Legislative Responses to the Medical Malpractice Crisis

> The solution to the problem of medical malpractice does not lie . . . in taking away the rights of patients and enlarging the rights of medical practitioners.[1]

In recent years there has been a perceived[2] medical malpractice "crisis." Although the underlying causes are in dispute,[3] the crisis has resulted from an increase in the number and amount of malpractice claims and awards.[4] As a consequence, malpractice insurance premiums for health care providers have risen dramatically.[5] The expense is ultimately passed on to the public in the form of increased costs for health care[6] as well as for health care insurance. State legislatures, in response to pressure from the medical community and out of concern for the quality and cost of health care for their constituents, have developed a variety of measures to alleviate the medical malpractice crisis, including modification of the tort laws. Although these modifications have assumed many forms, three basic groups can be discerned. The first group of modifications is directed toward limiting the amount of the patient's financial recovery. The second group alters substantive law to make plaintiff's recovery more difficult. The third group of modifications introduces screening panels or arbitration boards for medical malpractice claims.

This Comment will first examine the categories of tort modifications that have been formulated by state legislatures.[7] It will next focus on the constitutional issues raised by these modifications and then speculate on the possible effect of these changes on tort law. Finally, the public policy considerations that figure in solutions to the malpractice crisis will be

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1. James Sheeran, 1975 Speech to the Council of State Governments, *quoted in* CONSUMER REPORTS, Sept. 1977, at 545.

2. NEWSWEEK, June 9, 1975, at 58; U.S. NEWS AND WORLD REPORT, Jan. 20, 1975, at 53.

3. For a discussion of causation, see Bachman, *Doctors: Move Closer to Your Patients*, 11 TRIAL 25 (1975); Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 DUKE L.J. 1179; Waxman, *A Health Care Slide*, 11 TRIAL 23 (1975); Comment, *Recent Medical Malpractice Legislation—A First Check-up*, 50 TUL. L. REV. 655 (1976). Some of the possible underlying causes suggested by these articles include patient alienation, technological improvement in health care, media-influenced expectations of patients, and greater awareness of legal rights.

4. M. REDISH, LEGISLATIVE RESPONSES TO THE MEDICAL MALPRACTICE CRISIS: CONSTITUTIONAL IMPLICATIONS 2-3 (1977).

5. *Id.* at 1; N.Y. Times, June 1, 1975, at 1, col. 1.

6. M. REDISH, *supra* note 4, at 2.

7. Although this paper will discuss only legislative responses to the medical malpractice crisis, there are possible judicial responses as well. *See, e.g.*, Bly v. Rhoads, 216 Va. 645, 222 S.E.2d 783 (1976), which held that expert testimony was required to establish liability under the informed consent doctrine and that the standard of care used to establish negligence for a medical specialist would be the community standard. These issues have been the subject of legislation in some jurisdictions.

discussed and additional legislative responses that may be fairer to the victims of medical malpractice will be explained.

I. Reduction of Recoveries

Legislatures have adopted several statutes that are aimed at reducing the plaintiff's financial recovery. A plaintiff's recovery is most directly influenced by the setting of a maximum amount recoverable by any one plaintiff or for any one incident of malpractice.[8] Several states have adopted this approach, but the specified maximum amounts differ considerably. A few states have enacted exceptions to the maximum amount.[9] Statutes setting a maximum amount recoverable are of course aimed at preventing the huge recoveries that have been awarded in some cases. Although such measures effectively achieve the goal of limiting the amount recovered, the injured victim of medical malpractice is denied compensatory damages for any loss beyond the statutory maximum amount. Moreover, at least one state has eliminated punitive damages in medical malpractice cases brought on a theory of negligence.[10]

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8. *See, e.g.*, CAL. CIV. PROC. CODE § 3333.2(B) (West Supp. 1977): "In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000)." IDAHO CODE § 39-4204 (1977) provides:

> The limit of civil liability for damages of a licensed physician, as aforesaid, to or on the account of injury to or death of any one (1) patient arising out of any treatment or course of treatment shall be one hundred fifty thousand dollars ($150,000), and to or on account of injury to or death of two (2) or more patients arising out of any one (1) occurrence shall be an aggregate of three hundred thousand dollars ($300,000) . . . .

IND. CODE ANN. § 16-9.5-2-2 (Burns Supp. 1978) provides: "The total amount recoverable for any injury or death of a patient may not exceed five hundred thousand dollars ($500,000)." ILL. ANN. STAT. ch. 70, § 101 (Smith-Hurd Supp. 1977) provides that "the maximum recovery to which the plaintiff may be entitled or for which judgment may be rendered for any plaintiff is $500,000." Note that this section was held unconstitutional by the Illinois Supreme Court in Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976). LA. REV. STAT. ANN. § 40:1299.42 (West 1977) provides that "[t]he total amount recoverable for any injury or death of a patient may not exceed five hundred thousand dollars plus interest and costs." N.M. STAT. ANN. § 58-33-6 (Supp. 1976) provides that "[e]xcept for punitive damages and medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice may not exceed five hundred thousand dollars ($500,000) per occurrence." OHIO REV. CODE ANN. § 2307.43 (Page Supp. 1977) specifies that "[i]n no event shall an amount recovered for general damages in any medical claim . . . not involving death exceed the sum of two hundred thousand dollars." S.D. COMPILED LAWS ANN. § 21-3-11 (Supp. 1978) directs that "the total general damages which may be awarded shall not exceed the sum of five hundred thousand dollars. No limitation is placed on the amount of special damages . . . ."

9. *See, e.g.*, TEX. REV. CIV. STAT. ANN. art. 4590i § 11.02 (Vernon Supp. 1977):

> (a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for damages of that physician or health care provider shall be limited to an amount not to exceed $500,000. (b) Subsection (a) of this section does not apply to the amount of damages awarded on a health care liability claim for the expenses of necessary medical, hospital and custodial care received before judgment or required in the future for treatment of injury.

10. IDAHO CODE § 39.4210 (1977). In addition, DEL. CODE tit. 18, § 6855 (Supp. 1977) allows punitive damages "only if it is found that the injury complained of was maliciously intended or was the result of wilful or wanton misconduct by the health care provider . . . ." New Mexico and Oregon forbid payment of punitive damages from the patient compensation fund. N.M. STAT. ANN. § 58-33-7 (Supp. 1977); OR. REV. STAT. § 752.110 (1977).

Other statutory provisions that have been adopted are aimed at limiting financial recoveries in all cases of medical malpractice and not just in those likely to result in larger recoveries or punitive damages. One measure that has been adopted for at least some cases of medical malpractice is the abrogation of the collateral sources rule,[11] which provides that "payments from collateral sources do not reduce the amount recoverable in a personal injury action."[12] Some states have adopted statutes that require the financial recovery to be reduced by the amount received from collateral sources.[13] On the other hand, some statutes simply permit evidence of the amount received from collateral sources to be introduced before the jury.[14] It is assumed that the jury, after receiving evidence of collateral sources, will appropriately reduce the size of its verdict. Statutes differ not only with respect to requiring or permitting the jury verdict to be reduced by collateral sources, but also in their definitions of collateral sources.[15] Although there is a respectable argument that the collateral sources rule is antiquated, it seems illogical and unwise to modify the collateral sources rule only for medical malpractice torts.

Another measure that has received attention from legislatures during the crisis is the *ad damnum* clause, that is, the portion of the plaintiff's complaint that conveys the amount of money damages sought. A federal

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11. *See, e.g.*, ALASKA STAT. § 09.55.548 (Supp. 1976); ARIZ. REV. STAT. § 12-565 (Supp. 1977); CAL. CIV. PROC. CODE § 3333.1 (West Supp. 1977); DEL. CODE tit. 18, § 6862 (Supp. 1977); FLA. STAT. ANN. § 768.50 (West Supp. 1977); IOWA CODE § 147.136 (Supp. 1977); N.Y. CIV. PRAC. LAW § 4010 (McKinney Supp. 1977); OHIO REV. CODE ANN. § 2305.27 (Page Supp. 1977); S. D. COMPILED LAWS ANN. § 21-3-12 (Supp. 1977); WASH. REV. CODE ANN. § 7.70.080 (Supp. 1976).

12. Coyne v. Campbell, 11 N.Y.2d 372, 374, 183 N.E.2d 891, 892, 230 N.Y.S.2d 1, 1 (1962).

13. *See, e.g.*, ALASKA STAT. § 09.55.548 (Supp. 1976):

> Except when the collateral source is a federal program which by law must seek subrogation and except death benefits paid under life insurance, a claimant may only recover damages from the defendant which exceed amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group or governmental, and whether contributory or noncontributory.

IOWA CODE § 147.136 (Supp. 1977) provides that

> the damages awarded shall not include actual economic losses incurred or to be incurred in the future by the claimant . . . to the extent that those losses are replaced or indemnified by insurance, or by governmental, employment, or service benefit programs or from other source except the assets of the claimant or of the members of the claimant's immediate family.

