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# MEDICAL MALPRACTICE: ELIMINATING THE MYTHS†

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## I. INTRODUCTION

This Article places the latest series of attacks on Wisconsin's medical malpractice dispute resolution system in proper perspective. The Medical Society of Wisconsin and insurance industry lobbyists would have the legislature believe that we now face another medical malpractice crisis in Wisconsin. In fact, the current alleged crisis merely represents a renewed effort on the part of the Medical Society and the insurance industry to continue the curtailment of the rights of malpractice victims, begun in 1975, through the use of scare tactics and misleading press releases and public pronouncements. All of these assertions must be carefully analyzed before considering further modifications in Wisconsin's medical malpractice law.

While this Article is not intended as a comprehensive rebuttal of the attacks which are now being made by the Medical Society and insurance industry, it will demonstrate that many of these attacks are without basis. In order to determine what is best for Wisconsin and before making any fur-

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† This Article is adapted from the *Medical Malpractice White Paper of the Wisconsin Academy of Trial Lawyers* which was presented to the Wisconsin Legislature. It represents the work of five attorneys:

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ther modifications to our existing method of resolving malpractice claims, the legislature should take testimony from doctors, lawyers, economists, insurers, actuaries, consumers, and victims of malpractice. We believe such a comprehensive investigation will clearly demonstrate that there is no need to modify the existing system of malpractice dispute resolution.

## II. ISSUES AND PROPOSALS

The present challenge to Wisconsin's medical malpractice dispute resolution system raises several issues that should be examined. (1) Are doctors really paying greater medical malpractice premiums in real dollars than they did ten years ago? (2) What percentage of a doctor's income is expended for medical malpractice insurance? (3) Have unjustifiably low medical malpractice premiums resulted in a deficit in the Patient's Compensation Fund? (4) From an actuarial standpoint, is the Patient's Compensation Fund administrator properly taking into account panel awards? (5) To what extent is the deficit in the Patient's Compensation Fund a result of the failure of the Wisconsin Insurance Commissioner to surcharge doctors who have, through their malpractice, repeatedly caused losses to the fund? (6) What has the Medical Society done to discipline doctors who have repeatedly committed acts of malpractice? (7) Is the present alleged Wisconsin medical malpractice crisis merely the result of an orchestrated effort by medical societies throughout this country to limit the rights of victims on a state-by-state basis? (8) Are proposals to limit contingent fees intended to curtail the ability of medical malpractice victims to seek redress for their injuries? (9) Are the financial circumstances of medical malpractice insurance such that the insurers can only survive by further limiting victims' rights? (10) Is the current statutory restriction on attorney fees in section 655.013 of the Wisconsin Statutes being abused?

Any thorough investigation into our present system will reveal areas which could be improved. As attorneys, we are committed to maintaining justice in a system governing an ever changing society. The following proposals are designed to serve this purpose.

I. We propose that doctors who repeatedly commit acts of malpractice pay higher rated premiums.

II. We oppose any arbitrary limitations with respect to the Patient's Compensation Fund that are not proven to be economically and actuarially essential.

III. We oppose any damage "cap" on the amount an individual claimant may recover because the innocent victim and the overburdened taxpayer will thereby be required to subsidize medical malpractice.

IV. We propose that medical malpractice primary insurance limits be raised to \$500,000 per occurrence.

V. We oppose the amendment or repeal of section 655.245 of the Wisconsin Statutes which presently limits the right of doctors to interfere with settlements.

VI. We propose eliminating the limitation on contingent fees which currently exists in section 655.013 of the Wisconsin Statutes, and we oppose any further limitations on contingent fees.

VII. We propose that hearings at the formal panel level be bifurcated to provide for both a liability hearing and a damage hearing.

VIII. We propose the repeal of section 655.19(1) of the Wisconsin Statutes which allows formal panel findings to be admitted in circuit court actions.

IX. We propose altering the composition of formal panels to consist of three lay persons, one doctor, and one lawyer.

X. We propose that formal panels be subject to full voir dire and challenges for cause.

XI. We oppose frivolous suits, and we believe that frivolous suits, whether before the panel or in the courts, should be deterred by the fee and costs provisions of section 814.025 of the Wisconsin Statutes.

XII. We oppose the requirement that settlements over a specified amount be paid in installments, since such a requirement effectively "caps" awards.

XIII. We propose strengthening the conditional immunity provided in section 146.37 of the Wisconsin Statutes.

XIV. We propose that the Wisconsin Medical Examining Board promptly discipline physicians who are found to have committed multiple acts of medical malpractice.

### III. ELABORATION ON KEY ISSUES

The issues and proposals that generate the most attention go to the heart of the relationships between doctors, lawyers, and medical malpractice victims. These areas need to be understood before any modification of the present medical malpractice dispute resolution system is undertaken. This part of the Article will discuss: (1) the existence of a "crisis"; (2) the cost of insurance; (3) modifications concerning award limitations, contingent fees, and the locality rule; and (4) doctors who repeatedly commit acts of malpractice.

#### *A. The Existence of a Medical Malpractice Crisis*

The circumstances and conditions surrounding the alleged medical negligence crisis of 1975 must be reviewed to understand the situation today. One member of the 1975 Wisconsin Legislature made the following observation:

I can't help but believe that the "crisis" in Wisconsin may have been artificially developed. The sudden momentum is highly suspect.

