# A REVIEW OF FEDERAL MEDICAL MALPRACTICE TORT REFORM ALTERNATIVES

*Christopher S. Kozak**

## *I. Introduction*

Among the most well known and controversial legislative proposals of our day has been Congress' valiant, yet still unsuccessful, attempt to restrain the growth of health care expenditures by establishing a uniform, federally-run health system.[1] According to the Congressional Budget Office, Americans presently spend greater than one trillion dollars each year on health care.[2] Of that amount, the medical malpractice[3] insurance paid by health care providers accounts for approximately eight billion dollars (.73%)

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* B.A., Law & Society, Binghamton University, 1993; J.D., Seton Hall University School of Law, anticipated June 1996.

[1] *See generally* CONG. BUDGET OFF., AN ANALYSIS OF THE ADMINISTRATION'S HEALTH PROPOSAL (Feb. 1994). The Congressional Budget Office (hereinafter CBO) summarized the objectives of the Health Security Act, H.R. 3600/S. 1757, proposed by the 103d Congress. The CBO study enumerated the many budgetary and procedural complications that such a broad program is likely to encounter. *Id.* For one, the CBO expects that a nationwide health plan, by its nature, will be extremely selective about the technologies it prescribes to. *Id.* at 75. Hence, the plan's objective to narrow costs will be met, but at the expense of decreasing the demand for new research and development. *Id.* The American Bar Association (hereinafter "ABA") attributes the rising cost of health care to: (1) reliance on expensive modern technology; (2) the aging population burdening the government programs of Medicare and Medicaid; (3) high insurance premiums assessed to physicians and surgeons; and (4) the increasing costs of filing a malpractice suit. Philip Corboy, Statement to the *Subcomm. on Economic and Commercial Law of the House Comm. on the Judiciary* 4 (June 22, 1994) (Health Security Act—Malpractice Issues: Hearings on H.R. 3600).

[2] CONG. BUDGET OFF., MANAGED COMPETITION AND ITS POTENTIAL TO REDUCE HEALTH SPENDING 24 (May 1993) [hereinafter MANAGED COMPETITION]. The 1993 study estimated that Americans will be paying $1.089 trillion during 1995 on their health. Of that amount, most states have approximately the same expenditures on personal health care as the United States in the aggregate. GOV'T ACCT. OFF., HEALTH CARE SPENDING: NONPOLICY FACTORS ACCOUNT FOR MOST STATE DIFFERENCES 3 (1992) [hereinafter NONPOLICY FACTORS].

[3] JENNIFER O'SULLIVAN, CONG. RES. SERVICE, MEDICAL MALPRACTICE 1 (May 16, 1994). For the purposes of this note, "medical malpractice" will be defined as "any deviation from the accepted medical standard of care that causes injury to a patient." *Id.* "[T]he medical malpractice system is designed to hold the medical profession to an acceptable level of quality by deterring negligence." OFF. TECH. ASSESSMENT, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE 15 (1994) [hereinafter OTA REPORT].

of the nation's yearly health care expenditures.[4]

In response to these statistics, there has been a surge of legislation proposed in Congress directed at reducing medical malpractice premiums and costs.[5] Fear of a malpractice crisis[6] has influenced legislators and health care providers to push for tort reform[7] which restricts litigation and plaintiff damage awards.[8]

Successful reform depends on the severity of damage awards and a careful evaluation of present litigation trends.[9] Legal experts, however, dispute the actual frequency of patient claims and most recent studies indicate that there has been a leveling off of

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4 ELI GINZBERG, THE ROAD TO REFORM: THE FUTURE OF HEALTH CARE IN AMERICA 111 (1994). This estimate may not be reliable, because it cannot account for the costs of defensive medicine which may increase costs by five times or more. *Id.*; *see* discussion of defensive medicine, *infra* notes 36-66 and accompanying text.

5 *See infra* notes 57, 59, 67, 95, 158, 181, and 192 (listing various state statutes pertaining to self-referrals, practice guidelines, damage awards, collateral sources, periodic payments, and pre-trial review). *But cf.* NONPOLICY FACTORS, *supra* note 2, at 1, 13. National variances in, *inter alia*, personal income, health care provider's capacity (i.e. number of beds), and concentration of health services in urban areas are the nonpolicy factors that may cause a significant barrier to federal health policies. *Id.* States with similar policies have not been able to contain health care costs. *Id.* at 13.

6 *See generally* PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY (1985). In the mid-1970s, a malpractice crisis arose as premiums increased in some states by 500%. *Id.* at 97. The crisis developed out of the industry's ignorance of the cost and significance of malpractice litigation, mainly due to the lack of empirical data on the causes and effects of medical behavior. *Id.* at 99. Insurers, medical society programs, and the Insurance Services Office maintained data bases on claims, but their data could not account for the changes in claims frequency. Due to the unavailability of accurate information, premium rates lagged far behind the explosion in claims. *Id.* at 107. As a result, "[t]he huge premium increases of 1975 were largely a catching-up process following [the] lag in rates behind rapidly rising claim costs over the preceding four or five years." *Id.* at 225.

7 OTA REPORT, *supra* note 3, at 164. "Tort reform" consists of laws that change the protocol of tort claim procedures and resolution processes, lessening the burdens on the civil justice system. *Id.*

8 GOV'T ACCT. OFF., MEDICAL MALPRACTICE: ALTERNATIVES TO LITIGATION 1 (1992) [hereinafter ALTERNATIVES TO LITIGATION]. Tort reform is a legislative response which may limit claims filed by persons alleging to be the victims of negligence or substandard medical care. Most tort reform law includes restrictions on patient recovery, while other reforms address the procedure for filing a claim. *Id.*

9 *See generally* TEXAS MED. ASS'N AND TONN & ASSOC., MEDICAL PROFESSIONAL LIABILITY: AN EXAMINATION OF CLAIMS FREQUENCY AND SEVERITY IN TEXAS (1994) (reporting on the explosive growth and frequency of claims against physicians) [hereinafter TMA REPORT]; *but see* Mark A. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS OF INTERNAL MED. 780, 782 (1992) (concluding a study that found "the severity of patient injury had little effect on the probability of plaintiff payment").

claims since 1985.[10] In 1994, the American Medical Association (hereinafter AMA) reported that the number of claims against hospitals and physicians dropped at an average rate of 1.9% per year (claims per 100 physicians) since the large increases of the early 1980s.[11] This significant decrease is attributed to the high procedural cost associated with filing a medical malpractice claim.[12] Filing a cause of action usually entails exorbitant administrative costs, including outlays for medical reports, second opinions, and retention of expert witnesses.[13] The potential cost of claims not supported by evidence serves as a barrier to injured, indigent claimants because many attorneys will opt to forego the opportunity to represent that person.[14]

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10 MARTIN L. GONZALEZ, AM. MED. ASS'N, SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 41 (1994). Generally, statistics indicate that there has been a leveling off of claims since 1985. *Id; see also* ASS'N OF TRIAL LAW. OF AM., STRAIGHT TALK ON MEDICAL MALPRACTICE: SEPARATING FACT FROM FICTION 11-13 (1994) [hereinafter STRAIGHT TALK]. Because only one in every eight negligently-injured patients ever brings a claim, the number of lawsuits against physicians has been declining. *Id.* at 12. *See also* WORKING GROUP ON CIVIL JUSTICE SYSTEM PROPOSALS, AM. BAR ASS'N, BLUEPRINT FOR IMPROVING THE CIVIL JUSTICE SYSTEM 51 (1992) [hereinafter ABA BLUEPRINT]. Thousands of people with legitimate claims are denied access to the civil justice system either because they cannot afford the initial litigation costs or because it is a "labyrinth" that they cannot understand. *Id; but see* TMA REPORT, *supra* note 9, at 1 (claims data for Texas between 1983 and 1992 illustrated yearly increase and reported explosive growth in claims during the last two years).

