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Statutory Limitations on Medical Malpractice Recoveries

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STATUTORY LIMITATIONS ON MEDICAL MALPRACTICE RECOVERIES

I. INTRODUCTION

During the mid-1970s, medical malpractice insurance premiums for health care providers increased dramatically.[1] In response to the perceived medical malpractice insurance crisis, many states adopted legislation designed to lower premiums by limiting a patient's right to sue for malpractice injuries.[2] One such measure, in which the court places a limit on the amount of recoverable damages in a medical malpractice

1. For example, from 1972 to 1975 premium rates for Class I health care providers (usually general practitioners) in Arizona rose from $612 to $1,595 per year, an increase of 161%. Rates for Class V physicians (usually anesthesiologists and some types of surgeons) in Arizona increased 146%, from $3,700 to $9,119. *See* HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, AN OVERVIEW OF MEDICAL MALPRACTICE, 94th Cong., 1st Sess. 206 (Mar. 17, 1975) (Medical Malpractice Background Papers by Congressman James F. Hastings) [hereinafter OVERVIEW—BACKGROUND PAPERS]. In Michigan, Class I premiums rose 278%, from $194 to $735 in 1975 alone. Class V premiums rose 10% in 1975 from $2,676 to $4,551. Some rates in Michigan rose as much as 658%. *Id.* at 211.

2. States have adopted, with varying degrees of success, several types of laws limiting the right to sue for malpractice injuries. These laws include the following:

(1) Requirements that medical malpractice cases be submitted to a review panel. *See* Suchit v. Baxt, 176 N.J. Super. 407, 423 A.2d 670 (1980) (constitutional); Lacy v. Green, 428 A.2d 1171, 1174 (Del. 1981) (constitutional); Linder v. Smith, 629 P.2d 1187 (Mont. 1981) (constitutional); Aldana v. Holub, 381 So. 2d 231 (Fla. 1980) (unconstitutional); State *ex rel.* Cardinal Glennon Memorial Hosp. v. Gaertner, 583 S.W.2d 107 (Mo. 1979) (unconstitutional); Everett v. Goldman, 359 S.2d 1256 (La. 1978) (constitutional); Attorney General v. Johnson, 282 Md. 274, 385 A.2d 57 (1978) (constitutional); Paro v. Longwood Hosp., 373 Mass. 645, 369 N.E.2d 985 (1977) (constitutional).

(2) The abolition of the collateral source rule in medical malpractice cases. The collateral source rule provides that "if an injured person receives compensation for his injuries from a source wholly independent of the tort-feasor, the payment should not be deducted from the damages which he would otherwise collect from the tort-feasor." BLACK'S LAW DICTIONARY 238 (5th ed. 1979). *See, e.g.,* Doran v. Priddy, 534 F. Supp. 30 (D. Kan. 1981) (unconstitutional); Reese v. Rankin Fite Memorial Hosp., 403 So. 2d 158 (Ala. 1981) (constitutional); Pinnillos v. Cedars of Lebanon Hosp. Corp., 403 So. 2d 365 (Fla. 1981) (constitutional); Johnson v. St. Vincent Hosp., 273 Ind. 374, 404 N.E.2d 585 (1980) (constitutional); Rudolph v. Iowa Methodist Medical Center, 293 N.W.2d 550 (Iowa 1980) (constitutional); Eastin v. Broomfield, 116 Ariz. 576, 570

action, is particularly burdensome to the patient injured as a result of

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P.2d 744 (1977) (constitutional); Graley v. Satayatham, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (1976) (unconstitutional).

(3) Limitations on attorney contingency fees. *See, e.g.,* ARIZ. REV. STAT. ANN. § 12-568 (Supp. 1985) (fee subject to review by court); IDAHO CODE § 39-4213 (Supp. 1985) (fee limited to 40% of recovery); TENN. CODE ANN. § 29-120 (Supp. 1985) (fee limited to 33⅓% of recovery).

(4) Laws modifying the *res ipsa loquitur* doctrine in medical malpractice cases. *See e.g.,* WASH. REV. CODE § 4.24.290 (1982).

(5) Laws shortening the statute of limitations for medical malpractice actions. *See, e.g.,* Holmes v. Iwasa, 104 Idaho 179, 657 P.2d 476 (1983) (constitutional); Stephens v. Snyder Clinic Assoc., 230 Kan. 115, 631 P.2d 222 (1981) (constitutional); Mishek v. Stanton, 200 Colo. 514, 616 P.2d 135 (1980) (constitutional); Rohrabaugh v. Wagoner, 274 Ind. 661, 413 N.E.2d 891 (1980) (constitutional); Ross v. Kansas City General Hosp. & Medical Center, 608 S.W.2d 397 (Mo. 1980) (constitutional); Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) (unconstitutional); Anderson v. Wagner, 79 Ill. 2d 295, 402 N.E.2d 560, *appeal dismissed,* 449 U.S. 807 (1979) (constitutional).

(6) Tighter rules on qualifications of expert witnesses. *See, e.g.,* ARK. STAT. ANN. § 34-2602 (1981); ILL. REV. STAT. ch. 110, ¶ 58.2-.10 (1980); NEV. REV. STAT. § 41A.020 (1979). *See generally* Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis,* 1975 DUKE L.J. 1417.

Although states have pursued various methods of alleviating the perceived medical malpractice crisis, Congress has never enacted legislation concerning malpractice limits. Several bills dealing with the problem, however, were introduced in 1975. Senator Gaylord Nelson introduced the Federal Malpractice Insurance Act (S. 188, 94th Cong., 2d Sess. 1975), which provided for the establishment of a National Medical Malpractice Development Fund. The fund would have paid all medical malpractice claims above $25,000. Voluntary payments by insurers engaged in medical malpractice insurance would have financed the fund. OVERVIEW—BACKGROUND PAPERS, *supra* note 1, at 28.

