

Throwing Out the Baby with the Bathwater: Reform in the System for Compensating Obstetric Accidents

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Lawsuits for medical malpractice are supposed to serve two purposes: compensation of injured patients and deterrence of negligent conduct by doctors and hospitals. However, those goals are not being served in the area of obstetric medicine. Malpractice liability insurance premiums are increasing rapidly for obstetric care providers,¹ and as a result, delivery and perinatal care have become more expensive and less available. At the same time, compensation is distributed inequitably. The liability crisis is more acute in obstetrics than in any other medical specialty because the cost of compensating birth injury sufferers, who are disabled for their lifetimes, is very high and has escalated rapidly.²

The situation could improve if an alternative compensation system replaced malpractice lawsuits and insurance in the area of birth-related injuries. Virginia and Florida recently enacted innovative no-fault programs for compensating infants with birth-related injuries, under which administrative agencies award compensation to infants who suffer from one of a designated list of birth-related injuries.³ In another proposed alternative, the physician or hospital

1. The term "provider" is used to refer to all individuals and institutions who provide obstetric care, including obstetricians, family practitioners, nurse-midwives, and hospitals.

2. Obstetricians' malpractice insurance premiums have increased 171% from 1982 to 1986, as compared with only a 108% increase in general practitioners' malpractice insurance premiums and a 14% increase in the Consumer Price Index in the same period. C. Korenbrot, *Effects of Professional Medical Liability Premiums on Obstetric Providers and the Practice of Obstetrics* (prepared for Institute of Medicine, Nat'l Academy of Sciences) (July 1988) at 2 & Table 1. *See also* American College of Obstetricians & Gynecologists, *Premium Ranges of Professional Liability Insurance for Obstetricians/Gynecologists in the United States, and Professional Liability Insurance Premium Increases 1987 Over 1986* (Sept. 15, 1987).

3. Virginia Birth-Related Neurological Injury Compensation Act, 1987 Va. Acts 540, codified at Va. Code Ann. §§ 38.2-5000 to -5021 (1987 Supp.) [hereinafter Va. Act]; Act Relating to Medical Incidents, 1988 Fla. Laws Ch. 88-1 §§ 60-75 [hereinafter Fla. Act]. The Virginia and Florida statutes are identical in most respects, as the Florida Act copied the Virginia Act almost word for word.

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could offer the infant's family a guarantee of paying the full economic costs of disability shortly after a birth-related injury; in exchange, the injured infant's family would not be allowed to sue for malpractice. A third proposed system retains fault as the basis for paying compensation but uses an administrative agency rather than the courts to make the compensation decisions and to discipline negligent or impaired doctors.⁴

Part I of this analysis describes the background of the problem and sets out some data highlighting the obstetric malpractice crisis. Part II uses seven basic system components to describe the current tort system and the three alternative systems for compensating people with birth injuries: a system relying on providers' offers of economic damages, an administrative fault-based system, and a no-fault system. Part III evaluates and compares the four alternatives. Part IV recommends a program combining the basic structure of the Virginia and Florida plans with the best features of the other programs: experience-rated premiums, more dependable sources of financing, an agency with disciplinary powers, incentives for providers to initiate the process of compensation, and in-kind compensation to reduce moral hazard. Such a system will probably be superior to the other alternatives in providing fair compensation and reducing injuries and costs through a financially stable program. This analysis focuses on birth injuries, but many of the problems addressed and the policy approaches discussed could apply to medical malpractice generally.

I. Background of the Problem

Birth-related accidents, defined as iatrogenic injuries (caused by medical treatment) to newborns connected with delivery,⁵ impose high costs on affected infants, their families, and society. Hypoxia (oxygen deprivation) and trauma (mechanical injury) to fetuses and

4. American Medical Association/Specialty Society Medical Liability Project, *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based, Administrative System 90-96* (Jan. 1988) [hereinafter *AMA, Fault-Based Administrative System*].

5. The clinical mistakes most commonly alleged to cause these accidents are failure or delay in identification of fetal distress, delayed or improper performance of Caesarian sections, improper choice of vaginal delivery instead of Caesarian section, and improperly performed vaginal deliveries. These types of accidents cause brain damage which results in retardation, cerebral palsy, hearing loss and impaired vision. Risk Management Foundation of the Harvard Medical Institutions Inc., *Fetal Monitoring Problems During Labor Associated with Most Serious OB Claims*, *Forum*, vol. 5, no. 1 (Jan./Feb. 1984) 1-2.

newborns during or close to delivery can cause stillbirths and neonatal deaths; disabilities and malformities such as cerebral palsy, mental retardation, nerve deficits, hearing and vision impairment, and torticollis; and other less serious conditions such as cosmetic injuries and fractured bones.⁶ Infants with birth injuries usually need expensive, comprehensive medical care and often require life-long care and assistance.⁷ Retarded children with birth injuries usually require institutionalization by the age of seven, and often die young (more than 50% within six years of institutionalization, and 74% by age 20).⁸ Recent advances in medical science that enable physicians to save the lives of more endangered fetuses in risky deliveries also facilitate the survival of more infants with birth defects or birth injuries.⁹

State benefits and private health insurance pay part of the high costs of birth injuries, but much of the burden falls on the families of the injured infants, who may sue their obstetric health care providers in order to have them assume part of the costs. The tort system's primary purpose is to punish careless behavior and provide an incentive to other providers to avoid accidents. Together with liability insurance, the malpractice tort system also functions to compensate people who suffer injuries.¹⁰

The malpractice tort system has been identified with a crisis in the field of obstetric care.¹¹ As tort law provides some plaintiffs with higher and higher damage awards, malpractice insurance carriers have raised their premiums to obstetric care providers in order to

6. T. Barden, *Perinatal Care*, in *Gynecology and Obstetrics: The Health Care of Women* 595, 647-649 (2d ed. 1981).

7. The average cost of care for infants with mental retardation, cerebral palsy, and epilepsy is \$8,250 per year in California. Such infants—0.5% of all newborns in the state within their first year of life—are eligible for comprehensive services and institutionalization from the state. C. Korenbrot, C. Brindis & J. Becker, *Cost Impact of Eliminating Medi-Cal Paid Abortions* (Institute for Health Policy Studies, Univ. of Calif., San Francisco) 12-13 (June 1987). See D. Shepard, K. Pederson & C. Gallup, *No-Fault Compensation for Neurologically Impaired Infants: An Exploration of the Issues for the Insurance Panel*, Institute for Health Research, Harvard Community Health Plan 2-8 (Oct. 7, 1987) (describing services available for neurologically impaired children).

8. Chaney, Givens, Watkins & Eyman, *Birth Injury as the Cause of Mental Retardation*, 67 *Obstetrics & Gynecology* 771, 773 (1986).

9. Sokol, *Editorial: Perinatal Risk and Cerebral Palsy*, 251 *J.A.M.A.* 1868, 1869 (1984) (increase in cerebral palsy due to improved care and resultant decreased mortality).

10. W. Schwartz & N. Komesar, *Doctors, Damages and Deterrence: An Economic View of Medical Malpractice* (1978); G. Calabresi, *The Costs of Accidents: A Legal and Economic Analysis* (1970).

11. Note, *Innovative No-Fault Tort Reform for an Endangered Specialty*, 74 *Va. L. Rev.* 1487, 1495-96 nn. 43-45 (1988).