Although the Wisconsin Legislature had, as early as July of 1974, begun to address the problems relating to malpractice and was proceeding to pass legislation for the benefit of the medical community, we suddenly found ourselves faced with a "deadline" imposed by the insurance industry and medical profession . . . .

An atmosphere of confusion existed because fundamental changes in Wisconsin's tort liability system were being demanded, without providing the Legislature with the data necessary to evaluate the need for such changes.<sup>1</sup>

Just as they did in 1975, the Medical Society and the insurance industry in 1985 would have the legislature believe that they are faced with a sudden crisis which threatens the delivery of medical services in Wisconsin and throughout the country. In fact, the Medical Society has always reacted to the concept of medical malpractice with "an unhealthy paranoia."<sup>2</sup>

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1. Czerwinski, *Wisconsin's Medical Malpractice Crisis*, A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE 55 (D. Warren & R. Merritt, eds. 1976).

2. Ottensmeyer, *Contingent Fees in Medical Malpractice Litigation — A Qualitative Assessment*, 139 W.J. MED. 239, 243 (1983).

Doctors have always resented the very idea of medical malpractice.<sup>3</sup> Reading through the pages of the *Medical Economics* magazine, one is left with two impressions. First, prior to 1975, doctors appeared primarily concerned about the cost of medical malpractice insurance and accordingly focused their anger with respect to malpractice on the private insurance industry. After 1975, it appears that doctors and the insurance industry discovered that they could benefit each other by coordinating an attack on the alleged "cause" of their medical malpractice problems: the way in which medical malpractice disputes are resolved in our legal system. Second, one gains the impression that doctors and the insurance industry discovered in 1975 how to manipulate the press and public opinion so as to create the perception of a medical malpractice crisis. In so doing, the doctors and the insurance industry discovered that they were able to divert the attention of both the public and the legislature from the true cause of medical malpractice: the failure of the Medical Society and the insurance industry to identify, discipline, and remove from the profession those health care providers who through their negligence cause untold suffering and injury to an unsuspecting public.<sup>4</sup>

In fact, just as in 1975, the current efforts of the Medical Society and insurance industry lobbyists are a part of a national campaign to convince the public and legislature of each

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3. The editors of *Medical Economics* magazine made the following observation in October 1983:

With the malpractice crisis of the 1970s still fresh in your memory and the professional liability situation again heating up, you may think wistfully of a bygone era when this was a matter of little concern to America's physicians.

You wouldn't find any evidence that such an era ever existed by leafing through old copies of *Medical Economics*. W. Clifford Klenk reported in the March 1934 issue: "Summed up, the doctors' grievances are these: A few companies have a monopoly on the writing of malpractice insurance . . . Professional incomes have swooped drastically downward in the last five years while premium charges have increased. . . . [T]he insurance companies are promoting a racket."

An article two years later sounded this alarm: "Four Thousand Physicians Sued! And What To Do About It." In the '40s there were more articles about the growing malpractice threat.

Lavin, *Malpractice: A New Storm Is Looming*, MED. ECON., October 3, 1983, at 76 (editorial insert at 78).

4. This failure to address the true cause of medical malpractice has recently been noted in the pages of the *Milwaukee Journal*. See *Milwaukee J.*, Nov. 14, 1984, § 2, at 1, col. 1; *id.* Nov. 13, 1984, § 1, at 1, col. 1.

state that a medical malpractice crisis exists. In this way, it is hoped that medical malpractice "reform" can be brought about in this country on a state-by-state basis.<sup>5</sup> The proposed modifications in Wisconsin's system of medical malpractice dispute resolution reveal that the real concern of the doctors and the insurance companies lies in the elimination or significant curtailment of the rights of malpractice victims.<sup>6</sup>

The Wisconsin Legislature did not face a medical malpractice crisis in 1975; instead, the legislature was confronted by a public relations creation of the Medical Society and insurance industry lobbyists. The legislature was pressured into enacting legislation which restricted the rights of victims before the legislature could calmly and carefully examine the empirical evidence of the true picture of medical malpractice in Wisconsin.<sup>7</sup>

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5. It is surprising that Wisconsin doctors have permitted themselves to be swept along with the current national agitation to further modify malpractice laws. The Medical Society, with the assistance of the insurance industry, succeeded in modifying the law in Wisconsin in 1975 far more than did their colleagues in other states, and Wisconsin doctors benefited to a very substantial extent from the modifications which they imposed upon Wisconsin in 1975. See *infra* note 22 and accompanying text.

6. If the legislature permits itself to be used once again by the Medical Society and the insurance industry, its legislative mandates may be struck down as unconstitutional in the same way similar mandates have been struck down in other jurisdictions. For example, Illinois, New Hampshire, North Dakota, and Ohio courts have held unconstitutional the imposition of monetary limitations on recoveries in medical malpractice cases. See *Wright v. Central DuPage Hosp. Ass'n*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Simon v. St. Elizabeth Med. Center*, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (1976).