11 GONZALEZ, *supra* note 10, at 41-45. However, the 1992 claims rate of 8.9% (claims per 100 physicians) was the highest rate since 1985, when the claims rate was 10.2%. *Id.* It appears that, although the rate is leveling off, it is doing so at a harmfully high rate for physicians. As a result, premiums rose significantly through the late 1980s and have stabilized at $13,500 per year for each physician. *Id.* at 44. To indicate the relative rise in premiums, the AMA converted the 1992 figure into 1982 dollars, showing an average increase of 4.8% in insurance premiums. The rates changed from $5,800 per physician in 1982 to $9,300 in 1992 (disregarding inflation effect). *Id.*

12 PHYSICIAN PAYMENT REV. COMM'N, ANNUAL REPORT TO CONGRESS 291 (1994) [hereinafter ANNUAL REPORT].

13 *Id.* Also, because there is no legally defined standard of medical care in the courts, one must be defined in each new case. OTA REPORT, *supra* note 3, at 3. The legal standard of care takes into consideration each patient's unique medical condition, along with the accepted standard of medical practice as established by what is "customary and usual in the profession." *Id.* at 30 n.11 (quoting Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The Accepted Practice Formula*, 28 VAND. L. REV. 1213, 1234-36 (1975)).

14 *See* Helen R. Burstin et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697, 1700 (1993). Surprisingly, a recent case study illustrated that not only are indigent victims foreclosed from opportunities to adequate medical care and malpractice claim representation, but

Also, legislators have been motivated to enact medical malpractice tort reform to limit the extent of plaintiff damage awards.[15] Generally, patients with sufficient evidence to demonstrate a physician's negligence may be entitled to almost unlimited compensation.[16] To prevail, the patient need only show that the physician deviated from the medically accepted standard of care.[17]

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poor patients are less likely to sue when injured. First, physicians limit the care they provide to indigent patients. Physicians fear that these patients know that they have nothing to lose and everything to gain from initiating a malpractice suit. Consequently, the fear of litigation "[reduces] physician availability in poor neighborhoods and create[s] access barriers for the medically indigent." *Id.* at 1697. Second, economists believe that attorneys prefer to represent wealthy victims because indigent victims do not receive equally favorable jury verdicts. *Id.* at 1700. Jury awards for indigent people are less lucrative because of their low future earning potential and because of the traditional jury bias against poor claimants looking to make a "fast buck." *Id.*

The case-study illustrated that these perceptions are erroneous. *Id.* at 1697-701. In fact, of the 305 patients considered, 20% of the poor patients filed negligence suits against their physicians, as compared to 40% of the middle income patients. *Id.* at 1699. Because the poor sue less, tort reforms that protect physicians who fear malpractice litigation may be unwarranted. "[P]roposed legislation that would shield physicians who serve the poor from malpractice suits should be reconsidered. Such reforms are likely to further inhibit suits by poor patients, depriving the poor of any deterrent effect of tort litigation." *Id.* at 1701. Though the medical system shuts out many bona fide claims, malpractice suits must continue in order to improve the standard of care and reduce the incidence of negligence. GINZBERG, *supra* note 4, at 134.

15 Dr. Antonio Falcon, Statement to the *Subcomm. on Economic and Commercial Law of the House Comm. on the Judiciary* 2 (June 22, 1994) (Hearings on H.R. 3600). Windfall judgments for plaintiffs are commonplace in malpractice lawsuits whether or not the lawsuit actually merited recovery. *Id.; but see* Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 DUKE L. J. 217, 227 (1993) (illustrating that criticisms of jurors being biased are unfounded. There is no conclusive proof supporting the allegation that juries are psychologically motivated by their sympathy for plaintiffs). The common complaints against juries are that they are biased against the medical establishment and want to blame the health provider with the deepest pockets in order to guarantee compensation for the injured patient. The deep pockets hypothesis assumes that: (1) jurors tend to focus on plaintiff needs rather than on liability; (2) jurors believe that health provider defendants have the capacity to pay; and (3) jurors fail to understand that awards may potentially affect their own lives or society's welfare. *Id.* at 223.

16 Neil Vidmar, *The Unfair Criticism of Medical Malpractice Juries*, 76 JUDICATURE 118, 122 (1992). Juries may reasonably demand million dollar recoveries where liability was clear and damages were considerable. *Id.; but cf.* Nelson v. Trinity Medical Ctr., 419 N.W.2d 886 (N.D. 1988) (holding that a court may remit the verdict where it was clear that the jury had been influenced by sympathy and frustration with the health care provider's conduct).

17 Taragin, *supra* note 9, at 781. Physicians usually win cases where it was clear they abided by community health standards. *See infra* note 67-69, discussing the use of a legal-medical standard of care.

The problem today is that, depending on the expert witnesses used and the particular specialty being reviewed, there is a potential to view any physician conduct as a deviation.[18]

The objective of today's tort reform debate is to curb the growth of claims filed and large damage awards. Tort reform is intended to be the means of achieving a malpractice system that operates efficiently and consistently between like individuals.[19] The precise boundaries of these reforms has become somewhat of a filibuster in Congress.[20] Despite Congress' reluctance to commit to a particular proposal, there has been basic agreement as to the nature of the reform needed.[21] All reform suggestions typically include modifications of patient treatment procedures,[22] some form of limitations on damages,[23] and methods to streamline the claim

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18 OTA REPORT, *supra* note 3, at 30. Physicians are frustrated by the legal system that applies a different standard of care to each physician's conduct, depending upon the facts of the case. Experts can define the standard of the profession that was required in the case before the court. In fact, the lack of agreement in what the medical profession believes to be the correct standard of care results in inconsistent verdicts among similar cases. ANNUAL REPORT, *supra* note 12, at 291.

19 ANNUAL REPORT, *supra* note 12, at 293. Tort reform is a means towards the end of providing a better protocol for resolving claims and for establishing standards of care that treat like individuals similarly. However, the Physician Payment Review Commission (hereinafter PPRC) advocates that the ends of reform will better the malpractice system, but by no means will it become perfect. The PPRC expects states to scrutinize each federal reform provision against its state constitution. Consequently, national tort reform will not be easily accepted. *See id.*

20 *See generally* JENNIFER O'SULLIVAN, CONG. RES. SERVICE, MEDICAL MALPRACTICE (Mar. 1994) (explaining the various Congressional proposals to malpractice tort reform). During the 103d Congress, the following legislation contained health care reforms addressing medical malpractice: House bills: 16, 101, 144, 150, 191, 196, 200, 257, 834, 1192, 1398, 1572, 1625, 1691, 1771, 1814, 1976, 2433, 2624, 2851, 3080, 3115, 3222, 3600, 3698, 3704, 3918, 3955, 4274 and Senate bills: 223, 325, 631, 684, 728, 1057, 1533, 1579, 1743, 1757, 1770, 1807. *Id.*

21 James S. Todd, *Reform of the Health Care System and Professional Liability*, 23 NEW ENG. J. MED. 1733 (1993). Today's "crisis" has restricted the quality of our health care by: (1) adversely affecting the doctor-patient relationship; (2) making doctors reluctant to offer high-risk services in fear of probable litigation; and (3) influencing careful medical tactics involving often unnecessary and expensive additional testing which might limit the risk of liability. *Id.* *See infra* notes 36-66 and accompanying text discussing defensive medicine.

22 *See infra* notes 36-92 and accompanying text. Treatment procedures addressed include defensive medicine and creation of practice guidelines.

23 *See infra* notes 93-190 and accompanying text. Limits on awards include limits on non-economic and economic damages, abolishment of the collateral source rule, mandating periodic payments, and limits on attorney fees.

resolutions process.[24] Because there are many considerations to account for, it is unlikely that the ultimate legislation will achieve equity for all.[25] The purpose of this note is to explore the various alternatives Congress is considering to reform and control medical liability.

## *II. Legislative History—The Need for Reform*

Motivated by the aforementioned state of affairs in American health care, the 103d Congress set out to arrest the possibility of another medical crisis.[26] In 1993, Congress proposed the Health Security Act[27] which was expected, *inter alia*, to reform the medical

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24 *See infra* notes 191-242 and accompanying text. These methods include alternative dispute resolution and certificates of merit.