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cover their costs.¹² In response, obstetricians have curtailed their services and have raised their fees.¹³ Poor women who are covered by Medicaid or who are uninsured suffer the most as a consequence.¹⁴

II. *Alternative Solutions*

Systems for compensating sufferers of birth injuries, including the current malpractice tort law and liability insurance system and proposed alternatives, can be described and compared in terms of seven basic components of the system that can be varied to alter the system. These components, referred to as "design elements,"¹⁵ include (1) the compensable event; (2) the measure of compensation; (3) the payment mechanism; (4) the forum for resolution of disputes; (5) the method of implementation;¹⁶ (6) the initiation of the process; and (7) the mechanism for deterring injuries. This Part briefly explains each of the seven elements, and then uses them to describe the alternative compensation systems that are evaluated.¹⁷

12. Blair & Makar, *The Structure of Florida's Medical Malpractice Insurance Market: If It Ain't Broke, Don't Fix It*, 5 *Yale J. on Reg.* 427 (1988) (Florida malpractice insurance crisis due to increasing damage awards, not insurance company collusion). See also Nye, Gifford, Webb & Dewar, *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 *Geo. L.J.* 1495 (1988) (economic analysis of causes of the crisis).

13. In 1985, 12.3% of the physicians in the United States who were members of the American College of Obstetrics and Gynecology reported that they had stopped practicing obstetrics, 13.7% had reduced the number of deliveries performed, and 23.1% had curtailed high-risk obstetric care; 82.9% had increased their fees because of the increasing liability costs. American College of Obstetricians & Gynecologists, *Professional Liability Insurance and Its Effect: Report of a Survey of ACOG's Membership* (prepared by Needham Porter Novelli, Inc.), Tables 28 & 29 (Nov. 1985). About 60% of the increases in obstetricians' fees, and many other changes in obstetric practice, can be traced directly to the increasing costs of malpractice insurance. C. Korenbrot, *supra* note 2, at 15-23.

14. Medicaid reimburses only 48% of obstetricians' usual fees for a complete obstetrical package in the U.S., and 36% of obstetricians refuse to treat Medicaid patients. Mitchell & Schurman, *Access to Private Obstetrics/Gynecology Services Under Medicaid*, 22 *Med. Care* 1026-27, 1029 (1984). The malpractice crisis is compounding the higher risks (due to other causes) of birth injuries faced by the offspring of poor women. National Commission to Prevent Infant Mortality, *Malpractice and Liability: An Obstetrical Crisis* 9-10 (1988).

15. A. Meltsner & C. Bellavita, *The Policy Organization* 71 (1983).

16. Professor Abraham set out the first five of these design elements in his conceptual framework for medical liability reform. Abraham, *Medical Liability Reform: A Conceptual Framework*, 260 *J.A.M.A.* 68, 72 (1988).

17. This discussion is summarized on Table 1, *infra* at p. 416.

A. Design Elements for Defining Compensation Systems

The first design element is the decision rule that a system uses to determine whether or not to award compensation. The traditional decision rule in the tort system is fault.¹⁸ A second possible decision rule is cause: if the provider's conduct caused the injury, the patient receives compensation, regardless of fault.¹⁹ Birth injuries, however, are often caused by multiple factors, and it is often difficult to separate iatrogenic ailments from ailments due to underlying illnesses or risk factors.²⁰ The determination of whether the treatment caused the injury could be as difficult and administratively expensive as determining whether the provider was at fault. A similar but simpler decision rule, called a "designated compensable event" system, compensates patients suffering an ailment that is on a defined list of medical events that are more likely than not caused by medical treatment.²¹ Finally, loss (regardless of fault or even cause) is the decision rule used in private health insurance and in government social insurance programs.²²

The second design element is the measure of compensation paid to the injury sufferer. Full tort damages generally include medical expenses and lost wages together with damages for pain and suffering.²³ Alternative measures are full economic damages, including

18. In a system based on fault, compensation is awarded if the provider's conduct failed to conform to the customary medical standard of performance. Abraham, *supra* note 16, at 68; AMA, Fault-Based Administrative System, *supra* note 4, at 90-96.

19. *Cf.* Restatement (Second) of Torts § 402A (1965) (strict liability for selling dangerously defective products).

20. Chaney, Givens, Watkins & Eyman, *supra* note 8 (many congenital malformities misdiagnosed as birth injuries). The rapidly advancing technology in obstetrics complicates the determination of whether an adverse event can be traced to a physician's fault, or even whether a causal link can be traced to the physician's conduct. *See* Sokol, *supra* note 9 and accompanying text.

21. Havighurst & Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 *Milbank Memorial Fund Q. Health & Soc'y* 125 (1973); Havighurst, "Medical Adversity Insurance"—Has Its Time Come?, 1975 *Duke L.J.* 1233 [hereinafter Havighurst, "Medical Adversity Insurance"]. Creating such a list may be easier said than done. *See* P. Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* 217 (1985); Epstein, *Medical Malpractice: Its Cause and Cure*, in *The Economics of Medical Malpractice* (S. Rottenberg ed.) 245, 260-64 (1978). For an attempt to create such a list for certain specialties, see American Bar Association Commission on Medical Professional Liability, *Designated Compensable Event System: A Feasibility Study* (1979).

22. Abraham, *supra* note 16, at 69.

23. Pain and suffering damages are often the largest component of damage awards by juries. *See* G. Calabresi, *supra* note 10, at 215-25.

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actual out-of-pocket expenses but not damages for pain and suffering; or partial economic losses, reducing the compensation with deductibles, co-payment requirements, and other provisions.²⁴ Any one of these measures of compensation may be reduced to take account of collateral sources of compensation, such as health insurance or governmental benefits; if so, the collateral source providers may have a right of subrogation (recovery from the party responsible for paying compensation). The timing of compensation can also vary: compensation can be paid in a lump sum or periodically over a time period.

The measure of compensation is particularly difficult to assess with injured infants. It is impossible to estimate their lifetime lost earning power, because of the impossibility of knowing what occupation they would have had absent the injury and how long they would have lived. Furthermore, because it is difficult to distinguish between ailments caused by medical treatment and those caused by congenital factors, it is difficult to compute compensation based on the difference between infants' potential given the iatrogenic injury and their potential without the injury. These difficulties can be sidestepped by using a fixed schedule to determine compensation for specified losses,²⁵ or can be avoided by providing in-kind compensation, such as comprehensive services through a state agency.

The third design element is the payment mechanism, which depends on which parties are responsible for paying the compensation and what mechanisms they use to pool their risks. The current malpractice system uses third-party insurance in which providers are responsible for paying compensation and pool their risks through insurance. Holding providers responsible creates an incentive to avoid risky behavior, but third-party insurance dilutes this deterrent effect by spreading the risk of payment.²⁶ Other approaches include first-party insurance, such as health insurance, which enables patients who are responsible for paying for their own injuries to spread their risks; and government compensation funds, which

24. These provisions, frequently used by insurance systems, "are a means of limiting costs and creating incentives against overconsumption of benefits such as insured medical care." Abraham, *supra* note 16, at 69; K. Abraham, *Distributing Risk: Insurance, Legal Theory, and Public Policy* 1-7 (1986).

25. *Cf. Heckler v. Campbell*, 461 U.S. 458 (1983) (upholding use of schedule to determine Social Security disability benefits).

26. *See infra* notes 36-37 and accompanying text.

could pay full compensation and be supported through assessments on providers, insurers, patients, or the taxpayers at large.²⁷

The fourth design element is the forum for resolving disputes, the institution that makes the decision about whether to compensate in any given case. Courts make these decisions in the tort system. Judges decide matters of law and juries generally decide matters of fact. Although over 90% of cases are ultimately settled out of court,²⁸ those settlements are based on the perceived likelihood that courts will award compensation at trial.²⁹ Alternative institutions could be made responsible for decision-making: expert review panels (used alone or in combination with another decision-making body), binding arbitration, or a specialized administrative agency. In a simple first-party insurance system that uses loss or cause as the decision rule, insurance companies could resolve most disputes, with courts adjudicating contested denials of coverage.³⁰

The fifth design element is the method of implementation. Providers and patients can contract in advance of treatment for an alternative system.³¹ However, the legality of pre-treatment contracts waiving tort rights and providing for alternative systems is unclear.³² In particular, it is probably not possible to waive the right of unborn fetuses in advance of their birth.³³ The only other way to implement an alternative system is through legislation; such legislation could provide for an alternative mandatory system, or for an optional system. An optional system would have to determine a

27. Current government programs supporting some services for disabled children and adults constitute partial compensation. A government fund providing full compensation would be similar to social health insurance programs widely used in other countries. Another way to finance the program would be to raise revenues from increased taxes on cigarettes and alcohol, which would be more acceptable than funding from general revenues in most states.