14. *See, e.g.*, ARIZ. REV. STAT. § 12-565 (Supp. 1977):

> [D]efendant may introduce evidence of any amount or other benefit which is or will be payable to the plaintiff . . . .
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> Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any such benefits . . . .

N.Y. CIV. PRAC. LAW § 4010 (McKinney Supp. 1977) provides that

> evidence shall be admissible for consideration by the trier of the facts to establish that any such cost or expense was replaced or indemnified, in whole or in part from any collateral source . . . . Such evidence shall be accorded such weight as the trier of the facts chooses to ascribe to it.

15. *See, e.g.*, PA. STAT. ANN. tit. 40, § 1301.602 (Purdon Supp. 1978): "[D]amages awarded . . . shall be reduced by any public collateral source . . . ." ALASKA STAT. § 09.55.548 (Supp. 1976) provides that "a claimant may only recover damages from the defendant which exceed amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group, or governmental, and whether contributory or noncontributory."

commission studying the medical malpractice problem in the early 1970s was extremely critical of *ad damnum* clauses.[16] Its report stated:

> It is the opinion of the Commission that the astronomical amounts of damages set forth in malpractice complaints by attorneys are an unnecessary source of friction between the legal and medical professions. These large demands attract sensational newspaper coverage, impose needless anxiety and often unfounded notoriety upon defendant physicians, create a feeling of unfair persecution in the medical world and are of no special benefit to the plaintiff-patients. Accordingly, the Commission can see no merit but does see probable harm in perpetuating this practice.[17]

Apparently in response to such criticism, many state legislatures have adopted statutes that prevent the use of the *ad damnum* clause in medical malpractice or limit the clause to the jurisdictional amount.[18] Since these criticisms of the *ad damnum* clause appear to be valid for all tort complaints, legislatures that eliminate the *ad damnum* clause only for medical malpractice complaints seem to be selectively aiding a particular class of defendants.

Responding to the crisis, legislatures have frequently passed statutes assuring that any payments made by defendant to plaintiff before trial will not be introduced into evidence in a later trial or be construed in any way as an admission of guilt on the part of the defendant.[19] Although these statutes are common, it seems unlikely that a defendant or his insurer will make any payments unless liability is certain.

Some legislatures have also adopted periodic (installment) payments rather than a lump sum payment of the judgment.[20] Although insurers

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16. UNITED STATES DEP'T OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 38 (1973). [hereinafter cited as MEDICAL MALPRACTICE COMMISSION REPORT].

17. *Id.*

18. *See, e.g.*, ALA. CODE tit. 6, § 5-483 (1975); ALASKA STAT. § 09.55.547 (Supp. 1976); FLA. STAT. ANN. § 768.042 (West 1977 Supp.); HAW. REV. CODE § 671-4 (1976); GA. CODE ANN. § 81A-154 (1977); IND. CODE ANN. § 16-9.5-1-6 (Burns Supp. 1978); KY. REV. STAT ANN. § 304.40-270 (Baldwin Supp. 1977); MASS. ANN. LAWS ch. 231, § 60(c) (Law. Co-op Supp. 1977); N.Y. CIV. PRAC. LAW § 3017(c) (McKinney Supp. 1977); N. M. STAT. ANN. § 58-33-4 (1976 Supp.); OHIO REV. CODE ANN. § 2307.42C (Page Supp. 1977); TENN. CODE ANN. § 23-3416 (Supp. 1977); WIS. STAT. ANN. § 655.009(1) (West Supp. 1978).

19. *See, e.g.*, ALA. CODE tit. 6, § 5-487 (1975); ALASKA STAT. § 09.55.546 (Supp. 1976); CONN. GEN. STAT. ANN. § 52-184b (West Supp. 1977); DEL. CODE tit. 18, § 6861 (Supp. 1977); IND. CODE ANN. § 16-9.5-2-3 (Burns Supp. 1977); KY. REV. STAT. ANN. § 304.40-280 (Baldwin Supp. 1977); LA. REV. STAT. ANN. § 50.1299.42(C) (West 1977); MD. CTS. & JUD. PROC. CODE ANN. § 3-2A08 (Supp. 1977); N.M. STAT. ANN. § 58-33-4 (Supp. 1976); PA. STAT. ANN. tit. 40, § 1301.512 (Purdon Supp. 1977); WASH. REV. CODE ANN. § 5.64.010 (Supp. 1977). An example of a representative statute is ALASKA STAT. § 09.55.546 (Supp. 1976):

> In an action to recover damages under § 530-560 of this chapter, no advance payment made by the defendant health care provider or his professional liability insurer to or on behalf of the plaintiff is admissible as evidence or may be construed as an admission of liability for injuries or damages suffered by the plaintiff; however, a final award in favor of the plaintiff shall be reduced to the extent of any advance payment.

20. *See, e.g.*, ALA. CODE tit. 6, § 5-486 (1975); ALASKA STAT. § 09.55.548 (Supp. 1976); CAL. CIV. PROC. CODE § 667.7(a) (West Supp. 1977); FLA. STAT. ANN. § 768.51 (West Supp. 1977); WIS. STAT. ANN. § 655.015 (West Supp. 1978).

may advocate periodic payments,[21] it is not the usual method of paying judgments. Usually, legislatures have restricted the periodic payment option to certain types of damages or to larger recoveries, or have committed the matter to judicial discretion.[22] There are valid arguments that periodic payments ease the defendant's burden and that periodic payments that terminate upon the plaintiff's death do not undercompensate or overcompensate tort victims as lump sum payments do. There appears, however, to be no valid reason for restricting periodic payments to medical malpractice torts.

In discussions of the medical malpractice crisis, attorneys are often perceived as the real profiteers.[23] Although there is evidence that attorneys have not profited excessively,[24] it is not surprising that many legislatures have acted to curb possibly excessive contingent fees.[25] Some legislatures have set specific limits,[26] others have adopted a policy of "reasonable" attorneys' fees to be approved by the court.[27] In addition, some legislatures have required that attorneys offer clients an option of paying a fee calculated on the basis of time spent on the case in lieu of the usual contingent fee arrangement.[28] Although these measures may

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21. NEWSWEEK, July 10, 1978, at 10-11.

22. *See, e.g.*, ALA. CODE tit. 6, § 5-486 (1975):

> [If a] judgment is in excess of $100,000.00 the court, in its discretion, may order that: (1) There shall be deducted from the award, and paid to the plaintiff an amount sufficient to cover his out-of-pocket expenses as well as his attorney's fee. (2) The remainder of the award shall be paid to the plaintiff in monthly installments in an amount calculated to provide the plaintiff a lifetime income.

FLA. STAT. ANN. § 768.51 (West Supp. 1977) provides that "[The court may allow periodic payments when] future losses exceed $200,000"; WIS. STAT. ANN. § 655.015 (West Supp. 1978) provides that

> [i]f a settlement, arbitration award or judgment under this chapter provides for future medical expense payments in excess of $25,000, that portion of future medical expense payments in excess of $25,000 shall be paid into the future medical expenses fund. The commissioner shall develop by rule a system for managing and disbursing such moneys through periodic payment for these expenses.

23. MEDICAL MALPRACTICE COMMISSION REPORT, *supra* note 16, at 32. For an insurance advertisement depicting over 50% of a personal injury award going to an attorney on a contingent fee arrangement, see NEWSWEEK, July 10, 1978, at 10-11.

24. MEDICAL MALPRACTICE COMMISSION REPORT, *supra* note 16, at 33.

25. 2 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE § 20.07, at 74 n.60 (1977 Supp.) lists the states that have adopted restrictions on attorneys' fees for medical malpractice cases: Arizona, California, Delaware, Hawaii, Idaho, Indiana, Iowa, Kansas, Maryland, Nebraska, New York, Ohio, Oregon, Pennsylvania, Tennessee, Washington, and Wisconsin.

26. *See, e.g.*, PA. STAT. ANN. tit. 40, § 1301.604(a) (Purdon Supp. 1978), which provides:

> When a plaintiff is represented by an attorney in the prosecution of his claim the plaintiff's attorney fees from any award made from the first $100,000 may not exceed 30%, from the second $100,000 attorney fees may not exceed 25%, and attorney fees may not exceed 20% on the balance of any award. . . .

IDAHO CODE § 39-4213 (1977) provides that "it shall be unlawful for such attorney or attorneys to charge or collect an unreasonably large fee; further, such a fee, including reimbursed expenses, which in the aggregate equals or exceeds forty per cent (40%) of amounts recovered or collected shall be presumed to be unreasonable and uncollectible."

27. *See, e.g.*, ARIZ. REV. STAT. § 12-568 (Supp. (1977); HAW. REV. STAT. § 671-2 (Supp. 1977); WASH. REV. CODE ANN. § 7.70.070 (Supp. 1977).