Senators Daniel Inouye and Edward Kennedy also introduced legislation. The first bill, the National Medical Injury Compensation Insurance Act (S. 215, 94th Cong., 2d Sess. 1975), would have established a no-fault system of compensation for medical injuries. Doctors and other health care providers would pay premiums into a compensation fund, which would be used to pay claims made by injured patients. Patients would have the option of applying for compensation either to the fund or through the courts. The second bill, the National Medical Malpractice Insurance and Arbitration Act of 1975 (S. 482, 94th Cong., 2d Sess. 1975), would have required participation by both claimants and health care providers to arbitrate medical malpractice disputes. Although the arbitration would not be binding, the arbitration panel decision would be admissible as evidence in any court proceeding. *See* OVERVIEW—BACKGROUND PAPERS, *supra* note 1, at 28-29.

Congresswoman Marjorie Holt introduced a bill that would have established a Commission on Medical Malpractice Awards (H.R. 1305, 94th Cong., 2d Sess. 1975). The Commission would conduct a study on the feasibility of establishing medical malpractice damage limits. Congressman Dan Rostenkowski introduced a similar bill (H.R. 1378, 94th Cong., 2d Sess. 1975), providing for a study to be conducted by the National Academy of Sciences.

Most recently Congressmen Richard Gephardt and Henson Moore introduced the Alternative Medical Liability Act (H.R. 5400, 98th Cong., 2d Sess. 1984). This bill

malpractice. Although such laws raise substantial constitutional questions,[3] the United States Supreme Court has consistently refused to pass judgment on their validity.

In *Fein v. Permanente Medical Group*[4] the Supreme Court dismissed a challenge to a California law that limits noneconomic losses in medical malpractice actions to $250,000.[5] Justice White dissented, arguing that a substantial federal question existed.[6] He noted that two states[7] upheld the constitutionality of medical malpractice damage limits, while four states[8] invalidated the challenged laws on federal constitutional grounds. Justice White felt the Court should address the judicial split concerning this issue.

The medical malpractice damage limit issue focuses on whether the due process clause requires a state to provide an adquate compensation scheme to malpractice plaintiffs when it replaces those plaintiffs' common law right to recover full damages.[9]

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would apply only to states that have not enacted their own medical malpractice reforms by 1987. If a state fails to act, the bill applies to all patients whose care is paid for by the federal government. Damages include only economic losses (lost income, medical expenses, and attorneys' fees) and not non-economic losses (loss of earning capacity, pain, suffering, mental anguish, and loss of consortium).

3. Challengers to medical malpractice damages caps have relied primarily on the due process and equal protection clauses of the fourteenth amendment. They argue that the law violates due process by depriving the injured patient of his right under common law to fully recover his damages. Challengers claim that the damage limits violate equal protection by discriminating against only those plaintiffs who are severely injured. *See infra* notes 94-124 and accompanying text.

4. 106 S. Ct. 214 (1985).

5. CAL. CIV. CODE § 3333.2 (Deering 1984).

6. 106 S. Ct. at 214.

7. *See* Fein v. Permanente Medical Group, 38 Cal. 3d 137, 158, 695 P.2d 665, 680, 211 Cal. Rptr. 368, 383 (1985); Johnson v. St. Vincent Hosp., Inc., 273 Ind. 374, 404 N.E.2d 585, 602 (1980). A third state, Louisiana, had also upheld a damage cap under federal constitutional attack. *See* Sibley v. Board of Supervisors, 462 So. 2d 149 (La. 1985) ($500,000 limitation does not violate due process and equal protection guarantees of Constitution).

8. Carson v. Maurer, 120 N.H. 925, 941-43, 424 A.2d 825, 836-38 (1980); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978); Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (Comm. Pl. 1976); Baptist Hosp. v. Baber, 672 S.W.2d 296 (Tex. Ct. App. 1984). The court in *Simon* invalidated Ohio's provision in dicta.

9. The Supreme Court expressly left this issue open in Duke Power Co. v. Carolina Envtl. Study Group, 438 U.S. 59 (1978). In *Duke* an environmental organization and individuals who lived near partially constructed nuclear power plants brought suit seeking a declaration that the Price-Anderson Act was unconstitutional. *Id.* at 59. This Act limited the total liability that a defendant could incur in the event of a nuclear accident to $560 million. *Id.* The Court held that the Price-Anderson Act violated neither the

The Supreme Court must eventually decide the validity of statutory limitations on medical malpractice recoveries. Over one-quarter of the states have enacted such damage limits,[10] but state courts disagree on the constitutionality of these laws. Moreover, the malpractice crisis that spurred these laws in the 1970s is once again a concern pressuring many states to enact this type of legislation.[11]

II. DIVISION IN THE STATE COURTS

A. *Decisions Upholding Medical Malpractice Damage Limits*

In *Prendergast v. Nelson*[12] several health care providers brought a declaratory judgment action seeking a determination of the constitutionality of the Nebraska Hospital—Medical Liability Act.[13] The suit

due process nor equal protection clauses of the first amendment. *Id.* at 60-61. The Court held that it "need not resolve" the question of whether the due process clause required the Price-Anderson Act to either duplicate a victim's recovery at common law or provide a reasonable substitute remedy. *Id.* at 88. According to the Court, this inquiry was unnecessary because the Act provided a reasonably just substitute for the common law remedy. *Id.* at 61. The Court based its conclusion on three aspects of the law: (1) the law assured a $560 million fund for recovery; (2) Congress made a commitment in the Act to "take whatever action is deemed necessary and appropriate to protect the public from the consequences of" a nuclear accident; and (3) the statute required defendants benefitting from the Act to waive certain defenses, which relieved victims of the need to prove liability. *Id.*