28. P. Danzon, *supra* note 21, at 31.

29. Settlements also factor in the high administrative cost of trials. W. Schwartz & N. Komesar, *supra* note 10, at 13.

30. Abraham, *supra* note 16, at 71.

31. Professor Richard Epstein has suggested that malpractice should be a matter exclusively for contract law rather than tort law, as parties could agree in advance about how medical maloccurrences will be treated. Epstein, *Medical Malpractice: The Case for Contract*, 76 Am. B. Found. Res. J. 87 (1976). This proposal has been criticized as unworkable, since physicians and patients have unequal knowledge of risks. P. Danzon, *supra* note 21, at 209-11; Calabresi, *The Problem of Malpractice: Trying to Round Out the Circle*, in *The Economics of Medical Malpractice* (S. Rottenberg ed. 1978) 233, 234-35.

32. See, e.g., *Tunkl v. Regents of Univ. of Cal.*, 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963) (invalidating pretreatment contract waiving malpractice suit against hospital as an adhesion contract of exculpation).

33. *But see* Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 Va. L. Rev. 1451, 1457-59 (1988) (arguing that parents or guardians could waive rights of their children).

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background system in the event the option is not exercised; who could exercise the option (providers, patients, or both); and when the option could be chosen.³⁴ A third implementation method is not to implement any reforms and to retain the current system.

The sixth design element is the initiation of the process. Most systems presume that the representatives of injured infants initiate the process by bringing a claim against the provider. To do so, the representatives must identify the ailment as a birth-related injury and must find an attorney to represent them.³⁵ Alternatively, a system could create incentives for providers, who have more information, to initiate the compensation process; or some neutral third party, such as a government enforcement agency, could initiate the process.

The seventh design element is the mechanism the system uses to deter injury. One way the system could deter injurious conduct is by compelling providers who cause injuries to compensate the injured, creating a financial incentive to avoid injuries. However, risk-spreading liability insurance dilutes this deterrent signal. Insurers currently base medical malpractice insurance premiums solely on geographical location and nature of practice,³⁶ but premiums could be "experience-rated"—that is, set based on providers' past loss experience, which is a good predictor of future risk.³⁷ As an alternative mechanism for deterring carelessness or misconduct, a disciplinary board could investigate and sanction physicians who

34. Voluntary programs enable several systems to operate in tandem, which reduces the risk of "massive regulatory blunder." Epstein, *supra* note 21, at 260, 267. On the other hand, in a voluntary environment, high-risk individuals would opt for the system that provides greater coverage or coverage at a lower cost; this process, known as adverse selection, would threaten the system's financial stability. See K. Abraham, *supra* note 24, at 15.

35. Lay people are often unable to detect injuries, to know that they are compensable, or to procure legal representation. E. Roth & P. Rosenthal, Non-Fault Based Medical Injury Compensation Systems, in U.S. Department of Health, Education & Welfare, Report of the Secretary's Commission on Medical Malpractice (DHEW Pub. Nos. (OS)73-88 & (OS) 73-89), App. at 450, 455 (1973). Injured persons bring claims for only one out of every six incidents of hospital malpractice, and 40% of the incidents in insurance companies' files were reported by providers but never pursued by injured patients. P. Danzon, *supra* note 21, at 29. Injured persons may bring claims for as few as one out of every 15 incidents of malpractice. W. Schwartz & N. Komesar, *supra* note 10, at 11; L. Pocincki, S. Dogger & B. Schwartz, The Incidence of Iatrogenic Injuries, in U.S. Department of Health, Education & Welfare, App. at 50.

36. W. Schwartz & N. Komesar, *supra* note 10, at 14.

37. Experience rating decreases the amount of risk pooling, but improves the deterrent effect of a compensation system. *Id.* at 15-16. See also Havighurst & Tancredi, *supra* note 21, at 129-30. For the definition of experience rating, see K. Abraham, *supra* note 24, at 72.

cause injuries.³⁸ Sanctions could include revoking or restricting the physician's license to practice medicine.

B. Economic Damage Offer Proposal

Professor Jeffrey O'Connell has proposed an "economic damage guarantee"³⁹ program that would give physicians and other potential defendants an incentive to pay compensation voluntarily to injured persons.⁴⁰ Under O'Connell's proposed system, an injured infant's representatives would not be allowed to bring suit if the physician or hospital offered to pay full compensation for all economic losses promptly after the accident.

The most innovative aspect of O'Connell's proposal is that the provider's offer, rather than the injured's claim, would initiate the process. The decision rule is similar to that in the current system: "providers will make tenders only in those cases in which their conduct has been most faulty and in which it is most likely that a tort action would result in a large judgment, and conversely, they will not make a tender in the marginal cases in which they do not perceive a substantial risk of liability."⁴¹ Therefore, the likely compensation in the tort system provides a ceiling amount that would be the basis of the provider's decision whether to make an offer.

If the provider opted to make an offer, the measure of compensation would be full economic losses as incurred, including past and future medical costs, lost wages, and attorney's fees. However, the infant and family would lose the right to sue and the possibility of large pain and suffering damages, except in the case of intentional misconduct. As in the tort system, third-party insurance would be the payment mechanism.

38. Most states have such boards, but their disciplinary sanctions are generally not enforced strongly. See Public Citizen Health Research Group, *Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform* (1985) (arguing for stronger sanctions).

39. This appellation was coined in United States Department of Health & Human Services, Report of the Task Force on Medical Liability and Malpractice 45 (1987).

40. See, e.g., O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries*, 60 Minn. L. Rev. 501 (1976); O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 Nw. U.L. Rev. 589 (1982); Moore & O'Connell, *Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss*, 44 La. L. Rev. 1267 (1984); O'Connell, *A "Neo No-Fault" Contract in Lieu of Tort: Preaccident Guarantees of Postaccident Settlement Offers*, 73 Calif. L. Rev. 898 (1985) [hereinafter O'Connell, "Neo No-Fault"].

41. Moore & O'Connell, *supra* note 40, at 1283. Thus, if the plaintiff is likely to prevail and receive a damage award larger than the amount of an economic damage offer, the provider would make an offer. If it is uncertain whether the plaintiff would prevail or if the likely damage award is small, the provider will not make an offer and will risk liability in the tort system.

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The parties themselves would settle cases in most instances, except in the event that providers failed to make prompt offers, in which case the patients would have recourse to sue in tort. This reform could be put into place either through an enabling statute⁴² or through a contract made between the provider and the patient before the delivery begins.⁴³ It would be voluntary for the physician or hospital, but compulsory for the infant and family. If a prompt offer were made, they would be foreclosed from bringing a lawsuit.

