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I. INTRODUCTION

For the past ten years the health industry has been in the grip of a malpractice "crisis." Among crisis-watchers there is little agreement as to

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Author's Note: This article was written in the three and a half weeks following the passage of Missouri's new malpractice statute. With the considerable cooperation

the cause of this phenomenon. Health care provider groups point to massive increases in, and still escalating, malpractice insurance rates[1] and a consequent rise in health costs. They see a legal system which has failed to rein in the excesses of the jury system, frivolous suits on the rise, and the health industry being forced to adopt costly, defensive medicine.[2] Not surprisingly, patient advocates see things somewhat differently. For them the increase in malpractice litigation has been the necessary substitute for a lack of effective provider self-regulation aimed at improving the quality of health care. Further, the patient advocate, although conscious of rising health care costs, is convinced neither that insurers have raised their premiums solely because of increased malpractice litigation nor that such increased premiums have had, in percentage terms, the major impact claimed on the general increase in health care costs.[3]

Whatever the merits of either provider or patient arguments, the last few years have seen a discernible shift in the focus of the malpractice crisis debate. It is now apparent that most state legislatures both have accepted as fact that a crisis exists and become receptive to proposals for curative legislation designed to roll-back patient rights in the malpractice claim context.[4]

Missouri's new malpractice act is an example of such a legislative response. It does, however, have a unique feature. Rather than being the product of a bitter and public struggle between doctors' and lawyers' self-interest groups, it was a negotiated compromise. That such a concord was possible says much for both professions. It seems ironic, though, that on the very day the new Missouri act was signed into law, an American Bar

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of the Board of Editors of the Missouri Law Review its publication was expedited to give a preliminary analysis of the statute's background, provisions and possible interpretative and constitutional problems. At a late stage in the drafting of this article, the Supreme Court of Missouri handed down its opinion in Strahler v. St. Luke's Hosp., 706 S.W.2d 7 (Mo. 1986) (en banc). Some comments as to the implications of that opinion have been incorporated.

This article could not have been written without the encouragement and criticisms made, and the resources provided by, Professor Saul Boyarsky, Chairman, St. Louis Metropolitan Medical Society, Medical-Legal Committee. I owe him my deepest gratitude. The errors that remain and the opinions expressed are mine alone.

1. For Missouri statistics, see MISSOURI GOVERNOR'S TASK FORCE ON HEALTH CARE COSTS 34-36 (1984).

2. *See, e.g.*, the comments of Dr. Harry O. Cole, the then president of St. Louis Metropolitan Medical Society, St. Louis Post-Dispatch, Jan. 14, 1985 at 5A, col. 1.

3. *See generally* Terry, *The Technical and Conceptual Flaws of Medical Malpractice Arbitration*, 30 ST. LOUIS U.L.J. 571, 575-77 (1986).

4. For summaries of such crisis legislation, see Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489 (1977); Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1417; Comment, *Recent Medical Malpractice Legislation—A First Checkup*, 50 TUL. L. REV. 655 (1976).

Association (A.B.A.) committee recommended the complete rejection of the American Medical Association's proposals for malpractice law reform.[5] Unwittingly endorsing the work of their Missouri colleagues, however, the A.B.A. House of Delegates, while adopting their committee's report, also exhorted the two professions to "cooperate in seeking common solutions to these problems."[6]

The purpose of this article is to detail the background to the passage of the new statute, to undertake a preliminary analysis of the purpose and possible interpretations of the provisions to be found therein, and to suggest some of the constitutional issues that may arise for decision.

II. Missouri's First "Crisis" Legislation

Missouri's first response to the malpractice crisis was legislation enacted in 1976. Typical of 1970's responses to the "crisis," the legislature introduced a new medical malpractice statute of limitation which utilized an occurrence accrual date,[7] established a pretrial screening panel,[8] and prohibited the inclusion of any dollar figure in medical malpractice *ad damnum* clauses.[9]

Respectively, these provisions were designed to assist insurers in calculating premiums by reducing the long "tail" of claims, to screen out unmeritorious claims while encouraging settlement of meritorious ones, and to minimize unfavorable publicity when claims were filed.

The Missouri reforms were an appropriately muted response to the "first" crisis of the 1970's. Moreover, their conservative nature well befitted a jurisdiction that had eschewed any daring doctrinal developments in medical malpractice law.[10]

III. Crisis Legislation Before The Missouri Courts

Inevitably, Missouri's second "crisis" legislation will be subject to constitutional challenge. Until the recent decision in *Strahler v. St. Luke's Hos-*

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5. N.Y. Times, Feb. 4, 1986, at 1, col. 4.

6. 54 U.S.L.W. 2415, 2416 (Feb. 18, 1986); *see also* St. Louis Post-Dispatch, Feb. 12, 1986, at 1A, col. 6.

7. Mo. Rev. Stat. § 516.140 (1978), already utilized an occurrence rule. Section 516.105 widened the description of medical care providers benefiting, and introduced a special discovery rule for "foreign objects" cases, a tolling provision for minors and a ten year statute of repose in all cases. *Id.* § 516.105.

8. Mo. Rev. Stat. §§ 538.010-.080 (1978) (repealed 1984).

9. H.C.S.H.B. 1307, 78th General Session, amending Sup. Ct. R. 55.06 (May 12, 1976).

10. For a general primer on Missouri law, see Schwartz, *The Law of Medical Malpractice in Missouri*, 28 St. Louis U.L.J. 397 (1984).

pital,[11] Missouri Supreme Court review of the first crisis legislation resulted in a draw. The argument could be made that the total bar resulting from a restrictive statute of limitations is deserving of a harsher fate than the delaying/chilling approach of a pretrial panel.[12] Nevertheless, in *Ross v. Kansas City General Hospital and Medical Center*,[13] the Missouri Supreme Court upheld the constitutionality of Missouri's medical malpractice statute of limitations, whereas the year before in *State ex rel. Cardinal Glennon Memorial Hospital for Children v. Gaertner*,[14] the court had struck down Missouri's pretrial review panel.

The majority opinion in *Cardinal Glennon*[15] relied solely on a finding that the pretrial procedure violated Missouri's guarantee of access to the courts.[16] For Judge Simeone, concurring, the requirement that a judge be a member of the Professional Liability Review Board also violated Missouri's constitutional separation of powers.[17] In *Ross* such challenges obviously were not applicable. Instead, due process and equal protection violations were alleged. As to the former, the supreme court held that a statute of limitations only denied due process if "the time allowed for commencement of the action and the date fixed when the statute commences to run are clearly and plainly unreasonable."[18] With regard to the equal protection claim, the only classification complained of was the disparate treatment afforded between malpractice victims generally and "foreign object" malpractice victims.[19] Since there were several rational explanations for that particular classification, the court did not even address the appropriateness of "crisis" legislation.[20]

Indeed, of the members of the court who decided *Cardinal Glennon* and *Ross* it was only Chief Justice Morgan in his dissenting opinion in *Cardinal Glennon* who addressed the "crisis" issue and gave any indication as to how the Missouri Supreme Court would deal with, for example, an equal pro-

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11. 706 S.W.2d 7 (Mo. 1986) (en banc). *Strahler* is considered *infra* notes 198, 207-11, and accompanying text.

12. *See generally* Terry, *Missouri Statute of Limitations and Wrongful Birth*, 29 ST. LOUIS BAR J. 24, (1983) (correction reprint). *See also* Bartimus, Kavanaugh & Sullivan, *Protecting Plaintiff's Rights in the Medical Malpractice Crisis*, 53 UMKC L. REV. 26, 33-35 (1984).

13. 608 S.W.2d 397 (Mo. 1980) (en banc). *Quaere*: following the majority approach in *Strahler* would *Ross* be decided differently today? Surely the argument could be made that a woman who discovers her pregnancy more than two years after a tubal ligation apparently was performed is as effectively barred from access to the courts as the minor in *Strahler*.

14. 583 S.W.2d 107 (Mo. 1979) (en banc). *See generally* Comment, *Alternatives to Litigation: Pretrial Screening and Arbitration of Medical Malpractice Claims: Has Missouri Taken a Giant Step Backward?*, 50 UMKC L. REV. 182 (1982).

15. *Cardinal Glennon*, 583 S.W.2d at 110.

16. MO. CONST. art. I, § 14.

17. *Cardinal Glennon*, 583 S.W.2d at 111-12 (Simeone, J., concurring).

18. *Ross*, 608 S.W.2d at 400.

19. MO. REV. STAT. § 516.105 (1978) utilizes an occurrence accrual date for general claims, but a *discovery* rule for "foreign object" claims.

20. *Ross*, 608 S.W.2d at 399-400.

tection challenge premised on an irrational classification of medical malpractice victims as distinct from tort victims generally. According to the Chief Justice:

> The crisis created by medical malpractice claims is widely known. . . .
>
> The crisis which the legislation seeks to meet is not directly that facing the medical profession nor its insurers, but it is the threatened effect upon the health and welfare of the public caused by the threat to the deliverability of health care services.
>
> The increased cost of health care to the citizens of this and other states is already of grave concern.[21]

Not only did the Chief Justice make reference to a presumption about the validity of such legislation, but he considered the pretrial panels system to have been "a rational means for discouraging frivolous claims and encouraging settlement of malpractice claims."[22]

IV. THE CONCORD—BACKGROUND AND NEGOTIATIONS

Missouri's health care providers began to lobby in earnest for second generation crisis legislation in 1985, at the beginning of the first session of the 83rd General Assembly. The providers followed, *inter alia*, the "Action Plan" drawn up by the American Medical Association.[23] These lobbying efforts produced four bills. Collectively, these bills ensured the confidentiality of the proceedings and findings of peer review committees,[24] the abrogation of the collateral source rule,[25] a periodic payments scheme,[26] and a cap on noneconomic damage awards.[27] The peer review bill continued on its solitary way through the legislative process and was passed by the General Assembly on the final night of the legislative session.[28]

By March of 1985 the other proposed reforms had become the subject of a Senate Insurance Committee Substitute Bill (S.C.S. For S.B. No. 126).

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21. *Cardinal Glennon*, 583 S.W.2d at 117 (Rendlen, J., concurring).

22. *Id.*

23. AMERICAN MEDICAL ASSOCIATION, AMA SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE: ACTION PLAN (Feb. 1985) [hereinafter cited as ACTION PLAN]. The ACTION PLAN also was published in PROFESSIONAL LIABILITY IN THE 80'S REPORT 3, 9-16 (March 1985). The ACTION PLAN recommended legislative strategies and the types of legislative reforms encouraged by the AMA.

24. H.B. No. 357, 83rd General Assembly, 1st Sess. (1985). In effect this bill was designed to overturn the decision of the Missouri Supreme Court in State *ex rel.* Chandra v. Sprinkle, 678 S.W.2d 804 (Mo. 1984) (en banc). *See* Note, *The Missouri Rule: Hospital Peer Review is Discoverable in Medical Malpractice Cases*, 50 Mo. L. REV. 459 (1985).

25. S.B. No. 7, 83rd General Assembly, 1st Sess. (1985).

26. S.B. No. 49, 83rd General Assembly, 1st Sess. (1985).

27. S.B. No. 126, 83rd General Assembly, 1st Sess. (1985).

28. MSMA, LEGISLATIVE REPORT (June 17, 1985) H.B. No. 357, as enacted, was codified at Mo. REV. STAT. § 537.035(4) (Supp. 1986).