25 Todd, *supra* note 21, at 1734. "To achieve a workable, fair system, *everyone* with a stake in the outcome will have to be involved." *Id.* (emphasis added). Physicians will have to improve the quality and appropriateness of their care. *Id.* Patients should recognize that not every injury resulting from medical care is a product of negligence. *Id.*; Shelly Gehshan, *Solving Problems with Medical Malpractice Insurance* 8, *in* SOUTHERN REGIONAL PROJECT ON INFANT MORTALITY, PROBLEMS AND SOLUTIONS: BACKGROUND PAPERS FOR THE SOUTHERN LEGISLATIVE SUMMIT ON HEALTHY INFANTS AND FAMILIES (1990). Also, there must be rigorous enforcement of attorneys' professional responsibility to proscribe the filing of frivolous claims. ABA BLUEPRINT, *supra* note 10, at 54. In fact, according to the GAO, as much as 56.7% of all claims filed against physicians are dismissed without verdict or compensation. GOV'T ACCT. OFF., MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 80 (Apr. 1987).

Absolute equality may never be achieved with "conventional" tort reforms, because they invariably benefit defendants more often than plaintiffs by limiting access to the courts, defining what is compensable, and then placing a ceiling on the amount an injured person can recover. OTA REPORT, *supra* note 3, at 26.

26 GINZBERG, *supra* note 4, at 16. Throughout the 1970s and 1980s government and employers desperately attempted to stabilize the costs of health care. Today, however, the once-unnoticed difficulty of accessing care has emerged. *Id.* Presently, more than 39 million Americans are without insurance coverage. Adam Clymer, *National Health Program, President's Greatest Goal, Declared Dead in Congress*, N.Y. TIMES, Sept. 27, 1994, at A1, B10. Confronting the growing problem, Congress had to determine how to fashion a proposal that would provide insurance coverage and quality care without increasing expenditures. *See* THEODORE R. MARMOR, UNDERSTANDING HEALTH CARE REFORM 10 (1994). "Sensible reform should build on three fundamental principles . . . cost, access, and quality." *Id.* at 14.

27 H.R. 3600, 103d Cong., 1st Sess. (1993) [hereinafter H.R. 3600]; S. 1757, 103d Cong., 1st Sess. (1993). In September of 1993, President Clinton first elaborated the initiatives ultimately written into the Health Security Act before a joint session of Congress. *See* H. DOC. NO. 174, 103d Cong., 1st Sess. (1993) (Presidential Message No. 76). The Act was introduced jointly to Congress of November 20, 1993 by Representative Richard A. Gephardt (D-Mo.) in the House of Representatives and by Senator George J. Mitchell (D-Me.) in the Senate. H. REP. NO. 883, 103d Cong., 2d Sess. 80

malpractice liability system.[28] The proposed Act represented the first time in recent history that the government appeared to take seriously the idea of a national health reform.[29] As envisioned in House Bill 3600, Congress sought to establish a system of fair and expeditious resolutions for medical malpractice disputes.[30]

Unfortunately, the complexity and significant federal health care reform was not well received by the American public.[31] Hearings on malpractice reform issues were productive but did not receive the public attention necessary to raise an awareness of the

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(1995) [hereinafter H. REP. No. 883]; S. REP. No. 317, 103d Cong., 2d Sess. 10 (1994) [hereinafter S. REP. No. 317].

The breadth of the Act required the attention of many Committees to hold hearings on the varied provisions. *See* H.R. 3600, *supra* (referring the bill concurrently to the Armed Forces, Education and Labor, Government Operations, Energy and Commerce, Natural Resources, Judiciary, Post Office and Civil Service, Rules, Veterans' Affairs, and Ways and Means Committees). Specifically, the provisions pertaining to medical malpractice tort reform were sent to the Judiciary Committee. H. REP. No. 883, *supra*, at 77 (appropriately referred because sections dealing with "remedies and enforcement, medical malpractice, fraud and abuse . . . fall within the Committee's rule X jurisdiction." The Committee regularly hears issues pertaining to the issues of privacy, due process, equal protection, and civil rights—all of which issues are closely associated with medical malpractice litigation).

28 S. REP. No. 317, *supra* note 27, at 10. These reforms are found in subtitle D of title V of the Act. H. REP. No. 883, *supra* note 27, at 77. They include sections providing: "mandatory alternative dispute resolution before litigation; limits on attorney fees; collateral source reform; and periodic payment of future damages. Also, the [bill] authorizes Federal grants to states to determine the effectiveness of alternative approaches such as enterprise liability, no-fault liability, and the use of practice guidelines in malpractice actions." S. REP. No. 317, *supra* note 27, at 10.

29 GINZBERG, *supra* note 4, at 6. Both Presidents Reagan and Bush basically avoided the question of whether the federal government should intervene in health issues that had been regulated by the states. Bush unveiled a very moderate proposal on February 6, 1992. Clymer, *supra* note 26, at B10. The Bush plan was designed to reduce defensive medical practices by setting limits on damages and by proposing various anti-trust laws. ROBERT KAPLAN, THE HIPPOCRATIC PREDICAMENT: AFFORDABILITY, ACCESS, AND ACCOUNTABILITY IN AMERICAN MEDICINE 75 (1993). Because it was the first federal comprehensive health reform package, the plan raises much controversy as it was seen as a radical departure from the system existing at that time. *Id.* at 76. Additionally, Bush's plan met hellfire in the democratically-controlled Congress. To be successful, Bush's plan should have allowed for flexibility at the state level, so as to minimize the harsh realities of federalizing health care. *See id.* at 76-78.

30 S. REP. No. 317, *supra* note 27, at 261.

31 Robin Toner, *Autopsy on Health Care*, N.Y. TIMES, Sept. 27, 1994, at A1, B10. In fact, according to Senator Bob Dole (R-KS), "there was an overwhelming consensus on the part of the American people to put on the brakes . . . ." *Id.* Dole believed the rational for this sentiment was that Americans "feared an overdose of government control." Clymer, *supra* note 26, at A1.

true problems posed.[32] Issue to be resolved include determining how much physicians should be accountable for and which patients should be foreclosed from the litigation process.[33]

Though there has been no consensus on medical liability reform, Congress has recognized the need for it. For now, the individual states continue to dictate reform until Congress debates, hears testimony, discusses, and finally agrees on the form of reform it will enact.[34] Many commentators agree that the future of reform in this area depends not on overly comprehensive legislation, but rather on the articulated pursuit of goals which can be achieved in an incremental fashion.[35]

## *III. Reform of Physician Practices*

### A. *Defensive Medicine*

Perhaps the single most controversial issue in health care today is that of patients receiving avoidable injuries from unnecessary medical procedures.[36] Fueling this debate is the question of

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32 H. REP. NO. 883, *supra* note 27, at 80. On June 8, 1994, H.R. 3600 was considered by the subcommittee on Economic and Commercial Law. On June 22nd, the subcommittee conducted a hearing with testimony from representatives of victims, physicians, study groups, and lawyers. *Health Security Act—Malpractice Issues: Hearing on H.R. 3600 before the Subcomm. on Economic and Commercial Law of the House Comm. on the Judiciary*, 103d Cong., 2d Sess. (June 22, 1994) (this document has not yet been published). The House Bill was marked up to the Judiciary Committee on August 2nd. H. REP. NO. 883, *supra* note 27, at 80. On September 26, both houses agreed that all hopes for major health care restructuring were dead. *Why Health Care Fizzled: Too Little Time and Too Much Politics*, N.Y. TIMES, Sept. 27, 1994, at B11 [hereinafter *Why Health Care Fizzled*]. Rep. Gephardt, the Bill's sponsor, said, "[i]t became very clear very quickly that there was little or no support for meaningful reform . . . ." *Id.*

33 H. REP. NO. 883, *supra* note 27, at 77-78. Proper resolution of these questions are "essential for the success of any health care reform endeavor." *Id.* at 78. "While complex and sensitive issues considered by the Committee have received relatively little public attention during the national debate over health care reform, they have profound implications for economic and political freedom." *Id.* at 77-78.

34 S. REP. NO. 317, *supra* note 27, at 30.

35 *Why Health Care Fizzled*, *supra* note 32, at B10 (similar statements were made by Rep. Gephardt and Dr. P. John Seward, Chairman of the American Medical Association).