7. The Wisconsin Legislature was not the only one to fall victim to these scare tactics. In the State of Indiana, a full investigation was eventually conducted but only after that state's legislature had been convinced in 1975 to take away valuable rights of malpractice victims in the crisis atmosphere created by the medical society and insurance industry lobbyists. Indiana placed restrictions on valuable patient rights ostensibly to decrease the amount of unwarranted recoveries. However, the statistics which were later revealed showed that insurers of Indiana health care providers were not facing an actual increase in either the number or amounts of claims.

Health care providers and their insurers claimed that the number of suits and amounts of awards had seriously increased in Indiana in 1974. However, according to the annual financial statements filed by the Medical Protective Company and St. Paul Fire and Marine Insurance Company, the number of suits and amount of awards against health care providers in Indiana had actually decreased in 1974. See Note, *The Indiana Medical Malpractice Act: Legislative Surgery on Patients' Rights*, 10 VAL. U.L. REV. 303, 342 (1975) (citing J. Dickerson & G. Lodge, Indiana Senate Subcommittee on Insurance and Corporations (March 21, 1975)). The number of suits filed against the Medical Protective Company decreased from 658 in 1973 to 137 in 1974. See *id.* at

The Department of Health, Education, and Welfare (HEW) found that medical malpractice insurance was readily available in 1973.<sup>8</sup> Indeed, the HEW found that insurers at that time had renewed interest in the medical malpractice underwriting field and that some insurance companies were actively soliciting new malpractice business.<sup>9</sup> Yet, the medical community insisted that insurance was not readily available.

As evidence of the scare and pressure tactics used by the Medical Society and insurance industry lobbyists in 1975, the doctors gave the Wisconsin Legislature until July 1, 1975, to act on the demands of their lobbyists, or else they would stage a "strike." The Assembly Insurance and Banking Committee held hearings on the very eve of the July 1, 1975, deadline. Because of the artificial crisis, that committee was completely unable to identify and study the empirical evidence relied on by the doctors and the insurers. Had the legislature been given the opportunity to carefully review the empirical evidence which was then available, it would have concluded that there was no medical negligence crisis in 1975.

The empirical evidence presented to the legislature indicated that eighty-seven percent of the claims closed in 1974 were settled before trial and that fifty-three percent of jury verdicts were in favor of the plaintiff.<sup>10</sup> However, the awards

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343. During the same period, St. Paul Fire and Marine likewise experienced a decline in claims from 3,746 to 1,156. *See id.* And the total amount of damages paid to Indiana claimants in 1974 was \$1.5 million out of \$6.7 million collected in premiums. *See id.* at 337.

Illustrative of the misinformation prevalent during the 1975 "Indiana Crisis" is an article which appeared in the *Bloomington Daily Herald — Telephone*. It stated that the average award in malpractice cases during the period from 1970 to 1975 was reportedly \$282,403. *See Bloomington Daily Herald — Telephone*, January 14, 1975, at 1. In direct contrast to this article are the findings published by the Department of Health, Education, and Welfare. In that comprehensive report, it was disclosed that of those claimants nationwide who received payments, more than half obtained less than \$3,000 and only three percent of all claimants received payments in excess of \$100,000. *See SECRETARY'S COMMISSION, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE REPORT ON MEDICAL MALPRACTICE*, DHEW Pub. No. (O5), at 73-88 (1973) [hereinafter cited as HEW REPORT].

The California Legislature was also misled during this time period. *See Address by Keene, Annual Meeting of National Conference of State Legislatures (1975), cited in T. LOMBARDI, MEDICAL MALPRACTICE INSURANCE 110-11 (1975).*

8. *See HEW REPORT, supra* note 7, at 38-39.

9. *See id.* at 38.

10. *See Czerwinski, supra* note 1, at 54.



ranged from \$300 to \$233,500, and there was only one award over \$100,000 in the 146 cases analyzed by the committee in 1975.<sup>11</sup> In 1974, 97.3 percent of the Wisconsin claims settled were for less than \$40,000, and the average settlement was only \$8,856 in those cases in which a payment was made to a claimant.<sup>12</sup> The data also demonstrated that Wisconsin verdicts and settlements were more favorable to physicians than the national average of \$12,500.<sup>13</sup>

The Medical Society and insurance industry lobbyists did not achieve all of their objectives during the 1975 crisis created by them.<sup>14</sup> After waiting a respectable ten years, the Medical Society and insurance industry lobbyists have decided, both here and throughout the country, to create another artificial crisis in order to complete the curtailment of victims' rights begun in 1975. Many of the attempted tort reforms, some of which were rejected by the full legislature in 1975,<sup>15</sup> have again been put "on the table" by the Medical Society. Although the suggested reforms are the same, health care providers are now arguing that due to allegedly excessive malpractice claims and awards, malpractice insurance premiums are too high and the Wisconsin Patient's Compensation Fund has been placed in jeopardy.

### B. *The Cost of Medical Malpractice Insurance*

Fundamental to the claim of the medical community that another crisis is at hand is the underlying premise that the cost of medical malpractice insurance has become increasingly excessive. There is no claim that insurance is unavailable, only unreasonably priced. The only evidence offered by the State Medical Society in support of this point is the fact that

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11. *See id.*

12. *See id.* at 54-55.

13. *See id.* at 55.

