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A SURVEY OF MEDICAL MALPRACTICE TORT REFORM

SHIRLEY QUAL†

The medical malpractice insurance “crisis of availability” of the seventies has resurfaced as the “crisis of affordability” of the eighties. This Article surveys the various tort reform measures which have been proposed or enacted by the federal government and various state legislatures. Ms. Qual also examines the recent Minnesota tort reform legislation and concludes that although it is a realistic solution to the problem, it falls short of its goal of fully addressing the causes of the “crisis” by neglecting the crucial issue of physician discipline.

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INTRODUCTION

The medical malpractice crisis stunned the medical community, insurers, and the public for the first time in the early 1970's.¹ The crisis was characterized by drastically increased medical malpractice premiums for physicians,² increased frequency and severity of claims,³ and increased damage awards.⁴

1. See *Defensive Medicine and Medical Malpractice, 1984: Hearing before the Comm. on Labor and Human Resources, 98th Cong., 2d Sess.* 163 (1984) (statement of Elvoy Raines, American College of Obstetricians and Gynecologists). Mr. Raines, a professional liability expert, reported to the Senate Committee on Labor and Human Resources on July 10, 1984, that 80% of all medical malpractice lawsuits filed between 1935 and 1975 were filed in the last five years of that 40 year period. *Id.*

2. In mid-1975, physicians' and surgeons' insurance premiums were 100% higher than the previous year. See *The Problems of Insuring Medical Malpractice: Hearing Before the Subcommittee on Health of the Committee on Labor & Public Welfare, 94th Cong., 1st Sess.* 188 (1975).

3. In 1974, the St. Paul Companies estimated that the amount of claims they would receive in 1975 would increase 225% based on their annual claims growing each year from 2,538 claims logged against their company in 1970. AMERICAN MEDICAL ASSOCIATION SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE

At its peak in 1975, insurers were so shocked by this activity that they began to withdraw rapidly from the market of insuring health care providers, who had suddenly become high-risk insureds.⁵ Insurers still providing coverage in the medical malpractice area responded to this crisis by raising their premiums.⁶ Physicians and hospitals, in turn, increased their fees.⁷

State legislatures responded quickly. From 1975 through 1976, every state legislature made some attempt at tort reform to curtail medical malpractice claims.⁸ Whether these reforms had any effect on medical malpractice litigation or insurance costs is debatable. The "crisis," however, seemed to pass out

1984-85; PROFESSIONAL LIABILITY IN THE 80's, REPORTS 1-3, at 5. [hereinafter cited as AMA REPORT 1-3].

4. Million-dollar verdicts increased from three in 1975 to over 285 between 1979 and 1984. Hirsch, *Malpractice Crisis of the '80's*, LEGAL ASPECTS OF MED. PRAC., Oct. 1985, at 11.

5. See Sheehan, *The Medical Malpractice Crisis in Insurance: How it Happened and Some Proposed Solutions*, 11 F. 80 (1975).

6. Malpractice premiums for doctors and hospitals rose from \$61 million in 1960 to \$1 billion in 1975. T. LOMBARDI, MEDICAL MALPRACTICE INSURANCE: A LEGISLATOR'S VIEW 1 (1978). For a state-by-state summary of premium rates in 1975, see Sheehan, *supra* note 5, at 80.

7. Between 1975 and 1982, malpractice insurance premiums rose roughly 73%, while the cost of physicians' services rose 92%, and the cost of a hospital room rose 130%. P. DANZON, THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS: ANALYSIS OF CONTRIBUTING FACTORS 1-12 (1982) (Rand Corp. Inst. for Civil Justice Study) (copy on file at the William Mitchell Law Review office).

8. The following quotation summarizes the response of state legislatures:

In 1975, medical malpractice problems reached crisis proportions in many states As a result, 52 states and territories passed remedial legislation in a two-year period beginning in 1975 and ending in 1976. It is difficult to recall a problem in the history of the United States which generated more state legislation in such a short period of time.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC), MALPRACTICE CLAIMS, MEDICAL MALPRACTICE CLOSED CLAIMS, 1975-78, at 3 (Sept. 1980) (copy on file at the William Mitchell Law Review office). See generally Grossman, *State-by-State Summary of Legislative Activities on Medical Malpractice*, A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE 12 (D. Warren & R. Merritt eds. 1976) (containing comprehensive list of state legislative efforts during this time period); Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1417.

The tort reform legislation is advocated by medical societies and insurers in an effort to promote actuarial certainty for the insurance industry. The reforms allegedly reduce the number of medical malpractice suits and lower damage awards and attorneys' fees, providing additional cost savings to insurers. These cost reductions are theoretically passed on to society, resulting in lower insurance premiums for physicians and consequently, lowering health care costs to society. The reforms, however, have not proved to be effective, and have not achieved these goals. See, e.g., AMA REPORT 2, *supra* note 3, at 13; Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 S. CAL. L. REV. 829, 846 & n.102 (1979).

of the public eye—until today.⁹

This Article summarizes the history and potential causes of the medical malpractice crisis. It explores various tort reform methods employed by state legislatures attempting to alleviate pressures brought on by the 1975 medical malpractice crisis, and reviews the effects of tort reform on medical malpractice litigation. Current Minnesota law is discussed, followed by an analysis of the newly enacted legislation. Proposed national legislation is explained, followed by the author's conclusion. The purpose of this Article is to survey the use of, and evaluate the effectiveness of, "crisis" legislation enacted by other states, in order to provide insight for future attempts to do the same in Minnesota.

I. THE "MEDICAL MALPRACTICE CRISIS"—PAST AND PRESENT

A. History

The first medical negligence suit in the United States was recorded in 1794.¹⁰ It was not until the 1930's, however, that the number of medical malpractice suits began to grow,¹¹ and it was not until after World War II that the volume of claims began to increase steadily.¹² This increase did not achieve national attention until the early 1970's when its growth rate was so alarming that the phenomenon was dubbed a "crisis."¹³ This medical malpractice insurance dilemma became known as

9. See WOLFE, BERGMAN & SILVER, *MEDICAL MALPRACTICE: THE NEED FOR DISCIPLINARY REFORM, NOT TORT REFORM 1* (public citizen health research group report) [hereinafter cited as *THE NEED FOR DISCIPLINARY REFORM*]. The authors state:

Just as it did during the last malpractice crisis ten years ago, organized medicine has succeeded in diverting attention away from the issue of the dangerously inadequate discipline of doctors by going all out to pass state tort reform laws that will, in a variety of ways discipline injured patients or the families of dead patients and their lawyers instead of the doctors.

Id.

10. *Cross v. Guthery*, 2 Root 90 (1794).

11. Hirsch, *supra* note 4, at 5.

12. This increase coincided with the increased availability of medical care and the development of modern medicine and sophisticated technology. In post-war times, more people were able to afford medical care, which increased the number of encounters that could lead to a lawsuit. *Id.*

13. St. Paul Fire & Marine Insurance Company, long recognized as a leading medical malpractice carrier, reported that in 1969 it had one claim per 23 physicians, but in 1974, the ratio was one in every 10 physicians. In addition, in 1969 the average claim paid was \$6,075, increasing to \$12,534 in 1975—an increase of over 100%. T. LOMBARDI, *supra* note 6, at 11; see also *supra* notes 1-5.

the “crisis of availability” because so many insurers withdrew from the market that some physicians found it difficult to *find* insurance at any price.¹⁴

The crisis reached its peak in 1975.¹⁵ State legislatures across the country reacted swiftly, passing legislation curtailing access to the courts¹⁶ and facilitating the means by which health care providers could obtain liability coverage unavailable to them on the commercial market.¹⁷ The “crisis” faded from the public eye in the late 1970’s and early 1980’s, although health care costs and malpractice litigation costs continued to rise.¹⁸

Today, the public, insurance companies, and physicians are once again clamoring about a new medical malpractice crisis.¹⁹ This crisis has been entitled the “crisis of affordability”²⁰ because, unlike the the mid-1970’s, medical malpractice insurance is available, but its cost is claimed to be prohibitive.²¹

14. According to an American Medical Association survey reported in the January 1976 *American Medical News*, a significant number of physicians in about 25 states were having difficulty obtaining liability insurance. Munch, *Causes of the Medical Malpractice Insurance Crisis: Risks and Regulation*, in *THE ECONOMICS OF MEDICAL MALPRACTICE* 128 (S. Rottenberg ed. 1978). Most notorious perhaps, was the New York experience. Employers Insurance of Wausau, Wisconsin, pulled out of the market after having underwritten the New York Medical Society’s professional liability insurance for 25 years. Argonaut Insurance Company then agreed to provide coverage, after raising rates 93.5%. In late 1974, Argonaut requested an additional 200% increase, and shortly thereafter abandoned the New York market. See AMA REPORT 1, *supra* note 3, at 5.

15. AMA REPORT 2, *supra* note 3, at 13.

16. See *infra* notes 43-51 and accompanying text.

17. Many states passed Joint Underwriting Association (JUA) legislation to furnish insurance to health care providers unable to obtain liability insurance on the commercial market. These JUA’s, usually required insurance companies registered in the state to cooperate in supplying the liability insurance for these health care providers until the open market once again made that insurance available. See Munch, *supra* note 14, at 128.

18. Medical liability premiums increased by more than 80% between 1975 and 1983, reaching as much as \$80,000 per year for physicians practicing high risk specialties. Hirsch, *supra* note 4, at 8.

19. See Middleton, *The Medical Malpractice War*, NAT’L LAW J., Aug. 27, 1984, at 1, col. 1.

20. See AMA REPORT 1, *supra* note 3, at 8.

21. In Minnesota, for example, the Minnesota Medical Insurance Exchange has just published the projected average percentage increases for 1985 to be 28%. This percentage has risen from 22% in 1984, 11.6% in 1983, 15% in 1982, and 15% in 1981. Minnesota Medical Insurance Exchange is a physician-owned insurance company founded in 1980. *Minneapolis Star & Tribune*, July 24, 1985, at 1A, col. 3-4. Physician owned insurance companies were created in mid-1975, by doctors frustrated

B. Causes

A great deal of controversy surrounds the cause and existence of the current medical malpractice insurance crisis.²² One theory is that insurance companies have orchestrated the phenomenon by manipulating the medical malpractice insurance market to eliminate competition among insurers.²³ The

with the alternatives—exorbitant premiums or the lack of available insurance. See AMA REPORT 1, *supra* note 3, at 5.

Specialists are considering not practicing their specialties as a result of the expensive premiums and the likelihood of lawsuits. Young physicians are reportedly not entering those fields for the same reasons. A Florida medical association survey indicated that 25% of obstetricians in the state no longer deliver babies presumably as a result of the risk. AMA REPORT 1, *supra* note 3, at 11. Wisconsin reports that 18% of obstetricians have stopped accepting high risk patients. STATE MEDICAL SOCIETY OF WISCONSIN, REPORT TO THE LEGISLATIVE COUNCIL SPECIAL COMMITTEE ON MEDICAL MALPRACTICE 65 (Sept. 4, 1984) (copy on file at the William Mitchell Law Review office).

22. As Senator Edward M. Kennedy said about the crisis of 1975: "It is all too reminiscent of what happened to gas and oil prices during the Arab embargo." See T. LOMBARDI, *supra* note 6, at 1. An illustration of the theory that the insurance industry has fabricated the "crisis" for its own profit is exemplified in a California incident. See Carlova, *How Doctors Forced a Malpractice Carrier to Refund \$50 Million*, MED. ECON. 171-72 (1981). In 1976, physicians who obtained their medical malpractice insurance through Travelers Insurance Company on a contract with Southern California Physicians Council, were forced to pay a 486% increase to cover the higher losses Travelers expected in the future years. The physicians continued to pay high rates through 1978 when it was discovered that Travelers had made an enormous profit on its contract with the physicians. The Southern California Physicians Council demanded return of the excess premiums and ended up filing suit, resulting in a return of \$50,000,000 in premiums. *Id.* Cf. Jones v. State Bd. of Medicine, 97 Idaho 859, 872, 555 P.2d 399, 412 (1976) ("It is argued that the Act is a necessary legislative response to a 'crisis in medical insurance' in Idaho, but the record does not demonstrate any such 'crisis'"), *cert. denied*, 431 U.S. 914 (1977). But see T. LOMBARDI, *supra* note 6, at 2, "[d]espite serious misgivings about the [insurance] industry's response to the medical malpractice issue, the author in all fairness must state that there is little evidence to substantiate the point of view that the crisis was contrived for the benefit of the insurance company." *Id.*

23. "What we are witnessing is a manufactured crisis intended to bloat insurer profits and reduce victims' rights." Perlman, *Don't Confuse Me with the Facts*, 22 TRIAL, 1986 at 5 (quoting J. Robert Hunter, former Federal Insurance Administrator).

Major liability carriers stopped writing medical malpractice insurance in some states during the 1975 crisis. See *supra* note 14. This selective withdrawal allocated the medical malpractice market and eliminated competition among insurers, thus causing rates to rise dramatically. Londrigan, *The Medical Malpractice "Crisis,"* 21 TRIAL, 1985, at 23-24. See Bernier v. Burris, No. 85CH6627, slip. op. (Cook Co. Cir. Ct. Ill. Dec. 19, 1985), in which the Illinois circuit court for Cook County struck down the major portions of a statute which limited malpractice awards, stating "[t]here is no empirical data to support the claim that a medical malpractice insurance crisis exists in the state of Illinois." *Id.* at 2. The court found that the cause of the crisis was that insurance companies were raising their rates to recoup bad investments. *Id.*

insurance industry's power to accomplish this arises not only from the unique immunities that it enjoys from federal anti-trust laws,²⁴ but also from the absence of any effective state rate regulation.

