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HEALTH POLICY BULLETIN

FOCUS: A NEW PERSPECTIVE ON TORT REFORM

"Reform thinking has been excessively tort-centered," said Kenneth S. Abraham, Professor of Law, University of Virginia, and one of the fourteen legal scholars who participated in the American Law Institute's study, *Enterprise Responsibility for Personal Injury.* Abraham spoke at the first of two seminars scheduled by the Michigan Physicians Mutual Liability Company. In his address Abraham discussed the findings of the study and its implications for the tort system and other compensation systems.

He noted that the study was controversial, that it had been attacked as too liberal by industry and as too conservative by plaintiffs. The study's ultimate conclusion, he said, "was that they had been too optimistic about substitutes for tort law," and the defects of other systems means that "some version of the tort system will always be with us."

According to Abraham, the study's findings about medical liability were that the deterrent effect (corrective justice) was a minor value in tort cases because "malpractice is not generally an occasion for moral indignation," and the person who committed the injury does not pay the compensation—the insurer does. The principal differences between other forms of liability and medical liability are that the defendants are often individuals rather than corporations, and awards present monetary shocks to physicians because they often are personally liable for amounts in excess of their policy limits.

Abraham would like to see some demonstration projects created to test two alternative systems: organizational liability and an elective medical no-fault plan. In his view, under an organizational liability plan, if an incident happened in a hospital, the hospital would pay. Why? Because the hospital is in a position to effect change. He observed that when an airline accident happens through pilot error, it is the airline, not the pilot, that is sued. The advantages of organizational liability are that it removes physicians from liability, saves on legal costs (because it is a single defendant system), gives the hospital an incentive to improve its medical staff, retains the basis of liability, and permits patients to keep their rights. A basic result is an increase in hospital control over how medicine is practiced in hospitals.

An elective medical no-fault plan would compensate all categories of injury based on the cause; Abraham cited the Virginia plan for compensating birth-related neurologic injuries and the Federal Childhood Vaccine Injury Compensation Act as examples. Because these plans address compensable injuries beyond malpractice, they are broader and remove questions of fault from compensation decisions. He suggests that both a limited no-fault plan and a single defendant plan be operated simultaneously to permit evaluation of each. He also suggests making the systems optional initially rather than mandatory, that is, a surgeon could offer a patient the no-fault option prior to surgery.

How do providers react to Abraham's suggestions? Dennis Paradis, group vice-president for governmental relations, Michigan Hospital Association, has some concerns about the switch to organizational liability (single defendant concept). If the organizational entity that is liable is the hospital, Paradis wonders who bears the costs? He said, "I have not heard any discussion of how physicians share in the cost. It appears to be assumed that the hospital will bear the costs alone." (It should be noted that Abraham does realize that hospital reimbursement would have to be increased for the system to work.)

A second question that concerns Paridis is the physician's position. "If a physician buys into this approach, does the doctor lose the right to defend himself or herself?" he asked. He noted that current federal law requires incidents of malpractice to be sent to the National Practitioners Data Bank. "It is entirely possible that something could go on a physician's record where it would be available to other facilities without the physician having had any opportunity to defend his or her record, especially if the insurer decided it would be simpler to settle than to defend a particular case." Those caveats out of the way, Paradis said, "The single defendant concept has some real positive aspects that deserve a good look. It would provide a greater incentive for hospitals to monitor the quality of their medical staffs. If physicians had some financial risk in the system, they would have a greater interest in the quality of medical practice of their colleagues."

Michael DeGrow, director of governmental relations, Michigan Association of Osteopathic Physicians and Surgeons, is somewhat skeptical of the organizational liability approach. "I would hate to see a system that could damage our relationships with hospitals," he commented. "There are other alternatives and approaches that we, as part of the coalition [Michigan Medical Liability Reform Coalition], are still exploring," DeGrow noted.