Senate Bill 126[29] was aimed exclusively at the issue of damage quantum. If passed, it would have introduced a $350,000 cap on punitive damage awards,[30] a similar cap on compensatory noneconomic losses,[31] and a periodic payments scheme for future damages in excess of $50,000.[32] While the periodic payment scheme proposed would have allowed for a subsequent reduction[33] or cessation[34] of such future payments, increases in future payments were limited to economic damages and the maximum amount of any such increase was consumer price index-linked.[35] Unsurprisingly, S.B. No. 126 was supported by the then president of the St. Louis Metropolitan Medical Society,[36] but described by the Missouri Association of Trial Attorneys as "inevitably lead[ing] to the destruction of the rights of the public when the horror of serious malpractice strikes."[37]

Despite the lobbying efforts of the Missouri State Medical Association (MSMA)[38] and Medical Defense Associates (MDA),[39] Senate Bill 126 was effectively killed well before the end of the legislative session.[40]

The bill's defeat, however, led to a resolution setting up a Senate Interim Committee to develop reform measures to be introduced in the next session.[41] The Interim Committee, chaired by Senator James L. Mathewson, was charged with examining not just the malpractice "crisis" but also the products liability "crisis."[42] After an initial hearing in Jefferson City, the Interim Committee was to hold seven hearings around the state during September and October, 1985.[43]

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29. "An act relating to certain procedures in conjunction with malpractice litigation against health care providers," S.B. No. 126, 83rd General Assembly, 1st Sess. (1985), as substituted by the Senate Committee on Insurance, Apr. 11, 1985 [hereinafter cited as S.B. No. 126].

30. *Id.* § 3(2).

31. *Id.* § 3(1).

32. *Id.* § 2.

33. *Id.* § 2(3).

34. *Id.* § 2(5)—upon the death of the claimant.

35. *Id.* § 2(3).

36. St. Louis Post-Dispatch, Jan. 14, 1985, at 5A, col. 1.

37. MATA NEWS & LEGISLATIVE BULLETIN, 1985.

38. *See* MSMA, LEGISLATIVE REPORT (April 25, 1985).

39. *See* MEDICAL DEFENSE ASSOCIATES, MALPRACTICE LEGISLATION BULLETIN No. 1, May 3, 1985. MDA is a malpractice insurer. It held 15.93% of the malpractice insurance market in 1983.

40. *See* MEDICAL DEFENSE ASSOCIATES, MALPRACTICE LEGISLATION BULLETIN No. 2 (May 10, 1985).

41. *See* MSMA, LEGISLATIVE REPORT (May 9, 1985); MSMA, LEGISLATIVE REPORT (May 15, 1985).

42. 82 MISSOURI MED. 634 (Oct. 1985).

43. Aug. 26, Jefferson City; Sept. 26, Springfield; Sept. 27, Kansas City; Sept. 27, Independence; Sept. 28, Clinton; Oct. 21, Poplar Bluff; Oct. 22, St. Louis (City); Oct. 22, St. Louis (County). The minutes of the hearings before the Senate Interim Committee are on file with the Missouri Law Review.

At that first hearing, the provider position was made clear. Missouri was facing not just a malpractice *insurance* crisis[44] but, far more significantly, a *reinsurance* crisis.[45] The providers' "wish list" for substantive tort reform went further than the contents of the previous year's Senate Bill 126. Both the Missouri Hospital Association (MHA)[46] and the Missouri Medical Association (MSMA)[47] suggested a package containing a cap on noneconomic damages, the elimination of the collateral source rule, structured payments of large awards, the inclusion of settlements by released defendants in apportioning the relative fault of tortfeasors, the repeal of joint and several liability, and the introduction of a sliding scale for contingency fee arrangements.

Of far more importance, however, during this first hearing was the interest manifested by the Interim Committee that the principals of the involved interest groups should meet and attempt to reach some sort of compromise.[48] Thenceforth separate negotiations between the principals were to parallel the work of the Interim Committee.

These negotiations took place between the Missouri Association of Trial Attorneys (MATA) and a provider coalition. The coalition consisted of MSMA, MHA, and the Missouri Association of Osteopathic Physicians and Surgeons (MAOPS). The coalition also involved representatives of Missouri's "captive" malpractice insurance companies—the so-called "bed-pan mutuals." The coalition and MATA had three formal negotiating sessions.[49] It

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44. SENATE COMMITTEE ON MEDICAL MALPRACTICE AND PRODUCTS LIABILITY, INTERIM COMMITTEE ON MALPRACTICE HEARINGS August 26, 1985, at 15 [hereinafter cited as INTERIM COMMITTEE ON MALPRACTICE] (testimony of Dr. Garth Russell, MSMA).

45. *Id.* at 16-18 (testimony of Duane Duaner, President, Missouri Hospital Association (MHA)), at 28-31 (testimony of Dr. Garth Russell, MSMA).

46. MISSOURI HOSPITAL ASSOCIATION, CASE STUDY: MEDICAL MALPRACTICE INSURANCE, THE CRISIS IN MISSOURI 8-10 (1985).

47. INTERIM COMMITEE ON MALPRACTICE, *supra* note 44, at 19 (testimony of Dr. Garth Russell, MSMA). At this time MSMA also proposed an absolute cap on awards, the establishment of "fair and appropriate standards for expert witnesses" and the requirement of the filing of an expert's affidavit of opinion within 90 days of the filing of suit. *Id.* MSMA had already prepared itself for an intense and coordinated push for legislation in the second session when the MSMA Council adopted an action plan on August 24, 1985 (reprinted in ST. LOUIS METROPOLITAN MEDICAL SOCIETY, PLAN FOR MALPRACTICE CRISIS 4 (Oct. 1985)).

As evidence of provider seriousness in this regard consider that the Jackson County Medical Society (Jackson County had been the site of some particularly large jury awards, see Interim Committee On Malpractice, *supra* note 44, at 16-17 (testimony of Dr. Garth Russell)) ran television commercials prior to the Interim Committee's hearings there on Sept. 27. *See* MATA—IN BRIEF (Nov. 1985).

48. *See, e.g.*, INTERIM COMMITEE ON MALPRACTICE, *supra* note 44, at 47-49 (dialogue between Senator Robert Johnson and J. William Turley, President Missouri Association of Trial Attorneys (MATA)).

49. September 13th & 14th, November 2nd, and November 27th, 1985.

appears that the coalition goal was to put together a package that would satisfy their excess insurers and reinsurers.[50] In this regard, and of particular interest to MHA, considerable emphasis would be placed on what was to crystalize later in the negotiations as a modification of the joint and several liability rule. The MATA goal apparently was, first, to avoid a far more dangerous coalition—one between the health care providers and products manufacturers—by agreeing to a malpractice legislative package, and second, to exact an agreement on some moratorium on future malpractice legislation.[51]

Little meaningful agreement was reached during the first two negotiating sessions. At the third session, however, MATA conceded the joint and several liability issue in return for a four year moratorium and the splitting of the malpractice and products liability issues. The rest of the concord was then finalized. The noneconomic loss cap was agreed to at $350,000 per defendant, but a single "defendant" would include, for example, both the hospital and its employees. Further, the cap would be index-linked. The coalition's desire to include punitive awards within the noneconomic cap and MATA's contrary desire were compromised by excluding the punitive awards from the cap but making their award conditional upon a tougher substantive test. MATA's version of the affidavit of expert provision was adopted as was MATA's mandatory insurance proposal. The joint proposal[52] was then communicated to the Senate Interim Committee, which agreed on a bill apparently giving effect to the concord on January 8, 1986.[53] On January 27, and with only one clarifying amendment,[54] it was granted final approval by both House and Senate to become the first legislation passed by both houses in the legislative session.[55] The bill was signed by Governor Ashcroft on February 3,[56] and, due to the bill's emergency clause, the substantive changes to Mis-

50. The initial Coalition position was that the 1984-85 Missouri malpractice crisis was real, comprised of a crisis of affordability of liability coverage and availability of continuing, quality medical care, particularly in the obstetrical, neurosurgical, and orthopedic specialities. The Coalition pointed to the escalating frequency and severity of claims, "jumbo" awards handed down by runaway juries, and the large number of frivolous lawsuits filed, but subsequently dropped or lost.

51. The initial MATA position of denying the need for legislative malpractice reform to deal with "bad" doctors responsible for "bad" medical practice was later to shift to a focus on the poor investment practices of the malpractice insurance industry, albeit coupled with a sense that the Coalition was seeking "special interest" protective legislation in the face of MATA's protection of the interests of the injured victims of malpractice.

52. The full text of the agreement, aside from the moratorium and products liability/malpractice distinction, may be found at 83 MISSOURI MED. 20-21 (1986).

53. St. Louis Post-Dispatch, Jan. 9, 1986, at 6A, col. 4.

54. S.B. No. 663 § 11, 83rd General Assembly, 2d Sess. (1986) (codified at MO. REV. STAT. § 383.110 (11) (1986), [hereinafter cited as S.B. No. 663] was added in the House to make clear that the legislation only affected causes of action arising after the bill became law. *See* Joint Proposal § XI as communicated to the Senate Interim Committee: "legislation would affect any malpractice incidents occurring on or after the date of enactment." 83 MISSOURI MED. 20, 21 (1986).

55. St. Louis Post-Dispatch, Jan. 28, 1986, at 1A, col. 1.

56. St. Louis Post-Dispatch, Feb. 4, 1986, at 4A, col. 3.

souri's malpractice law[57] became effective immediately (albeit only with regard to causes of action arising on or after that date).[58]

V. Substantive Provisions

The cornerstone of the eventual agreement between the medical providers and the trial attorneys was the coupling of the procedural and substantive tort reforms with provisions designed to increase both the regulation and financial responsibility of members of the health care industry.[59] These aspects are reflected in the legislation as enacted.

A. *Provider Regulation*

As provider groups have urged the passage of more and more crisis legislation, so has one retort from patient advocates become familiar: there will be less malpractice if incompetent physicians are denied the opportunity to practice.[60] State licensure boards[61] seem to have attached a higher priority to dealing with criminal and drug or alcohol impaired physicians[62] than to disciplining incompetent members of the profession. Indeed, the Inspector General of the Health and Human Services Department recently concluded that, of physicians "whose clinical competence is in doubt," "strikingly few" have been prevented from continuing the practice of medicine.[63]

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57. S.B. No. 663 §§ 4-10.

58. *See supra* note 54.

59. *See* letter, dated Dec. 5, 1985, to MATA members from MATA President, J. William Turley (on file with Missouri Law Review).

60. *See, e.g.*, Bartimus, Kavanaugh & Sullivan, *supra* note 12, at 37-39. The then president of the American Medical Association echoed this thought in 1985, calling for tougher self regulation "to root out the incompetent, the negligent and the impaired among our colleagues." N.Y. Times, June 18, 1985, at 20, col. 5.

61. Missouri's licensing provisions are to be found at Mo. Rev. Stat. ch. 334 (1978 & Supp. 1986).

62. Lack of investigative resources is usually given as the reason for this prioritization. Thus, investigators for the New York Health Department of late have only been able to prosecute cases of "urgent public concern." N.Y. Times, Feb. 27, 1983, at 6E, col. 2; *see also* N.Y. Times, Apr. 3, 1985, at A17, col. 1:

> An examination of the cases against physicians disciplined last year by the State Department of Health and the Board of Regents, the licensing agency that acts on the Health Department's recommendations, showed that the highest percentage of them involved charges of fraud in Medicaid, the illegal prescribing or personal use of narcotics, alcoholism, and gross incompetence.

Id. See generally Fisher, *Missouri Board of Registration for the Healing Arts and the Imparied Physician*, St. Louis Metropolitan Med. (pts. 1-3) July/Aug., 1985 at 299, Sept., 1985 at 356, Oct., 1985 at 391.