The insurance industry denies this accusation, blaming the crisis on liberal doctrines adopted by the courts.²⁵ These doctrines include: discarding the locality rule,²⁶ adopting the

The court stated, "[a] sharp decline in the value of investments resulted in a reduction of 'reserves' for the payment of claims. The funding problems now asserted by the insurers, are of their own making, not the outgrowth of 'unforeseeable' [sic] increases in the number (frequency) and size (severity) of malpractice claims." *Id.* at 3. See also *Med-Mal Insurance "Crisis" is a Sham; State Statute Struck Down*, 5 LAW ALERT 114 Jan. 27 (1986).

24. 15 U.S.C. § 1012(b) (1982).

25. See Londrigan, *supra* note 23, at 25. The insurance industry advised its insureds to demand immediate "crisis" legislation to reform the tort system. *Id.*

26. See *Blair v. Eblen*, 461 S.W.2d 370, 372-73 (Ky. 1970) ("that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances"). The locality rule requires that a physician's conduct be judged by the standard of care which is acceptable in that particular community. The rule is criticized as being unreconcilable with the realities of modern medical practice, immunizing doctors from malpractice liability if they are the sole practitioner in their community, and preventing any possibility of obtaining expert testimony due to the "conspiracy of silence" in the plaintiff's locality. See *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 194, 349 A.2d 245, 249 (1975).

Some courts have wholly rejected the locality rule in favor of using a national standard to gauge a physician's acceptable standard of care. Courts adopting a national standard have both raised the standard of care, and have made it easier to prove cases by expanding the pool of potential expert witnesses to include those who are not doctors from that particular community. See, e.g., *Blair*, 461 S.W.2d at 372-73; *Pederson v. Dumouchel*, 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967) ("that degree of care and skill which is expected of the average practitioner in the class to which he belongs, acting in the same or similar circumstances").

Other courts relax the strict locality rule and apply the "same or similar locality" rule, enabling plaintiffs to obtain expert witnesses from other communities similar to their own. See, e.g., *Sinz v. Owens*, 33 Cal. 2d 749, 754, 205 P.2d 3, 5 (1949) ("same locality" or "vicinity"); *McGulpin v. Bessmer*, 241 Iowa 1119, 1129, 43 N.W.2d 121, 126 (1950) ("under like circumstances and in like localities"); *Karrigan v. Nazareth Convent & Academy, Inc.*, 212 Kan. 44, 50, 510 P.2d 190, 195 (1973) ("in the community where he practices, or similar communities").

Finally, some courts have adopted a national standard which only applies to specialists. See, e.g., *Kronke v. Danielson*, 108 Ariz. 400, 403, 499 P.2d 156, 159 (1972) ("the standard of care required of physicians in the same specialty practiced by the defendant"); *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968) ("standard of care and skill of the average member of the profession practicing the specialty"); *Christy v. Saliterman*, 302 Minn. 144, 166 & n.1, 179 N.W.2d 288, 302 & n.1 (1970) (standard of care is "the nationally recognized professional standard"); RESTATEMENT (SECOND) OF TORTS, § 299A comment d (1976).

discovery of the injury rule,²⁷ tolling minors' statutes of limitations pending the age of majority,²⁸ adopting the tort of emotional distress,²⁹ allowing recovery for pain and suffering,³⁰ accepting the lack of an informed consent as an independent tort,³¹ and adopting the doctrine of the loss of a chance.³²

Other commentators blame the medical malpractice crisis on advances in technology that began in the 1960's and which have dramatically changed the character of the physician-pa-

27. The majority of state courts have recently begun to interpret their statutes of limitation, which are framed in terms of accrual, as not beginning to run until the plaintiff discovers, or by reasonable diligence should have discovered, his injury. *See, e.g.,* *Jacoby v. Kaiser Foundation Hosp.*, 622 P.2d 613, 617 (Hawaii Ct. App. 1981); *see also* *Dawson v. Eli Lilly & Co.*, 543 F. Supp. 1330, 1338-39 (D.D.C. 1982). Some courts have gone even further and held that a cause of action does not accrue until the plaintiff discovers or should have discovered the negligence that caused the injury. *See, e.g.,* *Anderson v. Shook*, 333 N.W.2d 708, 712 (N.D. 1982); *Foil v. Ballinger*, 601 P.2d 144 (Utah 1979); *Hoffman v. Rockey*, 55 Or. App. 658, 639 P.2d 1284, 1286 (1982). Minnesota courts have stubbornly refused to follow this trend, holding instead that the statute of limitations begins to run when the physician's medical treatment for the particular condition ceases. *See* *Johnson v. Winthrop Laboratories, Div. of Sterling Drug, Inc.*, 291 Minn. 144, 149, 190 N.W.2d 77, 80 (1971).

28. *See, e.g.,* MINN. STAT. § 541.15 (1984), which provides that the statute of limitations is suspended on a cause of action accruing for an injury to a minor until the plaintiff reaches the age of majority. The plaintiff then has one year within which to bring suit. *Id.* Statutes such as these are controversial because they are thought to allow an unacceptable "long tail" of liability, making risk management an impossible burden. *Redish, Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 765 (1977).

29. *See, e.g.,* *State Rubbish Collectors Ass'n v. Siliznoff*, 38 Cal. 2d 330, 336, 240 P.2d 282, 285 (1952); *Barnett v. Collection Serv. Co.*, 214 Iowa 1303, 1312, 242 N.W. 25, 28 (1932); *Harris v. Jones*, 281 Md. 560, 566, 380 A.2d 611, 614 (1977); *Campos v. Oldsmobile Div. General Motors Corp.*, 71 Mich. App. 23, 25, 246 N.W.2d 352, 353 (1976); *Hubbard v. United Press Int'l*, 330 N.W.2d 428, 438 (Minn. 1983).

The majority of courts have accepted the intentional infliction of emotional distress as an independent tort, rather than as a "parasitic" cause of action pled only in conjunction with another tort. *See Harris*, 281 Md. at 564 & n.1, 380 A.2d at 613 & n.1.

30. California has led the move to limit award for pain and suffering. *See* *Fein v. Permanente Medical Group*, 695 P.2d 665, 680-81, 211 Cal. Rptr. 368, 382-85 (upholding CAL. CIV. CODE § 3333.2), *appeal dismissed*, 106 S.Ct. 214 (1985).

31. *See* *Cornfeldt v. Tongen*, 262 N.W.2d 684, 699 (Minn. 1977), *rev'd on other grounds*, 295 N.W.2d 638, 640 (Minn. 1980) (physician may be held liable for negligently failing to disclose risks of treatment to a patient subsequently harmed by those risks who would not have undergone the treatment had he known of the risks).

32. This theory of recovery requires plaintiff to prove that he lost a chance, not a guarantee, of recovery due to the defendants' negligence. *See generally* *King, Causation, Valuation and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353 (1981); *Wolfstone & Wolfstone, Recovery of Damages for the Loss of a Chance*, 28 MED. T. TECH Q. 121 (1981).

tient relationship.³³ Doctors no longer treat all the needs of their patients, but rather, focus only on one aspect of the patient's care, usually an area in which they specialize. The doctor's changing role causes a breakdown in the physician-patient relationship which alters the character of the relationship from one of a family confidant, to that of an anonymous technician. As a result, suing one's doctor has become much less of a personal effort than it was in the past. This problem is compounded by another byproduct of advanced technology—unreasonably high expectations of cure from medical treatment.³⁴ Yet, another commentator explains the crisis as a social phenomenon, claiming that the health care industry simply passed through phases in the 1960's and early 1970's which reflect the climate of American politics.³⁵

Physicians have not escaped blame for causing the crisis.³⁶ Malpractice is widespread, but there still is no effective discipli-

33. Robert W. Jamphis, M.D., President of the American Group Practices Association, stated three reasons for the crisis: (1) the breakdown of patient/doctor relationship; (2) the "Marcus Welby Syndrome"—expecting cures every time; and (3) the publicity of large damage awards. PROGRAM ON MEDICAL MALPRACTICE, NATIONAL CONFERENCE OF STATE LEGISLATURES AND HEALTH POLICY CENTER OF GEORGETOWN UNIVERSITY, Washington, D.C. (May 8, 1975).

34. *See id.*

35. P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 380 (1982). Professor Starr, an Associate Professor of Sociology at Harvard University, explains that the first phase of this crisis grew out of a period of agitation and reform in the first half of the 1970's. During that time, public pressure forced the law to provide broader entitlements to social welfare and stricter regulation of industry. *Id.* The general public's awareness of their civil rights, piqued by the demonstrations of the late '60's and early '70's, caused people to believe that medical care was a right, rather than a privilege, as was thought in the past. *Id.* at 389. Starr claims that around 1975, public preoccupation with inflation caused them to doubt the value of medical care. As a result, any movement toward a program of national health insurance was abandoned. *Id.* at 380.

This social climate caused physicians to experience the "end of a mandate" that had, for decades, allowed them unregulated financial freedom and unquestioned prestige and authority. *See generally id.* at 380-419. More people than ever before were being treated by the health care system in the United States under social programs developed during this time frame. *Id.* at 384-85. This, in turn, increased the number of potential victims of medical malpractice. These social factors, combined with inflation, caused medical costs to skyrocket. Those paying higher costs for medical care expected more from the treatment they received. *Id.* at 381-82.

36. *See Stein, Doctors Who Get Away with Killing and Maiming Must be Stopped.*, N.Y. Times, Feb. 2, 1986, at 23, cols. 2-5. Stein states: "American doctors are killing and maiming thousands of patients every year—and, for the most part, they are getting away with it. It is time that we in government, and the medical profession, came up with some remedies for this national tragedy." *Id.* at col. 2.

nary process to prevent incompetent physicians from practicing.³⁷ It is estimated that at any given time, up to fifteen percent of the nation's physicians are incompetent and unfit to practice medicine, yet these physicians continue to practice and to harm their patients.³⁸ Despite these statistics, state medical licensing boards revoked only 255 licenses in 1984, one for every 1,701 practicing physicians.³⁹ The lack of a uniform approach to this problem among the states, their use of disjointed disciplinary systems, and the medical profession's own reluctance to demand or to enforce the disciplining of their brethren, has helped to create and perpetuate the problem.⁴⁰

Of course, lawyers are also blamed for the state of the medical malpractice climate. Plaintiffs' lawyers have been characterized as greedy, and exploitative, and wholly unethical in pursuing large damage awards.⁴¹ Some commentators claim that contingency fees cause plaintiffs' attorneys to have too

37. Physicians are regulated by hospitals, medical societies, state licensing boards, and federal peer review organizations. Since there is no coordination of these efforts, however, incompetent physicians are able to move freely from hospital to hospital, or state to state as problems arise. See Brinkley, *U.S. Industry and Physicians Attack Medical Malpractice*, N.Y. Times, Sept. 2, 1985, at 10, col. 1. The Public Citizen Health Research Group reports that of nearly 400,000 nonfederal patient care doctors in the United States in 1983, only 563 had their licenses revoked, suspended, or were put on probation. THE NEED FOR DISCIPLINARY REFORM, *supra* note 9, at 1. This is true even though the HEW Malpractice Commission estimates that in 1983 203,000 people were injured while hospitalized due to doctors' negligence. *Id.* at 4.

38. The New York Times reports that an Illinois doctor, who had already been sued for malpractice at least 13 times, was ordered by a jury to pay a woman \$9 million for rendering her a quadriplegic after performing plastic surgery on her nose. Brinkley, *supra* note 37, at 1, col. 1.

39. *Id.* This is equal to .05 percent. "More than one-half of the disciplinary actions nationwide are reprimands or administrative actions that have little or no effect on a physician's right to treat patients." *Id.* at 10, col. 1.

40. Incompetent physicians increase medical costs. Errors lead to readmissions, longer hospital stays, expensive additional surgery and medications, as well as other unforeseen treatment, including malpractice lawsuits. *Id.* at 10, col. 1; Brinkley, *Medical Discipline Laws: Confusion Reigns*, N.Y. Times, Sept. 3, 1985, at 1, col. 3.

41. Anthony J. De Vito, a prominent New York medical malpractice defense lawyer, described his opposition as "plaintiff's attorneys who, while tenaciously guarding their lucrative turfs, react like a marauding [sic] school of piranhas, tearing gluttonously at the body which sustains them while, at the same time, pretending to pursue a course of justice!" De Vito, *Abuse of Litigation: Plague of the Medical Profession*, N.Y. ST. BAR J., July 1984, at 23, 24. This attack did not go without response from the plaintiff's bar. See, e.g., Magner, *Medical Malpractice: The Answers to Mr. De Vito*, N.Y. ST. BAR J., Nov. 1984, at 10.

large a stake in the outcome of lawsuits.⁴²

II. TORT REFORM LEGISLATION

The Lord giveth and the Lord taketh away. With respect to medical malpractice litigation, the courts giveth and the state legislatures taketh away.⁴³

Legislative tort reforms evolving in the area of medical negligence focus on curtailing medical negligence claims by modifying access to the courts, shifting the costs and burdens of litigation from the insurance and the medical industries to plaintiffs and their attorneys, and modifying evidentiary and procedural requirements. Nearly every state has enacted some type of tort reform, with certain states passing comprehensive packages of legislation.⁴⁴ This section identifies the various types of statutes enacted to accomplish tort reform. The tort reforms that are analyzed cause medical malpractice lawsuits to be a more complicated and burdensome procedure for the plaintiff, while implementing no procedure to regulate the insurance industry or to reduce the incidence of malpractice. Moreover, many of these tort reforms have been invalidated by courts as violative of both the federal and state constitutions.⁴⁵

A. *Modifying Access to the Courts*

1. *Statute of Limitations*

The most frequently utilized legislative tort reform is shortening statutes of limitation for medical malpractice causes of action.⁴⁶ Forty-one states have enacted legislation establishing a specific statute of limitations for medical liability cases. The majority of these statutes provide that the period of limitations begins to run and the cause of action accrues when the negligence occurs.⁴⁷ Recently, however, several courts have

42. See, e.g., F. MACKINNON, *CONTINGENT FEES FOR LEGAL SERVICES* 4, 5 (1964); Comment, *Are Contingent Fees Ethical Where Client is Able to Pay a Retainer?* 20 OHIO ST. L.J. 329, 339 n.53 (1959).

