text. In addition, it is common knowledge that often the safest doctors and hospitals—who undertake the most difficult cases and procedures—face the most malpractice suits and the highest malpractice costs. See N.Y. Times, May 10, 1976, at 23, cols. 2-5.
151. See notes 113-14, 126-27 supra and accompanying text.
152. Blum & Kalven, Ceilings, Costs, and Compulsion in Auto Compensation Legislation, 1973 Utah L. Rev. 341, 380 n.44.
It may not be without significance that after generations of experience, insurers are still apparently totally frustrated in trying to encourage industrial safety through variations in insurance rating techniques under workers' compensation insurance. As Professor Patrick Atiyah has written:

The [National Commission on State Workmen's Compensation Laws] studied the industrial accident level in States with very different levels of workmen's compensation benefits. On the basis of economic theory, it might have been supposed that in states where the benefits and therefore the premiums were higher, employers would take more care (and spend more money) to minimize accident costs by keeping the accident levels as low as possible. However, no systematic relationship was discovered between accident levels and benefit levels.[153] Even when comparisons were made between states with similar industrial backgrounds there was no observable correlation between accident levels and benefit levels. For example, Virginia, Georgia and Alabama had similar benefit levels but widely different accident levels; Pennsylvanias and New Jersey had very similar accident levels but vastly different benefits levels. The Commission concluded that the evidence suggests that "workmen's compensation insurance rates are not the strongest force affecting the frequency of accidents."[154]

... Although it would be wrong to overlook altogether the broad effect of market deterrence on accident cost... the details of the argument seem to depend too much on forms of fine tuning which are inappropriate to the circumstances. Thus, any suggestion that an elaborate system, placing carefully calculated accident costs attributable to each activity onto that activity, would be justifiable, seems quite unacceptable. Indeed, crude though the tort system itself may be, it is by no means certain that other systems of distributing accident costs will be any improvement from the point of view of [market]... deterrence. As we have seen, tort law does at least have the virtue from this point of view that it places some accident costs on those who cause accidents, and some on those who suffer them. From the point of view of [market]... deterrence this is a reasonable result, even though "fine tuning" might suggest a much more elaborate way of dividing the costs. The case against tort law, and the case for its replacement, do not depend on considerations of these kinds.

The difficulty of calculating social costs, and evaluating noneconomic costs and benefits, of allocating different costs to different activities, and of assessing the effect of [market]... deterrence in face of a market distorted [for example] by taxation, are such that [market]... deterrence can usually only operate in a rough and ready way at best. ... Since the whole exercise can only proceed on the basis of approximations and

153. Citing NATIONAL COMM'N ON STATE WORKMEN'S COMPENSATION LAWS, REPORT 97, fig. 5.5 (1972).
154. Citing id.
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guesses anyhow, there is little purpose to be served in ... [using] delicate instruments.155

On the question of deterrence, one involved in the struggle to enact no-fault auto insurance has a sense of *deja vu*: As to auto insurance reform, there were those who insisted that the real problems of auto insurance were with unsafe drivers or unsafe cars or unsafe roads or all three. The true solution to the problem of auto insurance therefore was seen in restructuring the system to somehow encourage greater safety (more energetic criminal prosecution of motorists, more refined merit rating, and more regulation of the design of the automobile, for example). Similarly, it was often said that paying people regardless of fault would lessen deterrence of unsafe driving. In point of fact, the variables of achieving or encouraging traffic safety are so vast that there is vigorous dispute about what steps to take.156 No-fault auto insurance has proved successful because its goal was kept narrowly focused: bettering compensation, and this to be done by simplifying the insured event through eliminating payment that had not only been based on an unmanageable criterion (fault) but that had included compensation for an item with an equally unmanageable criterion (pain and suffering). By eliminating those two cumbersome variables, it has been possible to use insurance dollars with vastly greater efficiency and expedition to pay for actual economic losses. This had also been the narrow focus that enabled workers’ compensation to successfully replace tort liability for industrial accidents over a half century before.