63. N.Y. Times, Feb. 4, 1986, at 9, col. 4: "The study concludes that 'the rate of disciplinary action has been increasing' in recent years 'but still falls far short of the estimated 5 to 15 percent of physicians who are not fully competent to practice medicine.'" *Id.*

At least two major problems have been identified as responsible for the defects in the current system of state licensure board regulation of physician incompetence: the great delays associated with license revocation procedures[64] and the relative failure of the health care provider industry to report cases of misconduct or incompetence.[65]

Missouri's new malpractice legislation seeks to remedy both of these problems. It has added a new provision to the licensure act permitting the State Board of Registration for the Healing Arts (Board of Healing Arts) to request the Administrative Hearing Commission[66] for an expedited licensure review in a case where there is constituted "a clear and present danger to the public health and safety." If the Board of Healing Arts meets its burden, the commission shall grant it the authority to temporarily suspend the physician's license.[67]

State licensure boards generally lack the resources to discover provider incompetence.[68] They must rely upon the lodging of complaints. The new Missouri legislation seeks to remedy this problem by placing a duty on hospitals[69] to report[70] to the appropriate licensing board any disciplinary action[71] taken (or, which might have been taken, absent her resignation) against a health care professional.[72]

Perhaps mindful of the increasing legal pressure on hospitals to screen, review, and supervise their medical staffs,[73] the statute permits a two-way flow of information. Members of the hospital reporter class may request reports of disciplinary action received by the licensing authority from other

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64. For example, see the statistics provided by investigations of the New York State Health Department and the New York State Health Commissioner. N.Y. Times, Feb. 27, 1983, at E6, col. 2.

65. As reported by the Inspector General of the Health and Human Services Department, N.Y. Times, Feb. 4, 1986, at 9, col. 4.

66. *See generally* MO. REV. STAT. §§ 621.015-.045 (Supp. 1986). *See also* Special Project, *Administrative Hearing Commission of Missouri: Fair Treatment for the Licensed Professional*, 37 MO. L. REV. 410 (1972).

67. MO. REV. STAT. § 334.102 (Supp. 1986). The grounds for licensure action by the Board of Healing Arts are the same as in the case of nonexpedited procedures. *See* MO. REV. STAT. § 334.100(21) (Supp. 1986) (including "incompetency").

68. This is according to the report of the Inspector-General of the Health and Human Services Department. N.Y. Times, Feb. 4, 1986, at 9, col. 4.

69. As defined in S.B. No. 663 § 1(3).

70. *Id.* at Sec. 2.

71. As defined, *id.* at Sec. 1(1).

72. Physicians, surgeons, dentists, podiatrists, pharmacists, psychologists, and licensed nurses. *Id.* at Sec. 1(2).

73. *See, e.g.*, Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972); Corleto v. Shore Memorial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (N.J. Super. Ct. Law Div. 1975); Darling v. Charleston Community Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966). *See generally* Lisko, *Hospital Liability Under Theories of Respondeat Superior and Corporate Negligence*, 47 UMKC L. REV. 171 (1978); Southwick, *Hospital Liability*, 4 J. LEG. MED. 17 (1983).

reporter class members.[74] Such mandated reports may not be used against a health care professional in any other judicial proceedings,[75] thus extending to such reports the privilege already enjoyed by the internal peer reviews independently conducted by the reporter class.[76]

What remains to be seen is whether this new duty to report will have the desired effect of discovering provider incompetence. In 1983, the New York State Health Commissioner was sharply critical of what he considered the general failure of hospitals to report professional misconduct,[77] despite the existence in that state of a mandatory reporting provision.[78]

B. *Malpractice Insurance*

In addition to introducing some minor amendments to Missouri law detailing the reporting duties of insurers with regard to malpractice claims,[79] the new act has introduced compulsory liability insurance ($500,000) for some providers.[80] The provision only applies to physicians and surgeons who have staff privileges at a hospital but who do not work there exclusively. The legislation is, therefore, aimed at providing sufficient compensation (and risk-spreading) in those cases that, under Missouri law,[81] are most difficult to

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74. S.B. No. 663 § 2(3).

75. *Id.* § 2(5). *But* does the statute clearly prohibit plaintiff from *discovering* the report/record? If plaintiff so obtains the substance of the report, *quaere* what admissible skeletons may be found in the cupboard?

76. *See* MO. REV. STAT. § 537.035(4) (Supp. 1986).

77. N.Y. Times, Apr. 3, 1985, at A1, col. 1.

78. *See* N.Y. PUB. HEALTH LAW § 2803-e (McKinney 1985).

79. The replacements for MO. REV. STAT. §§ 383.105, .110 (Supp. 1986) extend the reporting duties to self-insurers and increase the frequency of such formal reporting.

80. S.B. No. 663 § 3.

> 1. Beginning on January 1, 1987, any physician or surgeon who is on the medical staff or any hospital located in a county which has a population of more than seventy-five thousand inhabitants shall as a condition to his admission to or retention on the hospital medical staff, furnish satisfactory evidence of a medical malpractice insurance policy of at least five hundred thousand dollars. The provisions of this section shall not apply to physicians or surgeons who:
>
> (1) Limit their practice exclusively to patients seen or treated at the hospital; and
>
> (2) Are insured exclusively under the hospital's policy of insurance or the hospital's self-insurance program.
>
> 2. This section shall not in any way limit or restrict the authority of any hospital in this state to issue rules or regulations requiring physicians or other health care professionals to carry minimum levels of professional liability insurance as a condition of membership on a hospital medical staff.

81. *See, e.g.*, Porter v. Sisters of St. Mary, 756 F.2d 669 (8th Cir. 1985) (hospital not vicariously liable for negligence of emergency room doctor despite plaintiff's assumption that doctor was hospital employee).

establish under a vicarious liability theory[82] against the hospital that granted the staff privileges.

What is interesting about this new Missouri provision is its silence about enforcement. Typical mandatory malpractice insurance legislation[83] makes *licensure* dependent upon insurance.[84] Indeed, this appears to have been the intent of the coalition-MATA proposal transmitted to the Senate Interim Committee.[85] The Missouri provision as enacted, however, merely makes the furnishing of "satisfactory evidence of a medical malpractice insurance policy" a condition of the physician's "admission to or retention on the hospital medical staff."[86] Thus it is the hospital that is placed in the enforcement role. However, a hospital already had the power to condition staff privileges on the carrying of malpractice insurance,[87] a position that the new act impliedly confirms.[88] Furthermore, because a hospital may not be vicariously liable for the physicians to whom this section applies, it will have little incentive to police the provision.

This incentive would be furnished, however, if this requirement of physician insurance was read into the hospital's admission/retention duty of care with regard to the granting of staff privileges.[89] Then, a patient who failed to recover awarded damages from the physician could bring an action against the hospital for granting privileges to an uninsured or underinsured physician. If Missouri courts accept this argument, the new act will lead to a magnificent irony. A provision intended to provide a patient an effective remedy against a physician in a situation in which a hospital has no vicarious (secondary) liability will instead have the effect of imposing primary liability upon the hospital.

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82. *See generally* D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE § 16.08 (rev. perm. ed. 1984).

83. *See generally* Muranaka, *Compulsory Medical Malpractice Insurance Statutes: An Approach in Determining Constitutionality*, 12 U.S.F.L. REV. 599 (1978). *See also* State *ex rel.* Schneider v. Liggett, 223 Kan. 610, 576 P.2d 221 (1978) (mandatory malpractice insurance statute survives due process and equal protection challenge by physician).

84. *See, e.g.*, IDAHO CODE § 39-4208 (1977).

85. Joint Proposal § X, 83 MISSOURI MED. 20, 21 (Jan. 1986) stated: "A new law should be adopted adding *a requirement to physicians licensure* that physicians on a hospital staff in counties over 75,000 population would carry malpractice insurance of at least $500,000." *Id.* (emphasis added).

86. S.B. No. 663 § 3.1.

87. *See* Renforth v. Fayette Memorial Hosp. Ass'n, 178 Ind. App. 475, 383 N.E.2d 368 (1978), *cert. denied*, 444 U.S. 930 (1979); Pollock v. Methodist Hosp., 392 F. Supp. 393 (E.D. La. 1975) (applying Louisana law).

88. S.B. No. 663 § 3.2.

89. *See supra* materials cited note 73.

C. *Substantive and Procedural Tort Reforms*

The new Missouri legislation has introduced five modifications to the law of medical malpractice: (1) a $350,000 ceiling on noneconomic damages;[90] (2) the conditioning of the award of punitive damages upon a new substantive test;[91] (3) the institution of an optional scheme for the periodic payment of future damages;[92] (4) the introduction of a post-claim, pretrial requirement that plaintiff's attorney shall file an affidavit that he has an expert opinion showing negligence;[93] and (5) a change in the rules governing joint liability of, and apportionment between, medical codefendants.[94]

1. Noneconomic Damages Ceiling

In introducing a $350,000 cap on the recovery of noneconomic damages,[95] Missouri has joined the increasingly large number of jurisdictions attempting to deal with what the A.M.A. has termed "a primary cause of the grossly distorted awards in professional liability cases."[96]

For the purposes of the new statute, such noneconomic damages[97] consist of approximate claims for pain and suffering,[98] loss of enjoyment of life,[99] and loss of consortium.[100] Not only do such damages make up a large proportion of an award in a typical malpractice case,[101] but it has been argued that they provide the plaintiff with a source of funds from which to pay her attorney's fees.[102]

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90. S.B. No. 663 § 5.1-.4.
91. *Id.* § 5.5.
92. *Id.* § 7.
93. *Id.* § 8.
94. *Id.* § 9.
95. In order to discourage jury manipulation of its award so as to circumvent the ceiling, the existence of the statutory limitation must be kept from the jury. *Id.* § 5.3. It is the judge who will reduce the noneconomic award. *Id.* § 6.3. An award for future noneconomic damages may, of course, be subject to the act's provisions as to a periodic payments structure. *Id.* § 7.2.
96. ACTION PLAN, *supra* note 23, at 5.
97. Specifically, such damages are described in the statute as: "damages arising from nonpecuniary harm including, without limitation, pain, suffering, mental anguish, inconvenience, physical impairment, disfigurement, loss of capacity to enjoy life, and loss of consortium but shall not include punitive damages." S.B. No. 663 § 4(7).
98. *See generally* D. LOUISELL & H. WILLIAMS, *supra* note 82, §§ 18.03-.05.
99. *Id.* § 18.06.
100. *Id.* § 18.16.
101. The A.M.A. estimates that noneconomic damages account for 80% of that portion of an award that exceeds $100,000. Time, Feb. 24, 1986, at 60, col. 1.
102.
> [I]t is these damages that make it possible for the injured victim to recover his losses and also pay his attorney. The pain and suffering damages, in

Missouri's $350,000 damage ceiling is not as severe as some that have been introduced.[103] Moreover, it is index-linked,[104] and the limitation applies only to each "defendant."[105] However, in the act, "defendant" is given a unique definition.[106] For example, for purposes of the per defendant limitation, a plaintiff who successfully sued a hospital and, say, ten of its em-

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other words, are simply a means of financing the contingent-fee litigation, since without them the fee would come out of medical expenses of the client and even a successful lawsuit would then fail to compensate him.

D. DOBBS, REMEDIES § 8.1, at 550-51 (1973).

Contrast this view with a dissenting voice in Fein v. Permanente Medical Group, 695 P.2d 665, 689, 211 Cal. Rptr. 368, 392, *app. dism'd for want of federal question*, 106 S. Ct. 214 (1985). "For a child who has been paralyzed from the neck down, the only compensation for a lifetime without play comes from noneconomic damages. Similarly, a person who has been hideously disfigured receives only noneconomic damages to ameliorate the resulting humiliation and embarrassment." *Id.* (Bird, C.J., dissenting).

