

September 1991

A Free Market Analysis of the Effects of Medical Malpractice Damage Cap Statutes: Can We Afford to Live with Inefficient Doctors

Franklin D. Cleckley
West Virginia University College of Law

Govind Hariharan
West Virginia University, Department of Economics

Follow this and additional works at: <https://researchrepository.wvu.edu/wvlr>



Part of the [Medical Jurisprudence Commons](#)

Recommended Citation

Franklin D. Cleckley & Govind Hariharan, *A Free Market Analysis of the Effects of Medical Malpractice Damage Cap Statutes: Can We Afford to Live with Inefficient Doctors*, 94 W. Va. L. Rev. (1991).
Available at: <https://researchrepository.wvu.edu/wvlr/vol94/iss1/3>

This Article is brought to you for free and open access by the WVU College of Law at The Research Repository @ WVU. It has been accepted for inclusion in West Virginia Law Review by an authorized editor of The Research Repository @ WVU. For more information, please contact ian.harmon@mail.wvu.edu.

A FREE MARKET ANALYSIS OF THE EFFECTS OF MEDICAL MALPRACTICE DAMAGE CAP STATUTES: CAN WE AFFORD TO LIVE WITH INEFFICIENT DOCTORS?

FRANKLIN D. CLECKLEY*
GOVIND HARIHARAN**

I. INTRODUCTION	12
II. MEDICAL MALPRACTICE TORT REFORM.....	19
A. <i>Impetus for Tort Reform</i>	19
B. <i>Types of Reform Measures</i>	28
C. <i>Effectiveness of Reform</i>	30
III. MEDICAL MALPRACTICE TORT REFORM IN WEST VIRGINIA	33
A. <i>West Virginia Medical Practice Act</i>	35
B. <i>Malpractice Insurance Act</i>	37
C. <i>Medical Professional Liability Act</i>	39
1. Section 55-7B-3: Elements of Proof	39
2. Section 55-7B-4: Health Care Injuries, Limitations of Actions, Exceptions	41
3. Section 55-7B-5: Health Care Actions, Complaint; Specific Amount of Damages Not To Be Stated	42
4. Section 55-7B-6: Pretrial Procedures	43
5. Section 55-7B-7: Testimony of Expert Witness on Standard of Care.....	44
6. Section 55-7B-8: Limit on Liability for Non-economic Loss.....	45
7. Section 55-7B-9: Joint and Several Liability ...	46

* Arthur B. Hodges Professor of Law, West Virginia University College of Law; A.B. 1962, Anderson College; J.D. 1965, Indiana University at Bloomington; LL.M. 1969, Harvard University.

** Assistant Professor, Department of Economics, West Virginia University. M.A. 1983, U. Delhi, Ph.D., 1990, S.U.N.Y. at Buffalo, New York.

We are extremely thankful to Cedar J. Mansour, Vito Mussomeli and especially Louis Palmer for their excellent research assistance. We would also like to thank colleagues Robert Bastress, Jeff Lewin and former professor Patrick Heleen for their helpful and thoughtful comments.

IV.	JUDICIAL SCRUTINY OF MEDICAL MALPRACTICE DAMAGE CAPS	47
V.	FREE MARKET ANALYSIS OF DAMAGE CAPS.....	52
	A. <i>The Medical Malpractice Insurance Market</i>	52
	B. <i>Group Premium Paradigm</i>	54
	C. <i>Experience Rated Premium Paradigm</i>	57
	D. <i>Damage Cap Paradigm</i>	59
VI.	CAN WE AFFORD TO LIVE WITH INEFFICIENT DOCTORS?	61
VII.	EPILOGUE	68

I. INTRODUCTION

The national health care system¹ underwent dramatic cost increases during the 1970's² and 80's.³ In spite of vigorous efforts to

1. "The American health [care] system is a hybrid - partly government-managed, partly private, partly in-between; partly a model of excellence, and partly a disgrace." BUDGET OF THE UNITED STATES GOVERNMENT FISCAL YEAR 1992, H.R. Doc. No. 3, 102d Cong., 1st Sess. 13-14 (1991).

2. The following Table compares national health care expenditure and gross national product for the period 1970-79:

TABLE 1
COMPARISON OF GROWTH RATES OF GROSS NATIONAL
PRODUCT AND NATIONAL HEALTH EXPENDITURES 1970-79

Year	GNP		NHE		NHE as % of GNP
	Amount (billions)	Rate of growth	Amount (billions)	Rate of growth	
1970	\$1,015.5	5.3	\$ 75.0	14.3	7.4
1971	1,102.7	8.6	83.5	11.3	7.6
1972	1,212.8	10.0	94.0	12.6	7.8
1973	1,359.3	12.1	103.4	10.0	7.6
1974	1,472.8	8.3	116.1	12.3	7.9
1975	1,598.4	8.5	132.7	14.3	8.3
1976	1,782.8	11.5	150.8	13.6	8.5
1977	1,990.5	11.7	169.9	12.7	8.5
1978	2,249.7	13.0	189.7	11.7	8.4
1979	2,508.2	11.5	214.7	13.2	8.6

HEALTH INSURANCE ASSOC. OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA, 49 (1989) [hereinafter SOURCEBOOK].

For a general discussion on cost increases, see Clark C. Havighurst & James F. Blumstein, *Coping With Quality/Cost Trade-Offs in Medical Care: The Role of PSRO*, 70 NW. U. L. REV. 6, 9-15 (1975); Michael G. Michaelson, Comment, *Reagan Administration Health Legislation: The Emergence of a Hidden Agenda*, 20 HARV. J. ON LEGIS. 575, 576-583 (1983).

3. "Although the American health [care] system leads the world in research and in many specialized areas, its general performance is not yet satisfactory. Its costs continue to grow faster than both inflation and the economy. Total national expenditures on health now claim 13.5 percent of GNP. Federal health

reduce health care costs by federal⁴ and state⁵ governments, we have

spending is over 15 percent of the budget." BUDGET OF THE UNITED STATES GOVERNMENT FISCAL YEAR 1992, H.R. Doc. No. 3, 102d Cong., 1st Sess. 13 (1991). The following Table compares national health care expenditure and gross national product for the period 1980-87:

TABLE 2
COMPARISON OF GROWTH RATES OF GROSS NATIONAL
PRODUCT AND NATIONAL HEALTH EXPENDITURES 1980-87

Year	GNP		NHE		NHE as % of GNP
	Amount (billions)	Rate of growth	Amount (billions)	Rate of growth	
1980	\$2,732.0	8.9	\$248.1	15.6	9.1
1981	3,052.6	11.7	287.0	15.7	9.4
1982	3,166.0	3.7	323.6	12.8	10.2
1983	3,405.7	7.6	357.2	10.4	10.5
1984	3,772.2	10.7	388.5	8.8	10.3
1985	4,014.9	6.4	419.0	7.9	10.4
1986	4,240.3	5.6	455.7	8.7	10.7
1987	4,526.7	6.7	500.3	9.8	11.1

SOURCE BOOK, *supra* note 2 at 49.

For a general discussion on cost increases, see Andreas G. Schneider, *Legal and Political Pressures on Health Care Cost Containment*, 36 CASE W. RES. L. REV. 693 (1985); Carl J. Schramm, *A State-Based Approach to Hospital-Cost Containment*, 18 HARV. J. ON LEGIS. 603 (1981); David Parkin et al., *Aggregate Health Care Expenditures and National Income*, 6 J. HEALTH ECON. 109 (1987).

4. The following Table presents national health expenditure data for the federal government during the period 1970-85:

TABLE 3
FEDERAL SPENDING AS PERCENTAGE OF
NATIONAL HEALTH EXPENDITURES

Year	Federal Spending (billions)	Percentage of NHE
1985	\$127.6	30.4%
1984	111.9	28.9
1983	102.7	28.9
1982	93.2	29.0
1981	83.5	29.3
1980	71.0	28.7
1979	61.0	28.4
1978	53.8	28.4
1977	47.4	27.9
1976	42.6	28.2
1975	37.0	27.9
1974	31.0	26.6
1973	25.2	24.4
1972	22.9	24.4
1971	20.3	24.3
1970	17.7	23.6

Kenneth R. Wing, *American Health Policy In The 1980's*, 36 CASE W. RES. L. REV. 608, 651 (1985).

For examples of federal statutes aimed at controlling the cost of health care expenditure, see Health Maintenance Organization Act, 42 U.S.C. § 300e (1988); 42 U.S.C. § 242b (1988); 42 U.S.C. § 255 (1988).

It will be noted that medical malpractice reform measures were included in the federal budget proposal

entered the 90's with a great percentage of the population being unable to afford health care services.⁶ Along the road to the present

for fiscal year 1992. "To help keep health care costs down the Bush Administration would offer incentives to the states to enact a series of reforms . . . States would have until 1995 to adopt the reform package. Hospitals in states that did not enact tort law changes would face the loss of about \$800 million in federal Medicare funds in 1995." Insurance Information Institute, *Medical Malpractice*, Sept., 1991, available in LEXIS, Nexis Library, Omni file. See *infra* note 218, for the complete text of the proposal.

For a general discussion of federal legislation, see Clark C. Havighurst, *Regulation of Health Facilities and Services By Certificate of Need*, 59 VA. L. REV. 1143 (1973); Milton I. Roemer, *The Expanding Scope of Governmental Regulation of Health Care Delivery*, 6 U. TOL. L. REV. 591 (1974); Rand E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243 (1978); Kenneth R. Wing & Andrew M. Sifton, *Constitutional Authority for Extending Federal Control Over the Delivery of Health Care*, 57 N.C. L. REV. 1423 (1979); Ira G. Greenberg & Michael L. Rodburg, Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887 (1971).

5. The following Table presents national health expenditure data for state and local governments during the period 1970-85:

TABLE 4
STATE AND LOCAL SPENDING AS PERCENTAGE
OF NATIONAL HEALTH EXPENDITURES

Year	State and Local Spending (billions)	Percentage of NHE
1985	\$51.9	12.4%
1984	48.3	12.5
1983	45.4	12.8
1982	41.9	13.0
1981	38.1	13.3
1980	34.3	13.9
1979	29.8	13.9
1978	26.1	13.7
1977	22.7	13.3
1976	20.3	13.5
1975	19.3	14.5
1974	16.6	14.3
1973	14.2	13.7
1972	12.5	13.3
1971	11.4	13.6
1970	10.1	13.5

Wing, *supra* note 4 at 651.

For state statutes regulating health care costs, see MASS. ANN. LAWS ch. 6A §§ 31-39 (Law Co-op. 1988 & Supp. 1991); N.J. STAT. ANN. §§ 26:2H-2(e), 26:2H-18 (West 1987); OR. REV. STAT. §§ 442.400, 442.450 (1989); R.I. GEN. LAWS §§ 27-19-6, 27-19-7 (1989).

For a general discussion of state legislation, see Crozier, *State Rate-Setting: A Status Report*, 1 HEALTH AFF. 74 (1982); Alfonso Esposito et al., *Abstracts of State Legislated Hospital Cost-Containment Programs*, HEALTH CARE FIN. REV., Dec. 1982, at 129; Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE J. ON REG. 179 (1988); Lawrence S. Lewin et al., *State Health Cost Regulation: Structure and Administration*, 6 U. TOL. L. REV. 647 (1974); Carl J. Schramm, *State Hospital Cost Containment: An Analysis of Legislative Initiatives*, 19 IND. L. REV. 919 (1986); Frank A. Sloan, *Rate Regulation as a Strategy for Hospital Cost Control: Evidence from the Last Decade*, 61 MILBANK MEM. FUND Q. 195 (1983).

6. It was estimated that the uninsured population in the U.S. increased from 28.0 million in 1979

crisis in health care costs,⁷ some observers, notably health care providers⁸ and insurance underwriters,⁹ blamed skyrocketing costs on the civil judicial system.¹⁰ Tort reformers, as these observers were

to 36.8 million in 1986. Factors blamed for this large at-risk population include, "erosion of the Medicaid program's coverage of the poor; demographic shifts . . . and finally, increased health care insurance costs which have outpaced the growth in incomes." SOURCE BOOK, *supra* note 2 at 11 (1989). See generally Randall R. Bovbjerg & William G. Kopt, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857 (1986); Karen Davis & Diane Rowland, *Uninsured and Underserved: Inequities in Health Care in the United States*, 61 MILBANK MEM. FUND Q. 149 (1983); Pamela J. Farley, *Who Are the Underinsured?*, 63 MILBANK MEM. FUND Q. 476 (1985); Andreas G. Schneider & Joanne B. Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW. U. L. REV. 90 (1975); Keith Wrenn, *No Insurance, No Admission*, 312 NEW ENG. J. MED. 373 (1985).

7. The following Table reports personal consumption expenditure for health care services for the period 1970-87:

TABLE 5
PERSONAL CONSUMPTION EXPENDITURES FOR HEALTH CARE SERVICES

Year	Hospital Services (billions)	Physician Services (billions)	Medicine/ Appliances (billions)
1970	\$ 19.7	\$14.0	\$10.0
1971	23.2	15.3	10.5
1972	25.9	16.6	11.5
1973	28.8	18.4	12.5
1974	33.7	20.3	13.6
1975	40.1	23.5	14.9
1976	46.6	25.8	16.3
1977	53.3	29.6	17.4
1978	61.0	32.3	19.2
1979	70.0	36.3	21.6
1980	82.0	42.0	23.5
1981	96.8	49.0	25.8
1982	110.3	54.4	27.6
1983	119.6	61.1	30.3
1984	130.6	67.1	33.0
1985	140.2	73.5	36.0
1986	152.1	80.6	39.2
1987	167.4	93.9	42.9

SOURCE BOOK, *supra* note 2 at 57.

For a discussion of health care costs to consumers see, Robert J. Blendon & Drew E. Altman, *Public Attitudes About Health Care Costs*, 311 NEW ENG. J. MED. 613 (1984) (where it was reported that 53% of Americans favor more spending for health care); Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry*, 93 HARV. L. REV. 1416 (1980) (arguing that imperfect knowledge by consumers allows nonprofit hospitals to exploit health care costs); Gosfield, *Consumer Accountability in PSROs*, 6 U. TOL. L. REV. 764 (1974) (where it is argued that consumers should be allowed to have an input in cost and quality control decisions in government health care initiatives).

8. Health care provider refers to physicians and hospitals.

9. Unless otherwise indicated, the terms "insurance underwriters," "insurers," and "insurance industry" will be used interchangeably to refer to medical malpractice insurance carriers.

10. Among the many factors that make up health care expenditures is that of premium costs for medical malpractice insurance. Health care providers and insurers have argued that continued escalation

labeled,¹¹ rapidly set out upon a self-imposed mission¹² of decreasing health care costs¹³ by dismantling, state-by-state, medical malpractice tort laws.¹⁴

This article is primarily concerned with the analysis of one of the numerous measures of reform¹⁵ put forth by tort reformers:¹⁶

in medical malpractice premium costs is the result of unfavorable tort laws. For a general discussion, see Patricia M. Danzon, *Liability and Liability Insurance for Medical Malpractice*, 4 J. HEALTH ECON. 309 (1985); Jeffrey O'Connell, *No-Fault Insurance for Injuries Arising From Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21 (1975); Susan S. Septimus, Note, *The Concept of Continuous Tort as Applied to Medical Malpractice: Sleeping Beauty for Plaintiff, Slumbering Beast for Defendant*, 22 TORT INS. L.J. 71 (1986); S. Y. Tan, Note, *The Medical Malpractice Crisis: Will No-Fault Cure the Disease*, 9 U. HAW. L. REV. 241 (1987).

11. The terms "reformers" and "tort reformers" refer exclusively to health care providers and insurers, unless otherwise indicated. For a general discussion of tort reform in other areas, see Sylvia M. Demarest & David E. Jones, *Exemplary Damages as an Instrument of Social Policy: Is Tort Reform in the Public Interest?*, 18 ST. MARY'S L.J. 797 (1987); Dominick Vetri, *The Integration of Tort Law Reforms and Liability Insurance Ratemaking in the New Age*, 66 OR. L. REV. 277 (1987).

12. Regarding this mission, one commentator put it succinctly: "A drastic basic reform in the entire mechanism of malpractice litigation is an imperative necessity. . . . As a united professional group, physicians and surgeons can withstand any assault upon them via liability threats or actions." Bernard J. Ficarra, *Professional Liability v. Doctors of Medicine*, 1975 LEGAL MED. ANN. 117, 148 (1975).

13. For a discussion of specific measures aimed at reducing the cost of health care, see Keith A. Rosten & James S. Cline, *The Effect of Policy Language on the Containment of Health Care Cost*, 21 TORT INS. L.J. 120 n.1 (1985) (where it was suggested that the following factors contributed to the escalation of health care costs: "federal funding in 1946 of hospital construction, which led to an oversupply and therefore a tendency to over-utilize hospitals; an increase in the number of physicians available to provide medical services . . . advanced and much more expensive technology and equipment; increased longevity; the creation of government and private programs to pay for medical expenses, such as Medicare and Medicaid and group insurance; and a general lack of competition in the health care industry, coupled with little incentive on the part of the consumer to reduce costs."). See also Richard J. Frey, *Coalitions on Health Care Cost*, 3 HEALTH MATRIX 38, (Spring 1985); Miles Zaremaski & Joan Rehm, *Cost Containment (DRGs): A New Source for Litigation*, 3 HEALTH MATRIX 24, (Summer 1985).

14. See, e.g., Robert G. Byrd, *The North Carolina Medical Malpractice Statute*, 62 N.C. L. REV. 711 (1984); Scott I. Anderson, Comment, *Contribution Among Tortfeasors in Washington: The 1981 Tort Reform Act*, 57 WASH. L. REV. 479 (1982); Betsy A. Rosen, Note, *The 1985 Medical Malpractice Reform Act: The New York State Legislature Responds to the Medical Malpractice Crisis With a Prescription for Comprehensive Reform*, 52 BROOK. L. REV. 135 (1986).

15. For discussions of other tort reform measures, see Gregory A. Hicks, *Statutory Damage Caps are an Incomplete Reform: A Proposal for Attorney Fee Shifting in Tort Actions*, 49 LA. L. REV. 763 (1989); Victore Schwartz, *Tort Law Reform: Strict Liability and the Collateral Source Rule Do Not Mix*, 39 VAND. L. REV. 569 (1986); Jennifer Andrews, Note, *Questions Surrounding the Texas Medical Malpractice Statute of Limitations*, 38 BAYLOR L. REV. 751 (1986); Richard Boyle, Note, *Medical Malpractice Screening Panels: A Judicial Evaluation of Their Practical Effect*, 42 U. PITT. L. REV. 939 (1981); Nancy L. Manzer, Note, *1986 Tort Reform Legislation: A Systematic Evaluation of Caps on Damages and Limitations on Joint and Several Liability*, 73 CORNELL L. REV. 628 (1988).

16. See *infra* text accompanying notes 26-104. See also Jerry S. Phillips, *Tort Reform and Insurance Crisis in the Second Half of 1986*, 22 GONZ. L. REV. 277 (1986).

damage cap statutes¹⁷ for medical malpractice verdict awards.¹⁸ Our approach to this issue will be that of an economic or free market analysis.¹⁹ The application of free market analysis to legal issues is not novel.²⁰ Free market analysis has become an effective and efficient tool for investigating legal questions.²¹

The issue of medical malpractice damage caps²² provides a good example of a legal question that can be effectively analyzed from a free market perspective.²³ It was because of the effectiveness of

17. Damage cap statutes impose a limitation on the amount of verdict awards in medical malpractice actions. Statutes differ on the dollar amount of verdict award limitations, as well as on the imposition of caps, *i.e.*, noneconomic damage cap and/or economic damage cap. *See, e.g.*, COLO. REV. STAT. § 13-21-102.5(3)(a) (1989) (\$500,000 noneconomic cap); KAN. STAT. ANN. § 60-3407 (Supp. 1989) (\$1,000,000 economic and noneconomic cap); MASS. GEN. L. ch. 231 § 60-H (Supp. 1991) (\$500,000 noneconomic cap); MO. ANN. STAT. § 538.210 (Vernon 1988) (\$350,000 noneconomic cap); S.D. CODIFIED LAWS ANN. § 21-3-11 (1987) (\$1,000,000 economic and noneconomic cap); UTAH CODE ANN. § 78-14-7.1 (1987) (\$250,000 noneconomic cap); W. VA. CODE § 55-7B-8 (Supp. 1990) (\$1,000,000 noneconomic cap); WIS. STAT. ANN. § 893.55 (Supp. 1990) (\$1,000,000 noneconomic cap).