10. CAL. CIV. CODE § 3333.2(b) (West Supp. 1983) ($250,000 limit for non-economic losses); FLA. STAT. ANN. § 768.54 (1986) ($100,000 limit with participation in patient's compensation fund); IDAHO CODE § 39-4204 (1977) ($150,000 limit for total damages); ILL. REV. STAT. ch. 70, ¶ 101 (Supp. 1978) ($500,000 limit for total damages); IND. CODE ANN. § 16-9.5-2-2 (Burns 1983) ($500,000 limit for total damages); LA. REV. STAT. ANN. § 40:1299(B)(2) (West 1978) ($500,000 limit for total damages); MO. REV. STAT. § 383.110.5 ($350,000 limit for non-economic losses); NEB. REV. STAT. § 44-2825 (1982) ($500,000 limit for total damages); N.M. STAT. ANN. § 41-5-6 (1978) ($500,000 limit for total damages); N.D. CENT. CODE § 26.1-14-11 (1983) ($300,000 limit for total damages); OHIO REV. CODE ANN. § 2307.43 (Page 1981) ($200,000 limit for total damages); S.D. CODIFIED LAWS ANN. § 21-3-11 (Supp. 1985) ($1,000,000 limit for total damages); TEX. REV. CIV. STAT. ANN. art. 4590i (Vernon Supp. 1982) ($500,000 limit for total damages); VA. CODE § 8.10-581.15 (Supp. 1983) ($750,000 limit for total damages); W. VA. CODE § 55-7B-8 (Supp. 1986) ($1,000,000 limit for non-economic damages).

11. In 1983 doctors paid approximately $1.7 billion for malpractice insurance, up 17% from 1982. *Alternative Medical Liability Act: Hearings on H.R. 5400 Before the Subcomm. on Health of the House Comm. on Ways and Means*, 98th Cong., 2d Sess. 49 (1984) (statement of Rep. Gephardt). From 1974 to 1984, malpractice premiums increased by 131%. *Id.*

12. 199 Neb. 97, 256 N.W.2d 657 (1977).

13. NEB. REV. STAT. §§ 44-2801 to 44-2855 (1982).

was instituted after the state's Director of Insurance refused to implement the Act's provisions concerning malpractice limits.[14] The damage limit under the Nebraska Act was $500,000, but a patient could waive the provisions of the Act before undergoing treatment.[15] The Nebraska Supreme Court held that the $500,000 ceiling was a reasonable classification based on inherent differences between tort actions in which the patient elected to come under the Act and those in which the patient waived the provision of the Act.[16] Because the Act guaranteed a fund[17] for the payment of claims made under its provisions, the court found the $500,000 ceiling reasonable.[18] According to the court, a claimant who waived the Act and proceeded under common law had no such guarantee of payment.[19] Thus, the Court held that the Act did not violate the equal protection clause because the limitation was reasonable in light of the benefit also conferred by the statute. In addition, the elective nature of the Act undoubtedly played a key role in the decision.[20]

Unlike the Nebraska statute, the medical malpractice damage cap at issue in *Johnson v. St. Vincent Hospital, Inc.*[21] was nonelective.[22] The Indiana Supreme Court noted that the state's $500,000 damage limitation imposed a burden on those persons damaged in excess of $500,000, but no such burden existed for those having smaller claims.[23] In determining whether the burden violated equal protection, however, the court applied the rational basis test.[24] Because medical malpractice tort victims are not a suspect class and the victim's interest in being fully compensated is not a fundamental interest, the court held that the

14. 199 Neb. at 100, 256 N.W.2d at 662.

15. *Id.* at 115, 256 N.W.2d at 669. *See* NEB. REV. STAT. § 44-2821.

16. Only three of the seven justices subscribed to this portion of the decision. One justice thought the issue was nonjusticiable, while three justices believed the limitation was unconstitutional as special legislation.

17. NEB. REV. STAT. § 44-2829. An annual surcharge on each qualified health care provider establishes the fund. Each health care provider is responsible for any malpractice claims up to $100,000. *Id.* § 44-2825. The fund pays claims between $100,000 and $500,000. *Id.*

18. 199 Neb. at 115, 256 N.W.2d at 669.

19. *Id.*

20. *Id.*

21. 273 Ind. 374, 404 N.E.2d 585 (1980).

22. IND. CODE. ANN. §§ 16-9.5-1-1 to 16-9.5-10-5 (Burns 1983).

23. 273 Ind. at 397, 404 N.E.2d at 600.

24. *Id.*

classification need only have a "fair and substantial" relationship with the purpose of the legislation.[25] The court found such a relationship between the $500,000 limit and the promotion of health care.[26] The cap gave health care providers an incentive to participate in the patient compensation fund,[27] a risk-spreading mechanism designed as a partial alternative to private insurance.[28] Moreover, the limitation facilitated the determination of the annual surcharge paid by health care providers to the fund.[29]

In *Sibley v. Board of Supervisors*[30] the Louisiana Supreme Court also applied the rational basis test[31] to a $500,000 statutory limitation on medical malpractice damages.[32] The court held that the state's objective in assuring the continued availability of quality health care was a legitimate goal and found that the legislature could have rationally decided that the Act would promote the state's objective.[33] The court distinguished other cases that invalidated limitations on medical malpractice recoveries, noting that those courts specifically found no actual medical malpractice crisis in their respective states at the time the legislatures passed the statutes.[34] Thus, according to the court, the

25. *Id.*

26. *Id.* at 398, 404 N.E.2d at 601. The court stated:

> The Legislature could have reasonably considered a set limitation upon recoveries to be an essential part of any operable plan to spread the risk of loss to participating health care providers and to regulate the cost of them, and thereby meet the danger it perceived to the public welfare. . . . [W]e find a rational justification for the difference in treatment accorded the various groups identified within the rationality of the program launced by the Legislature to protect vital societal interests.