C. Administrative Fault-Based System

The American Medical Association (AMA) and 31 national medical specialty societies, including the American College of Obstetricians and Gynecologists (ACOG), have proposed that a state administrative agency have power both to resolve medical liability disputes and to discipline doctors.⁴⁴ This innovative proposal would create an administrative agency as the central decision making and dispute resolving institution.⁴⁵

The plan would retain negligence as the principle for decisions,⁴⁶ but because all the decisions would be rendered by a single, specialized agency rather than by multiple juries and judges, the standards expected of physicians could become more consistent from case to case, and consequently more rational and predictable for providers. Injured claimants would receive economic damages based on schedules promulgated by the agency's board, plus such non-economic damages (up to a determined maximum) as the hearing examiner

42. Legislators in the U.S. Congress and in the Massachusetts legislature have introduced similar plans, but the bills were not enacted. Alternative Medical Liability Act, H.R. 5400, 98th Cong., 2d Sess. (1984); Medical Offer and Recovery Act, H.R. 3084, 99th Cong, 1st Sess. (1985); Mass. H.B. 6829, 1985 Sess. § 34. See O'Connell, *Pragmatic Constraints on Market Approaches: A Response to Professor Epstein*, 74 Va. L. Rev. 1475, 1477 & nn. 9-11 (1988).

43. O'Connell, "Neo No-Fault," *supra* note 40. However, since the unborn infant cannot agree to a contract limiting her right to sue before delivery, the contractual option may not be available for birth injuries as it might for other types of malpractice. See Epstein, *supra* note 33 and accompanying text.

44. AMA, *Fault-Based Administrative System*, *supra* note 4, at 17.

45. The plan provides for detailed administrative procedures. An injured patient would bring a claim to the agency, which could provide a lawyer to represent the claimant. Peer review and settlement conference procedures would eliminate frivolous claims and would strongly encourage the parties to reach settlements. For cases that were not settled, hearing examiners (administrative law judges) could render decisions based on documentary evidence, or could conduct hearings. Parties could appeal adverse decisions to the agency's board, which would both adjudicate claims and develop rules and standards of care. Judicial review in the state appellate courts would be available.

46. The AMA/Specialty Society report proposes many changes in the legal standards, but these amount to fine tuning rather than systematic change. AMA, *Fault-Based Administrative System*, *supra* note 4, at 82-160.

found appropriate. The payment mechanism would be third-party insurance.

This system would deter injury both through the existing compensation incentive of the tort system, and also through direct disciplinary powers of the agency. The Board would collect information on physician performance from its own proceedings, peers, hospitals, credentialing organizations, and insurance companies, and would have extensive powers to restrict or revoke physicians' licenses and to refer physicians to drug or alcohol treatment programs.⁴⁷

D. No-Fault Compensation Program

Professor Albert Ehrenzweig first proposed a no-fault system, which he called "hospital-accident insurance," in 1964.⁴⁸ More recently, Professors Clark Havighurst and Laurence Tancredi put forward a detailed proposal for no-fault "medical adversity insurance."⁴⁹ Such a system could easily be tailored for injuries within one medical specialty, such as obstetrics.⁵⁰ The legislatures of Virginia and Florida both recently adopted similar compensation programs specifically for compensating birth injuries.⁵¹ This section describes the no-fault programs proposed by Havighurst and Tancredi and the programs adopted by Virginia and Florida in terms of the design elements.

1. *Decision rule.* Havighurst and Tancredi proposed a no-fault system based on designated compensable events (DCE). Ailments not designated as compensable would not be compensated through this system, but patients would have recourse to a personal injury lawsuit to allege fault. The definition of which events would be designated as compensable determines the number of payable claims.

47. Strong discipline by a medical board may be the best way to deter medical malpractice. See Public Citizen Health Research Group, *supra* note 38.

48. Ehrenzweig, Compulsory "Hospital-Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice," 31 U. Chi. L. Rev. 279 (1964).

49. Havighurst & Tancredi, *supra* note 21; Havighurst, *supra* note 21; Tancredi, Designing a No-Fault Alternative, 49 Law & Contemp. Probs. 277 (Spring 1986).

50. The American Bar Association sponsored a detailed feasibility study of such a system for surgery and orthopedics, for which a group of experts determined a list of compensable events and costs were estimated. American Bar Association Commission on Medical Professional Liability, *supra* note 21.

51. Va. Act, *supra* note 3; Fla. Act, *supra* note 3. For a general commentary and analysis of the Virginia program, see Note, *supra* note 11 (explaining plan in detail, analyzing its constitutionality, and suggesting amendments to statute); see also Epstein, *supra* note 33; O'Connell, *supra* note 42.

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A broad definition would be desirable to compensate more injuries, but could make the program overly costly. Too narrow a definition would make the plan more feasible financially, but could overly limit compensation and leave too many cases to the tort liability system, so that the plan would only marginally affect the problems it is designed to solve.

Both the Virginia and the Florida programs employ a decision rule defining the compensable event as "injury to the brain or spinal cord of an infant" which is caused by "the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital. . . ."⁵² Under both programs, the no-fault compensation system is the exclusive remedy for infants with compensable injuries and their families; they are barred from suing their providers or hospitals.

2. *Measure of compensation.* Havighurst and Tancredi proposed providing full economic damages, plus the possible addition of a scheduled amount of pain and suffering damages (especially for people with permanent afflictions).⁵³ They proposed enabling collateral source providers to be compensated under the plan for amounts paid out.⁵⁴ Payment of compensation regardless of collateral benefits (the traditional tort damages rule) or with a right of subrogation to the collateral sources (Havighurst and Tancredi's proposal) communicates the cost signal more efficiently to providers, as potential injurers. However, excluding collateral benefits spreads risks more broadly and makes the programs more feasible financially.

Virginia and Florida compensate injured infants for all reasonable expenses for hospital costs, other medical costs, rehabilitation, institutionalization, and other treatment costs, reduced by benefits received from collateral sources.⁵⁵ Neither state specifically

52. Va. Act, *supra* note 3, § 38.2-5001, para. 1; Fla. Act, *supra* note 3, § 61(2). The most significant difference between the two programs is that Virginia restricts coverage to injury "which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living," thus limiting coverage to babies whose injuries are so severe that many could be expected to die within a short time. Florida substitutes a broader definition of the injury, "which renders the infant permanently and substantially mentally and physically impaired," but covers only infants born "of term gestation" (infants who are not premature), thus excluding the most risky births. Both states exclude stillbirths.

53. Havighurst & Tancredi, *supra* note 21, at 128-29.

54. *Id.* at 129.

55. Florida further specifies that medically necessary drugs, equipment, and special transportation should be covered, as well as home care costs in lieu of institutionalization. Virginia compensates for lost wages based on a conclusive presumption of lifetime

compensates for the lost enjoyment of life or for pain and suffering, but Florida allows a non-economic damage award of up to \$100,000 to the infant's parents or legal guardians. Both states reduce the compensation by the amount received from collateral sources (such as Medicaid, other government benefits and first-party health insurance benefits). Both states pay compensation periodically, rather than in a lump sum, because the compensation is likely to be a large amount over the injured person's lifetime, and particularly because it is difficult to project the expected length of the lifetime, since many victims of birth injuries have tragically short lives.

3. *Payment mechanism.* Havighurst and Tancredi proposed that providers buy "Medical Adversity Insurance"; thus, just as in the tort system, providers would be held liable individually but would pool their risks through insurance. However, Havighurst and Tancredi also proposed experience-rated premiums for such insurance to improve the system's deterrent effect. Providers would have to buy both ordinary malpractice liability insurance and special no-fault insurance to compensate patients under this system.

Virginia and Florida created new state agencies to control the funds that pay claims and collect premiums.⁵⁶ These agencies appear before the workers' compensation agencies as a respondent and defend against claims. The agencies may participate in the reinsurance markets to cover their risk exposure, just as private insurers do. Participating obstetricians pay \$5,000 per year into the fund, and participating hospitals pay annual assessments of \$50 per delivery performed the previous year.⁵⁷ There is no provision for experience-rating premiums. Non-participating doctors of all specialties are required to contribute \$250 per year, and if additional funding is required, casualty insurers in the state will be assessed a surcharge of a proportion of their annual net direct premiums.⁵⁸

earning power (half the state's average private, non-farm wage over a working life from ages 18 to 65); Florida does not cover wages at all. Va. Act, *supra* note 3, § 38.2-5009; Fla. Act, *supra* note 3, § 69.