103. *See, e.g.*, CAL. CIV. CODE § 3333.2 (West Supp. 1986) ($250,000); N.H. REV. STAT. ANN. § 507-C:7II (1983) ($250,000). Some jurisdictions approximate this position by placing a cap on "general" but not "special" damages. *See, e.g.*, OHIO REV. CODE ANN. § 2307.43 (Baldwin 1984) ($200,000 in cases not involving death); S.D. CODIFIED LAWS ANN. § 21-3-11 (Supp. 1985) ($500,000); TEX. REV. CIV. STAT. ANN. art. 4590i § 11.02(a) (Supp. 1986) ($500,000). Some jurisdictions have not discriminated between types of damages and have enacted overall caps. *See, e.g.*, VA. CODE § 8.01-581.15 (1984) ($1,000,000).

However, *any* such limitation on recovery may have serious repercussions. *See* Fein v. Permanente Medical Group, 695 P.2d 665, 689, 211 Cal. Rptr. 368, 392, *app. dism'd for want of federal question*, 106 S. Ct. 214 (1985):

> At first blush, $250,000 sounds like a considerable sum to allow for noneconomic damages. However, . . . most large recoveries come in cases involving permanent damage to infants or to young, previously healthy adults. Spread out over the expected lifetime of a young person, $250,000 shrinks to insignificance. Injured infants are prohibited from recovering more than three or four thousand dollars per year, no matter how excruciating their pain, how truncated their lifespans, or how grotesque their disfigurement.

Id. (Bird, C.J., dissenting).

104. S.B. No. 663 § 5.4.

105. *Id.* § 5.1.

106. "Defendant" for purposes of sections 4 to 10 of this act shall be defined as:

> (1) A hospital as defined in chapter 197, RSMo, and its employees and physician employees who are insured under the hospital's professional liability insurance policy or the hospital's self-insurance maintained for professional liability purposes;
>
> (2) A physician, including his nonphysician employees who are insured under the physician's professional liability insurance or under the physician's self-insurance maintained for professional liability purposes;
>
> (3) Any other health care provider having the legal capacity to sue and be sued and who is not included in subdivisions (1) and (2) of this subsection, including employees of any health care providers who are insured under the health care provider's professional liability insurance policy or self-insurance maintained for professional liability purposes.

Id. § 5.2.

ployees would be limited to a $350,000 recovery, whereas if she successfully sued a hospital and an independent physician she could recover up to $700,000.

The act does not address the problems that may be caused by involvement in the litigation of a nonhealth care provider. For instance, suppose a hospital and a drug manufacturer are found liable on malpractice and products liability theories. The jury returns a verdict of $10,000,000 in favor of the plaintiff, apportioning the relative fault of the defendants at 50% each. The jury itemizes the noneconomic damages component of its award at $5,000,000.[107] Consider the following possible interpretations of the new act and their results.

(1) The judge considers that the $5,000,000 noneconomic damages part of the award was the result of an "action against a health care provider".[108] The judge reduces it to $350,000.[109] Thus, the hospital and manufacturer are jointly liable for the reduced award of $5,350,000.

(2) The judge considers that only 50% of the noneconomic award ($2,500,000) was against the hospital ("action against a health care provider") and so reduces only that portion of the award to $350,000.[110] Thus the total noneconomic award would be for $2,850,000, with $2,500,000 to be paid by the manufacturer, and $350,000 to be paid by the hospital.

(3) The judge reduces the noneconomic damages award to $2,850,000, as in the second example, and enters judgment in favor of the plaintiff. Because the damage cap provision does not effect the general rules as to joint and several liability,[111] the plaintiff seeks recovery of the full amount from the hospital. At best, the hospital will only be able to recoup the manufacturer's equitable share—50% of $2,850,000 ($1,425,000).

(4) The judge interprets the new act's noneconomic ceiling as applying only to actions in which all the defendants are "health care providers." When a nonhealth care provider is found to be a judgment defendant, the ceiling ceases to apply to any and all defendants. Thus, the plaintiff will recover the full $5,000,000 noneconomic award on traditional joint and several liability principles.

All four interpretations find support in the wording of the act. The second example given ($2,500,000 to be paid by the manufacturers; $350,000 by the hospital) seems to bear the closest resemblance to the intent of the MATA and coalition negotiators.

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107. Pursuant to S.B. No. 663 § 61.

108. *Id.* § 5.1.

109. Pursuant to S.B. No. 663 § 6.3.

110. The manufacturer is not a "defendant" for the purposes of § 5 and cannot claim the cap's benefit.

111. Even if the joint and several liability abrogation was applicable to a hospital-manufacturer situation, see *infra* text accompanying notes 156-65, that provision (§ 9.2) would not apply here because of the 50% liability shares.

2. Punitive Damage Claims

According to the American Medical Association,

> The damages awarded in a professional liability lawsuit are intended to provide compensation for injury. By definition, punitive damages are in addition to full compensation for a plaintiff's injuries. Punitive damages are particularly inappropriate in medical professional liability suits because state licensing boards, medical society and hospital peer review systems, and the criminal justice system provide adequate mechanisms to discipline physicians.[112]

Prior to the new legislation, the appropriate standard under Missouri law, for cases involving a punitive damage claim made in connection with a malpractice (negligence) submission, revolved around a showing of "complete indifference to or conscious disregard for the safety of others."[113]

Henceforth, Missouri law will require that plaintiffs meet the more stringent test that "an award of punitive damages against a health care provider . . . shall be made only upon a showing by a plaintiff that the health care provider demonstrated willful, wanton or malicious misconduct with respect to his actions."[114]

Although punitive damages are essentially "noneconomic," any such awards are excluded from the $350,000 damage ceiling.[115] Additionally, punitive damages are "past damages" and so should not be subject to the new statute's provisions with regard to the periodic payment of future damages.[116]

3. Structured Payment of Future Damages

The structuring of settlements to provide for the periodic payment of damages to a plaintiff is widely utilized today. Such an approach can hold major benefits for both the plaintiff and the defendant's liability insurer.[117] In practice, the parties will negotiate as to annuity packages which, when discounted for present value,[118] correspond to the nondisclosed lump sum settlement amounts the parties are promoting in the negotiations.

A periodic payment scheme for future damages introduced by statute is a very different animal. In the first place, such schemes apply to judgment

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112. ACTION PLAN, *supra* note 30, at 5-6. For a general treatment of punitive awards in malpractice cases, see D. LOUISELL & H. WILLIAMS, *supra* note 82, § 18.18.

113. M.A.I. 10.02 (3d ed. 1978, 1983 Rev.). *See generally* Smith v. Courter, 575 S.W.2d 199, 206-08 (Mo. Ct. App. 1978).

114. S.B. No. 663 § 5.5. A similar, albeit more elaborate, provision is to be found at DEL. CODE ANN. tit. 18, § 6855 (Supp. 1984); *cf.* 1985 Ill. Legis. Serv. P.A. 84-7, § 2-1115 (West) (abrogating punitive awards in malpractice cases).

115. S.B. No. 663 § 4(7).

116. *Id.* § 7.

117. *See* Frasca & Brady, *Structuring Settlements: Who Wins?*, 1982 TRIAL 41 (August).

118. *See* R. POSNER, ECONOMIC ANALYSIS OF LAW § 6.13 (2d Ed. 1977).

awards and not to settlements. In the second place, it is only "future" damages which are subjected to a typical periodic payments scheme.[119]

However, the most important distinction between a periodic payments scheme and a structured settlement is that the latter involves a fixed amount, albeit one that may fluctuate as to the dollar amounts involved in one or more of the future installments. The most widely touted advantage for a periodic payments scheme is that it opens up the possibility of adjusting the award to take account of postjudgment events. As has been stated:

> [P]eriodic payments would enable account to be taken of some of the actual, rather than forecast, changes after the trial. If a partially incapacitated plaintiff suffered a deterioration in his medical condition so that he became completely unable to work, it would be possible, if suitable review procedures could be established, to adjust his compensation accordingly. Similarly, if his condition improved so that he could take a better paid job than was first thought, his compensation might be reduced. In this respect, periodic payments would produce fairer results both for the plaintiff and for the defendant. Certain changes in economic conditions after the trial might also be taken into account. For example, provided that the necessary financial arrangements could be devised, the payments might be inflation proofed.[120]

Nevertheless, the periodic payment schemes that actually have been implemented have not involved any such sophisticated adjustment provisions. Rather, a simpler intent has evinced itself:

> [T]o eliminate the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended.[121]

In fact, the new Missouri periodic payments regime is similar to that provided for in the 1985 Senate Committee Substitute for S.B. No. 126.[122] Under the 1986 Act, the trier of fact will itemize the damages awarded so as to distinguish, first, between past and future damages; second, between economic and

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119. Compare ALA. CODE § 6-5-486 (1977), which suggests that past damages could, at the court's discretion, be paid out periodically. Note also that the Alabama statute does not contain any provision for the addition of interest on the unpaid sum. *Cf.* S.B. No. 663 § 7.2.

120. ROYAL COMMISSION ON CIVIL LIABILITY AND COMPENSATION FOR PERSONAL INJURY § 568 Cmnd. 7054-I (1978).

121. CAL. CIV. PROC. CODE § 667.7(f) (West 1980). *See generally* UNIF. PERIODIC PAYMENT OF JUDGMENTS ACT, 14 U.L.A. 22 (Supp. 1985).

122. The main differences are as follows: (1) S.B. No. 126's periodic payments scheme was triggered if future damages exceeded $50,000. The 1986 Act has a $100,000 total damages threshold. (2) S.B. No. 126 would have permitted the plaintiff to request an *increase* in his medical expenses award. The 1986 Act contains no such provision. (3) Under S.B. No. 126, the death of the plaintiff would have led to the cessation of payments as to future medical expenses *and* future pain and suffering damages. The 1986 Act curtails only the payment of future medical expenses.

noneconomic damages; and third, between future medical expenses and other future economic damages.[123] If the total amount of the award in the case exceeds $100,000, then either the plaintiff[124] or defendant[125] may request a structured, periodic payments scheme for the future damages awarded.

This request must be made "prior to the entry of judgment."[126] A request made after the entry of a lump sum judgment would not be timely.[127] Once the request for periodic payments has been made, an order to that effect must be included in the judgment. The judge is not given discretion in the matter.[128] However, the judge is given discretion to order the posting of security for future payments by the defendant,[129] and, although not supplied with any criteria, is responsible for setting the payment structure and (any) interest amount in the absence of agreement between the parties as to these matters.[130]

Upon the death of the plaintiff, the only payments that will cease are future medical expenses.[131] Payments reflecting, for example, future pain and suffering or lost earning capacity would continue to be paid by the defendant. It remains to be seen whether this small reduction in the amount of the "windfall" to the plaintiff's estate is worth the additional administrative costs associated with instituting a periodic payments scheme.

One further problem remains to be considered. Assume that the total judgment in favor of the plaintiff is $150,000. The trier of fact itemizes this as $50,000 in past damages and $100,000 in future damages; the defendant requests a periodic payments plan. The new act creates a presumption that the attorney's contingency fee will be paid when the judgment becomes final.[132] If the contingency was, for instance, 40% ($60,000), the plaintiff will leave the courtroom in debt to her attorney and without the funds to pay her previously incurred costs. Not only does this give rise to serious ethical concerns, but failure to advise a client of the potential for such a result might expose plaintiff's attorney to a legal malpractice action analogous to an informed consent case.[133]

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123. S.B. No. 663 § 6, by reference to the definitions found in § 4. For what constitutes such medical expenses, see D. LOUISELL & H. WILLIAMS, *supra* note 82, § 18.15.

124. The plaintiff's interest would be in beneficial tax consequences. *See* Frasca & Brady, *supra* note 117, at 42-43; *see also* UNIF. PERIODIC PAYMENT OF JUDGMENTS ACT, 14 U.L.A. 22, 23 (Supp. 1985).