36 *Malpractice: A Straw Man*, CONSUMER REP., July 1992, at 443 (quoting Randall Borbjerg, "The greatest single problem about malpractice is that there is a lot more of it out there than anyone is dealing with. . . . Patients are getting avoidable injuries and no one is stopping it").

In 1984, the most widely cited estimate of defensive medicine measured its costs to be $12.1 billion. OTA REPORT, *supra* note 3, at 47, app. J.; *contra* STRAIGHT TALK, *supra* note 10, at 6 (in 1991, the AMA assessed that defensive practices cost consumers

whether physicians are performing defensive medicine[37] because they are actually motivated by the fear of medical malpractice. The difficulty with categorizing defensive medical tactics is that physicians themselves do not realize its prevalence in their practice.[38] Also, it is sometimes difficult to separate which acts or omissions are performed in fear of litigation.[39]

The Office of Technology Assessment (hereinafter OTA) recently concluded the most comprehensive study of defensive medicine to date.[40] Using clinical scenarios, it surveyed physicians and found that between five and twenty-nine percent of all health care providers choose actions due to malpractice concerns.[41] De-

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$25 billion per year). *But cf.* SPECIAL COMM. ON MEDICAL PROFESSIONAL LIABILITY, AM. BAR ASS'N, PROFESSIONAL LIABILITY AND HEALTH CARE REFORM 3-4 (1993) [hereinafter ABA SPECIAL COMMITTEE] (defensive medicine is not capable of measurement because there is no absolute agreement as to the definition of the phrase); GINZBERG, *supra* note 4, at 141 (defensive medicine is not the only factor contributing to the increased costs of medical care. Economists must also consider the higher salaries of physicians, technological advancements, malpractice litigation, and the growing population).

37 OTA REPORT, *supra* note 3, at 3.

> "Defensive medicine" can best be described as: [D]octors order[ing] tests, procedures, or visits, or avoid[ing] high-risk patients or procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice liability... Under this definition, a medical practice is defensive even if it is done for other reasons (such as belief in a procedure's effectiveness, desire to reduce medical uncertainty, or financial incentives), provided that the primary motive is to avoid malpractice risk.

*Id.* "The most serious cost implications of malpractice suits . . . are not attributable to litigation but rather to the practice of defensive medicine by physicians." GINZBERG, *supra* note 4, at 51. *But see* ABA SPECIAL COMMITTEE, *supra* note 36, at 5 (finding no basis for assuming that competent and intelligent physicians perform unjustified procedures). *See also* DANZON, *supra* note 6, at 146 (citing the difficulty of determining what procedures are unjustifiably overused with respect to diagnostic tests, x-rays, and hospitalization of patients).

38 OTA REPORT, *supra* note 3, at 3. Over time what was once a conscious defensive medical practice in response to a concern for liability may become an unconscious act of daily practice. By its continuous use, the procedure can become a standard of that physician's practice and, quite possibly, the standard of others' practices also. *See id.*

39 Richard P. Bergen, *Defensive Medicine is Good Medicine*, 228 JAMA 1188 (1974). "Positive defensive medicine" exists in those instances when the physician orders additional health care that could benefit the patient. *Id.* "Negative defensive medicine" exists where malpractice motivates a physician to avoid certain patients or procedures, though it may be essential to the patient's welfare. *Id.* at 1189.

40 *See generally* OTA REPORT, *supra* note 3.

41 *Id.* at 5. The OTA collected its data by creating clinical scenarios which were designed to trigger defensive medicine as a possible option. For this reason, much of the OTA findings may have overestimated normal performance. *Id.* at 8. Overall, the OTA concluded that the median of all responses illustrated that eight percent of all

spite its many reaffirmations and discoveries about defensive medicine, the OTA stated that their only conclusive finding was that an accurate measurement of defensive medicine is virtually impossible.[42]

Malpractice is conceivable in nearly all medical procedures. These chances are aggravated when physicians have the responsibility to weigh the value of additional care or tests for particular patients, placing them in the untenable position of balancing costs and patient welfare with liability concerns.[43] At the same time, they must consider that even tests with negative findings have some value in establishing a positive diagnosis.[44] Therefore, any reform focusing on defensive medicine must distinguish between those procedures that are necessary or desirable and those performed

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diagnostic procedures are done for conscious defensive medical reasons. *Id.* at 56. By definition, unconscious defensive medicine could not be measured because doctors do not realize when their actions are motivated by a concern for liability. *Id.* at 22.

42 OTA REPORT, *supra* note 3, at 4. Polling physicians about their inclination to prescribe excessive procedures that are not socially desirable is inherently problematic. Physicians may be motivated to give a response that is the most approved action in their field. "[P]hysicians may respond [to a medical scenario] as if the survey [were] a medical board examination and justify their choices on purely clinical grounds when other factors do in fact operate." *Id.*

Determining whether a physician believes in the necessity of defensive practices depends on how *close to home* the malpractice claim hits. Figures illustrating the commonality of defensive medicine may not be reliable because the OTA believes that physicians tend to over-estimate their risk of being sued. *Id.* at 27. For instance, a practitioner who has been exposed to litigation, either directly or indirectly, is more likely to practice defensively. *Id.* at 37.

43 Bergen, *supra* note 39, at 1188-89. "The attending physician must determine whether the expected benefits from a test are sufficient to justify the cost and discomfort or hazard of the test." *Id.* at 1189. However, this decision is complicated by the fact that physicians do not know what behavior will result in a malpractice suit. OTA REPORT, *supra* note 3, at 11. It is their inability to predict the consequences of their acts that influences them to practice defensively. *See id.*

44 Bergen, *supra* note 39, at 1189. The omission of a test that may have a beneficial result cannot be justified merely because the costs are high. In fact, those who have insurance would probably be willing to spend the extra time and money on a test if it could have a minimal expected benefit, called "low-yield" medicine. VICTOR R. FUCHS, THE FUTURE OF HEALTH POLICY 159 (1993). These types of services provide some benefit to the patient while the cost to the insurer and society exceeds that benefit. "Low-yield" medicine is the most difficult to constrain because the additional services are not completely useless.

Also, doctors may be motivated to perform procedures that they believe are beneficial or effective. OTA REPORT, *supra* note 3, at 22. However, these procedures are generally excessive, because doctors may be overvaluing the benefits and the procedure may not precisely match the needs of the patient's condition. *See id.* at 22, 27, 37.

because of a fear of being vulnerable in a court of law.[45]

Besides the aforementioned physician's dilemma, doctors are also faced with considering the relative worth of technological advances.[46] Though probably not worth the additional expense in most cases, patients have come to expect the use of the most modern, sophisticated equipment that can increase the accuracy of their diagnosis.[47] These advances, if applied properly, can reduce the risk of liability and eliminate uncertainties. However, these improvements come at a high price.[48]

Presently, physician practices counter national goals by unnecessarily wasting medical resources.[49] The aim of legislators has been to reduce the incentive of physicians to practice defensively.[50] At the same time, the health care industry has sought to achieve a more efficient allocation of those resources by preventing unnecessary procedures through the imposition of medical guidelines.[51]

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45 *See* GINZBERG, *supra* note 4, at 51. Defensive medicine is useful to the extent that it increases physicians' concern for the welfare of the patient and raises their tolerance for liability. ABA SPECIAL COMMITTEE, *supra* note 36, at 5. *But see* Taragin, *supra* note 9, at 780 (stating that physicians that are too apprehensive about litigation can be a detriment to health care as these individuals are the most likely to shift out of high risk fields, thus leaving a shortage of doctors in certain areas).

46 *See* OTA REPORT, *supra* note 3, at 9. The availability of better technology could increase the consequences of not testing. *Id.* Also, consider that physicians are often wary of new medical technology that may not have been adequately applied to their patients' condition. *See id.*

47 ABA SPECIAL COMMITTEE, *supra* note 36, at 5. Patients rely on their belief that their physician will know what's wrong and will be able to direct them to the treatment that will best remedy the problem. GINZBERG, *supra* note 4, at 133. As a result, patients sometimes expect the impossible. David Sohn, *An Examination of Alternatives to Suit in Doctor-Patient Disputes*, 48 ALB. L. REV. 669, 671 (1984).