43. B. WERTHMANN, *MEDICAL MALPRACTICE LAW: HOW MEDICINE IS CHANGING THE LAW* 127 (1984).

44. AMA REPORT 2, *supra* note 3, at 13.

45. See *infra* notes 93 to 151 and accompanying text.

46. The states which have *not* established a separate statute of limitations for medical liability cases are Alaska, Arkansas, Connecticut, Idaho, New Jersey, Pennsylvania, Vermont, Virginia, West Virginia.

47. See, e.g., ALA. CODE § 6-5-482 (1975); COLO. REV. STAT. § 13-80-105 (Supp.

adopted the "discovery rule," which provides that the period begins to run from the time at which plaintiff discovered or should have discovered the injury through the use of reasonable diligence.⁴⁸ A few state courts have gone one step further by declaring that the statute does not begin to run until the plaintiff discovers the negligence that caused the injury.⁴⁹ These decisions lengthen the insurer's period of risk. To insure that interpretations of this type do not unreasonably extend the period of limitations, over half of these states have incorporated provisions with a maximum time limitation in which a claim may be brought.⁵⁰

The extended period of risk or "long tail" for insurers in medical malpractice claims is especially evident in the limitation statutes for minors, which, in most states, traditionally did not begin to run until the child reached the age of majority. In an effort to limit the risk period, several states have reduced the tolling period of the statute from when a child reaches the age of majority, to an arbitrarily chosen younger age.⁵¹

1985); DEL. CODE ANN. tit. 18, § 6856 (Supp. 1984); FLA. STAT. ANN. § 95-11 (West Supp. 1985); HAWAII REV. STAT. § 657-7.3 (1976 & Supp. 1984); ILL. REV. STAT. ch. 83 § 22.1 (1985); IOWA CODE ANN. § 614.1, subsec. 2 (West Supp. 1985); MO. ANN. STAT. § 516.105 (Vernon Supp. 1985); NEB. REV. STAT. § 25-208, 25-222 (1985); N.M. STAT. ANN. § 41-5-13 (1978); N.Y. CIV. PRAC. LAW § 203, 214-a (McKinney 1985); N.C. GEN. STAT. § 1-15(c) (1983); N.D. CENT. CODE § 28-01-18 (Supp. 1985); OHIO REV. CODE ANN. § 2305.11 (Page Supp. 1984); OR. REV. STAT. § 12.110 (1983); S.D. CODIFIED LAWS ANN. §§ 15-2-14.1, 15-2-22.1 (1984); TENN. CODE ANN. § 29-26-116 (1980); UTAH CODE ANN. § 78-14-4 (1984-85); WASH. REV. CODE ANN. § 4.16.350 (Supp. 1985-86); WIS. STAT. ANN. § 655.04 (West Supp. 1985).

48. See generally 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 1307 (rev. ed. 1973).

49. See *supra* notes 27, 28 and accompanying text.

50. See, e.g., ALA. CODE § 6-5-482 (1975); ARIZ. REV. STAT. ANN. § 12-542 (1985); CAL. CIV. PROC. CODE § 340.5 (West 1985); COLO. REV. STAT. § 13-80-105 (Supp. 1985); DEL. CODE ANN. tit. 18, § 6856 (2) (Supp. 1984); IND. CODE ANN. § 16-9.5-3-1 (West Supp. 1985-86); MD. CTS. & JUD. PROC. CODE ANN. § 5-109 (1984); MASS. GEN. LAWS ANN. ch. 231, § 60D (West 1985); MISS. CODE ANN. § 15-1-36 (1985); MO. REV. STAT. § 516.105 (1985); N.H. REV. STAT. ANN. § 507-C:4 (1983); N.M. STAT. ANN. § 41-5-13 (1978); N.Y. CIV. PRAC. LAW § 203 (McKinney 1985); N.C. GEN. STAT. § 1-17(b) (1985); OHIO REV. CODE ANN. § 2305.11 (Page Supp. 1984); R.I. GEN. LAWS § 9-1-14.1(a) (1985); S.D. CODIFIED LAWS ANN. § 15-2-14.1 to 15-2-22.1 (1985); TEX. HEALTH & SAFETY CODE ANN. art. 4590 § 10.01 (Vernon 1985); UTAH CODE ANN. § 78-14-4 (1984-85); WIS. STAT. ANN. § 893.56 (West 1985); WYO. STAT. § 1-3-107 (1985).

51. See, e.g., ALA. CODE § 6-5-482 (1975) (minor under age four has until age eight to file claim for medial negligence); CAL. CIV. PROC. CODE § 340.5 (West 1982) (minor under age six has three years or until his eighth birthday to file claim); DEL. CODE ANN. tit. 18, § 6856 (1974 & Supp. 1984) (minor under age six has three years

2. Arbitration

Several states have experimented with arbitration in the medical malpractice arena.⁵² Arbitration is usually a voluntary alternative to litigation.⁵³ Patients and health care providers enter into an agreement providing for arbitration of any dispute arising from the health care transaction. This agreement is a substitute for a jury trial, not a condition to one. The procedure attempts to assure a fast and efficient decision by an expert fact finder without the publicity or potential for an astronomical jury verdict. It is usually subject to only limited judicial review by a court on appeal.

Arbitration has been an unsuccessful alternative to the traditional court system because the parties are precluded from having "their day in court."⁵⁴ Patients are reluctant to give up this right and, therefore, this procedure is rarely used.⁵⁵

or until his sixth birthday to file claim); TEX. STAT. ANN. art. 4590: (Vernon 1976 & Supp. 1986) (minor under age twelve has until fourteenth birthday to file claim).

52. Although general malpractice claims may be arbitrated in at least 30 states under their general arbitration statutes, the following states have enacted arbitration legislation specifically for medical malpractice claims: ALA. CODE § 6-5-485 (1975); ALASKA STAT. § 09.55.535 (1985); CAL. CIV. PROC. CODE § 1295 (West 1982); GA. CODE ANN. § 9-9-112 (1982); ILL. REV. STAT. ch. 10, § 201 (1985); LA. REV. STAT. ANN. §§ 9:4230-:4236 (West 1983); ME. CODE ANN. tit. 24, §§ 2701-2715 (repealed by ch. 492, § 1 (1977)); MICH. COMP. LAWS ANN. § 600.5040 (West Supp. 1985); N.D. CENT. CODE 32-29.1 (repealed by ch. 358, § 1, 1981); OHIO REV. CODE ANN. §§ 2711.21-2711.24 (Page 1981); PA. STAT. ANN. tit. 40, § 1301.101 (Purdon 1985); S.D. CODIFIED LAWS ANN. § 21-25B-1 to 21-25B-26 (1979 & Supp. 1985); VT. STAT. ANN. tit. 12, § 7001-08 (1985); VA. CODE §§ 8.01-581.1 to 581.12 (1984).

Minnesota has an arbitration plan drafted by the Minnesota State Bar Association in 1975, entitled "An Experimental Arbitration Plan for Medical Liability Claims." This is to be used in conjunction with MINN. STAT. § 572 (1984), the general arbitration statute. For a discussion of its use, see Orwoll, *Medical Malpractice Arbitration*, BENCH & BAR OF MINN. Aug. 1985, at 31.

53. Courts have not imposed mandatory arbitration schemes due to the potential conflict with the constitutional right to a civil jury trial. See Redish, *supra* note 28, at 765.

54. Cf. *Obstetrics & Gynecologists Williams G. Wixted, M.D., Patrick M. Flanagan, M.D., William F. Robinson, M.D., Ltd. v. Pepper*, 693 P.2d 1259 (Nev. 1985) (court found arbitration agreement unenforceable as contract of adhesion because patient in weaker bargaining position than doctor).

55. In Minnesota, for instance, as of August, 1985, only 14 medical malpractice cases have been filed since September of 1975. Orwoll, *supra* note 43, at 31. Michigan has had a similar experience with their Medical Malpractice Arbitration Act of 1975, which, as of 1983, has been utilized for only 2-3% of the medical malpractice cases in that state. EVALUATION: STATE OF MICHIGAN MEDICAL MALPRACTICE ARBITRATION PROGRAM, TECHNICAL REPORT, VOL. I, ANALYSIS OF CLOSED MEDICAL MAL-

3. Pre-trial Screening

Pretrial screening panels designed to screen out nonmeritorious claims prior to trial have been adopted by many states. Pretrial screening generally requires a mandatory pretrial hearing to be conducted before a panel composed of physicians and attorneys.⁵⁶ The panel's decision is not binding on the parties, and therefore, does not preclude a plaintiff from subsequently bringing a lawsuit.⁵⁷ Consequently, these panels may not achieve the intended result of decreasing malpractice claims. States are split as to whether the panel's decision should be admissible in court.⁵⁸

Wisconsin, for example, has mandatory pretrial screening

PRACTICE CLAIMS 1976-1982, at 109 (1983); see MICH. COMP. LAWS ANN. § 600.5040 (West Supp. 1985).

56. See, e.g., WIS. STAT. ANN. § 655.17-.18 (West 1980). Wisconsin's formal panels are composed of two health care providers, one attorney, and two public members appointed by the governor. See *id.* § 655.03. The panel determines negligence, causation, and awards compensation. *Id.* § 655.065. These findings, however, are not binding on the parties unless the parties have agreed in writing to be so bound. *Id.* § 655.07. In Wisconsin, if either party commences a court action after the hearing, findings of formal panels are admissible in court, while findings of an informal panel are not. *Id.* § 655.19.

57. In at least one state, the fact that the panel decision was not binding was crucial to upholding the statute against constitutional attack based on the right to a trial. See *State ex. rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 261 N.W.2d 434 (1978) (Wisconsin statute providing for panel hearings as exclusive means for prosecution of medical malpractice claims not unconstitutional because it does not impair right to jury trial).

58. Statutes providing that the panel's decision is admissible in court include: ALASKA STAT. § 09.55.536 (1985); ARIZ. REV. STAT. ANN. § 12.567 (1985); CONN. GEN. STAT. § 38-196 (West 1985); DEL. CODE ANN. tit. 18, § 6811 (1984); FLA STAT. ANN. § 768.40 (West 1985) (held unconstitutional in *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980), and repealed by laws 1983, ch. 82-214 § 15); IND. CODE § 16-9.5-9.9 (1985); LA. REV. STAT. ANN. § 40:1299.47(H) (West 1985); MD. CTS & JUD. PROC. CODE ANN. § 3-2A-06 (1985); MASS. GEN. LAWS ANN. ch. 231, § 60B (West 1984); NEB. REV. STAT. § 44-2844 (1985); NEV. REV. STAT. § 41A.016 (1985) (expires by limitation June 30, 1989); N.D. CENT. CODE § 32-29.1 (repealed in 1981); OHIO REV. CODE ANN. § 2711.21 (Page 1985); PA. CONS. STAT. ANN. § 40-1301.308 (Purdon 1985) (held unconstitutional in *Mattos v. Thompson*, 491 Pa. 385, 421 A.2d 190 (1980)); R.I. GEN. LAWS § 10-19-1 to 10-19-10 (repealed in 1981 Laws ch. 187 § 2); TENN. CODE ANN. § 29.26-111 (1985) (Sunset 6183); VA. CODE §§ 8.01-581.8 (1985); WIS. STAT. ANN. § 655.19 (West 1980).

Statutes providing that the panel's decision is not admissible at a later trial are: ARK. STAT. ANN. § 34-2601-2602 (repealed 1985); HAWAII REV. STAT. § 671-16 (1984); IDAHO CODE § 6-1001 (1985); ILL. REV. STAT. ch. 10, § 201 (1985); ME. REV. STAT. ANN. tit. 24, § 2807 (1985); MO. REV. STAT. § 208.195 (1985); MONT. CODE ANN. § 27-6-606 (1985); N.H. REV. STAT. ANN. § 519A (1985); N.M. STAT. ANN. § 41-5-24 (1984); N.Y. JUDIC. LAW § 148a(4) (McKinney 1986).

panel hearings in all medical malpractice cases.⁵⁹ Wisconsin's experience, however, has proven that pretrial screening panels do not reduce the number of claims brought or the amount paid on claims.⁶⁰ Moreover, Wisconsin's system has not been effective in maintaining low medical malpractice insurance premiums.⁶¹

The Illinois Legislature recently enacted yet another pretrial screening procedure. In Illinois, a plaintiff is required to file a Certificate of Merit within 90 days of bringing an action for medical negligence.⁶² The Certificate of Merit consists of an affidavit stating the facts of the case, and a written report by a knowledgeable health care professional who has reviewed the case and deems it meritorious.⁶³ Failure to comply results in dismissal of the suit.⁶⁴

The pretrial screening panels have proven ineffective. Since plaintiffs are not bound by the panel's decision, and they are not precluded from using the court system despite having received an unfavorable panel decision. Therefore, pretrial screening frequently increases the costs of, and further delays, the final resolution of the dispute. On the other hand, the pretrial screening method, which requires a Certificate of Merit, will not delay or increase the costs of litigation since a medical expert is necessary to prove most claims.

59. See WIS. STAT. ANN. § 655.001-.27 (West 1980 & Supp. 1985), which also incorporates a patient compensation fund to be used in conjunction with the panels.