Nevertheless, the same emphasis, not on reform of the tort system, but on eliminating underlying causes is being urged for medical malpractice. Testifying before Congress, Dr. Sidney M. Wolfe, Director of the Health Research Group of Public Citizens, an organization sponsored by Ralph Nader, stated:

[In] ... working toward resolution of the malpractice crisis, the primary attention must be directed toward the [over—

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all] health care system as the real source of the crisis. ... The public is now faced with treating this expensive, wasteful, and often lethal disease called malpractice. Shall the treatment be symptomatic, or shall it get to the heart of the problem. Not surprisingly, virtually all of the solutions proposed thus far [such as no-fault insurance] avoid the central causal problems of poor quality and the deteriorated doctor (provider)/patient relationship and, instead, try to manipulate symptoms.\textsuperscript{157}

But to the extent that we abandon the narrow focus that has worked for industrial and auto accidents—to the extent that we let ourselves (at least at this point) be distracted by attempts primarily to encourage better or cheaper health care—we are very unlikely to achieve what can be achieved, namely, beneficial change in the tort system as applied to injuries in the course of medical treatment. This is not to say we should not, in structuring no-fault liability, be at all concerned about achieving greater safety or that we should scorn separate efforts aimed at that goal. Rather, we must keep in mind that safety is a very distant and difficult goal compared to the immediately beneficial results that can be gained by eliminating, wherever feasible, insurance payments based on fault and for pain and suffering. Lacking any clear indication that it will lessen deterrence (and the workers' compensation and auto no-fault experience certainly foretell no such result), we should get on with eliminating these counterproductive payments whenever and wherever possible. And we should be chary of encumbering a proposal that would accomplish this goal with controversial—and probably unworkable—governmentally mandated provisions designed to alter the methods of a very learned, proud, and entrenched profession.\textsuperscript{158}


\textsuperscript{158} Consider the analogy to Health Maintenance Organizations (HMOs). An HMO, such as the Group Health Co-operative of Puget Sound, is “an organization which provides comprehensive medical care, including preventive, diagnostic, outpatient, and hospital services, to a voluntarily enrolled consumer population in return for a fixed, prepaid amount of money.” Elwood, Restructuring the Health Delivery System: Will the Health Maintenance Strategy Work?, in HEALTH MAINTENANCE ORGANIZATIONS: A RECONFIGURATION OF THE HEALTH SERVICES SYSTEM 3 (1971) (University of Chicago, Center for Health Administration Studies), quoted in V. Fuchs, supra note 122, at 138. But also consider, for example, the effect on such organizations of tight governmental regulation, the supposed purpose of which is to ensure that they operate in the public interest. (And in reading the following, one might hypothetically substitute for “HMOs” the phrase “no-fault insurance for defined compensable events.”)
In other words, perhaps we can do something about encouraging safer and cheaper medicine, but let us not delay making changes in the tort liability system that have worked elsewhere in order to pursue other—much less immediately attainable—goals.

If, however, it turns out that in order to gain public acceptance, some substitute for the in terrorem role of medical malpractice is seen as necessary, one might turn to some form of uninsurable “tort fines”159 or mandatory deductibles40 in

For a time . . . the general support that the HMO idea commanded from virtually every direction except that of the American Medical Association (AMA), seemed to ensure a substantial commitment from the federal government. Only a few years later, however, while HMOs in various forms continue to grow in communities around the country, they no longer represent a major element in federal health policy. Politically, they have fallen victim not to new arguments or new evidence, but to a mixture of perseverance among their opponents [and] overzealousness among their friends . . . Out of these influences has come internally incoherent legislation, presumably intended to stimulate the development of prepaid plans, but in fact something of an impediment to their growth. The original purpose of the HMO strategy, which was to create self-regulating institutions and thereby minimize federal involvement, has been utterly frustrated by the most elaborate regulation imposed by Congress on any part of the health system . . . While some of these troubles may be temporary, . . . [t]hey are . . . suggestive, in a more general way, of the difficulties in changing an industry as resilient and politically resourceful as medical care.