56. The Virginia Birth-Related Neurological Injury Compensation Fund is created in Va. Act, *supra* note 3, § 38.2-5015, and the Florida Birth-Related Neurological Injury Compensation Association is created in Fla. Act, *supra* note 3, § 74.

57. Va. Act, *supra* note 3, § 38.2-5019. In Florida, the Act requires participation from all non-governmental hospitals in the state. Fla. Act, *supra* note 3, § 73(4). For a tabular summary of the financing mechanisms of the two programs, see Table 2, *infra* text accompanying note 93. Epstein notes that "the fees charged do not begin to approximate the risks that are covered," and predicts severe market distortions as a result. Epstein, *supra* note 33, at 1471, 1470-73.

58. In both Virginia and Florida, insurers may be assessed based on up to 1/4 of one percent of their net direct premiums. Va. Act, *supra* note 3, § 38.2-5020(B)(2); Fla. Act, *supra* note 3, § 73(5)(c)(3). Although Virginia set the amounts of the assessments rather arbitrarily as the result of a political compromise, see Framme, *Cinderella: The Story of*

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A no-fault program entails unknown and possibly very high costs. A critical question is who should bear the risk of unfunded liabilities or a default of the fund. In Virginia and Florida, state government agencies administer the funds, and therefore the states appear to assume the risk.⁵⁹ Other possible candidates could include the providers and hospitals, or their associations; the liability insurance carriers, who could be assessed for unfunded liabilities (this would ultimately cost other activities insured by those carriers, or would be borne by the carriers' shareholders); or the injured patients and their families—the plan could simply terminate periodic payments to them if funds were insufficient. This issue is difficult to resolve and could be politically explosive.

4. *Forum for resolving disputes.* Havighurst and Tancredi proposed a compensation scheme that “would be roughly analogous to the workmen’s compensation system,”⁶⁰ but did not detail how it would operate. They implied that private insurance companies would pay claims and that courts would continue to make decisions in the event of disputes between claimants and insurers.

Both Virginia and Florida make use of their existing workers’ compensation agencies, to which claimants bring claims and which have the authority to determine whether claims fall within the statutory definition and to award compensation to claimants.⁶¹ Thus, the programs take advantage of the expertise of the workers’ compensation agencies in handling similar claims, and save on the costs of setting up a new agency. A claim to the agency is the exclusive remedy for infants with compensable injuries and their families; they are barred from suing their providers or hospitals.

5. *Method of implementation.* Ehrenzweig, Havighurst and Tancredi envisioned a compulsory no-fault system enacted by the state legislature.⁶² The Virginia and Florida programs, enacted by statute, allow doctors and hospitals to choose whether or not to participate in the program. If they participate, they are immune from suit

HB1216, 114 Va. Medical 284 (May 1987) (account of political battle to enact Virginia law), Florida appears simply to have adopted these amounts from the Virginia Act even though they may be insufficient. See Table 2, *infra* text accompanying note 93.

59. Florida explicitly waives the state’s sovereign immunity, Fla. Act, *supra* note 3, § 62(3), so the state can be sued to pay compensation claims.

60. Havighurst & Tancredi, *supra* note 21, at 128.

61. Va. Act, *supra* note 3, § 38.2-5003; Fla. Act, *supra* note 3, § 63.

62. Ehrenzweig, *supra* note 48; Havighurst & Tancredi, *supra* note 21, at 128. Havighurst and Tancredi have proposed creating such a system by contract rather than by legislation. Havighurst, Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles, 49 Law & Contemp. Probs. 143 (Spring 1986); Tancredi, *supra* note 49.

for compensable injuries; if they opt not to participate, they are liable in tort for all injuries. For patients, however, the program is compulsory. If a participating physician delivered the baby in a participating hospital, an injured infant's representatives must bring claims in the no-fault system and may not sue. If the provider was not a participant, the injured infant may sue, but may not bring a no-fault claim.

The only way for a patient to avoid the compulsory system is to choose a doctor who is not participating. Expectant mothers would have the option of choosing obstetricians with no-fault malpractice coverage or providers against whom conventional tort suits could be brought. The Florida statute requires that participating providers and hospitals inform patients about the plan and explain it to them. The Virginia statute will probably be amended soon to include such a requirement.⁶³ However, expectant mothers are likely not to choose providers on the basis of such information. They are likely to remain relatively unenlightened, and possibly unable to make rational decisions about risk.⁶⁴

6. *Initiation of the process.* Both the Havighurst and Tancredi proposal and the Virginia and Florida statutes contemplate that the injured infant's representatives initiate the process by presenting a claim.

7. *Deterrence mechanism.* Havighurst and Tancredi proposed structuring the no-fault insurance system with a strict system of "experience-rating," under which providers and hospitals with a higher experience of compensable events would pay higher premiums. Experience-rating would penalize more risky providers, and would probably deter injurious conduct more effectively than the tort system.⁶⁵ Virginia and Florida do not provide for experience-rating premiums, and contain no other mechanism for deterring injuries.

III. *Assessment of the Alternatives*

The tort system and the alternative systems for compensating birth injuries can be compared and assessed in terms of three criteria: fair compensation, reduction of injuries and costs, and financial

However, as noted above, providers may not be able to bind an unborn fetus with a pre-treatment contract. See *supra* notes 33-43 and accompanying text.

63. Telephone interview with Sandra L. Kramer, attorney, Medical Society of Virginia, Richmond (Feb. 26, 1988).

64. W. Schwartz & N. Komesar, *supra* note 10, at 18.

65. See *supra* note 37 and accompanying text.

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Table 1
Summary of Analysis of Alternative Systems with Design Elements

Design Element	Malpractice Tort Law & Insurance	Economic Damage Offer	Fault-Based Administrative	Havighurst & Tancredi No-Fault	Virginia/Florida No-Fault
Decision Rule	Fault	Fault (tort baseline)	Fault	Designated compensable event	Designated compensable event
Measure of Compensation	Economic and punitive damages	Economic damages	Scheduled economic damages	Economic damages	Scheduled economic damages
Payment Mechanism	Providers (3rd party insurance)	Providers (3rd party insurance)	Providers (state fund)	Providers (1st or 3rd party insurance)	State fund (doctors, hospitals, insurers)
Forum for Resolving Disputes	Trial by jury (or settlement)	Settlement (tort as ceiling)	Administrative agency	Insurance company (or court)	Administrative agency
Method of Implementation	Status quo	Contract or statute	Statute	Contract or statute	Statute
Optional or Compulsory	Compulsory	Optional	Compulsory	Optional	Optional
Deterrence Mechanism	Liability (but insurance dilutes incentive)	Same as or less than tort	Disciplinary authority and liability	Liability with experience rating	Liability

feasibility.⁶⁶ First, systems should compensate people injured in birth-related accidents fully and promptly. The decisions and awards of compensation should be consistent and predictable from case to case. The system should ensure that the compensation fully covers costs over the course of disability.⁶⁷

Second, systems should minimize the sum of the costs of accidents, the cost of avoiding them, and the cost of administering the system.⁶⁸ A system should provide incentives to reduce the number and severity of birth-related injuries. Proposals should reduce the cost of avoiding accidents by discouraging wasteful, defensive medical practices undertaken solely to avoid liability. Also, administrative costs should be as low as possible.

