Things To Do (or Not) To Address The Medical Malpractice Insurance Problem

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I. INTRODUCTION

On January 5, 2005, U.S. President George W. Bush stood before a carefully selected audience and the media in Collinsville, Illinois. On stage, dozens of medical doctors and other health care personnel in white lab coats stood behind him, implicitly sending the message that he was there to support the medical profession and they supported him. He had come to Collinsville to promote medical malpractice tort law reform, a priority of the Bush administration and many other groups. Collinsville was chosen as the site because it is located in Madison County, the county selected by the American Tort Reform Association as number one in the nation on its top-ten list of "judicial hell-holes" because of its alleged pro-plaintiff legal climate.[1] It was also chosen because Illinois legislators, in consultation

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with various interest groups, were then engaged in the work that would eventually lead to Senate Bill 475 (P.A. 94-677).

In his nationally-televised remarks, President Bush discussed various things that, in his view, would contribute to increased availability and reduced costs in the health care system.[2] Coming to tort litigation, he stated:

> Many of the costs that we're talking about don't start in an examining room or an operating room. They start in a courtroom. (Applause.) What's happening all across this country is that lawyers are filing baseless suits against hospitals and doctors. That's just a plain fact. (Applause.) And they're doing it for a simple reason. They know the medical liability system is tilted in their favor. (Applause.) Jury awards in medical liability cases have skyrocketed in recent years. That means every claim filed by a personal injury lawyer brings the chance of a huge payoff or a profitable settlement out of court. That's what that means. Doctors and hospitals realize this. They know it's expensive to fight a lawsuit, even if it doesn't have any merit. And because the system is so unpredictable, there is a constant risk of being hit by a massive jury award. So doctors end up paying tens of thousands, or even hundreds of thousands of dollars to settle claims out of court, even when they know they have done nothing wrong.[3]

He went on to assert, among other things:

- In 2003, almost half of all American hospitals lost physicians or reduced services because of medical liability concerns.[4]
- Over the past two years, the liability crisis has forced 160 physicians to leave Madison and St. Clair (Illinois) Counties.[5]

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appellate practice at the law school level for over 30 years, but I have also been involved in civil trial and appellate consulting during all that time, and my practice has included a number of professional negligence cases, including medical malpractice. The majority of my practice in this area has been on behalf of plaintiffs.

1. *Judicial Hellholes 2004,* (Am. Tort Reform Found., Dist. of Columbia) Dec. 2004, at 7, 14, *available at* http://www.atra.org/reports/hellholes/2004/hellholes 2004.pdf.

2. George W. Bush, President of the United States, Address in Madison County, (Jan. 5, 2005) transcript *available at* http://www.whitehouse.gov/news/releases.2005/01.200501054.html. [hereinafter Bush Address in Madison County].

3. *Id.*

4. *Id.*

- "Junk" lawsuits have forced medical doctors to practice defensive medicine, writing prescriptions or ordering tests that really aren't necessary, just to reduce the potential of a future lawsuit.[6]
- Specialists have stopped taking emergency room calls, and doctors turn away patients with complicated, life-threatening conditions because they carry the highest risk for a lawsuit.[7]
- Defensive medicine drains some $60 billion to $100 billion from the economy.[8]
- The tort liability system is "out of control."[9]
- Trial lawyers sometimes sue all the doctors involved in the patient's case even if most of the doctors have nothing to do with the patient's injuries. "It's simply unfair to punish doctors who have done nothing wrong."[10]

However, it turns out that to the extent that these factual assertions can be checked, they are either not supportable at all, or else the evidence is conflicting. In a book published December 1, 2005, The Medical Malpractice Myth, Professor Tom Baker of the University of Connecticut School of Law masterfully assembles the evidence that, in fact almost all of the claims made to support tort reform in the area of medical malpractice are not consistent with the empirical data.[11] Neil Vidmar, Professor of Social Science and Law, Duke Law School, and Professor of Psychology, Duke University, is one of those whose studies have shown that the premises used to sell tort reform — such as an "explosion" of claims and increases in the size of verdicts — lack substance.[12]

It is not the purpose of this article to rehash the existing data. When all is said and done, it is clear that whatever the reasons, there is a very real problem. In his Collinsville remarks, President Bush related anecdotal evidence of doctors and hospitals whose med mal insurance premiums had

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5. *Id.*
6. *Id.*
7. *Id.*
8. Bush Address in Madison County, *supra*, note 2.
9. *Id.*
10. *Id.*
11. TOM BAKER, THE MEDICAL MALPRACTICE MYTH 22-44, 68-92 (2005). One recent case contains a detailed review of this data. Ferdon ex rel. Petrucelli v. Wisconsin Patients Compensation Fund, 701 N.W.2d 440, 465-89 (Wis. 2005).
12. *See, e.g.*, NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS (1997); Neil Vidmar, *Medical Malpractice and the Tort System in Illinois*, 93 ILL. B.J. 340 (2005).

risen dramatically in a short time span: a neurosurgeon whose annual premiums in two years rose from $131,000 to $265,000; a cardiologist whose premiums had risen in three years from $12,500 to $60,000; a rural hospital that closed its obstetrical unit due to an increase in annual premiums from $150,000 to $270,000; a patient who had to change doctors three times because her OB/GYNs left Illinois to practice in another state where, presumably, insurance premiums were lower.[13]

Overall, the problem is probably not quite as bad as these anecdotes would suggest. On average, a physician's premium is only 3.2% of his or her income[14] and liability costs are somewhere in the general area of one percent of total health care costs.[15] But it seems beyond dispute that if a significant number of physicians, hospitals, and other health care providers are paying eye-popping liability insurance premiums that to some degree needlessly raise the cost or impair the availability of health care, something must be done to address this problem.

In his remarks, President Bush mentioned only two solutions specific to medical negligence liability: a $250,000 cap on non-economic damages and some unspecified "joint and several liability reform" — presumably, to limit or abolish joint and several liability.[16] Neither of these reforms is likely to have any significant effect on medical malpractice insurance premiums in Illinois.[17] But there are various other proposals for reform, most of which have not been tried, and in this article I will propose some old and some new ones.

It is vitally important to understand that there is no simple, quick fix. This problem has been with us for many years, and if there were a quick

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13. Bush Address in Madison County, *supra*, note 2.

14. MEDICARE PAYMENT ADVISORY COMMISSION PUBLIC MEETING (Dec. 12, 2002) *available at* http:// www.medpac.gov/public_meetings/transcripts/12%2002%20combinedtranscripts.pdf. However, the amount paid varies dramatically with both the state where the physician practices and his or her specialty. For example, recently in Texas the average rate for an OB/GYN was $92,000, but only $26,000 for an internist. But in Florida the average premium for an OB/GYN was $201,000. *See* UNITED STATES GENERAL ACCOUNTING OFFICE, PUB. NO. GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 13 (June 27, 2003), *available at* http://gao.gov/new.items/d03702.pdf.

15. *Id.*

16. Bush Address in Madison County, *supra*, note 2.

17. The relationship between caps and medical malpractice insurance premiums is tenuous at best. *See, e.g.*, BAKER, *supra*, note 11; UNITED STATES GENERAL ACCOUNTING OFFICE, PUB. NO. GAO-03-836, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 10-11 (2003), *available at* www.gao.gov/new.items/d03836.pdf. And in Illinois, joint and several liability is the rule in medical malpractice cases at the behest of the medical profession. *See* 735 Ill. Comp. Stat. 5/2-1118.

and simple solution — caps of non-economic damages, for example — it would have been implemented long ago and the problem would have been solved by now. It is a complicated problem and it will require a multifaceted approach to its solution. Based on our experience to date, it seems clear that we will need to attack this problem from many different directions. And solutions must be reality-based.

As others have noted,[18] it is remarkable that so much data has been accumulated that refutes the public perception that the tort liability system is "out of control," that lawsuit frequencies and recoveries are "skyrocketing," and that the system is awash in "frivolous" lawsuits, and yet these myths have endured. I am not aware of studies on this, but it seems that the most likely reasons for this paradox are closely related to the extent to which this issue has become politicized.

Law reform is usually left to lawyers, judges, and law professors to work out. But tort reform has been on the American political agenda for decades. There are multiple reasons for this, but the most important reason is that there are large dollars at stake. If tort liability can be restricted, the entities that have to pay most tort judgments and settlements — businesses and insurance companies — save money. So those interests tend to promote tort law "reform," which has become another name for changes in the rules of tort law and procedure that favor defendants. These interests tend toward the right side of the political spectrum, and so groups aligned with defense interests lobby and contribute money to political entities and politicians who will advance their interests, who are on the political right. Groups opposed to cutting back on tort liability — victims' rights groups, lawyers who usually or exclusively represent plaintiffs, and labor unions — cluster on the left side of the political spectrum. When issues become politicized, facts become less important than hyperbole, anecdotal evidence, and specious assertions. Especially in this area, people believe what they are predisposed to believe and are impervious to evidence or arguments that are inconsistent with strongly held beliefs or agendas.[19]

A recent example of the politicization of this issue can be seen in the 2004 election in southern Illinois' Fifth Judicial District for a vacancy on the Illinois Supreme Court. In the most expensive judicial election in U.S. history, Republican candidate Lloyd Karmeier, a Circuit Court judge, defeated Gordon Maag, the Democratic candidate, a justice of the Illinois Appellate Court. The Illinois Appellate Court, Fifth District includes Madison and St. Clair Counties, and historically, in most district-wide judicial elections, the Democratic candidate has won. And in most judicial elections, the public knows little about the race and tends to vote along

18. *See* BAKER, *supra*, note 11.
19. *Id.*

party lines. But in the 2004 election, tort reform, business, insurance, medical, and legal groups on the right side of the political spectrum contributed about four-and-one-half million dollars to Judge Karmeier's campaign.[20] Interests on the other side of the spectrum contributed a like amount to Justice Maag's campaign.[21] As a result, the media blitz on both sides brought this contest to the public's attention. A significant part of the message in support of Judge Karmeier was directed at controlling the "runaway" tort litigation "machine" in Madison and St. Clair Counties, thereby reducing medical malpractice costs and keeping doctors from leaving southern Illinois.

Judge Karmeier won and took his seat on the Illinois Supreme Court. Perhaps a study could be designed to try to determine, so far as possible, why the voters chose Judge Karmeier over Justice Maag.[22] It is certainly reasonable to speculate that they were voting in favor of "tort reform" as they understood it — that electing Judge Karmeier would somehow result in keeping doctors in Illinois and curtailing "frivolous" lawsuits. After all, that was the dominant message of Judge Karmeier's supporters, and, no doubt, the message that was conveyed at meetings and personal contacts throughout the campaign.

It is unfortunate that "tort reform" has become a politicized term. All of us — lawyers, judges, law teachers, and citizens — should be in favor of responsible tort reform, using that term in its apolitical and best sense. Tort law, like every other area of the law, is always in need of reform. Times change, conditions change, society changes, and those changes and new developments result in some of the old laws becoming obsolete or inequitable. Sometimes we just figure out how to do things better, faster, or cheaper. I have been teaching and writing about tort law and procedure since 1973, and I have practiced tort law and procedure in trial and appellate courts since 1969. It is my professional responsibility to promote

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20. *See* the Illinois Campaign for Political Reform website at http://www.ilcampaign.org/cgi-win/icpr_Filer.exe?id=8502&sYR=2004.

21. *Id.*

22. The Illinois Campaign for Political Reform conducted an interesting survey after the 2004 Illinois Supreme Court election. *See* Illinois Campaign for Political Reform, *Illinois Statewide Survey On Judicial Selection Issues, Winter 2004-2005, at* http://www.ilcampaign.org/issues/judicial/judicial_poll/FullJudicialSurvey.doc (last visited Mar. 20, 2006). About 85% of voters believe the decisions of Illinois judges are influenced by campaign contributors, political party leaders, and special interest groups, according to a recent public opinion poll. *Id.* at 23-25. Despite this sentiment and a belief that judicial election campaigns have become too expensive, the poll showed Illinois voters continue to support an elected, rather than appointed, judicial system. *Id.* at 13. The poll demonstrated strong support for limits on how much money can be contributed to judicial election campaigns, and slightly more than one-half of those polled said they would support the public financing of judicial campaigns. *Id.* at 55, 57.

law reform, just as it is the responsibility of every lawyer, judge, and law professor. We may disagree as to what form that "reform" should take, but, in the compromise of those differences, we should see positive change. That must be our continuing goal.

To accomplish meaningful tort reform, we must, insofar as possible, depoliticize the discussion and give obeisance to the facts. We could start by abolishing the word "frivolous" from the discussion. The data is overwhelming, and, in addition, every practicing tort lawyer knows to a certainty from personal experience — a truly frivolous medical malpractice lawsuit is as rare as Oprah in a Wal-Mart. State and federal law already contain provisions that punish frivolous filings. Moreover, contrary to President Bush's assertions, the data shows that insurance companies do not cave in and settle nuisance cases — or, for that matter, cases where liability is highly doubtful.

It appears that "frivolous" in the political jargon means a case or claim in which, ultimately, the claimant(s) received nothing. To a lawyer, "frivolous" means totally without merit — having a zero chance of success. The fact that a claimant ultimately lost says nothing about whether the claim was frivolous in that sense. Almost all claims or cases have a less-than-100% chance of success. That means your case can have a ninety or eighty or seventy percent chance of success and you still could lose. And what about cases that have a less than 50% chance of success? By whose standard? A case that has an objective 30% chance of success (if that can even be measured) can still be brought if the claimant reasonably believes that the case has merit. It is up to the factfinder and the litigation process to determine whether the claim has merit or not.

Moreover, in our system, a plaintiff's burden of proof is "more probably true than not true." That means that if the ultimate decisionmaker weighs the evidence and decides that the balance in favor of the plaintiff is greater than 50%, the plaintiff wins. Other factfinders could go the other way. The nature of our system is that we have to decide cases with less than perfect knowledge and less than perfect certainty. In many cases the claimant must file a claim or lawsuit to find out what really happened. In many of those instances, once the claimant gets that information, the claim is dropped. That doesn't mean the claim was frivolous.

In addition, we have a strong policy that the courts should be open to all who have or may have a legitimate claim. In furtherance of that policy, it is better to err on the side of the claimant and to allow the claimant to have his or her day in court, even if that claim might seem at first glance to be a "long shot." The system in its present form is quite capable of weeding out truly frivolous claims.