This problem is not as prevalent in other countries. For example, although Britain's technology matches that found in the United States, its innovations are not as readily available, consumer demand is lower, and, therefore, it spends considerably less on its health care. FUCHS, *supra* note 44, at 78.

48 OTA REPORT, *supra* note 3, at 3. The more medical advancements made with doctors' blind acceptance of them, the more likely the chance that doctors' tolerance for medical risks will be raised. *Id.* at 15. Patients may not favor this result, but by lessening concerns for liability the costs attributable to defensive medicine will decline. *Id.*

49 FUCHS, *supra* note 44, at 160. The medical industry wastes its resources by commercializing its products and procedures by developing certain types of duplicative equipment and by encouraging the specialization of personnel in narrow fields. *Id.*

50 OTA REPORT, *supra* note 3, at 2.

51 *See infra* notes 67-84 elaborating on the practical effects of practice guidelines; *see also* DANZON, *supra* note 6, at 10. Economist Patricia Danzon stated that the best way to achieve an optimal allocation of medical resources would be "at the margin,

1. Self-Referral Increases Health Costs

Other than guidelines, some recent legislation addresses unnecessary medical practices by limiting "self-referrals."[52] In fact, the rising cost of medical care can be partly attributed to the growth of physician ownership of external testing facilities.[53] When self-referral is an option, it presents the physician or hospital with conflicts of interest and may prevent the recognition of their professional obligations.[54] Generally, medical professionals have a fiduciary responsibility to disclose to patients their pecuniary interest in prescribing additional treatment.[55] In doing so, they prevent their motives from being questioned later.

There has been a tremendous flood of legislation in this area addressing the need of consumers to make informed decisions when it comes to their health.[56] In fact, seventeen states require physicians to disclose to their patients whether they or immediate family members have a financial interest in the laboratory, diagnos-

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[where] a dollar spent on prevention saves a dollar of injury costs; this is true for each prevention activity—tests, monitoring of personnel, physician care, and so on." *Id.*

52 Arnold S. Relman, *"Self-Referral"—What's at Stake?*, 327 NEW ENG. J. MED. 1522 (1992). "Self-referral" occurs where a physician directs patients to an outside medical testing facility in which he or she has a direct pecuniary interest. *Id.* The increasing number of self-referral physicians has been suggested to be a direct result of the growing commercialism of the medical practice. *Id.*

53 ABA SPECIAL COMMITTEE, *supra* note 36, at 4.

54 Relman, *supra* note 52, at 1523; *see* Alex Swedlow et al., *Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians*, 327 NEW ENG. J. MED. 1502 (1992) (this study reinforced the allegation that physician ownership of diagnostic facilities leads to overuse and increased unnecessary costs). Self-referring doctors order additional procedures up to eight times more often than other doctors and charge up to seven times more than other facilities. Jean M. Mitchell & Jonathan H. Sunshine, *Consequences of Physicians' Ownership of Health Care Facilities—Joint Ventures in Radiation Therapy*, 327 NEW ENG. J. MED. 1497, 1501 (1992).

55 Relman, *supra* note 52, at 1523. A Florida study of joint ventures (or self-referrals) discovered that physicians chose the best patients for the testing facilities in which they had an investment interest. Mitchell & Sunshine, *supra* note 54, at 1499. Self-referring physicians "skim the cream" when they discriminate against poorer patients with less adequate insurance coverage. *Id.*

Furthermore, patients are at a significant disadvantage because they cannot assess the necessity of additional procedures themselves. "[I]t is unrealistic to expect a medical consumer, whose health is at stake, to vigorously question his or her doctor about the utility of a medical test." STRAIGHT TALK, *supra* note 10, at 8.

56 *Cf.* DANZON, supra note 6, at 13 (Ronald Coase once illustrated that if both parties are fully informed, such that they reduce the costs of contracting with each other, then the threat of loss and liability can be more evenly distributed between them).

tic, or therapeutic facility.[57] Informing patients is important because they rely on the expertise of their physicians.[58] Disclosure may remove some of the discretion from physicians, yet it may not completely prevent self-referral. To avoid this problem, a few states have considered more radical measures and have completely prohibited physician investment interests in certain testing facilities.[59]

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[57] *See* Swedlow, *supra* note 54, at 1502 (in 1992, the ABA House of Delegates approved the disclosure requirements). Disclosure of the physician's financial interest lessens the effect of the impropriety.

States that limit or restrict self-referral are: ARIZ. REV. STAT. ANN. § 32-1854.36 (1992) (unprofessional conduct if financial interest is not disclosed); CAL. BUS. & PROF. CODE § 650.01(f) (West 1993) (except as prohibited in (a) of this section the referred to entity shall disclose the physician's financial interest); FLA. STAT. ANN. § 455.25(1) (West 1986) (the patient must sign a written disclosure form detailing the financial interest and patient alternatives. Without disclosure, the physician will face disciplinary action for any split-fee arrangement. *See* FLA. STAT. ANN. § 458.331(1)(i) (West 1991)); HAW. REV. STAT. § 431:10C-308.7(c) (1992) (must disclose, except if the physician is in the same group practice with the health maintenance organization); LA. REV. STAT. ANN. § 1744B (West 1993) (requiring advance disclosure in writing of any financial interest in referral goods or services); MD. CODE ANN., HEALTH OCC. § 1-303 (1993) ("practitioner making a lawful referral shall disclose the existence of [his or her] beneficial interest"); MASS. GEN. L. ch. 112, § 12AA (1987) (referrals for physical therapy require disclosure of financial ownership interest to the patient); MINN. STAT. § 147.091(p)(3) (1989) (must disclose where physician has a significant financial interest); NEV. REV. STAT. § 439B.420.9 (1987) (physician must disclose); N.H. REV. STAT. ANN. § 125:25-b (1993) (health care provider ownership interest shall be disclosed in writing at the time of the referral); N.J. STAT. ANN. § 45:9-22.4 (1991), Governor's Recommendation Statement (practitioners with a significant beneficial interest shall disclose it to the patient); N.Y. PUB. HEALTH LAW § 238-d (McKinney 1993) (physicians may not make referrals without disclosing their financial relationship with outside health services); OKLA. STAT. ANN. tit. 59, § 725.4A (West 1992) (requires written disclosure of financial interest or remuneration received); PA. CONS. STAT. ANN. § 449.22 (1988) (prior to referral there must be disclosure of financial interest); S.C. CODE ANN. § 44-113-40 (Law. Co-op 1993) (requires written disclosure); TENN. CODE ANN. § 63-6-602 (1993) (where a potential conflict of interest exists, there must be disclosure); VA. CODE ANN. § 54.1-2964 (Michie 1986) (requires disclosure in bold print of any known material financial interest or ownership interest by the practitioner). Recently, even the 103d Congress proposed a version of a bill restricting physician self-referrals. H. REP. No. 601, 103d Cong., 2d Sess. pt.1, at 279-82 (1994).

[58] *See supra* note 55, illustrating patients' reliance on their health provider's knowledge and experience. Ill patients are highly vulnerable and must place confidence in their physician, trusting that she is both professionally competent and devoted to patient interests. E. Haaui Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1727 (1987).

[59] States that completely prohibit self-referrals are: CAL. BUS. & PROF. CODE § 650.01 (a) (West 1993) (unlawful to "refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy or diagnostic goods or services if the [physician] or his or her immediate family has a financial interest"); GA. CODE ANN.