During the question-and-answer period following Abraham's presentation, questions were raised about the

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ity approach, and physicians being reported to the National Practitioner Data Bank if they do not have any liability. Abraham's response to the no-fault cost question was that the costs already exist. In his view, a no-fault system would compensate patients on the same level as other disability systems that typically pay about 60 to 70 percent of after-tax income, a level of payment that he says "does not provide an incentive against work." He dismissed the question of conflicts between hospital attorneys and doctors by saying that since doctors would have no liability under the system, there would be no conflicts. Reporting doctors to the national data bank was all right even if they have no liability because "hospitals have a right to know about physicians; that is the object of the data bank."

What happens to the tort system? Does it go away? Not on your life. In a philosophical aside, Abraham remarked that "the only justification for the tort system and judges is respect for authority—that authority can be tested by the people. There is a symbolism in the courts that people respect."

FOCUS: WINNERS IN MEDICAL PROGRESS

The *Harvard Health Letter* recently published the results of the annual survey of its advisory board. Asked to identify the ten most important advances in medical research for the past year, the board identified eleven (two were tied). The board had much less trouble identifying the three most important advances: Human gene therapy, estrogen replacement therapy and its relationship to heart disease, and identification of the gene for FAP (familial adenomatous polyposis), a form of colon cancer.

The biggest winner is human gene therapy, a field that is simply exploding. Beginning with the experimental insertion of the gene for adenosine deaminase or ADA (persons who lack the gene for ADA have severe combination immunodeficiency disease and virtually no functioning immune system—the best known case is that of the "bubble boy") in 1990 into two girls, researchers have made tremendous strides in figuring out how to alter cells so that the altered cells will reproduce correctly. The next problem appears to be extending the life of the altered cells so that they will reproduce for longer periods of time.

Closely related to human gene therapy are the third and fourth place winners on the list, genetically engineered drugs that help patients tolerate the side effects of chemotherapy and the "decade of the mouse." Specially bred strains of mice that have severe combined immunodeficiency disease are receiving human tissues. The mice, since they cannot reject the foreign tissues, become hosts for human diseases; scientists then can manipulate genes to create particular human disorders and use the mice to screen treatments and medicines more effectively. Also related to human gene therapy is advance number seven, a technique that offers promise for restoring strength to muscles damaged by muscular dystrophy. The gene for dystrophin has been implanted in muscle cells in mice, enabling them to produce and distribute dystrophin normally.

Women received the good news that estrogen replacement therapy both reduces the risk of heart disease by about half and the incidence of other cardiovascular disease. This news, along with the previously discovered ability of estrogen therapy to retard the development of osteoporosis, appears to outweigh significantly the argument that a slightly increased risk of breast and uterine cancers is unacceptable. Other good news for women is the discovery (eighth place) that aspirin may be as useful to women as it is to men in reducing the risk of heart disease. Although the same study that demonstrated quite conclusively the benefits to women of estrogen replacement therapy also suggested that aspirin may reduce the risk of heart disease by 25 percent in women, further research is definitely needed.

For the 53,000 people in the United States who die of colorectal cancer every year, the discovery of the FAP gene (tenth place on the list) means that the outlook for early detection and treatment of colorectal cancers is vastly improved. While FAP by itself is a relatively rare form of colon cancer, the gene appears to play a significant role in the process that turns on other genes for other forms of colon cancer. Since about 50,000 people in this country carry the gene, the development of tests to discover its presence before the disease is present may mean that techniques for blocking the FAP gene's tumor-making function are not far off.

OF INTEREST

In the next thirty days, look for

- The House Committee on Public Health to report out HB 4341 (licensure for cigarette retailers), HB 4754 (exposure to AIDS for law enforcement officers), HB 5012 (testing of convicted sex offenders), HB 5152 (utilization review), HB 5153 (reporting iatrogenic infections), HB 5217 (health care information), HB 5291 (universal precautions), and HB 5298 (nursing home delicensure)
- The Senate Committee on Health Policy to take up SB 633 (HIV status of health care workers)
- The House and Senate to act on HB 4936, which would extend the sunset on Michigan's no-fault auto insurance law from March 31 to December 31, 199?

—Frances L. Faverman, Editor

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