Since we have an adversarial system, it is not unusual for a professional health care provider who has been sued to reasonably believe that the claim is without merit, even while the claimant (or the claimant's lawyer)

reasonably believes the opposite. As human beings, we tend to perceive through the lens of our own interests, biases, and prejudices. In the case of a health care provider, such as a physician, being sued is particularly painful. For most professionals, their self-image and sense of self-worth is closely tied to their work. We naturally tend to deny and resist any attempt to accept blame for substandard professional work. This makes it natural for a defendant professional to view any problematic claim as "frivolous."

It is important, therefore, that we abandon the idea that the goal of tort reform is to rid the system of "frivolous" claims; that is not the problem. It is equally important that we are sensitive to the health care professional's natural tendency to regard many claims as without merit. We should also bear in mind that health care professionals do not like the idea that the competence and quality of their professional conduct can be judged by juries of ordinary citizens untrained in their profession. In this respect, health care professionals are no different than any other defendant sued for professional negligence. It would be a mistake to create a special liability system for health care professionals, but that is another article.

When we create or change a tort law or procedural rule to address this problem, we must necessarily decide if the new rule will apply generally or only to medical malpractice cases. Any attempt to modify existing tort law to create special rules applicable only to health care defendants is problematic, for at least two reasons. First, there is a point beyond which the courts will find an equal protection violation or other constitutional violation if the rules applicable to certain defendants, such as health care professionals or other health care providers, are significantly more favorable to them than the rules applicable to other defendants. Second, apart from any constitutional question, there is an issue of fundamental fairness within the tort system. Up to a point, differences between categories of defendants can be justified if there is a good external policy reason. In the case of health care defendants, that external justification is to foster the availability of vital services at reasonable cost — certainly a worthwhile value. However, if these defendants are too heavily favored, they may be perceived as unfairly given a "pass" and not being held accountable for their negligence.

II. REFORM: FEDERAL OR STATE?

Should medical malpractice tort law reform be carried out at the federal level, the state level, or both? In recent years, there has been a strong effort to enact medical malpractice rules at the federal level, in effect imposing uniform tort law rules on the states in this area. President Bush featured medical liability reform in his 2004 campaign, and a bill to cap non-economic damages at $250,000 passed in the U.S. House of Represen-

tatives but failed in the Senate.[23] In 2005, bills were introduced in Congress that would preempt existing state laws governing medical malpractice lawsuits with:

- $250,000 caps on noneconomic damages;
- A three-year statute of limitations coupled with a one-year discovery rule; the statute of limitations for children would run until age eight;
- Limits on plaintiffs' attorneys' fees whether in settlement or judgment;
- Collateral source benefits admissible in evidence;
- Periodic payments for future damages exceeding $50,000;
- Standard guidelines for awarding punitive damages (clear and convincing evidence) and limitations on the amount awarded;
- Prohibitions on instructing the jury about any limitations to damage awards;
- Punitive damages unavailable against the manufacturer or distributor of a medical product approved by the Food and Drug Administration.[24]

These provisions would preempt all state laws that do not conform. Although this legislation failed to pass both houses of Congress, in his Collinsville remarks, President Bush stated that efforts at the federal level

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23. The Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2004, H.R. 4280, 108th Cong. (2004), passed the House of Representatives by a margin of 229 to 197. *See* Final Vote Results for Roll Call 166, *available at* http://clerk.house.gov/evs/2004/roll166.xml (last visited Mar. 20, 2006). In 2003, the House of Representatives approved the same legislation — the HEALTH Act of 2003. *See House Gives Nod to Medical Liability Bill with Federal Caps on Noneconomic Damages*, [71 Health Care—Damages] U.S.L.W. 2586, 2587 (Mar. 18, 2003).

24. *See* National Conference of State Legislatures, *Medical Malpractice Tort Reform, at* http://www.ncsl.org/standcomm/sclaw/medmaloverview.htm (last visited Mar. 20, 2006) [hereinafter National Conference]. The U.S. House of Representatives passed the Help, Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2005 on July 28, 2005 by a vote of 230 to 194. H.R. 5, 109th Cong. (2005), *available at* http://thomas.loc.gov/cgi-bin/bdquery/z?d109:HR00005:@@@X%20& (bill summary and status) (last visited Mar. 20, 2006). The bill was referred to Senate Committee on the Judiciary on July 29, 2005, where it remains. *Id.*

will continue. President Bush pressed this issue in his 2006 State of the Union Address.[25]

At the same time, the states have been busily engaged in tort reform, primarily directed at medical malpractice cases. According to the National Conference of State Legislatures, in 2005 forty-eight states saw the introduction of over 400 bills intended to address the medical malpractice liability issue.[26] These bills featured solutions such as limits on non-economic damages, malpractice insurance reform, and gathering lawsuit claim data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. During the first half of 2005, over sixty bills were passed and signed into law in thirty-one states.[27] We can be sure that we have not seen the last of reform efforts at the state level.

In this writer's view, it would be a serious mistake to preempt the on-going reform efforts at the state level by enacting federal legislation.[28] As others and I have argued, reform in this area is a complex problem that will require a multifaceted approach. States are the ideal laboratories to try out different mixes of solutions. Without such ongoing experiments, we are unlikely to find the optimal blend.

Moreover, the proposed federal legislation is unlikely to achieve the desired goals — manageable premiums, early screening of dubious claims, alternate methods of dispute resolution, and reduction of medical errors. As has been shown, caps *per se* seem to have little or no effect on premiums, and arbitrarily limit the damages of the most-severely injured. To the extent that they discourage claims, caps do not discriminate against weak claims but rather tend to discourage meritorious claims with substantial non-economic loss where the economic damages are small. No one has shown that statutes of limitations and repose cannot be dealt with adequately at the state level. Limitations on plaintiffs' attorneys' fees are unfair without similar limitations on defendants' attorneys' fees, and, in fact, studies have shown that the average compensation per hour for plaintiffs' attorneys is about the same as that of defense attorneys. Thus, it appears that limitations on plaintiffs' attorneys' fees are being proposed for some other nefarious reason.

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25. "And because lawsuits are driving many good doctors out of practice — leaving women in nearly 1,500 American counties without a single OB/GYN — I ask the Congress to pass medical liability reform this year." George W. Bush, State of the Union Address By the President (Jan. 31, 2006), transcript *available at* http://www.whitehouse.gov/stateoftheunion/2006/index.html.

26. National Conference, *supra* note 24.

27. *Id.*

28. Assuming, for the sake of argument, that the federal law would be constitutional.

Collateral source reform acts at the opposite end of the spectrum, discouraging meritorious claims, large and small, where the economic damages are largely covered by collateral sources. Standards for, and limitations on, punitive damages are worthy objectives, but there is no justification for federalizing these rules for one class of cases. Punitive damages rules should be developed at the state level and should apply to all types of personal injury cases, not just medical malpractice.[29] Periodic payments of damages is also a desirable goal, but, again, this should be pursued at the state level and apply to a broader range of cases.[30]

Federal legislation can only stifle the development of truly effective solutions at the state level. The National Conference of State Legislatures and many other groups oppose reform at the federal level. Let us hope that the opposition succeeds.

III. STATE LEVEL REFORM

As we have seen, the majority of states already have enacted various measures aimed at reforming their medical malpractice compensation and insurance systems. It is, of course, valuable to see what solutions have caught the fancy of lawmakers in other states. However, that is not the purpose of this article, nor is it to propose solutions for all jurisdictions. In my view, each state must fashion its own mix of solutions unique to its legal and political situation. Therefore, this article, while it may be useful in other jurisdictions as well, will be focused on Illinois.

IV. TORT LAW AND PROCEDURAL REFORM IN ILLINOIS: WHERE WE ARE

Significant medical malpractice reform legislation was enacted in Illinois in 2005, generally known as Senate Bill 475 (P.A. 94-677).[31] This legislation will be discussed below. However, this legislation is only the most recent in a series of measures enacted over several decades. Some of these efforts were not specific to medical malpractice cases, instead reforming all of tort law and procedure primarily as applicable to personal injury and death cases. Other legislation targeted medical malpractice cases.

The prior statutes that were intended, in whole or in part, to address the perceived hardships of medical professionals and institutions include:

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29. For example, in Illinois, punitive damages are not available in a medical malpractice case. 735 ILL. COMP. STAT. 5/2-1115 (2004). Nationally, no evidence can be found that punitive damages are a significant problem in medical malpractice cases.

30. Illinois law provides for periodic payment of damages in medical malpractice cases in certain instances. *See* 735 ILL. COMP. STAT. §§ 5/2-1701 to 5/2-1719 (2004).

31. *See* S.B. 475, 94th Gen. Assemb. (Ill. 2005).

A. RESPONDENTS IN DISCOVERY

If a lawyer was consulted by a potential claimant in a potential medical malpractice (or other) case where the statute of limitations or repose was about to run, the lawyer may have had insufficient time to conduct discovery to determine with some degree of assurance which of various potential defendants were the appropriate party or parties to be sued. In that case, the lawyer had no choice but to join all potential defendants and then later dismiss those who were found, through discovery, to have no liability. Those defendants — especially medical professionals — were most unhappy when local newspapers reported that they had been sued for malpractice. The Illinois Civil Practice Act now provides that the plaintiff may designate persons as "respondents in discovery" who are believed to have information essential to the determination of who should properly be named as additional defendants.[32] These persons are required to respond to discovery and may be joined as a defendant within six months of having been named, even though the relevant time for joining them, the applicable statue of limitations or repose, has since expired.

B. PRAYER FOR RELIEF

Plaintiff's prayer for relief may not specify the amount of damages sought,[33] and cannot contain a prayer for punitive damages.[34] These provisions are also intended to prevent damaging publicity resulting from the mere filing of a complaint. Of course, in Illinois, punitive damages are not available in medical or legal malpractice cases.[35]

C. AFFIDAVIT OF MERIT

Since 1985, Illinois has required an affidavit of merit to be attached to the complaint in any action "whether in tort, contract or otherwise, in which the plaintiff seeks damages for injuries or death by reason of medical, hospital, or other healing art malpractice."[36] Section 622 of the Illinois Code of Civil Procedure was amended by Public Act 94-677 in various ways, none of which changed the basic thrust of the requirements, but did make them somewhat stricter than before.[37] The pre-2005 version of the statute was held constitutional in *DeLuna v. St. Elizabeth's Hospital*,[38] and

32. *See* 735 ILL. COMP. STAT. 5/2-402 (2004).
33. 735 ILL. COMP. STAT. 5/2-604 (2004).
34. 735 ILL. COMP. STAT. 5/2-604.1 (2004).
35. 735 ILL. COMP. STAT. 5/2-1115 (2004).
36. 735 ILL. COMP. STAT. 5/2-622(a) (amended 2005).
37. Pub. Act 94-677, 94th Gen. Assemb. (Ill. 2005).
38. DeLuna v. St. Elizabeth's Hosp., 588 N.E.2d 1139, 1147 (Ill. 1992).

there is no reason to believe that the 2005 amendments will change that result.

The affidavit[39] must state that a qualified health professional knowledgeable in the area, who practices or practiced in the area within the last five years, or teaches or taught in the area within the last five years, and meets the expert witness standards of section 8–2501, has reviewed the claim and found that there is "a reasonable and meritorious cause" for filing the action, and that the *affiant* [40] has also concluded that there is reasonable and meritorious cause for filing the action.[41] The reviewing professional must be licensed in the same profession as the defendant. An affidavit must be filed for each defendant in the case. The name, address, license number and state of licensure of the reviewing health professional must be included. The information given by the reporting physician may not be used to discriminate against the professional in the issuance of medical liability insurance or the setting of the professional's medical liability insurance premium. In addition, a reviewing health care professional has immunity from civil liability for any good faith statements in her report.[42]

If plaintiff's lawyer was unable to obtain the required consultation within the statute of limitations, he or she can file an affidavit to that effect, in which case the statute is stayed while the plaintiff attempts to obtain this report (up to ninety days).[43] Plaintiff's lawyer may also get a ninety-day extension by filing an affidavit that he or she was unable to get the necessary medical records in time, assuming they were properly requested and not furnished within 60 days of the request.[44] If the plaintiff intends to rely on res ipsa loquitur, the affidavit, the report, and the complaint must so specify, and the reviewing health care professional must support that claim.[45] If the plaintiff claims lack of informed consent, the plaintiff's attorney must certify that the reviewing health care professional endorses that claim.[46]

Untrue statements in the affidavit, made without reasonable cause, may result in sanctions against the attorney, the plaintiff, or both. Failure to file the requisite affidavit and report results in dismissal of the complaint.[47]

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39. Prior to Pub. Act 94–677, the requirement was a report, not an affidavit.
40. i.e., the plaintiff's attorney, or the plaintiff if he or she is proceeding pro se.
41. 735 ILL. COMP. STAT. 5/2-622(a) (amended 2005).
42. 735 ILL. COMP. STAT. 5/2-622(f) (amended 2005).
43. 735 ILL. COMP. STAT. 5/2-622(a) (amended 2005).
44. *Id.*
45. 735 ILL. COMP. STAT. 5/2-622(c) (amended 2005).
46. 735 ILL. COMP. STAT. 5/2-622(d) (amended 2005).
47. 735 ILL. COMP. STAT. 5/2-622(e) (amended 2005).