Third, to be financially feasible, proposals must raise enough revenue to cover the costs they entail. In systems which are alternatives to the status quo, insurance funds should be "in balance"—that is, the savings generated by limitations on damage awards should be equal to or greater than any increase in benefits paid, so that the system can pay for itself and be stable.⁶⁹

The tort system and the alternative systems for compensating people with birth injuries can be compared and assessed in terms of these criteria.⁷⁰ There are trade-offs among criteria, and not all of them can be maximized at the same time. For example, too much compensation for birth injuries would threaten a system's financial feasibility. Nonetheless, it is possible to reach conclusions about the overall value of different systems.

A. *Evaluation of the Status Quo*

The tort system does not function well either in deterring malpractice or in compensating injured patients. First, the tort system compensates people unfairly, because the awards to injured newborns are erratic, unpredictable, and inconsistent.⁷¹ Lay juries

66. Cf. G. Calabresi, *supra* note 10, at 24-33 (proposing similar criteria for evaluating different systems).

67. E. Roth & P. Rosenthal, *supra* note 35, at 461-63.

68. G. Calabresi, *supra* note 10, at 26-31.

69. U.S. Department of Transportation, *Compensating Auto Accident Victims: A Follow-up Report on No-Fault Auto Insurance Experiences* (DOT-P-30-84-20) 3, 16 (May 1985) (defining "balance" for no-fault auto insurance).

70. Ideally, a comparative institutional analysis of different risk management systems would consider the interaction of different systems operating simultaneously. See Viscusi, *Toward a Diminished Role for Tort Liability: Social Insurance, Government Regulation, and Contemporary Risks to Health and Safety*, 6 *Yale J. on Reg.* 65 (1989).

71. Some injured patients do not get compensated, while others receive large windfalls. E. Roth & P. Rosenthal, *supra* note 35, at 453-56; Havighurst, "Medical Adversity

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with no expertise in deciding malpractice claims decide the facts of each case as the first and last case they ever see, often basing their decisions in large part on emotion rather than decision rules.⁷² Long delays occur between suffering injury and receiving compensation, forcing families to bear the costs in the meanwhile.⁷³ Many families find it difficult to initiate claims;⁷⁴ in fact, one study found that only one tenth of those with injuries due to medical negligence ever bring a claim at all.⁷⁵

The tort system is not effective in reducing the costs of birth accidents. Malpractice insurance insulates providers from damage awards and shields them from the economic incentive provided by damages. “[N]o individual physician has more than a slight pecuniary incentive to reduce the expected losses resulting from his own behavior.”⁷⁶ Furthermore, the diffused, case-by-case decision process involving inexperienced judges and juries yields decisions that are inconsistent to the point of randomness and does not consider the effects on medical practice as a whole. As a result, providers do not receive clear signals about what constitutes careless or inadequate care and are unable to adjust their conduct accordingly.⁷⁷

Defensive medicine associated with the tort system is essentially a high cost of avoiding accidents. Providers are more likely to be penalized for ordering too few tests or for failing to perform Caesarian sections, but not for ordering too many tests or for performing unnecessary Caesarian sections. Consequently, providers have incentives to perform procedures that are not medically justified in order to give the impression of reducing risk and to make a liability judgment less likely.⁷⁸ However, Professor Danzon points out that many of these problems are traceable to distortions from fee-for-service health insurance, rather than malpractice lawsuits.⁷⁹

Insurance,” *supra* note 21, at 1234-35. *See generally* J. O’Connell, *The Lawsuit Lottery: Only the Lawyers Win* (1979).

72. J. O’Connell & C.B. Kelly, *The Blame Game: Injuries, Insurance, and Injustice* 24-32 (1987); O’Connell, “Neo No-Fault,” *supra* note 40, at 899-900.

73. The average time from accidents to disposition of claims was 41 months for paid claims and 32 months for unpaid claims, with an overall average of 36 months. P. Danzon, *supra* note 21, at 193.

74. *See supra* note 35.

75. P. Danzon, *supra* note 21, at 29.

76. W. Schwartz & N. Komesar, *supra* note 10, at 14.

77. AMA, *Fault-Based Administrative System*, *supra* note 4, at 8-9, 90-96.

78. Havighurst, “Medical Adversity Insurance,” *supra* note 21, at 1235; E. Bernzweig, *Defensive Medicine*, in U.S. Department of Health, Education & Welfare, *supra* note 35, App. at 38; C. Korenbrot, *supra* note 2, at 19-21.

79. P. Danzon, *supra* note 21, at 149-50. Physicians do respond to the signals of the tort system, and many of the additional procedures may be beneficial, so it is “difficult to

The main problem with the malpractice tort system is that it engenders enormous administrative costs. Of every dollar paid in malpractice insurance premiums, only 30% to 40% is received by injured patients in compensation for injuries; in other words, 66 cents out of every dollar recovered by plaintiffs is consumed by attorneys' and expert witnesses' fees and court costs.⁸⁰ Litigation is tremendously time-consuming. Those plaintiffs who prevail experience average delays of three years between occurrence of their injuries and receipt of their awards.⁸¹ Trials also impose costs of time and emotional stress on providers and the injured infants' families which cannot be quantified.

The crisis in malpractice insurance reveals a financially unbalanced liability insurance system.⁸² The possibility of large damage awards is driving up premiums at a rapid rate,⁸³ causing a crisis in the availability of obstetric care.

B. Evaluation of the Economic Damage Offer Proposal

Any alternative to the tort system that reduces the size of disproportionately large damage awards but increases the number of paid claims would lead to fairer compensation at no additional cost. The economic damage offer proposal would distribute compensation more equitably, as everyone compensated would receive the same measure of economic damages rather than some receiving huge awards and others receiving small or no awards. Providers would initiate the process, and since they have more information about which injuries can be compensated and about how the system works, the economic damage offer system would probably reach more infants. However, because the likely damage award in tort would serve as the baseline that would determine whether providers make offers, the aggregate amount of compensation to injured infants would probably be lower, and the number of injured infants who would receive compensation still would not increase significantly.

draw the line between where good medicine stops and defensive practice begins." *Id.* at 146.

80. *Id.* at 186-87.

81. *Id.* at 193.

82. See *supra* notes 10-14 and accompanying text.

83. Insurance is costly in part because the risk of liability for obstetric malpractice has a "long tail": claims for injuries during a certain period may be presented years later. "Claims-made" policies (covering only those accidents for which claims are actually presented during the period) merely shift the cost and uncertainty of those latent claims from the insurers to providers. K. Abraham, *supra* note 24, at 50-51.

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The economic damage offer proposal would deter injurious conduct less successfully than the tort system. The liability insurance system would shield providers from the deterrent signal in the economic damage offer system in the same way as it does in the tort system. Because of the decreased likelihood of large damage awards and the reduced aggregate amount of compensation, the system's deterrent effect would probably be weaker than that of the tort system, leading ultimately to more birth injuries.

Providers would feel less pressure to practice unnecessary defensive medicine to avoid the appearance of liability under the economic damage offer system, because they would make offers only in cases of real malpractice.⁸⁴ By reducing the amount of litigation, this plan would reduce administrative costs below those of the current litigation-based system. However, due to moral hazard, the plan may entail added costs.⁸⁵ The commitment to pay all costs of treating injured infants as they are incurred would give the families or caretakers of those infants an incentive to spend without limit, knowing all costs would be covered. Thus, the full compensation of economic costs could turn out to be costlier than expected.⁸⁶ It is difficult to estimate how these factors balance and to assess whether the economic damage offer system would be more or less costly than the tort system.

The economic damage offer plan would eliminate unpredictably large damage awards for "pain and suffering" or for noneconomic damages. Malpractice insurers could make more confident predictions of their total payouts, and amounts paid out would be equal to or less than those in the tort system. Ultimately, the malpractice liability insurance system would be more stable under this proposal than under the current system.