28. *See, e.g.*, WIS. STAT. ANN. § 655.013 (West Supp. 1978), which provides that "an attorney shall offer to charge any client in a malpractice proceeding or action on a per diem or per hour basis." PA. STAT. ANN. tit. 40, § 1301.604(b) (Purdon Supp. 1977) provides: "A plaintiff has the right to elect

well benefit clients, in most cases legislatures have set rather generous limits for contingent fees. It seems that these limits would only discourage attorneys from taking very small claims. Of course, legislatures that require court approval of attorneys' fees may, in reality, be imposing a stricter standard since courts may set less generous limits.

Overall, these legislative responses seem to be a poor way to deal with the medical malpractice crisis. From a plaintiff's perspective, the most objectionable response is establishment of a maximum amount recoverable. Policy arguments might be made on the wisdom of eliminating the collateral sources rule, eliminating the *ad damnum* clause, or allowing periodic payments. Legislatures, in adopting these measures for medical malpractice cases but not other torts, seem unwilling to consider the pervasive public policy issues in their haste to resolve the malpractice crisis.

II. SUBSTANTIVE MODIFICATION

The report of the Commission on Medical Malpractice[29] was submitted in 1973, before the medical malpractice problem ripened to a crisis in 1975 and 1976. Thus, the report's credibility and impact may have been enhanced. The Commission recommended legislative modifications in five areas to alter case law that had become, at least in the Commission's view, too favorable to plaintiffs. The five areas included (1) the length of the statute of limitations, (2) the discovery rule under the statute of limitations, (3) the doctrine of informed consent, (4) the doctrine of *res ipsa loquitur*, and (5) liability for breach of express contracts.[30] Not surprisingly, initial legislative attempts to stem the malpractice crisis modified not only the locality rule but also the substantive law in these areas. These substantive changes were designed to make plaintiffs' recoveries more difficult and could even eliminate their causes of action altogether.

A. *Statute of Limitations*

Some states have recently shortened their statutes of limitations for medical malpractice claims.[31] In addition, many states now limit the time that minors have to bring suit.[32] The statutory modification with greatest

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to pay for the attorney's services on a mutually satisfactory per diem basis." IND. CODE ANN. § 16-9.5-5-1b (Burns Supp. 1978) provides: "A patient has the right to elect to pay for the attorney's services on a mutually satisfactory per diem basis. The election, however, must be exercised in written form at the time of employment."

29. MEDICAL MALPRACTICE COMMISSION REPORT, *supra* note 16.

30. *Id.* at 27-31.

31. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 25, § 13, at 176-220 for the text of the new statute of limitations. For example, Florida modified its statute of limitations for medical malpractice cases (based on a negligence theory) from four to two years and Mississippi likewise shortened its statute from six to two years.

32. *See, e.g.*, ARIZ. REV. STAT. § 12-564 (Supp. 1977) ("[T]he applicable period of limitations

impact, however, has been elimination of the discovery rule or its restriction to a specified number of years.[33] Under the discovery rule, the statute of limitations commences with the time the tort was or should have been discovered.[34] The discovery rule is helpful to a plaintiff who is aware of a continuing medical problem such as abdominal pain but unaware that the cause of the pain is a surgical sponge that was not removed during previous surgery.[35] Although it is difficult for a medical malpractice claim to be defended years after the incident, it is also impossible for plaintiffs to bring suits before discovering the source of their medical problems. Out of concern for the problems of creating a defense, legislatures adopting this measure may be eliminating valid claims. A more reasonable legislative approach, although it is not completely free from difficulty, is the retention of the discovery rule when there has been intentional concealment of malpractice by the physician or a foreign object has been unintentionally left inside the patient.[36] Even this more limited statutory provision, however, might eliminate valid claims to which the discovery rule could apply.

B. Res Ipsa Loquitur

Another doctrine that has received attention during the medical malpractice crisis has been *res ipsa loquitur*, a term that describes a type of circumstantial evidence.[37] In order to use *res ipsa loquitur*, a plaintiff usually has to meet the following requirements:

> (1) The event must be of the kind which ordinarily does not occur in the absence of someone's negligence;
> (2) It must be caused by an agency or instrumentality within exclusive control of the defendant;

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begins to run when the minor reaches his or her seventh birthday or on death, whichever occurs earlier."); OHIO REV. CODE ANN. § 2305.11 (Page Supp. 1977) ("[A] minor who has not attained his tenth birthday shall have until his fourteenth birthday [to bring suit].")

33. For a general discussion of the timing of state statutes of limitations, see 1 D. LOUISELL & H. WILLIAMS, *supra* note 25, §§ 13.06-09, at 369-78. For examples of limitations even when the negligence might be undiscovered, see DEL. CODE tit. 18, § 6856 (Supp. 1977), which provides that

> solely in the event of personal injury the occurrence of which during such period of 2 years was unknown to and could not in the exercise of reasonable diligence have been discovered by the injured person, such action may be brought prior to expiration of 3 years from the date upon which such injury occurred . . . .

See also FLA. STAT. ANN. § 95.11 (West Supp. 1978) ("[I]n no event [shall the bringing of action] exceed seven years from the date the incident giving rise to the injury occurred."); LA. REV. STAT. ANN. § 9-5628 (West 1977) ("[I]n all events such claims must be filed at the latest within a period of three years from the date of the alleged act, omission, or neglect.").

34. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 30, at 144 (4th ed. 1971).

35. *See, e.g.*, Armstrong v. Wallace, 8 Cal. App. 2d 429, 47 P.2d 740 (1935).

36. *See, e.g.*, CAL. CIV. PROC. CODE § 340.5 (West Supp. 1978): "In no event shall the time for commencement of legal action exceed three years unless tolled for any of the following (1) upon proof of fraud, (2) intentional concealment, or (3) the presence of a foreign body . . . ."

37. W. PROSSER, *supra* note 34, § 39, at 213.

(3) It must not have been due to any voluntary action or contribution on the part of the plaintiff.[38]

Although there has been general agreement on the requirements for application of the *res ipsa loquitur* doctrine, there has been less agreement on its procedural effect.[39]

The doctrine of *res ipsa loquitur* can be especially useful for plaintiffs in medical malpractice cases. Patients do not have knowledge of the manner in which unexplained injuries were received, especially if they were unconscious during treatment. For example, plaintiffs in medical malpractice cases have used the doctrine of *res ipsa loquitur* when objects were left in a patient's body during surgery,[40] when an injury occurred to a part of the body remote from the treatment area,[41] or when unexplained burns were received during the course of treatment.[42]

The issue of *res ipsa loquitur* has been litigated in an increasing number of appellate decisions; some jurisdictions have expanded the doctrine.[43] In light of these trends, the federal Commission on Medical Malpractice hoped that "doctrines like *res ipsa loquitur* [would] not be expanded judicially to the point where liability of health care providers is based solely on circumstantial evidence of negligence."[44] The Commission, however, did not advocate complete elimination of this doctrine but felt that it should be applied in the same way in medical malpractice as in other areas of tort law.[45]

Although there have been several proposals for restricting the availability of the *res ipsa loquitur* doctrine,[46] only a few legislatures have actually passed statutory provisions. One approach adopted by at least two legislatures has been the enactment of statutes that specifically enumerate the factual situations in which *res ipsa loquitur* can be used.[47]

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38. *Id.* at 214. Prosser noted that in addition to the three conditions that "some courts have at least suggested a fourth condition, that evidence as to the true explanation of the event must be more readily accessible to the defendant than to the plaintiff." *Id.*

39. Comment, *The Application of Res Ipsa Loquitur in Medical Malpractice Cases*, 60 Nw. U.L. REV. 852, 854 (1966). For an earlier discussion of *res ipsa loquitur*, see Louisell & Williams, Res Ipsa Loquitur—*Its Future in Medical Malpractice*, 48 CAL. L. REV. 252 (1960).

40. Armstrong v. Wallace, 8 Cal. App. 2d 429, 47 P.2d 740 (1935).

41. Brown v. Shortlidge, 98 Cal. App. 352, 277 P. 134 (1929); Thomsen v. Burgeson, 26 Cal. App. 2d 235, 79 P.2d 136 (1938).

42. Meyer v. McNutt Hosp., 173 Cal. 156, 159 P. 436 (1916); Timbrell v. Suburban Hosp., 4 Cal. 2d 68, 47 P.2d 737 (1935).

43. MEDICAL MALPRACTICE COMMISSION REPORT, *supra* note 16, at 29. The Commission reported that *res ipsa loquitur* was considered in 13.4% of the appellate court cases decided in the period 1961-1971 as compared to 6.3% of the cases decided prior to 1950.