D. AFFIDAVIT OF NON-MERIT

The mirror image of section 622 is section 1010 of the Illinois Code of Civil Procedure.[48] Under this section, in any action in which the plaintiff seeks damages for injuries or death by reason of medical, hospital, or other healing art malpractice, a party may, in lieu of answering or otherwise pleading, file an affidavit certifying that he or she was not directly or indirectly involved in the occurrence or occurrences alleged in the action, and request dismissal of the certifying party.[49] Any party may oppose the dismissal or move to vacate the order of dismissal and reinstate the certifying party if he or she can show that the certifying party was directly or indirectly involved in the occurrence or occurrences alleged in the action.[50] The party opposing the dismissal may, after the filing of an affidavit under this section, have discovery with respect to the involvement or noninvolvement of the party filing the affidavit, provided that such discovery is completed within sixty days of the filing of such affidavit.[51] It does not appear that the constitutionality of this provision has been tested.[52]

E. REVIEW PANEL

Public Act 84–7, which became law in 1985, amended and added various provisions of the Illinois Civil Practice Law, all dealing with "healing art malpractice."[53] Among other things, this statute established a system of review panels, provided for the periodic payment of future damages, modified the collateral-source rule, prohibited certain awards of punitive damages, and limited the amounts of contingent fees.[54] The sections dealing with review panels (sections 2–1012 to 2–1020 of the Civil Practice Act) provided a procedure for pre-trial review of cases of healing art malpractice.[55] Under this legislation, as a prerequisite to trial in a case for healing-art malpractice, a panel composed of a circuit judge, a practicing attorney, and a health-care professional had to convene and make a determination regarding liability and, if liability is found, damages.[56] Procedures were set out for maintaining rosters of judges, attorneys, and

48. 735 ILL. COMP. STAT. 5/2–1010 (2004).
49. 735 ILL. COMP. STAT. 5/2–1010(a) (2004).
50. 735 ILL. COMP. STAT. 5/2–1010(b) (2004).
51. *Id.*
52. In *Williams v. Davet*, the court applied this provision and held that the trial court erred in not dismissing a defendant who filed the requisite affidavit. No constitutional issues were raised. 802 N.E.2d 1255 (Ill. App. Ct. 1st Dist. 2003).
53. Pub. Act 84-7, 84th Gen. Assemb. (Ill. 1985).
54. *Id.*
55. *Id.*
56. *Id.*

health-care professionals from which the parties select the panel members.[57] The parties could agree to forgo the panels and proceed directly to trial, but all parties had to agree to do so.[58]

The panel proceedings were adversarial in nature. The parties and the panel could call and examine witnesses.[59] The judicial member of the panel was to preside over the proceedings and determine "all questions of law, including matters of evidence."[60] Following the hearing, the panel was to render a written decision, with questions of law determined by the judge and questions of fact determined by the panel as a whole.[61] The parties could unanimously agree to be bound by the panel's decision, and in that event, the decision of the panel would be conclusive and judgment would be entered on it.[62] Otherwise, if the panel's decision was unanimous, a party had to make a written acceptance or rejection of it; failure to reject the decision within twenty-eight days is deemed to be an acceptance of it, and, if all the parties accepted the decision, judgment would be entered on it.[63] If the parties had not agreed to be bound by the panel's decision or did not unanimously accept it, then the panel judge was to conduct a pretrial conference; following that, the matter proceeded to trial, as in any other case. The judge who presided over the panel could not preside at trial, and the panel's decision was not admissible at trial.[64] A party who rejected a unanimous decision by the review panel and who did not prevail on the issue of liability at trial would be liable for "the costs, reasonable attorneys' fees and expenses" of the prevailing party.[65]

The constitutionality of Public Act 84-7 came before the Illinois Supreme Court in *Bernier v. Burris*.[66] The court first rejected application of a "strict scrutiny" test.[67] Finding that no suspect or quasi-suspect classification was implicated, the court held that the "rational basis" test applied, and the appropriate standard for determining the plaintiff's challenges under the due process and equal protection provisions of the "Illinois and Federal constitutions is whether the legislation bears a rational relationship to a legitimate governmental interest."[68]

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57. ILL. REV. STAT. Ch. 110, paras. 2–1014, 2–1015 (1985).
58. ILL. REV. STAT. Ch. 110, para. 2–1012 (1985).
59. ILL. REV. STAT. Ch. 110, para. 2–1016(b) (1985).
60. ILL. REV. STAT. Ch. 110, para. 2–1016(a) (1985).
61. ILL. REV. STAT. ch. 110, para. 2–1017(a) (1985).
62. ILL. REV. STAT. ch. 110, para. 2–1018(a) (1985).
63. ILL. REV. STAT. ch. 110, para. 2–1018(b) (1985).
64. ILL. REV. STAT. ch. 110, para. 2–1018(d) (1985).
65. ILL. REV. STAT. ch. 110, para. 2–1019(c) (1985).
66. Bernier v. Burris, 497 N.E.2d 763 (Ill. 1986).
67. *Id.* at 768.
68. *Id.*

Ten years earlier, a similar screening panel provision in a comprehensive tort reform package was found unconstitutional in *Wright v. Central Du Page Hospital Association*.[69] The provisions considered in *Wright* similarly provided for three-member panels, composed of a circuit judge, an attorney, and a physician, to consider evidence and render a decision in actions for medical malpractice.[70] *Wright* found that the panel procedures violated provisions in the Illinois Constitution concerning the source of the judicial power and the jurisdiction of the circuit courts.[71] *Wright* also held that because the panel procedures violated those provisions, they were an unconstitutional burden on the right to a jury trial.[72]

The defendants in *Bernier* attempted to distinguish the panel procedures at issue in that case from those that were found unconstitutional in *Wright*. In *Wright*, the judicial member of the panel was to determine all procedural issues, including matters of evidence, and the law of evidence was to be followed unless the panel in its discretion determined otherwise.[73] Under the provisions at issue in *Bernier*, the judge on the panel was to determine all questions of law, including matters of evidence, and the law of evidence was to be followed, as determined by the judge.[74] Also, the provisions considered in *Wright* said simply that the panel was to make its decision according to the applicable substantive law and that the written decision was to contain the panel's conclusions of fact and law.[75] The corresponding provision at issue in *Bernier* provided that the panel is to make its decision according to the substantive law as determined by the judge, and that the panel's written decision is to contain the judge's conclusions of law and the panel's conclusions of fact.[76] Thus, under the statute at issue in *Bernier*, unlike the statute invalidated in *Wright*, the judicial member of the panel was the sole authority over legal issues. Nevertheless, the court in *Bernier* found that this was not enough to save the statute. According to the court, the problem in *Wright* — that the judicial member of the panel was forced to share his authority with the nonjudicial members — did not arise simply because the panel as a whole made legal and factual determinations.[77] Rather, the court in *Wright* was concerned that the nonjudicial members of the panel were given a judicial role, and the court there noted that the nonjudicial members of the panel

69. Wright v. Cent. Du Page Hosp. Ass'n, 347 N.E.2d 736 (Ill. 1976).
70. ILL. REV. STAT. ch. 110, paras. 58.2 - .10 (1975).
71. ILL. CONST. art. VI, §§ 1, 9.
72. ILL. CONST. art. I, § 13.
73. ILL. REV. STAT. ch. 110, para. 58.6(1) (1975).
74. ILL. REV. STAT. ch. 110, para. 2-1016(a) (1985).
75. ILL. REV. STAT. ch. 110, para. 58.7(1) (1975).
76. ILL. REV. STAT. ch. 110, para. 2-1017(a) (1985).
77. *Wright*, 347 N.E.2d at 740.

could make determinations, either legal or factual, contrary to those reached by the judge.[78] For that reason, the court found that the nonjudicial members of the panel were empowered to exercise a judicial function in violation of sections 1 and 9 of article VI of the Illinois Constitution.[79]

The court in *Bernier* found that the same problem inhered in the panel procedures at issue, and therefore the panel procedure of P.A. 84–7 was similarly unconstitutional.

> Under these provisions, the role of the judicial member of the panel must take one of two forms. Either he serves on the panel in his judicial capacity but is forced to share, with the two nonjudicial members, his judicial authority to make factual determinations, or he is denied his judicial authority and has no greater authority than the two other panel members. Neither alternative is suitable. Notably, statutes calling for the creation of three-member panels of circuit judges to carry out various functions have been held unconstitutional on the grounds that the legislature lacks the authority to create a new court and circuit judges do not act jointly or in a group. . . . If a panel of three circuit judges cannot operate constitutionally, it is difficult to see how a panel consisting of one circuit judge and two laymen can. In essence, the panel procedures at issue here do not adequately distinguish between the judicial and nonjudicial members; their fact-finding functions are still blended, as they were in Wright, and the circuit judge's fact-finding and decision-making authority is shared between the judge and the nonjudicial panel members.[80]

This part of the statute was repealed in 1990.[81]

F. INSTALLMENT PAYMENT OF JUDGMENTS

Public Act 84-7 also amended the Civil Practice Act to allow either party in a medical malpractice action to elect to have future damages paid in annual installments.[82] Under the statute as it existed prior to 2005, the election must be made prior to trial.[83] The details of these provisions are

78. *Id.*
79. *Id.*
80. *Bernier*, 497 N.E.2d at 770–71.
81. Repealed by Pub. Act 86-1028, Art. III, § 3-34, eff. Feb. 5, 1990.
82. The statute is currently Healing Art Malpractice Act of 1985, 735 ILL. COMP. STAT. 5/2–1701 to 5/2–1719 (2004).
83. 735 ILL. COMP. STAT. 5/2–1705 (2004).

not important here.[84] What is significant for our purposes is that these provisions were held constitutional in *Bernier*,[85] and they remain in place today.

G. COLLATERAL SOURCE RULE

Public Act 84-7, and its 1976 predecessor,[86] also modified the common-law collateral source rule.[87] Under the traditional collateral source rule, amounts received by the plaintiff from "collateral" sources (that is, sources not attributable to the defendant, such as the plaintiff's first-party insurance, employment benefits or governmental benefits) that overlap or duplicate damages recoverable from the defendant do not reduce the plaintiff's recovery.[88] In other words, even though the plaintiff is being compensated by the defendant for losses for which the plaintiff has already been reimbursed, the plaintiff and not the defendant is given the benefit of that reimbursement from a third party. The jury is not told about the third party, collateral source benefits, and the plaintiff may claim, for example, medical expenses, even though those expenses were paid by the plaintiff's own insurance or benefit plan.

Under this provision, now section 2–1205 of the Civil Practice Act, if the plaintiff recovers a judgment against a "licensed hospital or physician," a judgment may be partially reduced by benefits received from collateral sources.[89] Originally this provision allowed for the deduction of 50% of the benefits received for lost wages, from private or governmental disability programs, or for medical, hospital, nursing, or caretaking charges to 100%.[90] Public Act 84-7 also added language prohibiting reductions "for charges paid for medical expenses which were directly attributable to the adjudged negligent acts or omissions of the defendants found liable," and the statute now provides that the judgment is to be increased by the amounts paid in the two preceding years for premiums or other costs associated with obtaining the collateral benefits.[91] No reduction is made to the extent that the third party collateral source has a right of recoupment through subrogation, trust agreement, lien, or otherwise.[92] In addition, the

84. *See* JEROLD S. SOLOVY, ET AL., 4A ILL. PRAC., ILLINOIS CIVIL LIT. GUIDE §§ 7:25 to 7:43 (2004 ed.).
85. *Bernier*, 497 N.E.2d at 770–74.
86. ILL. REV. STAT. 1977, ch. 110, para. 68.4.
87. 735 ILL. COMP. STAT. 5/2–1205 (2004).
88. *See* RESTATEMENT (SECOND) OF TORTS § 920A (1979).
89. 735 ILL. COMP. STAT. 5/2-1205 (2004).
90. *Id.*
91. *Id.*
92. 735 ILL. COMP. STAT. 5/2-1205(2) (2004).

reduction cannot reduce the total judgment by more than 50%.[93] The court in *Bernier* sustained the constitutionality of this provision against attacks based on equal protection and special legislation grounds, and also rejected an attack based on an alleged conflict between this provision and the federal Social Security Act.[94]

H. PUNITIVE DAMAGES ABOLISHED

Public Act 84–7 enacted a provision, now section 2–1115 of the Code of Civil Procedure,[95] which provides: "In all cases, whether in tort, contract or otherwise, in which the plaintiff seeks damages by reason of legal, medical, hospital, or other healing art malpractice, no punitive, exemplary, vindictive or aggravated damages shall be allowed."[96] The court in *Bernier* sustained this provision, rejecting claims that it violated constitutional due process and equal protection provisions and constituted special legislation.[97]

I. PLAINTIFF'S ATTORNEYS' FEES

Public Act 84–7 also established a sliding scale of the allowable fees that an attorney may charge in representing a plaintiff in a medical malpractice action.[98] The provision defines a contingent fee as "any fee arrangement under which the compensation is to be determined in whole or in part on the result obtained" and provides that it may not exceed one-third of the first $150,000 recovered, one fourth of the next $850,000 recovered, and one fifth of any amount over $1 million.[99] In determining any lump sum contingent fee, any future damages recoverable by the plaintiff in periodic installments shall be reduced to a lump sum value.[100] The statute also provides that the trial court may review contingent fee agreements for fairness. "In special circumstances, where an attorney performs extraordinary services involving more than usual participation in time and effort the attorney may apply to the court for approval of additional compensation."[101]

The *Bernier* decision sustained this provision, reversing the trial court's determination that it violated "the separation-of-powers clause by invading the authority of the judicial branch to oversee the activities of attorneys, that it violated due process, that it may deny plaintiffs access to

93. 735 ILL. COMP. STAT. 5/2-1205(3) (2004).
94. *Bernier*, 497 N.E.2d at 774-76.
95. 735 ILL. COMP. STAT. 5/2–1115 (2004).
96. *Id.*
97. *Bernier*, 497 N.E.2d at 776-77.
98. Currently 735 ILL. COMP. STAT. 5/2–1114 (2004).
99. 735 ILL. COMP. STAT. 5/2–1114(a) (2004).
100. 735 ILL. COMP. STAT. 5/2–1114(b) (2004).
101. 735 ILL. COMP. STAT. 5/2–1114(c) (2004).

the courts, and that it constituted special legislation and violated principles of equal protection."[102]

J. RES IPSA LOQUITUR

The Civil Practice Act codifies a version of res ipsa loquitur applicable in cases of "alleged medical or dental malpractice."[103] The codification is essentially the same as the common-law doctrine.[104]

K. STATUTES OF LIMITATIONS AND REPOSE

Special statutes of limitations and repose apply to action for damages for injury or death against "any physician, dentist, registered nurse or hospital . . . arising out of patient care."[105] There is a two-year limitation period based on the discovery rule and a four-year statute of repose. If the person entitled to bring the action was under the age of 18 when the cause of action accrued, then the plaintiff has eight years from the date of the "act or omission or occurrence" that gives rise to the cause of action, but in no event can the cause of action be brought after that person's 22nd birthday.[106] The Illinois Supreme Court held this statute constitutional in 1979.[107]

L. EXPERT WITNESS STANDARDS

Beginning in 1985, the Code of Civil Procedure introduced criteria to be used by the trial court in determining whether a proposed expert witness qualifies as an expert and can testify "on the issue of the appropriate standard of care."[108] Although this statute is not limited on its face to medical negligence cases, it applies to cases in which "the standard of care given by a medical profession[al] is at issue,"[109] and those will almost always be medical malpractice cases.