60. State Medical Society of Wisconsin, *Medical Liability in Wisconsin: Problems and Recommendations for Change*, UPDATE 2 (Feb. 1985). Wisconsin State Medical Society reports on statutes from 1980 to 1984 show that the number of claims paid increased in those years 142% (from 66 to 160) and the average payments increased 65% (from \$24,889 to \$40,660). Minnesota has not had a pretrial screening mechanism, yet it has had a better experience with insurance claims. From 1981 to 1984, the two major Minnesota Medical malpractice insurers, St. Paul Fire & Marine, and Minnesota Medical Insurance Exchange (accounting for 85-90% of all medical malpractice insurance written in Minnesota) had an increase in the number of claims paid from 128 to 200 (56.2%), and the average claim paid increased only 14%, to over \$54,000. Statement by David Corum, Minn. Dept. of Commerce to the Minn. Medical Ass'n Commission on Medical Professional Liability, July 24, 1985, at 5.

61. See *supra* note 60 and accompanying text.

62. Act of June 25, 1985, ch. 110, ¶ 2-1018(3) 1985 Ill. Legis. serv. 8-10 (to be codified at ILL. REV. STAT. ch. 110, ¶ 2-622(3)).

63. *Id.* (1) (to be codified at ILL. REV. STAT. ch. 110, ¶ 2-622(1)).

64. *Id.* (3)(g) (to be codified at ILL. REV. STAT. ch. 110, ¶ 2-622(3)(g)).

B. *Shifting Costs and Burdens of Litigation*

1. *Awarding Costs*

In order to deter frivolous claims and defenses, some states have enacted legislation providing for the payment of reasonable attorney and expert witness fees against the unsuccessful party in addition to the usual court costs.⁶⁵ This type of statute varies the procedure from the usual civil trial in which the prevailing party may have court costs paid by the opposing party, but must still incur the expense of his own expert witness and attorney fees. The statutes vary from state to state; some are mandatory, and others are at the court's discretion when a party has shown bad faith or has brought a frivolous claim or defense.⁶⁶

2. *Limiting Attorneys' Fees*

The contingent fee arrangement has long been criticized as creating a conflict of interest for attorneys.⁶⁷ Critics of the contingent fee argue that it manifests in the attorney a personal interest in the outcome of the case. This personal interest creates incentive for an attorney to encourage the public to litigate and seek excessive damages.⁶⁸ To counteract this perceived problem, several states have enacted statutes which either authorize court approval of reasonable attorneys' fees or set limits as to the maximum amount attorneys may collect. Some states provide for a sliding fee scale, whereby the percentage of the contingent fee collected by the attorney decreases incrementally as the amount of the award increases.⁶⁹

Other states have enacted legislation which authorizes a court to approve or disapprove the reasonableness of the

65. CAL. CIV. PROC. CODE § 1029.6 (West 1980 & Supp. 1986); FLA. STAT. ANN. § 768.56 (West Supp. 1985) (repealed); MASS. GEN. LAWS ANN. ch. 231 § 60B (West 1985); NEB. REV. STAT. § 44-2834 (1984); N.H. REV. STAT. ANN. § 507-C:9 (1983) (claims or denials without reasonable cause); PA. STAT. ANN. tit. 40, § 1301.509 (Purdon 1985) (frivolous appeals); UTAH CODE ANN. § 78-14-7.5 (Supp. 1985) (limiting attorney contingent fee to 1/3).

66. See *supra* note 65.

67. See F. MACKINNON, *supra* note 43, at 5.

68. See Comment, *supra* note 42, at 339 n.53.

69. CAL. BUS. & PROF. CODE § 6146 (West Supp. 1986); DEL. CODE ANN. tit. 18, § 6865 (1984); N.H. REV. STAT. ANN. § 507-C:8 (1983); N.Y. JUD. LAW § 474-a (McKinney Supp. 1986); PA. STAT. ANN. tit. 40, § 1301.604 (Purdon Supp. 1985).

fees.⁷⁰ Another scheme restricts fees to a certain percentage of the plaintiff's award.⁷¹ Wisconsin, for example, restricts attorneys' fees by excluding all amounts reflecting previously paid medical expenses and future medical expenses in excess of \$25,000 from the amount upon which the contingency fee is based.⁷²

3. *Altering the Collateral Source Rule*

The collateral source rule prevents the value of any benefits received by the injured party from sources other than the tortfeasor to offset the damage recovery.⁷³ This rule is attacked as causing a windfall to plaintiffs, who may receive a double recovery of their claimed damages by receiving insurance benefits and a damage award for the same injury.⁷⁴ Since many insurers have a subrogation right against a judgment in a plaintiff's favor, which includes reimbursement for costs paid by the insurer, proponents of the rule argue that few plaintiffs ever actually receive overcompensation. Moreover, proponents argue that the rule prevents a tortfeasor from capitalizing on the good fortune and foresight of the plaintiff who has paid the premiums to insure his risk.⁷⁵ With the advent of the medical malpractice crisis, however, the collateral source rule has been criticized as contributing to inflated damage awards and unnecessary overcompensation.⁷⁶

State legislatures have taken two approaches to limit the effect of the collateral source rule. Some statutes allow the trier

70. ARIZ. REV. STAT. ANN. § 12-568 (1982); FLA. STAT. ANN. § 768.56 (West Supp. 1985); HAWAII REV. STAT. § 671-2 (Supp. 1984); IOWA CODE ANN. § 147.138 (West Supp. 1985); MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-07 (1984); NEB. REV. STAT. § 44-2834 (1984); TENN. CODE ANN. § 29-26-120 (1980) (reasonableness may be determined but fees may not exceed 33 1/3%); WASH. REV. CODE ANN. § 7.70.070 (Supp. 1986).

71. IND. CODE ANN. § 16-9.5-5-1 (West 1984) (15% of award); OR. REV. STAT. § 752.150 (1983). Note that the Federal Torts Claim Act limits attorneys' fees to 20% in the event of settlement and 25% in the event the suit is resolved by a judgment. 28 U.S.C. § 2678 (1982).

72. WIS. STAT. ANN. § 655.013 (West 1980).

73. See *Carson v. Maurer*, 120 N.H. at 939, 424 A.2d 825, 835-36 (1985). See generally Mocerri & Messina, *The Collateral Source Rule in Personal Injury Litigation*, 7 GONZAGA L. REV. 310 (1972).

74. *Carson*, 120 N.H. at 939, 424 A.2d at 835-36.

75. Mocerri & Messina, *supra* note 73, at 315.

76. See Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 SO. CAL. L. REV. 829, 949 (1979).

of fact to hear testimony regarding collateral source payments and to decide whether to offset any of the damage award.⁷⁷ A second type of statute actually abolishes the collateral source rule by requiring that the damage award be offset by the amount of collateral source payments without informing the jury of collateral sources.⁷⁸

4. *Limiting Damages*

Several states have enacted legislation restricting recovery of particular types of damages. These measures are implemented by either statutes placing caps on the amount of damages a plaintiff may recover,⁷⁹ or by statutes which limit the liability of physicians or other health care providers participating in state patient compensation funds.⁸⁰ Damage caps typically affect only the severely injured person, since damages awarded to those with lesser injuries do not reach the ceiling amounts. Thus, the most helpless party among those involved in medical malpractice litigation is burdened with the cost of malpractice. This is fundamentally unfair. Moreover, severely injured patients, such as paraplegics, quadraplegics, or brain damaged patients will undoubtedly require financial help from public

77. See, e.g., ARIZ. REV. STAT. ANN. § 12-565 (Supp. 1985); CAL. CIV. CODE § 3333.1 (West Supp. 1986); DEL. CODE ANN. tit. 18, § 6862 (Supp. 1984); NEB. REV. STAT. § 44-2819 (1984); N.Y. CIV. PRAC. LAW § 4010 (Consol. 1975) (repealed by 1984 N.Y. Laws, ch. 701 § 1); R.I. GEN. LAWS § 9-19-34 (1985); S.D. CODIFIED LAWS ANN. § 21-3-12 (1979); WASH. REV. CODE ANN. § 7.70.080 (Supp. 1986).

78. See, e.g., ALASKA STAT. § 09.55.548 (1983); FLA. STAT. ANN. § 768.50 (West 1985); IOWA CODE ANN. § 147.136 (West Supp. 1985); N.Y. CIV. PRAC. LAW § 4010 (repealed by 1984 N.Y. Laws, ch. 701, § 1); OHIO REV. CODE ANN. § 2305.27 (Page 1981); PA. STAT. ANN. tit. 40, § 1301.602 (Purdon Supp. 1985); TENN. CODE ANN. § 29-26-119 (1980).

79. See, e.g., CAL. CIV. CODE § 3333.2 (West Supp. 1986); ILL. REV. STAT. ch. 73, § 1065.302 (1985); IND. CODE ANN. § 16-9.5-2-2.1 (Burns Supp. 1985); LA. REV. STAT. ANN. § 40:1299.42 (West Supp. 1986); NEB. REV. STAT. § 44-2825 (1984); N.H. REV. STAT. ANN. § 507-C:7 (1983); N.M. STAT. ANN. § 41-5-6 (1978); N.D. CENT. CODE § 26.1-14-11 (Supp. 1985); OHIO REV. CODE ANN. § 2307.43 (Page 1981); S.D. CODIFIED LAWS ANN. § 21-3-11 (Supp. 1985); TEX. HEALTH & SAFETY CODE ANN. art. 4590i § 11.02(a) (Vernon 1985); VA. CODE § 8.01-581.15 (1984); WIS. STAT. ANN. § 655.27 (West Supp. 1985).

80. FLA. STAT. ANN. § 768.54 (West 1985) (repealed by 1984 FLA. LAWS ch. 232, § 4); HAWAII REV. STAT. § 671.31 (1976); ILL. REV. STAT. ch. 73, § 1065.300 (1985); IND. CODE ANN. § 16-9.5-4-1 (West Supp. 1985); KY. REV. STAT. § 304.40-330 (repealed by 1984 KY. ACTS ch. 300, § 20); LA. REV. STAT. ANN. § 1299.44 (West 1977 & Supp. 1986); NEB. REV. STAT. § 44-2829 (1984); N.M. STAT. ANN. § 41-5-25 (1985); N.D. CENT. CODE § 26-40.1-15 (1985) (repealed by 1983 N.D. LAWS ch. 332, § 26); WIS. STAT. ANN. § 655.28 (West Supp. 1985).

assistance programs unless they are adequately compensated since the amount necessary for their lifetime maintenance can easily surpass statutory limits. In that case, the cost of malpractice shifts from the private sector of the insurance and health care industries to the public sector.

5. *Creating a Patient Compensation Fund*

Some states have established funds to pay the portion of a judgment or settlement in excess of statutory ceilings.⁸¹ In order to limit its liability through this fund, a health care provider must be insured up to the statutorily designated amount. The funds are usually financed through annual surcharges assessed against health care providers, and held in trust to be invested by the insurance commissioner.⁸² This reform attempts to ensure compensation for malpractice victims and to spread the risk among health care providers.

6. *Mandating Periodic Payments*

Plaintiffs have traditionally received their damage awards in lump sum payments. Recently, however, such payments have become the subject of tort reform because they are more burdensome to insurers than periodic payments. Damages may include payments for anticipated future medical care, loss of future earning capacity, and future pain and suffering. A lump sum, which includes payment for future damages, may overcompensate the plaintiff who recovers or dies sooner than expected. In addition, an award that may be paid out over time is financially favorable for insurance companies, since the plaintiff's award may be used to generate income over the payment period. Consequently, a number of states have enacted legislation which permits or requires medical liability judgments to be paid in installments.⁸³

81. *See supra* note 80.

82. *See id.*

83. *See, e.g.*, ALA. CODE § 6-5-486 (1975); ALASKA STAT. § 09.55.548 (1983); ARK. STAT. ANN. § 34-2619 (Supp. 1985); CAL. BUS. & PROF. CODE § 6146 (West Supp. 1986); DEL. CODE ANN. tit. 18, § 6864 (1984); FLA. STAT. ANN. § 768.51 (West Supp. 1985); N.H. REV. STAT. ANN. § 507-C:7 (1983); N.D. CENT. CODE § 26-40.1-16 repealed by S.L. 1983, ch. 332, § 26; WIS. STAT. ANN. § 655.015 (West 1980 & Supp.).

C. *Modifying Evidentiary and Procedural Requirements*

1. *Limiting Res Ipsa Loquitur*

Res ipsa loquitur is a common law doctrine permitting a plaintiff to prove negligence by circumstantial evidence.⁸⁴ The doctrine requires the plaintiff to prove that the injury occurred while the instrumentality which caused the injury was under the exclusive control of the defendant, and that the cause of injury was one that ordinarily would not have occurred in the absence of negligence.⁸⁵ Perceived as a boon to increasing medical liability claims, the use of *res ipsa loquitur* has been limited or modified in some states.⁸⁶ These changes are an attempt to limit the number of *res ipsa loquitur* claims by raising the standard of proof in medical negligence cases above that required in other tort cases.