18. For a general discussion of judicial decisions on damage caps, see Stephen J. Schanz, *Michigan Medical Malpractice Reform: A Constitutional Analysis of Statutory Limitations on Noneconomic Damages*, 4 COOLEY L. REV. 457 (1987); Janai M. Powell, Note, *Challenging the Constitutionality of Noneconomic Damage Caps: Boyd v. Bulala and the Right to a Trial By Jury*, 24 WILLAMETTE L. REV. 821 (1988); Paul B. Weiss, Comment, *Reforming Tort Reform: Is There Substance to the Seventh Amendment*, 38 CATH. U. L. REV. 737 (1989). *See also*, Fein v. Permanente Medical Group, 695 P.2d 665, *appeal dismissed*, 478 U.S. 892 (1985); Lucas v. United States, 757 S.W.2d 687 (Tex. 1988).

19. *See generally* RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* (1986). The terms "economic analysis" and "free market analysis" will be used interchangeably throughout this article. The terms are to be understood as referring to "a pure system, one in which all economic activity proceeds through laissez-faire markets." ISRAEL M. KIRZNER, *DISCOVERY, CAPITALISM AND DISTRIBUTIVE JUSTICE* 4 (1989).

20. *See, e.g.*, Frank H. Easterbrook, *Criminal Procedure as a Market System*, 12 J. LEG. STUD. 289 (1983); Wendy J. Gordon, *Fair Use as Market Failure: A Structural and Economic Analysis of the Betamax Case and its Predecessors*, 82 COLUM. L. REV. 1600 (1982); Joseph T. Janczyk, *An Economic Analysis of the Land Title Systems for Transferring Real Property*, 6 J. LEG. STUD. 213 (1977); William Landes, *An Economic Analysis of the Courts*, 14 J. LAW & ECON. 61 (1971); Patrick Munch, *An Economic Analysis of Eminent Domain*, 84 J. POL. ECON. 473 (1976); Richard A. Posner & Michael W. McConnell, *An Economic Approach to Issues of Religious Freedom*, 56 U. CHI. L. REV. 1 (1989); Elizabeth Warren, *Trade Usage and Parties in the Trade: An Economic Rationale for an Inflexible Rule*, 42 U. PITT. L. REV. 515 (1981).

21. As one commentator noted, "Statutory or constitutional as distinct from common law fields . . . are permeated by economic concerns and illuminated by economic analysis." POSNER, *supra* note 20 at 21.

22. For further discussion, see Ronald E. Wagner & Jesse M. Reiter, *Damage Caps in Medical Malpractice: Standards of Constitutional Review*, 1987 DET. C.L. REV. 1005 (1987); June C. Arancibia, Note, *Statutory Caps on Damage Awards in Medical Malpractice Cases*, 13 OKLA. CITY U.L. REV. 135 (1988).

23. For economic analysis in other areas of medical malpractice tort reform, see Patricia M. Danzon, *An Economic Analysis of the Medical Malpractice System*, 1 BEHAV. SCI. & L. 39 (1983); Richard A.

this tool that we were ultimately led to the question: "Can we live with inefficient doctors?"²⁴

We will reserve resolution of this question until the last part of this article. Part II of the article provides an overview of the medical malpractice tort reform movement. Part III discusses medical malpractice tort reform in West Virginia. Part IV examines case law construing medical malpractice damage cap statutes. An economic analysis of damage caps is offered in Part V.

Part VI is a necessary and logical conclusion to the article flowing from the economic analysis that precedes it. As this article will point out, damage caps can, in fact, provide a minimal reduction in the cost of medical malpractice insurance. However, an unconscionable price is paid by the American public as a direct result of the imposition of a cap on medical malpractice awards. It is of primary importance that lawmakers rethink the question of damage caps. The health and the very lives of the American public hang precariously in the balance because of current thinking on this matter.

In spite of threats to state health care programs by the Bush Administration (Epilogue *infra*) regarding the enactment of damage cap statutes in every state by 1995, we cannot sacrifice human lives so that a handful of incompetent doctors can afford to buy expensive cars; surely, human beings are worth more than the trinkets they manufacture. State lawmakers must resist the pressure by the Bush Administration to force enactment of damage caps where they do not exist. Further, in those states where they do exist, this article fervently urges their repeal.

Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 VA. L. REV. 1451 (1988); Barry R. Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 CASE W. RES. L. REV. 985 (1985); M. W. Reder, *An Economic Analysis of Medical Malpractice*, 5 J. LEGAL STUD. 267 (1976); William D. Schwartz & Neil K. Komisar, *Doctors, Damages and Deterrence: An Economic View of Medical Malpractice*, 298 NEW ENG. J. MED. 1282 (1978).

24. For a detailed treatment of medical malpractice cases, see ANGELA M. HOLDER, *MEDICAL MALPRACTICE LAW* (1975); CHARLES KRAMER, *THE NEGLIGENT DOCTOR* (1968).

II. MEDICAL MALPRACTICE TORT REFORM²⁵

A. Impetus for Tort Reform

The 1970's have been characterized as a decade embroiled in a medical malpractice insurance availability crisis.²⁶ This was a period in which the demand for medical malpractice insurance greatly exceeded the supply of insurers.²⁷ On the other hand, the

25. Several matters should be kept in mind in considering our discussion of medical malpractice tort reform. First, "[m]edical malpractice denotes the basis for a civil action brought by a patient against a physician for injuries resulting from negligence." George J. Annas, et al., *Medical Malpractice Litigation Under National Health Insurance: Essential or Expendable*, 1975 DUKE L.J. 1335. Second, tort reform in this area took place initially in the middle 1970's. A resurgence of reform efforts took place in the middle 1980's. Third, states did not react uniformly in responding to demands for reform, i.e., no two medical malpractice reform statutes are the same in scope. Finally, we are concerned here with the primary argument used by tort reformers. That is, the argument that reformation of tort laws would significantly impact on health care costs. See generally Kenneth S. Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489 (1977); Robert M. Ackerman, *Medical Malpractice: A Time for More Talk and Less Rhetoric*, 37 MERCER L. REV. 725 (1986); Karen S. Edwards, *The Malpractice Crisis: A National Perspective*, 82 OHIO ST. MED. J. 641 (1986); Allen Redlich, *Ending the Never-Ending Medical Malpractice Crisis*, 38 MAINE L. REV. 283 (1986); David R. Smith, *Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws*, 38 OKLA. L. REV. 195 (1985); William A. Erickson, Note, *Judicial Review of Medical Malpractice Legislation*, 20 SUFFOLK U. L. REV. 523 (1986); Larry S. Milner, Note, *The Constitutionality of Medical Malpractice Reform: A National Survey*, 18 LOY. U. CHI. L.J. 1053 (1987); Clay B. Tousey, Jr., Comment, *Medical Malpractice Statutes: Special Protection for a Privileged Few*, 12 N. KY. L. REV. 295 (1985); Clay B. Tousey, Jr., Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1417.

26. See generally PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY* 97-117 (1985); Shirley Qual, *A Survey of Medical Malpractice Tort Reform*, 12 WM. MITCHELL L. REV. 417 (1986); Martin H. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759 (1977); Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS. 5 (1986); Francis C. Borgiovonni, Note, *The Illinois Legislature's Attempt to Resolve the Insurance Crisis: Too Much Tort Reform and Too Little Insurance Regulation*, 21 J. MARSHALL L. REV. 159 (1987).

27. Medical malpractice insurers are one of several types of insurers that make up the property and casualty insurance industry. The following Table reveals the number of insolvent property and casualty insurers for the period 1970-1979:

TABLE 6
PROPERTY/CASUALTY INSURER INSOLVENCIES 1970-79

Year	Number of Insolvent Carriers	Year	Number of Insolvent Carriers
1970	4	1975	20
1971	8	1976	6
1972	2	1977	6
1973	2	1978	6
1974	5	1979	3

1980's were plagued by a medical malpractice insurance affordability crisis.²⁸ This was a period in which the cost of some categories of medical malpractice insurance policies²⁹ exceeded the dollar amount many health care providers were willing or able to pay.³⁰

Ralph A. Winter, *The Liability Crisis and the Dynamics of Competitive Insurance Markets*, 5 YALE J. ON REG. 455, 482 (1988). See generally Paul G. Roberts, Note, *Insurance Company Insolvencies and Insurance Guaranty Funds: A Look at the Nonduplication of Recovery Clause*, 74 IOWA L. REV. 927 (1989) (discussing insurance industry insolvencies); see also Richard S. L. Roddis & Richard E. Stewart, *The Insurance of Medical Losses*, 1975 DUKE L.J. 1281 (discussing problems posed for insurers providing medical malpractice insurance).

28. See generally Kenneth S. Abraham, *Making Sense of the Liability Insurance Crisis*, 48 OHIO ST. L.J. 399 (1987); Robert L. Habush, *The Insurance Crisis: Reality or Myth? A Plaintiffs' Lawyer's Perspective*, 64 DEN. U.L. REV. 641 (1988); Susan Porter, *Is Ohio Heading for Another Malpractice Crisis*, 81 OHIO ST. MED. J. 29 (1985); George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521 (1987); Leonard W. Schroeter & William J. Rutzick, *Tort Reform: Being an Insurance Company Means Never Having to Say You're Sorry*, 22 GONZ. L. REV. 31 (1986). But see Frank P. Grad, *Medical Malpractice and The Crisis of Insurance Availability: The Waning Options*, 36 CASE W. RES. L. REV. 1058 (1985) (arguing that in the 1980's an availability crisis, not an affordability crisis was experienced).

29. A few commentators concluded that "[s]ignificant changes in the manner in which tort liability is established and damages assessed are cited as causes of dramatic rate increases." Richard N. Clarke, et al., *Sources of the Crisis in Liability Insurance: An Economic Analysis*, 5 YALE J. ON REG. 367, 389 (1988). However, another commentator has concluded that "increases in premium prices are generally justified. The increases are . . . an attempt to price insurance at levels commensurate with estimated cash flows." Nelson Lacey, *The Competitiveness of the Property-Casualty Insurance Industry: A Look at Market Equity Values and Premium Prices*, 5 YALE J. ON REG. 501, 515 (1988). The following Table presents the percentage increase of premiums in selected states between the period January 1986 and July 1987:

TABLE 7
PERCENTAGE INCREASE IN PREMIUM RATES FOR SELECTED
STATES BETWEEN JANUARY 1986 AND JULY 1987

State	Percentage Increase
Utah	99.0%
Colorado	73.0
North Carolina	60.0
New Mexico	55.0
Wyoming	50.0
Kentucky	46.0
Alabama	43.0
Pennsylvania	40.0
Florida	36.0

Note: The Table reflects increases in rates by physician-owned insurers.

Mark Crane, *Nobody's Laughing at Bedpan Mutuals Now*, MEDICAL ECONOMICS, April 18, 1988, at 125.

30. The following Table presents the median gross income for selected medical specialists for the year 1986:

TABLE 8
MEDIAN GROSS INCOME OF SELECTED MEDICAL SPECIALISTS FOR THE YEAR 1986

The availability and affordability dramas were ostensibly major subissues in the larger context of the health care cost crisis that has engulfed the nation for two decades.³¹ In order to appreciate how the availability and affordability issues were used effectively to promote tort reform,³² we will first look at the health care cost crisis during those two decades.

Medical Specialist	Income (thousands)
Neurosurgeon	\$359,820
Plastic Surgeon	357,240
Orthopedic Surgeon	353,980
Ophthalmologist	315,630
OBG	271,760
Internist	180,750
Pediatrician	168,180

Arthur Owens, *Doctors Earnings on the Rise Again*, MEDICAL ECONOMICS, September 7, 1987, at 219.

31. Commentators have attributed excessive health care costs to other factors, such as medical waste, defensive medicine, and the expense of new technology. See generally Karen S. Edwards, *Defensive Medicine: Health Care with a Pricetag*, 81 OHIO ST. MED. J. 38 (1985); David U. Himmelstein & Steffie Woolhandler, *Cost Without Benefit: Administrative Waste in U.S. Health Care*, 314 NEW ENG. J. MED. 441 (1986); John K. Iglehart, *The Cost and Regulation of Technology: Future Policy Directions*, 55 MILBANK MEM. FUND Q. 25 (1977); Maxwell J. Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 CASE W. RES. L. REV. 778 (1985); Thomas W. Moloney & David E. Rogers, *Medical Technology: A Different View of the Contentious Debate Over Costs*, 301 NEW ENG. J. MED. 1413 (1979); Seymour Perry & Flova Chu, *Commentary: Health Care Cost Containment and Technology Assessment*, 36 CASE W. RES. L. REV. 884 (1985); Eric L. Richards, *Antitrust and the Future of Cost Containment Efforts in the Health Profession*, 62 NEB. L. REV. 49, 51-55 (1983); Schroeder, *Curbing the High Costs of Medical Advances*, 1 BUS. & HEALTH 7 (1984).

32. The following Table illustrates how states responded to selected reform measures:

TABLE 9
MEDICAL MALPRACTICE TORT REFORM MEASURES ENACTED BY STATES AS OF 1987

State	Damage Cap	Periodic Payment	Collateral Source Rule	Conting. Fee	Arbitration
Ala.	yes	yes	yes	no	yes
Alaska	yes	yes	yes	no	yes
Ariz.	no	no	yes	yes	no
Cal.	yes	yes	yes	yes	yes
Colo.	yes	no	yes	yes	no
Conn.	no	no	yes	yes	no
Del.	no	no	yes	yes	no
Fla.	no	yes	yes	yes	yes
Ga.	yes	no	yes	no	yes
Haw.	yes	no	no	yes	no
Idaho	yes	no	no	no	no
Ill.	no	yes	yes	yes	yes
Ind.	yes	no	yes	yes	no
Iowa	no	no	yes	yes	no
Kan.	yes	yes	no	yes	no

Although there are numerous health care cost indicators or barometers,³³ we will focus strictly upon costs for community hospitals,³⁴ medicare, and medicaid.³⁵ The average cost to community

La.	yes	yes	no	no	yes
Me.	no	yes	no	yes	no
Md.	yes	no	no	yes	no
Mass.	yes	no	yes	yes	no
Mich.	yes	yes	yes	yes	yes
Minn.	yes	no	yes	no	no
Mo.	yes	yes	no	no	no
Mont.	no	yes	yes	no	no
Neb.	yes	no	yes	yes	no
N.H.	yes	no	no	yes	no
N.J.	no	no	yes	yes	no
N.M.	yes	yes	no	no	no
N.Y.	no	yes	yes	yes	yes
N.D.	no	yes	yes	no	no
Ohio	yes	yes	yes	no	yes
Okla.	no	no	no	yes	no
Ore.	yes	no	yes	yes	no
R.I.	no	yes	yes	no	no
S.C.	no	yes	no	no	no
S.D.	yes	yes	yes	no	yes
Tenn.	no	no	yes	yes	no
Tex.	yes	no	no	no	no
Utah	yes	yes	yes	yes	yes
Vt.	no	no	no	no	yes
Va.	yes	no	no	no	yes
Wash.	yes	yes	yes	yes	no
W.Va.	yes	no	no	no	no
Wis.	yes	no	no	yes	no
Wym.	no	no	no	yes	no

Note: Arkansas, Kentucky, Mississippi, Nevada, and North Carolina did not enact any of the measures listed, so they were excluded here. Further, several states had positive entries from this list that are shown as negative entries because they were repealed.

What the States Have Tried, MEDICAL ECONOMICS, Apr. 10, 1988, at 208-09.

33. See generally SOURCE BOOK OF HEALTH INSURANCE DATA (1970-1989).

34. For a discussion on community hospitals, see Ting and Valiante, *Future Capital Needs of Community Hospitals*, 1 HEALTH AFF. 14 (1982); Kenneth R. Wing & Burton Craige, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, 57 N.C. L. REV. 1165 (1979). The following Table presents community hospital costs for the period 1970-1987:

TABLE 10
AVERAGE COST TO COMMUNITY HOSPITALS
PER PATIENT DAY AND PER PATIENT STAY

Year	Average Cost Per Patient Day	Average Cost Per Patient Stay	Average Hospital Stay (days)
1987	\$539.96	\$3,850.16	7.2
1986	500.81	3,532.51	7.1
1985	460.19	3,244.74	7.1
1984	411.10	2,995.38	7.3
1983	369.49	2,789.18	7.6

hospitals per patient increased by 58.4%³⁶ during the period 1970 to 1974, 61.9% for the period 1975 to 1979,³⁷ and 62.6% for the period 1980 to 1984.³⁸ The average cost per patient stay increased 57.2% for the period 1970 to 1974,³⁹ 61.4% for the period 1975 to 1979⁴⁰ and 61.8% for the period 1980 to 1984.⁴¹

1982	327.37	2,500.52	7.6
1981	284.33	2,171.20	7.6
1980	245.12	1,850.96	7.6
1979	217.34	1,641.48	7.6
1978	194.34	1,474.21	7.6
1977	174.00	1,322.40	7.6
1976	151.80	1,168.90	7.7
1975	133.80	1,030.30	7.7
1974	113.60	886.10	7.8
1973	102.40	798.70	7.8
1972	105.30	831.70	7.9
1971	92.31	738.48	8.0
1970	81.01	664.28	8.2

SOURCE BOOK, *supra* note 2 at 61 [hereinafter Table 10].

35. For a general discussion of medicaid and medicare, see RASHI FEIN, *MEDICAL CARE MEDICAL COSTS*, 53-124 (1986); Marian Gornick, et al., *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, 7 HEALTH CARE FIN. REV. 13 (Supp. 1985); Robert W. Rosenblum, *Medicare Revisited: A Look Through the Past to the Future*, 9 J. HEALTH POL., POL'Y & L. 669 (1985); Kenneth R. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U. L. REV. 1 (1983). The following Table presents medicare and medicaid benefit payments:

TABLE 11
MEDICARE AND MEDICAID PAYMENTS AND POPULATION SERVED DURING 1972-1987

Year	MEDICARE		MEDICAID	
	Population (millions)	Payment (millions)	Population (millions)	Payment (millions)
1972	21.3	\$ 8,643	17.6	\$ 6,300
1973	23.5	9,583	19.6	8,639
1974	24.2	12,418	21.5	9,983
1975	25.0	15,588	22.0	12,242
1976	25.7	18,420	22.8	14,091
1977	26.5	21,773	22.8	16,239
1978	27.2	24,919	22.0	17,992
1979	27.9	29,313	21.5	20,472
1980	28.5	35,686	21.6	23,311
1981	29.0	43,442	22.0	27,204
1982	29.5	51,086	21.6	29,399
1983	30.0	57,443	21.6	32,391
1984	30.5	62,870	21.6	33,895
1985	31.1	70,391	21.8	37,507
1986	31.7	74,187	22.5	41,027
1987	32.4	79,904	23.2	45,098

SOURCE BOOK, *supra* note 2 at 32-33 [hereinafter Table 11].

36. See Table 10, *supra* note 34.

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

These cost increases might not have been problematic for the health care system if the system had experienced proportional increases in demand for services from community hospitals. However, there are strong data to suggest that the demand on community hospitals actually decreased. The average length of a community hospital stay (in days) decreased by 4.9% for the period 1970 to 1974,⁴² 1.3% for the period 1975 to 1979,⁴³ and 40.0% for the 1980 to 1984 period.⁴⁴

The problem of cost outpacing service demand⁴⁵ is further illustrated through medicare and medicaid programs. For the period 1972 to 1976, medicare enrollment increased by 20%, while payments increased 113.1%.⁴⁶ Medicaid figures for the same period revealed a 29.5% increase in recipients with a 123.7% increase in cost.⁴⁷ Medicare enrollment increased 9.4% from 1977 to 1981, while payments increased 99.5%.⁴⁸ The medicaid recipient population decreased by 3.5% during this time, while cost increased 67.5%.⁴⁹ For the period 1982 to 1986, medicare enrollment increased 9.8%, while payments increased 56.4%.⁵⁰ The medicaid population increased 4.2% during this period and cost increased 39.5%.⁵¹

These health care cost barometers provide a mere glimpse of the magnitude of the deepening health care cost crisis that occurred during the 1970's and 80's.⁵² These data support the premise that consumer demand during those decades was not the root cause of

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

45. One of the fundamental principles of economics is that of the inverse relation between price charged and quantity demanded. RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 4-5 (3d ed. 1986). This principle suggests that a rise in hospital costs, not attributed to an increase in patient service demand, would result in a decrease in patient service demand, provided a suitable substitute was available.

46. See Table 11, *supra* note 35.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. See *supra* notes 2 and 3.

the skyrocketing increases. During the 1970's, health care providers and medical malpractice insurers offered explanations for the bizarre cost increases which ultimately led to amendments of several state tort laws.⁵³

During the 1970's, health care providers attributed rising health care costs to the rise in medical malpractice insurance that had to be passed on to patients⁵⁴ and the practice of defensive medicine⁵⁵ as a consequence of the decrease in medical malpractice insurers. Insurers offered the following explanation for their role in health care costs: the manifold increase in medical malpractice tort litigation⁵⁶ and verdict awards⁵⁷ not only caused premiums to increase,⁵⁸ but also caused many insurers to leave the market.⁵⁹

53. See *supra* note 32.

54. Although no exact figure is ascertainable, it is generally acknowledged that a fair percentage of premium cost "is passed on to patients in the form of higher fees for medical services." PATRICIA M. DANZON, *MEDICAL MALPRACTICE* 132 (1985). See *infra* note 65.