14. For example, during the alleged crisis of 1975, the State Medical Society of Wisconsin asked for various tort reforms. According to Senate Bill 299, which was passed by the Senate under the great pressure noted previously, recovery for victims of medical negligence would have been limited to \$100,000 for bodily injury, even if 100% permanent impairment resulted. *See* 1975 Senate Bill 299 § 8. In cases of death to the patient, the maximum recovery would have been \$100,000 with \$5,000 for loss of companionship, plus funeral expenses. *See id.* The foregoing proposals ultimately were not enacted into law in 1975. *See* Czerwinski, *supra* note 1, at 52-55.

15. *See supra* note 14.

the malpractice premiums of physicians have risen in the past three years.<sup>16</sup> However, because of inflation, very few goods and services have not increased in price over the same period of time.

Statistics suggest that the Medical Society has grossly exaggerated the impact of malpractice premiums in the State of Wisconsin. According to a recent article in *Newsweek*, the average pre-tax net income of all self-employed physicians, at \$115,900, was still growing faster than inflation.<sup>17</sup> Expenditures for medical malpractice insurance by self-employed physicians represent only 3.5 percent of their gross income and only 8.3 percent of their overhead.<sup>18</sup> Overall prices for physicians' services have been outpacing overall inflation,<sup>19</sup> and the proposed increase in medical malpractice insurance premiums is not based upon a realistic assessment of medical malpractice claims data.<sup>20</sup> Yet, even with the increased cost of medical

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16. The legislature should adopt a no-nonsense attitude toward the Medical Society and the insurance industry concerning their claims that the cost of medical malpractice insurance may impinge upon the ability of health care providers to deliver reasonably priced services to the general public. Whenever doctors or insurance carriers are asked to produce evidence concerning their true incomes and the amount of their malpractice premiums, they provide a generalized response or no response at all. The legislature should require the Medical Society to produce detailed evidence demonstrating just how fast the net incomes of doctors have risen during the past ten years. Both the Medical Society and the insurance industry should also be required to provide detailed evidence to the legislature of just what percentage of health care providers' overhead is devoted to malpractice insurance protection.

17. See *Taking a Scalpel to Doctors*, NEWSWEEK, Jan. 14, 1985, at 58, 59.

18. See *id.*

19. See *id.* Similarly, *The Wall Street Journal* recently reported that medical malpractice premium costs represent only one to two percent of all health care costs and that even the highest premiums only represent about eight percent of a physician's gross income. See *The Wall Street J.*, Jan. 21, 1985, at 12, col. 5-6. Of course, medical malpractice premiums are paid from gross, as distinguished from net, income. According to a survey conducted by the editors of *Medical Economics*, the average gross income of all doctors in 1983 was \$157,500, while the average gross income of neurosurgeons was \$241,120. See Owens, *Are You Still Losing Out to Inflation?*, MED. ECON., Sept. 17, 1984, at 181, 185.

*The Milwaukee Sentinel* recently reported that as of July 1, 1985, when the new rates go into effect, general practitioners could be paying about \$4,000 a year for malpractice insurance premiums, a 75% increase. See *Milwaukee Sentinel*, Jan. 18, 1985, at 1, col. 1. However, general practitioners in Wisconsin will still be paying only 2.5 percent of their gross incomes for medical malpractice insurance premiums.

20. The 75% fee hike in medical malpractice insurance is the increase in fees for the Wisconsin Health Care Liability Insurance Plan which was recommended by the plan's actuaries. See *Wisconsin Health Care Liability Insurance Plan, Estimated Unpaid Claim Liabilities 12/31/84, Physicians & Surgeons Experience*, at 3, 21 (Nov. 20, 1984)

malpractice insurance, the expenditures for such insurance represent only a very small percentage of overhead and a small percentage of gross income for the general practitioner.<sup>21</sup>

The fact is that Wisconsin doctors have benefited financially to a significant degree from the modifications made in the law in 1975 as compared to their colleagues nationally. The Joint Legislative Audit Committee's November 1, 1982, evaluation of the Wisconsin Health Care Liability Insurance Plan (WHCLIP) observed:

When WHCLIP was established in 1975, neither the Office of the Commissioner of Insurance nor the Board of Governors believed the Plan would develop into Wisconsin's largest medical malpractice insurer. At that time the Insurance Commissioner's Office believed the Plan would "insure only the estimated 200-300 doctors unable to obtain coverage in the voluntary insurance market."

We identified two primary factors which have contributed to the growth of WHCLIP and make it difficult for private insurers to compete with the Plan: a) WHCLIP makes occurrence coverage available to all licensed Wisconsin health care providers, and b) *between 1975 and 1982 the Plan's rates decreased by about 69 percent.*<sup>22</sup>

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(prepared by Daniel J. Flaherty and Robert L. Sanders). In making this recommendation, however, the actuaries have ignored long-term trends concerning medical malpractice claims. Although the actuaries recognize that both the frequency and severity of medical malpractice claims have leveled off and even slowed, *see id.* at 2, 7, 10, they base their pricing decisions for the plan upon a "very conservative set of assumptions." *Id.* at 21. The claimed justification for this conservative approach is the fact that the excess premiums can always be refunded if the plan's claims experience is more favorable than expected. *See id.* at 3, 21.

21. *See supra* note 19.

22. *Office of the Commissioner of Insurance, The Wisconsin Health Care Liability Insurance Plan: An Evaluation by the State of Wisconsin Legislative Audit Bureau* [82-20], Nov. 1982, at 14 (emphasis added) [hereinafter cited as WHCLIP Report].