2. *Modifying Expert Witness Standards*

Expert witnesses play an important role in establishing liability in medical negligence cases. Due to the technical nature of these suits, and the particular standard of care required in certain circumstances, physicians are best judged by fellow physicians. Attempting to curtail medical malpractice claims, some states have enacted legislation which restricts the qualifications and use of expert witnesses. These statutes vary from making expert testimony mandatory in order to prevail in a medical negligence case,⁸⁷ to modifying the necessary qualifications of the expert, such as requiring the expert to practice within the state in which the claim is brought, to have practiced a certain percentage of his profession in the defendant's speciality, or to have practiced within the past year.⁸⁸

84. See generally W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON TORTS, §§ 37-40 (5th ed. 1984).

85. *Id.*

86. See, e.g., ALASKA STAT. § 09.55.550 (1985); CAL. CIV. PROC. CODE § 411.30 (West Supp. 1986); DEL. CODE ANN. tit. 18, § 6853 (Supp. 1984); FLA. STAT. ANN. § 768.45(4) (Supp. 1985); ILL. REV. STAT. ch. 110, § 2-1113 (1985); NEV. REV. STAT. § 41A.100(1) (1985); OKLA. STAT. ANN. tit. 76, § 21 (West Supp. 1985-86); R.I. GEN. LAWS § 9-19-33 (1985); TENN. CODE ANN. § 29-26-115 (1980); TEX. HEALTH & SAFETY CODE ANN. Art. 4590i § 7.01 (Vernon 1985).

87. See, e.g., DEL. CODE ANN. tit. 18, § 6853 (Supp. 1985); IDAHO CODE § 6-1013 (1979); NEV. REV. STAT. § 41A.100 (1985); N.D. CENT. CODE § 28-01-46 (Supp. 1985).

88. See, e.g., DEL. CODE ANN. tit. 18, § 6854 (Supp. 1984); FLA. STAT. ANN. § 768.45 (West Supp. 1985); OHIO REV. CODE ANN. § 2743.43 (Page 1981); TENN.

By enacting such legislation, states are not reducing the incidence of malpractice or its cost to patients, the medical community, or the public. These statutes also do not reduce the number of claims that can be brought. Rather, such measures simply frustrate the plaintiff's attempt to find a qualified expert who supports the position that his injuries resulted from medical negligence. The task of finding a doctor to testify against another doctor has always been difficult. This type of legislation makes that task more formidable.

3. *Limiting the Standard of Care*

In order to prevail in a medical negligence action, the plaintiff must establish that the health care provider departed from accepted standards of medical practice. Each state has its own standard with which the defendant must comply. Some states have enacted legislation that limits or modifies the standard of care required by health care providers within that state.⁸⁹ These statutes generally codify the "locality rule."

4. *Ad Damnum Clause*

The ad damnum clause is the part of the plaintiff's complaint which sets forth the recovery sought.⁹⁰ Many states have enacted legislation that either excludes or limits the monetary

CODE ANN. § 29-26-115 (1980); VA. CODE § 8.01-581.20 (1984); *see also* N.H. REV. STAT. ANN. § 507-c:3 (1983) (requiring trial court to qualify expert witness).

89. *See, e.g.*, ALA. CODE § 6-5-484 (1975); ALASKA STAT. § 09.55.540 (1985); ARIZ. REV. STAT. ANN. § 12-563 (1982); ARK. STAT. ANN. § 34-2614 (Supp. 1985); FLA. STAT. ANN. § 768.45 (West Supp. 1985); IDAHO CODE § 6-1012 (1979); LA. REV. STAT. ANN. § 9:2794(A) (West Supp. 1986); MICH. COMP. LAWS ANN. § 600.2912a (West Supp. 1985); NEB. REV. STAT. § 44-2818 (1985); NEV. REV. STAT. § 41A.100 (1985); N.H. REV. STAT. ANN. § 508.13 (1983); N.C. GEN. STAT. § 90-21.12 (1985); N.D. CENT. CODE § 26-40.17 (repealed by 1983 N.D. SESS. LAWS ch. 82 § 184); OKLA. STAT. ANN. tit. 76, § 17 (West 1985); TENN. CODE ANN. § 29-26-115 (1985); VA. CODE § 8.01-581.20 (1950); VT. STAT. ANN. tit. 12, § 1908 (1985); WASH. REV. CODE ANN. § 7.70.030-.060 (1985).

Some statutes provide standards for specific circumstances. For instance, the Florida statute states that the discovery of a foreign object left in a plaintiff's body is prima facie evidence of negligence. *See* FLA. STAT. ANN. § 768.45(4). The statute also provides that the failure of a health care provider to administer "supplemental diagnostic tests" is not actionable if the provider acted in "good faith and with due regard for the prevailing professional standard of care." *Id.*

90. *See* MORRIS, *The Ad Damnum Clause in THE AD DAMNUM CLAUSE: THE PROBLEM AND SOLUTION 2* (Defense Research Inst. 1965) (containing a history of the ad damnum clause).

amount claimed in an ad damnum clause.⁹¹ This reform seeks to reduce publicity surrounding medical malpractice suits. This tort reform is based on the theory that requests for large damage awards in the ad damnum clause contributes significantly to the medical malpractice crisis by inflaming emotion and encouraging other members of the public to seek similar large recoveries.⁹²

III. CONSTITUTIONAL CHALLENGES

Every major category of tort reform has been found unconstitutional by at least one state supreme court.⁹³ Courts have declared entire acts void, finding that the tort reform measures are so interrelated that it is impossible for any part of the law to stand if one provision is declared unconstitutional, despite severability clauses in the acts.⁹⁴ Commentators have questioned whether courts, in invalidating these statutes on constitutional grounds, have strained the meaning of the relevant constitutional provisions beyond all legitimate bounds.⁹⁵

91. ALA. CODE § 6-5-483 (1985); ALASKA STAT. § 09.55.547 (1985); ARIZ. REV. STAT. ANN. § 12-566 (1985); ARK. STAT. ANN. § 34-2618 (1985); COLO. REV. STAT. § 13-21-112 (1985); FLA. STAT. ANN. § 768.042 (West Supp. 1986); GA. CODE § 9-11-8 (1985); HAWAII REV. STAT. § 671-4 (1984); ILL. REV. STAT. ch. 110, ¶ 2-604 (Smith-Hurd); IND. CODE § 16-9.5-1-6 (1985); IOWA CODE ANN. § 619.18 (West 1985); KAN. STAT. ANN. § 60-208 (1985); KY. REV. STAT. § 304.40-270 (held unconstitutional in *McCoy v. Western Baptist Hosp.*, 628 S.W.2d 634 (Ky. App. 1981)); LA. REV. STAT. ANN. § 1299.42 (1985); ME. REV. STAT. ANN. tit. 24, § 2901 (1985); MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-02 (1985); MASS. GEN. LAWS ANN. ch. 231, § 60C (West 1985); MINN. STAT. § 544.36 (Supp. 1985); NEB. REV. STAT. § 44-2822 (1985); N.H. REV. STAT. ANN. § 507-C:6 (1985); N.M. STAT. ANN. § 41-5-4 (1985); N.Y. CIV. PRAC. LAW § 3017(C) (McKinney 1986); N.C. GEN. STAT. § 1A-1, Rule B (1983); OHIO REV. CODE ANN. § 2307.43 (1985); R.I. GEN. LAWS § 9-1-30 (1985); TENN. CODE ANN. § 29-26-117 (1985); TEX. HEALTH & SAFETY CODE ANN. ART. 4590(E) § 5.01; (Vernon 1986); UTAH CODE ANN. § 78-14-7 (1985); WASH. REV. CODE ANN. § 4.28.360 (1986); WIS. STAT. § 655.009 (1985).

92. See *Medical Malpractice Committee Report*, WIS. BAR BULLETIN, June 1975, at 19, where the committee recommends that Wisconsin abolish the *ad damnum* clause to "keep gamesmanship and emotionalism out of the litigation process." *Id.* The committee further stated that "it is inappropriate, and emotionally devastating to some physicians to have the news media report that doctors are being sued for huge sums of money." *Id.*

93. AMA REPORT 2, *supra* note 3, at 14.

94. See *Carson v. Maurer*, 120 N.H. 925, 946, 424 A.2d 825, 839 (1980); *Arneson v. Olson*, 270 N.W.2d 125, 137-38 (N.D. 1978).

95. See, e.g., *Redish*, *supra* note 28, at 763.

A. Standard of Review

Equal protection⁹⁶ and special legislation⁹⁷ arguments are the most common challenges to tort reform legislation.⁹⁸ Medical malpractice legislation has an unequal impact on one class of tort claimants—victims of medical malpractice. Thus, these statutes discriminate among classes of injured tort claimants.⁹⁹ Whether the legislation will be upheld often depends upon which standard of review the court utilizes in analyzing the legislation.¹⁰⁰

When analyzing suspect legislation under an equal protection challenge, courts use one of three standards of review—a rational basis, an intermediate, or a strict scrutiny standard.¹⁰¹ The strict scrutiny standard is applied if the court deems that a fundamental right¹⁰² or a suspect classification¹⁰³ is at issue. States differ as to whether the right to receive adequate medi-

96. The United States Constitution provides: "No state shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

97. Many state constitutions contain provisions which prohibit the enactment of special laws to benefit a particular class. The Illinois Constitution provides: "The General Assembly shall pass no special of local law when a general law is or can be made applicable." ILL. CONST. art. IV, § 13.

98. AMA REPORT 2, *supra* note 3, at 14. The North Dakota Supreme Court invalidated its entire medical malpractice act on primarily equal protection grounds. See *Arneson*, 270 N.W.2d at 136.

99. Redish, *supra* note 28, at 769. In *Graley v. Satayatham*, 343 N.E.2d 832 (Ohio Ct. Com. Pleas 1976) the court stated:

There is no satisfactory reason for this separate and unequal treatment. There obviously is "no compelling governmental interest" unless it be argued that any segment of the public in financial distress be at least partly relieved of financial accountability for its negligence. 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.

Id. at 320, 343 N.E.2d at 837.

100. See generally Harper, *Which Equal Protection Standard for Medical Malpractice Legislation*, 8 HASTINGS CONST. L.Q. 125 (1980).

101. *Id.*

102. The United States Supreme Court has limited the fundamental rights category to rights "explicitly or implicitly guaranteed by the Constitution." *San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. 1, 28 (1973).

103. A classification is "suspect" when the "class is . . . saddled with such disabilities or subjected to such a history of purposeful unequal treatment, or relegated to such a position of unequal powerlessness as to command extraordinary protection from the majoritarian political process." *San Antonio Independent School Dist.*, 411 U.S. at 28.

cal care is a fundamental right.¹⁰⁴ If the court finds that a fundamental right is at stake, the state must show that the statute is necessarily related to a compelling governmental interest.¹⁰⁵ If no fundamental right is involved, the rational basis standard is applied and, a statute is valid if it is rationally related to a legitimate state objective.¹⁰⁶

A third, intermediate, standard has been applied to invalidate medical malpractice legislation challenged on an equal protection basis.¹⁰⁷ This test applies to "suspect classifications," or "near fundamental" rights. Although the Supreme Court has limited the application of the intermediate standard test to cases involving classifications based on gender and illegitimacy,¹⁰⁸ some state courts have expanded the classifications to which this standard applies to include the right to recover for personal injuries.¹⁰⁹ Using this standard, a court determines whether the classification substantially furthers the asserted purpose for the classification.¹¹⁰ In contrast to the rational basis standard, the intermediate standard requires a state to provide a greater justification for its classification.¹¹¹ It entails a close scrutiny of the legislative means and ends, with

104. *Id.* The Nebraska Supreme Court stated that the right to receive adequate medical care is a fundamental right. *Prendergast*, 199 Neb. 97, 114, 256 N.W.2d 657, 668 (1977). *But cf. Carson*, 120 N.H. at 931, 424 A.2d at 830 ("right to recover for one's injuries is not a fundamental right"); *accord Jones v. State Bd. of Medicine*, 97 Idaho 859, 870, 555 P.2d 399, 410 (1976), *cert. denied*, 431 U.S. 914 (1977).

105. *See, e.g., Austin v. Litvak*, 682 P.2d 41, 49 (Colo. 1984) (three year statute of repose in medical malpractice claim violated state equal protection guarantee). *See Wilson, The Supreme Court, the Equal Protection Clause, and the Three Faces of Constitutional Equality*, 61 VA. L. REV. 945 (1975).

106. For states applying a rational basis test, see *State ex rel Schneider v. Liggett*, 223 Kan. 610, 618, 576 P.2d 221, 227-28 (1978), *appeal dismissed*, 439 U.S. 808 (1978); *Prendergast*, 199 Neb. at 113, 256 N.W.2d at 667; *State ex rel Strykowski v. Wilkie*, 81 Wis. 2d 491, 508, 261 N.W.2d 434, 442 (1978).

107. *See, e.g., Jones*, 97 Idaho at 866, 555 P.2d at 411; *Johnson v. Saint Vincent Hosp. Inc.*, 273 Ind. 374, 397, 404 N.E.2d 585, 600 (1980) (fair and substantial relationship between classification and purpose of legislation); *Carson*, 120 N.H. at 933, 424 A.2d at 831 ("whether challenged classifications are reasonable and have a fair and substantial relation to the object of the legislation"); *Arneson*, 270 N.W.2d at 133 ("close correspondence between statutory classification and legislative goals"). This intermediate standard has been called a "means scrutiny" test. *Woods v. Holy Cross Hosp.*, 591 F.2d 1164, 1172 (5th Cir. 1979)

108. *See Lalli v. Lalli*, 439 U.S. 259, 265 (1979) (illegitimacy); *Reed v. Reed*, 404 U.S. 71, 76-77 (1971) (gender).

109. *Carson*, 120 N.H. at 931-32, 424 A.2d at 830-31.

110. *See Jones*, 97 Idaho at 865-67, 555 P.2d at 413-16.