55. Defensive medicine "has been estimated to cost at least \$15 billion and perhaps as much as \$40 billion." Max W. Fine & Jonathan H. Sunshine, *Malpractice Reform Through Consumer Choice and Consumer Education: Are New Concepts Marketable?*, *LAW & CONTEMP. PROBS.*, Spring 1986, at 213, 215. James E. Ludlam, *Payment Systems, Cost Management, and Malpractice*, *HOSPITALS*, Nov. 1, 1984, at 102. See generally *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 *DUKE L.J.* 1179, 939; David Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 *DUKE L.J.* 1179, 1189-1192; Laurence R. Tancredi & Jeremiah A. Barondress, *The Problem of Defensive Medicine*, *SCIENCE*, May 26, 1978, at 879; Zuckerman, *Medical Malpractice: Claims, Legal Costs, and the Practice of Defensive Medicine*, 3 *HEALTH AFFAIRS* 128 (1984). The following Table presents cost data for additional medical services (defensive medicine) for the year 1987:

TABLE 12
DEFENSIVE MEDICINE COST PER PATIENT AND PHYSICIAN DISTRIBUTION

Additional Cost Physician	Per Patient Distribution
\$100,000 or more	14%
50,000-99,999	12
40,000-49,999	2
30,000-39,999	7
20,000-29,999	18
10,000-19,999	26
5,000-9,999	11
1,000-4,999	6
1-999	4

How Much Doctors' Defensive Tactics Raised Patients' Costs Last Year, *MEDICAL ECONOMICS*, Apr. 18, 1988, at 100.

56. See PATRICIA M. DANZON, *MEDICAL MALPRACTICE* 58-83 (1985).

57. *Id.*

58. One commentator has concluded "that fluctuations in premiums and availability of insurance is inevitable in an environment of uncertainty such as that resulting from the unpredictability of common

Several states reformed their tort laws during the 1970's in an effort to curtail the impact of verdict awards in medical malpractice litigation.⁶⁰ By the 1980's, the availability crisis had subsided.⁶¹ However, health care costs continued to soar.⁶²

Once the 1970's availability argument lost its force, health care providers and insurers searched for another general theory to explain continued rising health care costs. The theory chosen for the 1980's was that of affordability.⁶³ Health care providers argued

tort law." Ralph A. Winter, *The Liability Crisis and the Dynamics of Competitive Insurance Markets*, 5 YALE J. ON REG. 455, 457 (1988). The following Table presents assessed medical malpractice premium charges by insurers for the period 1975-1986:

TABLE 13
MEDICAL MALPRACTICE PREMIUMS WRITTEN BY INSURERS
FOR THE PERIOD 1975-1986

Year	Premiums Written	Annual % Change
1975	\$ 895,435,000	—
1976	1,132,790,000	26.5%
1977	1,247,798,000	10.2
1978	1,215,789,000	-2.6
1979	1,204,326,000	-0.9
1980	1,275,603,000	5.9
1981	1,338,299,000	4.9
1982	1,490,270,000	11.4
1983	1,568,001,000	5.2
1984	1,774,754,000	13.2
1985	2,769,230,000	56.0
1986	3,491,905,000	26.1

Note: Medical malpractice premiums were previously included in the general liability category of insurers and were not separately tabulated until 1975.

INSURANCE INFORMATION INSTITUTE, PROPERTY/CASUALTY FACT BOOK 29 (1987-88).

59. It has been suggested by one commentator that governmental regulation in the insurance industry was a factor in causing insurers to leave the medical malpractice market. Specifically, the commentator reported that "[d]enial of requested rate increases or approval of the claims-made form, or both, were directly responsible for the withdrawal of the group carrier in New York, northern California, Maryland, Massachusetts, Rhode Island, and South Carolina, for example." PATRICIA M. DANZON, *MEDICAL MALPRACTICE* 108 (1985).

60. See *supra* note 32.

61. The availability crisis subsided largely because "[t]he majority of states passed legislation which provided for the availability of medical malpractice insurance by establishing joint underwriting agencies, *i.e.*, insurance pools that were to carry the obligation of malpractice insurance, or by authorizing the establishment of mutual insurance companies by physician organizations or medical societies." Frank P. Grad, *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, 36 CASE W. RES. L. REV. 1058, 1076-1077 (1985).

62. The average rate of growth for national health care expenditure for the period 1980-1984 was 12.7%. See Table 2, *supra* note 3.

63. See *supra* note 28.

that a renewed escalation in the cost of malpractice insurance had to be borne by patients (as in the 1970's) in order for the health care system to remain sound.⁶⁴ The insurers argued, as they did in the 1970's, that they had to increase premium costs due to continued increases in medical malpractice litigation and verdict awards.⁶⁵

Many state legislatures accepted the affordability theory and continued the tort reform process begun in the 1970's.⁶⁶ By the

64. Fees charged by physicians reflect the cost of medical malpractice insurance, though the full extent is not known. For a general discussion of physician fees, see Pamela J. Farley, *Theories of the Price and Quantity of Physician Services*, 5 J. HEALTH ECON. 315 (December 1986); Jonathan A. Showstack, et al., *Fee-for-Service Physician Payment: Analysis of Current Methods and Their Development*, 16 INQUIRY 230 (1979). The following Table presents a comparison of percentage increases in physician fees and the consumer price index:

TABLE 14.
PERCENTAGE GROWTH IN PHYSICIANS' FEES
AS COMPARED TO THE CONSUMER PRICE INDEX

Year	Physician Services	CPI
1983	7.5%	3.8%
1984	6.0	4.0
1985	6.9	3.8
1986	7.8	1.1
1987	6.3	4.4
1988	7.5	4.4

Physicians' Fees and the CPI, MEDICAL ECONOMICS, October 2, 1989, at 78.

65. See generally E. Kathleen Adams & Stephen Zuckerman, *Variation in the Growth and Incidence of Medical Malpractice Claims*, 9 J. HEALTH POL., & POL'Y L. 475 (1984); Patricia M. Danzon, *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims*, 48 OHIO ST. L.J. 413 (1987); Myran F. Steves, Jr., *A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability Insurance System*, 1975 DUKE L.J. 1305, 1309-1316. The following Table presents the median premium charges for selected specialists for the periods 1983 and 1988:

TABLE 15.
MALPRACTICE PREMIUMS FOR SELECTED
MEDICAL SPECIALIST

Specialist	Premium Cost 1983	Premium Cost 1988	Percentage Change
OBG	\$11,840.00	\$34,170.00	189.0%
Pediatrician	2,030.00	5,680.00	180.0
Neurosurgeon	16,000.00	43,500.00	172.0
G. Surgeon	8,500.00	22,500.00	165.0
Internist	2,430.00	6,090.00	151.0

Premiums Have Been Soaring Across the Board, MEDICAL ECONOMICS, Jan. 16, 1989, at 174.

66. It has been determined that "[d]uring 1986, fifteen states passed legislation that limited the amount of recovery for noneconomic losses." Jane C. Arancibia, Note, *Statutory Caps on Damage Award in Medical Malpractice Cases*, 13 OKLA. CITY U. L. REV. 135, 141 (1988). See generally, Nancy L. Manzer, Note, *1986 Tort Reform Legislation: A Systematic Evaluation of Caps on Damages and Limitations on Joint and Several Liability*, 73 CORNELL L. REV. 628 (1988).

end of the 1980's, most states reformed some aspect of their tort system in an effort to decrease health care costs.⁶⁷

B. *Types of Reform Measures*⁶⁸

During the availability and affordability crisis, tort reformers successfully linked the cost of medical malpractice insurance to the rising costs of health care.⁶⁹ This acted as a battering ram in a national assault upon state tort laws. In one solid lobbying voice, tort reformers insisted that reformation of state tort systems would lead to a significant decrease in the cost of health care.⁷⁰ Tort reformers supported their position with two secondary arguments. They argued that: (1) the doctrinal rules governing tort actions were unfair and inappropriate for medical malpractice litigation;⁷¹ and (2) the civil justice system permitted an explosive increase in the number and size of medical malpractice verdicts.⁷²

The doctrinal rules argument can be summarized under six categories:⁷³ (1) tort rules favored plaintiffs;⁷⁴ (2) statutes of limitation

67. See *supra* note 32.

68. See generally Gary T. Dance, *Medical Malpractice: Prelitigation Screening Panels in Idaho*, 19 IDAHO L. REV. 31 (1983); Kevin G. Quinn, *The Health Care Malpractice Claims Statute: Maryland's Response to the Medical Malpractice Crisis*, 10 U. BALT. L. REV. 74 (1980); Steven R. Ripps, *The Ohio Medical Malpractice Statute: An Analysis*, 4 OHIO N.U. L. REV. 24 (1977); Stephen A. Hurst, Comment, *Alternatives to Litigation: Pretrial Screening and Arbitration of Medical Malpractice Claims: Has Missouri Taken a Giant Step Backward?*, 50 U.M.K.C. L. REV. 182 (1982); Dean A. Lerner, Note, *Iowa Code Section 147.136, Which Abolishes the Collateral Source Rule in Medical Malpractice Cases, is Not Unconstitutional Based on a Rational Relationship Test*, 29 DRAKE L. REV. 849 (1980); Karlen J. Moe, Comment, *The Montana Medical Malpractice Panel Act: Origin, Procedure, and Effect*, 44 MONT. L. REV. 281 (1983); B. Richard Young, Comment, *Medical Malpractice in Florida: Prescription for Change*, 10 FLA. ST. U. L. REV. 593 (1983).

69. By indicating a successful linkage of the two issues, it is not to be inferred that the linkage resulted in a successful resolution of either problem.

70. Of course, health care expenditure continued to increase throughout the 1970's and 1980's. See Table 1, *supra* note 2, and Table 2, note 3.

71. See F. Patrick Hubbard, *The Physicians' Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform"*, 23 GA. L. REV. 295, 310 (1989).

72. *Id.*

73. *Id.*

74. See generally Katherine R. Bowden, Comment, *Standard of Care for Medical Practitioners: Abandonment of the Locality Rule*, 60 KY. L.J. 209 (1971); Joan Vogel & Richard Delgado, *To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes*, 28 U.C.L.A. L. REV. 52 (1980); Wayne D. Landsverk, Note, *Informed Consent as a Theory of Medical Liability*, 1970 WIS. L. REV. 879; Mary E. Mann, Note, *Medical Specialist May Be Found Negligent as a Matter of Law Despite Compliance with the Customary Practice of the Specialty*, 28 VAND. L. REV. 441 (1975).

were too long;⁷⁵ (3) inappropriate rules for compensatory relief;⁷⁶ (4) inappropriate rules for punitive damages;⁷⁷ (5) unfair administrative costs;⁷⁸ and (6) lack of a mechanism to deter frivolous claims.⁷⁹

The second argument raised by tort reformers is straight forward. During the 1970's and 1980's, the civil justice system experienced a significant increase in the number of medical malpractice claims filed and a marked increase in verdict awards.⁸⁰

Tort reformers used both arguments effectively in revamping tort laws in many states.⁸¹ Among the tort law changes enacted by many states were the following: (1) damage caps;⁸² (2) shorter statutes of limitation;⁸³ (3) screening panels;⁸⁴ (4) limitations on

75. See generally Paul E. Caprioglio, Note, *A Four Year Statute of Limitations for Medical Malpractice Cases: Will Plaintiff's Case be Barred?*, 2 PACIFIC L.J. 663 (1971); Comment, *Malpractice Statute of Limitations in New York: Conflict and Confusion*, 1 HOFSTRA L. REV. 276 (1973); Darryl S. Vhuger, Comment, *Medical Malpractice Statute of Limitations in Washington*, 57 WASH. L. REV. 317 (1982).

76. See generally, Stephen D. Sugarman, *Serious Tort Law Reform*, 24 SAN DIEGO L. REV. 795 (1987).

77. See generally, Robert D. Cooter, *Economic Analysis of Punitive Damages*, 56 S. CAL. L. REV. 79 (1982); John D. Long, *Punitive Damages: An Unsettled Doctrine*, 25 DRAKE L. REV. 870 (1976); Steven G. Schumaier & Brian A. McKinsey, *The Insurability of Punitive Damages*, A.B.A. J., Mar. 1986, at 68.

78. See generally David M. Trubek et al., *The Costs of Ordinary Litigation*, 31 U.C.L.A. L. REV. 72 (1983).

79. See generally John M. Johnson & G. Edward Cassady, *Frivolous Lawsuits and Defensive Responses to Them — What Relief is Available?*, 36 ALA. L. REV. 927 (1985).

80. Danzon, *supra* note 65. See also Marc Galanter, *The Day After the Litigation Explosion*, 46 MD. L. REV. 3 (1986).

81. See *supra* note 32.

82. See, e.g., S.D. CODIFIED LAWS ANN. § 21-3-11 (1987). For a discussion see, Wesley Leonard & Marcia B. Stevens, Comment, *Legislative Limitations on Medical Malpractice Damages: The Chances of Survival*, 37 MERCER L. REV. 1583 (1986); Jason A. Parson, Note, *Medical Malpractice Damage Caps: Navigating the Safe Harbors*, 65 WASH. U. L.Q. 565 (1987); Lisa A. Treviranus, Comment, *Medical Malpractice: Constitutional Implications of a Cap on Damages*, 7 N. ILL. U. L. REV. 61 (1987).

83. See, e.g., WASH. REV. CODE ANN. § 4.16.350 (West Supp. 1991). For a discussion, see Jennifer Andrews, Note, *Questions Surrounding the Texas Medical Malpractice Statute of Limitations*, 38 BAYLOR L. REV. 751 (1986).

84. See, e.g., MASS. ANN. LAWS ch. 231, § 60B (Law Co-op. Supp. 1990). For a discussion, see William J. Curran, *Screening Panels in Malpractice Cases: Some Disturbing Progress Reports*, 302 NEW ENG. J. MED. 954 (1980); Stephen S. Morrill, *The Illinois Medical Malpractice Reform Act of 1985: A Constitutional Analysis of the Medical Review Panel Procedure*, 35 DEPAUL L. REV. 345 (1986); Richard F. Boyle, Note, *Medical Malpractice Screening Panels: A Judicial Evaluation of Their Practical Effect*, 42 U. PITT. L. REV. 939 (1981).

minority status;⁸⁵ (5) modification of joint and several liability rules;⁸⁶ (6) creation of excess insurance funds;⁸⁷ (7) abolition of *ad damnum* clauses;⁸⁸ (8) periodic payment of large verdicts;⁸⁹ and (9) limiting contingency fee arrangements.⁹⁰

C. Effectiveness of Reform

The impact of tort reform on health care expenditure is a separate issue from the impact of tort reform on medical malpractice litigation and the cost of medical malpractice insurance. While data exist which suggest that tort reform has not significantly affected the cost of health care⁹¹ and malpractice insurance,⁹² it may have had some significant effect on medical malpractice litigation.⁹³

Data relating to the issue of health care expenditure reveals the steady increase of health care cost as a percentage of the gross national product. From 1970 to 1974, national health care expenditure increased by 54.8%. The average rate of health care ex-

85. See, e.g., N.C. GEN. STAT. § 1-17(b) (Supp. 1990). For a discussion, see Cheryl L. Harner, *The Repeal of Washington's Infant Tolling Statute in Medical Malpractice Cases: State Constitutional Challenges*, 22 GONZ. L. REV. 133 (1986); Roger L. Pardieck, *The Disappearing Rights of Plaintiffs Under a Legal Disability*, 20 IND. L. REV. 385 (1987).

86. See, e.g., CAL. CIV. CODE §§ 1431.1-1431.5 (Deering Supp. 1991). For a discussion, see Thomas V. Harris, *Washington's 1986 Tort Reform Act: Partial Tort Settlements After the Demise of Joint and Several Liability*, 22 GONZ. L. REV. 67 (1986); Mike Steenson, *Recent Legislative Responses to the Rule of Joint and Several Liability*, 23 TORT INS. L.J. 482 (1988).

87. See, e.g., IND. CODE ANN. § 16-9.5-4-1 (Burns Supp. 1991). For a discussion, see Robin B. Stickney, *1985 Amendments to the Indiana Medical Malpractice Act*, 19 IND. L. REV. 403, 409-411 (1986).

88. See, e.g., UTAH CODE ANN. § 78-14-7 (1987). For a discussion, see Prentiss E. Feagles et al., Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1417, 1451-1453.

89. See, e.g., DEL. CODE ANN. tit. 18 § 6864 (1989). For a discussion, see Donovan Flora, *Periodic Payment of Judgments in Washington*, 22 GONZ. L. REV. 155 (1986); Roger C. Henderson, *Designing a Responsible-Periodic Payment System for Tort Awards: Arizona Enacts a Prototype*, 32 ARIZ. L. REV. 21 (1990).

90. See, e.g., ARIZ. REV. STAT. ANN. § 12-568 (1982). For a discussion, see Philip H. Corboy, *Contingency Fees: The Individual's Key to the Courthouse Door*, LITIG., Summer 1976, at 27; Roger Feldman, *The Determinants of Medical Malpractice Incidents: Theory of Contingency Fees and Empirical Evidence*, ATL. ECON. J., July 1979, at 59; Ralph Slovenko, *Medical Malpractice and the Lawyer's Contingent Fee*, 12 J. PSYCHIATRY & L. 587 (1984).

91. See Table 1, *supra* note 2 and Table 2, note 3.

92. See Table 13, *supra* note 58.

93. Danzon, *supra* note 65.

penditure growth for this period was 12.0%, while it averaged 7.7% of the gross national product.⁹⁴ Health care expenditure for the period 1975 to 1979 increased by 61.8% with an average rate of growth of 13.0%. As a percentage of the gross national product, health care expenditure averaged 8.5% for this period.⁹⁵ For the period 1980 to 1985, there was an increase in health care expenditure of 55.9%. Its average growth rate was 12.7% and it averaged 9.9% of the gross national product.⁹⁶

The most revealing factor from the above data is the steady increase of health care cost as a percentage of gross national product. The question which the scope of this article is not prepared to answer, and one which other commentators have not posed, is whether health care expenditure would have taken a larger bite out of the gross national product if tort reform had not taken place. The answer to this question is of central concern for future state and federal legislation designed to reverse the direction of health care costs.

Data regarding federal spending as a percentage of national health care expenditure break down as follows: (1) For the period 1970 to 1974, federal spending for health care increased 75.1%, averaging 24.7% of health care expenditure, and (2) from 1975 to 1979, federal spending for health care increased 64.9% and averaged 28.2% of health care expenditure. Spending by the federal government for the period 1980 to 1984 increased 57.6%, averaging 29% of health care expenditure.⁹⁷

On the state level, spending for national health care increased 64.3% during the period 1970 to 1974, while state spending as a percentage of health care expenditure was 13.7%. From 1975 to 1979, state spending for health care increased 54.4%, while it averaged 13.8% as a percentage of health care expenditure. For the period 1980 to 1984, state spending for health care increased 40.8%,

94. See Table 1, *supra* note 2.

95. *Id.*

96. See Table 2, *supra* note 3.

97. See Table 3, *supra* note 4.

while averaging 13.1% for this period as a percentage of health care expenditure.⁹⁸

While federal and state spending for health care services may seem alarming in the midst of reform measures designed to decrease costs, personal consumption expenditures reveal greater concerns about the ineffectiveness of the reform measures. During the period 1970 to 1974, personal consumption expenditures for hospital services increased 71.1% and expenses for physician services increased 45.0%. From 1975 to 1979, personal consumption expenditures for hospital services increased 74.6% and for physician services increased 54.6%. For the period 1980 to 1984, personal consumption expenditures for hospital services increased 59.3% and for physician services increased 59.8%.⁹⁹

The data presented above do not factor out the impact of inflation on health care costs. In spite of this omission, the magnitude of the percentage increases suggests that inflation was not a crucial issue.

Although studies have shown that tort reform has impacted in some areas of medical malpractice litigation,¹⁰⁰ no study has revealed that the reforms have had a significant impact on medical malpractice insurance costs.¹⁰¹ The results of a study designed to determine the frequency and severity of malpractice claims for the period 1975 to 1984 for states enacting tort reform measures¹⁰² revealed the following: (1) shorter statutes of limitation reduced claim frequency by 8.0%; (2) abolished or modified collateral source rules reduced claim severity up to 18.0% and reduced claim frequency by 14.0%; (3) damage caps reduced claim severity by 23.0%, and; (4) none of the other measures (*e.g.*, screening panels and

98. See Table 4, *supra* note 5.

99. See Table 5, *supra* note 7.

100. Danzon, *supra* note 65.

101. See Frank A. Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J. HEALTH POL., POL'Y & L. 629 (1985) (where the commentator concluded that reforms did not have an impact on the cost of premiums).