Our review of liability insurance in six other midwestern states (Iowa, Illinois, Indiana, Michigan, Minnesota, and Ohio) shows that none of these states' governments has found it necessary to become as involved in insuring providers as Wisconsin. . . . *However, we do believe that it is significant to note that of the six states we contacted only one state, Indiana, operates a plan similar to WHCLIP, but on a much smaller scale.*

*Id.* at 21 (emphasis added).

Of course, WHCLIP is only intended to meet the primary insurance requirements of doctors in Wisconsin. Nevertheless, the primary insurance needs of doctors constitute a significant portion of their medical malpractice insurance expense.

Part of the cost problem is due to the current deficit in the Patient's Compensation Fund, a result not attributable to lawyers. The State Medical Society's actuaries have found that the deficit is the direct result of actuarial miscalculations made in years past.

The current Fund deficit is the result of fees which, in the early years of the program, were not sufficient to satisfy ultimate liabilities of the Fund. The current Fund fees were developed to be actuarially sound, and consequently should be sufficient to pay the ultimate losses for the 1984-85 Fund year.<sup>23</sup>

The legislature should carefully review the current administration of both WHCLIP and the fund by the Wisconsin Insurance Commissioner. The Legislative Audit Committee's evaluation of WHCLIP has already suggested that there is entirely too much state involvement in Wisconsin malpractice insurance matters,<sup>24</sup> and serious questions are raised by the evaluation as to whether WHCLIP should be returned to the competitive marketplace of private insurance companies.<sup>25</sup>

The legislature should also consider the possibility that the Office of the Insurance Commissioner has not properly administered the fund. It does not appear that medical malpractice premiums in the private marketplace have been rising at a particularly alarming rate throughout the rest of the country.<sup>26</sup>

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23. Letter from actuary Gary Josephson to Legislative Council Staff Attorney Pam Russell (Sept. 14, 1984). The fund deficit is not a function of the frequency and severity of claims. Claims are only as frequent and severe as the injuries caused by malpractice. Fund deficits can and should be controlled by the adoption of proper actuarial and underwriting standards and practices.

Instead of increasing malpractice premiums or adjusting primary or excess coverage limits (several of the options recommended by the Medical Society's own actuaries), the Medical Society would have the legislature eliminate the current fund deficit and control future deficits at the expense of the rights of medical malpractice victims.

24. See WHCLIP Report, *supra* note 22, at 14, 28-34.

25. See *id.* at 28-34.

26. What's worse, most of the pros feel that premiums in some states — New York particularly — are unrealistically *deflated*, partly to be competitive and partly because insurance regulators have held them down. . . .

Insurers stress that for the most part, rate hikes in the 1980s have been more modest than in the 1970s.

Lavin, *supra* note 3, at 93.

Moreover, instead of sacrificing the rights of malpractice victims, even if a fund deficit exists which is not attributable solely to improper actuarial computations on the part of the Insurance Commissioner, greater emphasis should be placed on loss prevention<sup>27</sup> and the elimination of negligent health care providers from practice. The legislature should require the Medical Society and the insurance industry to demonstrate that they have done everything in their power to eliminate negligent health care providers before the rights of innocent victims of malpractice are placed in further jeopardy by needless revisions in the medical malpractice dispute resolution system in Wisconsin.<sup>28</sup>

C. *Proposed Modifications of the Existing Malpractice Dispute Resolution System.*

The Medical Society has proposed a number of modifications to the existing malpractice dispute resolution system which are now the focus of the latest scare and pressure tactics of the Medical Society and insurance industry lobbyists. The proposed modifications include limitations on awards to victims of malpractice and limitations on fees paid to the attorneys of those victims. Additionally, it has been suggested that Wisconsin reinstate the so-called "locality rule."

1. Award limitations

The Medical Society argues that three different types of limitations should be placed upon awards to victims of medical negligence.<sup>29</sup> First, the Medical Society proposes an abso-

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27. "The insurance insiders point, however, to several major factors that could mitigate a [malpractice] crisis — state legislative reform, competition in the industry, and, perhaps most important, strong emphasis on loss prevention and risk management." *Id.* at 76.

28. Another possible solution to the fund deficit might be the establishment of health care institution self-insurance programs. These programs have received a great deal of attention recently in medical literature. *See, e.g.,* McGovern, *Medical Professional Liability*, TOPICS IN HEALTH CARE FINANCING, Spring 1983, at 27.

29. Dr. Robert Condon recently wrote:

Should we seek legislation to limit awards? I think it is not likely to be successful and, even if we succeeded, would have very little impact on the malpractice problem. The American Medical Association in its 1983 report of public opinion suggested that 61 percent of the public supported limitations on malpractice awards. However, the 1983 Public Attitude Survey conducted by the All-Industry Research Advisory Council came to an opposite conclusion. Only 27 percent

lute cap of \$1,000,000. Second, the Medical Society proposes a \$100,000 limit on the amount the fund is required to pay on any one claim in any one year.<sup>30</sup> And third, the Medical Society proposes a \$100,000 cap on non-economic damages — pain, suffering, disability, and diminution in the victim's ability to enjoy life.