Id.

27. *Id.* Annual surcharges on all health care providers in Indiana creates the fund. IND. CODE ANN. § 16-9.5-4-1 (Burns 1983). Each physician must be insured in the amount of $100,000 per occurrence, and $300,000 in the annual aggregate. The fund pays claims in excess of a health care provider's insurance coverage. IND. CODE ANN. § 16.9.5-2-6 (Burns 1983).

28. 273 Ind. at 398, 404 N.E.2d at 601.

29. *Id.*

30. 462 So. 2d 149 (La. 1985).

31. *Id.* at 155-57.

32. LA. REV. STAT. ANN. § 40:1299.39(B) (West Supp. 1985). The Louisiana Act is substantially similar to the Indiana Act. *See supra* notes 20-28 and accompanying text (discussion of Indiana Act).

33. 462 So. 2d at 156.

34. *Id.* at 156 n.8. The court noted that the courts in Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978), and Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983), each found that "no actual medical malpractice existed in those states and therefore the legislative

statutory limitations could not possibly further those statutes' goal of combating the malpractice crisis.[35]

The malpractice limitation at issue in *Fein v. Permanente Medical Group*[36] differed substantially from the limitations upheld in Nebraska, Indiana, and Louisiana. The California statute limited non-economic losses to $250,000.[37] In *Fein* an attorney sued a partnership of physicians for failing to diagnose and prevent his heart attack.[38] The jury awarded Fein almost $800,000 for lost wages and medical expenses, and an additional $500,000 for non-economic damages.[39] Applying the California statute, the trial court reduced the non-economic damage award to $250,000.[40] Fein challenged this reduction on both due process and equal protection grounds.[41] He claimed that the statute violated his due process rights by limiting the potential recovery of medical malpractice claimants without providing an adequate benefit to compensate for the limitation.[42] Because the statute impinged upon economic rights, the court required that it merely be rationally related to a legitimate state interest.[43] The court held that due process did not require the state to provide *quid pro quo* to justify the statute.[44] Moreover, according the court, even if due process required compensatory

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solution obviously could not further the stated aims of the statutes." 462 So. 2d at 156, n.8.

35. *Id.*

36. 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (1985).

37. CAL. CIV. CODE § 3333.2 (West Supp. 1983) provides: "(a) In any [medical malpractice] action . . . the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage. (b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000)."

38. 38 Cal. 3d at 144, 695 P.2d at 670, 211 Cal. Rptr., at 373.

39. *Id.*

40. *Id.* at 145-46, 695 P.2d at 671, 211 Cal. Rptr. at 374.

41. *Id.* at 157, 162, 695 P.2d at 679, 682, 211 Cal. Rptr. at 382, 385.

42. *Id.* at 157, 695 P.2d at 679, 211 Cal. Rptr. at 382.

43. *Id.* at 158, 695 P.2d at 680, 211 Cal. Rptr. at 383. The court relied in part on Werner v. Southern California Newspapers, 35 Cal. 2d 121, 216 P.2d 825 (1950), in which the court applied a rational basis test to a statute that allowed recovery of "special damages" only for a plaintiff bringing a libel or slander action against a newspaper. Damages for loss of reputation, shame, mortification, and hurt feelings ("general damages") were not recoverable. The *Fein* court noted that "[t]he 'general damage/special damage' distinction . . . is similar to the 'noneconomic damage/economic damage' distinction established by section 3333.2." *Id.* at 158 n.15, 695 P.2d at 680 n.15, 211 Cal. Rptr. at 383 n.15.

44. *Id.* at 158, 695 P.2d at 680, 211 Cal. Rptr. at 383.

benefits, a viable medical malpractice insurance industry was an adequate benefit for the legislation's detrimental effect on malpractice plaintiffs.[45]

Fein also challenged the reduction on the grounds that it violated his equal protection rights by discriminating within the class of medical malpractice victims.[46] The court held, however, that the legislature had a reasonable basis for drawing a distinction between economic and non-economic damages.[47] The court recognized evidence showing that the consumer bears the cost of non-economic damages.[48] Thus, the court held that the legislature could have reasonably concluded that such damages should be limited.[49] Additionally, the court found that the legislature reasonably could have determined that an all-inclusive limit would provide a more stable base on which to calculate insurance rates.[50] The court also noted that the fixed $250,000 limit would promote settlements by eliminating "the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble."[51]

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45. *Id.* at 160 n.18, 695 P.2d at 681-82 n.18, 211 Cal. Rptr. at 385 n.18.

46. *Id.* at 162, 695 P.2d at 682, 211 Cal. Rptr at 385. Fein actually posited two equal protection arguments. First, he claimed that the statute violated equal protection by discriminating between medical malpractice victims and other tort victims, because the limit on non-economic damages applied only in medical malpractice cases. Second, he argued that the statute impermissibly discriminated against the class of medical malpractice victims by barring recovery only to those whose non-economic damages exceed $250,000. The court quickly disposed of the first contention by noting that the legislature was responding to a medical malpractice insurance crisis, and that it was therefore rational to treat medical malpractice tort victims differently than other tort victims. *Id.*

47. *Id.* at 162, 695 P.2d at 683, 211 Cal. Rptr. at 386.

48. *Id.* at 159, 695 P.2d at 681, 211 Cal. Rptr. at 384.

49. *Id.* at 160, 695 P.2d at 681, 211 Cal. Rptr. at 384. The court distinguished those cases that had invalidated limitations on medical malpractice damages:

> With only one exception, all of the invalidated statutes contained a ceiling which applied to both pecuniary and nonpecuniary damages, and several courts—in reaching their decisions—were apparently considerably influenced by the potential harshness of a limit that might prevent an injured person from even recovering the amount of his medical expenses.