102. Danzon, *supra* note 65.

limits on contingency fees) had any significant impact on claim frequency or severity.¹⁰³

As the nation begins to move through the 1990's, the awesome specter of runaway health care costs continues to haunt us. During the preceding two decades, many states attempted to halt this menacing cost creature by rewriting tort laws. Tort reform has failed to have a significant impact on health care costs. Any continued efforts to attack the problem through tort reform appear to be futile. The ultimate resolution to controlling health care costs lies beyond tort reform.

III. MEDICAL MALPRACTICE TORT REFORM IN WEST VIRGINIA¹⁰⁴

West Virginia's experience with medical malpractice is no better or worse than that of other states.¹⁰⁵ The efforts of West Virginia in assuring its citizens qualified and competent doctors is traceable to its prosecution of *Dent v. State of West Virginia*.¹⁰⁶ This oft-cited case¹⁰⁷ involved the prosecution of an individual "in the State

103. *Id.* The Danzon study was drawn into question by the different conclusion reached by Professor Sloan. Sloan, *supra* note 101.

104. During a meeting with a group of business persons in Bluefield, West Virginia, in 1986, state Supreme Court Justice Thomas Miller was quoted as saying the following regarding the medical malpractice litigation explosion:

There has been no increase in court case filings in our state for the last five years. We just don't have that kind of litigation explosion that people talk about and that occur in other states such as California. The jury verdicts in our state are not outrageous or excessive in the main.

West Virginia News Briefs, UPI, June 24, 1986, available in LEXIS, Nexis Library, Omni File.

105. For a general discussion of the development of medical malpractice law in West Virginia, see Michael J. Farrell, *The Law of Medical Malpractice in West Virginia*, 82 W. VA. L. REV. 251 (1979); Hale J. Posten, *The Law of Medical Malpractice in West Virginia*, 41 W. VA. L.Q. 35 (1934) wherein the commentator concluded that:

[t]he law of medical malpractice in West Virginia has developed slowly and, in general, consistently

[T]here is an uneasiness in some quarters regarding our system of resolving medical malpractice cases The concern to be addressed is the protection of the injured patient's rights without a premature destruction of the medical doctor's career.

Id. at 283. See also FRANKLIN D. CLECKLEY, *HEALTH CARE AND THE LAW* (1979); E. PERRY JOHNSON & JOSEPH S. BEESON, *SURVEY OF WEST VIRGINIA LAW AFFECTING DELIVERY OF HEALTH CARE* (1973).

106. 129 U.S. 114 (1889). See also *Lawson v. Conaway*, 16 S.E. 564 (W. Va. 1892); *Kuhn v. Brownfield*, 12 S.E. 519 (W. Va. 1890).

107. *E.g.*, *Pacific Mut. Life Ins. Co. v. Haslip*, 111 S. Ct. 1032 (1991); *Browning-Ferris Indus. of Vermont, Inc. v. Kelco Disposal, Inc.*, 492 U.S. 257 (1989); *Daniels v. Williams*, 474 U.S. 327 (1986); *Lowe v. S.E.C.*, 472 U.S. 181 (1985); *Davis v. Scherer*, 468 U.S. 183 (1984); *O'Bannon v. Town Court*

Circuit Court of Preston County, West Virginia, for unlawfully engaging in the practice of medicine . . . without a diploma, certificate, or license”¹⁰⁸ After finding the state’s statute requiring physicians be licensed was not unconstitutional, the United States Supreme Court affirmed the defendant’s conviction.

In spite of the state’s longstanding commitment of assuring its citizens qualified and competent doctors,¹⁰⁹ medical malpractice has persisted. The state’s legal system, however, has been vigilant in enforcing the rights of victims of medical malpractice through its tort laws.¹¹⁰ That is, the legal system has been a dutiful mech-

Nursing Ctr., 447 U.S. 773 (1980); *Nixon v. Administrator of General Services*, 433 U.S. 425 (1977); *Ingraham v. Wright*, 430 U.S. 651 (1977); *Moody v. Daggett*, 429 U.S. 78 (1976); *Wolff v. McDonnell*, 418 U.S. 539 (1974).

For examples of periodicals citing the *Dent* opinion, see Elizabeth H. Hadley, *Nurses and Prescriptive Authority: A Legal and Economic Analysis*, 15 AM. J.L. & MED. 245 (1989); Thomas L. Jipping, *Informed Consent to Abortion: A Refinement*, 38 CASE W. RES. L. REV. 329 (1988); Toni M. Massaro & Thomas L. O’Brien, *Constitutional Limitations on State-Imposed Continuing Competency Requirements for Licensed Professionals*, 25 WM. & MARY L. REV. 253 (1983); John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405 (1983); Jeffrey F. Chase-Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445 (1987); James M. Peterson, Note, *Massachusetts Medical Society v. Dukakis: Are Medicare Beneficiaries Better Off?*, 14 J. CONTEMP. L. 151 (1988).

108. *Dent*, 129 U.S. at 117.

109. The state legislature’s efforts to control the quality and competency of doctors practicing in West Virginia can be seen through the following examples of legislation aimed at addressing this area: State Board of Health Act, 1881 W. Va. Acts ch. 60, *amended and replaced by* 1980 W. Va. Acts ch. 83, *codified at* W. VA. CODE § 30-3-1 to 17; State Department of Health Act, 1915, W. Va. Acts ch. 11, § 12, *amended and replaced by* 1980 W. Va. Acts ch. 83, *codified at* W. VA. CODE § 30-3-11; Osteopathic Physicians and Surgeon Act, 1923 W. Va. Acts ch. 40, *as amended, codified at* W. VA. CODE § 30-14-1 to 15; Board of Chiropractic Examiners Act, 1925 W. Va. Acts ch. 20, *as amended, codified at* W. VA. CODE § 30-16-1 to 17; Medical Licensing Board Act, 1949 W. Va. Acts ch. 97, *repealed by* 1980 W. Va. Acts ch. 83.

110. See, e.g., *Davis v. Wang*, 400 S.E.2d 230 (W. Va. 1990) (malpractice resulted in death of patient); *Hulmes v. Catterson*, 388 S.E.2d 313 (W. Va. 1989) (malpractice resulting from misdiagnosis); *Morris v. Boppana*, 387 S.E.2d 302 (W. Va. 1989) (malpractice led to amputation of patient’s leg); *Sansom v. Physicians Assoc., Inc.*, 386 S.E.2d 480 (W. Va. 1989) (malpractice led to death of automobile accident patient); *Martin v. Charleston Area Medical Ctr.*, 382 S.E.2d 502 (W. Va. 1989) (malpractice resulted in death of patient); *Shia v. Chvasta*, 377 S.E.2d 644 (W. Va. 1989) (patient suffered stroke from negligent administering of excessive vitamin K); *Reager v. Anderson*, 371 S.E.2d 619 (W. Va. 1988) (malpractice led to amputation of patient’s leg); *Thomas v. Raleigh Gen. Hosp.*, 358 S.E.2d 222 (W. Va. 1987) (negligence in insertion of endotracheal tube caused patient to lose normal speech); *Michael v. Henry*, 354 S.E.2d 590 (W. Va. 1987) (malpractice led to death of patient); *Roberts v. Stevens Clinic Hosp., Inc.*, 345 S.E.2d 791 (W. Va. 1986) (malpractice led to death of infant); *Paintiff v. City of Parkersburg*, 345 S.E.2d 564 (W. Va. 1986) (negligent failure to diagnose caused patient to have an abortion); *Totten v. Adongay*, 337 S.E.2d 2 (W. Va. 1985) (failure to diagnose patient’s broken wrist); *Renner v. Asli*, 280 S.E.2d 240 (W. Va. 1981)

anism for enforcing the rights of medical malpractice victims, until the state's tort reformers ran roughshod over the legislature in 1986 and forced enactment of the Medical Professional Liability Act.¹¹¹ Before discussing this Act, we think it only fair to the state legislature that a discussion is given regarding other legislation involving health care providers.

A. *West Virginia Medical Practice Act*¹¹²

In spite of the loud national cry for medical malpractice tort reform during the 1970's, West Virginia's legislature did not take action to cut off the right of its citizens to full compensation for injuries resulting from medical malpractice. However, before the end of the 1980's, massive pressure from the lobbying efforts of the state's tort reformers left an indelible scar on the rights of medical malpractice victims.

The legislature's first meaningful attempt at eradicating the real problem behind medical malpractice, *i.e.*, negligent and incompetent doctors, occurred in 1980 with the passage of the West Virginia Medical Practice Act.¹¹³ "Prior to the passage of this act,

(misdiagnosis of injury to patient's arm); *Brown v. Bluefield Mun. Bldg. Comm'n*, 280 S.E.2d 101 (W. Va. 1981) (malpractice caused patient to have permanent kidney and renal impairment); *Harrison v. Seltzer*, 268 S.E.2d 312 (W. Va. 1980) (malpractice led to amputation of patient's leg); *Hill v. Clarke*, 158 S.E.2d 159 (1967) (negligent cataract operation left patient blind in right eye); *Morgan v. Grace Hosp., Inc.*, 144 S.E.2d 156 (W. Va. 1965) (foreign object left in patient's body); *Duling v. Bluefield Sanitarium, Inc.*, 142 S.E.2d 754 (W. Va. 1965) (negligent treatment led to death of patient).

111. See W. VA. CODE § 55-7B-1 to 11 (Supp. 1990).

112. See W. VA. CODE § 30-3-1 to 17 (1986).

For a general discussion of this Act, see William N. Walker & Patricia W. Williams, *The New Medical Practice Act: Implications for Medical Discipline*, 76 W. VA. MED. J. 233 (1980). For cases citing sections of the Act see, *In re Jellen*, 521 F. Supp. 251 (N.D. W. Va. 1981); *Mahmoodian v. United Hosp. Ctr., Inc.*, 404 S.E.2d 750 (W. Va. 1991); *Pritchard v. Catterson*, 401 S.E.2d 475 (W. Va. 1990); *Walton v. Casey*, 370 S.E.2d 141 (W. Va. 1988); *Daily Gazette Co., Inc. v. West Virginia Bd. of Medicine*, 352 S.E.2d 66 (W. Va. 1986); *North v. West Virginia Bd. of Regents*, 332 S.E.2d 141 (W. Va. 1985); *Daily Gazette Co., Inc. v. Committee on Legal Ethics*, 326 S.E.2d 705 (W. Va. 1984).

113. The Act was summarized in its preamble as follows:

An Act . . . establishing the West Virginia board of medicine in lieu of the medical licensing board of West Virginia and giving it certain broad powers and duties with respect to the licensing of the practices of medicine and surgery and podiatry and certifying of physician assistants in the state and to the disciplining of said practices and related matters . . . prescribing qualifications for licenses to practice medicine and surgery and podiatry . . . providing for biennial renewal of licenses to practice medicine and surgery and podiatry . . . regulating the unauthorized practice

a license to practice medicine in effect conferred a lifetime privilege on an individual. Conviction of a felony was virtually the only grounds for removal of a license."¹¹⁴ This Act was a progressive and bold initiative to provide effective measures for rooting out negligent and incompetent doctors.

The Act created the West Virginia Board of Medicine.¹¹⁵ Aside from having the authority to "issue a license to practice medicine and surgery or to practice podiatry to any individual who is qualified to do so,"¹¹⁶ the Board was also given the unprecedented power to "independently initiate disciplinary proceedings . . . based on information received from medical peer review committees, physicians, podiatrists, hospital administrators, professional societies and others."¹¹⁷

The importance and significance of this Act was aptly stated by one commentator:

This represented the first major change in the medical practice law since 1931. It has brought West Virginia into the company of those states which are in tune with the times and recognize the intense public interest in matters of health policy

[The Act] stands as model legislation reflecting cooperation between organized medicine and our State Legislature in a truly altruistic fashion. This law gives us opportunities and challenges to help our colleagues, as well as to protect the public consumers of medical care. The problem of the impaired physician is pervasive in our society, and prevention and early intervention probably will be more effective than attempts to modify established behavior.¹¹⁸

of medicine and surgery and podiatry and prescribing criminal penalties and limitations; giving broad powers to the board of medicine to discipline physicians and podiatrists; providing for the disclosure of medical peer review committee information and reporting of professional malpractice and professional incompetence . . . prescribing the grounds for license denial and discipline of physicians and podiatrists; relating to investigations by the board and physical and mental examinations; providing for hearings and reporting by the board; relating to the suspension, revocation, termination and restriction of licenses to practice medicine and surgery and podiatry and the denial of applicants seeking to be so licensed, both after and before a hearing

1980 W. Va. Acts ch. 83.

114. William N. Walker & Patricia W. Williams, *supra* note 112.

115. See W. VA. CODE § 30-3-5 (1986).

116. W. VA. CODE § 30-3-10(a) (1986).

117. W. VA. CODE § 30-3-14(a) (1986).

118. William N. Walker & Patricia W. Williams, *supra* note 112 at 233-35.

B. *Malpractice Insurance Act*¹¹⁹

The sweeping powers granted to the West Virginia Board of Medicine did not bring about a halt to medical malpractice in the state. Incompetent doctors continued to practice their negligence. As a consequence, medical malpractice insurance premiums rose to unprecedented heights.¹²⁰ Escalating costs in premiums were a “wake-up call” for the state’s tort reformers to come out of hibernation. In doing so, they joined the national chorus of medical malpractice tort reform that echoed across the nation during the 1980’s.

Unfortunately, success followed the lobbying efforts of the state’s tort reformers in 1986. As a result, the state legislature enacted two major pieces of legislation aimed at controlling the cost of medical malpractice insurance.¹²¹ One of those pieces of

119. Passage of this Act brought on what has been described as, “[t]he Great Malpractice Insurance Scare of 1986 . . . in West Virginia . . .” Michael Abramowitz, *W. Va.’s Malpractice Insurance Crisis Ends: Legislature Reverses Course, Eases New Curbs to Keep Firm From Ending Coverage*, WASH. POST, May 24, 1986, at D9. The “scare” occurred because

[s]oon after the law was signed by [Governor] Moore . . . the state’s five largest medical malpractice insurance companies sent out notices to most of the 7,000 doctors and 58 hospitals in the state that they would cancel their coverage by June [1986]. The companies asserted the bill infringes upon their ability to make sound business judgments.

Michael Abramowitz, *W. Va. Court Halts Insurer’s Cancellations*, WASH. POST, May 10, 1986, at D1. Shortly after the insurers sent out cancellation notices “the state’s attorney general . . . filed suit against the insurers, accusing them of violating West Virginia’s antitrust laws. [The attorney general] sought a temporary injunction preventing the cancellations, which was turned down by a state circuit court. However, in a 5-0 ruling, the state Supreme Court granted the injunction . . .” *Id.* The crisis surrounding this Act was eventually quelled after the state legislature, in the First Extraordinary Session of 1986, amended the Act to the satisfaction of insurers. *See* 1986 W. Va. Acts 1st Ex. Sess., ch. 17.

120. In a report released by the state’s attorney general in 1986, it was revealed that the five largest insurers in the state earned premiums and profits at the following levels in 1985: (a) Continental Casualty Co., \$10.6 million (earned premiums) and 73.6% (profit); (b) Ohio Hospital Insurance Co., \$4.2 million (earned premiums) and 13.2% (profit); (c) St. Paul Fire & Marine Insurance Co., \$2.4 million (earned premiums) and 58.7% (profit); (d) National Fire Insurance Co. of Hartford, \$423,000 (earned premiums) and 209.2% (profit); (e) American Casualty Co. of Reading, Pa. \$99,000 (earned premiums) and 297.8% (profit). *Report by West Virginia Attorney General Shows Profits by Insurers Ranged to 297%*, [State Developments] 51 Antitrust & Trade Reg. Rep. (BNA) No. 1281, at 363 (Sept. 11, 1986).

121. The following Table presents premiums paid by West Virginia health care providers and claims paid by insurers for the period 1980-89:

TABLE 16.
PREMIUMS EARNED AND LOSSES PAID BY MEDICAL
MALPRACTICE INSURERS IN WEST VIRGINIA 1980-89*

legislation was the Malpractice Insurance Act.¹²² This Act accomplished several things.¹²³ First, it amended section 33-20-2 of the *West Virginia Code*,¹²⁴ so as to place primary regulation of medical malpractice insurers under a separate statute. Second, the Act created a statute specifically regulating medical malpractice insurers.¹²⁵ Third, the Act created a statute regulating cancellation and nonrenewal of medical malpractice insurance policies.¹²⁶

Year	Direct Premiums Earned (millions)	Direct Losses Paid (millions)
1980	\$13,235,000	\$ 6,655,000
1981	12,452,000	5,664,000
1982	13,358,000	6,662,000
1983	14,437,000	11,497,000
1984	17,182,000	8,913,000
1985	24,547,000	16,853,000
1986	29,198,000	12,142,000
1987	35,628,000	15,239,000
1988	38,304,000	21,181,000
1989	36,491,000	23,347,000

*These figures do not include excess coverage data.

WEST VIRGINIA INSURANCE COMMISSIONER'S ANNUAL REPORT (1980-89).

122. This Act was codified under three articles: W. VA. CODE § 33-20-2, §§ 33-20B-1 to 7, and §§ 33-20C-1 to 5 (1988). The preamble to the Act gives its purpose as:

An Act . . . pertaining to . . . medical malpractice insurance policies only; establishing procedures for disapproval of filings; requiring the commissioner to hold a public hearing within the initial sixty day waiting period on certain filings which request a rate increase; providing for review by the commissioner of rules, rates and rating plans; requiring insurers to submit to the commissioner certain information annually . . . requiring the commissioner, by legislative rule, to establish methods allocating investment and other income; describing the circumstances under which a policy of malpractice may be canceled . . . requiring insurers to provide reasons for cancellation; requiring a notice period for cancellation; requiring a sixty day notice in the case of a nonrenewal of a policy or contract providing malpractice insurance; providing for hearings and review to insured persons aggrieved by cancellations.

1986 W. Va. Acts 1st Ex. Sess., ch. 17.

123. For a general discussion of issues surrounding tort liability insurers, see Gary T. Schwartz, *The Ethics and the Economics of Tort Liability Insurance*, 75 CORNELL L. REV. 313 (1990); Jay Angoff, *Insurance Against Competition: How The McCarran-Ferguson Act Raises Prices and Profits in the Property-Casualty Insurance Industry*, 5 YALE J. ON REG. 397 (1988); Eliot Martin Blake, *Rumors of Crisis: Considering the Insurance Crisis and Tort Reform in an Information Vacuum*, 37 EMORY L.J. 401 (1988); Frank T. Herdman, Comment, *Doctors, Insurers, and the Antitrust Laws*, 37 BUFF. L. REV. 789 (1988); George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521 (1987); DOUGLAS CADDY, LEGISLATIVE TRENDS IN INSURANCE REGULATION (1986).

124. See W. VA. CODE § 33-20-2(b)(6) (1988).

125. See W. VA. CODE §§ 33-20B-1 to 7 (Supp. 1990).

126. See W. VA. CODE §§ 33-20C-1 to 5 (Supp. 1990).

C. *Medical Professional Liability Act*¹²⁷

The second major legislative initiative in 1986 in the area of medical malpractice was enactment of the Medical Professional Liability Act.¹²⁸ This Act, tragic in its consequences to victims of medical negligence, carved out separate and unequal tort laws to govern the disposition of medical malpractice actions. The “Legislative Findings and Declaration of Purpose” section of the Act states, in part:

That it is the duty and responsibility of the Legislature to balance the rights of our individual citizens to adequate and reasonable compensation with the broad public interest in the provision of services by qualified health care providers who can themselves obtain the protection of reasonably priced and extensive liability coverage

. . . .
Therefore, the purpose of this enactment is to provide for . . . reforms in the common law and statutory rights of our citizens to compensation for injury and death¹²⁹

The purpose of the Act, in essence, was to control the cost of medical malpractice insurance by stripping malpractice victims of their right to full compensation for medical negligence that caused injuries, maiming, and death. In this part of the Article we will briefly discuss some of the provisions of this Act.

1. Section 55-7B-3: Elements of Proof¹³⁰

Section 55-7B-3 essentially abolished the “locality rule” in medical malpractice actions.¹³¹ Interestingly enough, the state Su-

127. See W. VA. CODE §§ 55-7B-1 to 11 (Supp. 1990).

128. During the time that we put this article together the state Supreme Court had construed only one section of this Act, and that was section 55-7B-7. However, it has been learned that the Court recently accepted the petition of a medical malpractice case styled *Robinson v. Biswas*, Civil Action No. 88-C-3685, which should present the Court with an opportunity to interpret other sections of the Act.