111. *See id.*

less deference accorded to legislative judgments.¹¹² Instead of determining the merits of the asserted legislative goal of ameliorating the medical malpractice crisis, the court asks whether a crisis, does in fact exist, and then, whether the challenged legislation substantially furthers the goal of alleviating that crisis.¹¹³ Continued use of this standard to determine the validity of malpractice legislation may result in a proliferation of "suspect classifications" or an expansion of fundamental rights.¹¹⁴

Courts have also applied special legislation arguments in testing the validity of tort reform.¹¹⁵ Many state constitutions provide that a special law benefitting a class of persons may not be passed when a general law is, or can be, applicable.¹¹⁶

B. *Modifying Access to the Courts*

Critics of pretrial screening panels argue that the panels violate the due process¹¹⁷ and equal protection¹¹⁸ clauses of the Constitution, as well as unconstitutionally providing for the performance of judicial functions by nonjudicial entities.¹¹⁹ These panels have also been found to deny a claimant's fundamental right of access to the courts.¹²⁰ The most critical factor in upholding the constitutionality of a pretrial screening panel is whether the review is mandatory or voluntary.¹²¹ If mandatory, it may be struck down as violating the right of ac-

112. *See id.*

113. *See* Redish, *supra* note 28, at 773.

114. *See* Harper, *supra* note 99, at 137.

115. *See* Redish, *supra* note 28, at 773.

116. *See supra* note 97.

117. *See* Lacy v. Green, 428 A.2d 1171, 1176-77 (Del. Super. Ct. 1981) (holding that revealing panel's findings to jury is not violative of due process).

118. *See* Beatty v. Akron City Hosp., 67 Ohio St. 2d 483, 424 N.E.2d 586 (1981) (holding statute did not violate equal protection); *accord* Lacy, 428 A.2d at 1178.

119. *See* Wright v. Central DuPage Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736, 739 (Ill. 1976). For courts holding these panels constitutional, *see* Johnson, 404 N.E.2d 585; Everett v. Goldman, 359 So.2d 1256 (La. 1978); Attorney General v. Johnson, 282 Md. 274, 385 A.2d 57, *appeal dismissed*, 439 U.S. 805 (1978); Paro v. Longwood Hosp., 373 Mass. 645, 369 N.E.2d 985 (1977); Linder v. Smith, 629 P.2d 1187 (Mont. 1981).

120. *See* Cardinal Glennon Memorial Hosp., 583 S.W.2d 107, 110 (Mo. 1979). But *see* Comiskey v. Arlen, 55 A.D.2d 304, 390 N.Y.S.2d 122 (1976), *aff'd*, 43 N.Y.2d 696, 401 N.Y.S.2d 200, 372 N.E.2d 34 (1977), in which the court held that the statute providing for a medical malpractice panel did not deny the fundamental right of access to the courts. The screening panel, however, was convened *after* the court proceedings were commenced.

121. *See* AMA REPORT 2, *supra* note 3, at 16.

cess to courts,¹²² the right to a jury trial,¹²³ or the separation of powers doctrine.¹²⁴ Arguably, if the panel determines liability, or if its decision is seen as a form of expert evidence relied upon at a later trial, this is an improper usurpation of judicial power.¹²⁵ This argument lacks substance, however, due to the non-binding nature of the panel's findings.¹²⁶ If the panel is voluntary, it will escape these challenges. In complying with these constitutional requirements, however, a panel is unlikely to achieve the goals of efficiency and screening out nonmeritorious claims.¹²⁷

Permitting the panel's decision to be admitted into evidence at a subsequent trial is challenged as diluting the right to a jury trial.¹²⁸ Although the panel's decision is not binding at the later trial, its decision may unduly influence a jury, and thus preclude the plaintiff's right to receive a meaningful jury trial.¹²⁹ Courts have rejected this argument, finding that the panel merely provides the jury with the opinion of an expert panel, which the plaintiff may rebut at trial.¹³⁰ This controversy does not arise in jurisdictions in which the panel's findings are not admitted into evidence at a later trial.¹³¹

Administration of pretrial screening or arbitration panels may also lead to constitutional challenges.¹³² The pre-litigation burden requiring a plaintiff to undergo the cost and delay of a pretrial process as a condition to trial may effectively deprive a plaintiff of state guaranteed access to the courts.¹³³

122. *Cardinal Glennon Memorial Hosp.*, 583 S.W.2d at 109-10.

123. *See Mattos v. Thompson*, 491 Pa. 385, 391, 421 A.2d 190, 196 (1980).

124. *See Wright*, 347 N.E.2d at 739-40.

125. *But see Redish*, *supra* note 28, at 795 (stating that this is a strained concept of separation of powers).

126. *Id.*

127. *AMA REPORT 2*, *supra* note 3, at 16.

128. *See Comiskey v. Arlen*, 390 N.Y.S. 2d 122, 127-28 (1976); *Simon v. Saint Elizabeth Medical Center*, 355 N.E.2d 903, 907-08 (Ohio Ct. Com. Pl. 1976).

129. *Redish*, *supra* note 28, at 792.

130. *See Comiskey*, 390 N.Y.S. 2d at 125-26; *see also Eastin v. Broomfield*, 116 Ariz. 576, 580-81, 570 P.2d 744, 748-49 (1977) (admissibility of panel findings is merely rule of evidence, not violation of right to jury trial); *Prendergast*, 199 Neb. at 110, 256 N.W.2d at 665-66 (mere rule of evidence does not usurp judicial function).

131. *See Redish*, *supra* note 28, at 793; *Comment*, *supra* note 8, at 1461 & n.222.

132. *AMA REPORT 2*, *supra* note 3, at 16.

133. *See Aldona*, 381 So. 2d 231, 236-38 (medical malpractice statute ten month jurisdictional period unconstitutional as applied); *Simon*, 355 N.E.2d at 907-08 (statute providing for compulsory arbitration before medical malpractice screening panel found unconstitutional). *But see Johnson*, 282 Md. at 299, 385 A.2d at 71 (additional

The Florida Supreme Court invalidated its pretrial procedures, finding them to be arbitrary and capricious and violative of a plaintiff's due process rights. In support of this conclusion, the court stated that the procedure had "proven unworkable and inequitable in practical operation."¹³⁴

Courts have struck down special statutes of limitation for minors on the grounds that such limitations violate equal protection¹³⁵ or arbitrarily deny minors their right to seek redress for injuries.¹³⁶ Measures to shorten the statutes of limitation for all medical malpractice victims have been unsuccessfully attacked as special legislation or as violating the equal protection clause of the fourteenth amendment.¹³⁷

Limitation statutes have also been altered so that the discovery rule applies only to situations where a foreign object is discovered in a plaintiff's body.¹³⁸ This type of statute has been successfully challenged as discriminating between different members of the class of medical malpractice claimants.¹³⁹ Cur-tailing or limiting the discovery rule in medical malpractice cases may violate state constitutional right of access provisions as well.¹⁴⁰

cost and delay of mandatory pretrial arbitration does not violate due process); *Mattos*, 491 Pa. at 390-91, 421 A.2d at 196 (arbitration procedure is not impermissible burden on constitutional right to jury trial).

134. *Aldona*, 381 So. 2d at 237.

135. See *Schwan v. Riverside Methodist Hosp.*, 6 Ohio St. 3d 300, 452 N.E.2d 1337, 1338 (1983).

136. *Carson*, 120 N.H. at 936, 424 A.2d at 833.

137. See, e.g., *Barrio v. San Manuel Div. Hosp.*, 143 Ariz. 111, 692 P.2d 290 (Ariz. App. 1983) (statute of limitation does not violate equal protection); *Mishek v. Stanton*, 616 P.2d 135 (Colo. 1980) (statute of limitation does not violate equal protection or constitute special legislation); *Duffy v. King Chiropractic Clinic*, 17 Wash. App. 693, 595 P.2d 435 (1977) (statute of limitation is not violative of equal protection provisions of state or federal constitutions). But see *Austin v. Litvak*, 682 P.2d 41, 48 (Colo. 1984) (statute of limitation violates equal protection to the extent that it denies application of the discovery rule to negligently misdiagnosed medical malpractice plaintiffs).

138. See *Carson*, 120 N.H. at 935, 424 A.2d at 833.

139. See *id.*; but see *Allrid v. Emory Univ.*, 249 Ga. 35, 285 S.E.2d 521, 524-25 (1982) (upholding classification which granted foreign object victims an exception to the Georgia statute of limitation on the theory that the classification eliminated the danger of belated, false or frivolous claims), *aff'd*, 251 Ga. 367, 306 S.E.2d 905 (1983).

140. *Redish*, *supra* note 28, at 791.

C. *Shifting the Costs and Burdens of Litigation*

State statutes abolishing the collateral source rule only in medical malpractice cases have been successfully challenged on equal protection grounds for discriminating against medical malpractice claimants.¹⁴¹ Other courts, however, have held that this legislation is constitutional, finding that it bears a reasonable relationship to the legitimate state interest of ensuring the availability of adequate medical care.¹⁴²

Fixed caps on the amount of damages that victims can recover have been vulnerable to constitutional challenges. Courts have found these limitations void for arbitrarily limiting the rights of injured plaintiffs to recover.¹⁴³ Other courts have found that the limitations deny patients equal protection by precluding the most seriously injured victims from fully recovering for their injuries.¹⁴⁴ Still, other courts have rejected limitations on recovery, stating that the asserted general societal *quid pro quo* provided by the limitation, in the form of reduced insurance premiums and lower medical costs, did not extend to the seriously injured malpractice victim.¹⁴⁵ Similarly, courts have found that allowing a court to order periodic payments to eliminate the "bonus element of a judgment," such as when a judgment includes future damages and a patient dies prematurely, unreasonably discriminates in favor of health care providers, and unduly burdens seriously injured plaintiffs.¹⁴⁶

Statutes limiting contingent fee agreements have also been

141. *Carson*, 120 N.H. at 940-41, 424 A.2d at 836-37; see also *Doran v. Priddy*, 534 F. Supp. 30 (D. Kan. 1981) (permitting evidence of collateral source at trial only in medical malpractice cases invalid); *Graley v. Satayatham*, 343 N.E.2d 832 (Ohio Ct. Com. Pl. 1976) (court found statute requiring collateral benefits received by claimant be listed only in complaints for medical malpractice violated equal protection).

142. *Eastin v. Broomfield*, 116 Ariz. 576, 583, 570 P.2d 744, 751-52 (1977); *Pimilos v. Cedars of Lebanon Hosp. Corp.*, 403 So.2d 365, 367-68 (Fla. 1981); *Rudolph v. Iowa Methodist Medical Ctr.*, 293 N.W.2d 550, 558-60 (Iowa 1980).

143. See, e.g., *Wright*, 63 Ill. 2d 313, 330, 347 N.E.2d 736, 742-43.

144. *Carson*, 120 N.H. at 943, 424 A.2d at 838; *Arneson*, 270 N.W.2d at 136; *Simon*, 355 N.E.2d at 906; *Duren v. Suburban Community Hosp.*, 482 N.E.2d 1358, 1362-63 (Ohio Ct. Com Pl. 1985). But see *Fein v. Permanente Medical Group*, 211 Cal Rptr. 308, 695 P.2d 665, 680-82 (1985) (non-economic damage limitation of \$250,000 upheld); *Prendergast*, 199 Neb. at 115, 256 N.W.2d at 669 (claimant elects cap in return for guaranteed payment).

145. See *Wright*, 63 Ill.2d at 328, 347 N.E.2d at 742. But see *Prendergast*, 199 Neb. at 120-21, 256 N.W.2d at 671 ("there is no merit to the argument that if a common law right is taken away, something must be given in return").

146. See *Carson*, 120 N.H. at 944, 424 A.2d at 838.

challenged.¹⁴⁷ Arguably, this type of reform aggravates the problem by acting as an incentive for attorneys to advise their clients to seek higher verdicts and settlements in order to maximize their own fees.¹⁴⁸ The New Hampshire Supreme Court has held that this reform violates equal protection by discriminating between one class of plaintiffs and their attorneys.¹⁴⁹ The court also stated that sliding scale attorneys' fees interfere with the freedom to contract between an attorney and his client, and unfairly make medical malpractice cases unattractive to attorneys.¹⁵⁰ Contingent fee limitations create a potential impediment to injured plaintiff's access to the courts, since a plaintiff's ability to sue is often dependent upon the contingency fee system.¹⁵¹

IV. MINNESOTA'S RESPONSE

Prior to 1986, the Minnesota Legislature had been relatively dormant with respect to crisis medical malpractice tort reform. During the 1986 legislative special session, however, strong tort reform measures were enacted,¹⁵² which affect all civil actions, as well as some measures directed specifically at medical negligence actions.¹⁵³

147. *See id.* at 944-45, 424 A.2d at 838-39.

148. AMA REPORT, *supra* note 3, at 15.

149. *Carson*, 120 N.H. at 945, 424 A.2d at 838-39.

150. *Id. Contra Johnson*, 273 Ind. at 401-02, 404 N.E.2d at 602-03; *Roa v. Lodi Medical Group, Inc.*, 37 Cal. 3d 920, 925-34, 211 Cal Rptr. 77, 79-85, 695 P.2d 164, 164-72 (1985) (limit on attorneys' fees does not violate equal protection, due process, or separation of powers doctrine).

151. *Cf. Carson*, 120 N.H. at 945, 424 A.2d at 839.

152. Act of March 25, 1986, ch. 455, §§ 60, 79-84, 86-89, S.F. No. 2078 (to be codified in scattered sections of the Minnesota Statutes.) [hereinafter cited as S.F. No. 2078].

Neither the Minnesota Session Law Service, nor the Laws of Minnesota for 1986 were published at the writing of this Article. Consequently, the citations to the new legislation will refer to the House file number (S.F. No. 2078) as indicated above.

153. The Minnesota Medical Association initiated a Commission in Professional Liability in 1985. From the Commissioner's report, several proposed bills were drafted. The most substantial by Kathleen Blatz, (Rep. I.R. Bloomington) which would have implemented, among other things, a mandatory pretrial certification of expert review, a five-year limit on the tolling of the statute of limitations for minors, elimination of punitive damages, a \$250,000 limit on non-economic damages, abolition of the collateral source rule, and a provision for periodic payments of damages exceeding \$100,000. *See MINNESOTA MEDICAL ASSOCIATION, REPORT OF THE MINNESOTA COMMISSION ON PROFESSIONAL LIABILITY* (Nov. 1985) (copy on file at the William Mitchell Law Review office).