44. *Id.*

45. *Id.*

46. Comment, *supra* note 3, at 677.

47. *E.g.*, NEV. REV. STAT. § 41A.100 (1977):

[A] rebuttable presumption that personal injury or death was caused by negligence arises where evidence is presented that the personal injury or death occurred in any one or more of the following circumstances: (a) a foreign substance other than medication or a prosthetic device was unintentionally left within the body of a patient following surgery; (b) an

Unfortunately, it is very hard to enumerate all the factual situations in which the *res ipsa* doctrine would be appropriate. Another statutory provision, adopted by Texas, expressly states that the "doctrine of *res ipsa loquitur* shall only apply to health care liability claims against health care providers or physicians in those cases in which it has been applied by the appellate courts of this State as of this subchapter."[48] In essence, Texas wants no further expansion of the doctrine. These partial limitations on *res ipsa* are responsive to the Commission's concerns, for complete elimination might prevent a plaintiff from proving a valid claim of malpractice. Nevertheless, the statutes that enumerate fact situations probably still present difficulty for certain plaintiffs. Plaintiffs who possess the traditional common-law prerequisites for the application of the doctrine but lack the specific fact situation required by the statute lose the use of a valuable doctrine and possibly the lawsuit.[49] It would be better for legislatures to concentrate on formulating the necessary prerequisites for general application of this tort doctrine instead of enumerating special medical malpractice fact situations to which it can be applied.

C. *Doctrine of Informed Consent*

The doctrine of informed consent provides that "when a patient gives his express consent to a surgical procedure or a particular course of therapy the physician may nevertheless be held liable if the patient can show that he was not adequately informed of the risks and consequences of the operative procedure or course of therapy."[50] The basis of this doctrine, in the words of Judge Cardozo, is that "a person has a right to determine what will be done with his own body."[51]

Although it is difficult to dispute the patient's right to make informed decisions regarding his body, concern has been expressed about the recent evolution of the doctrine of informed consent.[52] For example, one article has commented that the doctrine of informed consent evolved in some jurisdictions from a physician's "duty not to make material misrepresentation concerning potential dangers to a duty to reveal all possible untoward

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explosion or fire originating in a substance used in treatment occurred in the course of treatment; (c) an unintended burn caused by heat, radiation or chemicals was suffered in the course of medical care; (d) an injury was suffered during the course of treatment to a part of the body not directly involved in such treatment or proximate thereto; or (e) a surgical procedure was performed on the wrong patient or the wrong organ, limb or part of a patient's body.

See also DEL. CODE tit. 18, § 6853 (Supp. 1977).

48. TEX. REV. CIV. STAT. ANN., art. 4590i (Vernon Supp. 1978).

49. It has been suggested that "*res ipsa* cases are easy for a plaintiff to present and enjoy a high measure of success." Comment, *supra* note 3, at 677.

50. MEDICAL MALPRACTICE COMMISSION REPORT, *supra* note 16, at 29.

51. Schloendoff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

52. *See* Plant, *The Medical Malpractice Crisis*, 20 LAW QUADRANGLE NOTES 12 (U. of Mich. Winter 1976).

results."[53] Alsobrook, citing four recent cases,[54] has suggested that the doctrine of informed consent is evolving from a medical standard to a legal standard.[55] Originally, the standard for informed consent was what physicians in the community or similar communities would disclose to the patient. Hence, expert testimony was needed. Recently, some jurisdictions have formulated the standard of informed consent to emphasize what the patient needs to know instead of what physicians normally disclose. When the emphasis is on the patient's need to know, expert testimony is not required to establish the standard.[56] The Commission on Medical Malpractice pointed to an increasing number of cases employing the informed consent doctrine.[57] The Commission's specific concern centered upon "evidence that courts are beginning to apply the doctrine unevenly in order to hold a physician liable when the patient's injury is severe but he lacks sufficient evidence to prove the physician was negligent."[58] The Commission, therefore, did not wish to eliminate the doctrine of informed consent but did hope to eliminate its "uneven application."[59] Although perspectives may differ on the evolution of the informed consent doctrine, there is general agreement that the doctrine has become increasingly useful to plaintiffs. In fact, one authority has commented that the doctrine has grown so favorable to plaintiffs that it has become routine to include a count charging lack of informed consent in any medical malpractice complaint.[60]

Several states have enacted statutes that make the doctrine of informed consent less favorable to plaintiffs.[61] One approach has been to codify limitations on the doctrine and possible defenses. For example, the New York statute

> creates several limitations. First, such cases may be brought only after non-emergency therapy or diagnostic procedures which involve invasion or

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53. Comment, *supra* note 3, at 675.

54. Canterberry v. Spence, 464 F.2d 772 (D.C. Cir. 1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972); Fogal v. Genesee Hosp., 41 App. Div. 2d 468, 344 N.Y.S.2d 552, *aff'd mem.*, 345 N.Y.S.2d 989 (1973).

55. Alsobrook, *Informed Consent: A Right to Know*, 40 INS. COUNSEL J. 580 (1973). For additional discussion of the informed consent doctrine, see Marks, *Informed Consent in Medical Malpractice Cases*, in DEFENSE RESEARCH INSTITUTE, DEFENSE OF MEDICAL MALPRACTICE CASES 57 (D. Hirsch ed. 1977); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970).

56. Alsobrook, *supra* note 55, at 587. Alsobrook notes that although expert testimony is not necessary to establish the standard, it still is important in deciding the "ultimate issue." *Id.*

57. MEDICAL MALPRACTICE COMMISSION REPORT, *supra* note 16, at 29.

58. *Id.*

59. *Id.* at 30.

60. Plant, *supra* note 52, at 15.

61. *See, e.g.*, ALASKA STAT. § 09.55.556 (Supp. 1976); DEL. CODE tit. 18, § 6852 (Supp. 1977); FLA. STAT. ANN. § 768.132 (West Supp. 1978); HAW. REV. STAT. § 671-3 (1976); IDAHO CODE §§ 39-4301 to 4306 (1977); IOWA CODE § 147.137 (Supp. 1977); LA. REV. STAT. ANN. § 40.1299.40 (West 1977); N.Y. PUB. HEALTH LAW § 2805d (McKinney 1977); NEV. REV. STAT. §§ 41A-110 to 120 (1977); OHIO REV. CODE ANN. § 2317.54 (Page Supp. 1977); R.I. GEN. LAWS § 9-19-32 (Supp. 1977); TENN. CODE ANN. § 23-3417 (Supp. 1977); UTAH CODE ANN. 78-14-5 (1977).

> disruption of the integrity of the body. Second, expert medical testimony is required and the burden of proof is on the plaintiff to prove lack of informed consent. Third, it sets up four defenses (common knowledge of the risk; patient's willingness to take the risk or unwillingness to be informed of it; consent not reasonably possible; reasonable expectation of adverse effect of disclosure) not always recognized by the courts.[62]

Another approach to informed consent has been to formalize the procedural significance of consent forms signed by patients. For example, Iowa prescribes specifications that a written consent must meet;[63] if the requirements are met, there is a rebuttable presumption that informed consent has been given.[64] Louisiana has gone even further and established a signed consent form that creates a presumption of informed consent that can only be rebutted by evidence that the signing of the form "was induced by misrepresentation of material facts."[65]

There has been general criticism of the judicial evolution of the informed consent doctrine.[66] On the other hand, the use of a written consent form to establish a statutory presumption of informed consent deserves censure. A hospitalized patient is not likely to demand, or even understand, his legal rights; "[a] routine procedure established by law to obtain a consensual signature does not guarantee that a patient has knowledgeably agreed to treatment."[67] There can be reasonable disagreement about the wisdom of a statute such as New York's,[68] which clearly allows the medical community to set the standards for informed consent. This writer believes that legislatures should not accord such power to the medical community despite the malpractice crisis. Patients' rights would appear to be much better protected when the standard for informed consent is formulated by a less self-interested group than the medical community.

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62. Plant, *supra* note 52, at 15.

63. IOWA CODE § 147.137 (Supp. 1977). This statutory provision requires that a written consent, in order to create the presumption,

> 1. [s]ets forth in general terms the nature and purpose of the procedure or procedures together with the known risks if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures, with the probability of each such risk as reasonably determinable.
> 2. Acknowledges that the disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.
> 3. Is signed by the patient for whom the procedure is to be performed, or if the patient for any reason lacks legal capacity to consent, is signed by a person who has legal authority to consent on behalf of that patient in those circumstances.

64. *Id.*

65. LA. REV. STAT. ANN. § 40:1299.40 (West 1977).

66. *See, e.g.*, Plant, *supra* note 52, at 15.

67. Comment, *supra* note 3, at 678.

68. This statute has been described as an "improvement in the present situation." Plant, *supra* note 52, at 15.

D. *Locality Rule*

During the crisis, legislatures have become concerned with the locality rule. In its earliest form, the locality rule provided that a physician should be held only to the standard of care that prevailed in the very community in which he practiced.[69] This rule completely shielded sole practitioners in a community from liability. Even in communities with more than one physician, however, it was extremely difficult for plaintiffs to elicit expert testimony on community standards because of the well-known "conspiracy of silence" among physicians.[70] Some jurisdictions never accepted this earliest version of the locality rule, apparently because of its harshness. Gradually, most jurisdictions adopted a standard of care that related to prevailing practices in similar communities.[71] Even this modified version of the locality rule was whittled away by exceptions; the complete demise of the locality rule had in fact been predicted.[72]

The medical malpractice crisis has created a resurgence in the locality rule. In order to emphasize that physicians should only be held to the standard of care prevalent in the same or a similar community, a few states have codified the locality rule.[73] At least one state legislature enacted the locality rule as the standard of medical care available in either the community or the state, as "appropriate."[74]

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69. W. PROSSER, *supra* note 34, § 32, at 164; Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408 (1969). For additional discussion of the locality rule, see Decyk & Hirsch, *The Medical Standard of Care*, in DEFENSE RESEARCH INSTITUTE, DEFENSE OF MEDICAL MALPRACTICE CASES 29 (D. Hirsch ed. 1977); Comment, *Medical Malpractice—The Locality Rule and the Conspiracy of Silence*, 22 S. C. L. REV. 810 (1970).