129. W. VA. CODE § 55-7B-1 (Supp. 1990).

130. This section provides:

The following are necessary elements of proof that an injury or death resulted from the failure of a health care provider to follow the accepted standard of care:

(a) The health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances; and

preme Court abolished the common law medical malpractice locality rule approximately three months before section 55-7B-3 became effective. The judicial ruling occurred in *Paintiff v. City of Parkersburg*,¹³² wherein the Court stated:

[I]f a plaintiff in a malpractice action is not permitted to obtain expert testimony of a physician who practices outside the domain of the defendant doctor, he may be denied completely the opportunity of proving the negligent acts of which he complains Much has been written about the obsolescence of the locality rule. We have nothing to add to the oceans of ink and forests of paper that have been pressed into service to hasten the rule's demise. We will only add that the locality rule is abolished in West Virginia, and we shall not miss it.¹³³

The Court did not mention whether it was aware that the state legislature was planning to abolish the locality rule by statute, so we must assume that it was a mere coincidence that the rule was abolished twice in the space of a few months. At any rate, section 55-7B-3 requires that a medical malpractice plaintiff prove that the defendant failed to exercise the degree of care, skill, and learning expected of a reasonable, prudent doctor in the defendant's profession or specialty.

While section 55-7B-3, standing alone, gives the impression that the Act is pro-plaintiff; *i.e.*, paves the way for plaintiffs to recover by breaking the strangle-hold caused by the local conspiracy of

(b) Such failure was a proximate cause of the injury or death.

W. VA. CODE § 55-7B-3 (Supp. 1990).

131. Under the strict and narrow version of this rule, the competence of an expert medical witness to testify about standard of care is determined by his familiarity with the care ordinarily exercised in the same locality in which the defendant practiced The locality rule came into being in the 19th century and was premised upon the thought that it was unfair to hold the country doctor to the same stringent standard as the supposedly more learned doctors practicing in large urban centers.

Hundley v. Martinez, 158 S.E.2d 159, 166-67 (W. Va. 1967). For a general discussion of the locality rule, see Michael M. Belli, *Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956); E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719 (1987); Brian Ribble-Smith & Arthur W. Hafner, *The Effect of the Information Age on Physicians' Professional Liability*, 36 DEPAUL L. REV. 69 (1986).

132. 345 S.E.2d 564 (W. Va. 1986).

133. *Id.* at 567.

silence,¹³⁴ this is but a discouraging illusion. The remaining sections of the Act take away or limit fundamental rights of medical malpractice victims.

2. Section 55-7B-4: Health Care Injuries; Limitations of Actions; Exceptions.¹³⁵

Section 55-7B-4 is a peculiar, if not misguided, statute of limitation on medical malpractice actions. It was poorly drafted and will no doubt require judicial interpretation to untangle its built-in confusion. The area of concern we address relates to the section's maximum ten-year period in which to bring a medical malpractice action.

134. By "conspiracy of silence" we refer to doctors being reluctant to testify against each other in medical malpractice cases. See, e.g., *Farley v. Meadows*, 404 S.E.2d 537 (W. Va. 1991). Here the plaintiffs could not get any local doctor to be an expert witness in their medical malpractice case. Although the plaintiffs, correctly so, attributed this to the conspiracy of silence, Justice Neely, writing for the Court, displayed insensitivity to the dimensions of this problem by stating:

[I]t is obvious from the abundance of medical malpractice cases that go to trial around the United States, and from the profusion of medical experts advertising their services in the back of legal magazines, that many doctors will gladly don their boxing gloves for a reasonable fee and testify about malpractice matters away from their own home towns.

Id. at 540.

What Justice Neely failed to take into consideration in his superficial assessment, is the cost to the plaintiffs in *Farley* in having to transport a doctor into the state to act as an expert witness. This cost is probably small for a large firm, but for a sole practitioner or small firm, the specter of having to pay an out of state medical expert's traveling and lodging expenses — on top of the fee for testifying — becomes a problem. Evidently this cost factor was insurmountable in *Farley*. For a general discussion of the conspiracy of silence, see Joseph Kelner, *The Silent Doctors — The Conspiracy of Silence*, 5 U. RICH. L. REV. 119 (1970); Richard M. Markus, *Conspiracy of Silence*, 14 CLEV.-MARSHALL L. REV. 520 (1965); David E. Seidelson, *Medical Malpractice Cases and the Reluctant Expert*, 16 CATH. U.L. REV. 158 (1966).

135. This section provides:

(a) A cause of action for injury to a person alleging medical professional liability against a health care provider arises as of the date of injury, except as provided in subsection (b) of this section, and must be commenced within two years of the date of such injury, or within two years of the date when such person discovers, or with the exercise of reasonable diligence, should have discovered such injury, whichever last occurs: Provided, That in no event shall any such action be commenced more than ten years after the date of injury.

(b) A cause of action for injury to a minor, brought by or on behalf of a minor who was under the age of ten years at the time of such injury, shall be commenced within two years of the date of such injury, or prior to the minor's twelfth birthday, whichever provides the longer period.

(c) The periods of limitation set forth in this section shall be tolled for any period during which the health care provider or its representative has committed fraud or collusion by concealing or misrepresenting material facts about the injury.

W. VA. CODE § 55-7B-4 (Supp. 1990).

Subsection 55-7B-4(a) provides a limitation period for adults to bring a medical malpractice action. This subsection requires an action be brought no later than two years from the date of injury or discovery of the injury, with a maximum ten-year period to discover the injury before it is no longer actionable.

While subsection 55-7B-4(a) is more or less clear in its intent, subsection 55-7B-4(b) is a little more difficult to interpret. Subsection 55-7B-4(b) states that if a minor under the age of ten suffers a medical malpractice injury, he or she must bring an action prior to his or her twelfth birthday or within two years of the date of the injury. The question we have, which the section does not explicitly or implicitly answer, is whether or not the maximum ten-year period of discovery in subsection 55-7B-4(a) applies to subsection 55-7B-4(b). The issue lends itself to valid arguments either way.

Subsection 55-7B-4(b) takes a draconian-like bite out of the rights of minors when section 55-2-15¹³⁶ is taken into consideration. Under section 55-2-15, the statute of limitations for bringing a tort cause of action may be tolled for minors until they reach majority age. Subsection 55-7B-4(b) appears to abrogate this right for minors who are victims of medical malpractice.

3. Section 55-7B-5: Health Care Actions; Complaint; Specific Amount of Damages Not To Be Stated.¹³⁷

Section 55-7B-5 is one of the few straightforward and unambiguous sections in the Act. This section states, in part, that “[i]n

136. This section provides:

If any person to whom the right accrues to bring any such personal action, suit or scire facias, or any such bill to repeal a grant, shall be, at the time the same accrues, an infant or insane, the same may be brought within the like number of years after his becoming of full age or sane that is allowed to a person having no such impediment to bring the same after the right accrues, or after such acknowledgment as is mentioned in section eight [§ 55-2-8] of this article, except that it shall in no case be brought after twenty years from the time when the right accrues.

W. VA. CODE § 55-2-15 (1981).

137. This section provides:

In any medical professional liability action against a health care provider, no specific dollar

any medical professional liability action against a health care provider, no specific dollar amount or figure may be included in the complaint”¹³⁸ In effect, section 55-7B-5 abolishes the *ad damnum* clause in medical malpractice actions. The utility of this section is doubtful. Generally, in tort actions, it is likely already reversible error to mention to the jury the amount of damages not proven in evidence.¹³⁹

4. Section 55-7B-6: Pretrial Procedures.¹⁴⁰

Several matters are taken up in section 55-7B-6. Subsection 55-7B-6(a) provides that, in a medical malpractice action, a man-

amount or figure may be included in the complaint, but the complaint may include a statement reciting that the minimum jurisdictional amount established for filing the action is satisfied. However, any party defendant may at any time request a written statement setting forth the nature and amount of damages being sought. The request shall be served upon the plaintiff who shall serve a responsive statement as to the damages sought within thirty days thereafter. If no response is served within the thirty days, the party defendant requesting the statement may petition the court in which the action is pending to order the plaintiff to serve a responsive statement.

W. VA. CODE § 55-7B-5 (Supp. 1991).

138. *Id.*

139. In *Bennett v. 3 C Coal Co.*, 379 S.E.2d 388 (W. Va. 1989), it was stated that,

This Court recently expressed disapproval of the practice of advising the jury concerning the monetary figures of the *ad damnum* clause. ‘In the trial of negligence cases, the better practice is to withhold any monetary figure from the jury’s consideration which might be suggestive of amounts not proven in evidence.’

Id. at 396 (quoting *Jordan v. Bero*, 210 S.E.2d 618 (W. Va. 1974) and *Abdulla v. Pittsburgh & Weirton Bus Co.*, 213 S.E.2d 810, 823 (W. Va. 1975).

140. This section provides:

(a) In each medical professional liability action against a health care provider, not less than nine nor more than twelve months following the filing of answer by all defendants, a mandatory status conference shall be held at which, in addition to any matters otherwise required, the parties shall:

(1) Inform the court as to the status of the action, particularly as to the identification of contested facts and issues and the progress of discovery and the period of time for, and nature of, anticipated discovery; and

(2) On behalf of the plaintiff, certify to the court that either an expert witness has or will be retained to testify on behalf of the plaintiff as to the applicable standard of care or that under the alleged facts of the action, no expert witness will be required. If the court determines that expert testimony will be required, the court shall provide a reasonable period of time for obtaining an expert witness and the action shall not be scheduled for trial, unless the defendant agrees otherwise, until such period has concluded. It shall be the duty of the defendant to schedule such conference with the court upon proper notice to the plaintiff.

(b) In the event that the court determines prior to trial that either party is presenting or relying upon a frivolous or dilatory claim or defense, for which there is no reasonable basis in fact or at law, the court may direct in any final judgment the payment to the prevailing party

datory status conference be held not more than twelve months after a defendant files an answer. Subsection 55-7B-6(a)(1) instructs the parties to inform the trial court, at the mandatory status conference, of contested facts and issues and the progress of discovery. Subsection 55-7B-6(a)(2) requires that the plaintiff inform the trial court, at the mandatory status conference, "that either an expert witness has or will be retained to testify on behalf of the plaintiff as to the applicable standard of care or that under the alleged facts of the action, no expert witness will be required."¹⁴¹

Subsection 55-7B-6(b) has "teeth" in it, so to speak, because it penalizes a plaintiff or defendant for alleging a frivolous claim or defense. This subsection grants the trial court the discretion to make a pretrial determination of whether or not a frivolous claim or defense is being presented. If so, "the court may direct in any final judgment the payment to the prevailing party of reasonable litigation expenses, including deposition and subpoena expenses, travel expenses . . . and such other expenses necessary to the maintenance of the action, excluding attorney's fees and expenses."¹⁴²

5. Section 55-7B-7: Testimony of Expert Witness on Standard of Care.¹⁴³

Section 55-7B-7 requires that a plaintiff provide an expert witness in a medical malpractice action to show the applicable stan-

of reasonable litigation expenses, including deposition and subpoena expenses, travel expenses incurred by the party, and such other expenses necessary to the maintenance of the action, excluding attorney's fees and expenses.

W. VA. CODE § 55-7B-6 (Supp. 1990).

141. *Id.* § 55-7B-6(a)(2).

142. *Id.* § 55-7B-6(b).

143. This section provides:

The applicable standard of care and a defendant's failure to meet said standard, if at issue, shall be established in medical professional liability cases by the plaintiff by testimony of one or more knowledgeable, competent expert witnesses if required by the court. Such expert testimony may only be admitted in evidence if the foundation, therefor, is first laid establishing that: (a) The opinion is actually held by the expert witness; (b) the opinion can be testified to with reasonable medical probability; (c) such expert witness possesses professional knowledge and expertise coupled with knowledge of the applicable standard of care to which his or her expert opinion testimony is addressed; (d) such expert maintains a current license to practice medicine in one of the states of the United States; and (e) such expert is engaged or qualified in the same or substantially similar medical field as the defendant health care provider.

W. VA. CODE § 55-7B-7 (Supp. 1991).

dard of care and the defendant's failure to meet the standard. This section was construed by the state Supreme Court in *Gilman v. Choi*.¹⁴⁴ This case came to the court on a certified question from the Circuit Court of Mason County. The Court was asked to decide whether section 55-7B-7 was in conflict with Rule 702 of the West Virginia Rules of Evidence which provides that an individual may testify as an expert if he or she is qualified because of knowledge, skill, experience, training, or education. The Court failed to answer the question as presented by the trial court and elected, instead, to respond by holding that section 55-7B-7 was valid under Rule 601 of the West Virginia Rules of Evidence, which provides that every person is competent to be a witness except as otherwise provided for by statute or the rules of evidence.¹⁴⁵

6. Section 55-7B-8: Limit on Liability for Noneconomic Loss.¹⁴⁶

Section 55-7B-8 is the state's damage cap provision for medical malpractice actions; the central legislative measure tort reformers across the nation wanted enacted by every state legislature. It establishes the sum of one million dollars as a maximum amount of recovery for noneconomic damages in medical malpractice actions.

Although the majority of medical malpractice damage cap statutes have been construed by state supreme courts, section 55-7B-8 has not yet been interpreted by the West Virginia Supreme Court of Appeals.¹⁴⁷ The present Court may or may not find the section unconstitutional, but the language in *Sargent v. Malcomb*¹⁴⁸ suggests that the issue of noneconomic damages is a question for the jury:

144. 406 S.E.2d 200 (W. Va. 1990).

145. Chief Justice Neely dissented, in part, in the *Gilman* opinion. The Chief Justice indicated that he believed Rule 702 of the West Virginia Rules of Evidence was in conflict with section 55-7B-7, and that he would defer to the will of the legislature and hold that section 55-7B-7 prevails over Rule 702.

146. This section provides: "In any medical professional liability action brought against a health care provider, the maximum amount recoverable as damages for noneconomic loss shall not exceed one million dollars and the jury may be so instructed." W. VA. CODE § 55-7B-8 (Supp. 1991).

147. This section is at issue in a recent case the Court has agreed to hear. *See supra* note 128.

148. 146 S.E.2d 561 (W. Va. 1966).

There is no exact formula or standard for placing a money value on such matters as pain, suffering, and mental anguish resulting from personal injuries or embarrassment resulting from bodily disfigurement or scars. The law recognizes that the aggregate judgment of twelve duly selected and properly qualified jurors represents the best method yet devised for fixing the amount of just compensation to the injured plaintiffs in such cases.¹⁴⁹

The language in *Sargent* should be a compelling echo from the past, guiding the present Court when it construes section 55-7B-8. This section is a clear indication of the rich and powerful protecting themselves at the expense of the economically disadvantaged and politically powerless. Section 55-7B-8 is a deadly cancer, eating away at the integrity and impartiality of our state legal system. It must be surgically removed by the Court or through the voting capacity of the citizens of this state.

7. Section 55-7B-9: Joint and Several Liability.¹⁵⁰

The controlling or significant language in section 55-7B-9 is found in subsection 55-7B-9(b), where it states:

149. *Id.* at 566.

150. This section provides:

(a) In the trial of a medical professional liability action against a health care provider involving multiple defendants, the jury shall be required to report its findings to the court on a form provided by the court which contains each of the possible verdicts as determined by the court.

(b) In every medical professional liability action, the court shall make findings as to the total dollar amount awarded as damages to each plaintiff. The court shall enter judgment of joint and several liability against every defendant which bears twenty-five percent or more of the negligence attributable to all defendants. The court shall enter judgment of several, but not joint, liability against and among all defendants which bear less than twenty-five percent of the negligence attributable to all defendants.

(c) Each defendant against whom a judgment of joint and several liability is entered in a medical professional liability action pursuant to subsection (b) of this section is liable to each plaintiff for all or any part of the total dollar amount awarded regardless of the percentage of negligence attributable to him. A right of contribution exists in favor of each defendant who has paid to a plaintiff more than the percentage of the total dollar amount awarded attributable to him relative to the percentage of negligence attributable to him. The total amount of recovery for contribution is limited to the amount paid by the defendant to a plaintiff in excess of the percentage of the total dollar amount awarded attributable to him. No right of contribution exists against any defendant who entered into a good faith settlement with the plaintiff prior to the jury's report of its findings to the court or the court's findings as to the total dollar amount awarded as to damages.

(d) Where a right of contribution exists in a medical professional liability action pursuant to subsection (c) of this section, the findings of the court or jury as to the percentage of negligence

In every medical professional liability action, the court shall make findings as to the total dollar amount awarded as damages to each plaintiff. The court shall enter judgment of joint and several liability against every defendant which bears twenty-five percent or more of the negligence attributable to all defendants. The court shall enter judgment of several, but not joint, liability against and among all defendants which bear less than twenty-five percent of the negligence attributable to all defendants.¹⁵¹

The intent of section 55-7B-9 is to make certain that a codefendant whose medical malpractice caused less than twenty-five percent of the injury to the victim is not jointly liable for the full amount awarded as damages. The obvious dilemma this section presents for a plaintiff is that of a situation with several codefendants, none of whom is found to contribute twenty-five percent or more in causing the injury and only one of which is not judgment proof. Under such a scenario, a plaintiff would get less than twenty-five percent of the verdict award. Such a situation is unconscionable.

IV. JUDICIAL SCRUTINY OF MEDICAL MALPRACTICE DAMAGE CAPS¹⁵²

Arguably the most controversial medical malpractice reform initiative put forth by tort reformers was the measure calling for

and liability of the several defendants to the plaintiff shall be binding among such defendants as determining their rights of contribution.

W. VA. CODE § 55-7B-9 (Supp. 1991).

Further, § 55-7B-9(c) was cited recently in *Board of Educ. of McDowell County v. Zando, Martin & Milstead, Inc.*, 390 S.E.2d 796, 803 n.5 (W. Va. 1990).

151. W. VA. CODE § 55-7B-9(b).

152. See note 17 herein for a general discussion on damage cap statutes. The following list of state statutes impose medical malpractice damage caps: ALA. CODE § 6-5-544, 6-5-547 (Supp. 1990); ALASKA STAT. § 09.17.010 (Supp. 1990); CAL. CIV. CODE § 3333.2 (Deering Supp. 1991); COLO. REV. STAT. § 13-21-102.5(3) (1987); FLA. STAT. ANN. § 768.80 (West Supp. 1991); HAW. REV. STAT. § 663-8.7 (Supp. 1990); IDAHO CODE § 6-1603 (1990); IND. CODE ANN. § 16-9.5-2-2 (Burns 1990); KAN. STAT. ANN. § 60-3407 (Supp. 1990); LA. REV. STAT. ANN. § 40:1299.42 (West Supp. 1991); MD. CTS. & JUD. PROC. CODE ANN. § 11-108 (1989); MASS. GEN. L. ch. 231 § 60-H (Supp. 1991); MO. ANN. STAT. § 538.210 (Vernon 1988); NEB. REV. STAT. § 44-2825 (1988); N.H. REV. STAT. ANN. § 507-C:7 (1983); N.M. STAT. ANN. § 41-5-6 (Michie Supp. 1991); OHIO REV. CODE ANN. § 2307.43 (Anderson 1991); OR. REV. STAT. § 18.560(1) (1989); S.D. CODIFIED LAWS ANN. § 21-3-11 (1987); TEXAS CIV. STAT. ANN. § 4590i(K) (West Supp. 1991); UTAH CODE ANN. § 78-14-7.1 (1987); VA. CODE ANN. § 8.01-581.15 (Michie 1984); WASH. REV. CODE § 4.56.250(d)(2) (1988); W. VA. CODE § 55-7B-8 (Supp. 1991); WIS. STAT. ANN. § 893.55 (West Supp. 1990). See also Table 9 *supra* note 32.

a limitation on recovery for economic¹⁵³ damages, noneconomic damages,¹⁵⁴ or both; *i.e.*, damage cap proposals. Support for this statement can be found in the numerous legal contests that have been fought over the validity of damage cap statutes.¹⁵⁵ One commentator captured the essence of this controversy by stating:

It is hard to imagine a statutory provision that more blatantly favors a special class than one that limits the damages an injured person may recover from a [physician]. No such consideration is afforded any other professional who negligently injures another person.¹⁵⁶

Of course the idea or fact of limiting verdict awards is not confined to the area of medical malpractice. State legislatures have

153. The following statutes are examples of statutes limiting both economic and noneconomic damages in medical malpractice cases:

In any verdict returned against a health care provider in an action for malpractice . . . which is tried by a jury or in any judgment entered against a health care provider in such an action which is tried without a jury, the total amount recoverable for any injury to, or death of, a patient shall not exceed one million dollars.