159. As yet unenacted in any state, tort fines are, as the term implies, a hybrid of tort and criminal law. Conceptually, a wrongdoer inflicting injury would be “fined” an amount appropriate to his wrongdoing (and not necessarily related to the victim’s losses) with the proceeds going to injury victims and with insurance disallowed. See A. Ehrenzweig, “Full Aid” Insurance for the Traffic Victim—A Voluntary Compensation Plan 33 (1943), also published in a slightly revised version in 43 Calif. L. Rev. 1, 41 (1955).

160. Of course, to the extent that no-fault compensable events are not limited to “avoidable” consequences, see notes 58-59 supra and accompanying text, the occasions for physician pay-out will be highly fortuitous and not so much within the control of the physician. If that is so, why use deductibles? But even if compensable events were limited to avoidable consequences, I would leave the question of deductibles to the market, at least initially. Picking the right level of deductible that would sufficiently “punish” the doctor and yet do so “fairly” would be awesomely tricky business. Query whether government officials, either legislators or administrators, can pick the right figure for various specialties and procedures and keep them current.

Keep in mind, too, the problems created by deductibles under conventional liability insurance. If the deductible is large enough to “jolt” the insured, he will be tempted to veto any settlement, especially if he carries a large amount of coverage above the deductible. After all, settlement means certain liability, while litigation means at least a chance
order to chastise the health care provider who "causes" compensable events.\textsuperscript{161} My only point is that working out such imposingly innovative devices is fraught with perils, and we should do so only as a last resort.

of avoiding payment and, even if the litigation is lost, no responsibility on the part of the insured for payment above the deductible amount. This is really the mirror image of the situation—about which there has been much writing and even litigation—where an insurer has written low limits on an insured. In that situation, the insurer may be inclined to refuse settlement on the ground that settlement means certain payment, while litigation means at least a chance of avoiding payment and no responsibility for payment beyond the policy limits. R. Keeton, Insurance Law—Basic Text § 7.8 (1971). Also, to the extent that physician resistance to insurer settlement is now a problem, see J. O'Connell, supra note 17, at 17, 29, 40, even though the insurer pays the whole settlement under present medical malpractice insurance, doctors' reaction might well be exacerbated under a system requiring them actually to pay some of the settlement. If the amount of the deductible were very substantial (which it would have to be in order to serve as a deterrent), one could not expect health care providers to be bound by the insurer's decision to settle. It would be anomalous that while under the present system, supposedly premised on genuine fault, there is no requirement that health care providers bear a portion of payment, under a system not turning on fault there would be.

All this might be avoided by requirements, for example, that insureds bear all or a portion of litigation expenses when they veto an insurer's decision to settle; but structuring such arrangements would still be very tricky. Better, perhaps, to let the parties do it, if at all, by voluntary arrangements than by inflexible fiat from governmental officials, whether legislative or administrative.

\textsuperscript{161} It is very significant, is it not, that so few criminal prosecutions are pressed against doctors arising out of malpractice or against businessmen arising from defective products. This would seem to indicate very few heinous acts, would it not, since a "butchering" doctor or brutal manufacturer would be an attractive target for a district attorney. Perhaps even more significant is how relatively rare are claims—and a fortiori successful claims—against doctors for punitive damages in civil cases for personal injury. That, too, tells us a great deal about how relatively rare are heinous acts by health care providers or businessmen...