125. Note that "defendant" is given a special definition by S.B. No. 663 § 5.2.

126. *Id.* § 7.2.

127. Craven v. Crout, 163 Cal. App. 3d 779, 784, 209 Cal. Rptr. 649, 652 (1985).

128. Fein v. Permanente Medical Group, 695 P.2d 665, 677-78, 368 Cal. Rptr. 368, 380-81, *app. dism'd for want of federal question*, 106 S. Ct. 214 (1985).

129. S.B. No. 663 § 7.3.

130. *Id.* § 7.2.

131. *Id.* § 7.5. "Medical damages" as defined at § 4(6).

132. *Id.* § 7.4.

133. *See generally* Martyn, *Informed Consent in the Practice of Law*, 48 GEO. WASH. L. REV. 307 (1979).

In fact, the solution to this problem may lie in the hands of the trial judge. The act provides that "[a]t the request of any party . . . the court shall include in the judgment a requirement that future damages be paid *in whole or in part* in periodic or installment payments . . . ."[134] As already noted,[135] the trial judge when so requested, is not given discretion with regard to the basic issue as to whether to structure the judgment. Nevertheless, the provision could be interpreted to give the judge discretion as to whether the "whole" or only a "part" of the future damages award should be structured. Thus, in our example, the judge could deduct an amount (say $30,000) from the $100,000 future damages award which when combined with the past damages ($50,000) will produce a sum sufficient to pay the attorney's fees and immediate medical expenses ($80,000). The judge will then structure the payment of the remaining $70,000. In any event, it is to be hoped that attorneys will modify their contingency fee agreements to provide for installment payment of the attorneys' fees in the event of a periodic payments structure being ordered at judgment. Such a method of dealing with the contingency fee is already utilized by some attorneys who negotiate structured settlements for their clients.

4. Affidavit of Negligence

Henceforth, and no later than ninety days after she has filed her clients' petition, the plaintiff's attorney will be required to file an affidavit to the effect that she has obtained a written opinion from a health care provider that the defendant fell below the requisite standard of care, said breach having caused the damages complained of.[136]

Several difficulties arise regarding this provision. First, its utility is far from clear. This is not a settlement-encouraging provision like the "notice of intention to file suit" legislation found in other jurisdictions.[137] Neither

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134. S.B. No. 663 § 7.2 (emphasis added).

135. Fein v. Permanente Medical Group, 695 P.2d 665, 211 Cal. Rptr. 368, *app. dism'd for want of federal question* 106 S. Ct. 214 (1985).

136. S.B. No. 663, § 8.1, provides:

> In any action against a health care provider for damages for personal injury or death on account of the rendering of or failure to render health care services, the plaintiff or his attorney shall file an affidavit with the court stating that he has obtained the written opinion of a legally qualified health care provider which states that the defendant health care provider failed to use such care as a reasonably prudent and careful health care provider would have under similar circumstances and that such failure to use such reasonable care directly caused or directly contributed to cause the damages claimed in the petition.

Id. The 90-day timing provision is found at § 8.4.

137. *E.g.*, N.H. REV. STAT. ANN. § 507-C5 (1983); VA. CODE § 8.01581.1 (1984); *see also* Dougherty v. Olivero, 427 A.2d 487, 489 (Me. 1981): "The purpose of [Maine's] notice-of-claim requirement is to provide a mandatory 90-day waiting period during which medical malpractice claims can be settled without litigation through the use of the dispute resolution procedures established [under statute]."

does it give the defense advance notice of plaintiff's theories of liability or causation, because there is no requirement that the opinion of plaintiff's reviewer be attached to the affidavit.[138] It does not move forward the time at which plaintiff must endorse her expert,[139] because there is no requirement that plaintiff's reviewer shall also be plaintiff's expert at trial. Indeed, all that is expected of the reviewer is that she be "legally qualified," which, in Missouri, does not necessarily mandate current licensure.[140]

At best, this affidavit provision will hinder somewhat plaintiff's attorney who has a totally unmeritorious case and who may have filed suit and gambled on conducting a successful "fishing expedition" during the discovery process.

At worst, and herein lies the second major problem with the affidavit provision, this totally procedural device may, unwittingly, run counter to some aspects of Missouri's substantive malpractice law. As drafted, the new act calls for the affidavit from plaintiff or her attorney "in any action against a health care provider . . . on account of the rendering of . . . health care." In such a case, the affidavit from the reviewing professional must state that the defendant "failed to use such care as a reasonably prudent and careful health care provider would have under similar circumstances."[141] Not only does this constitute an unwarranted deviation from the wording of Missouri's approved jury instruction in malpractice cases,[142] but apparently ignores those situations, such as foreign objects[143] or battery[144] cases, where the substantive standard of care is not custom based.[145]

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138. *Cf.* 1985 Ill. Legis. Serv. P.A. 84-7, § 2-622(a)(i) (West). *But see* Jagoe v. Blocksom, 440 A.2d 1022 (Me. 1982), discussing Maine's analogous pre-claim affidavit provision, ME. REV. STAT. ANN. tit. 24, § 2903 (Supp. 1985), which is also designed to weed out unmeritorious claims. "We reject the defendants' attempts to convert a notice of claim into a pre-action discovery device." *Jagoe*, 440 A.2d at 1025.

139. For the endorsement of expert witnesses, see FED. R. CIV. P. 26(b)(4)(A)(i); Mo. SUP. CT. R. 56.01(b)(4)(a), *see also* Manahan v. Watson, 655 S.W.2d 807 (Mo. Ct. App. 1983) (defendant's expert should not have been permitted to testify because of defendant's failure to answer interrogatories as to name and expected testimony subject matter of his expert).

In practice the defense will file a motion for a protective order requesting the court to require that plaintiff endorse his expert or experts at least, for example, ninety days prior to trial.

140. *See* Eichelberger v. Barnes Hosp., 655 S.W.2d 699 (Mo. Ct. App. 1983); *cf.* 1985 Ill. Legis. Serv. P.A. 84-7, § 2-622(a)(1).

141. S.B. No. 663 § 8.1.

142. M.A.I. 11.06 (3d ed. 1978); *see* Gridley v. Johnson, 476 S.W.2d 475 (Mo. 1972).

143. *See, e.g.*, Laughlin v. Christensen, 1 F.2d 215, 217 (8th Cir. 1924) (no requirement of expert testimony in case involving surgical sponge left in abdominal cavity).

144. For the distinction between "no-consent" (battery) and "no-informed consent" (negligence, often utilizing the "custom" standard) cases, see Mink v. University of Chicago, 460 F. Supp. 713, 716-18 (N.D. Ill. 1978).

145. *See, e.g.*, Swan v. Tygett, 669 S.W.2d 590, 592 (Mo. Ct. App. 1984) (plaintiff could make use of *res ipsa loquitur* doctrine when she had received an injury

Furthermore, under the affidavit provision the plaintiff's reviewer must also give her (expert) opinion as to causation. Yet Missouri law also recognizes causation issues in malpractice cases where expert testimony is not required.[146] The purpose of the affidavit provision is to discourage or hinder the making of unmeritorious claims. It would be a strange result if plaintiff's attorney in the most meritorious of cases—one for which expert testimony is *not* required by the courts—nevertheless must suffer the trouble and expense of acquiring expert review after filing the complaint.

The third flaw in the affidavit provision is in regard to its sanctions. If the plaintiff's attorney does not file the required affidavit, the defendant may move for dismissal, albeit without prejudice.[147] The affidavit provision as drafted, however, fails to consider the situation where an affidavit of obtained opinion has been filed but is, in some (non-technical)[148] way defective. Consider the following hypotheticals. First, plaintiff's (scrupulous) attorney files an affidavit of opinion but the reviewer was negligent in performing the review. Second, plaintiff's (unscrupulous) attorney files an affidavit *without* having obtained a reviewing expert's opinion. Third, plaintiff's (unscrupulous) attorney and her reviewer conspire over the issue of review and an affidavit is filed in a situation where no reasonable reviewer would have given an opinion of negligence or causation.

Assume that the defectiveness of plaintiff's attorney's affidavit is exposed. What sanctions will follow? Unlike the Missouri provision, the Illinois statute is specific, providing that the defense may recover reasonable expenses incurred and attorneys' fees caused by the defect.[149] Furthermore, in the case of our first hypothetical (negligent reviewer), the Illinois statute grants a reviewer who had acted in good faith civil immunity from (presumably) a negligence action brought by plaintiff's attorney to offset her own statutory

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unrelated to the operative procedure); Goodenough v. Deaconess Hosp., 637 S.W.2d 123, 126 (Mo. Ct. App. 1982) (no expert testimony required when nurse assistant failed to adjust kneeling board prior to making examination using proctoscopic table).

Of course, the argument could be made that "the rendering of or failure to render health care services" (S.B. No. 663 § 8.1) does not include such cases. However, because the same introductory wording is used elsewhere in the act, this would remove these cases from, for example, the noneconomic damages and structured payments provisions.

Note also that Illinois has a specific rule for *res ipsa loquitur* cases in its affidavit statute. *See* 1985 Ill. Legis. Serv. P.A. 84-7, § 2-622(c) (West).

146. *See, e.g.*, Robbins v. Jewish Hosp., 663 S.W.2d 341, 345 (Mo. Ct. App. 1983) ("sudden onset" rule applied); Pinky v. Winer, 674 S.W.2d 158, 160 (Mo. Ct. App. 1984) (plaintiff's own nonexpert testimony sufficed).

147. S.B. No. 663 § 8.5. The Illinois provision is similar: 1985 Ill. Legis. Serv. P.A. 84-7, § 2-622(g). *Quaere*: the effect on the period of limitations in the case of such a dismissal? Presumably the answer is to be found in Missouri's "savings" statute. *See* MO. REV. STAT. § 516.230 (1978).

148. For a "technical violation" issue (*in casu*, concerning whether "under oath"), see Paradis v. Webber Hosp., 409 A.2d 672 (Me. 1979); *cf.* Jagoe v. Blocksom, 440 A.2d 1022 (Me. 1982).

149. 1985 Ill. Legis. Serv. P.A. 84-7, § 2-622(e) (West).

liability to the defendant.[150] Absent such statutory immunity under the Missouri statute, plaintiff's attorney would still be able to bring such an action.[151]

In our last two hypotheticals, the defendant would be the one to bring an action against the plaintiff's attorney (second hypothetical) or against the attorney and his reviewer (third hypothetical). In either case, the defendant would have to establish the existence of a private right to damages for perjury, an issue not yet decided by Missouri courts.[152]

Of course, a threshold question must be addressed. How would the defendant's attorney (or, in the case of the first hypothetical, the plaintiff's attorney) ever discover what happened? Under the affidavit provision, plaintiff's attorney is under no obligation to name his reviewer. Further, the defendant's opportunity to depose the reviewer would not arise unless the plaintiff named the reviewer as her expert.[153] A very different situation obtains under the Illinois statute where, following judgment or dismissal of plaintiff's claim, the defense may depose plaintiff's reviewing health professional.[154]

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150. *Id.* § 2-622(f), providing that "a reviewing health professional who in good faith prepares a report used in conjunction with an affidavit required by this Section shall have civil immunity from liability which otherwise might result from the preparation of such report."

151. *See, e.g.*, Danyo v. Argonaut Ins. Co., 318 Pa. Super. 28, 464 A.2d 501 (Pa. Super. Ct. 1983) (professional liability carrier had duty to defend physician-expert in action brought by attorney for negligence in preparation of medical report).

152. Tufts v. Madesco Inv. Corp., 524 F. Supp. 484 (E.D. Mo. 1981); *see also* MODEL CODE OF PROFESSIONAL RESPONSIBILITY DR 1-102 (1980).