Id. at 161, 695 P.2d at 682, 211 Cal. Rptr. at 385. The "one exception" that the court referred to is Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980). However, the court had little trouble distinguishing *Carson*, recognizing that the New Hampshire court applied an intermediate scrutiny standard of review. The *Fein* court found such a standard inconsistent with California's standard. *Id.* at 161 n.19, 695 P.2d at 682 n.19, 211 Cal. Rptr. at 385 n.19.

50. *Id.* at 163, 695 P.2d at 683, 211 Cal. Rptr. at 386.

51. *Id.* (citing Brief of Amicus). As a final rationale, the *Fein* court remarked that

B. *Decisions Invalidating Medical Malpractice Damage Limits*

The first case to decide the validity of a medical malpractice damage cap was *Wright v. Central DuPage Hospital Association*.[52] Although the plaintiff challenged the $500,000 limitation on federal constitutional grounds,[53] the court found it unnecessary to decide these issues.[54] Instead, it concluded that the limitation violated the state constitution as arbitrary and as a special law.[55] In disposing of the case, however, the court addressed the hospital association's argument that the statute provided a *quid pro quo* for the loss of recovery by lowering medical care costs for all recipients of medical care.[56] The court stated that this *quid pro quo* does not extend to the seriously injured medical malpractice victim who might not recover all of his medical expenses.[57]

In *Jones v. State Board of Medicine*[58] the Idaho Supreme Court reached the federal constitutional issues but found the record insufficient to render a decision.[59] In *Jones* several physicians and hospitals brought a declaratory judgment action against the state board of

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"the legislature simply may have felt that it was fairer to malpractice plaintiffs in general to reduce only the very large noneconomic damage awards, rather than to diminish the more modest recoveries for pain and suffering and the like in the great bulk of cases." *Id.* Chief Justice Bird's dissenting opinion found this justification strange:

> The notion that the Legislature might have concentrated the burden of medical malpractice on the most severely injured victims out of considerations of fairness certainly has the advantage of originality. . . . If 'fairness' can justify the present limit, it is hard to imagine a statute that could be invalidated under the majority's version of equal protection scrutiny.

Id. at 174, 695 P.2d at 691, 211 Cal. Rptr. at 394 (Bird, C.J., dissenting).

52. 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

53. *Id.* at 308, 347 N.E.2d at 741.

54. *Id.* at 316, 347 N.E.2d at 739.

55. *Id.* at 318, 347 N.E.2d at 741-43. The court stated:

> Although we do not hold or even imply that under no circumstances may the General Assembly abolish a common law cause of action without a concomitant *quid pro quo*, we have consistently held that to the extent that recovery is permitted or denied on an arbitrary basis a special privilege is granted in violation of the Illinois Constitution. . . . We are of the opinion that limiting recovery only in medical malpractice actions to $500,000 is arbitrary and constitutes a special law in violation of section 13 of article IV of the 1970 Constitution. . . .

Id. at 320, 347 N.E.2d at 743.

56. *Id.* at 319, 347 N.E.2d at 742.

57. *Id.*

58. 97 Idaho 859, 555 P.2d 399 (1976).

59. *Id.* at 876, 555 P.2d at 416.

medicine, seeking a declaration that the state's damage limitation[60] was unconstitutional. The court held that a recovery limit satisfies equal protection standards only if it bears a fair and substantial relationship to the asserted purpose of the act.[61] The asserted purpose of the Idaho Act was to alleviate the alleged medical malpractice crisis in the state.[62] Because the record did not contain factual information indicating whether or not a malpractice crisis actually existed the Idaho at the time of the Act's passage, the court remanded the case for further factual determinations.[63]

The North Dakota Supreme Court was the first court to invalidate a medical malpractice damage limit on federal constitutional grounds.[64] In *Arneson v. Olson*[65] the statute at issue limited medical malpractice recoveries to $300,000.[66] Although the limitation did not apply unless a patient consented to its provisions,[67] the court accorded this factor

60. IDAHO CODE § 39-4204, -4205 (1977) (repealed 1981).

61. 97 Idaho at 871, 555 P.2d at 413-14.

62. *Id.* at 862, 555 P.2d at 402.

63. *Id.* at 876, 555 P.2d at 416.

64. A $200,000 damage limitation was invalidated on federal constitutional grounds with surprisingly little discussion in Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (Comm. Pl. 1976). Relying on Graley v. Satayatham, 343 N.E.2d 832 (Comm. Pl. 1976), which had invalidated other portions of Ohio's Medical Malpractice Act, the court found that the damage cap violated equal protection. 355 N.E.2d at 912. The portion of the opinion invalidating the damage cap was only dicta, however, because the plaintiff had not prayed for damages in excess of $200,000. *Id.* at 905. Nevertheless, *Simon* is significant because it was the first case to purportedly invalidate a medical malpractice damage cap on federal constitutional grounds.

In *Graley* the court invalidated certain pleading requirements as conflicting with the Ohio Rules of Civil Procedure and held that the elimination of the collateral source rule in medical malpractice cases violated the equal protection clause of the fourteenth amendment. Concerning the equal protection claim, the court held:

> There is no satisfactory reason for this separate and unequal treatment. . . . To articulate the requirement is to demonstrate its absurdity, for at one time or another every type of profession or business undergoes difficult times, and it is not the business of government to manipulate the law so as to provide succor to one class, the medical, by depriving another, the malpracticed patients, of the equal protection mandated by the constitution.

343 N.E.2d at 837.

65. 270 N.W.2d 125 (N.D. 1978).