One might delineate certain acts—such as operating on the wrong side or the wrong organ—for which tort exemptions could never be gained. But, of course, the longer such a list becomes the shorter will be the list for which prompt no-fault benefits can be paid. Nor should one attempt to divide the line for no-fault purposes between ordinary negligence (which could be the subject of no-fault benefits with a corresponding tort exemption) and gross negligence (for which a tort action always remains possible). Such a line will simply escalate the level and bitterness of accusation—as has happened, for example, under automobile guest statutes, where an accusation of gross negligence becomes a prerequisite to payment. See J. O'Connell, supra note 17, at 164-55; W. Prosser, Handbook of the Law of Torts 186-87 (4th ed. 1971).
VI. FURTHER RESEARCH FOR IMPLEMENTING ELECTIVE NO-FAULT

What further research is necessary as a prelude to instituting elective no-fault insurance (either by statute or contract)? Initially, still using medical maloccurrences for purposes of illustration, funds might be obtained to finance meetings involving doctors in various specialties, hospital officials, lawyers, insurance executives, underwriters and actuaries, and possibly representatives of the National Association of Insurance Commissioners to formulate usable and representative lists of compensable events for various medical specialties and hospitals. Once such lists are compiled, it will be necessary to determine the effect that paying for such events will have on insurance costs. That, in turn, must be done by researching the effect of such payment on the costs of claims (average claim cost) and on the number of claims (claim frequency). As to average claim cost, it must be determined what savings are effected by not paying for (1) legal and insurance expenses incurred in determining fault and the monetary value of pain and suffering, (2) pain and suffering itself, and (3) amounts already paid by other sources, such as Blue Cross and sick leave. As to claim frequency, it must be determined how many more claims must be paid once claims are paid regardless of whether the health care provider can be proven negligent.

Such studies could be done either hypothetically or by actually paying certain numbers of claims on a no-fault basis. A hypothetical study could be done either retrospectively or prospectively. If done retrospectively, closed claim files of insureds and insurers should be examined to determine the effect that no-fault payment would have had on average claim cost and claim frequency. Medical data should be used to estimate what the effect of no-fault payment on claim frequency would have been. Since insurance payment has been based on common-law tort criteria, existing records will by no means reveal all the claims that would be eligible for payment once common-law tort liability criteria are abandoned. But medical data are often available to ascertain the number of adverse results from given medical procedures, regardless of whether the adverse results are negligently induced. A prospective study, on the other hand, would begin with study of claim files as they are closed to determine the relevant data and with similar supplementary use of medical data to determine the effect of no-fault payment on claim frequency. A possible disadvantage of a retrospective study is
that the available data may not have been collected in the most suitable form. Such a defect poses no problem for a prospective study since one can define at the outset what data to collect. But a corresponding disadvantage of a prospective study is the delay in waiting for claims to be closed. Of course, it might prove possible to combine these methods to supplement and cross-check each other.

As to hypothetical versus factual studies, hypothetical studies have, by definition, an unreal quality about them. Actual payments on a no-fault basis might be somewhat different from hypothetical predictions as to what payment of such claims might entail. But, of course, an experiment in actually paying claims on a no-fault basis is a much more ambitious undertaking than a hypothetical study. On the other hand, it is by no means unfeasible. Cooperating hospitals, for example, might well be willing to experiment with actually contracting to pay on a no-fault basis for certain adverse results of in-house surgery or other accidents. Whoever funds such no-fault research may need to provide an additional subsidy to cover unexpectedly large losses. But with or without a subsidy, a “stop loss” provision 162 could ensure that only a committed amount was exposed in the experiment.

Whichever of these research methods is adopted, measures should begin immediately for expediting experimentation by simplifying the insured event for medical maloccurrences. Such simplification can best be achieved by implementing, wherever feasible, guaranteed but limited payment for predictably adverse results as a replacement for the present “roulette” system of medical malpractice compensation under which injured patients are forced to pursue the remote possibility of a relatively huge settlement or verdict.

