PRAGMATIC CONSTRAINTS ON MARKET APPROACHES: A RESPONSE TO PROFESSOR EPSTEIN

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As someone who participated in the planning and (somewhat peripherally) in the drafting and passage of the Virginia Birth-Related Neurological Injury Compensation Act (Injured Infant Act),1 perhaps my comments on the statute will help highlight the strengths—and possible weaknesses—of Professor Richard Epstein’s provocative article.2

For several years prior to the initial drafting of the Injured Infant Act,3 I had been consulting with the Medical Society of Virginia (Society), the professional society of Virginia’s physicians, about tort reform and its application to medical malpractice. The basic thrust of my advice was that bills typically advocated by medical societies, insurers, and others potentially subject to professional and commercial liability were likely to be rejected or watered down or, indeed, to be relatively ineffective even if passed in pristine form. Typically, the laws pay injured tort claimants less than they might be paid if they asserted their common law rights, or make it harder for them to be paid, if they are paid at all.

In the first category are laws that limit pain and suffering awards to, for example, $100,000, $250,000, or $500,000; eliminate or substantially curb the amount of or the occasions for punitive damages; and deduct from claimants’ tort awards other insurance benefits already payable from collateral sources, such as health and disability insurance.

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1 Va. Code Ann. §§ 38.2-5000 to -5021 (Supp. 1987). To avoid any confusion, I will refer to the initial drafts of the Injured Infant Act as the “Injured Infant Bill.”


3 For a full description of the content and passage of the statute, see Note, Innovative No-Fault Tort Reform for an Endangered Specialty, 74 Va. L. Rev. 1487 (1988).

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The second category includes laws that heighten the standard for liability—requiring, for example, that a tort claimant demonstrate the defendant's fault by a more demanding level of proof, such as clear and convincing evidence; place a cap on the contingency fee of the claimant's counsel by, for example, a ceiling of 40% on the first $50,000 awarded, with the share diminishing gradually to 10% of any recovery over $200,000; abolish or alter the doctrine of joint and several liability whereby a defendant's share of any liability would be limited to his or her share of responsibility for the harm, resulting in, for example, a defendant who is adjudged 25% responsible being liable, at most, for 25%—and not possibly all—of any damage award; alter the statute of limitations by reducing the period for bringing the lawsuit; and penalize those asserting marginal claims.

The point I tried to make to the Society was that "solutions" to the problems of tort liability that limit the amount or availability of compensation to injured persons—who already find it very difficult to be paid for injuries incurred in the course of health care—are questionable solutions indeed. I also urged that as long as the system (no matter how marginally modified) requires that claimants prove fault on the part of health care providers (with or without caps) and entails payment to claimants for pain and suffering, the system would be unworkable as an insurance mechanism for both claimants and defendants. I contended that it was not without significance that the two reforms that had fundamentally altered, and arguably greatly improved, coverage for personal injury—namely, workers' compensation and no-fault automobile insurance laws—each represented a balanced change, in which accident victims gave up their common law rights but received substantial benefits in return. In effect, such laws made it easier for accident victims to be paid but paid them less by eliminating as criteria for payment both defendants' fault and their pain and suffering. Thus, these two unworkable variables plaguing tort liability for per-


sonal injury were eliminated.\textsuperscript{6}

At the same time, I was quick to point out the special problems of defining a no-fault insured event for medical malpractice—problems (effectively described by Professor Epstein)\textsuperscript{7} that did not exist to nearly the same extent in drafting workers' compensation and no-fault auto insurance laws.\textsuperscript{8}

As a partial solution to the problem of defining a no-fault medical malpractice system, I proposed to the Society for its legislative agenda a so-called "early offers approach," adapted from my academic writing, and adopted by United States Representative Richard Gephardt and then-Representative Henson Moore in a federal bill generally applicable to health care providers,\textsuperscript{9} and by Massachusetts Governor Michael Dukakis in a state bill applicable to obstetrical cases\textsuperscript{10} and in a later proposed modification applicable to general surgery.\textsuperscript{11} Under the version of the Injured Infant Bill considered by the Society, any health care provider facing a medical malpractice claim would have the option of offering the injured patient, within a maximum of 180 days, periodic payment of the claimant's net economic loss—prompt payment compared to what the tort system entails. Such payment would cover any further medical expenses, not already covered by a collateral source, including rehabilitation and wage loss. The payment would also require a reasonable hourly fee for the patient's lawyer. Once such an offer of payment is made, a claimant refusing it must then prove his case by both a heightened standard of care (gross or wanton conduct) and proof (beyond a reasonable doubt, or at least by clear and convincing evidence), with both the losing claimant and his lawyer being held jointly liable for the fees of the defendant's counsel. Note that under such a bill, the problems of rigidly defining

\textsuperscript{6} See O'Connell, A Proposal to Abolish Defendant's Payments for Pain and Suffering in Return for Payment of Claimant's Attorney's Fees, 1981 U. Ill. L. Rev. 333, 344-48; supra notes 4, 5.