VA. CODE ANN. § 8.01-581.15 (Michie 1984).

For a specific discussion of the statute, see M. Margaret Branham Kimmel, Comment, *The Constitutional Attack on Virginia's Medical Malpractice Cap: Equal Protection and the Right to Jury Trial*, 22 U. RICH. L. REV. 95 (1987).

(a) In any medical malpractice liability action:

(1) The total amount recoverable by each party from all defendants for all claims for noneconomic loss based on causes of action . . . shall not exceed a sum total of \$250,000; and

(2) . . . the total amount recoverable by each party from all defendants for all claims shall not exceed a sum total of \$1,000,000.

KAN. STAT. ANN. § 60-3407 (Supp. 1990).

For a specific discussion of the statute, see Elizabeth A. Schartz et al., Comment, *Caps, Crisis and Constitutionality — Evaluating the 1986 Kansas Medical Malpractice Legislation*, 35 KAN. L. REV. 763 (1987).

154. The following statutes are examples of statutes limiting noneconomic damages in medical malpractice cases:

In any medical professional liability action brought against a health care provider, the maximum amount recoverable as damages for noneconomic loss shall not exceed one million dollars and the jury may be so instructed.

W. VA. CODE § 55-7B-8 (Supp. 1990).

For a specific discussion of the statute, see Jill Oliverio, Note, *To Cap or Not to Cap Damage Awards: That is the Constitutional Question*, 91 W. VA. L. REV. 519 (1988).

In any action against a health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care services, no plaintiff shall recover more than three hundred fifty thousand dollars per occurrence for noneconomic damages from any one defendant

MO. ANN. STAT. § 538.210 (Vernon 1988).

155. See *infra* note 167.

156. June Smith Tyler, Comment, *Medical Malpractice Statutes: Special Protection for a Privileged Few?*, 12 N. KY. L. REV. 295, 313 (1985).

found other areas in our social fabric in which to impose limitations on compensation for tort.¹⁵⁷ Moreover, many courts use self-imposed legal devices such as remittitur¹⁵⁸ and judgment notwithstanding the verdict¹⁵⁹ to control compensation to plaintiffs.¹⁶⁰ Regardless of the context in which verdict limitations have arisen, they invariably come into conflict with the deeply-rooted rights of plaintiffs.¹⁶¹

Medical malpractice damage cap statutes are fundamentally antithetical to the three primary objectives of tort law.¹⁶² That is, damage caps: (1) do not punish wrongdoers;¹⁶³ (2) encourage potentially harmful activities;¹⁶⁴ and (3) deny full compensation to

157. See, e.g., ALA. CODE § 6-11-21 (Supp. 1990) (limit on recovery for punitive damages); DEL. CODE ANN. tit. 10 § 4013 (Supp. 1990) (limit on recovery against state); IDAHO CODE ANN. § 6-926 (1990) (limit on recovery against state); IND. CODE ANN. § 34-4-16.5-4 (Burns 1986) (limiting amount recoverable from state); KAN. STAT. ANN. § 60-19a01 (Supp. 1990) (limit on recovery for pain and suffering); MD. STATE GOV'T CODE ANN. § 12-104 (1984) (limit on recovery against state); MINN. STAT. ANN. § 65B.51(3) (West 1986) (limiting noneconomic damages in automobile accident cases); MINN. STAT. ANN. § 549.23 (West 1988) (limiting amount recoverable for loss of consortium); MO. ANN. STAT. § 537.045 (Vernon Supp. 1991) (limit on recovery against parent for tort of minor); NEV. REV. STAT. ANN. § 598A.170 (1989) (limit on recovery in action brought by attorney general); N.H. REV. STAT. § 507-B:4 (Supp. 1990) (limit on recovery against state); VA. CODE ANN. § 8.01-38.1 (Michie Supp. 1990) (limit on recovery for punitive damages); W. VA. CODE § 55-7A-2 (Supp. 1990) (limit on recovery against parent for tort of minor).

158. For a general discussion, see Francis X. Busch, *Remittiturs and Additurs in Personal Injury and Wrongful Death Cases*, 12 DEFENSE L.J. 521 (1963); Jack B. Draper, Comment, *Remittitur: Or, the Law of Diminishing Returns*, 24 TENN. L. REV. 1155 (1957).

159. For a general discussion, see Franklin H. Nachman, *Posttrial Alchemy: Judgments Notwithstanding the Verdict*, LITIGATION, Spring 1989, at 13; William P. McLaughlan, *An Empirical Study of Civil Procedure: Directed Verdicts and Judgments Notwithstanding Verdict*, 2 J. LEGAL STUD. 459 (1973).

160. Other devices available to courts in affecting verdicts include default judgment, summary judgment, and directed verdict. For a discussion, see David P. Currie, *Thoughts on Directed Verdicts and Summary Judgments*, 45 U. CHI. L. REV. 72 (1977); Martin B. Louis, *Federal Summary Judgment Doctrine: A Critical Analysis*, 83 YALE L.J. 745 (1974); Paul B. Weiss, Comment, *Reforming Tort Reform: Is There Substance to the Seventh Amendment?*, 38 CATH. U. L. REV. 737, 758-761 (1989).

161. See, e.g., *Condemarin v. University Hospital*, 775 P.2d 348 (Utah 1989) (finding statute limiting liability of state government entity unconstitutional). For a general discussion in this area, see Fleming James, Jr., *Tort Liability of Governmental Units and Their Officers*, 22 U. CHI. L. REV. 610 (1955).

162. That is, to punish the wrongdoer, deter unsafe behavior, and compensate the accident victim. Steven D. Smith, *The Critics and the "Crisis": A Reassessment of Current Conceptions of Tort Law*, 72 CORNELL L. REV. 765 (1987); see also George P. Fletcher, *Fairness and Utility in Tort Theory*, 85 HARV. L. REV. 537 (1972); David G. Owen, *Deterrence and Desert in Tort: A Comment*, 73 CALIF. L. REV. 665 (1985).

163. It has been argued that tort law is inappropriate as a vehicle for punishment. As one commentator put it, "the punishment rationale seems more compatible with Mosaic law's 'eye for eye' . . . approach than with an 'enlightened' twentieth-century jurisprudence." Smith, *supra* note 162, at 776.

164. The court in *Hoem v. State*, 756 P.2d 780 (Wyo. 1988), articulated this concern as follows:

accident victims.¹⁶⁵ In spite of this rather harsh but obvious assessment of damage cap statutes, tort reformers vigilantly advocated the installation of medical malpractice damage caps in virtually every state during the 1970's and 1980's. Their efforts were not in vain. At least twenty-seven state legislatures capitulated to the reformers' demand for medical malpractice damage caps by the end of the 1980's.¹⁶⁶

Almost as quickly as state legislatures enacted damage cap statutes, medical malpractice victims began challenging the constitutionality of such statutes in state courts.¹⁶⁷ The legal arguments varied, but included many of the following state constitutional challenges: (1) denial of equal protection;¹⁶⁸ (2) special legislation;¹⁶⁹ (3) denial of trial by jury;¹⁷⁰ and (4) denial of open court.¹⁷¹

[I]f the medical profession is less accountable than formerly because of the special treatment it is afforded by [damage caps], then a relaxation of medical standards may occur with the public as the victim. '[T]o find that the protection and special dispensation given to health delivery tortfeasors . . . is in the best interest of public health is illogical to the point of irrationality.'

Id. at 783 (third alternation in original) (citations omitted).

165. "Certainly the limitation of recovery does not provide adequate compensation to patients with meritorious claims; on the contrary, it does just the opposite for the most seriously injured claimants." *Arneson v. Olson*, 270 N.W.2d 125, 135 (N.D. 1978).

166. See Table 9, *supra* note 32.

167. The following cases challenged the constitutionality of damage cap statutes: *Fein v. Permanente Medical Group*, 695 P.2d 665 (Cal. 1985); *Smith v. Department of Ins.*, 507 So.2d 1080 (Fla. 1987); *Jones v. State Bd. of Medicine*, 555 P.2d 399 (Idaho 1976), *cert. denied*, 431 U.S. 914 (1977); *Wright v. Central Du Page Hosp. Ass'n*, 347 N.E.2d 736 (Ill. 1976); *Johnson v. St. Vincent Hosp., Inc.*, 404 N.E.2d 585 (Ind. 1980); *Kansas Malpractice Victims Coalition v. Bell*, 757 P.2d 251 (Kan. 1988); *Williams v. Kushner*, 549 So.2d 294 (La. 1989); *Sibley v. Board of Supervisors of Louisiana State University*, 462 So. 2d 149 (La. 1985); *Prendergast v. Nelson*, 256 N.W.2d 657 (Neb. 1977); *Carson v. Maurer*, 424 A.2d 825 (N.H. 1980); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Duren v. Suburban Community Hosp.*, 482 N.E.2d 1358 (Ohio C.P. 1985); *Rose v. Doctors Hosp.*, 801 S.W.2d 841 (Tex. 1990); *Lucas v. U.S.*, 757 S.W.2d 687 (Tex. 1988); *Etheridge v. Medical Center Hosp.*, 376 S.E.2d 525 (Va. 1989); *State ex rel. Strykowski v. Wilkie*, 261 N.W.2d 434 (1978).

168. See, e.g., *Carson v. Maurer*, 424 A.2d 825 (N.H. 1980) (where damage cap statute was found to violate state constitutional guarantee of equal protection). *But see* *Fein v. Permanente Medical Group*, 695 P.2d 665 (Cal. 1985) (where court found damage cap statute did not violate state constitutional guarantee of equal protection).

169. See, e.g., *Wright v. Central Du Page Hosp. Ass'n*, 347 N.E.2d 736 (Ill. 1976) (court found damage cap statute to be special legislation that violated state constitution). *But see* *Etheridge v. Medical Center Hosp.*, 376 S.E.2d 525 (Va. 1989) (where court found damage cap statute was not special legislation).

170. See, e.g., *Kansas Malpractice Victims v. Bell*, 757 P.2d 251 (Kan. 1988) (where damage cap statute was found to violate state constitutional guarantee of trial by jury). *But see* *Johnson v. St. Vincent*

The reception of these arguments by state courts was best summed up by the court in *Duren v. Suburban Community Hospital*,¹⁷² where it was said that the “scheme of shifting responsibility for loss from one of the most affluent segments of society [*i.e.*, physicians] to those who are most unable to sustain that burden, *i.e.*, horribly injured or maimed individuals is not only inconceivable, but shocking to [the] conscience.”¹⁷³

Although state courts are split on the question of whether or not medical malpractice damage cap statutes are constitutional,¹⁷⁴ a slim majority have found damage cap statutes unconstitutional on state constitutional grounds.¹⁷⁵ Courts finding such statutes constitutional have done so using a rational basis test,¹⁷⁶ while

Hosp., Inc., 404 N.E.2d 585 (Ind. 1980) (where damage cap statute was found not to be a violation of state constitutional guarantee of trial by jury).

171. *See, e.g.*, *Smith v. Dep’t of Ins.*, 507 So.2d 1080 (Fla. 1987) (where damage cap statute found to be in violation of state constitutional guarantee of open court). *But see* *Sibley v. Board of Supervisors of Louisiana State University*, 462 So.2d 149 (La. 1985) (where damage cap statute was found not to be in violation of state constitutional guarantee of open court).

172. 482 N.E.2d 1358 (Ohio C.P. 1985).

173. *Id.* at 1363. Of course, this summation is representative of those courts that found damage cap statutes unconstitutional. The position of those courts finding damage cap statutes constitutional, was summed up best by the court in *Fein v. Permanente Medical Group*, 695 P.2d 665 (Cal. 1985), where it was said that

[i]t is well established that a plaintiff has no vested property right in a particular measure of damages, and that the Legislature possesses broad authority to modify the scope and nature of such damages So long as the [statute] is rationally related to a legitimate state interest, policy determinations as to the need for, and the desirability of, the enactment are for the Legislature.

Id. (alterations in original, last alteration added) (quoting *American Bank & Trust Co. v. Community Hosp.*, 683 P.2d 670 (Cal. 1984)).

174. The following courts found damage cap statutes did not violate their respective state constitutions: *Fein v. Permanente Medical Group*, 695 P.2d 665 (Cal. 1985); *Johnson v. St. Vincent Hosp., Inc.*, 404 N.E.2d 585 (Ind. 1980); *Sibley v. Board of Supervisors of Louisiana State University*, 462 So.2d 149 (La. 1985); *Prendergast v. Nelson*, 256 N.W.2d 657 (Neb. 1977); *Rose v. Doctors Hosp.*, 801 S.W.2d 841 (Tex. 1990); *Etheridge v. Medical Center Hosp.*, 376 S.E.2d 525 (Va. 1989); *State ex rel. Strykowski v. Wilkie*, 261 N.W.2d 434 (Wis. 1978).

175. The following courts found damage cap statutes violated their respective state constitutions: *Smith v. Department of Ins.*, 507 So.2d 1080 (Fla. 1987); *Jones v. State Bd. of Medicine*, 555 P.2d 399 (Idaho 1976), *cert. denied*, 431 U.S. 914, (1977); *Wright v. Central Du Page Hosp. Ass’n*, 347 N.E.2d 736 (Ill. 1976); *Kansas Malpractice Victims Coalition v. Bell*, 757 P.2d 251 (Kan. 1988); *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988); *Williams v. Kushner*, 549 So.2d 294 (La. 1989); *Carson v. Maurer*, 424 A.2d 825 (N.H. 1980); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Duren v. Suburban Community Hosp.*, 482 N.E.2d 1358 (Ohio Com.Pl. 1985).

176. *See, e.g.*, *Fein v. Permanente Medical Group*, 695 P.2d 665, 679 (Cal. 1985).

those finding just the opposite have done so using variations of mid-level analysis.¹⁷⁷

V. FREE MARKET ANALYSIS OF DAMAGE CAPS

The focus of this part is to provide an economic analysis of the effects of a cap on verdict awards in medical malpractice cases. In order to facilitate the reader's understanding of this part, we will provide a few words on its outline. First, section A provides background information for the type of economic environment in which our analysis will take place. Section B provides an economic analysis of the effects of group premiums¹⁷⁸ in a market without damage caps. Section C provides an economic analysis of the effects of experience rated premiums¹⁷⁹ in a market without damage caps. Section D provides an economic analysis of the effects of group premiums and experienced rated premiums in a market with damage caps.

A. *The Medical Malpractice Insurance Market*

Medical malpractice insurance refers to an insurance arrangement made between a doctor and an insurer. Under such an arrangement, the insured doctor makes a predetermined periodic payment, *i.e.*, a premium payment, to the insurer in return for which, in the event of a malpractice verdict award against the doctor, the insurer will pay the damages. The premium charged by the insurer can generally be classified into two types: (1) group premiums under which the premium charged any doctor reflects the odds of the bad state occurring for an entire group of doctors

177. See, *e.g.*, *Arneson v. Olson*, 270 N.W.2d 125, 133 (N.D. 1978).

178. For a general discussion of group premiums, see David J. Nye, et al., *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L.J. 1495 (1988).

179. For a discussion of experience rated premiums, Lori L. Darling, Note, *The Applicability of Experience Rating to Medical Malpractice Insurance*, 38 CASE W. RES. L. REV. 224 (1987); Blane F. Nye & Alfred E. Hofflander, *Experience Rating in Medical Professional Liability Insurance*, 55 J. RISK & INS. 150 (1988).

specialized by their specific field of practice and location;¹⁸⁰ and (2) experience rated premiums under which the premium any individual doctor pays will reflect that individual's specific odds of malpractice. Within any type of premium, the actual size of the premium will vary depending on the frequency with which malpractice is committed by the group or individual, as the case may be, and the average size of awards.

To simplify our analysis, assume that the insurance market is competitive and thus insurers can freely enter or exit the market as opportunities dictate.¹⁸¹ For an insurer to stay in the market and provide insurance, it must receive at least as good a rate of return from providing this service as it can get from the best alternative project that can be undertaken.¹⁸² If the rate of return is higher than in other ventures, more insurers will enter the market to provide insurance services. This would drive prices, and thus the rate of return, to lower levels until there is no longer any incentive for new insurers to enter or for existing insurers to leave the market. The profits that the insurer can make in such a market will, therefore, be equivalent to what it can make from the best alternative project. Economic profits, or accounting profit after deducting the opportunity cost of the best alternative project foregone, will then be zero. The economic cost to the insurer of providing the insurance is the amount of money it expects to pay out for malpractice claims, *i.e.*, the probability of malpractice awards

180. See *infra* note 186 for elaboration of bad state and its opposite, good state. For a general discussion of premium rate making, see Emilio C. Venezian, *Ratemaking Methods and Profit Cycles in Property and Liability Insurance*, 52 J. RISK & INS. 477 (1985); James S. Ang & Tsong-Yue-Lai, *Insurance Premium Pricing and Ratemaking in Competitive Insurance and Capital Asset Markets*, 54 J. RISK AND INS. 767 (1987); Nelson Lacey, *The Competitiveness of the Property-Casualty Insurance Industry: A Look at Market Equity Values and Premium Prices*, 5 YALE J. ON REG. 501 (1988).

181. For a discussion of the role government regulations have on rate making, see Scott Harrington, *The Impact of Rate Regulation on Prices and Underwriting Results in the Property-Liability Insurance Industry: A Survey*, 51 J. RISK & INS. 577 (1984); Paul L. Joskow, *Cartels, Competition and Regulation in the Property-Liability Insurance Industry*, 4 BELL J. ECON. 375 (1973); John R. Rizzo, *The Impact of Medical Malpractice Insurance Rate Regulation*, 56 J. RISK & INS. 482 (1989).

182. For a discussion of profit issues in this area, see William B. Fairley, *Investment Income and Profit Margins in Property-Liability Insurance: Theory and Empirical Results*, 10 BELL J. ECON. 192 (1979); Raymond D. Hill, *Profit Regulation in Property-Liability Insurance*, 10 BELL J. ECON. 172 (1979); Alan Kraus & Stephen A. Ross, *The Determination of Fair Profits for the Property-Liability Insurance Firm*, 37 J. FIN. 1015 (1982).

multiplied by the amount of the award, plus the opportunity cost of undertaking this particular venture.¹⁸³ The insurer's revenue is the amount of premium it collects per insurance policy multiplied by the number of insurance policies sold. An insurer in a competitive market can then charge only a level of premium, *i.e.*, a fair premium, at which the economic cost that it expects to incur, including the opportunity cost, is equal to the revenue it generates.

Doctors purchase malpractice insurance to protect themselves from having to pay out large sums of money to malpractice victims. The probability of malpractice occurring depends on the quality of the doctor and the level of effort put forth by the doctor to avoid negligence. For any given premium, the lower the quality of the doctor and the lower the level of effort generally put forth by him or her, the greater will be his or her willingness to purchase insurance. The premium that he or she pays is determined in the insurance market, either on a group premium basis or on an experience rated basis.¹⁸⁴

B. Group Premium Paradigm

In a group insurance scheme, the insurers are only able to charge a premium on the basis of group characteristics and location. Thus, a neurosurgeon in one locality will pay the same premium as another neurosurgeon in the same locality.¹⁸⁵

183. The insurance industry in general operates in an economic cycle, *i.e.*, a pattern of high profits for a given period, then low returns and a return to high profits again. For a discussion of this cycle, see Lawrence A. Berger, *A Model of the Underwriting Cycle in the Property/Liability Insurance Industry*, 55 J. RISK & INS. 298 (1988); see J. David Cummins & J. Francois Outreville, *An International Analysis of Underwriting Cycles in Property-Liability Insurance*, 54 J. RISK & INS. 246 (1987); Leroy F. Simmons & Mark L. Cross, *The Underwriting Cycle and the Risk Manager*, 53 J. RISK & INS. 155 (1986).

184. For a general discussion of the insurance market, see Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963); Philip J. Cook & Daniel A. Graham, *The Demand for Insurance and Protection: The Case of Irreplaceable Commodities*, 91 Q.J. ECON. 143 (1977); Issac Ehrlich & Gary S. Becker, *Market Insurance, Self Insurance and Self Protection*, 80 J. POL. ECON. 623 (1972); Richard Zeckhauser, *Medical Insurance: A Case Study of the Tradeoff between Risk Spreading and Appropriate Incentives*, 2 J. ECON. THEORY 10 (1970).

185. For a general discussion of how medical malpractice is distributed among doctors, see, Emilio C. Venezian et al., *The Distribution of Claims for Professional Malpractice: Some Statistical and Public Policy Aspects*, 56 J. RISK & INS. 686 (1989).