66. N.D. CENT. CODE § 26-40.1-11 (1978) (repealed 1983).

67. *Id.* § 26-40.1-04. This provision provided that a patient or his representative could elect to be bound by the terms of the statute by signing an acknowledgement. If a patient required emergency treatment, the provisions of the statute applied without consent. If the patient did not consent, the physician could decide whether or not to provide services.

little weight and found that a physician was under no obligation to provide care to a patient who refused to consent.[68] Thus, according to the court, a patient must either consent or travel outside the state to obtain treatment.[69] The court refused to decide whether a state could limit the right to recover damages without providing a *quid pro quo*, and instead held that a state may never arbitrarily limit or eliminate a pre-existing right.[70] The court found that the statute did not even satisfy this lower standard of review.[71] Although one of the stated purposes of the Act was to eliminate the expense involved in nonmeritorious malpractice claims,[72] the court ruled that the $300,000 limit did nothing to achieve this goal.[73] Rather, the Act reduced meritorious and nonmeritorious claims.[74] The limitation also did not serve the stated purpose of assuring the availability of medical services at reasonable costs.[75] The court found that the incidence of malpractice claims in North Dakota was far lower than the national average.[76] Moreover, premiums in North Dakota were the sixth lowest in the country.[77] Because North Dakota was not experiencing an availability or cost crisis, the court held that the Act violated the equal protection clause in that it could not possibly achieve its stated purposes.[78]

The damage cap at issue in *Carson v. Maurer*,[79] similar to that upheld in *Fein*, limited damages for non-economic losses to $250,000.[80] New Hampshire modeled its damage limit after California's statute.[81]

68. 270 N.W.2d at 134.

69. *Id.*

70. *Id.* at 135.

71. *Id.*

72. N.D. CENT. CODE § 26-40.1-01 stated that the purposes of the Act were:
[T]o assure the availability of competent medical and hospital services to the public in North Dakota at reasonable costs; to provide prompt and efficient methods for eliminating the expense involved in nonmeritorious malpractice claims; to provide adequate compensation to patients with meritorious claims; and to encourage physicians to enter the practice of medicine in North Dakota and remain in such practice as long as they are qualified to do so.

73. 270 N.W.2d at 135-36.

74. *Id.*

75. *Id.* at 136.

76. *Id.*

77. *Id.*

78. *Id.* at 135.

79. 120 N.H. 925, 424 A.2d 825 (1980).

80. N.H. REV. STAT. ANN. § 507-C:7II (Supp. 1979).

81. 120 N.H. at 941, 424 A.2d at 836.

The New Hampshire Supreme Court, however, struck down the law on equal protection grounds.[82] The court found a weak relationship[83] between rate reduction and the means chosen to attain the goal for two reasons. First, damage awards constitute only a small part of total insurance premium costs. Second, few individuals suffer non-economic damages in excess of $250,000.[84] The court found that these facts indicated the damage limit would do little to reduce premiums. The court also expressed concern that the Act placed the burden of rate reduction on those most seriously injured.[85]

The most recent case to invalidate a medical malpractice damage limitation was *Baptist Hospital v. Baber*.[86] The *Baber* court, relying on *Arneson v. Olson*,[87] summarily struck down Texas' $500,000 damage cap as violative of equal protection.[88] The court noted that several courts had relied on the presence or absence of a *quid pro quo* to the disadvantaged class as a factor in their decision.[89] Although the court recognized that the Supreme Court has never imposed such a requirement,[90] it held that the presence of a *quid pro quo* would strengthen the statute's constitutionality.[91] The court then found that the hospital

82. *Id.*

83. Unlike the other courts that invalidated their medical malpractice acts using the rational basis test, the *Carson* court applied intermediate scrutiny in reviewing the provisions of its statute. *Id.* Under intermediate scrutiny, the means used by the legislature must be substantially related to achievement of important state objectives. *See* Craig v. Boren, 429 U.S. 190 (1976).

84. 120 N.H. at 941, 424 A.2d at 836.

85. *Id.* at 942, 424 A.2d at 837. The court stated: "It is simply unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured and therefore most in need of compensation." *Id.*

86. 672 S.W.2d 296 (Tex. 1984).

87. *See supra* notes 64-78 and accompanying text.

88. 672 S.W.2d at 298. The holding was limited to hospitals, the only defendant in the case. *Id.*

89. *Id. See, e.g.*, Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978); Simon v. St. Elizabeth Medical Center, 97 Idaho 859, 555 P.2d 399 (1976); Wright v. Central DuPage Hosp. Assoc., 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

90. The Supreme Court expressly left open the question of whether due process requires a legislatively enacted compensation scheme to be a *quid pro quo* for the common law remedy it replaces in Duke Power Co. v. Carolina Envtl. Study Group, 438 U.S. 59 (1978).

91. 672 S.W.2d at 298.

failed to show any such *quid pro quo*.[92]

III. CONSTITUTIONALITY OF STATUTORY LIMITS ON MEDICAL MALPRACTICE CLAIMS

Although victims of malpractice challenge damage limits on a variety of grounds, courts are most receptive to challenges based on due process or equal protection. If the Supreme Court acts in this area, the federal question requirement[93] dictates that its decision will be based on one of these grounds.

A. *Due Process*

Most courts addressing the constitutionality of medical malpractice damage limitations question whether the scheme confers an adequate *quid pro quo* to compensate the malpractice victim's loss of his common law remedy. Because under common law no limit exists on the amount of recoverable damages,[94] a scheme violates due process if it displaces the common law remedy without conferring some benefit on the victim.[95] Several courts conduct this inquiry pursuant to an equal protection challenge, concluding that if a scheme unreasonably burdens fundamental rights, it also violates equal protection.[96] Because this theory derives from substantive due process, the analysis is essentially the same.