Prior to the 2005 amendments, the statutory standards were:

> (a) Relationship of the medical specialties of the witness to the medical problem or problems and the type of treatment administered in the case;

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102. *Bernier*, 497 N.E.2d at 777.
103. 735 ILL. COMP. STAT 5/2–1113 (2004).
104. *See* Walker v. Rumer, 381 N.E.2d 689 (Ill. 1978).
105. 735 ILL. COMP. STAT. 5/13–212(a) (2004).
106. 735 ILL. COMP. STAT. 5/13–212(b) (2004).
107. Anderson v. Wagner, 402 N.E.2d 560, 562-72 (Ill. 1979).
108. 735 ILL. COMP. STAT. 5/8–2501 (2004).
109. *Id.*

> (b) Whether the witness has devoted a substantial portion of his or her work[110] time to the practice of medicine, teaching or University based research in relation to the medical care and type of treatment at issue which gave rise to the medical problem of which the plaintiff complains;
>
> (c) whether the witness is licensed in the same profession as the defendant; and
>
> (d) whether, in the case against a nonspecialist, the witness can demonstrate a sufficient familiarity with the standard of care practiced in this State.[111]

The 2005 amendment strengthened the first standard, concerning the relationship between the expert's specialty and the medical issues in the case, as follows: "Whether the witness is board certified or board eligible, or has completed a residency, in the same or substantially similar medical specialties as the defendant and is otherwise qualified by significant experience with the standard of care, methods, procedures, and treatments relevant to the allegations against the defendant."[112] It also amended subsection (c) to read, "whether the witness is licensed in the same profession with the same class of license as the defendant if the defendant is an individual."[113]

Although the trial court has some discretion in the application of these standards, it is undoubtedly a narrowly bounded discretion. The purpose, of course, is to prevent a plaintiff in a medical malpractice case from getting to the jury through an expert witness who is not a "real" expert in the field, such as one who is not board certified in the same field as the defendant, or who is a professional expert witness.

M. JOINT AND SEVERAL LIABILITY

Calls for medical malpractice tort reform usually include a plea to abolish joint and several liability and replace it with several liability. Under the traditional form of joint and several liability, if more than one defendant is found liable to the plaintiff, judgment is entered against all defendants in the full amount of the plaintiff's damages, and plaintiff can satisfy his judgment in whole or in part from any or all of the defendants found liable. Of course, the plaintiff is entitled to only one satisfaction. As a practical

110. 735 ILL. COMP. STAT. 5/8-2501 (amended 2005).
111. 735 ILL. COMP. STAT. 5/8–2501 (2004).
112. 735 ILL. COMP. STAT. 5/8-2501 (amended 2005).
113. *Id.*

matter, now that contribution is routinely available, a defendant who has had to pay more than its proportionate share of the damages can recover the excess from the other defendants who have paid less, if they have the resources. This has the effect of shifting the risk of uncollectibility to the defendants. If all defendants are collectible, then after adjustments through the mechanism of contribution, each defendant will wind up paying no more than its proportionate share.

Under several liability, if two or more joint tortfeasors are found liable to the plaintiff, judgment is entered against each liable defendant only in proportion to that defendant's share of the total fault. For example, under several liability, judgment will be entered against a defendant whose share of the total fault is 30% for only 30% of the plaintiff's damages, leaving the plaintiff to collect the rest (if she can) from the other liable defendants. Thus, several liability shifts the risk of uncollectibility to the plaintiff.

Today, some jurisdictions have retained traditional joint and several liability for all cases, some have adopted several liability for all cases, but about half of U.S. jurisdictions (including Illinois) have compromised between the two and have adopted some hybrid form, incorporating aspects of both.[114] Illinois' hybrid, in my view, is one of the best.[115] In most cases, the statute provides:

> [a]ll defendants found liable are jointly and severally liable for plaintiff's past and future medical and medically related expenses. Any defendant whose fault, as determined by the trier of fact, is less than 25% of the total fault attributable to the plaintiff, the defendants sued by the plaintiff, and any third party defendant except the plaintiff's employer, shall be severally liable for all other damages. Any defendant whose fault, as determined by the trier of fact, is 25% or greater of the total fault attributable to the plaintiff, the defendants sued by the plaintiff, and any third party defendants except the plaintiff's employer, shall be jointly and severally liable for all other damages.[116]

This has the effect of retaining joint and several liability as to all defendants whose share of the total fault (as defined) is 25% or greater, but making those defendants whose share of the total fault is less than 25% only severally liable.

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114. *See* Edward J. Kionka, *Recent Developments in the Law of Joint and Several Liability and the Impact of Plaintiff's Employer's Fault*, 54 LA. L. REV. 1619, 1630-34. (1994).

115. *See* 735 ILL. COMP. STAT. 5/2–1117 to 2-1118 (2004).

116. *See* 735 ILL. COMP. STAT. 5/2–1117 (2004).

The interesting thing about Illinois, however, is that the next section of the statute[117] provides: "Notwithstanding the provisions of Section 2–1117, in any medical malpractice action, as defined in Section 2–1704, based upon negligence, any defendants found liable shall be jointly and severally liable."[118] One might wonder, why would medical malpractice cases be an exception to the general rule, such that traditional joint and several liability applies to all defendants regardless of how small a given defendant's share of the fault might be?

The answer is that the medical profession itself sought this exception. In medical negligence cases involving multiple defendants, a given defendant did not want to be put in the position of arguing in favor of a high degree of liability for other defendants in order to minimize that defendant's share of the fault. If Illinois' hybrid rule applied, a defendant whose share would arguably be low would necessarily have to attempt to shift the blame to the other defendants in order to try to come in under the 25% threshold and thereby reduce his or her damages exposure. The medical professionals want to be able to present a united defense, arguing nonliability as to all defendants. In addition, since defendants in medical negligence cases are typically insured, frequently by the same insurance company, or are otherwise collectible, several liability offers them no advantage over traditional joint and several liability. Following payment of the judgment and adjustment based on contribution, all defendants will wind up paying no more than their proportionate share of the total liability anyway.

Thus, barring some unforeseen change of position by Illinois' medical professionals, the tort reformers' plea for a shift to several liability in medical negligence cases will likely continue to be rejected in Illinois. The issue has already been addressed. It was not included in the 2005 tort reform package, Public Act 94–677, suggesting that there was no perceived need to revisit this issue at this time.[119]

V. PUBLIC ACT 89-7

Public Act 89–7, a comprehensive tort reform bill, became effective on March 9, 1995. This Act was not specifically directed toward medical malpractice cases; it applied to tort-based personal injury and death cases

117. 735 ILL. COMP. STAT. 5/2–1118 (2004). The special rule for medical malpractice and toxic tort cases, retaining pure joint and several liability, was found constitutional in *Unzicker v. Kraft Food Ingredients Corp.* 783 N.E.2d 1024, 1039-41 (Ill. 2002).

118. 735 ILL. COMP. STAT. 5/2–1118 (2004).

119. Bills to change Illinois to pure several liability across the board are currently pending in the Illinois General Assembly, but their passage is doubtful. H.B. 4981, S.B. 2893, 94th Gen. Assemb. (Ill. 2005).

generally. But several of its provisions were fully applicable in medical negligence cases. These included (1) a $500,000 cap on compensatory damages for non-economic injuries,[120] (2) allocation of fault and several liability provisions,[121] (3) amendments to the Joint Tortfeasor Contribution Act,[122] and (4) certain jury instructions.[123] In *Best v. Taylor Machine Works*,[124] the Illinois Supreme Court held Public Act 89–7 unconstitutional in its entirety. Although the *Best* decision moots the reforms in P.A. 89–7, we will focus on the caps provision because the 2005 tort reform bill, Public Act 94–677, includes a new version of non-economic damages caps.

A. THE $500,000 CAP

The most important feature of Public Act 89-7 was the $500,000 cap on non-economic damages.[125] The cap was premised on certain legislative findings: (1) limiting non-economic damages will improve health care in rural Illinois; (2) more than 20 states limit non-economic damages; (3) the cost of health care has decreased in those states; (4) non-economic losses have no monetary dimension, and no objective criteria or jurisprudence exists for assessing or reviewing non-economic damages awards; (5) such awards are highly erratic and depend on subjective preferences of the trier of fact; (6) highly erratic non-economic damages awards subvert the credibility of such awards and undercut the deterrent function of tort law; (7) such awards must be limited to provide consistency and stability for all parties and society; and (8) "a federal executive branch working group" determined that limiting non-economic damages was the most effective step toward legislative reform of tort law because it reduces litigation costs and expedites settlement.

In addition to the above legislative "findings," the preamble to Public Act 89–7 posits certain legislative "purposes" which relate to the limit on non-economic damages. These stated purposes are: to reduce the cost of health care and increase accessibility to health care; to promote consistency in awards; to reestablish the credibility of the civil justice system; to establish parameters or guidelines for non-economic damages; to protect the economic health of the state by decreasing systemic costs; and to ensure the affordability of insurance.[126]

120. 735 ILL. COMP. STAT. 5/2–1115.1 (2004).
121. 735 ILL. COMP. STAT 5/2–1116 to 2-1117 (2004).
122. 740 ILL. COMP. STAT 100/3.5 to 5 (2004).
123. 735 ILL. COMP. STAT 5/2–1107.1 (2004).
124. Best v. Taylor Machine Works, 689 N.E.2d 1057 (Ill. 1997).
125. 735 ILL. COMP. STAT 5/2-1115.1 (2004).
126. Pub. Act 89-7, 89th Gen. Assemb. (Ill. 1990).

The preamble also declares, "It is the public policy of this State that injured persons injured through negligence or deliberate misconduct of another be afforded a legal mechanism to seek compensation for their injuries."[127]

It is apparent that most of these "findings" are not facts but matters of opinion that are hotly contested in every tort reform debate. Even the alleged "facts" — such as that the cost of health care has decreased in states with caps on non-economic damages — are not supported by the data, and even if they are shown to be true in a specific instance, it remains to be shown whether the reason for the decrease is the imposition of caps. In any event, notwithstanding these "findings," the Illinois Supreme Court concluded that the cap in P.A. 89–7 violated the special legislation clause of the Illinois Constitution,[128] and also violated the separation of powers clause[129] because it invaded the power of the courts to limit excessive awards of damages, a power it found to be unique to the judiciary.[130]

The plaintiffs in *Best* supported their attack on the "findings" by affidavits and other empirical evidence showing that there is no reliable evidence proving that a limit on non-economic damages corresponds to a significant impact on the cost or availability of health care or that non-economic damages and the costs of liability insurance are directly linked.[131] In fact, court filings in the law division of the Circuit Court of Cook County actually declined from 1980 to 1994.[132] The plaintiffs' submissions also showed that the other supposed effects of caps were speculative or based on anecdotal evidence.

The court discussed its previous decision in *Wright v. Central Du Page Hospital Ass'n*,[133] in which it invalidated a $500,000 cap on non-economic damages that was limited to medical malpractice cases. In *Wright*, the limitation on compensatory damages in medical malpractice actions was determined to be arbitrary and a special law in violation of the special legislation clause of the Illinois Constitution. The damages limit conferred a special privilege on medical malpractice tortfeasors by insulating them from fully compensating plaintiffs for fairly assessed damages. Consequently, relief to an injured plaintiff depended solely on an arbitrary classification, in violation of the prohibition against special legislation.[134] It would, of course, have been possible for the supreme court

127. *Id.*
128. ILL. CONST. of 1970, art. IV, § 13.
129. ILL. CONST. of 1970, art. II, § 1.
130. ILL. CONST. of 1970, art. VI, § 1.
131. *Best*, 689 N.E.2d at 1068.
132. *Id.*
133. *Wright*, 347 N.E.2d 736 (Ill. 1976).
134. *Id.*

in *Best* to distinguish the *Wright* case on the ground that a cap applicable only to health care professionals and hospitals was different from a cap applicable generally to all tortfeasors. But it did not, finding that even the broader-based cap in P.A. 89–7 was unconstitutionally discriminatory because of its disparate impact on different plaintiffs whose claims to non-economic damages were indistinguishable. We will consider the *Best* court's rationale again in reference to P.A. 94–677.

B. JOINT AND SEVERAL LIABILITY REVISITED

Public Act 89–7 also substituted the pure form of several liability for Illinois' hybrid form of joint and several liability referred to above in all personal injury and death actions.[135] A defendant found liable was

> severally liable only for that proportion of recoverable economic and non-economic damages, if any, that the amount of that defendant's fault, if any, bears to the aggregate amount of fault of all other tortfeasors, as defined in Section 2-1116, whose fault was a proximate cause of the death, bodily injury, economic loss, or physical damage to property for which recovery is sought.[136]

Interestingly, subsection (b) of this provision preserved joint and several liability as to health care defendants if the caps on non-economic damages were found to be invalid.[137]

The Illinois Supreme Court in *Best* invalidated the amendment to section 2–1117, instituting pure several liability but excepting medical malpractice plaintiffs, on the ground that the exception for medical malpractice cases was not rational and therefore created an improper classification, in violation of the special legislation prohibition. Then, having invalidated subsection (b), the court found that subsection (a), which imposed pure several liability as to all other defendants, could not stand because it could not be severed from subsection (b). Without (b), (a) no

135. 735 ILL. COMP. STAT. 5/2–1117 (2004).

136. *Id.*

137. 735 ILL. COMP. STAT. 5/2–1117(b) (2004):

> (b) Notwithstanding the provisions of subsection (a), in any healing art malpractice action based on negligence or wrongful death, any defendants found liable shall be jointly and severally liable if the limitations on non-economic damages in Section 2–1115.1 of this Act are for any reason deemed or found to be invalid.

Id.

longer reflected the legislative intent regarding joint and several liability, and therefore the entire section was unconstitutional.[138]

Since the court invalidated the shift to several liability in P.A. 89–7 on rather narrow grounds, the possibility remains open that a properly drafted statute establishing several liability across the board would pass constitutional muster. About a dozen states have done just that.[139] Nevertheless, as previously noted, the issue does not appear to be "hot" at present.