70. Comment, *supra* note 69, at 817.

71. *Id.*

72. "[I]t is a safe prognostication of the law's future direction to say the locality rule, long in the process of shrinking, will gradually disappear almost completely." Waltz, *supra* note 69, at 415.

73. Alabama requires "such reasonable care, diligence and skill as physicians, surgeons, and dentists in the same general neighborhood, or the same general line of practice . . . ." ALA. CODE tit. 6, § 5-484 (1975). The Louisiana standard is

> the degree of knowledge or skill possessed or the degree of care ordinarily exercised by physicians or dentists practicing in the same community or locality to that in which the defendant practices; and where the defendant practices in a particular specialty and where the alleged acts of medical negligence raise issues peculiar to the particular medical specialty involved then the plaintiff has the burden of proving the degree of care ordinarily practiced by physicians or dentists within the involved medical specialty.

LA. REV. STAT. ANN. § 9-2794 (West Supp. 1978). Tennessee prescribes "the recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which he practices or in a similar community at the time the alleged injury or wrongful death occurred." TENN. CODE ANN. § 23-3414 (Supp. 1977).

74.

> [The standard of care to be applied is] the degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth; provided, however, that the standard of care in the locality or in similar localities in which the alleged act or omission occurred may be applied if, after considering the health care services and health care facilities available in such locality or similar localities and the customary practice in such locality or other similar localities, it is determined that the local standard of care is more appropriate than the statewide standard.

VA. CODE § 8.01-5.81.12:1 (1977).

Although codifications of the locality rule might perhaps be defended as a realistic appraisal of the degree of expertise a patient can expect from a physician, they are nevertheless highly vulnerable to criticism. With improved educational opportunities and communication[75] there is little justification for a small town doctor to be less expert than a metropolitan area doctor claiming the same degree of specialization. Although facilities in some small towns might perhaps be underequipped, modern transportation ordinarily allows access to better-equipped facilities. Furthermore, these codifications impede achievement of higher standards. "Where the standard of care in a community lags behind modern medical developments to the point that the whole medical community's practice approaches negligence, the locality rule becomes unfair."[76] Legislatures contemplating revival of the locality rule should critically consider its ramifications.

E. *Breach of Contract*

The Commission on Medical Malpractice expressed concern about the use of contract theory in medical malpractice cases.[77] Typically, a contract action in medical malpractice alleges a breach by the physician of an oral promise for good results or cure. The Commission found that "[w]ith increasing frequency"[78] plaintiffs were turning to a contract theory of recovery, especially when the statute of limitations had run on their negligence actions. Statutes of limitations are generally longer for contract actions than for negligence actions.[79] The Commission succinctly stated its concern:

> Where an oral guarantee of good results is actually made and proved, the courts have permitted recovery of damages on the basis of breach of contract. In some instances, however, courts are unfairly allowing stale malpractice cases to be pursued under a contract theory solely to permit damages to be awarded to injured patients. While those cases are few in number, the Commission is concerned that they do not become a precedent that would expand unduly the area of professional liability.[80]

Although the Commission did not make specific recommendations, some states have adopted a statute of frauds provision to permit an action based on a promise of good results only if the promise is in writing.[81]

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75. W. PROSSER, *supra* note 34, § 32, at 165, comments that these societal changes led to the "abandonment" of any fixed locality rule.

76. Comment, *supra* note 3, at 678.

77. MEDICAL MALPRACTICE COMMISSION REPORT, *supra* note 16, at 30.

78. *Id.*

79. *Id.*

80. *Id.*

81. *See, e.g.*, ALASKA STAT. § 09.55.547 (Supp. 1976); DEL. CODE tit. 18, § 6851 (Supp. 1977); FLA. STAT. ANN. § 725.01 (West Supp. 1978); IND. CODE ANN. § 16-9.5-1-4 (Burns Supp. 1978); KY. REV. STAT. ANN. § 304.40-300 (Baldwin Supp. 1977); LA. REV. STAT. ANN. § 40:1299.41C (West 1977);

These measures do allow a physician to be optimistic and provide psychological support without fear of a lawsuit. On the other hand, a physician may have induced a patient to use his services by unfulfilled, perhaps unfulfillable, promises of success. Patients are likely to be unaware of the statutory requirement, or reluctant to ask the physician for a writing. Therefore, such statutes effectively eliminate a contractual cause of action for breach of a promise of good results. A more carefully drafted statutory provision might address concerns expressed by the Commission on Medical Malpractice without eliminating a valid cause of action in contract. For example, the statute of limitations for breach of an express contract in medical malpractice cases could be made coterminous with the statute of limitations for the negligence action. A plaintiff would thus be unable to pursue a stale negligence claim in the guise of a contract action, but contract theory would remain available when specific facts warrant its use.

F. *Summary*

To be fair, substantive law must reflect the competing equities of plaintiffs and defendants in medical malpractice cases. Legislatures, however, have tended to enact statutes that disproportionately favor defendants. Because substantive law changes may completely eliminate a plaintiff's cause of action, they have potentially greater impact on the affected plaintiffs than statutory provisions that limit financial recovery. An equitable solution to the medical malpractice crisis will not be achieved by eliminating valid recoveries. Because of the possibly severe impact of these changes in substantive tort law, legislatures should carefully consider the consequences of such modifications.

III. Screening Panels and Arbitration Boards

A. *Screening Panels*

In the wake of the medical malpractice crisis, many states have formulated screening panels to evaluate the validity of claims prior to trial.[82] Although their structures and procedural effects vary,[83] the panels are designed to eliminate litigation and thereby reduce costs.

OHIO REV. CODE ANN. § 1335.05 (Page Supp. 1977); PA. STAT. ANN. tit. 40, § 1301.606 (Purdon Supp. 1977); UTAH CODE ANN. § 78-14-6 (1977).

82. Screening panels have been adopted by statute in the following states: Alaska, Arizona, Arkansas, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Missouri, Nebraska, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Virginia, and Wisconsin. 2 D. LOUISELL & H. WILLIAMS, *supra* note 25, § 20.07, at 74 n.61.

83. For discussion of screening panels, see A. HOLDER, MEDICAL MALPRACTICE LAW 408-13 (2d ed. 1977); Gibbs, *The Montana Plan for Screening Medical Malpractice Claims*, 36 MONT. L. REV. 321 (1975); Harlan, *Virginia's New Medical Malpractice Review Panel and Some Questions It Raises*, 11 U. RICH. L. REV. 51 (1976); Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York: An Alternative to Litigation*, 2 HOFSTRA L. REV. 261 (1974); Comment, *supra* note 3; Comment, *Medical-Legal Screening Panels as an Alternative Approach to Medical*

It has been suggested that screening panels will weed out invalid claims.[84] Plaintiffs retain the option of proceeding to trial even when the panel's finding has not been favorable to them, but unfavorable findings by screening panels may discourage plaintiffs from pursuing their claims.[85] On the other hand, screening panels can encourage settlement of valid claims. If the panel's finding is unfavorable to the defendant, the defendant or, in the usual case, the defendant's insurer is more likely to settle a valid claim without litigation.[86]

Although the purpose of screening panels is to reduce costs, it is nevertheless possible that employment of mandatory screening panels might actually increase costs.[87] If the screening panel becomes a required additional step in the litigation process, then panel-related expenditures for expert testimony and attorneys' time could significantly increase the cost of bringing or defending medical malpractice actions. Only if it effectively eliminates later litigation can the screening panel reduce costs.

The effectiveness of the screening panel has not been conclusively demonstrated, but a study was recently undertaken to compare screening panels in New Mexico, New York, New Jersey, and Pennsylvania.[88] The study's major conclusion was that the panel must be mandatory for all medical malpractice cases in order to be effective, since nonmandatory panels are ignored.[89] In addition, the study stressed that the panel "must be equitable and offer the parties and their attorneys a real alternative to a jury trial."[90]

Malpractice Claims, 13 WM. & MARY L. REV. 695 (1972); Note, *The New Mexico Medico-Legal Malpractice Panel—An Analysis*, 3 NEW MEX. L. REV. 311 (1973).