A. *Modifying Access to the Courts*

1. *Statute of Limitation*

Until just recently, Minnesota's medical malpractice statute of limitation had remained essentially unchanged since its adoption in 1945. This statute provides that an action based on negligence by physicians or hospitals must be brought within two years of the negligent act.¹⁵⁴ Prior to 1986, the most significant change in the limitations statute was in its breadth. The statute was expanded to include not only physicians, surgeons and dentists, but also "all other health care professionals."¹⁵⁵ With respect to the limitation statutes, the 1986 legislation affects only plaintiffs under the age of 18 who are victims of medical negligence.¹⁵⁶ The new statute applies to all medical malpractice actions commenced on or after January 1, 1987, and provides that the period of limitations may not be suspended for more than seven years or for no more than one year after the age of minority ceases.¹⁵⁷

2. *Arbitration*

There is no specific arbitration statute for medical malpractice cases in Minnesota, however, an arbitration plan was developed by a subcommittee of the Minnesota State Bar Association in 1971.¹⁵⁸ This procedure utilizes the general

154. Minnesota Statutes section 541.07 provides:

Except where the uniform commercial code or this section otherwise prescribes, the following actions shall be commenced within two years:

(1) for libel, slander, assault, battery, false imprisonment, or other tort, resulting in personal injury, and all actions against physicians, surgeons, dentists, other health care professionals as defined in section 145.61, and veterinarians as defined in chapter 156, hospitals, sanitoriums, for malpractice, error, mistake, or failure to cure, whether based on contract or tort.

MINN. STAT. § 541.07 (1984).

155. 1984 MINN. LAWS ch. 608 § 4. This change shortened the time in which a plaintiff was required to file suit against nurses, dental hygienists, and other health care professionals who previously could have been found to fall under the six-year statute of limitations.

156. S.F. No. 2078, *supra* note 152, § 79 (to be codified as amended at MINN. STAT. § 541.15(a)(1) (1986)).

157. *Id.* § 79 (to be codified as amended at MINN. STAT. § 541.15(b) (1986)). This provision has been interpreted by those who drafted it to provide that the two-year statute of limitations does not begin to run until seven years after the cause of action arises. Therefore, the child has nine years within which to bring a claim, unless he reaches the age of 18 first, and then the child must bring the claim by his 19th birthday. Under no circumstances may the period of limitation be less than two years.

158. See Orwoll, *Medical Malpractice Arbitration*, BENCH & B. MINN., Aug. 1985, at

Minnesota Arbitration Statute,¹⁵⁹ and specifically provides for a voluntary agreement between patients and health care providers to arbitrate their claims.¹⁶⁰ The procedure has been so seldomly used,¹⁶¹ however, that it is difficult to evaluate its effect on medical malpractice litigation other than to surmise that, as a result of its infrequent implementation by practitioners, it has had no effect whatsoever.¹⁶²

3. Certificate of Review

The 1986 reform measures include a statute which requires that a certification of expert review accompany the service of summons and complaint in all medical malpractice cases commencing on or after August 1, 1986.¹⁶³ The certifying affidavit must be signed by the plaintiff's attorney and state that the case has been reviewed by "an expert whose qualifications provide a reasonable expectation that the expert's opinions could

31. The plan was drafted by the Minnesota State Bar Association (M.S.B.A.) Legal-Medical Committee, and was supported by the Board of Governors, the Minnesota Medical Association (M.M.A.), and the Minnesota Hospital Association (M.H.A.). *Id.* The medical and bar associations selected 140 lawyers and 90 doctors as potential arbiters. *Id.* The plan calls for a prehearing conference to be held and formal discovery is permitted, as in a court trial. *Id.* at 32. The applicable hearing procedure, however, is that of a general arbitration hearing. *Id.* The arbiters issue written findings of fact and conclusions of law, and the decision is appealable. *Id.*

159. MINN. STAT. § 72.08-40 (1984).

160. Orwoll, *supra* note 151, at 31.

161. *Id.* This plan was originally received with great support by the medical and legal community in June of 1975. However, as of August 1985, the experimental plan had only processed 14 cases. *Id.*

162. Michigan has had a similar experience with their Medical Malpractice Arbitration Act, enacted in 1975. MICH. COMP. LAWS ANN. § 600.5040-.5065 (Supp. 1985); see Mengel, *The Constitutional and Contractual Challenges to Michigan's Medical Malpractice Arbitration Act*, 59 J. OF URBAN L. 319 (1982). The Michigan Act is quite similar to the Minnesota plan. It is a wholly voluntary contractual arrangement between physician and patient which may only be entered into prior to treatment. See Mengel, at 321. The Michigan Act, like Minnesota's plan, is informal, involving a panel of medical and legal members. *Id.* Similarly, the Michigan Act has had very little, if any, effect on medical malpractice litigation in that state. APPLIED SOCIAL RESEARCH, INC., EVALUATION: STATE OF MICHIGAN MEDICAL MALPRACTICE ARBITRATION PROGRAM, TECHNICAL REPORT, VOL. 1, ANALYSIS OF CLOSED MEDICAL MALPRACTICE CLAIMS 1976-1982 (Oct. 1983). Only 2-3% of all medical malpractice cases in Michigan have utilized the Act to resolve their claims. *Id.* at 109, 111.

163. S.F. No. 2078, *supra* note 152, § 60 (to be codified at MINN. STAT. § 145.682 (1986)). If the suit must be commenced before expert review can be obtained in order to preserve plaintiff's claim, the plaintiff must serve an affidavit along with the summons and complaint specifying this and then serve defendant or defense counsel with the certifying affidavit within 90 days after service of the summons and complaint.

be admissible at trial.”¹⁶⁴ The expert must be of the opinion that one or more of the defendants has deviated from the applicable standard of care, thereby causing the plaintiff’s injury.¹⁶⁵

In addition to the certifying affidavit, a plaintiff must provide the defendant with an affidavit identifying the expert witnesses upon whose testimony the plaintiff will rely at trial within 180 days after commencement of the suit.¹⁶⁶ The affidavit must include the identity of each expert, the substance of the facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. These new requirements must be met only in cases and to issues in which expert testimony is necessary to prove a prima facie case of medical negligence.¹⁶⁷ The statute also provides that the parties can agree to extensions of the time limits or that the court may extend these time limits upon a showing of good cause.¹⁶⁸ The penalty for noncompliance with these requirements is harsh—upon motion, those issues in the case requiring expert testimony will be dismissed with prejudice.¹⁶⁹

Although the implementation of this statute will likely expedite the pretrial discovery process and reduce the frequency of frivolous claims, it may also cause the dismissal of meritorious

164. *Id.* § 60 (to be codified at MINN. STAT. § 145.682, subd. 3(a) (1986)) See *Cornfeldt v. Tongen*, 262 N.W.2d 684, 699 (Minn. 1977), *rev'd on other grounds*, 295 N.W.2d 638, 640 (Minn. 1980) for a description of an expert who is qualified to testify.

165. S.F. No. 2078, *supra* note 152, § 60 (to be codified at MINN. STAT. § 145.682, subd. 3(a) (1986)).

166. *Id.* § 60 (to be codified at MINN. STAT. § 145.682, subd. 4 (1986)). Plaintiff must disclose the expert’s name, substance of facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. This may be provided in an affidavit executed by plaintiff or his attorney, or by answer to expert interrogatories. *Id.* Minnesota Rules of Civil Procedure require that answers to expert’s interrogatories be based upon the same criteria prior to trial, therefore, this portion of the new law changes only the time frame within which this requirement must be completed.

167. *Id.* § 60 (to be codified at MINN. STAT. § 145.682, subd. 2 (1986)). Evidently, excluding the rare *res ipsa loquitur* cases where lay persons are able to grasp the issues and determine negligence without the help of an expert.

168. *Id.* § 60 (to be codified at MINN. STAT. § 145.682, subd. 4 (1986)).

169. *Id.* § 60 (to be codified at MINN. STAT. § 145.682, subd. 6 (1986)). Upon motion, the action will be dismissed with prejudice if plaintiff’s attorney fails to comply within 60 days of defendant’s demand for the certifying affidavit. Failure to comply with the expert identification requirement results in mandatory dismissal with prejudice upon motion of the defendant. Note that *pro se* plaintiffs must also comply with this provision.

claims, since plaintiffs may be unable to comply with the arbitrary time frame. Thus, the already difficult task of locating a qualified physician willing to testify against the defendant physician will be further complicated by a short time frame.

B. *Shifting the Costs and Burdens of Litigation*

Shifting the costs and burdens of litigation has been the most popular response to rising insurance costs in other states. Until the recent legislation, Minnesota had not invoked any of the mechanisms used to achieve the goal of this type of tort reform. All civil actions commenced on or after August 1, 1986, however, will be subject to collateral source calculations,¹⁷⁰ a \$400,000 limit on intangible losses,¹⁷¹ a requirement that juries allocate damages as past, future, and intangible,¹⁷² and a discounting of future damages to present value.¹⁷³

1. *Collateral Source Rule*

The new collateral source rule provides that in *any* civil action where liability is admitted or determined, a party may file a motion for determination of collateral sources within ten days of the verdict if damages include an award for losses compensable by collateral sources up to the date of the verdict.¹⁷⁴ Once the motion is filed, the parties must submit written evidence of the amount of collateral sources paid to benefit the plaintiff, except those for which subrogation rights have been asserted.¹⁷⁵ Amounts incurred by or on behalf of the plaintiff or his immediate family to secure the right to payment from a collateral source for the two years prior to accrual of the cause of action shall also be submitted as evidence.¹⁷⁶ The court shall then offset these two values and reduce the verdict accordingly.¹⁷⁷ The jury will not be informed of the plaintiff's collateral sources.¹⁷⁸

170. *Id.* § 80 (to be codified at MINN. STAT. § 548.36 (1986)).

171. *Id.* § 88 (to be codified at MINN. STAT. § 549.23, subd. 2 (1986)).

172. *Id.* § 89 (to be codified at MINN. STAT. § 549.24 (1986)).

173. *Id.* § 86 (to be codified at MINN. STAT. § 604.07, subds. 2, 3 (1986)).

174. *Id.* § 80 (to be codified at MINN. STAT. § 548.36, subd. 2 (1986)).

175. *Id.* § 80 (to be codified at MINN. STAT. § 548.36, subd. 2(1) (1986)).

176. *Id.* § 80 (to be codified at MINN. STAT. § 548.36, subd. 2(2) (1986)).

177. *Id.* § 80 (to be codified at MINN. STAT. § 548.36, subd. 3 (1986)).

178. *Id.* § 80 (to be codified at MINN. STAT. § 548.36, subd. 5 (1986)).

2. *Limiting Damages*

The new tort reform legislation provides that in all civil suits, "intangible damages" shall not exceed \$400,000.¹⁷⁹ Intangible damages are defined as embarrassment, emotional distress, and loss of consortium, and do not include pain, disability, or disfigurement.¹⁸⁰ Again, the jury is not informed of this limitation.¹⁸¹ A plaintiff's verdict is further discounted in all civil cases claiming personal injury, wrongful death, or loss of means of support by reducing future damages to their present day value.¹⁸² Evidence of projected future earnings and loss of future earning capacity cannot be based on inflationary changes or general economic statistics and must be reasonably certain to occur.¹⁸³ Those statutory changes affecting the actual amount paid in a verdict will be facilitated by a new provision requiring the jury to break down its assessment of damages into past and future damages and to further specify the amount of intangible losses within those two categories.¹⁸⁴

3. *Contingent Attorneys' Fees*

The traditional contingent attorneys' fee arrangement is also changed by the 1986 reform. Pursuant to the new legislation, contingent attorneys' fees will be based on the award as adjusted to comply with the new collateral source rule.¹⁸⁵ Any subrogated provider of collateral sources must pay the same percentage of attorneys' fees as paid by the plaintiff and its proportionate share of the costs *if* it is not separately represented by counsel in its action to recover collateral payments.¹⁸⁶

179. *Id.* § 88 (to be codified at MINN. STAT. § 548.23, subd. 2 (1986)). Note also that subdivision 4 of section 548.23 makes it clear that "this section does not create a new cause of action for intangible loss." *Id.*

180. *Id.* § 88 (to be codified at MINN. STAT. § 548.23, subd. 1 (1986)).

181. *Id.* § 88 (to be codified at MINN. STAT. § 548.23, subd. 3 (1986)).

182. *Id.* § 86 (to be codified at MINN. STAT. § 604.07, subd. 2 (1986)).

183. *Id.* § 86 (to be codified at MINN. STAT. § 604.07, subd. 3 (1986)).

184. *Id.* § 89 (to be codified at MINN. STAT. § 549.24 (1986)).

185. *Id.* § 80 (to be codified at MINN. STAT. § 548.36, subd. 4 (1986)).

186. *Id.* This section appears to encourage plaintiff's counsel to represent the subrogated collateral source provider as well as the plaintiff in order to maintain attorneys' fees equivalent to the pre-adjustment award.