153. MO. SUP. CT. R. 56.01(a)(4)(b). Consider the situation where plaintiff's attorney *does* endorse the reviewer as his expert for the trial. Two defense tactics suggest themselves. Both will be greeted by plaintiff objections as to relevance. First, the defense will be interested in the expert's regular employment as a plaintiffs' reviewer as well as his regular employment as a plaintiffs' expert, because this tends to establish the bias or interest of the expert. *See* R. HASL & J. O'BRIEN, MISSOURI LAW OF EVIDENCE § 5-6 (1984). Second, suppose that through questioning the defense obtains an admission from the expert that the pre-affidavit review was made and opinion given without, say, an examination of the plaintiff's file (or without a physical examination of the plaintiff). The defense could then question the weight that should be given to the expert's testimony at trial, on the basis that the plaintiff's expert was predisposed to an opinion that the defendant's medical care had been substandard. The future will speak as to the advisability of plaintiffs' attorneys' use of the same physician as both reviewer and expert in the same case. *Quaere*: could plaintiff's attorney argue work product?

154. The full Illinois provision is as follows:

> Allegations and denials in the affidavit, made without reasonable cause and found to be untrue, shall subject the party pleading them or his attorney, or both, to the payment of reasonable expenses, actually incurred by the other party by reason of the untrue pleading, together with reasonable attorneys' fees to be summarily taxed by the court upon motion made within 30 days of the judgment or dismissal. In no event shall the award for attorneys fees and expenses exceed those actually paid by the moving party, including the insurer, if any. In proceedings under this paragraph (e), the

5. Joint Liability and Relative Fault

Today, the starting point for any discussion of Missouri law relating to joint tortfeasors and contribution rules of course must be the Supreme Court's decision in *Missouri Pacific R.R. Co. v. Whitehead & Kales Co.*[155] At that time the court introduced a relative fault approach to non-contractual indemnity and contribution between non-contractual judgment and nonjudgment tortfeasors. Missouri's new statutory rule for malpractice cases runs counter to one of the basic principles underlying *Whitehead & Kales* while at the same time supplying a solution to one of the questions that that case left unanswered.

(i) Joint and Several Liability

With regard to the former, the court in *Whitehead & Kales* when summing up its holding stated: "Plaintiff continues free to sue one or more concurrent tortfeasors as he sees fit and nothing that transpires between them as to their relative responsibility can reduce or take away from plaintiff any part of his judgment."[156]

Under the new act, the jury will continue to assess the relative fault of the codefendants and express their equitable shares in percentage terms.[157] However, the legislation has departed from the traditional rules of joint and several liability in providing that: "any defendant against whom an award of damages is made shall be jointly liable only with those defendants whose apportioned percentage of fault is equal to or less than such defendant."[158] In so providing, while several liability is preserved, joint liability is subjected to a pyramiding rule.[159]

Take the situation where a plaintiff successfully establishes the liability of a hospital, a surgeon, and a referring physician. The jury apportions the relative fault of the defendants as follows: hospital—30%, surgeon—30%, and referring physician—40%. Under the new act, the referring physician will be jointly liable for 100% of the damages. The hospital and the surgeon will not be jointly liable for the referring physician's 40% but will be jointly

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> moving party shall have the right to depose and examine any and all reviewing health professionals who prepared reports used in conjunction with an affidavit required by this Section.

1985 Ill. Legis. Serv. P.A. 84-7, § 2-622(e) (West).

155. 566 S.W.2d 466 (Mo. 1978) (en banc).

156. *Whitehead & Kales*, 566 S.W.2d at 474.

157. S.B. No. 663 § 9.1.

158. *Id.* § 9.2.

159. For a discussion of more radical proposals with regard to the joint and several liability rule, see Comment, *Abrogation of Joint and Several Liability: Should Missouri be Next in Line?*, 52 UMKC L. REV. 72 (1983). *See also* Comment, *Where is the Principle of Fairness in Joint and Several Liability—Missouri Stops Short of a Comprehensive Comparative Fault System*, 50 MO. L. REV. 601 (1985).

liable for each other's 30% shares. Because of the statute's special definition of "defendant,"[160] however, this would not be the case if the surgeon either was a hospital employee or was insured under the hospital's malpractice policy. In this modified situation, the hospital and surgeon would be considered a single "defendant" with an apportioned share of 60% relative fault. Therefore the hospital/surgeon would be jointly liable for the referring physician's 40% but the referring physician would escape joint liability for the hospital/surgeon share.

There is an additional quirk flowing from this statutory definition of "defendant." It is arguable that the modification to the joint liability rule would be inapplicable in a situation in which the other liable defendant was not a "health care provider."[161] For example, assume that a hospital was held to be 10% responsible, a nonemployee physician 20%, and an underinsured drug manufacturer 70% liable. The hospital would not be jointly liable for the physician's 20% (not "equal to or less than" 10%) but would be jointly liable for the manufacturers' 70% (not a "defendant").

Somewhat strange (from the health care provider's perspective) results flow, therefore, from the use of this extended definition of "defendant." Given the absence of any such suggestion in the MATA-coalition proposals[162] and the placement of this definition in the noneconomic damages cap section[163] rather than in the general definition section,[164] it is suggested that some doubt exists as to whether this extended definition was meant to have applied to the entire statute rather than just to the noneconomic damages section.[165]

(ii) Relative Fault of Settling Defendants

The second provision of the new act, dealing with contribution and relative fault, concerns settling tortfeasors, an issue not addressed in *Whitehead & Kales.*[166] Once again, consider the example of a plaintiff filing suit against a hospital, a nonemployee surgeon, and a referring physician. Let us suppose that, if the case had been so tried, the jury would have apportioned liability at hospital—50%, surgeon—30%, and physician—20%, and assessed

160. S.B. No. 663 § 5.2(1).

161. As defined in § 5.2, which itself makes use of the "health care provider" definition in § 4(5).

162. In the concord, (see 83 MISSOURI MED. 20-21 (Jan. 1986)), the joint and several liability provision merely refers to "defendant" and "defendants." *Id.* § VI(a). Only the noneconomic damages provision incorporates the extended definition of "defendant." *Id.* § I(b).

163. S.B. No. 663 § 5.2.

164. *Id.* § 4.

165. It is suggested that § 5.2 should have commenced with the phrase, "'Defendant' for the purposes of *this* section," rather than the draftsman's "sections 4 to 10 of this act shall be defined as: . . . ."

166. For a most helpful examination of some of the problems arising, see Comment, *Problems for Joint Tortfeasors Under Whitehead & Kales: The Need for a Duty of Good Faith*, 27 ST. LOUIS U.L.J. 929 (1983).

a total liability of $1,000,000. However, before trial the surgeon settles the plaintiff's claim against her for $100,000. Under Missouri's contribution statute,[167] that $100,000 settlement would be deducted from a subsequent $1,000,000 verdict against the hospital and physician alone. If the surgeon's relative fault had been assessed by the jury she would have been liable for $300,000. In other words, the remaining tortfeasors would have been liable for the additional $200,000 split between the two of them according to their percentages of relative fault, as assessed by the jury. Furthermore, the hospital and physician would not have been able to bring a contribution action for that sum (the "extra" $200,000) against the settling surgeon.[168]

One suggested solution for this problem was that rather than reduce the award by the amount of the settlement, it should be reduced by that percentage of relative fault attributed to the settling tortfeasor.[169] Thus, in our example, the hospital would be liable for $500,000 and the physician $200,000. The $300,000 of liability allocated to the surgeon would be satisfied by the $100,000 settlement.

This solution has been adopted by Missouri's new malpractice act, which provides that "the claim of the releasing person against other persons or entities is reduced by the amount of the released persons' or entities' equitable share of the total obligation imposed by the court pursuant to a full apportionment of fault under this section as though there had been no release."[170]

Under this new provision, the apportionment of relative fault is for the jury.[171] Yet, our hypothetical settling surgeon, having been dismissed from the case, will not be able to fight her own battle in the courtroom. Indeed, the nonsettling defendants will have an incentive to "sandbag" the surgeon, thus placing the plaintiff in the position of proving not only the nonsettling defendants' negligence but the settling defendant's non-negligence as well.[172]

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167. Mo. REV. STAT. § 537.060 (Supp. 1986).

168. *Id.* For the converse situation, where the settling tortfeasor brings an action against nonsettling, nonjudgment joint tortfeasors, see Stephenson v. McClure, 606 S.W.2d 208 (Mo. Ct. App. 1980); Mid-Continent News Co. v. Ford Motor Co., 671 S.W.2d 796 (Mo. Ct. App. 1984).

169. *See* Parks v. Union Carbide Corp., 602 S.W.2d 188, 202-05 (Mo. 1980) (en banc) (Welliver, J., dissenting); *see also* State *ex rel.* Maryland Heights Concrete Contractors Inc. v. Ferriss, 588 S.W.2d 489, 492-93 (Mo. 1979) (en banc) (Donnelly, J., dissenting).

The issue was again raised in Gustafson v. Benda, 661 S.W.2d 11, 15 n.10 (Mo. 1983) (en banc). Cognizant of section 537.060's effect of reducing the total award by the amount of the settlement, the supreme court urged the legislature (somewhat ironically given the *Gustafson* majority's views as to legislative inactivity) to replace section 537.060 with a relative fault rule based on the UNIFORM COMPARATIVE FAULT ACT § 6, 12 U.L.A. 45-46 (Supp. 1986). According to the comment therein: "Although it may have some tendency to discourage a claimant from entering into a settlement, this solution is fairly based on the proportionate-fault principle." *Id.* at 46, Commissioners Comment to § 6.

170. S.B. No. 663 § 9.3.

171. *Id.* § 4(2).

172. *See, e.g.*, Paul v. N.L. Indus., 624 P.2d 68 (Okla. 1981).

Following the jury's apportionment of relative fault and determination of the total award, it will be for the trial judge to reduce the award by the amount of the released defendant's settlement prior to entering judgment.[173]

VI. The Concord, The Act, and Constitutional Review

Whatever the practical effects and interpretative problems that may follow from the new act, it is its constitutionality that will raise the greatest furor. Some threshold issues must first, however, be addressed. The concord is to last for four years, and yet the new act's substantive and procedural tort reforms apply only to causes of action arising after its enactment. Given the painfully slow progress of a malpractice suit towards trial, can the supreme court be expected to have decided on the act's constitutionality within the life of the concord?[174] Furthermore, and raising some delicate ethical issues, would a member of the plaintiff's bar *want* to challenge the act?[175] If a provision in the act were successfully challenged would that effectively bring the concord to an end,[176] or would the members of MATA and the coalition consider themselves to be under an obligation to redraft the invalidated section(s)?

Such speculation aside, which of the new act's provisions are likely to be challenged? It is suggested that the affidavit and punitive damages provisions will be treated by the plaintiffs' bar merely as the irritants they are, and will not prompt constitutional review. Furthermore, in practice, and particularly given that the new act has also introduced mandatory malpractice insurance for a large number of physicians and surgeons, the modification to the joint and several liability rule will not cause sufficient problems to make review worthwhile. Therefore, any initial constitutional battles will be with regard to the periodic payments and noneconomic cap provisions. The most likely challenges to these provisions will be on the bases that they are violative of the plaintiff's state and federal equal protection guarantees and the guarantee of "certain remedy" provided by the Missouri Constitution.[177]

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173. *See* M.A.I. § 1.06, Committee's Comment (1983 New) (West Supp. 1983).

174. Of course, any such ruling would affect the existing accrued claims.

175. Consider in this regard, Model Code Of Professional Responsibility EC 5-21 ("Desires of Third Persons"), DR 7-101 ("Representing a Client Zealously") (1980).