C. Evaluation of the Administrative Fault-Based System

The administrative fault-based system would provide fairer compensation than either torts or the economic damage offer plan. The agency would award more consistent amounts of compensation to infants with comparable injuries. The decision process would be

84. Moore & O'Connell, *supra* note 40, at 1285-87.

85. Insurance systems create a perverse incentive, called "moral hazard," for people who are insured against a risk to engage in conduct that increases the risks of that occurrence or for people who are covered to make greater claims. Like the closely related phenomenon of adverse selection, *see supra* note 34, moral hazard raises the costs and threatens the financial balance of insurance systems. *See* K. Abraham, *supra* note 24, at 14-16.

86. Moore & O'Connell, *supra* note 40, at 1283.

more rational than either the tort system or the economic damage offer proposal, which is based largely on the tort system.

The program would achieve a vast improvement over the current system in deterring the misconduct that causes medical injuries, since the same authority that would administer claims would also have power to discipline physicians in more substantial, non-financial ways. Also, if the determinations were more accurate than under tort law, then the deterrent signals would be transmitted more accurately.

This system would reduce the costs of avoiding accidents. It would be more accurate than judicial determinations and would eliminate the needless procedures that make it less likely for courts to determine that a provider has been negligent. Providers would also have more incentive to practice the kind of "defensive" medicine that actually reduces risks, since determinations would be made by reference to a more clearly and rationally defined standard of care.

The costs of setting up the new administrative agency (or the cost of reconstituting an existing agency such as a worker's compensation board or board of medical quality assurance) and the claims processing procedures initially would entail considerable costs. In the long run, these costs would probably be less than the enormous costs of litigation. The system provides roughly the same incentive to settle as the tort system. Thus, the administrative costs of this plan would be less than those of the tort system, but might exceed those of the economic damage offer plan, which relies primarily on settlements between the parties.

The system would result in a greater number of claimants receiving smaller amounts, and the decisions and settlements would be more attuned to the actual level of risky behavior. The amounts would be more rational and predictable, reducing liability insurance costs. Therefore, the malpractice liability insurance system would be more "in balance" than the tort system, but it is difficult to predict how the system's financial feasibility would compare with that of the economic damage offer proposal.

D. Evaluation of the No-Fault Compensation Program

A no-fault plan probably would compensate injured infants more fairly and promptly than any of the other alternatives.⁸⁷ Fault-based

87. Although the plans compensate victims equitably, the funding mechanism is not equitable. See Note, *supra* note 11, at 1518-19.

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systems compensate infants suffering injuries due to negligence but not those whose injuries are not due to negligence. This system would eliminate that arbitrary distinction, and would compensate all infants with injuries that fall within the prescribed definition. The plan would be consistent as all infants and families facing similar costs would receive similar amounts of compensation. However, the plan would leave to the traditional tort system those infants with injuries that fall outside the compensable definition. The distinction between the types of injuries defined as compensable and non-compensable may be as arbitrary a way of deciding who receives compensation as the negligence standard.

Because it would be relatively easier to determine whether or not a case falls within the compensable definition than whether or not a provider was at fault, the compensation would be made much more quickly than in any of the fault-based systems. Avoiding determination of fault will eliminate much of the cost of litigation. However, litigation would continue, not over the issue of negligence but over the issue of whether the injury fell within the compensable definition. Families with injured infants who could receive huge damage awards in tort litigation but would receive only modest compensation in the no-fault system will claim that injuries fall outside the definition; families with injured infants who could be compensated under the no-fault plan but might not be likely to prevail in tort litigation will claim that their injuries are within the definition of compensable injuries. Litigation over these "boundary" cases will probably ensue.⁸⁸

One of the greatest drawbacks of the Virginia and Florida no-fault plans is that neither contains any mechanism for deterring birth accidents. Both plans remove birth accidents from the tort system, thus eliminating the (admittedly weak) deterrent signal provided by the possibility of liability for malpractice. Havighurst and Tancredi proposed a no-fault system with experience-rated premiums, which would provide an effective deterrent.⁸⁹

The greatest area of uncertainty over a no-fault system is whether it can be financially stable. It is still unknown how the Virginia and

88. See Epstein, *supra* note 33, at 1470. See generally Henderson, The Boundary Problems of Enterprise Liability, 41 Md. L. Rev. 659 (1982). Similar boundary litigation over "verbal thresholds" in auto accident no-fault systems subsided after a few years in most no-fault jurisdictions as courts clarified the standards. U.S. Department of Transportation, *supra* note 69, at 100-104. However, in the birth injury area, technology and medical understanding are constantly changing, so such boundary litigation might not subside.

89. See *supra* note 37 and accompanying text.

Florida plans are working.⁹⁰ The Virginia statute went into effect on January 1, 1988, and the Florida statute went into effect on January 1, 1989. Therefore, there is no working experience to evaluate these plans.⁹¹

The legislatures of Virginia and Florida passed the programs despite the likelihood that neither plan will be financially self-supporting as enacted (although they could be if funding assessment levels were increased). Table 2 shows the cost estimates that were presented to the legislatures while they were considering the legislation. The number of claims per year in the Florida cost estimate (and presumably also in the Virginia estimate) was based on the number of malpractice liability claims under the current tort system involving compensable birth-related injuries. If a significant number of birth injuries do not enter the tort liability system but would be compensated under these programs, then there could be many more claims. The programs could be significantly more costly if it is difficult to distinguish between injuries caused by birth-related accidents and injuries due to other causes such as congenital birth defects or maternal drug abuse.⁹²

90. There is evidence that the Virginia program has relieved the crisis in malpractice insurance coverage for obstetricians by removing the worst risks from the system. Note, *supra* note 11, at 1499-1500. See *infra* note 99.

91. No claims have yet been presented to either the Virginia or the Florida funds since the plans were enacted; thus, no information is yet available on the performance of the programs. Telephone interview with Eleanor Pyles, Virginia Birth Related Injury Compensation Fund, Richmond (Mar. 20, 1989); telephone interview with Carol Shirkey, Florida Birth-Related Neurological Injury Compensation Association, Tallahassee (Mar. 30, 1989).

92. Epstein criticizes the Virginia program's definition of the compensable event, pointing out that "it is often difficult to distinguish serious injuries caused at or before birth from those caused by birth defects." Epstein, *supra* note 33, at 1469. He speculates that a mother's abuse of cocaine can cause severe fetal brain defects that might "not be distinguish[able] from the compensable injuries under the statute." *Id.*

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Table 2
Virginia and Florida Birth Injury Compensation Plans⁹³

	<u>Virginia</u>	<u>Florida</u>
<u>Claims costs:</u>		
Number of qualifying birth injury claims made per year	40	60
Estimated average cost per qualifying claim	\$ 500,000	\$ 750,000
<u>Total annual cost</u>	<u>\$20,000,000</u>	<u>\$45,000,000</u>
<u>Funding sources:</u>		
Participating physicians	\$ 3,000,000	\$ 5,000,000
VA: 600 @ \$5,000		
FL: 1,000 @ \$5,000		
Other physicians	\$ 2,250,000	\$ 5,000,000
VA: 9,000 @ \$250		
FL: 20,000 @ \$250		
Participating hospitals	\$ 4,250,000	\$ 8,500,000
VA: 85,000 deliveries @ \$50		
FL: 170,000 deliveries @ \$50		
Insurance companies	\$10,625,000	\$ 3,750,000
VA: \$4,250,000,000 @ 0.25 %		
FL: \$1,500,000,000 @ 0.25 %		
<u>Total annual funding</u>	<u>\$ 7,875,000</u>	<u>\$22,250,000</u>
<u>Annual Deficiency</u>	<u>\$12,125,000</u>	<u>\$22,750,000</u>

As with any insurance system, moral hazard and adverse selection threaten the financial feasibility of the no-fault plan.⁹⁴ Moral hazard affects both providers and families of the injured infants. In the absence of experience-rating (as in the Virginia and Florida plans), providers know that injuries will be compensated and that there will be no liability for malpractice, so they may allow more injuries to occur. Families of injured patients who know that all costs are covered will lose any incentive to reduce the costs of treatment. Even

93. Sources of data in table:

Virginia: "HB 1216 Virginia Birth Related Neurological Injury Compensation Act Cost Estimates" (1987) (furnished to author by Sandra L. Kramer, attorney, Medical Society of Virginia, Richmond) (based on actuarial study conducted by Tillinghast, Nelson & Warren, Inc., Atlanta, GA, and on reported premiums from Va. Bureau of Insurance). See also D. Shepard, K. Pederson & C. Gallup, *supra* note 7, at 15-16.