2. Federal Options

The federal government joined the movement against self-referral in 1990 when it enacted 42 U.S.C. § 1395nn.[60] This section prohibits financial relationships between physicians and certain designated health services in order to curb remuneration[61] abuses and other self-dealing arrangements that may affect the quality of Medicaid health care.[62]

To be effective, a broader federal policy is needed that covers all health providers, not just those dealing with Medicaid. That policy would be more aggressive than section 1395nn and would develop ethical guidelines that both decrease excessive costs and maintain public confidence in the legitimacy of the profession.[63]

There is limited potential for national legislation that can curtail defensive medicine.[64] If Congress attempts reform here, it will be difficult to predict its success, if any, because we still have not determined what aspects of medical liability motivate doctors to practice defensively.[65] There is, however, a consensus that the federal policy adopted must, at least, be geared towards decreasing the ability and incentive of physicians to engage in defensive

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§ 43-1B-4 (1993) (prohibited from self-referring, but not if physician discloses pursuant to § 43-1B-6); ILL. ANN. STAT. ch. 225, para 47/20 (Smith-Hurd 1993) (prohibits self-referral unless (a) the physician is employed with the referral facility or will directly provide the care at that facility, or (b) there is no reasonable alternative facility); ME. REV. STAT. ANN. tit. 22, § 2085(1), (7) (West 1993) (practitioners are prohibited from referrals in which they have an investment interest, unless (1) the physician is employed with the referred-to facility or will directly provide the care at that facility, or (2) there is a community need. Under both exceptions there must be full disclosure).

60 42 U.S.C. § 1395nn (1990).

61 "Remuneration" is the payment made for services offered without expectation of payment. WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 997 (1988).

62 *See* 42 U.S.C. § 1395nn(e)(3)(A) (requiring that physicians be unlimited with respect to services normally performed, that they are restricted to only perform additional services that are necessary and reasonable, that their arrangements with each other for services be specified in writing, and that compensation be determined in advance).

63 *See* Relman, *supra* note 52, at 1524. But as with any federal policy, it must not derogate the reputations of those it addresses. *See id.* (discounting the benefits of voluntary ethical guidelines, because a national policy may have a negative effect on the public's perception of the medical profession. People do not look favorably upon a profession that needs federal supervision).

64 *See* OTA REPORT, *supra* note 3, at 10-19.

65 *Id.* at 10.

practices.[66]

### B. *Practice Guidelines*

In efforts to curb the costs associated with defensive medicine and physician liability, a few states have enacted legislation called practice guidelines.[67] The guidelines define the standard of medical care to be used in certain clinical situations.[68] Three approaches common to practice guidelines are: risk management, clinical-practice requirements, and data collection requirements.[69]

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66 *Id.* at 16. For the malpractice system to be effective, "first [it] must provide physicians with information as to what care is acceptable; second [it must allow] physicians [to] be able to improve the quality of care they offer." *Id.* at 29. *See infra* notes 67-84 and accompanying text discussing the standard of care. Merely limiting damages or claims frequency does not address the problems doctors have in predicting patient behavior. OTA REPORT, *supra* note 3, at 11.

67 Particular state statutes requiring medical practice guidelines are: FLA. STAT. ANN. § 408.02 (West 1993); KY. REV. STAT. ANN. § 216B.145 (Michie/Bobbs-Merrill 1994); ME. REV. STAT. ANN. tit. 24, § 2971 (Supp. 1991); OR. REV. STAT. § 414.720 (1993); and VT. STAT. ANN. tit. 12, § 7003 (1993). Other states have considered experimenting with guidelines and make their use voluntary; some examples of these statutes are: ARIZ. REV. STAT. ANN. § 20-2315 (1993); MINN. STAT. ANN. § 79.251 (West 1993); MONT. CODE ANN. § 50-4-402 (1993); N.J. STAT. ANN. § 4:22-16 (West 1994); N.Y. PUB. HEALTH LAW § 2804-a (McKinney 1994); and N.C. GEN. STAT. § 58-68A-10 (1993).

68 GOV'T ACCT. OFF., MEDICAL MALPRACTICE: MAINE'S USE OF PRACTICE GUIDELINES TO REDUCE COSTS 26 (Oct. 1993) [hereinafter MAINE STUDY]. "Practice guidelines" are statements designed to assist important decisions that the practitioner makes for the patient. "[They] are intended partly to improve the average quality of care and partly to insure that resources are used appropriately and effectively." MANAGED COMPETITION, *supra* note 2, at 37.

Guidelines enable physicians to determine more easily what standard of care they will be held accountable for before treatment begins. MAINE STUDY, *supra* at 1-3. Decreasing the uncertainty that influences physicians to perform tests and procedures is intended to benefit patients. It allows them to realize savings by compelling physicians to avoid unnecessary services. At the same time, patient outcomes should improve because they will be subject to less avoidable injuries. Also, although the types of treatment administered are changing, the level of patient satisfaction in that care has tended to remain the same. Scott R. Weingarten et al., *Practice Guidelines and Reminders to Reduce Duration of Hospital Stay for Patients with Chest Pain*, 120 ANNALS OF INTERNAL MED. 257, 260 (1994) (documenting the use of practice guidelines in coronary care units. The study found that mandating the physician to acknowledge guideline recommendations for each patient decreased the length of hospitalization and resulted in a total cost reduction of $1,397 per patient).

69 MAINE STUDY, *supra* note 68, at 31. Risk management programs are intended to prevent physician negligence. These programs include informational seminars on: cutting-edge or high-risk procedures, improving patient communication, targeting the use of informed consent, risk analysis, and claims study. Gehshan, *supra* note 25, at 9. Clinical-practice requirements prescribe the procedures practitioners should fol-

These are successful to the extent that they can shift physician practice patterns away from the impetus to act defensively.[70]

The standardization of minimal actions necessary for care affords physicians protection from malpractice suits.[71] This promotes physician confidence when deciding to or abstaining from ordering additional tests and procedures, and allows for more efficient allocations of medical resources.[72] In particular, guidelines are most worthwhile to high risk specialties where there is the greatest need to reduce malpractice claims and awards.[73] Physicians in high risk fields are most likely to participate in practice guideline programs because of their susceptibility to malpractice claims.[74]

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low in particular situations. MAINE STUDY, *supra* note 68, at 1-3. Data-collection requirements encourage physicians to fully document patient contact, condition, offered treatment, and results. *Id.*

70 Jonathan Lomas et al., *Do Practice Guidelines Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians*, 321 NEW ENG. J. MED. 1306 (1989). To be successful at influencing physician behavior to comport with the guideline recommendations, the reform enacted must have incentives for compliance. *Id.* at 1306, 1310. There must be a local enforcement feature in it that can offset forces acting against physician compliance, such as: threats of malpractice litigation, lack of confidence in clinical abilities, or economic and socioeconomic pressures. *Id.* at 1310. *But see* Weingarten, *supra* note 58, at 261 (guideline recommendations can successfully work for the patient's benefit, without the need for incentives).

71 MAINE STUDY, *supra* note 68, at 26.

72 *Id.* at 29. Additionally, the enforcement of the guidelines can motivate practitioners to upgrade their services and to invest in better equipment necessary to satisfy the standards. The effectiveness of the system depends on physicians only ordering procedures that are necessary for guideline compliance. *Id.* at 26. More efficient allocation of physician resources could improve access to health care for more people, especially those with lower income. *Id.* at 5.

This may be an appropriate solution to the defensive medicine crisis outlined above; however, practice guidelines are also immeasurable. Robert B. Keller, Statement to the *Subcomm. on Economic and Commercial Law of the House Comm. on the Judiciary* 7 (June 22, 1994). Just as the extent of defensive medicine is immeasurable, the effect of practice guidelines on the quality of health care cannot be quantified. While the use of guidelines may satisfy its purposes by suppressing meritless claims, it may actually increase the amount of litigation when it clarifies the standard of proof necessary for injured patients. "Nevertheless, it remains unclear whether developing and adopting additional practice guidelines would reduce or increase the average cost of care for the conditions they covered." MANAGED COMPETITION, *supra* note 2, at 37.

73 MAINE STUDY, *supra* note 68, at 8. The following specialties are generally considered high risk: internal medicine (the 1992 average liability premiums paid by self-employed physicians in this field was $8,500/yr.); surgery ($20,600/yr.); obstetrics/gynecology ($33,500/yr.); radiology ($10,000/yr.); and, anesthesiology ($17,200/yr.). GONZALEZ, *supra* note 10, at 44.