C. MEDICAL RECORDS DISCLOSURE

Public Act 89–7 also contained a provision imposing a mandatory consent requirement by which every patient who files a personal injury lawsuit was deemed to agree to the unlimited disclosure of his or her entire medical history, records, and other medical information to any party who has appeared in the action and who requests that information.[140] This provision had already been struck down in a companion case, *Kunkel v. Walton*,[141] primarily on separation-of-powers grounds. The court in *Best* reaffirmed its holding in *Kunkel*, finding that the statute was in fatal conflict with Illinois Supreme Court rules dealing with discovery.[142] The court also found that the Illinois Constitution's right to privacy was violated by a provision that gave any litigant access to a patient's confidential medical records unrelated to the subject matter of plaintiff's lawsuit.[143] A plaintiff-patient does not, by the simple act of filing suit, consent to *ex parte* discussions between his treating doctor and defense counsel, nor does he consent to disclosure of confidential information unrelated to the subject matter of his lawsuit.[144] The court found a constitutional source for the protection of the patient's privacy interest in medical information and records that are not related to the case, and in preserving patients' fiduciary and confidential relationships with their physicians.[145]

D. JURY INSTRUCTIONS

Public Act 89–7 also included a new provision, section 2–1107.1,[146] containing three jury instructions to be given in tort actions. One instruction would have prevented the jury from being informed about the cap on

138. *See* Best v. Taylor Mach. Works, 689 N.E.2d 1057 (Ill. 1997).
139. Kionka, *supra*, note 114.
140. 735 ILL. COMP. STAT. 5/2–1003(a) (2004).
141. Kunkel v. Walton, 689 N.E.2d 1047 (Ill. 1997).
142. *See* Best v. Taylor Machine Works, 689 N.E.2d 1057 (Ill. 1997).
143. *Id.*
144. *Id.*
145. *Id.*
146. 735 ILL. COMP. STAT. 5/2–1107.1 (2004).

non-economic or punitive damages.[147] Since the cap itself was held unconstitutional, that instruction was invalid. The other two instructions were not necessarily invalid, however, had they stood alone. One of these jury instructions would have required the court to inform the jury that compensatory and punitive damage awards are not taxable.[148] The other instruction would have prevented the jury from being informed that the plaintiff would not recover any damages if his or her contributory negligence exceeded 50% percent.[149] Because of its determination that the valid provisions of the act were not severable from the invalid provisions, it struck these two instructions without expressing any opinion regarding their constitutionality independent of the act.

E. OTHER PROVISIONS

There were other provisions of P.A. 89–7 that are not material here — for example, several dealing specifically with products liability actions. Those provisions also fell because of the *Best* court's determination that the unconstitutional provisions were not severable from the remainder of the act.

F. THE END

Thus, in the final analysis, P.A. 89–7 came to naught. No significant reform legislation passed in the ten years intervening between P.A. 89–7 and P.A. 94–677, enacted in 2005. Public Act 89–7 was passed and signed into law during a brief time when Illinois had a Republican House, a Republican Senate, and a Republican governor, a rare situation in this state. By the time of the *Best* decision, the Illinois House once again had a Democratic majority, and so tort reform faced an uphill climb. In 2003, Democrats regained the majority in the Illinois Senate and a Democratic governor took office for the first time since 1977. But even though in 2005 Illinois had a Democratic majority in the Illinois General Assembly and a Democratic governor, the pressure for further reform, specific to medical malpractice, had increased during the intervening ten years to the point that some sort of reform legislation had become a practical necessity.

VI. 2005 MEDICAL MALPRACTICE TORT REFORM: PUBLIC ACT 94–677

Tort reform efforts in Illinois climaxed again in 2004–2005 with (1) the Maag-Karmeier Illinois Supreme Court election in the Fifth District,

147. *Id.*
148. *Id.*
149. *Id.*

and (2) the 2005 reform legislation, Public Act 94–677,[150] signed into law by the governor on August 25, 2005. Both campaigns — the election and the campaign for P.A. 94–677 — featured the theme, "Keep Doctors in Illinois." One can still see bumper stickers with that slogan, printed on a green strip in the shape of the wristband a hospitalized patient wears.[151]

Based on the empirical research to date, and on our knowledge of the litigation system, there is serious question as to whether either of these "reforms" will produce that effect, but time will tell. How did P.A. 94–677 build on prior legislative reforms? Just as in the case of previous tort reform legislation, the act operates in several different areas. The main provisions include:

- A cap on non-economic damage awards of $500,000 for physicians and $1 million for hospitals;[152]

- An increase in the number of medical investigators and Medial Disciplinary Board members;[153]

- Changes to the affidavit of merit (previously discussed), requiring disclosure of the consulting physician's name, and that the physician meets the expert witness standards of the expert witness qualifications statute;[154]

- An increase in the standards to be used by the trial court in certifying expert witnesses;[155]

- The use of annuities for the payment of portions of the award for medical costs;[156]

- Good faith immunity extended to physicians who provide free home visits or free care in free clinics;[157]

- Allowing physicians to offer grief and apology without the statement being used against them ("Sorry Works");[158]

150. Also known by its bill designation, S.B. 475, 94th Gen. Assemb. (Ill. 2005).
151. *See* www.keepdoctorsinillinois.org.
152. Pub. Act 94-677, 94th Gen. Assemb. (Ill. 2005).
153. *Id.*
154. *See supra* n. 39 and accompanying text.
155. Pub. Act 94-677, 94th Gen. Assemb. (Ill. 2005).
156. *Id.*
157. *Id.*
158. *Id.*

- Enhanced insurance regulation of med mal insurance;[159] and

- Good faith immunity for persons reporting to peer review committees alleged violations of the Medical Practice Act.[160]

A. DAMAGES CAPS

"Once more unto the breach, dear friends, once more . . . ."[161] Caps on non-economic damages are here again, limited (as they were the first time) to medical negligence cases. The Act adds section 2–1706.5 to the Civil Practice Act;[162] subsection (a) provides:

> (a) In any medical malpractice action or wrongful death action based on medical malpractice in which economic and non-economic damages may be awarded, the following standards shall apply:
>
> (1) In a case of an award against a hospital and its personnel or hospital affiliates, . . . the total amount of non-economic damages shall not exceed $1,000,000 awarded to all plaintiffs in any civil action arising out of the care.
>
> (2) In a case of an award against a physician and the physician's business or corporate entity and personnel or health care professional, the total amount of non-economic damages shall not exceed $500,000 awarded to all plaintiffs in any civil action arising out of the care.
>
> (3) In awarding damages in a medical malpractice case, the finder of fact shall render verdicts with a specific award of damages for economic loss, if any, and a specific award of damages for non-economic loss, if any. The trier of fact shall not be

159. *Id.*

160. *Id.*

161. WILLIAM SHAKESPEARE, KING HENRY THE FIFTH, IN THE COMPLETE WORKS OF WILLIAM SHAKESPEARE 458, 468 (Chancellor Press ed. 1987) (Henry V, urging his soldiers forward during the siege of Harfleur in 1415).

162. 735 ILL. COMP. STAT. 5/2–1706.5(a) (amended 2005).

> informed of the provisions of items (1) and (2) of this subsection (a).

Under subsection (b), in a medical malpractice action, if an individual plaintiff earns less than the state's annual average weekly wage, "any award may include an amount equal to the wage the individual plaintiff earns or the annual average weekly wage."[163]

Apparently, the purpose of this section is to cap non-economic damages at $500,000 per individual defendant who is a physician or other "health care professional" (including that individual defendant's business or corporate entity-employer) and $1 million per hospital (including in the cap both the hospital and any hospital "personnel" found individually liable). Thus, if two physicians and a hospital are found liable as joint tortfeasors for a single indivisible injury, the plaintiffs' total non-economic damages will be capped at $2 million, and the plaintiff(s) cannot collect more than $500,000 each from the physicians and $1 million from the hospital.

Certain questions arise from the obvious ambiguities in the statute. For example, what is meant by hospital "personnel"? Suppose a hospital is held vicariously liable for the negligence of a nurse and an employed physician and plaintiff's total non-economic damages are $3 million. Under subsection (a)(2), it would appear that the cap would limit the plaintiff's damages against the nurse and the doctor to $500,000 each, or a total of $1 million. Can the plaintiff then recover an additional $1 million from the hospital? Moreover, how would the caps work if a hospital-employed physician is responsible for an injury and a hospital nurse aggravates that injury? One can imagine other uncertain scenarios.

Another striking feature of this statute is that the caps apply to "all plaintiffs" collectively. This means that if a patient is seriously injured such that another family member has a claim for loss of services or consortium, each single cap applies to both claims. It also means that in a wrongful death case where there are several beneficiaries entitled to recover, each single cap applies to all the beneficiaries collectively.

Also troublesome is the provision that the caps are to be hidden from the jury.[164] In my opinion, this sort of paternalistic and dishonest concealment is always wrong. In addition, it creates serious fairness issues, given the fact that some knowledgeable jurors will already know about the caps, while others will not. Therefore, different juries deciding the same case would be operating in different contexts, depending on who happened to be in the particular jury pool. It would be preferable to instruct the jury that

163. 735 ILL. COMP. STAT. 5/2–1706.5(b) (amended 2005). The apparent purpose of this subsection is to respond to criticism that a cap on non-economic damages will fall hardest on non-wage-earning plaintiffs, such as children, the elderly, and homemakers.

164. 735 ILL. COMP. STAT. 5/2–1706.5(a)(3) (amended 2005).

there is a cap on non-economic damages, but that its verdict should be for the total economic and non-economic loss and it should disregard the caps; the court will adjust the verdict based on the caps post-trial.

One can imagine other problematic issues. But an analysis of interpretation issues in section 2–1706.5 is beyond the scope of this article. However, one issue does need to be discussed here — is section 2–1706.5 constitutional?

In *Wright v. Central Du Page Hospital Ass'n*,[165] a 1976 decision, the Illinois Supreme Court held that a $500,000 limit on *all* compensatory damages in medical malpractice actions[166] violated the equal protection and special legislation provisions of the Illinois Constitution. The plaintiffs in *Wright* argued that the compensatory damages limit arbitrarily classified and unreasonably discriminated against the most seriously injured victims of medical malpractice. The court agreed, holding that the General Assembly did not have the power to prescribe arbitrary limitations on an injured plaintiff's compensatory damages. The court found that limitations on compensatory damages in medical malpractice actions created a special privilege for medical malpractice tortfeasors by insulating them from fully compensating plaintiffs for fairly assessed damages. Consequently, relief to an injured plaintiff depended solely on an arbitrary classification, in violation of the prohibition against special legislation.[167]

In *Best v. Taylor Machine Works*,[168] a 1997 decision, the Illinois Supreme Court held a $500,000 across-the-board cap on non-economic damages unconstitutional, on several grounds. (By "across-the-board," I mean the cap applied to all common law, statutory, or other actions for injuries or wrongful death based on negligence or products liability. It was not limited to medical malpractice cases.) The first ground was that the cap violated the special legislation prohibition of the Illinois Constitution.[169] The court will review legislation under a "rational basis" standard when, as with Public Act 89–4 (and, presumably, Public Act 94–677), neither a fundamental right nor suspect classification is involved. The court will look at "whether the classifications created by section 2-1115.1 are based on reasonable differences . . . and whether the basis for the classifications is sufficiently related to the evil to be obviated by the statute."[170] In *Best*, the

165. *Wright*, 347 N.E.2d 736 (Ill. 1976).

166. ILL. REV. STAT. 1975, ch. 70, para. 101.

167. *Wright*, 347 N.E.2d at 743. The *Wright* case also invalidated other provisions of P.A. 79-960: mandatory medical review panels and a provision limiting medical malpractice insurance rate increases. Justices Underwood and Ryan dissented from the part of the opinion holding caps unconstitutional.

168. *Best*, 689 N.E.2d 1057 (Ill. 1997).

169. *Id.* at 1069–78.

170. *Id.* at 1071.

court found the classifications created by across-the-board caps arbitrary and unreasonable. The court used three examples. The first involved three plaintiffs injured as a result of the same tortfeasor's negligence. One suffered pain, disability and disfigurement for a month; the second for a year; and the third for the rest of his life. In this hypothetical, the jury awarded the first two plaintiffs $100,000 for non-economic loss, the third $1 million (which, of course, would have been reduced to $250,000 by the cap.) The court found that in this example, the cap failed to provide consistency or rationality to a jury's seemingly inconsistent decision to award plaintiffs A and B the same amount for very different noneconomic injuries. Therefore, the legislative goal of providing consistency is not met by the damages cap. With respect to plaintiff C, section 2-1115.1 arbitrarily and automatically reduces the jury's award for a lifetime of pain and disability, without regard to whether or not the verdict, before reduction, was reasonable and fair.[171] In addition, tortfeasors are treated differently without any justification.

Another example illustrated another arbitrary classification. An individual loses a leg as a result of a defective forklift, and the other leg as a result of a car accident a year later, both as a result of negligence. If the jury in each case awards $400,000 for non-economic loss, the plaintiff can collect the full $800,000. But if the same plaintiff loses both legs in a single accident, also caused by negligence, and the jury assesses the plaintiff's non-economic loss at the same amount, $800,000, the plaintiff could only recover a total of $500,000 for non-economic loss. In the *Best* court's view, this is an unconstitutionally arbitrary classification.[172]

In a third example, the court noted that the statute limited non-economic loss only in certain categories of tort cases — those involving death, bodily injury, or property damage. It did not limit recovery of non-economic loss in other cases, such as invasion of privacy, defamation, intentional or negligent infliction of emotional distress, damage to reputation, and breach of fiduciary duty.[173] This, too, is an arbitrary classification, according to the court.

The *Best* court also held that the cap violated the separation of powers clause of the Illinois Constitution.[174] It is a traditional and inherent power of the judicial branch of government to control excessiveness of verdicts by ordering a remittitur in appropriate cases.[175] Deference is given to the "careful deliberative process of the jury" and that can be overcome only if

171. *Id.* at 1075.
172. *Id.*
173. *Id.*
174. *Best*, 689 N.E.2d at 1081; ILL. CONST. of 1970, art. II, § 1.
175. *Best*, 689 N.E.2d at 1079.

the trial court determines that the verdict is excessive. Remittitur must be considered on a case-by-case basis. Therefore, an arbitrary cap on non-economic damages improperly undercuts the power and obligation of the judiciary.

Having held the cap unconstitutional on those two grounds, the *Best* court did not address additional arguments that the cap violated the constitutional right to a jury trial and the right to a certain remedy. Justice Miller, the lone dissenter, thought that the cap was not unconstitutional because the cap could be found to be rationally related to the purpose of the legislation.