\textsuperscript{7} See Epstein, supra note 2, at 1451-52, 1464-66, 1468-70.

\textsuperscript{8} See J. O'Connell, Ending Insult to Injury: No-Fault Insurance for Products and Services 70-73 (1975).

\textsuperscript{9} H.R. 5400, 98th Cong., 2d Sess. (1984); see Moore & O'Connell, Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss, 44 La. L. Rev. 1267 (1984). For further justification of the terms of the federal bill, see J. O'Connell & C. Kelly, supra note 5, at 129-35.

\textsuperscript{10} Mass. H.B. 6829, 1985 Sess. § 34.

\textsuperscript{11} Neither the federal bill nor the Massachusetts bill and proposal has yet passed into law.
the insured event are avoided. But in any given case when the costs of litigating (including transaction costs, the potential risks of an adverse verdict, or both) exceed the net economic losses of the injured party, prompt payment of those losses is likely to result. By not compelling payment in any given case, control of the obligation to pay an unmanageable number of new claims is achieved.\textsuperscript{12}

The Society gave this proposal prolonged and serious consideration. As was the case in Massachusetts, however, the principal problem of medical malpractice liability was that presented by the practice of obstetrics. Consequently, an alternative approach was pursued in the Injured Infant Bill. Presenting a system comparable to workers' compensation, this bill proposed that no-fault payments be traded for economic loss in a defined set of serious obstetrical cases. Those payments would provide the exclusive remedy in such cases.

Dispositive of the Society's decision to back the Injured Infant Bill was an opinion from one of the state's principal medical malpractice insurer, the Virginia Insurance Reciprocal,\textsuperscript{13} that only a bill removing the worst obstetrical cases from the insurer's exposure would induce the insurer to cover obstetrical risks.\textsuperscript{14} The early-offers approach, though obviously lessening such exposure, did not eliminate it and did not therefore go far enough in the insurer's eyes.

With that constraint in mind, the Injured Infant Bill became the focus of the reform efforts of the Society.\textsuperscript{15} In a key session attended by physicians, insurance company executives, lawyers, and lobbyists in a Richmond hotel room on New Year's Eve, 1986, the draft terms of the bill were brought forward and closely examined.

In that session I urged (I am sure less cogently) many of the considerations raised by Professor Epstein—especially the problems of externalities and defining the compensable event.\textsuperscript{16} As to the former, I urged that one could not confidently predict the frequency of claims

\textsuperscript{12} See J. O'Connell & C. Kelly, supra note 5, at 128-35.
\textsuperscript{13} A reciprocal insurance exchange is defined as "[a]n unincorporated group of individuals, called subscribers, who mutually insure one another, each separately assuming his share of each risk. Its chief administrator is an attorney in fact." T. Green, R. Offsler & J. Bickley, Glossary of Insurance Terms 167 (1980).
\textsuperscript{15} A pivotal figure for the Society in its support of balanced reform of medical malpractice liability laws and insurance was the very able chairman of its professional liability committee, Dr. Ronald K. Davis, ably assisted by Dr. James L. Graphery, among others.
\textsuperscript{16} See Epstein, supra note 2, at 1468-73.
even under the bill's relatively precise definitional criteria, or the stra-
tegic behavior of claimants and their lawyers in trying to come within
the definition if tort claims were weak, or fall outside the definition if
tort claims were strong. As to externalities, quite apart from the eco-
nomics and equity of making all health care providers (including, for
example, psychiatrists and internists) pay for injured infant cases, I
raised more urgently the economics and equity of holding the casualty
insurance industry liable for any possible shortage of funds needed to
pay compensable claimants under the bill. Such a residual liability
would fall, I argued, largely on automobile owners because auto
insurance is the largest source of insurance payment into the casualty
insurance industry. Why should auto owners pay for such cases?
"How about the laundry business?" I asked rhetorically, trying to
illustrate the externality point.