84. A. HOLDER, *supra* note 83, at 408; Comment, *supra* note 3, at 679.

85. A. HOLDER, *supra* note 83, at 410; Comment, *supra* note 3, at 681.

86. A. HOLDER, *supra* note 83, at 409-10.

87. Comment, *supra* note 3, at 681. See Wade, *A Conspectus of Manufacturers' Liabilities for Products*, 9 THE REPORTER 3, 11 (1978) for a discussion of screening panels in products liability cases.

88. INSTITUTE OF JUDICIAL ADMINISTRATION AND AMERICAN BAR ASSOCIATION, MEDICAL MALPRACTICE PANELS IN FOUR STATES (1977) [hereinafter cited as MALPRACTICE PANELS].

89. *Id.* at 42.

90. *Id.* Although this study concluded that the data were insufficient to determine precisely how screening affected case disposition, it identified characteristics of the panels that disposed of the greatest number of cases. The study recommended that panels should be mandatory for all medical malpractice claims, and proposed the following:

1. Panels must decide liability and damages
2. Legislation must give "teeth" to panel findings
3. The panel chairperson must be disposition-oriented and have the authority to control the procedure
4. Panel members must have medical and legal expertise
5. Panelists' performances must be reviewed
6. Parties must be able to object to panelists for due cause
7. Materials must be as complete as the expert panelists think necessary
8. Procedures must be informal with open questioning and discussion
9. Panels must discuss all findings with the parties
10. Panel hearings and their findings should be confidential
11. Complete data must be kept on panel outcomes
12. Panelists should be given immunity from civil suit for actions performed in connection with panel duties
13. Panel members, except the chairperson, need not be paid.

Id. at 39-42.

Unlike legislative modifications discussed earlier in this Comment, impartial screening panels could eventually benefit both plaintiffs and defendants. Although their effectiveness has yet to be confirmed empirically, screening panels seem fairer than the harsh and mechanical statutory limitations on causes of action and recoveries that have recently been adopted by legislatures attempting to cope with the malpractice dilemma.

B. *Arbitration Boards*

Arbitration boards have also been proposed to reduce litigation in medical malpractice cases[91] and are in fact available in several states.[92] It is crucial, however, to distinguish between binding and nonbinding arbitration. After an unfavorable *nonbinding* arbitration decision, the plaintiff is free to pursue his case in a trial de novo. Hence, a system of nonbinding arbitration is indistinguishable from a screening panel system.[93] A plaintiff who agrees to *binding* arbitration must abide by the decision of the arbitration board and forego any judicial remedies.[94]

Statutory schemes differ in their requirements of when the victim must agree to binding arbitration. The plaintiff who agrees to binding arbitration after the injury has occurred is likely to have consulted with an attorney about the desirability of arbitration. Attorneys, however, are likely to recommend against arbitration unless the board is perceived as impartial and its awards are commensurate with jury verdicts.[95] Additionally, attorneys are likely to be wary of binding arbitration since there is no right of appeal.[96] When the statute permits post-injury election, contact with counsel educates the patient about the availability of binding arbitration but at the same time serves to dissuade the patient from electing arbitration.

More difficult issues are raised by statutory schemes that allow the plaintiff to agree to binding arbitration prior to the incident of alleged medical malpractice.[97] Typically, patients sign the agreement for binding

91. For discussion of arbitration, see A. HOLDER, *supra* note 83, at 413-20; Coulson, *Arbitration of Medical Malpractice Claims*, 3 OHIO N. L. REV. 507 (1975); Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, 58 VA. L. REV. 947 (1972); Comment, *Medical Malpractice Arbitration: A Comparative Analysis*, 62 VA. L. REV. 1285 (1976).

92. Arbitration for medical malpractice claims has been the subject of legislation in the following states: Alabama, Alaska, California, Illinois, Louisiana, Michigan, Ohio, South Dakota, Vermont, Virginia, and Wisconsin. For an overview of these arbitration systems, see Ladimer, *Statutory Provisions for Binding Arbitration of Medical Malpractice Claims*, 1976 INS. L. J. 405.

93. Comment, *supra* note 3, at 682.

94. A. HOLDER, *supra* note 83, at 413.

95. The Institute of Judicial Administration reported that attorneys tended to "distrust" screening panels and did not use them unless they were made mandatory. It seems likely that the same would be true of arbitration boards. MALPRACTICE PANELS, *supra* note 88, at 39.

96. A. HOLDER, *supra* note 83, at 413.

97. For an example of a statutory provision allowing an agreement to arbitrate to be formulated prior to treatment, see OHIO REV. CODE ANN. §§ 2711.22-.24 (Page Supp. 1977). Under the statute, the patient has a right to withdraw from the agreement within a specified period of time.

arbitration as part of the routine procedure for admission to a hospital. In an empirical study conducted in California, "400,000 patients in the 9 participating hospitals signed arbitration clauses on the admissions form and only 200-300 refused to do so."[98] Those who refused were "lawyers, lawyers' wives and legal secretaries."[99] One commentator has suggested that "this group was the only one operating with any genuine understanding of the implications of the clause."[100] Patients signing these arbitration agreements prior to treatment probably do not understand that they are foregoing their right to judicial remedies in the event of medical malpractice.

Since the understanding and possibly even the voluntariness of pretreatment consent to arbitration is questionable, grave doubts are raised about its constitutionality. Whatever the disposition of the constitutional issues, the effectiveness of binding arbitration has yet to be precisely determined. Although binding arbitration, like the screening panel, inherently favors neither plaintiff nor defendant, boards might possibly be biased in actual operation. The use of arbitration systems to resolve medical malpractice disputes deserves further study.

IV. CONSTITUTIONAL ISSUES

The constitutionality of tort law modifications relating to medical malpractice has been questioned extensively by commentators.[101] Few state high courts have rendered decisions on point; lower courts have split, even within a given state.[102] The United States Supreme Court has not yet spoken, but might conceivably address these issues before too long.

A. *Constitutionality of Screening Panels*

The legislative innovation most frequently subjected to constitutional challenge is the screening panel,[103] which, from a plaintiff's perspective, would seem one of the less objectionable contemporary tort law modifications. Perhaps the novelty and broad impact of the screening

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98. A. HOLDER, *supra* note 83, at 418.

99. *Id.*

100. *Id.*

101. *See, e.g.*, Harlan, *supra* note 83; Note, *Constitutional Perspective on the Indiana Malpractice Act*, 51 IND. L.J. 143 (1975); Note, *The Indiana Malpractice Act: Legislative Surgery on Patients' Rights*, 10 VAL. U.L. REV. 303 (1976); Note, *Medical Malpractice—Constitutionality of Limits on Liability*, 78 W. VA. L. REV. 381 (1975).

102. For a discussion of decisions in Ohio, see Knepper, *Review of 1976 Tort Trends*, 26 DEF. L.J. 1, 15 (1977).

103. Eastin v. Broomfield, 116 Ariz. 576, 570 P.2d 744 (1977); Carter v. Sparkman, 335 So.2d 802 (Fla. 1976); Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); Paro v. Longwood Hosp., 369 N.E.2d 985 (Mass. 1977); Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977); State *ex rel.* Strykowski v. Wilkie, 81 Wis. 2d 491, 261 N.W.2d 434 (1978).

panels have attracted these attacks, which have for the most part proved unsuccessful.[104]

Some jurisdictions require mandatory submission of the claim to the panel before a complaint may be filed. It has been argued that such mandatory submission is a denial or restriction of the right of access to the courts. The Nebraska Supreme Court in *Prendergast v. Nelson*[105] rebutted this argument: "Claimants are not denied access to the courts [but] merely required to follow a certain procedure before submitting their claims to the courts." The Florida Supreme Court, in *Carter v. Sparkman*,[106] expressed similar sentiments: "Although courts are generally opposed to any burden being placed on the rights of aggrieved persons to enter the courts because of the constitutional guaranty of access, there may be reasonable restrictions prescribed by law."

An equal protection argument has also been utilized: medical malpractice victims are denied equal protection because the law requires mandatory submission of their claims to panels and does not require submission of claims of other tort victims. Two courts that have entertained the equal protection challenge found that screening panels did not violate equal protection.[107] Both courts found the classification permissible under the rational basis test.[108]

Plaintiffs in *Paro v. Longwood Hospital* raised an argument of substantive due process, contending that a legislature can not abrogate a common law right without providing a substitute.[109] The court believed that introduction of the screening panel did not change any substantive rights but merely modified the procedure that a plaintiff must follow. Even assuming, *arguendo*, that substantive rights had been eliminated, the *Paro* court suggested that the panel would serve as an effective substitute and thus invalidate the substantive due process objection to the screening panel.[110]

It has been urged that the screening panel is an unconstitutional usurpation of judicial authority. The Arizona Supreme Court rejected this argument, holding that there was no violation because the plaintiff could obtain a trial de novo.[111] One court, however, has found the screening panel unconstitutional on a similar theory. The Illinois

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104. The screening panel was, however, found unconstitutional in Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

105. 199 Neb. 97, 103, 256 N.W.2d 657, 663 (1977).

106. 335 So.2d 802, 805 (Fla. 1976).