PROPOSITION ONE: Group premiums can force high quality doctors out even if they did not bring about any change in the level of effort undertaken by the doctors.¹⁸⁶

186. Proof of Proposition 1:

Suppose there are two equally likely types of doctors, high quality and low quality, with associated probabilities of malpractice of p_h and p_l respectively, with $p_h < p_l$. With all insurers facing the same opportunity costs, under perfect competition the "fair" premium charged will be given by the condition that economic profits are zero. Thus,

$$EII = P_h M - 1/2 (p_h + p_l) M = 0 \quad (1)$$

where EII is the expected profits per insurance contract sold, p_i is the premium per dollar of insurance purchased, M is the amount of insurance coverage sold. This implies that

$$P_i^* = 1/2 (p_h + p_l) \quad (2)$$

Since $p_h < p_l$, the "fair" premium P_i^* is smaller than the probability of malpractice for the low quality doctor but higher than the probability for the high quality doctor.

The doctors are assumed to derive utility from their consumption out of net income (income net of insurance expenditure and out of pocket malpractice awards paid). Their consumption in the bad state (when malpractice occurs) is given by $Bad = Y - P_i M - D + M$, where Y is income, $p_i M$ is the total premium paid, D is the size of damage awarded, and M is the amount covered by the insurance policy. The utility received in the bad state is U(Bad). Similarly, in the good state (when malpractice does not occur) consumption is given by $Good = Y - P_i M$, since the premium has to be paid regardless of whether there is malpractice or not. The utility received in the good state is thus U(Good). The expected utility for a doctor of type $i = h, l$, is then,

$$EU = p_i U(Bad) + (1-p_i) U(Good) \quad (3)$$

This condition defines the expected utility from consumption or income as the weighted average of the utility in the two states, weighted by the respective probabilities of occurrence:

The optimal choice of insurance purchase is then determined by the following first order condition for optimality:

$$\frac{p_i U_i(Bad)}{(1-p_i) U_i(Good)} = \frac{P_i^*}{(1-P_i^*)} \quad (4)$$

Equation 4 equates the rate at which the doctor is willing to substitute income or compensation in the good state for income in the bad state (the marginal rate of substitution) to the rate at which the insurer will provide insurance. Each dollar of income given up in the good state entails a potential loss in utility in the good state of $(1-p_i) U_i(Good)$, while if that dollar is transferred to the bad state there is a potential increase in utility of $p_i U_i(Bad)$. The ratio of these two is the Marginal Rate of Substitution in consumption from the good to the bad state. Each additional unit of insurance purchased at a premium of P_i^* results in a loss in income in the good state of P_i^* , and a gain of $(1-P_i^*)$ in the bad state. This ratio is the right hand side term in equation 4.

For a high quality doctor the probability of malpractice, p_h , is lower than for a low quality doctor whose probability is p_l . Thus, $p_h < p_l$, and $(1-p_h) > (1-p_l)$ which implies that the rate at which the high quality doctor is willing to trade income in the good state for income in the bad state as given by the marginal rate of substitution is smaller than for the low quality physician. Since under the group premium scheme, they both face the same premium of P_i^* , the right hand side is the same for both qualities but the left hand side is smaller for the high quality doctor. This means that for the high quality doctor the price that the insurer charges for transferring income from the good to the bad state is too high relative to what that doctor is willing to pay. The opposite is true for the low quality doctor. Thus, the high quality doctor will not purchase this insurance because it is too costly and may find it worthwhile to leave if insurance is an absolute requirement. The low quality doctors, on the other hand, will find it more than worth their while to purchase as much insurance as they can.

Under a group premium, the insurer charges the same level of premium to all the doctors in a group. This premium will be based on the average number and size of malpractice awards made against doctors in that group. A high quality doctor who has had few malpractice incidents will pay a premium that is too high relative to that doctor's true odds of malpractice, while a low quality doctor who has had many malpractice incidents will be paying a premium that is based on the average quality of the entire group and is thus lower than a premium that truly captures his or her odds of malpractice. As a result, high quality doctors are forced to subsidize low quality doctors. Such a situation is called adverse selection¹⁸⁷ which, by making such insurance a bad buy for the high quality doctors, forces them to leave that group or locality.

PROPOSITION TWO: Group premiums provide incentives for doctors to reduce the level of effort they put into lessening the occurrence of malpractice.¹⁸⁸

Under a group premium structure, the premium paid is not greatly affected by the frequency with which any one doctor in

187. For a general discussion of adverse selection, see George A. Akerlof, *The Market for Lemons: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970); Arthur J. Hosios & Michael Peters, *Repeated Insurance Contracts with Adverse Selection and Limited Commitment*, 104 Q.J. ECON. 229 (1989); C. Wilson, *The Nature of Equilibrium in Markets with Adverse Selection*, 11 BELL J. ECON. 108 (1980); Bruce C. Greenwald, *Adverse Selection in the Labour Market*, 53 REV. CON. STUD. 325 (1986).

188. Proof of Proposition 2:

Suppose now that the probability of malpractice by any doctor is, to an extent, within the control of the doctor. Through spending time in ensuring proper care they can reduce the probability of malpractice occurring. Thus, the probability of malpractice p_i is a decreasing function of the level of effort, e_i , undertaken by doctor i . The cost of each unit of effort is c . Consumption or net income in either state Good or Bad is now smaller by ce_i , which is the total cost of effort. The optimal choice of the level of effort and insurance is then determined from maximizing

$$p(e_i)U(\text{Bad}) + (1-p(e_i))U(\text{Good}) \quad (5)$$

The first order condition for the optimal level of insurance is the same as equation 4, while the choice of the optimal level of effort is given by the solution to

$$p_i'(U(\text{Bad})-U(\text{Good})) = (c+1/2 p_i M) [p_i U_i(\text{Bad}) + (1-p_i) U_i(\text{Good})] \quad (6)$$

The left hand side of this equation is the expected benefit to the doctor from an additional unit of effort, while the right hand side is the cost (net of any effect on premium) of an additional unit of effort expended. Due to the group structure of the premium, the reduction in insurance cost P_i due to any additional effort for any one doctor, is less than the actual reduction in the probability of malpractice by doctor i . Thus, the net cost of effort is higher with the group premium. Moreover, this reduction in premium cost is granted to all members of the group regardless of which member actually put in the effort. Each member then has no incentive to spend any effort and would rather have someone else put in the effort, the benefits of which will be shared by all.

the group commits malpractice because it will have only a small effect on the average frequency or incidence of malpractice for the entire group. When putting forth any effort involves some cost in terms of time or money and the rewards, *i.e.*, reduced premiums, are low, a doctor who does not have to pay for a verdict award from his or her own pocket will be less inclined to put in greater effort at the margin. Such an effect of premiums which does not reflect individual effort on the insured's level of effort is called moral hazard.¹⁸⁹

COROLLARY ONE: By discouraging high quality doctors and providing few incentives for high levels of effort, group premiums increase the incidence of malpractice.

From propositions one and two, group premiums discourage doctors with low incidence of malpractice from staying in that field or locality on which the group is based, and offer the doctor few rewards for taking better care or effort to prevent malpractice. With more negligent doctors in a group and a lower level of care taken to prevent malpractice, the incidence of malpractice will be higher.

C. Experience Rated Premium Paradigm

With experience rated premiums, the level of premium charged any doctor is determined by the performance of that particular doctor with regard to the incidence of malpractice claimed against him or her. The following propositions address the effect of experience rating on doctor behavior.

PROPOSITION THREE: For any given level of effort, experience rated premiums will force low quality doctors out.¹⁹⁰

189. For a general discussion of moral hazard, see Herbert G. Grubel, *Risk, Uncertainty and Moral Hazard*, 38 J. RISK & INS. 99 (1971); Bengt Holmström, *Moral Hazard and Observability*, 10 BELL J. ECON. 74 (1979); Mark V. Pauly, Comment, *The Economics of Moral Hazard*, 58 AM. ECON. REV. 53 (1963); Steven Shavell, *On Moral Hazard and Insurance*, 93 Q.J. ECON. 541 (1979).

190. Proof of Proposition 3:

With experience rated premiums, the insurer is able to charge each doctor *i*, according to their individual probabilities, p_i . Thus, the "fair" premium is $P_i^* = p_i$, for $i=h, l$.

The optimal choice of doctor *i*, is again given by equation 4. Substituting for the individual premium,

Under this scheme, the level of premium paid by high quality doctors is low to reflect their low probability of malpractice, while the low quality doctors will pay a high premium to reflect their high incidence of malpractice. Thus, no adverse selection problem exists, and the doctors who are of low quality will find it too expensive to continue in their profession.

PROPOSITION FOUR: Experience rated premiums offer appropriate incentives to encourage doctors to expend effort and care to a level that is higher than under group rated schemes.¹⁹¹

Since a doctor who undertakes a lot of care to prevent malpractice is rewarded in the form of lower premiums, the doctor will find it worthwhile to increase his or her effort to a level at which the benefits and costs for additional effort are equal. Thus, there is no moral-hazard problem either.

COROLLARY TWO: Experience rated premiums are more likely to decrease the incidence of malpractice.

From propositions three and four, experience rated schemes discourage low quality doctors from practicing medicine and encourage doctors to take proper care to prevent malpractice. Both of these lower the incidence of malpractice.

P_i^* in equation 4, we have

$$\frac{p_i U_i(\text{Bad})}{(1-p_i) U_i(\text{Good})} = \frac{p_i}{(1-p_i)} \quad (7)$$

which implies that $U_i(\text{Bad}) = U_i(\text{Good})$ or income in the bad and good states are equal. Thus, the amount of insurance purchased by doctor i , is equal to the size of the damage, D . Since the high quality doctor faces a premium that corresponds to his or her low probability of malpractice, while the low quality doctor faces a higher premium, the problem of "adverse selection" no longer arises.

191. Proof of Proposition 4:

With individualized experience rated premiums, the premium paid by doctor i is equal to that doctor's probability of malpractice. If the probability of malpractice is lowered through effort there is an equivalent reduction in premium. Therefore, $P_i^* = p_i'$. The optimal choice of effort is then determined as the solution to

$$p_i'(U(\text{Bad}) - U(\text{Good})) = (c + p_i' M)[p_i' U_i(\text{Bad}) + (1-p_i') U_i(\text{Good})] \quad (8)$$

Since the net cost of an additional unit of effort is now smaller than under group premiums, the level of effort is higher. This is true for both high and low quality doctors. There is no longer a "moral hazard" problem since each individual receives a reduction in their premium only to the extent of effort they themselves put in.

D. *Damage Cap Paradigm*

We will now analyze the effects of a damage cap on the incidence of malpractice under both group and experience rated schemes.

PROPOSITION FIVE: A cap on the size of malpractice awards can generally be expected to lower premium costs under both group and experience rated schemes.¹⁹²

The cap on the size of awards has the effect of lowering the expected cost to the insurer for providing the insurance service. In a competitive market, the insurer is forced to charge a fair price or premium. Unless doctors are totally unresponsive to changes in the premium, the insurer will have to offer insurance at lower premiums. The extent to which the premium is reduced will depend on the responsiveness or elasticities of both the insurer's supply of insurance services and the demand for it.

PROPOSITION SIX: For any given level of effort, a cap on the size of awards may encourage more low quality doctors to enter the field.

The proof for this follows from propositions one and three. Under both group and experience rated schemes, lower premiums, attributed to the cap, reduce the cost to the low quality doctor of practicing his or her trade and the size of adverse malpractice awards. This attracts more low quality doctors into the profession. The high quality doctors are not likely to be as responsive because their demand for insurance against a low occurrence event is less responsive to the premium costs. This is due to their low probability of malpractice.

192. Proof of Proposition 5:

The "fair" premium that an insurer can charge is given as the solution to

$$P_r M - p_r M = 0 \quad (9)$$

where M is the amount of insurance coverage. If there is a reduction in the amount insurers have to pay out, D , the expected cost to the insurer is smaller. The new "fair" premium is then determined from

$$P_r M - p_r D = 0 \quad (10)$$

which can be solved as

$$P_r^* = p_r D/M \quad (11)$$

The smaller D is, the smaller the premium is, P_r^* .

PROPOSITION SEVEN: A cap on the size of awards is likely to reduce the level of effort and care taken to prevent the incidence of malpractice.

The proof follows from propositions two and four. Lower premiums, due to the cap, increase the number of doctors who purchase insurance. This includes those who had previously been self insured.¹⁹³ Self insured doctors are likely to take more precautions in preventing malpractice since they have to pay out of their own pockets. With the purchase of group insurance, there is less return for taking proper care.

COROLLARY THREE: A cap on the size of awards is likely to increase the incidence of malpractice.

This follows from propositions six and seven. Since there is likely to be a higher percentage of low quality doctors after the cap than before, and since the larger demand for the insurance provided by the insurer reduces the level of care taken to prevent malpractice, the cap may actually increase the incidence of malpractice.

SUMMATION

Medical malpractice damage caps increase the probability of a patient suffering negligent injury or death by a treating doctor. This is the unfortunate consequence of attempting to control the cost of malpractice insurance through damage caps. The threat of a large verdict award, whether real or illusory, serves a necessary disciplinary function in the medical profession. Lives have been saved and permanent injuries averted because of the pressure placed on doctors by the threat of large verdict awards. Removing this threat is tantamount to intentionally killing or permanently injuring untold numbers of American citizens. No government can legitimately turn against its people in this manner. The heritage of our nation speaks better of our lawmakers than this. Our her-

193. For a general discussion of self-insured, see, Patrick L. Brockett et al., *Self-Insurance and the Probability of Financial Regret*, 51 J. RISK & INS. 720 (1984).

itage cries out for more responsible and sober action than what has befallen and threatens to befall us.

If we are to help competent doctors, and we must, get out from under the financial burden of excessively high malpractice insurance, we should do so not at the expense of innocent patients, but through a process that assures us that only incompetent doctors pay the high cost of their incompetency. The insurance industry must be guided to the realization that experience rated premiums provide the most equitable method for insuring doctors. If lawmakers fail to bring this point to fruition, innocent people will die or be permanently disfigured by that small percentage of doctors who are not qualified to be in the medical profession.

VI. CAN WE AFFORD TO LIVE WITH INEFFICIENT DOCTORS?

The term “inefficient” is a conceptual device that masks more than it reveals.¹⁹⁴ To say that a law student is inefficient in his or her studies or that an automobile manufacturer is inefficient in the production of cars conveys very little information. To understand the dynamics embedded in the term “inefficient,” we must locate the substantive consequences that can follow from inefficient study habits or automobile production.¹⁹⁵ Of course, our concern here is not with study habits or automobile production, though both are worthy of analysis. Our interest at this time is to briefly explore some of the substantive consequences of having inefficient doctors in the medical profession.¹⁹⁶

194. For the purpose of this section the term “inefficient” is confined to the context of doctors who cause injury to patients through negligence.

195. For example, inefficient study habits by a law student could lead to poor grades and eventual academic dismissal from law school. Academic expulsion could lead to suicide by a distraught law student or cause a law student to resort to violence against law school faculty. On the other hand, if a law student with inefficient study habits was allowed to graduate and somehow managed to pass a bar exam, legal malpractice could become the only thing this former law student masters. The point of this example is simply to draw attention to the fact that the term inefficient is a conceptual nicety that has very little real value until you begin to explore its potential consequences.

196. We say substantive consequences in recognition of the fact that there are nonsubstantive consequences flowing from the retention of inefficient doctors. For example, the lost income to efficient doctors as a result of income going to inefficient doctors. Of course, determining what are substantive and non-substantive consequences is necessarily a subjective process.

Grave human tragedies invariably flow from allowing inefficient doctors to exist in the medical profession.¹⁹⁷ This is illustrated by the conservative estimate that 200,000 people per year suffer injury or death due to medical negligence.¹⁹⁸ Even more disturbing is the revelation that as many as 10,000 patients die each year specifically from negligently administered anesthesia.¹⁹⁹ It has also been determined that 20% of all hospital patients leave the hospital with a condition they did not have when they arrived.²⁰⁰ Adding

197. In a 1990 report released by Public Citizen Health Research Group, a list was compiled of the names of 6,892 doctors who had been punished by medical boards in 41 states. Punishment was handed down for such offenses as substandard care, over-prescribing drugs, sexual abuse, alcohol or drug abuse, and criminal convictions. At the time of the release of the report all of the doctors on the list were still practicing medicine. The head of Public Citizen, Dr. Sidney M. Wolfe, was quoted as saying, "If your doctor is among the 6,892 on this list, you ought at least to question the quality of his or her care." Anne Hazard, *States News Service*, June 28, 1990, available in LEXIS, Nexis Library, Omni File.

The admonition by Dr. Wolfe should not be lightly discounted. As a case on point, take the medical malpractice history of Dr. Frederick Huffnagle, an orthopedic surgeon. At the time a news story was done on him, he had settled 5 malpractice claims in Massachusetts and had 4 pending claims in California. One of his Massachusetts victims, Beatrice Higgins, "could walk . . . when she was admitted to Hunt Memorial Hospital with arthritis. Huffnagle implanted an artificial knee that was the wrong size When he removed it later . . . he fractured a bone and ruptured a tendon. Today Higgins, 73, only leaves the Danvers Nursing Home in a wheelchair." UPI, June 15, 1986, available in LEXIS, Nexis Library, Omni File.

198. Sidney M. Wolfe, *Doctor's Malpractice Plan Ignites New Conflict: Letting Doctors Be Judges Is a Conflict of Interest*, WASH. POST, Jan. 19, 1988, at Z10, LEXIS, Nexis Library, Omni File. In spite of the alarming number of estimated medical malpractice victims, "new findings indicate that few victims of malpractice ever file suit, and fewer still are compensated." Jane E. Brody, *Personal Health*, N.Y. TIMES, Apr. 26, 1990, at 14, available in LEXIS: Nexis Library, Omni File.

199. Sperling, *The Dark Side of Medical Care*, USA TODAY, May 12, 1988. As a further illustration, the New York State Department of Health issued a report in which it was determined that in 1988 there were 8,485 medical malpractice incidents filed in the state. At least 375 deaths and 500 permanent injuries resulted from the reported malpractice incidents. The report was highlighted with the following examples: a 35 year-old woman was negligently killed during a gynecological operation involving laser surgery; a 55 year-old patient received third-degree burns on her neck, chest and arm after doctors allowed a laser to ignite drapes in the operating room; and a 5 year-old girl and a 27 year-old man died as a result of improper dosages of potassium. Michael O'Malley, *Hospital Accidents: Malpractice Incidents on the Rise*, UPI, Oct. 6, 1989, available in LEXIS, Nexis Library, Omni File.

200. Sperling, *supra* note 199. The following Table presents the total malpractice claims filed with the Texas State Board of Medical Examiners for the period 1978-1984. The Table points out that over 80% of the negligent injuries took place in hospitals:

TABLE 17:
CLAIMS FILED, TYPES OF NEGLIGENCE
AND LOCATION OF NEGLIGENCE 1978-1984

Type of Negligence	# Claims Filed	Location of Negligence	# Claims Filed
Fail to Treat	2,452	Hospital	6,282

to this grave parade of human errors is a report indicating that 35% of surgical deaths and 50% of postoperative complications are due to medical negligence.²⁰¹

While these figures may seem disturbing or even alarming, they do not begin to tell the story of the medical horror that inefficient doctors perpetrate on the American public.²⁰² It is a story without precedent in the annals of tort litigation;²⁰³ a story that is clothed

Negligent Surgery	2,203	Office	705
Negligent Treatment	1,649	Emergency Room	243
Fail to Diagnose	546	Outpatient Facility	91
Negligent Diagnosis	226	Not Determined	50
Unnecessary Surgery	177	Nursing Home	19
Not Determined	73	Patient's Home	15
Lacked Consent	65		
Fail to Operate	9		
Breach of Confidence	5		

Medical Malpractice In Texas: Are We Covering Up The Symptoms Instead Of Curing The Disease?, PUBLIC CITIZEN OF TEXAS.

201. Lauren Chambliss & Sharon Reier, *How Doctors Have Ruined Health Care*, FINANCIAL WORLD, Jan. 9, 1990, at 46. For an example, take the publicized death of photographer Bob East. His death resulted from an operation he had to remove a cancerous eye.

A formaldehyde-like solution meant to receive and preserve the cancerous eye tissue was mistakenly injected into [him]. The toxic fluid traveled quickly to the brain, causing irreversible damage. Mr. East was declared brain dead. Five days later, Mr. East's wife . . . accepted the inevitable and instructed physicians to remove her husband from life-support machinery. Mr. East died within minutes.

Jon Nordheimer, *One Death, Many Questions in Miami*, N.Y. TIMES, Mar. 10, 1985, at 22, available in LEXIS, Nexis Library, Omni File.