74 MAINE STUDY, *supra* note 68, at 8.

Guidelines that prescribe the care a physician should use relieve courts' burdens by eliminating the need to formulate new standards of care in each case.[75] The use of practice parameters shifts the focus from the peculiarity of each individual's condition to physician compliance with the accepted standard.[76] Under this system, the physician need only demonstrate sufficient evidence that he has complied with the accepted standard to avoid litigation.[77]

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[75] *See id.* at 2. Most guidelines serve only as recommendations that the physician may disregard, but at the expense of it being used in court to establish the standard of care. It is hoped that by setting out approved medical standards in writing, practitioners will be motivated to conform to them. *See id.* at 1-3. Thus, written medical standards would result in shifting the motivation away from the fear of litigation and decreasing unnecessary health care costs. *Id.*

Practice guidelines may be given the force of law when included in statutory form. *See, e.g.*, ME. REV. STAT. ANN. tit. 24, § 2971 (Supp. 1991), *amended* ME. LAWS C. 319 (June 17, 1991). If given the force of law, guidelines may be used to support a presumption of the stated standard of care "without the need for accompanying medical expert testimony." MAINE STUDY, *supra* note 68, at 20. Lessening the need for experts to define the applicable standard of care could reduce the costly battles between experts who define the necessary standard of care in each case. Keller, *supra* note 72, at 7; *but see infra* notes 78-80, discussing the many problems with defining a legal-medical standard of care.

[76] ALTERNATIVES TO LITIGATION, *supra* note 8, at 11. The law establishing the guidelines can make its application in court subject to the discretion of the health care provider or make it available to all parties. *See* MAINE STUDY, *supra* note 68, at 26-27. For example, on January 1, 1992, Maine launched its Medical Liability Demonstration Project, which incorporated 20 practice guidelines for four specialties (anesthesiology, emergency medicine, obstetrics/gynecology, and radiology) and made them only available to defendants. *Id.* at 20. In effect, a guideline can be an affirmative defense that cannot be presented by patients wishing to show a physician's failure to comply with it unless the physician has already offered the standard as evidence. *Id.* at 26; *see also* Falcon, *supra* note 15, at 20 (stating that health care organizations would support guideline programs "so long as they require that practice guidelines be used exclusively as an affirmative defense by defendants in liability cases"); *but see* Laura Wittkin, Statement to the *Subcomm. on Economic and Commercial Law of the House Comm. on the Judiciary* 13 (June 22, 1994) (on behalf of the Center for Patients' Rights, Wittkin noted that exclusive use of a standard is grossly one-sided and inherently unfair to injured plaintiffs).

On the other hand, where the standard has been open to all parties, it has become a significant part of malpractice litigation for claimants. ANNUAL REPORT, *supra* note 12, at 298. Plaintiffs' attorneys are more likely to use guidelines to establish the standard than are defense attorneys, "possibly because guidelines may provide cheaper or stronger evidence of the standard of care than expert testimony." Keller, *supra* note 72, at 9. The existence of an applicable guideline can influence lawyers to accept or reject a case and can affect the vigor with which the attorney pursues case resolution. *See id.* (claiming one-quarter of attorneys polled by the PPRC stated that a guideline played a part in their decision to drop or pursue a case to settlement).

[77] ALTERNATIVES TO LITIGATION, *supra* note 8, at 11; Taragin, *supra* note 9, at 782-83

Herein lies the most disputable aspect of the system: Can the medical standard of care, set in law, be made to conform to each injury now and in the future?[78] In effect, overly comprehensive practice guidelines may call for a standard of care where one does not exist.[79] In the end, the issue will be left to the trier of fact to ascertain the evidentiary weight it will give the standard of care.[80]

Until now, the only substantive practice guideline statutes have been promulgated by the states.[81] State demonstration projects have proved that guideline managed systems work best

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(study showing that medical malpractice verdicts turn on the issue of the standard's defensibility, not the severity of the patient's injury. In cases where the standard of care was questionable or against the physician, damages were paid in 91% of the cases surveyed. It concluded that "in a malpractice case, the physician's care is usually defensible and [ ]the plaintiff usually does not receive payment").

78 Morreim, *supra* note 58, at 1728. Medical science is imperfect and incapable of being frozen to one strict definition of care due to constant technical advances and patient maladies. In fact, good health care may be more appropriately a combination of defined standards and physician judgment under the circumstances. "Good health care requires the clinical judgment that arises not only from scientific generalizations but also from experience, knowledge of things that have not been quantified into scientific data, and [ ] from professional intuition." *Id.* at 1729. Practice guidelines must take into account the reality that things change and allow some flexibility for human judgment. *See id.*

79 Keller, *supra* note 72, at 7. There is a risk to applying a rigid standard of care in court. For one, courts may decide to carve out exceptions in certain cases. By way of *stare decisis*, a new standard will be installed, one that has not been formulated by the medical profession. *See id.* As a result, there may be increased litigation concerning amendments to the guideline. Thus, the purpose of reform, to reduce the costs of litigation, will not be efficaciously served. Additionally, courts may outright reject the guideline, thereby raising doubts as to its effectiveness. Also, physicians may be dissuaded from relying on it for their protection. *Id.*

80 ABA SPECIAL COMMITTEE, *supra* note 36, at 13. Given the many intricacies of a malpractice action, the evidence of compliance with a guideline standard may not be conclusive, because: (1) sometimes the entities creating the guideline standard have been forced to reach a compromise when drafting it; (2) medical standards are constantly changing; and (3) guidelines are often too general in their attempt to establish catch-all standards. *See id.* at 13-14. Undue reliance on standardized medical practice has been coined "cookbook medicine" or "checklist litigation." MAINE STUDY, *supra* note 68, at 17, 28. One commentator noted that:

> The adoption of practice parameters will create checklist litigation (and perhaps [cookbook] medicine). Proof of deviation will create an inference of negligence while proof of compliance will be evidence of due care .... The question we want to have answered in the courtroom is, "Did the doctor practice acceptable medicine under all of the circumstances?" We don't want liability to rest on whether or not the doctor missed an item on a checklist.

*Id.* at 28 (quoting a defense attorney for Medical Mutual Insurance Company).

81 *See supra* note 67 for a list of the states with practice guidelines projects.

when they lay down incentives that solicit universal physician participation, local enforcement provisions, and constant reminders of standard recommendations for physicians.[82] Based on the relative accomplishments in the states, the federal government may advance comparable national demonstration projects.[83] A proposal for federal guidelines, however, may be premature at this point. Additional data must first be collected to ascertain whether particular state actions have reduced litigation and to what extent the patient's quality of care has been affected.[84]

### C. *Enterprise Liability*

The standard of medical care may be improved by the institutionalization of malpractice liability, which may decrease the costs of health care.[85] Shifting liability away from health care providers induces cost efficiencies not available under other reforms. Today, the trend towards the integration of hospital ownership and staffing has made enterprise liability a practical mechanism to deal with liability.[86] It can reduce administrative costs, ensure quality care,

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82 *See* Lomas, *supra* note 70, at 1306, 1310. It has been proven that physicians who have witnessed the success of the guidelines in practice, are aware of local quality assurance techniques, and know the specifics of the actual recommendation are most likely to comply with guideline recommendations. Note that constant education is necessary to ensure the success of practice parameters because, "physicians fail[ ] to comply with guideline recommendations when they [do] not receive direct and concurrent reminders." Weingarten, *supra* note 68, at 261. Constant physician education is a prerequisite to the success of practice guidelines. *See id.*

83 ANNUAL REPORT, *supra* note 12, at 299. Before there can be an institution of federal practice parameters, however, there must be further monitoring and research done to determine their strength in actual litigation and to what extent the parties rely on them. *Id.*

84 MANAGED COMPETITION, *supra* note 2, at 37. The government must first collect data that compares the costs, outcomes, and quality of care pertaining to the use of nationalized standards with the health services currently being provided. "[State] experience should be assessed, paying particular attention to whether these actions have promoted or impeded the appropriate use of guidelines in litigation and in patient care." ANNUAL REPORT, *supra* note 12, at 299.

85 *See, e.g.*, H.R. 3600, *supra* note 27, at § 5311. These proposals are called "Enterprise Liability." This program shifts the burden of liability from physicians to the health plan in which he or she participates.