But at that meeting on New Years Eve—and thereafter—it became
increasingly clear that the choice, at least for the indefinite future, was
between the Injured Infant Bill (or some comparable version of it),
with all its infirmities, and the present system. Thus, in the end, I
supported a bill much more inflexible than the early-offers approach I
had first championed.

I must at this point confess that during all these discussions of the
Injured Infant Bill, my interest was somewhat "academic." I realized
from fairly long experience in lobbying the Virginia legislature on
other insurance matters how conservative that body is (as is the
state)\(^{17}\) and how radical the bill was. I therefore privately considered
the bill largely an exercise in futility. Advocating balanced reform
and knowing that this bill far exceeded anything being proposed in
other states, including far more "liberal" states such as New York,
California, and Massachusetts, I was pleased that the Society adopted
such an approach. But I tended to consider the bill an interesting
experience in presenting an idea that might ultimately help change
attitudes. Here, of course, I was thankfully proved wrong. The key

\(^{17}\) Virginia has yet to adopt a general rule of comparative negligence, for example. Cf. Va.
Code Ann. § 56-416 (1986) (substituting doctrine of comparative negligence for that of
contributory negligence in context of negligent failure of railroad to give statutory signals).

As long-time Democrats, my wife, Virginia, and I (she from New York City and I from
Massachusetts) arrived in Virginia in 1980, having lived for 15 years in Illinois. A friend from
Illinois who had preceded us to Virginia was showing my wife around, explaining the area.
The subject of politics came up and our friend said, "Well, Virginia, they're Democrats around
here, but not your kind of Democrat."
player voicing optimism on the bill’s passage was attorney Lawrence Framme, Chairman of the Virginia Democratic Party and a very experienced political hand within the state. He thought such a bill had a real chance, given all the problems presented by injured infants, particularly in rural Virginia. With the vigorous and imaginative help of Senator Wiley Mitchell and Delegate Clifton “Chip” Woodrum, the Injured Infant Bill swept through the legislature in just a few weeks in early 1987.18

I now come to the thrust of Professor Epstein’s article. The alternative of contracts, whereby prior to treatment a patient would agree to alter her common law rights, was not on the agenda at that New Year’s Eve meeting. In fact, for many months before and after the passage of the bill, I worked—and am still working—with the Virginia Insurance Reciprocal on post-accident contracts whereby common law rights are waived in return for relatively prompt payment of less than common law damages. Unfortunately, however, the crafting and administration of such post-treatment contracts, dependent on individual waivers of rights, is a slow, uncertain process. Moreover, no one believed that a contract, whereby prior to treatment patients (especially young, poor, and relatively uneducated rural and inner city mothers) would waive their common law rights, was a viable solution to the problem. Not only were no insurance companies in Virginia, or elsewhere, known to be willing to use such innovative contracts, but there were real fears that courts would strike down such contracts.19

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18 For a good description of the bill’s passage, see Framme, supra note 13.
19 As Professor Epstein wrote in an earlier book,

Virtually all of the general discussions of malpractice law and virtually all of the judicial opinions upon the subject take it for granted that the specification of the substantive rules of medical malpractice rests, in the absence of legislative command, upon the courts and that the parties themselves are not free to vary those terms by private arrangement. Although most courts have not expressly stated the extent to which specific provisions in the physician-patient contract are void and unenforceable for reasons of public policy, some uneasy combination of the doctrines of unequal bargaining power, contracts of adhesion, economic duress, and unconscionability today block any private effort to contract out of the judicially mandated liability rules for medical malpractice.

In an exchange with Professor Epstein some years ago, I urged that courts would not uphold contractual solutions that did not entail the same kind of tradeoff involved in workers' compensation and automobile no-fault insurance—namely, an assurance of payment for substantial economic losses in return for a waiver of tort claims.20 Professor Epstein, on the other hand, seemed to suggest that contracts that simply made it harder for patients to recover or ensured less recovery (or both) were a promising approach to the dilemmas posed by medical malpractice litigation.21

Regardless of whether I interpret his views correctly, I think, based on our writings, that we are now in agreement that contracts that assure payment of economic loss as a condition of a pre-treatment waiver of common law rights provide a sensible alternative for much personal injury tort liability.22 The problem of defining the insured event for medical malpractice claims, however, under either a contract or legislation, remains intractable.23 Moreover, finding an insurer to experiment with such contracts has proven fruitless (believe me, I've tried),24 especially in view of the free-rider problem. An insurer who experiments with such a contract faces the certainty of start-up costs and the risks suggested above that a court will strike down the contract, and that, even if it is not struck down, the experiment will fail because of an unexpected rise in claim frequency. In

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24 See O'Connell, supra note 4, at 906 & nn.31-33.
addition, the insurer also knows that if the experiment does work, other insurers can then copy it without cost, given the impossibility of effectively copyrighting insurance contracts.