202. An article in the *New York Times* gave the following account of hospitals in New York City that were fined for causing negligent injuries to patients: Booth Memorial Medical Center was fined \$4000 after a kidney dialysis patient died when the water supply to the dialysis unit was mistakenly connected to the hospital's air-conditioning system which sent a toxic chemical into the water system of the dialysis unit; St. Luke's Hospital was fined \$5000 after a psychiatric patient who was under suicide watch jumped to his death while in the hospital's care; Beth Israel Medical Center was fined \$5000 for prematurely discharging an AIDS patient who died five days later; Long Island Medical Center was fined \$16,000 for failing to diagnose a spinal malignancy which resulted in making a 13 year-old patient a paraplegic; St. Barnabas Hospital was fined \$4000 in the death of a patient that was caused by the injection of the wrong drug. Ronald Sullivan, *Hospital Fined for Toxic Flow Fatal to Patient*, N.Y. Times, Apr. 10, 1987, at B24, available in LEXIS, Nexis Library, Omni File.

203. For example, take the tragic case of John Chavez. He was "a 30-year-old man who was left blind and partly disabled after complications during what was to have been a minor surgery on his ankle." Sonni Efron, *Malpractice Victim Gets \$3.8 Million*, L.A. TIMES, Dec. 21, 1990, at 6, available in LEXIS, Nexis Library, Omni File. The case of Bruna DeCeglia was tragically similar to Chavez. She went to a "medical center in 1983 for radiation therapy after having a brain tumor surgically removed at another hospital . . . The medical center chronically aimed 180 radiation beams a day at the wrong spot. The angle of the beam was such that they aimed the beam at her optic nerve. About a year after radiation she went blind . . ." Alvin E. Bessent & Monte R. Young, *\$2M Given to 2 Victims of Medical Malpractice*, NEWSDAY, Sept. 14, 1990, at 25, available in LEXIS, Nexis Library, Omni File. Medical malpractice was

in a garment of respectability. It is no great secret that the vast majority of the American public view doctors as god-like.²⁰⁴ The high esteem in which doctors are viewed has anesthetized our basic instinct to rebuke and chastise those who cause harm or fatal injury because of carelessness, if not outright indifference.

The imposition of damage caps is another manifestation — a potent and nefarious sign — of our divine-like perception of the medical profession. Not only do damage caps tell the medical profession that we do not mind if inefficient doctors continue to practice,²⁰⁵ the caps also tell victims of malpractice that their suffering²⁰⁶ is inconsequential compared to the happiness of inefficient doctors. As America moves roughshod into the high-tech complexity of the future, someone must tug on our nation's ear and ask: "Can we afford to live with inefficient doctors?"²⁰⁷ A cursory exami-

also traced to the birth of a brain damaged child named Jill Heary. "The hospital records establish that the entire medical team simply failed Jill and her parents The tragic fact is that this baby had been perfectly healthy right up to two hours before she was born. Jill is now a profoundly retarded quadriplegic." *\$3 Million Malpractice Suit Settled for Infant*, PR Newswire, Jan. 9, 1989, available in LEXIS, Nexis Library, Omni File.

204. In a news article reporting on Illinois' damage cap statute, it was said that "[t]he state's new medical malpractice law elevates doctors to a special privileged class that is above the gods" *Law Has Put Physicians Above Gods*, CHI. TRIB., Mar. 28, 1986, at 1, available in LEXIS, Nexis Library, Omni File.

205. The following incident illustrates the temerity of the criminal justice system to the issue of medical malpractice. "This year [1986] the former top heart surgeon at Bethesda Naval Hospital was convicted of negligent homicide and involuntary manslaughter after the death of three patients. The surgeon was nearly blind in one eye. One of the patients was so roughly handled during surgery that his chest could not be closed after the operation." Mortimer B. Zuckerman, *Physician Heal Thyself*, U.S. NEWS & WORLD REPORT, July 21, 1986, at 68, available in LEXIS, Nexis Library, Omni File. The convictions were later overturned and the doctor "has been reinstated in the American College of Surgeons. He is relicensed in Texas and Pennsylvania, and has applied in New York." *Charges of Malpractice by Dr. Donal Billing*, Radio TV Reports, (PBS Television Broadcast, Feb. 5, 1989, at 7).

206. "There's no way you can understand what I've been through mentally with this," Patricia Renfro was quoted as saying at a hearing before the House Judiciary Committee. She was one of several victims of medical malpractice who testified before the committee in 1986. The mental suffering she spoke of resulted from having breast tissue surgically removed and replaced with an implant. The surgery took place because her doctor diagnosed her as a high-risk patient for cancer. "However, upon seeking a second opinion, she found she was actually a low-risk cancer patient who underwent a needless operation." Because of her doctor's negligence, she had to have five operations and was expected to undergo many more. It was reported that her doctor was facing "malpractice lawsuits by more than 20 women on whom he performed mastectomies." Gary E. Duda, *Victims Tell Committee of Malpractice Experience*, UPI, Feb. 10, 1986, available in LEXIS, Nexis Library, Omni File.

207. Subsidizing inefficient doctors through damage cap statutes is not the same as providing a tax break incentive so that inefficient steel manufacturers may stay in business. The ultimate penalty society

nation of the evidence compiled to date leaves little doubt as to the answer.

For example, a five-year study was undertaken by researchers who analyzed 5,000 medical records of hospital patients around the country. The study was done to determine the appropriateness of doctors performing three medical procedures; carotid endarterectomy, coronary angiography, and intestinal endoscopy. The researchers found that 17.0% of the coronary angiographs and intestinal endoscopies were unnecessarily performed, while a full two-thirds of the carotid endarterectomies were performed unnecessarily. More alarming than this was the discovery that 10.0% of the patients who underwent carotid endarterectomies died or suffered a stroke as a direct result of the procedure.²⁰⁸ The findings from this study prompted one of the researchers to state profoundly, "If you're 50 and have to look forward to another operation at 58, you may want to think twice."²⁰⁹

pays in extending the practice of inefficient doctors is death. It is as simple and horrifying as that. Inefficient doctors are licensed killers. In a study conducted by two physicians, 377 medical records of patients in 12 hospitals were analyzed. The study found that 182 patients died while hospitalized and from that number 49 deaths were preventable. Robert W. & Robert H. Brook, *Preventable Deaths: Who, How Often and Why*, 109 ANNALS OF INTERNAL MEDICINE 582, 585 (1988). The following Table reveals the conditions that the 49 preventable death patients were being treated for and the negligence that led to their deaths:

TABLE 18.
FREQUENCY AND CAUSE OF PREVENTABLE DEATH

Cause	Mycocardial Infarction %	Pneumonia %	Cerebro-Vascular Acc. %
Inadequate treatment of angina	41	—	—
Inadequate fluid management	16	20	10
Inadequate control of arrhythmias	10	—	—
Inadequate hemodynamic monitoring	9	—	—
Improper antibiotics	—	30	—
Inadequate oxygen management	—	22	—
Inadequate diagnostic work-up	1	13	45
Inadequate treatment of cerebral edema	—	—	16
Inadequate management of sepsis	5	—	14
Other	18	15	15
TOTAL	100	100	100

Mycocardial infarction deaths = 23

Pneumonia deaths = 17

Cerebrovascular Accident deaths = 9

Id.

208. *Doctor Is This Operation Necessary?*, 12 RAND RESEARCH REVIEW 1 (Fall 1988).

209. *Id.* at 3. To underscore the seriousness of thinking twice before having surgery, we add the story of an open-heart surgery that was performed on the wrong patient. At the time this story was reported,

In what has been called the most comprehensive medical malpractice study to date, a group of Harvard researchers analyzed the medical records of over 30,000 patients admitted to New York hospitals in 1984. The results of this study enabled the researchers to make the following estimates: (1) out of 2.7 million patients entering New York hospitals in 1984, 27,000 were victims of medical malpractice; and (2) nearly 7,000 deaths were caused by medical malpractice.²¹⁰ The results of the Harvard study prompted one commentator to say: "It is a horrifying thought to think that one out of every 100 people who goes into a hospital will be hurt by their physician. More physicians must be disciplined. More physicians must be checked for ability to do their job If they do not or cannot do their job, they should lose the right to practice."²¹¹

Implicit in the commentator's words is the knowledge that the medical profession does not adequately police itself.²¹² As is too often the case in many professions, self-regulation is a license for no regulation.²¹³ State medical boards have repeatedly failed the

disciplinary action was "still pending against Dr. Daniel Knauf . . . who operated on the healthy [patient] in 1988, for letting an assistant, who was not a doctor, examine the patient before surgery instead of doing it himself." *Doctor Operates on Wrong Woman*, CHI. TRIB., August 5, 1990, at 3, available in LEXIS, Nexis Library, Omni File.

210. Richard A. Knox, *Study Cites Malpractice System's Toll*, BOSTON GLOBE, Mar. 1, 1990, at 1, available in LEXIS, Nexis Library, Omni File.

211. Daniel Kramer, *The Harvard Study: An Analysis*, N.Y.L.J., Mar. 9, 1990, at 1, available in LEXIS, Nexis Library, Omni File.

212. Every state has a medical board, usually fully staffed by doctors, that issues licenses to individuals to practice medicine. "Generally, licensure boards discipline physicians for conduct described as harmful to public health or involving moral turpitude Despite what appears to be broad authority to act under state law . . . licensure boards generally take few disciplinary actions." Kathleen L. Blaner, *Physician Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May Be Worse Than the Disease*, 37 CATH. U. L. REV. 1073, 1079 (1988).

As an example, a study done by the Illinois Coalition for Consumer Rights revealed that the medical licensing board of Illinois disciplined only 24 doctors from the period covering 1974 to 1986. The cause for alarm here is brought out by the fact that "[d]uring 1984 and 1985, the state's Medical Disciplinary Board reported more than 800 medical malpractice settlements in Illinois, including 168 settlements of more than \$100,000" *Study: Bad Doctors Go Unpunished*, U.P.I., Feb. 3, 1987, available in LEXIS, Nexis Library, Omni File.

213. Take the case of Dr. Milos Klvana, who was convicted of second-degree murder in the deaths of eight newborns and a fetus. In sentencing the doctor to 53 years in prison, Los Angeles Superior Court Judge Judith C. Chirlin stated that the Medical Board of California must "accept responsibility for at least some of the deaths," because of its repeated failures to investigate the doctor properly and stop him

medical profession and the American public.²¹⁴ This uncomfortable realization becomes even more pernicious in light of damage cap statutes. With hardcore evidence clearly demonstrating that state medical boards will not “get tough” with their members,²¹⁵ it be-

from practicing medicine. Virginia Ellis & Robert Steinbrook, *Medical Board Lagging in Disciplinary Action; Doctors: A Judge's Rebuke of State Agency's Role in Klvana Case Underscores Criticism From Other Sectors*, L.A. TIMES, May 13, 1990, at 1, available in LEXIS, Nexis Library, Omni File.

214. “At the New York City hearings on medical malpractice [in 1986], the editor of the New England Journal of Medicine testified that out of an estimated 20,000-30,000 unfit doctors practicing medicine in the United States in 1984, only 721 had experienced serious disciplinary consequences . . .” Zuckerman, *Physician Heal Thyself!*, *supra* note 205. The article went on to say that “President Reagan’s Secretary of Health and Human Services, Dr. Otis Bowen, stated . . . that nowhere near enough doctors were being disciplined by review boards. [Dr. Bowen] said that 5 to 15 percent of practicing physicians should be disciplined, many of them for drug or alcohol-related problems.” *Id.*

For example, take the case of Joyce Palso. Before having cosmetic surgery done to her abdomen, she contacted the California Medical Board to check the credentials of Dr. James Dean, the doctor who was going to operate on her. She was told that the medical board had “nothing on him.” However, in truth, “[w]hat the staff of the state medical board did not tell her was that 11 malpractice suits had been filed against James E. Dean . . .” A week after her operation she developed complications, which Dr. Dean described as normal after-effects of surgery. The truth of the matter was that she “was suffering from a life-threatening post-surgical infection of a heart valve that would require six hospitalizations and open heart surgery to correct In January 1987, the board revoked Dean’s license . . . a conclusion the board said was based on an investigation of [Joyce] Palso’s case and several others, including one that resulted in a patient’s death.” Sarah Glazer, *How Much Do You Know About Your Doctor?*, WASH. POST, Mar. 5, 1991, at Z10, available in LEXIS, Nexis Library, Omni File.

215. The following Table presents data showing the number of doctors having serious disciplinary action taken against them for the period 1985-1987:

TABLE 19:
SERIOUS DISCIPLINARY ACTIONS AGAINST DOCTORS BY
STATE LICENSING BOARDS 1985-87*

State	Number of Serious Actions			Number of Doctors Practicing
	1985	1986	1987	
Alabama	9	8	8	6,323
Alaska	0	2	5	724
Arizona	22	12	9	7,303
Arkansas	9	6	3	3,664
California	121	121	94	71,349
Colorado	14	24	25	7,028
Connecticut	4	9	7	9,833
Delaware	1	2	6	1,290
D.C.	8	9	9	3,819
Florida	55	75	128	27,851
Georgia	48	73	60	10,524
Hawaii	4	8	15	2,506
Idaho	5	4	3	1,341
Illinois	44	73	67	25,537
Indiana	39	57	30	8,731
Iowa	20	26	26	4,384
Kansas	10	7	2	4,460
Kentucky	28	22	41	6,188
Louisiana	21	13	21	8,453

comes frightening to think of what lies ahead in the annals of medical negligence²¹⁶ now that tort laws are being written in such a way that medical negligence is no longer being adequately policed in civil courts. The American public is likely to pay, for a long time to come, a tremendous premium unless law makers realize we cannot afford to live with inefficient doctors.²¹⁷

VII. EPILOGUE

As our nation moves into the 1990's, we must do so with some degree of guarded caution. The world stage is rapidly changing its

Maine	4	6	3	2,306
Maryland	12	11	26	15,000
Massachusetts	22	42	69	19,766
Michigan	22	14	34	17,549
Minnesota	19	30	28	9,535
Mississippi	6	8	21	3,416
Missouri	39	38	49	9,996
Montana	0	2	1	1,323
Nebraska	0	4	4	2,762
Nevada	16	4	9	1,676
New Hampshire	1	1	4	2,149
New Jersey	76	49	59	18,883
New Mexico	2	4	4	2,735
New York	60	167	259	57,779
North Carolina	17	26	23	11,783
North Dakota	4	2	4	1,136
Ohio	39	58	39	21,744
Oklahoma	23	21	26	4,994
Oregon	25	28	23	5,877
Pennsylvania	57	27	28	28,476
Rhode Island	9	3	4	2,489
South Carolina	17	16	19	5,522
South Dakota	1	1	6	1,004
Tennessee	14	10	8	9,285
Texas	44	41	43	29,207
Utah	19	17	13	3,128
Vermont	1	1	3	1,469
Virginia	42	39	29	12,311
Washington	19	11	23	10,079
West Virginia	7	19	29	3,281
Wisconsin	9	26	45	9,234
Wyoming	1	0	1	706

* Disciplinary action includes revocation of license, suspension, and probation.

PUBLIC CITIZEN (1989).

216. Compounding the problems damage cap statutes cause to the health of society is the equally menacing fact that even if an inefficient doctor is banned from practicing medicine in one state, the public in another state is not safe from his or her incompetence. "At present, a doctor may get into trouble in one state and set up shop in another with little danger his [or her] poor record will follow him [or her] . . . The new doctor in town may have a blacklist 50 pages long, but there will be no way for his [or her] patients to find out." Lauren Chambliss & Sharon Reier, *How Doctors Have Ruined Health Care*, FINANCIAL WORLD, Jan. 9, 1990, at 49.

217. In a comment on our health care system, former Surgeon General C. Everett Koop wrote, "We have a system that is distinguished by a virtual absence of self-regulation on the part of those who provide care — hospitals and health care workers, primarily physicians — but distinguished as well by the absence of such natural marketplace controls as competition in regard to price, quality or service." *Id.* at 48.

scenery and new actors are bidding for starring roles in the coming production that will unfold in the year 2000. America, no doubt, will have an opportunity to be a dominant player when the dust settles and the world curtain rolls up. There is a crucial question, however, which we must confront now, before the curtain rises: Will America play a dominant role throughout the millennium that is swiftly approaching, or will we lose our opportunity to play a dominant role shortly after the millennium begins due to self-destruction? Whether we realize it or not, the longevity of our nation's preeminence will be determined in the decade that is upon us. History waits for no nation and, in a Darwinian sense, it takes no prisoners. History will banish us to obscurity, just as it has banished past great nations, if we incorrectly resolve the critical issues that test us at this very hour.

This Article has not attempted to address all the critical issues confronting our nation at this time. Our concern has been limited to but one of these issues — unyielding health care costs. In wrestling with this unbridled beast, we have not attempted to struggle head-on with it. Such an effort requires far greater space than this Article will afford us. Instead, we have chosen to hold up a yellow flag of warning regarding an issue that has been unwisely tied to the health care cost crisis. Written on this yellow flag of caution was the following: (1) solving the crisis in costs of medical malpractice insurance will not slow the pace of soaring health care costs; (2) reforming tort laws will not appreciably slow the pace of medical malpractice insurance costs; and (3) reformation of medical malpractice tort laws has and will continue to directly cause preventable deaths and permanent injuries.

The pressing urgency of our flag is inextricably wrapped up in the proposal the Bush Administration unleashed in its 1992 budget package.²¹⁸ This proposal seeks to force the nation to walk down

218. The following is the full text of President Bush's proposal:

MEDICAL PROFESSIONAL LIABILITY REFORMS. — From 1984 to 1988 medical malpractice premiums rose from approximately \$1.9 billion to \$4.2 billion. This has led some physicians to alter their behavior in an effort to avoid liability — often choosing to discontinue high-risk practices or to engage in unnecessary defensive medicine. Growing liability costs and unnecessary defensive medicine contribute to high health care costs that are a problem for everyone.

a path that, heretofore, only a handful of states were committed to walking. The Administration's medical malpractice tort reform proposal must be vigorously challenged and ultimately defeated. There is little room for compromise on this matter. The health and lives of literally every American rest on this issue. Insulating the medical profession from the vitality of our tort laws is a form of deregulation that will not lead to bankruptcies that often follow deregulation — its consequences are far more serious.

There is no rational relationship between punishing victims of medical malpractice and lowering the cost of medical malpractice insurance or health care costs in general. The only relationship that exists between these issues is a lobbying relationship. The Administration's proposal is a mirror image of the tort reform package the medical profession and insurance industry have peddled for two decades in state legislative halls across the nation. It does

The Administration's reform package will include proposals that encourage States to:

- [1] Cap the amount of allowable non-economic damages. In the 26 States that have limited total damages, malpractice rates have declined significantly;
- [2] Eliminate joint and several liability for noneconomic damages;
- [3] Eliminate the collateral source rule that allows for double recovery;
- [4] Require structured payments for malpractice awards, as opposed to lump sum payments;
- [5] Promote pretrial alternative dispute resolution, including mediation and pretrial screening panels, to encourage reasonable settlements;
- [6] Implement procedures to enhance the quality of care.

Additionally, at the Federal level the Administration will propose to apply these tort reforms to Federal courts; to begin a pilot program in the Federal Employees Health Benefits Program that offers alternative dispute resolution; and to improve the quality of medical care through enhanced effectiveness research and improved peer review.

To avoid preempting State laws and to encourage States to adopt liability reforms within a reasonable three-year time period, the Administration will propose to initiate, beginning in 1995, budget neutral incentive pools in Medicare and Medicaid.

Under the proposal, the Department of Health and Human Services would pool:

- [1] A portion of the annual increase (1 percent of total payments) in Medicare prospective payments for hospitals — approximately \$800 million in 1995;
- [2] A portion (2 percent) of the State Medicaid match for staff salaries and expenses. State match rates average 53 percent. This pool would amount to approximately \$90 million in 1995. The proposal does not affect Medicaid provider reimbursement.

States that adopt a requisite number of reforms would share in the pool. Those States would receive enhanced Medicaid administrative match rates and their hospitals would receive supplemental payments. This structure provides incentives for the States to quickly adopt reforms — the States that act first will receive a reward, as will the State's hospitals.

EXECUTIVE OFFICE OF THE PRESIDENT OF THE UNITED STATES, BUDGET OF THE UNITED STATES GOVERNMENT
FISCAL YEAR 1992, PART TWO 278-79 (1991).

not take a genius to see that the tort reformers have sneaked into the backdoor of the White House and convinced the Administration to force the majority of the states to do that which previously they have resisted as wrong.

At a time when our nation has an estimated thirty million or so citizens without health care coverage, the Administration's proposal seeks to add to this number by cutting federal dollars to states that refuse to endanger the lives and health of their citizens by enacting medical malpractice tort reform measures. The Administration's proposal is a threat of death or injury to every American. The American public must unite and stand up to this threat, for it is as real as the forces that have convinced the Administration to take this course.