C. *Modifying Evidentiary and Procedural Requirements*

1. *Punitive Damages*

Pretrial procedures have been altered by the 1986 legislation. First, punitive damages may not be claimed in the summons and complaint in any civil action.¹⁸⁷ The legal basis for punitive damages must be alleged in a motion to amend the complaint.¹⁸⁸ The motion must be supported by one or more affidavits stating the factual basis for the claim.¹⁸⁹ The movant has the burden of proving with prima facie evidence of the allegations before the court may grant the motion.¹⁹⁰

2. *Access to Treating Physician's Opinions*

The second pretrial alteration affects only medical malpractice claims. Formerly, a plaintiff bringing a claim for medical malpractice was deemed to have waived his physician-patient privilege. Defendants were thus able to gain access to a plaintiff's medical records and obtain deposition testimony relating to a plaintiff's medical condition. Pursuant to the new legislation, claims commenced or pending on August 1, 1986, will also allow defendants access to a plaintiff's treating physician by permitting informal interviews if the treating physician consents.¹⁹¹ The defendant is required to give prior notification to plaintiff's counsel of the informal conference so that he may attend.¹⁹²

3. *Ad Damnum Clause*

In 1978, the Minnesota Legislature required that *ad damnum* clauses in actions for damages of unliquidated amounts state only that they are deemed to be over \$50,000, unless the amount requested was less than \$50,000.¹⁹³ As in other jurisdictions, the asserted purpose of this legislation was to reduce

187. *Id.* § 82 (to be codified at MINN. STAT. § 549.191 (1986)).

188. *Id.*

189. *Id.*

190. *Id.* The statute also provides: "For purposes of tolling the statute of limitations, pleadings amended under this section relate back to the time the action was commenced." *Id.*

191. *Id.* § 84 (to be codified as amended at MINN. STAT. § 595.02, subd. 4 (1986)). If the treating physician does not consent to an informal meeting, his deposition may be taken by defendant without a court order. *Id.*

192. *Id.*

193. Act of April 5, 1978, ch. 738, 1978 Minn. Laws 838.

publicity generated by large damage claims.¹⁹⁴

D. Insurance Regulation

The 1986 legislature passed several insurance reporting and regulating provisions.¹⁹⁵ One provision requires liability insurers such as those providing medical malpractice coverage, to provide the Commissioner of Insurance with annual reports, including direct writings in Minnesota and the United States, direct premiums written, net investment income, incurred claims, reserves, actual increased expenses and net operation, and underwriting gains or losses. This measure increases the accountability of the professional liability insurer. Prior legislation already required Minnesota professional liability insurers to report, on a quarterly basis, any medical malpractice awards or settlements made on behalf of their insureds.¹⁹⁶ In addition, such insurers are required to report and maintain records of the subject doctors.¹⁹⁷ The pre-1986 legislation also provided for Attorney General investigations of those doctors as necessary.¹⁹⁸ Neither the newly enacted reporting measures or the previously existing statutes directly address a solution to the medical malpractice crisis, but rather, exist to

194. MINN. STAT. § 544.36 (1984). The statute provides:

In a pleading in a civil action which sets forth an unliquidated claim for relief, whether an original claim, cross-claim, or third-party claim, if a recovery of money is demanded in amount less than \$50,000, the amount shall be stated. If a recovery of money in an amount greater than \$50,000 is demanded, the pleading shall state merely that recovery of reasonable damages in amount greater than \$50,000 sought.

Id. A similar proposal was discussed by the Legislature in 1976, but was not passed. See Heins, *Statutory Changes in Minnesota Tort Law-1978*, HENNEPIN LAW., Sept.-Oct. 1978, at 6.

195. MINN. STAT. § 65A.32 (1984) (amended by section 42 of the bill to include liability and casualty insurers in the FAIR plan); MINN. STAT. § 70A.04, subd. 2 (market insurance rates); MINN. STAT. § 70A.06, subd. 1 (every licensed insurer must file rates with Commissioner before they may become effective and Commissioner may require supporting data); and MINN. STAT. § 70A.11, subd.1 (if Commissioner disapproves of rates, policy holder receives a refund plus interest).

196. MINN. STAT. § 147.111 (Supp. 1985). Subdivision 1 of section 147.11 provides:

Four times each year as prescribed by the Board, each insurer authorized to sell insurance described in Section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to physicians . . . against whom medical malpractice settlements or awards have been made to the plaintiff.

Id.

197. MINN. STAT. § 147.073 (1985).

198. *Id.*

provide the Insurance Commissioner and the public with information regarding the medical malpractice insurance industry, and a mechanism to identify incompetent physicians. Hopefully, the data gathered pursuant to these statutes will shed some light on the role that the insurance industry plays in the medical malpractice crisis.

In addition to the previously discussed reporting requirements, the 1986 legislative session renewed the Joint Underwriting Association Act (JUA).¹⁹⁹ The JUA provides that all insurers authorized to provide personal injury coverage in Minnesota fund an association created to provide professional liability insurance to health care providers unable to obtain insurance on the voluntary market.²⁰⁰ Acknowledging that the insurance crisis is more widespread than just medical malpractice, the legislators promulgated an all-purpose JUA to be used by "any person or entity" unable to obtain liability insurance through ordinary means.²⁰¹

V. THE NATIONAL RESPONSE

In response to the medical malpractice crisis, the "Medical Offer and Recovery Act" (Act) was introduced in Congress in the Spring of 1984.²⁰² The Act attempts to add uniformity to ad hoc state tort reforms. The Act is modeled after a proposal advanced by Professor Jeffrey O'Connell.²⁰³ It adopts a no-

199. S.F. No. 2078, *supra* note 152, § 15 (to be codified at MINN. STAT. §§ 62F.01-.14 (1986)).

200. *Id.* § 15 (to be codified at MINN. STAT. § 62F.02, subd. 1 (1986)).

201. *Id.* § 27 (to be codified at MINN. STAT. § 62I.08 (1986)).

202. H.R. 3084, 99th Cong., 1st Sess., *reprinted in* 131 CONG. REC. H3053 (1985). [hereinafter cited as H.R. 3084]. The Act was originally entitled "The Alternative Liability Act" and was introduced by Representatives W. Hensen Moore (R. La.) and Richard A. Gephardt (D. Mo.) to the House of Representatives. H.R. 5400, 98th Cong., 2d Sess. (1984). Senator David Durenburger (R. Minn.) introduced the Act to the Senate. S. 2690, 98th Cong., 2d Sess. (1984). Several bills were introduced into Congress as a result of the perceived "crisis." See Studley & Nye, *Federal Malpractice Bills*, in LEGISLATURE'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE, *supra* note 7, at 22.

203. O'Connell, *Offers That Can't be Refused: Foreclosure of Personal Injury Claims by Defendants Prompt Tender of Claimants' Net Economic Losses*, 77 Nw. U.L. REV. 589 (1983). O'Connell's proposal is intended to eliminate what he perceived as the three major problems with the present personal injury compensation system: (1) payment based on fault; (2) payment for pain and suffering; and (3) duplication of recovery because of the collateral source rule. O'Connell specifically recommends that the medical malpractice tort system be overhauled to (1) minimize litigation transaction costs which result from the complexity of proving and defining fault; (2) spread compensation to more victims by reducing their recovery; and (3) enforce internalization of the

fault scheme permitting a health care provider to extinguish a patient's common law remedy to sue in tort. The health care provider is allowed to promptly tender an offer to pay the patient's net economic losses once a patient makes a claim.²⁰⁴ The offer itself extinguishes the patient's access to the legal system, thereby giving the defendant the choice of implementing this Act, or utilizing the existing tort system.²⁰⁵ The advantages of this proposal to the defendant are that it relieves the defendant health care provider from paying any non-economic damages²⁰⁶ or amounts previously paid to the claimant through collateral sources,²⁰⁷ and that it eliminates the burdens and cost of complex, expensive litigation.

Under the Act, the patient must accept the tendered offer in total satisfaction of his personal injury claim, because once the offer is made, the patient is left with no other remedy. The Act specifically precludes claims for non-economic loss, loss of earning capacity,²⁰⁸ claims for wrongful death,²⁰⁹ and injuries intentionally inflicted by health care providers.²¹⁰

After the offer is made, the claimant is required to submit proof of wage loss and medical costs, including rehabilitation costs and replacement services resulting from the claimant's injuries.²¹¹ The claimant is compensated for 100% of his wage loss, reduced by any substitute work performed.²¹² The claimant is further compensated for products, services, and accommodations reasonably needed for medical care, remedial treatment, rehabilitation, and occupational training.²¹³ Replacement services are defined as reasonable expenses incurred by the patient's family in obtaining the ordinary and reasonable services that the patient provided to the family

costs of the system to those who actually caused the injuries—the health care providers. *Id.*

204. H.R. 3084, § 1821(a)(1)(A).

205. *Id.*

206. *Id.* § 1822(b)(3).

207. *Id.* (b)(4).

208. *Id.* (b)(3).

209. *Id.* § 1821(a)(1)(B)(ii).

210. *Id.* (a)(3). In the case of an intentionally inflicted injury, the injured individual may elect, within 90 days of the date of an offer tendered by a health care provider, to receive benefits under the Act within 90 days after the date of an offer tendered by a provider. *Id.*

211. *Id.* §§ 1822(d)(1)(2); 1823(a)(1)(A).

212. *Id.* § 1822(b)(2)(B).

213. *Id.*

before the personal injury.²¹⁴ The patient may receive services necessary to *treat* pain and suffering attributable to the injury, even though the Act does not provide compensation for pain and suffering.²¹⁵

The provider must pay the claimed amount within 30 days of the submission of proof of cost.²¹⁶ The amount paid is reduced by any funds recovered by the claimant from a collateral source.²¹⁷ Court approval is mandatory for settlements over \$5,000.²¹⁸ Additionally, a court will be consulted in the event of a dispute over issues involving discovery, physical or mental examinations, amount or type of compensation to be paid, or patient refusal to submit to a type of treatment or surgery recommended by the health care professional.²¹⁹

The Act encourages states to enact similar legislation. In the absence of a similar state law, the Act would apply to all federally funded health care programs, such as Medicare, Medicaid, and VA benefits. The Act further encourages states to establish assigned claims plans with participating insurance companies.²²⁰ Failure to do so permits the Secretary of Health & Human Services to maintain such a program within the state.²²¹

Although based on O'Connell's proposal, the Act implements all of the plaintiff-limiting elements, but does not provide a *quid pro quo* to balance the parties' interests.²²² The original proposal was amended in 1985 to incorporate two major provisions to alleviate that problem. First, absent any action by the defendant, the patient may initiate arbitration proceedings to determine whether the defendant should be required to pay economic losses.²²³ This determination is based on the fault, if any, of the defendant.²²⁴ This addition is an attempt to balance the decision-making power between the physician and the patient, giving the patient a means to trigger

214. *Id.* (b)(2)(C).

215. *Id.* (b)(1)(A).

216. *Id.* § 1823(a)(1)(A).

217. § 1822(b)(1).

218. *Id.* § 1825(a).

219. *Id.* § 1824(a)(2); *id.* (b)(1); *id.* (b)(3)(c).

220. *Id.* § 1826(b)(1).

221. *Id.* (b)(2).

222. § 1821(a)(1)(B).

223. *Id.*

224. *Id.*

his entry into the system.²²⁵ Second, if the patient refuses the defendant's offer to pay economic losses, the patient may sue in court, but for general damages only.²²⁶ In other words, the patient is no longer foreclosed from a common law remedy, but if the patient chooses the tort system, the patient loses the possibility of recovering economic damages. Conversely, if the patient accepts the offer, the patient foregoes the possibility of recovering non-economic damages. This latter change is based on the idea that once a patient has refused a defendant's offer to pay economic damages, he has "waived" compensation for those items.²²⁷

CONCLUSION

The excessive costs involved in medical malpractice litigation, both monetary and emotional, result from the parties' failure to work together toward their common goals. Doctors, insurance companies, and patients share common goals: to reduce the occurrence of medical malpractice; to adequately compensate victims of medical malpractice; and to decrease the costs of litigation and medical care. Each interest group, however, continues to vehemently advocate its own position, rather than pooling resources with the other groups. The problem should be approached with a more realistic attitude toward compromise. The new legislation in Minnesota appears to adopt a more realistic approach. The legislation, however, does not require compromise from all parties involved—notably physicians. Physician discipline was not addressed by the legislation. There is no question that medical negligence is occurring, yet none of the recently enacted legislation ad-

225. In O'Connell's proposal, the patient is guaranteed that if the defendant fails to tender an offer and the patient brings a lawsuit, the defendant-physician cannot assert any defenses based on the patient's fault. This proposal further enhances the patient's position by shifting the burden of proving "no fault" to the defendant-physician once the patient has established a prima facie case of liability.

226. This second change is most likely drawn from a suggestion by O'Connell that additional elements may be necessary to encourage the use of his new system and that adding a term such as the second one "would serve as further inducement to claimants with substantial economic losses to accept settlement. . . ." O'Connell, *supra* note 98, at 624.

227. Cf. Eisberg & Orenstein, *The Federal Alternative Medical Liability Act: Wrong Problem, Wrong Solution*, MINN. TRIAL LAW, Sept.-Oct. 1984 at 4; Orenstein, *Protecting Patient's Rights During the So-called Malpractice Crisis*, MINN. TRIAL LAW, May-June 1985 at 10.

dresses this aspect of the problem. Although many of the Minnesota Medical Malpractice Commission's recommendations became cornerstones for the recent state tort reform, the recommendations of the Commission addressing this issue were not adopted. Minnesota is not alone in its reluctance to address physician discipline. Virtually no effective physician disciplinary process is utilized in any of the states.

With time, the effect of the recent statutory changes on medical negligence litigation in Minnesota will be ascertainable. The information obtained by the Insurance Commissioner will help to assess the adequacy of the insurance market, and provide consistent accurate data with which to evaluate the effect of the legislative changes. The lack of objective data in the past has been a considerable stumbling block in analyzing the medical malpractice crisis. The absence of physician disciplinary measures, however, guarantees that the incidence of malpractice will not decline. This is the next area of tort reform which should be addressed by the legislature.