The primary benefit offered as justification for the *quid pro quo* requirement is that damage caps reduce the liabilities of health care providers, resulting in lower malpractice insurance premiums. This lowered liability insures that quality health care will be available in the state at a reasonable cost. Although conflicting evidence exists, most litigants do not dispute that some benefit may accrue to patients by limiting the liability of health care providers.[97] The primary question

92. *Id.*

93. 28 U.S.C. § 1257 (1982).

94. The only limitation is one of reasonableness. Under common law principles a judge is obligated to reduce a damage award that is not in accordance with the evidence. *See, e.g.*, Beagle v. Vasold, 65 Cal. 2d 166, 180-81, 417 P.2d 673, 681, 53 Cal. Rptr. 129, 137 (1966). The judgment at least afford the plaintiff opportunity to make remittitur to avoid a new trial. *See, e.g.*, Bucher v. Krause, 200 F.2d 576 (7th Cir.), *cert. denied*, 345 U.S. 997 (1952).

95. *See supra* notes 41-45, 56-57 and accompanying texts.

96. *See supra* note 89 and accompanying text.

97. *See infra* notes 107-11 and accompanying text.

is whether lower medical costs for all health care recipients adequately benefit the severely injured malpractice victims who must bear the burden of such reductions. Because state courts disagree on the answer to this constitutional question, the Supreme Court must give guidance.

The *Baber*,[98] *Carson*,[99] and *Arneson*[100] courts specifically found that lower medical costs for all health care recipients do not adequately compensate the severely injured malpractice plaintiff.[101] The *Arneson* court held that the recovery limitation does not provide adequate compensation to patients with meritorious claims, but instead detrimentally affects the most seriously injured claimants.[102] Perhaps more realistically, the *Carson* court recognized that the malpractice plaintiff received some compensation in the form of lower medical costs, but found such compensation totally inadequate. The court held that imposing the burden of supporting the medical care industry solely upon the most severely injured and economically needy was both unfair and unreasonable.[103]

Alternatively, the *Fein* and *Johnson* courts found that the preservation of health care services adequately justified the burden imposed on malpractice plaintiffs.[104] The *Fein* court held that "even if due process principles required some quid pro quo to support the statute, it would be difficult to say that the preservation of a viable medical malpractice insurance industry in this state was not an adequate benefit for the detriment the legislation imposes on malpractice plaintiffs."[105] The *Johnson* court went even further, reasoning that many malpractice plaintiffs will continue to depend upon health care providers for the rest of their lives to treat the injuries resulting from prior negligence.[106] Thus, the availability of health care services may benefit the malpractice plaintiff more than the average citizen.

The *Fein* and *Johnson* opinions place too much emphasis on the assertion that availability of health care services through lower premiums

98. *Baber*, 672 S.W.2d at 298.

99. *Carson*, 120 N.H. at 941-43, 424 A.2d at 837-38.

100. *Arneson*, 270 N.W.2d at 134-35.

101. *See supra* notes 64-92 and accompanying text.

102. 270 N.W.2d at 135.

103. 424 A.2d at 837.

104. *Fein*, 38 Cal. 3d at 160 n.18, 695 P.2d at 681-82 n.18, 211 Cal. Rptr. at 385 n.18.

105. *Id.*

106. *Johnson*, 273 Ind. at 396, 404 N.E.2d at 599.

adequately compensates the malpractice plaintiff. Malpractice premiums constitute less than one percent of the nation's health care bill.[107] Strong evidence also indicates that medical costs rise regardless of malpractice legislation and a decline in insurance premiums.[108] For example, malpractice premiums rose steadily in California prior to the enactment of the medical malpractice damage limit, and decreased of three years after.[109] Between 1975[110] and 1981, however, the cost for a hospital stay increased from $217 to $547 per day.[111] Thus, the theory that decreased malpractice premiums will in turn reduce medical costs, a theory that courts and even litigants have freely accepted, is dubious.

Even if correct, this premise should be entitled to little weight. The fact that many health care providers can continue to operate or that medical costs will be lower hardly compensates the severely injured plaintiff. A plaintiff whose damages have been reduced by $300,000 takes little comfort in knowing that his doctor's bill is $10 cheaper.

B. *Equal Protection*

Medical malpractice damage limits also implicate the equal protection clause. First, the statutes distinguish between tort victims in general and medical tort victims. Second, the statutes distinguish between classes of medical tort victims—those whose damages are less than the fixed recovery limit and those whose damages exceed the limit. Courts faced with equal protection challenges to medical malpractice damage limits must initially decide which standard of review to apply. The courts disagree on the proper standard[112] and need the Supreme Court to provide guidance.

Despite their differences, the state courts agree that damage caps should not be subject to strict scrutiny. Strict scrutiny requires that the legislative act be necessary to achieve a compelling government inter-

107. Zaremski & Weibel, *There Is No Answer to the Medical Malpractice Crisis*, 6 J. LEGAL MED. 265, 266 (1985). Medical malpractice premiums cost the nation $3 billion per year, while the nation spends more than $300 billion per year on health care. *Id.*

108. *See generally* Greenwald & Mueller, *Medical Malpractice and Medical Costs*, in THE ECONOMICS OF MEDICAL MALPRACTICE 65 (S. Rottenberg ed. 1978).

109. *See* Neubauer & Henke, *Medical Malpractice Legislation*, 21 TRIAL 64, 65 (1985). The statistics in this article were based on a California Hospital Association study involving 420 of the state's 650 hospitals. *Id.*

110. *Id.* California passed its statute in 1975.

111. *Id.*

112. *See infra* note 115.

est.[113] Courts apply strict scrutiny when a statute either burdens fundamental rights or creates a suspect classification.[114] Because a person's interest in recovering malpractice damages in excess of a stated amount is not fundamental, strict scrutiny is not warranted. Strict scrutiny is also inapplicable under the suspect classification prong. The classifications created by medical malpractice damage limitations are not within the narrowly defined classifications recognized by the Supreme Court as suspect.