Tom Hullverson, a partner of the St. Louis firm Hullverson, Hullverson & Frank, Inc., and a member of the MATA negotiating team (see letter from MATA president to MATA members dated Dec. 5, 1985), is reported to have contended that the new law may be violative of constitutional guarantees of equal protection, and to have stated that: "Health care providers have a very special interest in the law . . . and the new law accords them special treatment." St. Louis Bus. J., Feb. 10-16, 1986, at 12, col. 3.

176. The majority of the provisions of the concord and the act would, of course, continue in force because of the act's severability clause. S.B. No. 663 § 10.

177. Challenges on the basis of deprivation of substantial due process (Mo.

A. *Equal Protection*

The most commonly utilized attack on malpractice crisis legislation—particularly limitations on quantum—over the past decade has been that it

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CONST. art. 1, § 10), interference with the right to trial by jury (*Id.* § 22(a)), and the rule against one statute dealing with multiple subjects (*Id.* art. 3, § 23), are also considered to be likely.

A due process challenge would be premised on the diminution of the value of plaintiffs' malpractice actions without the legislative provision of an adequate *quid pro quo*. *See* Note, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981). Absent Missouri's adoption of the *quid pro quo* approach, it is suggested that the due process review will track the equal protection/rational basis analysis detailed *infra* text accompanying notes 180-98. *En passant* it should be noted that the United States Supreme Court soon may be prepared to consider a *quid pro quo* argument.

In Fein v. Permanente Medical Group, 106 S. Ct. 214 (1985), the Supreme Court dismissed an appeal from the Supreme Court of California on the basis that it disclosed no substantial federal question. In his lone dissent, Justice White stated:

> Whether Due Process requires a legislatively enacted compensation scheme to be a quid pro quo for the common law or state law remedy it replaces, and if so, how adequate it must be, thus appears to be an issue unresolved by this Court, and one which is dividing the appellate and highest courts of several states. The issue is important, and is deserving of this Court's review. Moreover, given the continued national concern over the 'malpractice crisis,' it is likely that more states will enact similar types of limitations, and that the issue will recur. I find, therefore, that the federal question presented by this appeal is substantial, and dissent from the Court's conclusion to the contrary.

Id. at 216.

When Justice White dissented from the same result in Roa v. Lodi Medical Group, 106 S. Ct. 421 (1985) (White, Brennan, J.J., dissenting), he was joined (without opinion) by Justice Brennan. As the number of examples of restrictive malpractice legislation grows, the Supreme Court may be moving towards a determination, once and for all, of their validity.

A "right to trial by jury" violation would be premised on the role given the judge in both the structured payments provision (*i.e.*, setting the timing of installments and the interest rate), and the noneconomic damages cap (*i.e.*, reducing the award to $350,000). *See, e.g.*, American Bank & Trust Co. v. Community Hosp., 36 Cal. 3d 359, 375-76, 683 P.2d 670, 680-81, 204 Cal. Rptr. 671, 681-82 (1984). *Compare id.* at 689-94 (Bird, C.J., dissenting). Note, however, that one of the problems faced by the Supreme Court of California is not present in the Missouri Statute. Senate Bill No. 663 § 6.1 clearly places the itemization of awards in the hands of the jury.

The "multiple subjects" challenge (see, e.g., Westin Crown Plaza Hotel Co. v. King, 664 S.W.2d 2 (Mo. 1984) (en banc)), would be premised on the "marriage" of provisions designed to reduce/stabilize insurance rates with a provision designed to expedite physician action. This challenge will fail if the court adopts a broad characterization of the new statutory provisions as, for example, designed to alleviate the malpractice crisis.

violates the equal protection clauses of state and federal constitutions.[178] Most jurisdictions have rejected this argument.[179]

To make a case before Missouri courts about the violation of equal protection guarantees,[180] a challenger (the plaintiff-patient in the underlying malpractice action) must show, first, that the statutory provision is *factually*

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178. *See generally* Smith, *Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws*, 38 OKLA. L. REV. 195, 202-19, 220-21 (1985); Comment, *Alternatives to the Medical Malpractice Phenomenon: Damage Limitations, Malpractice Review Panels and Countersuits*, 34 WASH. & LEE L. REV. 1179, 1182-86 (1977); Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 S. CAL. L. REV. 829 (1979); Comment, *Statutes Limiting Medical Malpractice Damages*, 32 FED'N INS. COUNS. Q. 247, 250-57 (1982); Comment, *Medical Malpractice: A Sojourn Through the Jurisprudence Addressing Limitation of Liability*, 30 LOY. L. REV. 119 (1984).

179. *See* Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985); Fitz v. Dolyak, 712 F.2d 330 (8th Cir. 1983); DiAntonio v. Northampton-Accomack Mem., 628 F.2d 287 (4th Cir. 1980); Woods v. Holy Cross Hosp., 591 F.2d 1164 (5th Cir. 1979); Reese v. Rankin Fite Mem. Hosp., 403 So. 2d 158 (Ala. 1981); Eastin v. Broomfield, 116 Ariz. 576, 570 P.2d 744 (1977); Gay v. Rabon, 280 Ark. 5, 652 S.W.2d 836 (1983); American Bank & Trust Co. v. Community Hosp., 36 Cal. 3d 359, 683 P.2d 670, 204 Cal. Rptr. 671 (1984); Barme v. Wood, 37 Cal. 3d 174, 689 P.2d 446, 207 Cal. Rptr. 816 (1984); Roa v. Lodi Medical Group, 37 Cal. 3d 920, 695 P.2d 164, 211 Cal. Rptr. 77, *app. dism'd for want of federal question*, 106 S. Ct. 421 (1985); Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368, *app. dism'd for want of federal question*, 106 S. Ct. 214 (1985); Lacy v. Green, 428 A.2d 1171 (Del. Super. Ct. 1981); Pinillos v. Cedars of Lebanon Hosp. Corp., 403 So. 2d 365 (Fla. 1981); LePelley v. Grefenson, 101 Idaho 422, 614 P.2d 962 (1980); Benier v. Burris, 113 Ill. 2d 219, 497 N.E.2d 736 (1986); Anderson v. Wagner, 79 Ill. 2d 295, 402 N.E.2d 560 (1979), *app. dismissed*, Woodward v. Burham City Hosp., 449 U.S. 807 (1980); Johnson v. St. Vincent Hosp., 273 Ind. 584, 404 N.E.2d 585 (1980); Rudolph v. Iowa Methodist Medical Center, 293 N.S.2d 550 (Iowa 1980); Stephens v. Snyder Clinic Ass'n, 230 Kan. 115, 631 P.2d 222 (1981); Everett v. Goldman, 359 So. 2d 1256 (La. 1978); Sibley v. Board of Supervisors, 462 So. 2d 149 (La. 1985); Attorney General v. Johnson, 282 Md. 274, 385 A.2d 57, *app. dismissed*, 439 U.S. 805 (1978); Paro v. Longwood Hosp., 373 Mass. 645, 369 N.E.2d 985 (1977); Linder v. Smith, ___ Mont. ___, 629 P.2d 1187 (1981); Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977); Perna v. Pirozzi, 92 N.J. 446, 457 A.2d 431 (1983); Armijo v. Tandysh, 98 N.M. 181, 646 P.2d 1245 (Ct. App. 1981); Comiskey v. Arlen, 55 A.D.2d 304, 390 N.Y.S.2d 122, *aff'd*, 43 N.Y.2d 696, 372 N.E.2d 34, 401 N.Y.S.2d 200 (1976); Roberts v. Durham County Hosp. Corp., 56 N.C. App. 533, 289 S.E.2d 875 (1982), *aff'd.*, 307 N.C. 465, 298 S.E.2d 384 (1983); Beatty v. Akron City Hosp., 67 Ohio St. 2d 483, 424 N.E.2d 586 (1981); Allen v. Intermountain Health Care, 635 P.2d 30 (Utah 1981); Duffy v. King Chiropratic Clinic, 17 Wash. App. 693, 565 P.2d 435 (1977); State *ex rel.* Strykowski v. Wilkie, 81 Wis. 2d 491, 261 N.W.2d 434 (1978).

Cf. Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976) (remanded to trial court for fact finding as to "crisis"), *cert. denied*, 431 U.S. 914 (1977); Wentling v. Medical Anesthesia Serv., 237 Kan. 503, 701 P.2d 939 (1985); Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978); Duren v. Suburban Community Hosp., 482 N.E.2d 1358 (Ohio Common Pleas); Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983). *See generally* Annot., 80 A.L.R.3d 583 (1977).

180. Specifically, that such statutory provisions were violative of the guarantees to be found at U. S. CONST. amend. XIV, § 1, cl. 2, and Mo. CONST. art. 1, § 2.

defective (i.e., produces unequal treatment) and second, that such unequal treatment is at odds *legally* with one or more constitutional guarantees.

In the case of the noneconomic damage ceiling and structured award provisions of the new Missouri malpractice act, there is obvious unequal treatment. First, under both statutory modifications, medical malpractice victims are treated differently from other victims of negligent defendant behavior. Second, within the class of malpractice victims there is now unequal treatment. With regard to structured awards, plaintiffs who are to receive more than $100,000 in total damages are to be treated differently from those with less damages. With regard to the damage cap, plaintiffs awarded more than $350,000 of noneconomic damages are to be treated differently from those awarded a lesser amount.

Turning to the question of whether such factual defects violate (i.e., are legally defective) equal protection guarantees, the key obviously is the level of scrutiny utilized by the court. Of course, it is arguable that a judicial decision as to the type of scrutiny is no more than a conclusory rationalization of an "off-camera" decision either to uphold or invalidate the provision in question. Nevertheless, at least theoretically, review should consist of a structured process involving three steps. First, what is the appropriate standard of scrutiny to be utilized: strict scrutiny, intermediate review (substantial relationship), or rational basis? Second, what is the substance of the test so utilized; including within that substantive test, a determination of the burden of proof? Third, what evidence will the court take into account in determining governmental compliance with the appropriate standard of review?

It is accurate to state as a general proposition that malpractice crisis legislation will attract the lowest level of review—the rational basis test. Because the judiciary has not characterized personal injury litigation as a "fundamental right," strict scrutiny is inapplicable.[181] Furthermore, the intermediate standard of review has, in general, been eschewed by state courts in the context of malpractice crisis legislation.[182] It is predicted therefore that the Missouri courts will adopt the rational basis test in reviewing the new malpractice act.[183]

Support for this position comes from the dissenting opinions of Judge

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An analysis closely paralleling that suggested for equal protection would be undertaken if review was undertaken under Mo. CONST. art. 40(6)-(30).

181. *See, e.g.*, Carson v. Maurer, 120 N.H. 925, 931, 424 A.2d 825, 830 (1980); *cf.* Kenyon v. Hammer, 688 P.2d 961, 971-75 (Ariz. 1984) (perhaps explicable on the basis of very specific provisions contained in the Arizona Constitution).

182. *Cf.* Fein v. Permanente Medical Group, 38 Cal. 3d 137, 178-79, 695 P.2d 665, 694, 211 Cal. Rptr. 368, 397-98 (1985) (Mosk, J., dissenting); Carson v. Maurer, 120 N.H. 825, 932-33, 424 A.2d 825, 831 (1980); Arneson v. Olson, 270 N.W.2d 125, 133 (N.D. 1978).