These award limitations are contrary to fundamental fairness because they leave victims grossly uncompensated. They would be arbitrarily imposed, regardless of the amount of expense the victim must incur for medical care to treat the condition created or aggravated by the act of malpractice, regardless of the magnitude of the past or future wage loss, and regardless of how pervasive or how chronic the pain, suffering, and disability of the victim.<sup>31</sup>

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of the respondents to that poll indicated that limiting malpractice awards was a good idea.

Condon, *The Malpractice Problem: A Surgeon's Viewpoint*, 83 WIS. MED. J. 9, 14 (Oct. 1984).

30. If the ultimate liability of the fund is to be restricted to some certain dollar amount, why should health care providers not be required to obtain private excess liability insurance umbrellas? The cost of these excess liability umbrellas would not contribute significantly to the overhead expense of health care providers.

31. The insidious nature of these proposals is illustrated by the following hypothetical scenario. The Jones' one year-old daughter develops meningitis. Through the negligence of the family physician, the infection goes unchecked; a one year-old girl is rendered a spastic quadraparetic, but is left with a normal intelligence quotient (I.Q.). In other words, she cannot control her arms or legs; she cannot engage in functional speech; she has an enormous experience deficit which contributes to developmental and cognitive delays and now requires care twenty-four hours a day.

Through the testimony of an ergonomist (human factors engineer), it is possible to determine the amount it will cost to provide wheelchair access, physical and occupational therapy, medical and therapy equipment, environmental control, live-in aides, dental and medical goods and services, and other necessities. The price tags on these items, together with the necessary augmentative communication equipment to aid in human interaction and educational development, typically will exceed \$2,000,000. Add to this figure the fair and reasonable compensation to the girl who had a lifetime ahead of her, and to the parents who must now provide extraordinary care for their daughter 24 hours a day for the next 17 years. Taking into account the anxiety and mental suffering of the victim and the change in the relationship between the parents and child, experience suggests a non-economic loss award in excess of \$1,000,000. Thus, the total award would probably be \$3,000,000.

Now consider the effect of each of the three award limitations proposed by the Medical Society. First, if the total limit on claims were set at \$1,000,000, the Jones family's award would be reduced to \$1,000,000, which is one-third of the probable value of their claim and only 50% of the total of the necessary out-of-pocket expenses. Under this

As with most of the proposals by the Medical Society aimed at restricting patients' rights, there is no empirical data available which would support the contention that such restrictions will save substantial dollars. In fact, the savings would be insignificant when compared to the injustice done to the injured parties. An analysis of what has occurred because of the cap imposed on wrongful death recoveries for loss of society and companionship is instructive. In a recent *Milwaukee Journal* article, the ramifications of Wisconsin's wrongful death statute were explored: "Wisconsin attorneys reject dozens of wrongful death cases each year, because it would cost more to try the cases than the families could receive in return."<sup>32</sup> Similarly, limitations on medical malpractice damage recoveries are against public policy because they will inhibit the vigorous prosecution of meritorious claims.

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proposal, the non-economic losses would be totally uncompensated because the out-of-pocket expenses exceed the proposed limitations on claims.

Compensation for all of the pain, suffering, and disability of the family of this girl is limited to \$100,000 under the Medical Society's proposal. This girl, who would have walked, run, jumped, and played with her siblings, friends, and schoolmates; who would have raised her voice in song; whose body is now, as a result of the medical negligence, racked with spastic paralysis; who would have experienced with her family the miracle of human growth to independence, now requires care 24 hours a day. Someone must bathe her, brush her teeth, dress her, and change her diapers — now and forever. The family excursions and vacations must always be altered to take into account her limited abilities and special access needs.

Live-in help becomes a part of the Jones' everyday existence, and the intimacy of family life is compromised. Special schools, special teachers, and special transportation must be provided. Always there is the mental suffering as the girl watches children her age and younger quickly advance beyond her abilities. They walk, they run, they roll in the grass; they jump rope, they play ball and laugh; the Jones girl can only sit and watch and wonder. For all of this and much more the Medical Society proposes a total award of \$100,000. For the physical and mental pain and suffering, the incredible diminution in the ability to enjoy life, the anxiety, the change in the relationship between the family members, the incredible physical restrictions and for what the future holds for this girl's life, the Medical Society proposes that the fair and reasonable compensation be limited to \$100,000.

Finally, the Medical Society proposes that the Patient's Compensation Fund be obligated to pay no more than \$100,000 per year on any claim. Since damage awards earn 12% interest by statute, an award of \$1,000,000 would produce \$120,000 per year. This is more than enough to satisfy the fund's obligation under the Medical Society's proposal. Under the Society's proposal the victim would never receive any of the principal of the award; it would remain in the fund's control. The proposal would not only deprive the victim of the use of the principal sum, but also nullify an award of compensation to the victim. The claimant would be paid \$100,000 per year in taxable interest income and never a dime of the principal sum.

32. *Milwaukee J.*, Dec. 15, 1983, § 2, at 4, col. 1.