107. Eastin v. Broomfield, 116 Ariz. 576, 570 P.2d 744 (1977); Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).

108. "[T]he classification must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of legislation, so that all persons similarly circumstanced shall be treated alike." Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920).

109. 369 N.E.2d 985, 991 (Mass. 1977).

110. *Id.*

111. Eastin v. Broomfield, 116 Ariz. 576, 580-81, 570 P.2d 744, 748-49 (1977).

Supreme Court found that the panel had been impermissibly vested with a judicial function that, according to the state constitution, must be vested exclusively in the courts.[112] In making its ruling, the Illinois court may have taken into account the specific functions and characteristics of the Illinois panel. The Illinois legislature had provided that the panel should make its decision according to substantive law and determine damages. Furthermore, the plaintiff and the defendant could choose to be bound by the panel's decision.[113] The court, having found that the panel had been unconstitutionally vested with a judicial function, said that it followed that the panel was an impermissible restriction on the right to trial by jury.[114] The Illinois court left the door open, however: "Because we have held that these statutes providing for medical review panels are unconstitutional . . . we do not imply that a valid pretrial panel procedure cannot be devised."[115]

It has been asserted that to allow submission of panel's findings as evidence in subsequent jury trials denies the constitutional right to trial by jury. The argument is that the jury will be unduly influenced by the panel's finding and will be unable to render a truly independent judgment.[116] The courts facing this argument have concluded, however, that juries would be able to maintain a proper perspective on the weight to be accorded the panel's findings.[117]

Although screening panels per se have generally been found constitutional, objectionable features of particular screening panel procedures have been struck down. For example, the Arizona statute requirement to be a violation of access to the courts and therefore before proceeding to trial. The Arizona Supreme Court found the bond requirement to be a violation of access to the courts and therefore unconstitutional.[118] The Florida Supreme Court construed the Florida statute to avoid an equal protection violation. The statute allowed the screening panel's finding to be admitted into evidence at a later trial when the plaintiff and defendant had both participated in the hearing before the screening panel. The Florida statute was silent, however, about the effect of a defendant's nonparticipation in the screening panel's proceedings. The Florida court construed the statute to allow the fact of the

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112. Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 321-22, 347 N.E.2d 736, 739-41 (1976).

113. For a brief overview of the Illinois panel and a discussion of the *Wright* case, see Stewart, *Constitutionality of Remedial Legislation in the Field of Professional Liability*, 18 FOR THE DEFENSE 73 (1977).

114. Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 324, 347 N.E.2d 736, 741 (1976).

115. *Id.*

116. Eastin v. Broomfield, 116 Ariz. 576, 581, 470 P.2d 744, 749 (1977); Prendergast v. Nelson, 199 Neb. 97, 109-10, 256 N.W.2d 657, 666 (1977).

117. *Id.*

118. Eastin v. Broomfield, 116 Ariz. 576, 585-86, 570 P.2d 744, 753-54 (1977).

defendant's nonparticipation in the screening panel's proceedings to be admitted into evidence at a later trial.[119]

B. *Constitutionality of Limitations on Recovery*

In *Wright v. Central DuPage Hospital*[120] the Illinois Supreme Court considered the constitutionality under the Illinois and federal constitutions of the Illinois statutory provision limiting recovery in medical malpractice actions to $500,000. Plaintiffs had argued that the law denied equal protection because it drew an impermissible distinction between them and less seriously injured victims of medical malpractice who could recover fully. The court agreed and found the provision violative of the equal protection clause of the state constitution. The court declined to consider whether the statute violated the equal protection clause of the federal constitution.[121]

The North Dakota statutory recovery limit of $300,000 was challenged in *Arneson v. Olson*.[122] The North Dakota Supreme Court found that this statutory ceiling on recovery violated the equal protection clause not only of the state constitution but also of the United States Constitution.[123] When Idaho's statutory ceiling on medical malpractice recovery was challenged, in *Jones v. State Board of Medicine*,[124] the Idaho Supreme Court faced both equal protection and substantive due process arguments. The Idaho Supreme Court avoided ruling on the merits and remanded the case for further factfinding and conclusions.

Although the Nebraska Supreme Court, deciding *Prendergast v. Nelson*,[125] upheld the constitutionality of the state statutory limitation of recovery to $500,000, its decision is not necessarily inconsistent with *Arneson*, *Wright*, and *Jones* because the Nebraska statute clearly differs from the statutory provisions in Illinois, North Dakota, and Idaho. In Nebraska, the statutory limit on recovery is elective. If the plaintiff chooses to proceed under the Hospital-Medical Liability Act and hence be assured of the availability of funds for any judgment, he must agree to the recovery limitation. If, however, the plaintiff does not follow Hospital-Medical Liability Act procedure, he is not bound by any upper limit. Although this statutory limit was challenged as a special privilege, the Nebraska Supreme Court in rejecting this challenge emphasized the elective nature of the limit.[126]

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119. Carter v. Sparkman, 335 So.2d 802, 805 (Fla. 1976).
120. 63 Ill. 2d 313, 347 N.E.2d 736 (1976).
121. *Id.* at 329-30, 347 N.E.2d at 743.
122. 270 N.W.2d 125 (N.D. 1978).
123. *Id.* at 135-36.
124. 97 Idaho 859, 876, 555 P.2d 399, 416 (1976), *cert. denied*, 431 U.S. 914 (1977).
125. 199 Neb. 97, 114-15, 256 N.W.2d 657, 668-69 (1977).
126. *Id.*

Two of the few constitutional challenges to statutory ceilings on recovery for medical malpractice have been clearly successful. Thus, the constitutionality of such ceilings, especially if they are mandatory, is questionable.

C. *Constitutionality of Other Provisions*

Other provisions of the legislation spawned by the malpractice crisis have been challenged sporadically. The Wisconsin Supreme Court has held that a provision authorizing periodic payments from the patient compensation fund when awards exceeded one million dollars was reasonable and did not violate the fourteenth amendment equal protection clause.[127] Two recent cases upheld the constitutionality of statutes of limitations[128] but in neither was elimination or restriction of the discovery rule at issue.[129]

The constitutionality of the abrogation of the collateral sources rule also has been challenged.[130] The Arizona Supreme Court found the provision allowing evidence of collateral sources violated neither the due process and equal protection clauses of the United States Constitution nor the provision of the state constitution that proscribed limits on recoveries for personal injuries or death.[131] The Nebraska statute governing

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127. State *ex rel.* Strykowski v. Wilkie, 81 Wis. 2d 491, 261 N.W.2d 434 (1978). The Wisconsin statutory scheme allowed periodic payments from the patient compensation fund established for the benefit of malpractice victims. The court held that "[d]elayed payment of very large awards is not inimical to the interest of the claimant, and protects the fund from the effect of catastrophic awards or judgments which would otherwise threaten the solvency of the fund. These provisions are reasonable." *Id.* at 511, 261 N.W.2d at 443.

128. Cioffi v. Guenther, 370 N.E.2d 1003 (Mass. 1977); Taylor v. Karrer, 196 Neb. 581, 244 N.W.2d 201 (1976). In *Taylor*, the plaintiff attempted to bring the lawsuit after the statute of limitations had run. The court in its opinion specifically expressed approval of the discovery rule but noted that the facts of the case did not indicate any difficulty in discovering the alleged negligence. Specifically, the court held that the two year statute of limitations did not violate the state constitution as special legislation even though this statute of limitations was only applicable to "professional negligence." The court also held that this statute was not void for vagueness.

The *Cioffi* case presented a more difficult issue. The applicable Massachusetts statute of limitations in effect prior to January 1, 1976 imposed a three year limitation, but a minor had until his eighteenth birthday to bring his action. In 1975, however, the legislature approved a new statute of limitations effective January 1, 1976. This new statute still allowed a three year limitation, but a minor under the age of six was given only until his ninth birthday to bring an action. Plaintiff brought an action on December 28, 1976 for an alleged act of negligence that had occurred in 1971 when he was nine. Plaintiff argued in vain that the statute of limitations that became effective on January 1, 1976 could not constitutionally be applied to him. The Massachusetts Supreme Court held that a shortened statute of limitations can constitutionally be applied to an accrued cause of action as long as sufficient time is allowed after the enactment of the statute of limitations for persons to bring their action. In this case the court held that the legislature had allowed sufficient time and therefore the statute was applicable to the plaintiff.

129. For a lower state court decision on this issue, see Woodward v. Burnham City Hosp., 60 Ill. App. 3d 285, 377 N.E.2d 290 (1978), holding the four year statute of limitations for medical malpractice unconstitutional as special legislation violative of the Illinois constitution.

130. Eastin v. Broomfield, 116 Ariz. 576, 583-85, 570 P.2d 744, 751-53 (1977); Prendergast v. Nelson, 199 Neb. 97, 115-17, 256 N.W.2d 657, 669 (1977).