In many ways, Professor Epstein's article echoes earlier debates over the passage of workers' compensation statutes shortly after the turn of the century. There is no need, argued many economists, for inflexible workers' compensation acts to deal with workplace injuries. If such an approach makes sense, the argument followed, markets will more flexibly and subtly provide them. The question remains whether and when markets would have addressed this problem.\(^\text{25}\) Even after passage of workers' compensation acts in state after state, no auto insurance contract provision of any significance has emerged in over seventy years to replace what strikes many as the scandal\(^\text{26}\) of tort liability as it applies to auto accidents.\(^\text{27}\) Here, again, we have had to wait for, and in many jurisdictions are still waiting for, statutory no-fault solutions that, though admittedly are imperfect, would greatly improve on the common law.\(^\text{28}\)

Returning to that Richmond hotel room on New Year's Eve, 1986, the choice was between the common law system as it applies to obstetrical cases and the (admittedly imperfect) Injured Infant Bill. I had some, but not too much, hesitation in opting to support experimentation with the bill—with all its problems so effectively cataloged by Professor Epstein\(^\text{29}\)—as an alternative to be tried and from which to learn. To have opposed it in favor of possible contractual solutions far down the road would have made the best, namely a remote contractual solution, the enemy of the good, namely an immediately achievable no-fault system. Moreover, the Injured Infant Bill was surely more preferable than the certainly bad present tort system.

In one respect, Professor Epstein's approach and the one I (somewhat hesitantly) supported as adopted by the Virginia legislature could be combined. Rather than waiting for purely private contrac-

\(^{25}\) See P. Cane, Atiyah's Accidents, Compensation and the Law 515 (4th ed. 1987); O'Connell, supra note 20, at 674-75.

\(^{26}\) See id. at 898-903.

\(^{27}\) For contractual proposals along these lines, which were never adopted, see O'Connell, Liability Lottery, supra note 24; O'Connell & Beck, supra note 24. Here, again, the free-rider problem obstructs experimentation. See supra text accompanying note 24.

\(^{28}\) See O'Connell and Joost, Giving Motorists a Choice Between Fault and No-Fault Insurance, 72 Va. L. Rev. 61, 61-75 (1986).

\(^{29}\) See Epstein, supra note 2, at 1464-73.
tual solutions, the legislature could pass a statutory compensation bill that specifically authorizes contractual variations, subject to the approval by a defined public body (perhaps the state insurance regulatory office) and based on minimum standards of equity. In one sense, the Injured Infant Act arguably incorporates that solution by not making its provisions mandatory for health care providers. Could not health care providers (or their insurers), dissatisfied with both the common law and the Injured Infant Act, formulate alternative contractual approaches, especially if the law proves unworkable for the reasons Epstein incisively lists, or for other reasons? In that regard, however, note that despite workers’ compensation statutes long being elective in many jurisdictions, more sensible and flexible contractual variations have not emerged. But specific statutory authorization of variations might have helped to foster such a contractual approach—especially with the benefit of Professor Epstein’s perceptive thoughts.

At any rate, we are all in Professor Epstein’s debt for cogently reminding those of us involved in the drafting and passage of the Injured Infant Act to face up to the difficulties of the alternative we wrought and to other solutions toward which we all ought also to be struggling.

30 The statute could provide that only “balanced” contractual variations of common law rights would be allowed, and either prescribe minimum no-fault benefits that must be supplied in return for pre-accident waivers of tort rights, or leave the precise definition of the standards and their application to a statutorily authorized administrative body, which would approve pre-accident waivers according to standards set by the administrative body, in accord with general criteria set forth in the statute. See J. O’Connell, supra note 8, at 155; R. Keeton, Basic Text On Insurance Law § 2.10(b) (1971).

31 See Epstein, supra note 2, at 1464-73.