The recovery limitations proposed by the Medical Society are also unconstitutional. Damage limitations constitute a denial of a tort victim's constitutional right to have damages determined in a trial by jury. The right to a trial by jury is guaranteed to our citizens in both the United States<sup>33</sup> and Wisconsin Constitutions.<sup>34</sup>

The Medical Society's proposal to limit damage awards in medical malpractice actions is directly contrary to a long line of judicial decisions which clearly establish the jury as the appropriate body to determine damages in tort actions.<sup>35</sup> The unfairness of the Medical Society's proposal to limit the amount of damages a victim may receive is obvious. Just as troubling, however, is the fact that the Medical Society's proposal is clearly an effort to deny malpractice victims their right to a trial by jury.<sup>36</sup>

## 2. Restrictions on contingent fees

Whenever special interest groups want to deny consumers the "key to the courthouse," they attack the contingent fee contract. The attackers are invariably the opponents of, and never the clients of, contingent fee lawyers. Insurance compa-

33. The seventh amendment provides:

In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.

U.S. CONST. amend. VII.

34. The pertinent provision provides in part: "The right of trial by jury shall remain inviolate, and shall extend to all cases at law without regard to the amount in controversy . . ." WIS. CONST. art. I, § 5.

35. See, e.g., *Toulon v. Nagle*, 67 Wis. 2d 233, 245, 226 N.W.2d 480, 487 (1975) (citing *Campbell v. Sutliff*, 193 Wis. 370, 214 N.W. 374 (1927)).

36. The constitutional infirmity of the Medical Society's damage limitation proposals exists regardless of the fact that these cases would still be decided by a jury. The infringement upon a major function of the jury is no less unconstitutional because it is indirect, instead of direct. The practical effect of the proposed damage limitation is to establish an irrefutable presumption that persons injured by medical negligence can never experience losses in excess of \$1,000,000. This clearly is unconstitutional. The Medical Society is in effect attempting to embarrass the legislature by compelling the enactment of damage limitations which the Wisconsin Supreme Court has already suggested cannot survive constitutional scrutiny. Cf. *State ex rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 261 N.W.2d 434 (1978). It must be remembered that the courts in Illinois, New Hampshire, North Dakota, and Ohio have all held the imposition of monetary limitations on recoveries in medical malpractice cases unconstitutional. See *supra* note 6.



nies and doctors can afford to pay lawyers by the hour. Most victims of negligence cannot. Those who are injured most severely, those who have had their ability to earn a living destroyed, are the ones who can least afford legal services and, at the same time, are the ones who need it most. It is these people in particular who have been targeted by the State Medical Society in its most recent attempt to dispose of the "key to the courthouse."

During the alleged medical negligence crisis of 1975, the contingent fee system was the subject of considerable criticism. Health care providers maintained that greedy attorneys, hungry for fat contingent fees, generated suits that would not otherwise have been brought, thus driving up the number of claims against them and making the health care providers less insurable risks. The providers further appeared to resent the fact that in those cases in which the victim prevailed, thirty-three to forty percent of the award went to the plaintiff's attorney. In fact, the desire to limit contingent fees is an attempt by the Medical Society and insurance industry lobbyists to reduce the number of malpractice claims by minimizing the margin of profit for plaintiffs' attorneys. In so doing, it is hoped that plaintiffs' attorneys will be less willing to handle malpractice suits.

This hope would no doubt materialize into fact. The proposed legislation to limit contingent fees would decrease the number of claims brought because it will increase the number of cases which plaintiffs' lawyers will not handle.<sup>37</sup> However, it will do so at the expense of those persons who have the greatest need for a remedy.<sup>38</sup>

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37. In a study conducted by the Rand Corporation's Institute for Civil Justice, it was estimated:

Imposition of limits on contingent fees charged by plaintiffs' attorneys seemed to:

Cut the average settlement by 9%.

Raise the portion of cases dropped from 43% to 48%.

Reduce the share of cases going to verdict from 6.1% to 4.6%.

P. DANZON & L. LILLARD, *THE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS* 26 (1982) (published by the Institute for Civil Justice of the Rand Corp.) [hereinafter cited as *Rand Study*]. This evidence is from an independent research organization which does not represent medical doctors, insurance companies, or plaintiffs' attorneys.

38. The *HEW Report* revealed that contingent fee attorneys declined to handle suits involving smaller claims, whether meritorious or not, because they are not profita-

As to those cases which are commenced, limiting contingent fees will place plaintiffs' counsel at a disadvantage vis-a-vis defense counsel. Without corresponding limitations on defense fee arrangements,<sup>39</sup> defense attorneys will be able to expend more time and effort on trial preparation than plaintiffs' counsel. As a result, the defense will be better prepared.

Another assertion, never supported by evidence, is that the contingent fee system promotes frivolous lawsuits. Logic says otherwise. If a frivolous suit is one which has no basis, then it is one which will be lost and one which will generate no fee for the claimant's lawyer. There is no greater incentive for a lawyer to separate good cases from bad than the contingent fee system since attorneys are not paid unless they prevail.<sup>40</sup> Instead of eliminating frivolous claims, limiting contingent fees will reduce meritorious malpractice litigation by reducing the cost effectiveness of such litigation.