183. *See, e.g.*, Laughlin v. Forgrave, 432 S.W.2d 308, 314-15 (Mo. 1968) (en banc); State *ex rel.* Cardinal Glennon Mem. Hosp. for Children v. Gaertner, 583 S.W.2d 107, 116-17 (Mo. 1979) (Morgan, C.J., dissenting); Ross v. Kansas City Gen. Hosp. & Medical Center, 608 S.W.2d 397, 399 (Mo. 1980) (en banc). For Missouri

Blackmar and Judge Welliver in *Strahler v. St. Luke's Hospital.*[184] The plurality in *Strahler* struck down Missouri's malpractice statute of limitations as it applies to minors on the basis of Missouri's guarantee of access to the courts.[185] Neither Judge Blackmar nor Judge Welliver, however, construed that guarantee as being absolute. Both saw the issue of constitutionality of the statute of limitations as based on a balancing test.[186] Thus, their approaches to that balancing process give some indication as to how they would react to an equal protection challenge against the new malpractice act.

According to Judge Blackmar: "It is not for us to say whether there is or is not a malpractice crisis. It is sufficient that the legislature may legitimately concern itself with the possibility that health providers will be at severe disadvantage if forced to defend themselves against claims based on long past events."[187] Judge Welliver was equally as forthright:

> It is not the function of this Court to determine whether or not there exists a malpractice crisis or a medical cost crisis. These are questions of legislative fact for the people of this state to decide via their legislature. Nor do I believe that it was irrational for the legislature to distinguish between minors over ten and minors under ten.[188]

One line of analysis may upset the prediction that the rational basis (lowest tier) review standard will be utilized. The Missouri Constitution provides for "certain remedy afforded for every injury to person."[189] This right of "certain remedy" has been described as "fundamental."[190] If held to encompass non-interference with an award of damages determined by a jury, then a strict scrutiny analysis may be still appropriate in the context of an equal protection challenge.[191]

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decisions utilizing a rational basis test in the general context of personal injury litigation, see Winston v. Reorganized School Dist., 636 S.W.2d 324 (Mo. 1982) (en banc); Crane v. Riehn, 568 S.W.2d 525 (Mo. 1978).

184. 706 S.W.2d 7 (Mo. 1986) (en banc).

185. Mo. CONST. art. I, § 14.

186. Specifically, Judge Welliver saw the analysis as akin to that used in due process challenges. *Strahler*, 706 S.W.2d at 18 (Welliver, J., dissenting).

187. *Id.* at 14 (Blackmar, J., dissenting).

188. *Id.* at 20 (Welliver, J., dissenting).

189. Mo. CONST. art. I, § 14.

190. Lohse Patent Door Co. v. Fuelle, 215 Mo. 421, 449, 114 S.W. 997, 1004 (1908).

191. See, for example, White v. State, ____ Mont. ____, ____, 661 P.2d 1272, 1275 (1983), holding that MONT. CONST. art. II, § 16, guaranteeing "speedy remedy . . . for every injury of person, property, or character," assured fundamental right status for "all recognized compensable components of injury, including the right to be compensated for physical pain and mental anguish and the loss of enjoyment of living," and, therefore, was subject to strict scrutiny analysis. A similar argument failed in Sibley v. Board of Supervisors, 462 So. 2d 149, 157 (La. 1985). *See also* State Bd. of Registration for the Healing Arts v. Griffen, 651 S.W.2d 475, 479-80 (Mo. 1983) (en banc) (examples of fundamental rights given as "freedom of speech," "freedom of the press," "freedom of religion," "the right to vote," and "the right to procreate").

Assuming, however, that the Missouri courts adopt the rational basis standard of review, what is the substance of that standard? Although there are a multitude of judicial expressions of the test, in practice they can be summarized as falling within one of two general approaches: (1) the "rational *legislature*" test and (2) the "rational *legislation*" test. The former is essentially subjective, posing the questions whether a legislature could have envisaged a rational relationship between its unequal classification and its legislative goals.[192] The latter has objective characteristics, moving toward an intermediate scrutiny standard and examining the substance of the alleged relationship between the legislation and the legislative goals.[193]

Intimately linked to this choice between these approaches to determining rational basis will be a court's view as to what evidence properly should be considered. Thus, a court that applies the "rational legislation" variant will be more interested in evidence as to whether, in practice, the legislation is achieving its legislative goals.[194] On the other hand, the application of the "rational legislature" approach does not require evidence either of the success or failure of the legislation[195] nor even of the very existence of the problem (here, the malpractice "crisis") that it was designed to alleviate.[196] What little authority there is suggests that, in the malpractice context at least, the Missouri Supreme Court seems to lean toward the less rigorous "rational legislature" approach.[197]

If the court utilizes this less rigorous standard of review, it may well decide that a rational legislature could have determined that Missouri was faced with a malpractice crisis, thus justifying the unequal classification of malpractice victims compared to negligence victims generally. This position would comport with the views of Judge Welliver who, while dissenting in *Strahler v. St. Luke's Hospital*, stated: "I believe that the classification of minors who are tort victims of a health care provider and minors who are victims of other tortfeasors is rationally related to the legitimate state interest of controlling malpractice insurance costs."[198]

Furthermore, the unequal classifications within the new act, based on the particular monetary amounts awarded, also could be seen as the products of a rational legislature. With regard to the structured payments cut-off point

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192. *See, e.g.*, American Bank & Trust Co. v. Community Hosp., 36 Cal. 3d 359, 683 P.2d 670, 204 Cal. Rptr. 671 (1984).

193. *See, e.g., id.* at 699 (Bird, C.J., dissenting).

194. *See, e.g., id.* at 684-86 (Mosk, J., dissenting).

195. *See, e.g., id.* at 679 (Kaus, J.).

196. *See, e.g.*, Carson v. Maurer, 120 N.H. 925, 933, 424 A.2d 825, 831 (1980); *cf.* Bernier v. Burris, No. 85-345, slip op. at 2 (Ill. Cir. Ct. Cook County Dec. 19, 1985) ("There is no empirical data to support the claim that a medical malpractice insurance crisis exists in the State of Illinois."), *aff'd in part, rev'd in part*, 113 Ill. 2d 219, 497 N.E.2d 763 (1986).

197. *See* cases cited *supra* at note 183; *see also* State Bd. of Registration for the Healing Arts v. Griffen, 651 S.W.2d 475, 481 (Mo. 1983) (en banc).

198. *Strahler*, 706 S.W.2d at 20 (Welliver, J., dissenting).

of $100,000, a rational legislature could have viewed the imposition of periodic payments in the case of small awards as not being worthwhile given the attendant administrative costs that would be incurred by the parties and the court. With regard to the $350,000 cap on noneconomic damages, the court might well conclude that a rational legislature may have considered that it was particularly large malpractice awards that were the cause of rising malpractice insurance premiums and threatened insurer withdrawal from the Missouri market.

B. *The Guarantee of "Certain Remedy"*

Section 14 of the Missouri Bill of Rights provides: "That the courts of justice shall be open to every person, and certain remedy afforded for every injury to person, property or character, and that right and justice shall be administered without sale, denial or delay."[199] It was on the basis of this provision that the supreme court struck down Missouri's pretrial review panel procedure in *State ex rel. Cardinal Glennon Memorial Hospital v. Gaertner*.[200] *Cardinal Glennon* turned on the importance the court attached to the right of access to the courts,[201] and the specific constitutional prohibition against delay found in section 14.[202]

With regard to Missouri's new noneconomic damages cap and, to a lesser extent, structured payments provision, two questions arise for consideration. First, will the court place as much weight on the "certain remedy" guarantee as on the access to courts provision? Second, will "certain remedy" be construed to include a guarantee of unlimited (or, in the case of the structured payments provision, unfettered) personal injury quantum?

In 1908, the Supreme Court provided a provisional answer to that first question when it described the guarantee of "certain remedy" as follows:

> The constitution of our state guarantees liberty to every citizen, and a certain remedy in the laws for all injuries or wrongs which he may receive in his person, property, or character; and the rights so guaranteed are fundamental, and can be taken away only by the law of the land, or interfered with, or the enjoyment thereof modified, only by lawful regulations adopted as necessary for the general public welfare.[203]

Far more difficult, however, is predicting the reach of the "certain remedy" guarantee. It seems that a total *denial* of *any* remedy would run counter to

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199. Mo. CONST. art. I, § 14.

200. 583 S.W.2d 107, 110 (Mo. 1979). The case is further considered *supra* note 14.

201. *Id.*

202. *Id.* at 111 (Simeone, J., concurring).

203. Lohse Patent Door Co. v. Fuelle, 215 Mo. 421, 449, 114 S.W.2d 997, 1004 (1908).

the constitutional guarantee,[204] but would this be the case with a statutory *reduction* of quantum? Case law from other jurisdictions suggests not. For example, the Supreme Court of Idaho considered an argument that a medical malpractice damage cap was invalid in the face of a constitutional provision guaranteeing "a speedy remedy . . . for every injury of person."[205] The court concluded: "To adopt that argument would be to hold that the common law as of 1890 governs the health, welfare and safety of the citizens of this state and is unalterable without constitutional amendment."[206]

Some light has been shed on the Missouri position by the supreme court's recent decision in *Strahler v. St. Luke's Hospital*.[207] The argument therein concerned the constitutionality of the malpractice statute of limitations as applied to minors. Clearly, the majority of the court analyzed the issue presented as going to the "access to the courts" aspect of Article I, section 14.[208] While both concurred in the majority opinions, Judge Billings[209] and Judge Robertson[210] were careful to expressly exclude any prejudgment of the new malpractice act's limitation on noneconomic damages.

Nevertheless, at least one explanation for Judge Welliver's well researched dissent is that he foresaw the plurality's firm stance on a somewhat absolutist approach to the "access to the courts" provision in Article I, section 14 as being readily transferable to its "certain remedy" guarantee. As he stated: "If it is unconstitutional to apply such a statute of limitation to actions for malpractice, why it is not also unconstitutional to attempt to limit the amount of recovery or place a cap on the amount of recovery in medical malpractice actions?"[211]

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204. Harryman v. L&N Buick-Pontiac, 431 S.W.2d 193, 195-96 (Mo. 1968); De May v. Liberty Foundry Co., 327 Mo. 495, 506, 37 S.W.2d 640, 645 (1931); *see also* Strahler v. St. Luke's Hosp., 706 S.W.2d 7 (Mo. 1986) (en banc).

205. Jones v. State Bd. of Medicine, 97 Idaho 859, ___, 555 P.2d 399, 404 (1976).

206. *Id.* at ___, 555 P.2d at 404; *see also* Sibley v. Board of Supervisors, 462 So. 2d 149, 157 (La. 1985); *cf.* Kenyon v. Hammer, 142 Ariz. 69, ___, 688 P.2d 961, 971-75 (1984); White v. State, ____ Mont. ____, ____, 661 P.2d 1272, 1275 (1983).

207. 706 S.W.2d 7 (Mo. 1986) (en banc).

208. *Id.* at 9, 12 (Robertson, J., concurring).

209. *Id.* at 12 n.9 : "Questions concerning limiting the amount of recovery, 'caps,' . . . are not before us in this case."

210. *Id.* at 12-13 (Robertson, J., concurring).

> Nor does this decision necessarily portend ill for the legislature's current effort to revamp the law of medical malpractice. That legislation is not presently before us; we may not now judge its adherence to constitutional standards. Those who would attack that legislation should find no greater comfort in the principal opinion than already exists in *Cardinal Glennon*.

Id.

211. *Id.* at 20 (Welliver, J., dissenting) (footnote omitted).

VII. Conclusion

Beyond doubt, the concord and resulting legislation illustrate something of a breakthrough in the formulation of medical malpractice crisis legislation. The act is not without its technical problems and, in several instances, may have failed to convey the intent of the negotiating parties. Its passage, however, coupled with the concord's four year moratorium on legislative action, present to the Missouri legislature a unique opportunity: to study the workings of the new act and its effect (if any) on malpractice insurance rates. In 1990, additional legislation may be necessary. When that time comes, the legislature should insist that lawyers and doctors are to be joined at the negotiating table by noncaptive insurers and representatives of patients' groups.