131. 116 Ariz. 576, 583-85, 570 P.2d 744, 751-53 (1977). The Arizona Supreme Court stated that this statutory provision did not deprive the plaintiff of any property protected by due process and

collateral sources has also been challenged. In Nebraska if the plaintiff elects to proceed under the Hospital-Medical Act procedure and be assured of funds for any judgment, the statute requires that any recovery be reduced by any nonrefundable insurance benefits that the plaintiff receives.[132] The Nebraska Supreme Court held that this statute did not violate the state constitution's stricture against impairment of the obligation of contract. The court concluded there was nothing in this collateral sources rule that impaired any contract, and commented favorably that the legislative purpose was to avoid windfalls for the plaintiff.[133] In the same decision, the court held that the legislature had the power to subject attorneys' fees to court review.[134]

D. Arneson v. Olson: *A Change of Direction?*

Although the few decisions in the highest state courts show a clear trend toward finding tort law modifications constitutional, one recent case, *Arneson v. Olson*,[135] swims against this tide. North Dakota's medical malpractice statute, like most, dealt with several problems simultaneously. It imposed a ceiling on recovery and modified the doctrines of informed consent, *res ipsa loquitur*, and collateral sources. Rather than analyzing the constitutionality of each of these provisions separately as other courts had done, the North Dakota Supreme Court considered the cumulative effect of these provisions and held them violative of patients' due process rights, hence unconstitutional.[136] The court's opinion acknowledges that individually some of these provisions would meet the test of constitutionality. The court correctly perceived that the aggregated provisions of medical malpractice legislation may well raise constitutional questions that individual provisions do not. The court reasoned that the act would

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further held the provision was not so unreasonable that it would violate due process. The court asserted that

> [t]he rule was intended by the legislature to give the jury the true extent of the damages sustained by the plaintiff thereby. By scaling down the size of jury verdicts by the amount of collateral benefits the plaintiff may have received, the legislature could reasonably assume that a reduction in premiums would follow.

Id. at 585, 570 P.2d at 753. The opinion of the court did not directly address the serious equal protection problem of differential treatment of medical malpractice victims.

132. Plaintiff received credit for any insurance premiums that he had paid.

133. 199 Neb. 97, 115-17, 256 N.W.2d 657, 669 (1977). In its decision the court discussed the elective nature of the remedy. The court stated, however: "Even if the remedy were not elective, this provision would be in the same category as the ceiling provided by the act and is justified by reason of the public purpose sought to be served by the act." *Id.* at 116, 256 N.W.2d at 669. This statement underscores the very favorable treatment that this "medical malpractice" legislation has initially received in the courts.

134. 199 Neb. 97, 116-17, 256 N.W.2d 657, 669-70 (1977). This court reasoned that since attorneys are court officers, subjecting their fees to court review is "not out of line with existing practice." *Id.* at 117, 256 N.W.2d at 669.

135. 270 N.W.2d 125 (N.D. 1978).

136. *Id.* at 137.

not have been enacted without the unconstitutional sections and therefore found the entire act unconstitutional.[137]

In its opinion, the North Dakota Supreme Court expressly discussed the absence of a malpractice crisis in North Dakota,[138] a circumstance that might have figured prominently in the decision. Courts elsewhere may have been understandably reluctant to strike down legislation that was passed in an attempt to deal with a genuinely critical social problem. Nevertheless, as the malpractice crisis stabilizes[139] or more effective solutions than tort law modifications are found, courts in other states seem likely to follow North Dakota's lead. Instead of being an aberrational decision, *Arneson v. Olson* may augur a more critical judicial attitude toward the constitutionality of tort law modifications.

V. Persistent Issues and Potential Solutions

It is highly doubtful that the public actually desires to have medical malpractice victims go unrecompensed, despite its eagerness to alleviate the medical malpractice crisis and maintain high quality health care. The admittedly enormous costs of compensation must be balanced against the unfairness of forcing victims of malpractice to shoulder all or part of their grave financial burden.

In response to this dilemma, legislatures have taken affirmative steps apart from statutory modification of tort law. Some states have taken an active role in providing or supplementing malpractice insurance. Louisell and Williams list five measures that legislatures have adopted: "1) establishment of joint underwriting authorities, 2) authorization of mutual insurance companies established by physicians and/or hospitals, 3) control of malpractice insurance rates, 4) restrictions on notice of cancellation, and 5) establishment of state controlled funds for payment of awards in excess of certain amounts."[140] Although such legislation might be criticized for favoring a special group, it largely eliminates the problem of incomplete recovery and distributes the financial loss over society.

Another legislative approach that merits attention is adoption of measures aimed at prevention of medical malpractice. Among these measures are

> 1) the encouragement of better surveillance of the practice of medicine (immunity from civil liability to those serving on "peer review" committees and exemption from discovery of files of such committees), 2) the requirement of continuing education as a condition of maintaining professional licenses,

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137. *Id.*

138. *Id.* at 136.

139. Ingrassia, *Medical Malpractice Shows Signs of Abating*, Wall St. J., Apr. 19, 1977, at 1, col. 1.

140. 2 D. Louisell & H. Williams, *supra* note 25, § 20.07, at 71. For discussion of a proposed bill to involve the federal government in insurance, see Nelson, *Mushrooming Malpractice: A Federal Rx*, 11 Trial 19 (1975).

3) the requirement of peer review, and 4) long range studies of the malpractice problem, including the continuing collection of litigation and insurance information.[141]

This approach is commendable because it attempts to remedy at least some of the underlying problem. Critics have questioned its effectiveness, arguing that because medical malpractice stems from fundamentally competent physicians making occasional mistakes and not from the general incompetence of physicians, measures aimed at increasing competence will have no effect on the medical malpractice crisis.[142] Empirical data are needed to evaluate the effectiveness of these preventive measures.

CONCLUSION

After consideration of the various legislative responses to medical malpractice problems, the only safe generalization is that no generalization is possible. Rather, the wisdom, fairness, and effectiveness[143] of each provision must be separately evaluated. Careful investigation of the effectiveness of screening panels is especially needed.

Statutory modification of traditional doctrines in response to the medical malpractice crisis has already complicated and diversified tort law. If medical malpractice statutes are found to be effective and constitutional, other special interest groups may seek analogous treatment,[144] with the

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141. 2 D. LOUISELL & H. WILLIAMS, *supra* note 25, § 20.07, at 71-72.

142. Plant, *supra* note 52, at 15; Comment, *supra* note 3, at 686-87.

143. It is very difficult to evaluate the effectiveness of the tort law modifications, in no small part because legislatures have adopted several diverse measures simultaneously. Moreover, the public may be becoming more aware of the causal connection between higher jury verdicts and higher insurance costs, which ultimately results in higher health care costs. For a series of advertisements by an insurer stating dramatically these causal connections, see NEWSWEEK, Apr. 17, 1978, at 26-27; NEWSWEEK, Nov. 7, 1977, at 12-13; NEWSWEEK, Jan. 30, 1978, at 12-13.

The medical profession in turn has responded to malpractice suits with actions for malicious prosecution. For a discussion of malicious prosecution suits as well as other causes of action (abuse of process, intentional infliction of mental distress, prima facie tort, and defamation), see Birnbaum, *Physicians Counterattack: Liability of Lawyers for Instituting Unjustified Medical Malpractice Actions*, 45 FORD. L. REV. 1003 (1977); Note, *Physician Counter-Suits: Malicious Prosecution, Defamation and Abuse of Process As Remedies for Meritless Malpractice Suits*, 45 U. CIN. L. REV. 604 (1976). These actions are not likely to be successful because most malpractice actions involve at least a colorable claim for relief. Nevertheless, the availability of these actions to the physician might deter a plaintiff from pursuing a meritless or weak claim. There has been at least one legislative response to supplement these common-law actions. TEX. REV. CIV. STAT. ANN. art. 4590i (Vernon 1977) makes available to a physician an action against a claimant or a claimant's attorney who filed suit in "bad faith." "Bad faith" is defined in the statute as filing and maintaining a claim "with reckless disregard as to whether or not reasonable grounds exist for asserting the claim." Like the common-law actions, this statutory provision should discourage invalid claims.

144. For a discussion of lobbying for legislative changes to meet the products liability "crisis," see Wade, *supra* note 87, at 10-11. Some of the changes recommended to meet the products liability crisis bear a striking similarity to the legislative responses to the malpractice crisis. For example, screening panels are proposed, as well as changing the statute of limitations to run from the time a product was marketed and not from the time of injury.

eventual result that basic tort principles will be greatly altered. If recovery ceilings, abrogation of the collateral sources rule, elimination of the *ad damnum* clause, and other changes are legislatively desirable, it would seem far better to avoid piecemeal action under pressure of crises and to make the desired changes for all tort cases after careful deliberation. In addition to tort law modifications, there are other legislative responses that might offer greater promise of stemming the medical malpractice crisis without unfairly limiting or eliminating the victims' recoveries. Legislatures should consult, perhaps commission, empirical studies of the various approaches to assist their search for effective solutions to the pressing problems of medical malpractice.

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