VII. DISABILITY INSURANCE AS AN ALTERNATIVE TO INSURANCE FOR DEFINED COMPENSABLE EVENTS

It may turn out that the device of listing compensable events under elective no-fault insurance for medical injuries will prove too difficult to arrange (depending, as it does, on the intense cooperation and coordination of doctors, lawyers, insurers, and in-

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162. A "stop loss" provision is designed to cut off exposure to losses at a certain point. In this case, once loss reserves of a given amount are committed, no further no-fault contracts would be offered.
An alternative—and arguably simpler device—might be worth considering, especially (but not exclusively) for hospitals. Under this proposal, a health care provider would agree in advance of surgery to provide disability insurance covering further medical expense and wage loss (up to $200 per week) once any other health insurance or sick leave applicable to the patient had been exhausted. Such insurance would cover any disability commencing within a certain number of hours or days after surgery (the precise time to be determined in the insurance policy). In return for every one dollar of disability coverage, the health care provider would contract with the patient for a corresponding exemption from medical malpractice liability. In other words, if the health care provider contracted with the patient to provide, say, $10,000 of disability insurance, such provider might secure an exemption for medical malpractice liability up to $20,000 of tort liability damages. The particular multiple would turn on how much disability insurance could be purchased from the savings that would result if malpractice insurance premiums were calculated on the basis of this tort exemption. It might turn out to be on a ratio of 1:1 or 1:2 or, on the other hand, even higher, because of the large number of claims that might have to be paid under such disability insurance. In light of the relatively remote chance that any given patient would ever be paid from medical malpractice insurance and the long delay in payment if made, the exchange might appeal to most patients at almost any ratio.

That the new coverage is disability insurance—covering any disability leading to further medical expense or wage loss—would dispense with problems of exhaustively defining adverse results from particular medical procedures. Litigation over whether a particular adverse result was, in fact, within the scope of the definition would also be avoided. Note that payment under such disability insurance could be defined to commence only after the normal recuperative period—also defined in the policy—for the particular medical procedure.

If it turns out that providing coverage for wage loss as well as for the cost of further medical care is too expensive, the disa-

163. See text accompanying note 32 supra.
164. See generally note 118 supra and accompanying text.
bility insurance contract could be written to cover only medical care costs. And since medical care is furnished in kind by the health care provider, this coverage might be much less expensive. Here, too, because of the uncertainty and delays of payment under traditional medical malpractice insurance, most patients would probably readily agree to substitute certain payment for needed medical care for an uncertain claim for tort damages.

Furthermore, the advantages of greater assurance of payment are so undeniable that even if the costs of such disability insurance turn out to be so much greater than tort liability insurance that health care providers cannot offer it as a substitute (even without including wage loss), they might nonetheless offer it to patients for an additional charge. Such an arrangement might still be advantageous to the patient, since he would not bear the full cost of the coverage. The health care provider would pay the premium to the extent of his savings from the lower malpractice insurance rates attributable to the tort exemption feature of disability insurance.

As a further inducement to lower costs, the tort exemption could be based on a sliding scale. Thus when the health care provider offers disability benefits of a very substantial amount (such as $200,000), a total tort exemption might be secured in return. Moreover, a total exemption might be justified for even much lower disability benefits ($50,000 or less), depending on comparative tort and disability insurance costs.

Note that health care providers would not be obliged to offer such disability insurance to all patients. Aged patients or others particularly susceptible to adverse surgical results might be excluded. Furthermore, no patient would be required to accept the substitution of disability insurance for medical malpractice liability. And such disability insurance need not cover death benefits.

Finally, as with the proposal for elective no-fault medical malpractice insurance, a stop loss device could be employed to ensure that only a predetermined amount of the insurers’ resources were exposed in an experiment with disability insurance.