Will the caps in P.A. 94–677 fare any better? It is certain that they will soon be challenged. There are only two ways in which the Illinois Supreme Court could find these caps constitutional. The first is by simply rejecting the holdings of the *Wright* and *Best* cases, this time agreeing with Justice Miller's dissenting opinion in *Best* that there is a rational basis for a cap on non-economic damages, whether across-the-board or limited to medical malpractice cases. Considering the strength of the holdings in *Wright* and *Best*, it seems very unlikely that the court would simply find those cases wrongly decided.

The only other way to sustain the caps in P.A. 94-677 would be to find that societal conditions have sufficiently changed during the intervening years, and that caps have somehow become a rational response to the now-compelling need to reduce med mal insurance premiums and thereby lower the cost and improve the availability of health care in Illinois. In my view, this is not very likely either.[176]

In determining the constitutional issue, the supreme court must balance the cost of caps — the unfairness of the classification, and the interference with the judicial power of remittitur and the right to trial by jury — against the rationality of the legislature's determination that caps will be efficacious. Those attacking the constitutionality of the caps will be able to muster strong empirical evidence that caps *per se* have little or no effect on med mal insurance premiums. Given the court's findings in *Wright* and *Best* with respect to the costs referred to above, it seems highly doubtful that the court will distinguish those cases in order to sustain the caps in P.A. 94-677.

Those seeking to sustain the constitutionality of the caps can point to the fact that during the years since *Wright*, courts in some other jurisdic-

176. For a contrary position, urging that caps should be sustained, see Carolyn Lees, *The Inevitable Reevaluation of Best v. Taylor in Light of Illinois' Health Care Crises*, 25 N. ILL. U. L. REV. 217 (2005).

tions have sustained caps against similar constitutional challenges.[177] But the court in *Best* found unpersuasive the argument that other states have sustained caps.[178] There is no reason to believe that this same argument will have improved with age.

Can the court hold the caps unconstitutional and sustain the other provision of the statute? Ordinarily, one might have thought this to be at least possible. But section 995 of P.A. 94-677 provides: "Inseverability. The provisions of this Act are mutually dependent and inseverable. If any provision is held invalid, then this entire Act, including all new and amendatory provisions, is invalid."[179] Most likely, this provision was intended to up the ante with respect to the Illinois Supreme Court's decision whether to invalidate the caps. It is always possible that the inseverability of the various provisions of P.A. 94-677 would result in the court viewing the caps as simply one part of the entire legislative solution package, and it might be able to justify the caps in the context of the act as a whole. This does not seem very likely either. The *Best* court did not hesitate to invalidate P.A. 89-7 in its entirety on the ground that the unconstitutional provisions were inseverable from the rest. Section 995 of P.A. 94-677 does no more than the court did on its own in *Best*. Thus, it seems doubtful that section 995 is sufficient to save either the caps or the statute as a whole.

If this is the result, it will be most unfortunate. In my view, most of the other provisions of P.A. 94-677 range from unobjectionable to highly desirable. It is a shame that the caps provision could not have been declared to be severable. The problem is that the proponents of the current round of reform have featured caps as the panacea, despite all the empirical evidence that caps are ineffective to reduce premiums and arbitrarily limit valid claims, not so-called "frivolous" claims. This insistence on caps is puzzling, except for the fact that a major player in the push for reform — liability insurance companies — like caps because they provide a greater degree of certainty in damages and thereby improve the companies' ability to actuarially calculate premiums. But, as I will later suggest, there are better ways than caps to provide this greater certainty.

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177. *See* Carol A. Crocca, Annotation, *Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims*, 26 A.L.R.5th 245 (1995). In one of the most recent decisions, *Ferdon ex rel. Petrucelli v. Wisc. Patients Compensation Fund*, 701 N.W.2d 440 (Wis. 2005), Wisconsin invalidated its $350,000 cap (adjusted for inflation) on non-economic damages in med mal cases. The court's opinion contains a thorough review of the law and empirical evidence in this area as of mid-2005.

178. *Best*, 689 N.E.2d at 1077–78.

179. Pub. Act 94-677, § 995, 94th Gen. Assemb. (Ill. 2005).

B. WHAT ELSE IS THERE?

If P.A. 94-677 somehow survives constitutional challenge, there are several other provisions of the act that will take effect.

i. Insurance Regulation

A major part of Public Act 94-677 involves changes to the insurance code that make medical malpractice insurance rate making and approval more transparent and subject to greater scrutiny. Under pre-existing law, rates could not be excessive or discriminatory, and must be related to anticipated losses and expenses for the class of doctors insured. Under the 2005 amendment to section 155.18 of the Insurance Code,[180] each insurance company must report its rates and rating schedules to the Secretary of Financial and Professional Regulation ("the Secretary") before the rate can go into effect. The rates must be based on sound actuary principles. The Secretary may hold public hearings to discuss the rates and may request information to support the rates. A public hearing may be called at the Secretary's discretion, at the request of 1% of the insureds, or when the rate increase is greater than 6%. This information may also be made available to the public. If there is no justification for the rate increase, the Secretary may impose a $1,000 daily penalty for all violations until the increase is reversed.

This section requires insurance companies to give the insured the option to make quarterly premium payments. The companies may offer deductibles to the insured. They may also offer discounts on premiums for insured's participation in risk management activities.

Prior to this change, the rates, etc., were reported to the Director of Insurance. The Secretary is now allowed to determine when rates are excessive and inadequate, instead of adhering to definitions in the bill.

Under section 155.18(a), the Secretary is to establish a Professional Liability Insurance Resource Center on the Internet.[181] The site will have information about the different insurance companies and links to their websites, which is to be updated annually.

Under section 155.19, each insurance company must still report to the Secretary all suits in which its physicians are involved, but the recording and reporting requirements were changed.[182] Records of lawsuits, including the nature of the dispute, the amount of the dispute, and its disposition, will

180. 215 ILL. COMP. STAT. 5/155.18 (amended 2005).
181. 215 ILL. COMP. STAT. 5/155.18(a) (amended 2005).
182. 215 ILL. COMP. STAT. 5/155.19 (amended 2005).

now be made available to the general public, but will not include the name(s) of the parties.[183]

Each insurer and certain other entities must file a report with the Secretary (formerly the Director of Insurance).[184] The report includes mainly financial information with losses, claims and cumulative losses of the year, as well as surplus information. The companies that must report and what needs to be reported remained largely unchanged. However, additional information from medical liability insurers is now required. Medical liability insurers must report the amount paid and lost for each county for the past ten years. Cumulative losses per year must be shown and broken into categories, as well as reserve and surplus studies. This information will be made available to the public on a company-by-company basis. The Secretary may request other information as he or she feels necessary.

The first hearings under these new provisions have been held, and, as a result of these hearings, the director of the Illinois Department of Insurance has ordered ISME (the largest Illinois medical malpractice insurer) to freeze its rates and, if possible, to reduce them by 3.5%.[185]

ii. Medical Discipline[186]

The Medical Disciplinary Board was reformed. The Board was increased from nine to eleven members, but not more than six can be from the same political party. All members are voting members. The Board should contain five licensed physicians including, if possible, one of each of the following: a physician practicing neurosurgery, a practicing OB/GYN, a physician practicing cardiology, a physician practicing osteopathy or osteopathic medicine, and a practicing chiropractor. Some things remained the same, such as four members of the Board should not be associated with providing health care and each member will serve a term of four years.[187]

An investigator will now be appointed for every 2,500 physicians and will serve at the will of the Board. The members of the Board are immune from personal liability for work done for the Board. The Board will continue to maintain a physician list.[188]

The authority of the Board is extended to allow it to refuse to renew a physician's license. The Board will continue to be able to suspend a

183. *Id.*

184. 215 ILL. COMP. STAT. 5/1204 (amended 2005).

185. *See*, http://www.idfpr.com/NEWSRLS/03142006ISMIEDecision.asp; Links to transcripts of these hearings may be found at http://www.iltla.com/Medical%20Malpractice/med_mal_info.htm.

186. 225 ILL. COMP. STAT. 60/7 (amended 2005).

187. *Id.*

188. *Id.*

physician's license or take necessary disciplinary action for a number of reasons enumerated in this section. This section added compliance with the Ephedra Prohibition Act, but the other potential reasons for discipline remained the same and include performing an illegal abortion, conviction of a felony, gross negligence, unethical conduct, fraud, abusing drugs, etc. The amount the Board may fine physicians was increased from $5,000 to $10,000 per violation.[189]

The statute of limitations for disciplinary action against a physician is extended from five to ten years. This limitation does not apply when there is a continuing pattern of abuse. Settled claims may be investigated within two years of notification of the claim.[190]

This section also outlines standards for rules adopted by the Board. The Board may order mental or physical examination of a physician, and order compliance with any treatment suggested. Any failure to comply with these requests will be referred to the Secretary for determination of appropriate action.[191]

iii. Reports Relating to Professional Conduct and Capacity

The requirement for some entities to report regarding the professional conduct and capacity of physicians did not change. Health care institutions must report when any person with clinical privileges is terminated or has his or her privileges restricted. Professional associations must report when the association or society makes a final determination a person has committed unprofessional conduct, or if the person is mentally or physically disabled in a way that will endanger patient care. Professional liability insurers shall report the settlement of a claim or final judgment in favor of a plaintiff for negligence in medical care. States attorneys and state agencies must report as well.

The reports must now include not only the name and address of the subject of the report, but also the name and date of birth of the patient the report concerns. The other reporting information remained the same.

The Board may subpoena medical records of those involved when the case is one of death or permanent bodily injury. This information may now be conveyed to law enforcement if there is an ongoing criminal investigation.

Notification to the person who is the subject of the reports remains the same, but that person is allowed to submit a written statement and any medical records in response, within thirty days. Review protocol remained

189. *Id.*
190. *Id.*
191. *Id.*

the same where, if upon review of the record, there are not sufficient facts to warrant further investigation, the Board will report to the Secretary who may decide to investigate further, or notify the involved parties of the decision.

Immunity from liability for participating in peer review was added. Individuals involved in the investigation of these claims are immune from liability for acts within the scope of the board not willful and wanton in nature.

The Board may continue to enter into agreements with certain associations to assist in reviewing cases. Those participating in the investigation will be immune from any liability that might result from the investigation. The attorney representing the party seeking relief may now be required to provide the Board with medical records, if requested. Compliance with this provision does not violate the attorney-client privilege.

A "Patient's Right to Know" law was added. A profile of each physician will be made available to the public by the Board. This profile will include the name of the physician, any criminal convictions, any disciplinary action taken within the past five years and final disciplinary actions, any restrictions on character or competence taken by a hospital within the past five years, medical malpractice claims and settlements occurring within the last five years, and a professional history, including the medical school the physician attended, date of graduation, specialty board certification, years in practice and location of practice. The report will also include the primary location of the physician's practice, publications, professional and community involvement, whether translating services are available at the office, and whether the physician is a Medicaid provider. This profile will be given to the physician sixty days prior to publication for approval. The physician may elect to omit or include medical school faculty appointments, publications, and information concerning community involvement and awards.

iv. Affidavit of Merit

The affidavit of merit requirement was enhanced, as previously discussed.[192]

v. Guaranteed Payment of Future Medical Expenses and Costs of Life Care

Section 2-1704.5 was added to the Civil Practice Act to enhance the availability of periodic payment of damages. Within five days of a verdict in favor of the plaintiff, either party or the court may enter an order for

192. *See supra* note 39 and accompanying text.

payment of future medical expenses and costs of life care to be made through an annuity agreement. The trier of fact will determine the present cash value of any future medical expenses and life care and the annual composite rate of inflation that should be applied to the costs. The jury will not be made aware of the possibility to purchase an annuity. If the annuity company defaults, the defendant must purchase a new annuity. When an annuity is purchased, the defendant must pay 20% of the present cash value of the determined future medical expenses and cost of life care. Annual payments would then be made. The plaintiff may negotiate and assign the annuity to another for a lump sum when faced with unanticipated financial hardship under terms to be approved by the court.

vi. Admissions by a Health Care Provider

Section 8-1901 of the Civil Practice Law now provides that providing or paying for medical, surgical, hospital or rehabilitation services or offering such payment will not be construed as an admission of liability. These offers shall not be admissible as evidence unless the person making the offer insists they be admitted.

Public Act 94-677 adds subsection (b) to this section, allowing a physician or health care provider to make any expression of grief, apology or explanation within a certain period of time. Any such communication shall not be admissible as any kind of evidence in court or other tribunal.

vii. Expert Witness Standards

Expert witness standards were amended as previously discussed.

viii. "Sorry Works!" Pilot Program Act

One of the most important features of Public Act 94–677 is the "Sorry Works!" program. With the enactment of this law, Illinois becomes the first state to adopt a pilot "Sorry Works!" program as a part of the solution to the med mal insurance problem.[193] "Sorry Works!" is a plan being promoted by a national coalition of doctors, insurers, patients, lawyers, hospital administrators, and researchers to provide an alternative to medical

193. *See "Sorry Works! Pilot Program Passes Illinois General Assembly,"* The Sorry Works! Coalition, June 2, 2005, *at* http://www.sorryworks.net/media20.phtml; *"Sorry Works! Pilot Program Legislation,"* The Sorry Works! Coalition, *at* http://www.sorryworks.net/article7.phtml; *"Sorry Works! Pilot Program Passes Illinois General Assembly- Medical Malpractice Crisis Solution,"* Medical News Today, June 2, 2005, *at* www.medicalnewstoday.com/medicalnews.php?newsid=25537.

malpractice litigation.[194] The program encourages the hospital staff and physicians to evaluate situations that resulted in an undesirable outcome. If the result was caused by either the hospital's or physician's error, then the hospital is to approach the patient or the patient's family and discuss the situation. The hospital and physician are encouraged to apologize for mistakes and offer fair settlements. The patient is encouraged to obtain counsel.