The Medical Society has alternatively asserted that the contingent fee should be graduated in such a way that the per-

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ble. See HEW REPORT, *supra* note 7, at 32-33. Furthermore, the *HEW Report* suggests that since a fee is not forthcoming when a suit is unsuccessful, the time, expense, and effort involved in such cases force attorneys to separate the cases involving questionable liability from those in which the medical negligence is more apparent. See *id.* at 33. Limiting contingent fees would have the effect of depriving seriously injured poor people of the competent counsel they must have to successfully prosecute claims against well-defended insurers. According to the Rand Study, any significant restriction on contingent fees will result in a 48% increase in rejected cases. See Rand Study, *supra* note 37, at 26. "About half of the claims dropped would have produced an award for the plaintiff if taken to verdict." *Id.* at 19.

39. The *HEW Report* found that total fees earned by plaintiffs' lawyers in ordinary tort litigation were comparable to the hourly fees paid to defense attorneys. See HEW REPORT, *supra* note 7, at 33. Unlike ordinary tort litigation, Chapter 655 of the Wisconsin Statutes provides a two-tier trial system. Accordingly, it follows that many more hours are required to fully litigate a case under Chapter 655 than in ordinary tort litigation. The increased preparation and litigation time presents no problem to defense counsel, who are paid by the hour. On the other hand, Chapter 655 naturally works to reduce the cost effectiveness of plaintiffs' litigation. If contingent fees were restricted with no similar restriction on defense fees, the system would unfairly discriminate based on the wealth of the parties.

In the *HEW Report*, it was discovered that "the average number of plaintiff-lawyer hours spent on zero recovery litigated cases is 440 hours per case." *Id.* If one assumes a \$100 hourly rate, then the average plaintiff's attorney invests at least \$44,000 in fees in zero recovery cases. This does not take into account the well-known expert witness fees advanced by plaintiff's counsel in payment to medical doctors for testifying in medical negligence cases. These expert fees regularly exceed \$20,000 and often reach \$100,000 or more per case.

40. See *id.* at 32-33.

centage of the fee earned would decrease as the recovery increases. Even members of the medical profession have acknowledged the absurdity and the danger of this proposal. According to Dr. David J. Ottensmeyer:

*If contingent fees progressively decline as a percentage of the recovery further conflict between lawyer and client is possible.*

Does the possible additional recovery for a client require a disproportionate amount of additional effort that is not marginally beneficial for the lawyer? Also because such a fee is payable without regard to time spent on the case by a lawyer, it may be to the lawyer's advantage (however unethical) to settle it quickly and on terms that are not in the best interests of the client.<sup>41</sup>

### 3. The locality rule

The Medical Society has asked the legislature to reinstate the discarded rule of law called "the locality rule." This rule required a patient to call an expert witness who not only practiced the same specialty as the defendant doctor, but practiced it in the same community. Patients were thus forced to produce testimony from those who were most reluctant to testify: colleagues and friends. What resulted was the "conspiracy of silence."

The Medical Society overlooks the fact that the Wisconsin Supreme Court abolished the locality rule in 1973.<sup>42</sup> The Medical Society would now have the legislature overrule the carefully reasoned decision of our supreme court that permits a plaintiff to establish the standard of care and breach thereof through evidence of the standard of care of the average practitioner of the class to which the defendant belongs, without regard to community. In abolishing the locality rule, the supreme court relied on a survey done by the *Stanford Law Review* and the Stanford University School of Medicine.<sup>43</sup> The supreme court reported that the results of the survey con-

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41. Ottensmeyer, *supra* note 2, at 241 (emphasis added).

42. See *Shier v. Freedman*, 58 Wis. 2d 269, 206 N.W.2d 166 (1973).

43. See *id.* at 282, 206 N.W.2d at 173. Among those queried in connection with the preparation of that survey were the American Medical Association, the American Hospital Association, the American Specialty Boards, medical specialty societies, and publishers of medical specialty journals. The purpose of the survey was to determine the extent to which the practice of medicine within recognized specialties differed across the country.

firmed the obvious: there was no basis in fact for the locality rule.<sup>44</sup>

Nothing has changed since 1973 which would justify the legislature in overturning the well-researched and well-reasoned decision of our Wisconsin Supreme Court. The locality rule is, and should remain, history.

#### *D. Doctors Who Repeatedly Commit Acts of Malpractice*

One of the principal problems existing in the State of Wisconsin is that perpetrators of multiple acts of medical negligence are permitted to continue practicing without censure or limitation. Further, neither the Medical Society nor the Commissioner of Insurance has taken any steps to surcharge these repeat offenders so that their premiums reflect the risk they create, and neither the Medical Society nor the Commissioner of Insurance has in the last nine years attempted to rid the profession of those doctors who continually commit acts of malpractice.

The failure to discipline doctors who continually commit acts of malpractice is one of the primary reasons for increased malpractice litigation and insurance premiums.<sup>45</sup> We suggest the legislature investigate curbing the problem of repeat offenders rather than curbing the rights of innocent patients.

#### IV. CONCLUSION

Restricting the rights of victims or penalizing their attorneys in order to curb an alleged medical malpractice crisis makes as much sense as fining victims of reported crime in order to curb crime. The legislature is now on the verge of facing another artificial crisis created by the Medical Society and insurance industry lobbyists. We urge the legislature to resist the pressure and scare tactics of those lobbyists and to carefully weigh all of the evidence before considering any further modifications to our Wisconsin malpractice dispute resolution system.

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44. See *id.* at 280-83, 206 N.W.2d at 171-73.

45. See *supra* note 4 and accompanying text.