VIII. ELECTIVE NO-FAULT REFORM IN BROAD PERSPECTIVE

Recently, Daniel Patrick Moynihan, in urging favorable consideration of elective no-fault insurance, called no-fault auto insurance “the one incontestably successful reform [proposed in]
ELECTIVE NO-FAULT

... the 1960's." It is significant that the principal dispute as to no-fault auto insurance for personal injury concerns whether and how it is to be extended beyond the states where it has been enacted. No state in which it has been enacted is seriously considering abandoning it, but every state that does not have it is debating whether to adopt it. Even more significantly perhaps, after more than 50 years of experience with no-

166. Moynihan, Foreword to J. O'Connell, supra note 17, at xi. See note 99 supra and accompanying text.

167. Auto no-fault laws that wipe out tort suits (so-called "true" no-fault laws as opposed to "spurious" ones; for a discussion of the distinction, see J. O'Connell, supra note 17, at 24 n.4) have meant genuine—and arguably dramatic—improvement in law and insurance applicable to personal injury resulting from auto accidents. For favorable reports on no-fault as applied to personal injury in New York, Connecticut, and New Jersey, see N.Y. Times, Oct. 5, 1975, § E (News of the Week), at 6, cols. 4-8. There may be a need to increase the tort threshold (which claims based on fault cannot be pursued) because of rising costs for auto insurance in New York State. See N.Y. Times, Dec. 21, 1975, § E (News of the Week), at 5. See also id., Jan. 24, 1976, at 1, cols. 1-3; id., Jan. 25, 1976, at 1, cols. 5-7. As to Massachusetts, Benjamin Taylor of the Boston Globe staff writes: "It was hoped the law would root out phony claims and eliminate costly legal fees thereby halting the rapid rise of insurance rates for bodily injury coverage which occurred during the late 1960s. As John O'Connor, a spokesman for the insurance industry, said 'It worked beyond anyone's wildest dreams.'" Boston Sunday Globe, Oct. 12, 1975, at 37, col. 4. For favorable reports on no-fault in Minnesota, see St. Paul Dispatch, Sept. 25, 1975, at 33, cols. 3-6; and Minneapolis Star, Sept. 25, 1975, § B, at 8, col. 1. For a more documented appraisal of the success of no-fault as applied to personal injury, see Hearings, supra note 99, at 402-34 (testimony of Robert Keeton). For an appraisal of no-fault auto insurance as on the whole successful, though plagued by, among other things, inflation and the elimination of too few tort suits by low tort thresholds, see Wall St. J., Jan. 21, 1976, at 1, col. 6.

Admittedly, as Professor Keeton points out, "the possibilities for improvement of the [auto insurance] system [as applied to car damage] ... are very modest in comparison with the dramatic improvements affected by a real no-fault system for injuries to people." Hearings, supra note 99, at 676. This is largely because the savings of eliminating payment for pain and suffering and lawyers' fees are not applicable (since car damage cases are often arbitrated inexpensively and expeditiously between insurance companies). Indeed, most of the public dissatisfaction with the operation of no-fault insurance has stemmed from its application to property damage. See Boston Sunday Globe, Oct. 12, 1975, at 37, cols. 2-5. In Michigan, see note 37 supra and accompanying text, and in Florida, Kluger v. White, 281 So. 2d 1 (Fla. 1973), the property damage provisions of the no-fault laws have been ruled unconstitutional.

fault workers' compensation, none of the 50 states that have adopted it has ever seriously considered voluntarily abandoning it. Moynihan has attempted to place elective no-fault liability in a broad socio-political context. He cites the rise in distrust of business and professionals, as we'll as government, exemplified in the increasing aggressiveness—but concomitant futility—of the consumer movement:

There is an element . . . in the new consumerism which is not reassuring at all . . . . I fear that American education is in-

168. According to the National Commission on State Workmen's Compensation Laws:

We have discussed the implications of abolishing workmen's compensation and reverting to . . . negligence suits, a remedy abandoned some fifty years ago. This option is still inferior to workmen's compensation. . . . [Tort] liability suits [are] a drawn-out, costly and uncertain process that was dismissed long ago as a means of dealing with occupational injuries and diseases.

NATIONAL COMM'N ON STATE WORKMEN'S COMPENSATION LAWS, REPORT 25, 45 (1972).