Florida: Letter from Jerome F. Vogel, Actuary, Bureau of Rates, Fla. Dept. of Insurance to Pamela Birch Fort, Staff Director, Fla. Senate Commerce Committee (Jan. 11, 1988).

94. See *supra* notes 34 and 85.

before any accident occurs, families will be less likely to self-insure against birth injuries (i.e., they might buy health insurance that excludes coverage of catastrophic health care connected with birth injuries for their dependents). Such reduction of collateral benefits would increase the financial burden on the plan if an injury occurs.

If many more injured infants bring claims than currently bring suit, such adverse selection would make the no-fault system much more costly than the current malpractice tort system of compensation. Since about three-quarters of malpractice tort claims tried to verdict and half of claims resolved out of court result in no liability for defendants,⁹⁵ the guaranteed compensation of the plan could encourage many more meritorious claims to be brought. Also, in a voluntary program with no mechanism for deterrence like Virginia's and Florida's, less competent or more risky providers would be more likely to opt into the plan, thus raising the costs.

IV. Policy Recommendations

The defects of the Virginia and Florida plans can be cured by combining some of the best features of the other systems to create an alternative no-fault plan. First, the premiums or assessments levied on providers could be experience-rated, as proposed by Havighurst and Tancredi. Experience-rated premiums give providers an incentive to avoid birth injuries, since providers with higher than average numbers of birth injuries would pay increased premiums. However, to avoid giving doctors and hospitals an incentive to refuse to handle risky deliveries, the experience-rated premiums should be adjusted to take account of the riskiness of the provider's practice. Because experience-rated premiums are based on cumulative accident experience rather than determinations of liability in specific cases, the providers themselves would have an incentive to determine steps to reduce the incidence of birth injuries. Therefore, there would be no need for wasteful defensive medicine, and injury avoidance would be less costly and more efficient.

Experience-rating combined with a voluntary program could cause adverse selection. Providers with higher than average accident experiences and consequently higher premiums might opt not to participate in the no-fault program. The deterrent function of experience-rating could be weakened if these providers opted instead to take part in the tort and (non-experience-rated) malpractice

95. P. Danzon & L. Lillard, *The Resolution of Medical Malpractice Claims: Research Results and Policy Implications* vi (1982).

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insurance system. This adverse selection effect could be mitigated if the program were universal and compulsory for all providers,⁹⁶ or if once providers opt into the program they are not allowed to opt out.

However, the departure of riskier providers from the program as their assessments rise would have some beneficial effects. Through the reverse of adverse selection, providers who opt to stay in the no-fault program would tend to be those with the lowest accident experience. The incentives created by experience-rating would therefore improve the financial stability of a voluntary program.

A second improvement to the no-fault program would be to change the payment mechanism to provide more dependable financing for the system. Obstetricians and hospitals, who would be released from malpractice liability under a no-fault plan, should pay all or most of its costs.⁹⁷ Such a plan should cause a reduction in malpractice liability premiums because many malpractice risks would be removed from the liability system.⁹⁸ Physicians and hospitals theoretically should be willing to contribute an amount to this plan that is up to one dollar less than the amount by which their malpractice premiums would be reduced.

Third, a disciplinary deterrence mechanism like that in the administrative fault-based proposal should be adopted. The same administrative agency that decides whether compensation is paid could also have the power to discipline providers. It could use its information on adverse medical outcomes to initiate disciplinary action against providers where warranted. Such an agency would essentially serve as a strengthened and reconstituted board of medical

96. A commentator on the Virginia program has recommended that the plan be amended to require mandatory participation for three reasons: (1) to ensure equal treatment for all infants suffering birth injuries; (2) to make it easier to predict financing requirements; and (3) to prevent opting out by physicians who inaccurately assess the risks they face. Note, *supra* note 11, at 1514-16.

97. Providers pay only a small proportion of the cost of the Virginia and Florida programs. See Table 2, *supra* text accompanying note 93, for a breakdown of the financing of those programs.

98. The Virginia Bureau of Insurance has required insurers to reduce malpractice premiums of obstetricians who participate in the program by an actuarially reasonable amount (generally 10% to 20%). Telephone interview with Robert Miller, Deputy Commissioner, Va. Bureau of Insurance, Richmond (Mar. 11, 1989). Florida may follow suit, but has not yet done so. Telephone interview with Carol Shirkey, *supra* note 91. During the legislative debate, two insurance companies had promised to end moratoria on new malpractice insurance policies for obstetricians if the bill passed. Letter from Gordon D. McLean, Executive Vice-President of Virginia Professional Underwriters, Inc., to Ronald K. Davis, M.D., Virginia Surgical Associates (Jan. 13, 1987); Letter from Michael S. Mullen, President, Medical Protective Company, to Delegate Clifton A. Woodrum (Feb. 18, 1987).

quality assurance for obstetricians. If necessary, the agency would have sufficient medical information to adjust the statutory definition of compensable events⁹⁹ through generalized administrative rulemaking or through decisions in particular cases and a gradual "common law" process.

Fourth, the compensation could be provided in a way that would control moral hazard. Moral hazard arises in any system that provides compensation for losses as they are incurred. In medical care, families and caretakers of injured children lack an incentive to control expenses. This problem would be eliminated if compensation were provided in kind, as comprehensive services through an agency or other organization. An existing state agency serving the needs of people with developmental disabilities, or private health maintenance organizations under contract with the compensation fund program, could pay for all the injured child's expenses. The same agency could also collect the premiums and administer the funds. A separate agency would determine whether claims should be paid, discipline providers, and set standards of care.

Fifth, providers could be given an incentive to initiate the compensation process in a no-fault system, as in the economic damage offer system. Such an incentive to initiate the process could be similar to that provided in the economic damage offer proposal. Providers who knew of compensable birth-related injuries but failed to report them could be liable for punitive damages (as in O'Connell's proposal) or could be liable to pay a standard monetary penalty, either to the injured patient or to the fund.

V. Conclusion

A no-fault administrative system for compensating infants with birth-related injuries promises to provide fairer compensation, better deterrence of injuries, and lower costs than the other systems considered. Such a no-fault program, if properly designed, could be a creative and powerful policy tool to solve the obstetric care availability crisis. The Virginia and Florida programs serve as instructive models for other states in implementing a no-fault birth injury compensation plan, although aspects of their systems should be altered.

99. The definition of the compensable event should be broadened by combining Virginia's and Florida's definitions by using Florida's broader definition of the level of disability but without the restriction to births of term gestation. See *supra* note 52. Intentionally inflicted injuries should be compensable, but the fund should have the right to sue the provider for subrogation, and coverage by the no-fault system should not preclude the infant or family from suing for punitive damages.

Compensating Obstetric Accidents

Such systems for birth injuries could serve as models for addressing medical malpractice generally. More research is needed to assess the financial feasibility of a program such as that outlined here. This information will be useful in creating a system that will provide long-term compensation to injured infants and their families, deter malpractice, and improve the availability of obstetric care.