A federal bill has been introduced to encourage hospitals to apologize after medical errors and negotiate fair compensation.[195] The "Sorry Works!" program was developed in 2000 in Lexington, Kentucky for the VA hospital. The success of the program led to the adoption of the program in all VA hospitals.[196] Other than that, it has been attempted only at certain hospitals, until now.[197]

The pilot program allows two Illinois hospitals to try "Sorry Works!" risk-free for a two-year period. One hospital may participate during the first year of the program; one more may be allowed to participate during year two. Participating hospitals and physicians must promptly apologize for mistakes and offer fair settlements. The hospital should encourage the patients and families to obtain legal counsel to help protect their rights and assist in negotiations. The hospital must report to the committee their total costs of verdicts, settlements, and defense litigation for the five preceding years. The committee shall then develop standards to compare past costs and costs under the "Sorry Works!" program. If the hospital's costs under the program exceed past costs, the hospital may apply for a grant for the difference.

A nine-member committee will oversee the project. The President of the Senate, the Minority Leader of the Senate, the Speaker of the House of Representatives, and the Minority Leader of the House of Representatives shall each appoint two members and the Secretary or her designee shall serve. The committee will select hospitals to participate in the program, publish data, and report to the Governor and General Assembly annually.

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194. *See* Sorry Works! Coalition, *at* http://www.sorryworks.net/index.phtml.

195. S.B. 1784, "The National Medical Error Disclosure and Compensation (MEDiC) Act of 2005," introduced by Senator Hillary Rodham Clinton and Senator Barack Obama on September 28, 2005. The bill is pending in the Senate Committee on Health, Education, Labor, and Pensions. *See* http://thomas.loc.gov/cgi-bin/bdquery/z?d109:SN01784:@@@X.

196. *"Sorry Works! Now the Rule in All VA Hospitals,"* Sorry Works! Coalition, *at* http://www.sorryworks.net/article19.phtml (Accessed Feb. 28, 2006); Directive 2005-049, *"Disclosure of Adverse Events to Patients,"* Department of Veterans Affairs, Veterans Health Administration (Oct. 27, 2005), *available at* http://www.sorryworks.net/pdf/VA_Link.pdf.

197. *Id.*

The program may be terminated by a two-thirds vote by the committee. If the program is not terminated by the committee, it shall end after its second year of operation.

If this pilot program is successful, it will serve as a basis for a broader implementation of the program.

VII. BACK TO THE FUTURE: WHERE DO WE GO FROM HERE?

Will Public Act 94–677 — if it survives constitutional attack — be the answer to the medical malpractice insurance problem? Not likely, but it is a start. Important new features of Public Act 94-677, not found in prior tort reform attempts, include better oversight of medical malpractice insurance rate making and rate approval, making the process more transparent and subject to greater scrutiny, and better methods of identifying problem physicians. Certainly, insurance reform must be an important part of the solution, but by itself it is not enough. Identifying substandard health care providers is also beneficial, but they are not the major cause of high medical malpractice insurance rates.

Like reform efforts elsewhere, Illinois reform efforts always feature caps on non-economic damages. But the answer is not caps alone, or even law reform alone. Prior efforts at tort reform have both been misconceived (and found unconstitutional) or, to the extent implemented, have not had a significant impact on the problem. We must also dispel the notion that the problem is "frivolous" medical malpractice lawsuits. Frivolous claims are rare, and if there are any, they get weeded out long before they could get to trial. Significantly, nothing in any prior tort reform legislation (with the single exception of the affidavit of merit) does anything to address frivolous claims.

The problem of high medical malpractice insurance rates is a complex, multi-dimensional problem, not amenable to simple, even three- or four-part solutions. If there were a simple solution, someone or some state would have found it by now and there would be no ongoing problem.

Reform must be multi-faceted. Ideally, it should attack the problem on five major fronts: (1) changes in tort law and procedure; (2) reduction of litigation costs; (3) insurance reform, regulation, and oversight; (4) changes in health care delivery systems and procedures; and (5) development of alternative claim resolution procedures.

Above all, reform must take place at the state level, not the national level. We must permit the states to continue to be laboratories in which new and different ideas are tried to see what works and what does not. In addition, although in general, tort law is similar throughout the United States, the states' tort laws and procedures differ in their details, and each state has its own unique history and jurisprudence in this area. A "one-size-fits-all" solution will do violence to our time-honored tradition that tort law

is within the states' domain. For these reasons, this paper focuses on Illinois, but perhaps some of these suggestions can be adapted to other states.

In the remainder of this paper, I will suggest several things to do (or not do) to address this problem. Some of these ideas are new; many are not. But this list is just a starting point. There is a vast body of literature on this subject, a small part of which is cited in the appendix to this paper. Many of these books and articles contain interesting ideas beyond those that are on my list. My first and most important suggestion is to create a task force to study this problem in a new way, with a law professor-reporter who will devote major time to this project. The reporter and the task force should look carefully at any and all ideas from whatever source, and put forward any and all that, in the judgment of the task force, show promise.

Note that all of these suggestions are severable. I am under no illusion that they will all be met with equal enthusiasm. They are put forward for purposes of discussion with the hope that at least some will be adopted, or will lead to further proposals that will be adopted.

A. THE ILLINOIS MEDICAL MALPRACTICE TASK FORCE

The most important thing to do to address this problem is to create a task force to study the issues and develop a comprehensive plan. The first problem, of course, is the mechanism for creating the task force. Probably, it should be done by legislation so that it can be funded by public funds and the members of the task force and the reporter can be high-profile appointments by, I suppose, the governor. In the alternative, it could be done through an NGO, such as a foundation.

The task force should consist of, say, two representatives of each constituency with a stake or interest in the problem. The groups represented should include: (a) state representatives and senators, equally balanced between Democrats and Republicans; (b) physicians or physicians groups; (c) hospitals and (perhaps) other health care providers; (d) representatives from medical malpractice insurers or insurance organizations; (e) patients' groups; (f) trial lawyers who specialize in this area who exclusively represent (f1) plaintiffs and (f2) defendants; (g) judges; (h) others. Every effort should be made to balance the task force so that no "side" of these issues predominates.

Most importantly, the persons appointed must be carefully selected. They must be individuals who are highly respected in their fields and who are known to be fair and of the highest integrity. They must be individuals in whom the public and the politicians have confidence, so that their recommendations carry weight. A person should be appointed the chair of the task force who is well-known and a highly regarded leader in Illinois,

with no vested or other interest in the outcome, and who is a master at chairing and mediating such a diverse group.

The task force must also have a professor-reporter, selected not only because of his or her expertise in tort law, insurance, and civil procedure, but who has not staked out a position at one end or the other of this issue. This person should be a recognized scholar in these fields, so that his or her conclusions and recommendations are viewed with confidence. The professor-reporter should be paid, and ideally should take the position on a leave of absence from his or her academic position so as to be able to devote full-time to this project for a number of months. The first task of the professor-reporter would be to become thoroughly familiar with the vast body of scholarship and empirical research that already exists. One of the most serious problems in the ongoing reform effort is that those charged with addressing these issues have full-time jobs and do not have the time or the expertise to study the available sources. The professor-reporter would then become a valuable resource for the task force, and would also serve as its draftsperson for its reports and proposals.

One of the most important benefits of the proposed structure of this task force will be to de-politicize (to the extent possible) the reform effort. All of the reform efforts to date, in Illinois and elsewhere, are characterized by a high degree of politicization. I do not mean to deprecate the hard work of those involved in these efforts, and we should commend them for their good-faith attempts to strike a workable balance between competing political positions. But to achieve the best possible solution, we must go beyond political considerations and focus on the real goals — lower med mal insurance costs, better health care, better availability of health care where needed, faster and better resolution of claims, and the like. If the proposals of this task force are seen to be fair, objectively reasonable, and well-supported by research, and not merely a political compromise, then they should garner the public support necessary for enactment, regardless of the political climate of the state at that time. And if the proposals carry the weight of a blue ribbon, well-respected committee, their chances for enactment increase accordingly.

B. TEACH LAW TO DOCTORS IN MEDICAL SCHOOL AND BEYOND

One of the reasons for the polarization of the debate on medical malpractice reform is that, by and large, most physicians and other health care providers do not know enough about the legal system, and in particular do not understand or like the adversary system. They are prone to serious misconceptions about how the legal system works. They need to understand how the tort system functions. They must understand that health care professionals must be treated essentially the same as other litigants in order for the system to be perceived as fair. And they must understand that a

claim ordinarily is not an attack on their professional competence. Everyone — no matter how competent — makes mistakes, whether driving a car or on the job. Most medical negligence is no different in principle than running a (medical) "stop sign." We all must accept responsibility when our error has consequences.

C. INSURANCE: CLOSER STATE REGULATION OF PREMIUMS AND INSURANCE PRACTICES

Public Act 94-677 contains valuable changes to the Illinois Insurance Code to provide better regulation of medical malpractice insurance rates and practices. If the Act is sustained, then we should simply allow these changes to go forward and see how they work. If P.A. 94-677 is invalidated, then these insurance reforms should be promptly reenacted.

Insurance companies generally make their income from investments, in bonds and other conservative financial instruments, on the premiums collected from doctors. Premiums are usually invested for six years, the interval between the time a claim occurs and it is paid. When investment income is high, insurers can operate profitably even when losses on malpractice claims exceed income from premiums. State insurance regulations generally require an insurer to lower premiums when investment income is expected to be high; conversely, when investment income is expected to be low, insurers raise premium rates.

Income from bonds, which comprise 80% of insurers' investment income, has declined steadily since 2001 and is down overall since 1995. A General Accounting Office (GAO) study found that the top fifteen medical malpractice insurers' investment income fell from 5.6% in 2000 to 4% in 2002. The decline in investment income contributed in part to premium rate increases.[198]

As profits declined, many malpractice insurers were forced out of the market. Nationally, 14% of medical malpractice insurers have quit writing policies since the 1990s, while some states have seen 40% of these insurers exit the market. As a result of the lack of pressure from competition, insurers are able to raise rates.

The restrictions California placed on medical malpractice insurers, through Proposition 103, are widely credited with reducing medical malpractice premiums in that state.[199] In fact, while California is often cited by the proponents of caps to prove that caps are effective in reducing medical malpractice insurance premiums, it is more likely that the reduction

198. Valerie Witmer, *A Patient Perspective: Focusing on Compensating Harm*, 13 ANNALS HEALTH L. 589, 592 (2004).

199. Brandon Van Grack, *The Medical Malpractice Liability Limitation Bill*, 42 HARV. J. ON LEGIS. 299, 316 (2005).

in medical malpractice insurance rates in California is attributable to the insurance regulation and restrictions that accompanied the enactment of caps, and not to the caps themselves.

The most important single thing that can be done to control medical malpractice insurance premiums is to provide transparency and public oversight to the insurance rate-making process. Closer scrutiny and regulation of medical malpractice insurance is justified by the fact that health care is vital, analogous to an essential public utility. It must be a state and national priority to work to make health care for all as affordable and available as possible.

D. INSURANCE: AN ALTERNATIVE TO CAPS

As previously noted, it is my opinion that the most important reason medical malpractice liability insurers favor caps is that they provide greater actuarial predictability in the setting of premiums, and prevent the occasional large verdict from severely impacting the profitability of this line in that particular year. I do not suggest that there is anything wrong with this. Profitability is essential. But caps are inherently arbitrary and discriminatory, and the available evidence suggests that caps, by themselves, have little or no effect in reducing insurance premiums.

My proposal is that, in lieu of caps, all medical malpractice liability insurance policies have policy limits of $1 million per incident per insured. To cover judgments in excess of the applicable policy limits, a state fund would be created which would act as an excess insurer, much the same as excess insurance policies do. This fund could be funded from several sources, to reduce the impact on any one source. Possible sources would include (a) a small percentage (say, 1% or less) of each collected medical malpractice judgment; (b) a small tax on all medical malpractice insurers selling policies in Illinois, based on total premium revenue; (c) a small part of the licensing fee paid by all health care professionals and entities; and (d) state funds for the balance, justified on the ground that health care is a public good and a public necessity. Then, when any judgment exceeds the available private insurance, the excess would be paid by the state fund. There might even be a high cap on this fund's payment per case. If excess insurance is available, the fund could purchase that insurance.[200]

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200. Somewhat similar proposals have been made. *See, e.g.*, Patrick J. Kelley, *The Medical Malpractice Insurance Crisis: What Can Be Done?*, 21 ILL. ST. B. ASS'N HEALTH CARE LAW. 5 (March 2005); Frank A. Sloan, et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, 54 DEPAUL L. REV. 247 (2005). As the latter article discussed, patient compensation funds already exist in several states, although they differ from my proposal. Existing PCFs as well as my proposal should be considered.

The establishment of this fund would have the secondary effect of creating a further incentive for the state and medical malpractice insurers to take additional steps to reduce the incidence of medical negligence.

E. INSURANCE: CLASSIFICATION OF RISKS

One controversial proposal that has been floated is to reduce medical malpractice liability premium rating categories according to physician type. For example, a major Illinois insurer, ISMIE, reportedly has thirteen different rating categories. The proposal is that the rating categories be reduced to, say, no more than eight. Compressing the rating categories would immediately lower the premiums of the highest-risk specialties by anywhere from 25% to 40%. The result, however, would be a small increase in the rates of all other physicians in the non-high-risk categories.

ISMIE has opposed this change. While it might seem contrary to equitable and market considerations to compress the number of rating categories, the fact is that any rating system is basically arbitrary unless it individually evaluates and rates each insured. It is in the interest of all non-high-risk physicians to preserve the availability of high-risk specialists to which to refer cases. It is also in the interest of patients and first-party health care insurers to preserve such specialists, and patients and health care insurers ultimately pay these premiums anyway. Serious consideration should be given to reducing the number of rating categories so as to spread the cost of such insurance more broadly.

On the other hand, rating categories should also be examined to be sure that they reflect not only specialty and location but also incidence of successful claims and other negative factors. Thus, within rating categories, rates should reflect individual factors, such that insureds who have proved to be high individual risks should pay correspondingly higher rates.

F. ADR: MINI-TRIALS

Many courts, including most federal district courts, now have some form of voluntary mediation program or other form of alternative dispute resolution (ADR).[201] However, ADR is not likely to be used in medical malpractice cases without providing some additional incentive to the parties. Clearly, alternative dispute resolution methods are one attractive option, but so far no viable method has been found.[202] Pre-trial screening panels have been found invalid in Illinois, and no alternative has been

201. Alternative Dispute Resolution Act of 1998, 28 U.S.C. §§651-658 (2000) (mandates that courts authorize, establish, and promote the use of ADR, including mediation, arbitration, mini-trial and summary jury trial, in all civil actions).

202. Perhaps the "Sorry Works!" program will help fill this need.

proposed or attempted. Forcing the parties to a medical malpractice case to try the case twice is a significant burden and adds an additional layer of costs.