The ironic thing about criticism of auto no-fault is that, in large measure, it has stemmed from four associations—two insurance associations (the American Mutual Insurance Alliance and the National Association of Independent Insurers) and two lawyer associations (for the plaintiffs, the Association of Trial Lawyers of America, and for the defendants, the Defense Research Institute). See Wall St. J., Jan. 21, 1976, at 1, col. 6. And it is precisely these groups that have labored energetically—and in large measure successfully—to see to it that any no-fault law is crippled by a low tort "threshold," with the result that relatively few claims based on fault are eliminated. Thus, insurers must stand ready in far too many cases to respond to both no-fault and fault-based claims. Having labored to see to it such no-fault laws are passed, these organizations and their members then point to such emasculated laws as proof that no-fault laws don't work as well as their genuine supporters promised. But those genuine supporters urged—and are urging—an elimination of all but the most serious claims based on fault (for example where damages for pain and suffering exceed $5000 or where total disability exceeds 90 days), while the insurers and trial lawyers mentioned above have seen to it that tort thresholds, where enacted at all, allow claims based on fault to be brought whenever medical expenses exceed amounts as low as $500. See J. O'Connell, supra note 17, at 24-25, nn. 4, 5, 6, 12. See also J. O'Connell, THE INJURY INDUSTRY AND THE REMEDY OF NO-FAULT INSURANCE 110-21 (1971). Indeed, these same insurers and trial lawyers advocate no-fault plans that mandate no elimination of tort claims whatsoever. But simply adding on no-fault coverage without ensuring the elimination of any claims based on fault would seem to raise inevitable risks of much higher costs. For discussion of this approach, see Hearings, supra note 99, at 691-712 (testimony of Robert Keeton and Craig Spangenberg); J. O'Connell & R. Henderson, TORT LAW, NO-FAULT AND BEYOND: TEACHING MATERIALS ON COMPENSATION FOR ACCIDENTS AND ILLNEss IN MODERN SOCIETY 306-07 (1975).

169. "It may be possible to make a strong case against either markets or [governmental] administration systems, but if we are against both we are in trouble." A. LINBECK, POLITICAL ECONOMY OF THE NEW LEFT 32 (1971).
creasingly turning out persons of socially active dispositions who do not understand or accept how the American economic system works and that this is going to have the most baleful consequences for that system. It is going to become overregulated and oversued, undercapitalized and underproductive. 170

Writes Moynihan:

Distrust grows—or is alleged to grow—practically in proportion to the measures taken to allay it. Hence, the latest news from Washington is that an enlightened Republican senator, in the course of the debate over the Consumer Protection Agency, has asked who is going to represent the consumer before the agency designed to represent the consumer before the agencies designed to represent the consumer. Literally, I quote:

OMBUDSMAN FOR CONSUMERS: Senator Taft has filed an amendment to the Consumer Protection Bill, now before the Senate, which would create an "ombudsman Agency" to oversee activities of a new Agency for Consumer Advocacy proposed by the Bill. Taft fears the ACA would become "an irresponsible and unrestrained super-agency, speaking only for a few, more vocal interest groups" while ignoring the real interest of the consuming public.

One recalls a pressing issue from the McCarthy days, formulated, as I recall, by Zero Mostel: "Who's going to investigate the man who investigates the man who investigates me?" 171 "It is here," asserts Moynihan, "that [elective no-fault liability insurance] . . . assumes an almost unique importance, for while modest seeming, it addresses the largest of questions." 172

Since elective no-fault insurance for products and services is self-executing, without the need for a new and cumbersome bureaucracy, such as those ordained by PSROs, it is, for Moynihan, a prototype of the kind of innovative, pragmatic, cooperative, and mutually beneficial reform that is essential to our society. It is, he writes, conservative . . . in the sense that Justice Frankfurter was conservative. [It] . . . values highly those things the legal system can do, and . . . is concerned that [the legal system] . . . not seek to overdo. An overextended system, dealing with ever more peripheral issues, eventually becomes incapable of dealing with those vital and central issues for which it was created. The image of empires collapsing on their marches comes to mind. [The proponents of elective no-fault liability do] . . . not want us litigating ourselves into a stalemate and paranoid society. We could do so. We could take all the fun out of it, all the pride out of it, and that would be such a waste, such a loss. [Not long ago] . . . a Congressional study on medical malpractice [was] subtitled 'The Patient Versus the Physician.'