The states disagree, however, on whether to apply the rational basis test or some type of intermediate level scrutiny.[115] The rational basis test merely requires that a statute be rationally related to achieving a legitimate state objective.[116] Courts commonly apply the test to social or economic regulations.[117] Intermediate level scrutiny varies, but commonly requires that a statute be substantially related to achieving important state objectives.[118] Court apply the intermediate level scrutiny to some gender,[119] illegitimacy,[120] and alienage classifications.[121]

Although both the *Arneson* and *Johnson* courts applied intermediate scrutiny, each did so for different reasons. The court in *Arneson* applied intermediate scrutiny because it had earlier applied that standard in evaluating the state's automobile guest statute,[122] which it consid-

113. *See* Korematsu v. United States, 323 U.S. 214 (1944); Gunther, *Foreword: In Search of Evolving Doctrine On A Changing Court: A Model For A Newer Equal Protection*, 86 HARV. L. REV. 1 (1972).

114. *See* United States v. Carolene Products Co., 304 U.S. 144, 152 n.4 (1938).

115. The courts in Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978), and Johnson v. St. Vincent Hosp., Inc., 273 Ind. 374, 404 N.E.2d 585 (1980), applied intermediate level scrutiny although they reached opposite results. The courts in Fein v. Permanente Medical Groups, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (1985), Sibley v. Board of Supervisors, 462 So. 2d 149 (La. 1985), Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980), Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (Comm. Pl. 1976), and Baptist Hosp. v. Baber, 672 S.W.2d 296 (Tex. Ct. App. 1984), applied the rational basis test.

116. *See* Williamson v. Lee Optical Co., 348 U.S. 483, 488-89 (1955); Gunther, *supra* note 113, at 20.

117. *See* Williamson v. Lee Optical, 348 U.S. at 488-89; McGowan v. Maryland, 366 U.S. 420 (1961).

118. *See* Craig v. Boren, 348 U.S. 483 (1955).

119. *Id.*

120. Trimble v. Gordon, 430 U.S. 762 (1977); Levy v. Louisiana, 391 U.S. 68 (1968).

121. *See* Foley v. Connelie, 435 U.S. 291 (1978).

122. *See* Johnson v. Hassett, 217 N.W.2d 771, 780 (N.D. 1974) (holding North Dakota's automobile guest statute unconstitutional).

ered similar to the damage limitation. The *Johnson* court applied a "fair and substantial relationship" test because it construed the Supreme Court to have applied that standard in *Duke Power Co. v. Carolina Environmental Study Group.*[123] Little justification exists for applying such heightened scrutiny. The medical malpractical damage limitations discriminate against all classes, unlike discrimination against gender, illegitimacy, or alienage classifications.[124] Medical malpractice tort victims have not historically experienced discrimination. Nor are these victims politically powerless to influence lawmakers. Lawyers, a group sympathetic to medical malpractice plaintiffs, have considerable influence over legislatures. Damage caps are more akin to social or economic regulations, and courts should evaluate them under the rational basis test.

Even under the rational basis test, however, many states' damage limits should fail. For a damage cap to be rationally related to a legitimate state purpose, the state must have suffered from a malpractice insurance crisis justifying the damage limitation. The state's goal of reducing premiums is not valid if a crisis never existed. Considerable evidence demonstrates that malpractice crises never existed in many of the states with medical malpractice damage limits.[125] Insurance representatives who sell malpractice insurance testified before the Subcommittee on Health of the Committee on Labor and Public Welfare that the cost and availability of malpractice insurance was a serious problem in only nine states.[126] Of the fifteen states that have enacted damage caps, only four were listed among the nine "crisis states."[127] Thus,

123. *See supra* note 9.

124. Footnote 4 of the *Carolene Products* case, 304 U.S. 144 (1938), indicates that legislation directed at discrete and insular minorities may warrant heightened scrutiny because such legislation "curtail[s] the operation of those political processes ordinarily to be relied upon to protect minorities. *Id.* at 153 n.4. Here, medical malpractice plaintiffs are not such a minority.

125. *See infra* note 126.

126. *Federal Medical Malpractice Insurance Act: Hearings Before the Subcomm. on Health of the House Comm. on Labor and Public Welfare*, 94th Cong., 1st Sess. at 869-70 (April 7-15, 1975).

127. The nine states were Alaska, California, Florida, Indiana, Maryland, Michigan, New York, North Carolina, and Ohio. The four "crisis states" that have enacted damage limitations are California, Florida, Indiana, and Ohio. *See supra* note 10. Several states that have enacted damage limitations did so some time after these hearings. Presumably, a malpractice insurance crisis could have developed in these states during the intervening period.

when a state responds to an undocumented malpractice crisis, courts should strike down the legislation because the state's goal is not valid.

IV. CONCLUSION

The states are currently in sharp disagreement over the validity of medical malpractice damage limitations. In due process terms, the courts disagree on whether a compensation scheme requires an adequate *quid pro quo* for the common law remedy it replaces. If so, the question remains whether the availability of health care or reduced medical costs constitute an adequate *quid pro quo*. Due process requires such *quid pro quo*, and the availability of health care at reduced costs does not constitute adequate consideration to malpractice victims. In terms of equal protection, the courts disagree on the proper standard of review. Moreover, the question of whether a malpractice crisis existed in several states is the subject of conflicting evidence. For medical malpractice compensation schemes, the rational basis test is appropriate, but even this test is not met by many of the states that have enacted medical malpractice damage limits. Unless the Supreme Court acts in this area, the law will continue to produce conflicting results.

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