One procedure that has promise is the summary jury trial. Local Rule 16.3 of the United States District Court for the Southern District of Illinois provides, in part:

> To encourage and promote the use of alternative dispute resolution in this district, the parties shall use an early neutral evaluation in the form of a settlement conference in all civil cases . . . . The court may, in its discretion, set any civil case for summary jury trial or other alternative method of dispute resolution which the court may deem proper.[203]

The summary jury trial has proved to be effective, especially in major cases. In the usual form, the trial takes less than a day. Each party appears before a jury, makes an opening statement, and then gives a summary of the evidence it will present. (No actual witnesses are called.) After closing arguments, the jury returns a verdict (which, of course, is merely advisory and nonbinding). Each side then has a preliminary indication of the strength or weakness of its case, and this frequently results in a settlement.

It is doubtful that, in Illinois, such a procedure could be required as a condition to going to trial in a medical malpractice case. However, there would seem to be no reason why a rule similar to Local Rule 16.3 could not be implemented, applicable to all cases, giving the trial court discretion to order a summary jury trial in appropriate cases. I propose that this idea be fully explored.

G. FOCUS ON LITIGATION COSTS

A significant part of each medical malpractice liability insurance premium dollar goes to pay the costs of defense. Certainly, in many cases defense costs will be high because the stakes are high, and no one on the defense side — the doctor or hospital, the insurer, or the defense law firm — wants to be in the position of having lost the case because they skimped on defense costs to save money. Yet, having seen first-hand litigation at the trial level in a variety of cases, it is obvious that whoever is paying the bills for the costs of defense is often paying too much.

It is interesting that tort reform proposals usually focus exclusively on reducing plaintiffs' attorneys' fees. In fact, Illinois has such a statute,

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203. U.S. DIST. CT. RULES S.D. ILL. R. 16.3

limiting plaintiffs' contingent fees in medical malpractice cases.[204] But no one ever suggests that we should scrutinize defense lawyers' fees, even though there is no evidence that plaintiffs' lawyers, as a class, earn more than defense lawyers, as a class.

Whoever is paying the costs of defending a medical negligence case — most often, an insurance company, but sometimes a self-insured entity — should establish systems to ensure that defense legal fees and out-of-pocket expenses are necessary and proper. And they can also more closely monitor cases to look for opportunities to settle before trial, to promote ADR, and to settle prior to appeal when the chances of success on appeal are remote, all of which will also reduce defense costs. I have no doubt that too many cases are tried, or appealed, because there is no one to step up and take responsibility for bringing the case to an end.

H. REDUCE INCIDENTS OF MEDICAL ERRORS

It would seem to be stating the obvious, but an often-ignored remedy to rising medical malpractice premium rates is to reduce the number of incidents of malpractice or what could arguably be claimed to be malpractice. Professor Bryan Liang has been a leader in this area, suggesting a new systems approach that focuses on safety and quality in the health care system.[205] First, a system-based error detection system is needed that includes disclosure, analysis and discussion. The team's membership needs to include all disciplines: nurses, physicians, technicians, administrative and management. Dr. Liang suggests team members should have the ability to assess errors through systems engineering tools and root cause analysis. The team can then use the information to develop systems-based error reduction methods to decrease incidents of malpractice.

Interestingly, this is the approach taken by one group of medical professionals, anesthesiologists, with great success.[206]

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204. 735 ILL. COMP. STAT. 5/2–1114 (2004).

205. *See, e.g.*, Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Health Care*, 30 AM. J.L. & MED. 501 (2004). Professor Liang, a former colleague of this author, is Professor and Executive Director, Institute of Health Law Studies, California Western School of Law; Co-Director and Adjunct Associate Professor of Anesthesiology, San Diego Center for Patient Safety, University of California San Diego School of Medicine, San Diego, CA. B.S. MIT; Ph.D. University of Chicago Harris School of Public Policy Studies; M.D. Columbia University College of Physicians & Surgeons; J.D. Harvard Law School.

206. *See* TOM BAKER, THE MEDICAL MALPRACTICE MYTH (2005).

I. "SORRY WORKS!"

As previously noted, Illinois' pilot "Sorry Works!" program shows great promise. This and similar programs encourage direct contact between health care providers and victims or relatives of deceased victims. A key feature is the ability to disclose information about what happened without prejudicing the health care provider in subsequent litigation. Many lawsuits are filed because victims and their families cannot find out what happened. Doctors and hospitals understandably refuse to provide information that could incriminate them in subsequent litigation. So the victims have no choice but to file suit so they can obtain that information in discovery. By facilitating the exchange of information, and even admissions of fault by health care providers, settlements often result and overall claim payouts are reduced.

Everything possible should be done to help the "Sorry Works!" pilot program succeed. Even if P.A. 94–677 is held unconstitutional, it will probably not be before the "Sorry Works!" pilot program is finished. And whether it is "Sorry Works!" or some similar program, we need to find a way to make this concept work in the long term.[207]

J. EXCEPTIONS TO CAPS

As previously discussed, the available evidence shows that caps have little or no effect on medical malpractice insurance rates, and they arbitrarily reduce the damages of those most severely injured. In Illinois, caps have twice been held unconstitutional, and the caps in P.A. 94–677 are likely to suffer the same fate. But if not, and if caps are to be permitted, then a system of judicial review should be allowed to circumvent the statutory limits in cases where catastrophic injury occurs. Justice may require judicial intervention in cases where the victim would be inadequately compensated because of caps. If remittitur, in the form of caps or otherwise, is appropriate in the interest of justice, then so is additur.[208]

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207. There is much interesting literature on this. See, e.g., Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55 (2005). The leading medical malpractice insurer in Colorado, COPIC, has created a program called the "3Rs" — recognize, respond, and resolve. The program allows eligible physicians to participate in return for lower malpractice rates. However, this program differs from the Illinois pilot program because the physician must first contact the insurance company to discuss the situation before offering an apology. Also, if the patient obtains legal representation, the patient forfeits participation in the program. *COPIC's 3Rs Program*, 3R PROGRAM NEWSLETTER Vol. 1, Issue 1 (March 2004) *available at* http://www.callcopic.com/publications/3rs/vol_1_issue_1_mar_2004.pdf.

208. Prof. Patrick Kelley has put forward a somewhat similar proposal, that in all tort liability claims for personal injury, non-economic damages be limited to three times the total

K. NO-FAULT INSURANCE: JUST SAY NO

Some writers have suggested a no-fault system to compensate victims of medical mistakes. Under a no-fault system, doctors and patients would pay into a "local injured-patient compensation fund" that would eliminate the need for medical malpractice liability insurance. Theoretically, physicians and hospitals would report all errors without fear of the threat of litigation, and the patient would receive an automatic no-fault payment. Medical boards would investigate medical errors and learn which doctors have patterns of sub-standard care. The medical community could learn from its errors and patients would be compensated for any injury regardless of negligence.[209]

A no-fault system might require an injury threshold based on severity of injury in order to avoid a great amount of administrative resources being expended to resolve relatively minor claims; thus some injured patients would go uncompensated. Victims suffering similar harms receive similar compensation. Pain and suffering might be able to be calculated using established schedules or indexed to compensation awards. Some uniform payment for death cases would need to be established.

Although a no-fault system has a certain attractiveness because of its simplicity and the elimination of adversarial litigation, unfortunately, it is not a workable solution. The costs are simply too great, even with a reduced schedule of benefits.[210]

VIII. CONCLUSION

Tort reform, especially medical malpractice tort reform, is not a sport for the short-winded or simple-minded. It requires a multi-faceted, reality-based approach. Public Act 94–677 may or may not survive constitutional attack — most likely, the latter. But if it does not, the banner must be picked up again. Most parts of Public Act 94–677, that is, everything

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economic damages, but with discretion in the trial judge to sustain verdicts in excess of this cap when the judge determines that this limit would preclude adequate compensation. Kelley, *supra*, note 200). Prof. Kelley's proposal would be a reasonable alternative if hard caps are not sustained, but his proposed alternative cap of three times economic loss also presents constitutional problems in Illinois, even if it is applied across-the-board. In addition, I find the "three-times-economic-loss" cap only a slight improvement over hard caps. As an alternative to any kind of cap, I would prefer strengthening and systematizing the trial court's remittitur function. But that is another article.

209. Alec S. Bayer, *Looking Beyond the Easy Fix and Delving into the Roots of the Real Medical Malpractice Crisis,* 5 HOUS. J. HEALTH L. & POL'Y 111 (Spring 2005); David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J. L. & MED. 225 (2001).

210. *See* TOM BAKER, THE MEDICAL MALPRACTICE MYTH (2005).

except the caps, represent either a good start or at least a start. But with or without Public Act 94–677, much remains to be done to address the problem effectively. This time, let us go forward with a bi-partisan, carefully researched effort and make Illinois a model for reform that is responsible, fair, and that actually accomplishes the desired ends.

This article is intended to be only preliminary. I have not attempted to survey the vast body of literature available on this subject, all of it valuable and full of interesting ideas. A sample of recent articles is listed in the appendix to this article. It is intended merely to show that there is a wealth of resource material available. Likewise, I have not attempted to discuss every proposed solution contained in that literature. That is the reason I recommend a task force with a professor-reporter who has the time and expertise to comb this literature and the skill to present the best ideas to the task force for its consideration.

As Shakespeare's King Henry V said, "once more unto the breach."[211]

IX. APPENDIX

The following list is intended to be a tantalizing sample (not comprehensive) of the recent literature dealing with this issue. It is intended to show that there is a vast body of literature available to anyone with the time and motivation to read it, and that simplistic answers to the med mal insurance problem are essentially a waste of time.

The starting point for any literature review should be the Symposium, Starting Over: Redesigning the Medical Malpractice System (Tenth Annual Clifford Symposium on Tort Law and Social Policy), published in 54 DePaul L. Rev. Number 2 (Winter 2005). The more-than-a-dozen articles published there are not included in the following list.

Monique A. Anawis, *Medical Malpractice: Innovative Practice Applications*, 6 DEPAUL J. HEALTH CARE L. 309 (2003) (speech).

Alec Shelby Bayer, Note, *Looking Beyond the Easy Fix and Delving into the Roots of the Real Medical Malpractice Crisis*, 5 HOUS. J. HEALTH L. & POL'Y 111 (2004).

211. WILLIAM SHAKESPEARE, KING HENRY THE FIFTH, IN THE COMPLETE WORKS OF WILLIAM SHAKESPEARE 458, 468 (Chancellor Press ed. 1987) (Henry V, urging his soldiers forward during the siege of Harfleur in 1415).

Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 357 (2005).

David Boohaker, et al., *Health, Torts, and Civil Practice*, 21 GA. ST. U. L. REV. 178 (2004).

Roger N. Braden & Jennifer L. Lawrence, *Medical Malpractice: Understanding the Evolution - Rebuking The Revolution*, 25 N. KY. L. REV. 675 (1998).

Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263 (Summer 2004).

Bruce A. Finzen & Brooke B. Tassoni, *Regulation of Consumer Products: Myth, Reality and the Media*, 11 KAN. J.L. & PUB. POL'Y 523 (2002).

Barry R. Furrow, *The Current Medical Liability Insurance Crisis: An Overview of the Problem, Its Catalysts and Solutions*, 13 ANNALS HEALTH L. 505 (2004) (speech).

Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?*, 37 AKRON L. REV. 417 (2004).

Chandler Gregg, Note, *The Medical Malpractice Crisis: A Problem With No Answer*, 70 MO. L. REV. 307 (2005).

James A. Higgins, *Recent Developments in Oklahoma Law: Oklahoma's Tort Reform Act: Texas-Style Tort Reform or Texas-Size Compromise?*, 57 OKLA. L. REV. 921 (2004).

Thomas Horenkamp, Comment, *The New Florida Medical Malpractice Legislation and Its Likely Constitutional Challenges*, 58 U. MIAMI L. REV. 1285 (2004).

Michael S. Hull, et al., *House Bill 4 and Proposition 12: An Analysis With Legislative History*, 36 TEX. TECH L. REV. 1 (2005).

Chris D. Jones, Note, *Medical Negligence Lawsuits in Oklahoma: An Empirical Study*, 31 OKLA. CITY U. L. REV. (forthcoming 2006).

Eleanor D. Kinney, *Administrative Law Approaches to Medical Malpractice Reform*, 49 ST. LOUIS U. L.J. 45 (2004).

Kenneth D. Kranz, *Tort Reform 1997-98: Profits v. People?*, 25 FLA. ST. U. L. REV. 161 (1998).

Amanda R. Lang, Note, *A New Approach to Tort Reform: An Argument for the Establishment of Specialized Medical Courts*, 39 GA. L. REV. 293 (2004).

Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501 (2004).

Jordyn K. McAfee, *Medical Malpractice Crisis Factional or Fictional?: An Overview of the GAO Report as Interpreted by the Proponents and Opponents of Tort Reform*, 9 MICH. ST. J. MED. & LAW 161 (2005).

Kevin McManus, Comment, *Finding a Cure for High Medical Malpractice Premiums: The Limits of Missouri's Damage Cap and the Need for Regulation*, 49 ST. LOUIS U. L.J. 895 (2005).

Kelly K. Meadows, Note, *Resolving Medical Malpractice Disputes in Massachusetts: Statutory and Judicial Initiatives in Alternative Dispute Resolution*, 4 SUFFOLK J. TRIAL & APP. ADVOC. 165 (1999).

Chris A. Messerly & Genevieve M. Warwick, *Nowhere to Turn: A Glance at the Facts Behind the Supposed Need for Tort "Reform,"* 28 HAMLINE L. REV. 489 (2005).

Ann H. Nevers, *Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing?*, 1 PEPP. DISP. RESOL. L.J. 45 (2000).

Melissa Patterson, *The Medical Malpractice Crisis: The Product of Insurance Companies and a Threat to Women's Health*, 8 QUINNIPIAC HEALTH L.J. 109 (2004).

Ralph Peeples & Catherine T. Harris, *Learning to Crawl: The Use of Voluntary Caps on Damages in Medical Malpractice Litigation*, 54 CATH. U. L. REV. 703 (2005).

E. Farish Percy, *Checking Up on the Medical Malpractice Liability Insurance Crisis in Mississippi: Are Additional Tort Reforms the Cure?*, 73 MISS. L.J. 1001 (2004).

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