170. Moynihan, supra note 166, at xviii-xix.
171. Id. at xvi.
172. Id. at xviii.
This is a relation [we do] ... not want. It won't help doctors and it won't help patients. Similar confrontational, adversary relations are developing seemingly everywhere. They can't succeed. When everyone sues, no one gets satisfied. (Our experience with the automobile brought us after the fact to that realization) ... The legal system becomes ever more encumbered. ... Justice ... is not done. ... Free systems come more and more to be seen as threatening; regulation ever more normal and necessary. Thereafter regulation of the regulators. And thence regulation of the regulators of the regulators. This is the way systems die.173

Earlier, Moynihan, in discussing the advantages of no-fault auto insurance, had stated that the proponents of no-fault insurance "are right in the all-important perception as to what it is Americans are good at. We are good at maintaining business relationships once a basis of mutual self-interest is established. [No-fault insurance] . . . would establish one."174 Elective no-fault insurance allows doctors and their patients and manufacturers and their customers to bypass both lawyers and bureaucrats, with all their self-serving cumbersomeness, in dealing with accidental injuries suffered in the course of medical treatment or from defective products. It too, then is an excellent example of establishing a relationship based on mutual self-interest. As such, writes Moynihan, it is not "merely ... concerned with aspects of tort liability [...] it is concerned with ... those particulars whereby a free society remains free."175

Professor Luke Cooperrider also has discerned the essence of elective no-fault insurance. In identifying the practical consequences of adopting such a system, he, too, comments perceptively on the ramifications for American social policy:

The tort system is strongly condemned, not only because it treats accident victims badly, but also because in the process it dissipates the resources that could otherwise provide more adequately for their needs. It could be argued that it is arraigned for not doing what it was never designed to do. Tort law is a system of conflict resolution, by nature contentious. It is difficult to see how it could be otherwise, or how it could come to be thought of as a likely machine for the efficient treatment of massive social problems. However that argument would beg the question. If it makes sense, for either compassionate or economic reasons, for society to replace the economic losses of all those who become the fortuitous victims of a technological environment—and it can scarcely be denied that this reflects the trend of the times even in tort litigation—then it surely makes sense to seek a more efficient way of doing it than the tort sys-

173. Id. at xix-xx.
175. Moynihan, supra note 166, at xx.
tem provides. It makes sense to try to put it on an insurance basis rather than a litigation basis. If... a comprehensive social insurance system that would provide not only for medical care, but also for income maintenance, is not for us in the foreseeable future, then one must look to the private sector. There one finds that a significant part of the problem is already treated on a first party basis through medical insurance and service contracts, various employment related fringe benefits, and some public benefit systems. The problem is to provide a supplementary plan to replace economic losses not absorbed by these systems for those persons to whom they apply, and also to bring the less well connected members of society under the umbrella. The most immediate access to this part of the problem seems to lie through the liability system, as there is no other obvious way of bringing in from the cold those who do not presently enjoy the benefits provided by our conglomeration of private sector medical expense and income protection devices—which is what the automobile no-fault statutes, in their limited way, have accomplished in respect to the injuries to which they apply. The solution proposed here for other categories of accidental injury is by no means so neat as that which was possible in respect to automobile accidents, but that is due to the intractability of the subject matter... 176

In sum, elective no-fault insurance does provide the only practicable means of immediately “bringing in from the cold” many of those whose losses from accidents outstrip their collateral resources.

We should get on with that task.