86 Keller, *supra* note 72, at 6. Vertical integration between health plan organizations and physicians (e.g. health maintenance organizations (hereinafter HMO), universities, or county hospitals) has become a popular method to combine efforts and reduce duplicative administrative costs. Enterprise liability furthers these efficient ends. Yet, enterprise liability will most likely not be as effective where the enterprise

and relieve physicians of their fear of litigation.[87]

Yet, enterprise liability does have its shortcomings. Because the enterprise has no personal stake in defending against claims, it is more likely to settle actions that do not appear frivolous in the early stages of litigation.[88] The enterprise's only concern is to retain a respectable balance sheet. Thus, shifting liability to an indirect and financially viable party could significantly increase the number of malpractice claims and the sizes of the damage awards.[89] Moreover, there may be no incentive that can eliminate

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and the physician are separate because there are no incentives to work as a unit to achieve the most efficient outcome. *See id.* at 6-7.

87 *See* ANNUAL REPORT, *supra* note 12, at 299. Administrative relief will be attained because the physician's insurer can be eliminated from the mix, leaving the health plan organization as the only defendant. Savings will be realized by eliminating the physician's need to maintain separate individual and corporate insurance policies. *Id.* Insurers oppose implementation of the enterprise liability project on a full-scale, as they may not be prepared to defend large numbers of claims. Robert Pear, *Clinton Advisors Outline Big Shift for Malpractice*, N.Y. TIMES, May 20, 1993, at A1.

Also, enterprises that can be liable will have an incentive to ensure that physicians uphold the relevant standards of medical care. ANNUAL REPORT, *supra* note 12, at 299. To avoid claims against their organizations, officials will be diligent to carefully select doctors with the best performance records, to monitor physician care, and to institute risk management programs. *Id.; but see* OTA REPORT, *supra* note 3, at 88 (physicians resent restrictions on their autonomy and object to assessments of their abilities by officials). Additionally, physicians employed under the same enterprise will be encouraged to monitor their colleagues' performance to collectively ensure that their payor (enterprise) is not subjected to extraordinary liability. *See* ANNUAL REPORT, *supra* note 12, at 299. These "[q]uality assurance structures that link physicians and engage them in quality review could pave the way for better quality improvement activities and an easier transition of enterprise liability." *Id.* at 300.

Enterprise liability may put to rest the psychological burdens and fears of defending against malpractice suits. OTA REPORT, *supra* note 3, at 13. The immunization from personal liability can allow the physician to be secure in his medical choices. But at the same time, increased oversight and threatened disciplinary action from the enterprise may have the effect of reviving fears of litigation and defensive practices. *See id.*

88 Pear, *supra* note 87, at A1. Health plan insurers may settle cases even where the attending physician used the appropriate standard of care. Physicians adamantly object to this because such practices scar their reputation without adequately defending against it. In fact, some may say that "[e]nterprise liability . . . not only will fail to diminish costs, it will probably give economic life to cases that otherwise would have been flushed out of the system." A. Blackwell Stieglitz, *Defense Counsel Will Find the President's Medical Malpractice Proposals So Benign as to be Meaningless*, NAT. L.J., Jan. 17, 1994, at 27.

89 *See* OTA REPORT, *supra* note 3, at 13. A shift in liability away from the doctor may legitimize the assumption that injured patients feel more comfortable suing institutions rather than the individual who performed the resulting negligent care. It relieves the plaintiff's moral conscience to know that her actions will not directly af-

the costs with recognizable effects on reducing liability and little, if any, anticipated benefit to the patient (i.e. defensive medicine).[90]

As a federal directive, enterprise liability projects may be useful as the integration of both health plans and physicians become more widespread. If current analysis of the present demonstration projects concludes that injured patients' propensity to sue does not change when liability has shifted, then enterprise liability would improve the quality of medical care in a cost efficient manner.[91]

## *IV. Reform of Damages*

### A. *Non-Economic, Economic, and Punitive Damages*

Most tort reform efforts have focused on limiting damages by imposing relief ceilings on patient recoveries.[92] These limitations aim to eliminate subjectivity associated with claims for bodily harm damages.[93] Because it is nearly impossible to assign a numeric value to a physical injury, jury verdicts for compensation are unpredictable.[94]

As a result of this uncertainty, thirty-one states have enacted reforms specifically regulating damage awards.[95] The American

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fect the physician's practice. Hence, more plaintiffs will bring their claims to suit. *Id.* Furthermore, juries knowing that the defendant-enterprise has "deep pockets" will likely render larger damage awards. *See* Pear, *supra* note 87, at A14. If the health plan consistently pays out large awards, doctors will assume the brunt of the losses in lower wages as a consequence. *Id.*

90 OTA REPORT, *supra* note 3, at 13 (organizations have no financial incentive to eliminate defensive medicine). There is no empirical evidence, however, whether defensive medicine will continue if liability is shifted away from the physician to a health plan. *Id.* at 88.

91 *See* OTA REPORT, *supra* note 3, at 87.

92 61 AM. JUR. 2D *Physicians, Surgeons, etc.* § 373 (1981).

93 Vidmar, *supra* note 16, at 124. "There is no scale by which the detriment caused by suffering can be measured and hence there can be only a very rough correspondence between the amount awarded and the extent of the suffering." RESTATEMENT (SECOND) OF TORTS § 903, cmt. a (1979).

94 Vidmar, *supra* note 16, at 122. In fact, juries would be more consistent if they were given more guidance with respect to their instructions and how to interpret medical expert testimony. *Id.* at 124.

95 The following was originally compiled in AM. TORT REFORM ASS'N, STATE LAWS ON MEDICAL LIABILITY (May 1994) [hereinafter STATE LAWS]: ALA. CODE §§ 6-5-544 to -547 (1987) ($400,000 limit on non-economic damages held unconstitutional in Moore v. Mobile Infirmary Assoc., 592 So.2d 156 (Ala. 1991), one million dollar limit on wrongful death actions); ALASKA STAT. § 09.17.010 (1986) (non-economic losses capped at $500,000); CAL. CIV. CODE § 3333.2 (West 1975) ($250,000 non-economic limit upheld in Fein v. Permanente Medical Group, 695 P.2d 665 (1985)); COLO. REV.

Bar Association criticizes these reforms as yet another legislative response that deprives the most seriously injured of full and ade-

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STAT. § 13-64-302.5 (1990) (proscribing punitive damages in certain cases); DEL. CODE ANN. tit. 18, § 6856 (1976) (punitive damages awardable only upon a showing of malicious intent to injure and wanton misconduct); FLA. STAT. ANN. §§ 766.207 to .209 (West 1988) (non-economic damages limited to $250,000, but held unconstitutional in University of Miami Sch. of Medicine v. Echarte, 585 So.2d 293 (Fla. Dist. Ct. App. 1991)); HAW. REV. STAT. § 657-7.3 (1986) (pain and suffering damages with a ceiling of $375,000); IDAHO CODE § 6-1606 (1990) (non-economic damages limited to $400,000, adjusted yearly according to the state's average income); ILL. REV. STAT. ch. 110, para. 2-1115 (1985) (eliminating punitive damages); IND. CODE § 16-9.5-2-2 (1989) (total cap on damages of $750,000, upheld in Bova v. Roig, 604 N.E.2d 1 (Ind. App. Ct. 1992)); KAN. STAT. ANN. § 60-19a02 (1988) (limiting non-economic damages to $250,000); LA. REV. STAT. ANN. § 40:1299.42 (West 1990) (total damages limited to $500,000, upheld in Butler v. Flint Goodrich Hosp., 607 So.2d 517 (La. 1992)); MD. CODE ANN. CTS. & JUD. PROC. § 11-108 (1986) (non-economic damages may not exceed $350,000); MASS. GEN. LAWS ANN. ch. 231, § 60H (1986) (total damages limited to $500,000, unless the limitation is shown to cause a substantial or permanent loss or impairment); MICH. COMP. LAWS § 600.1483 (1986) (non-economic damages capped at $225,000, subject to annual adjustment to the consumer price index); MINN. STAT. §§ 549.20 to .23 (1990) (punitive damages are awardable only upon proof of willful indifference or deliberate disregard for care. Pain and suffering damages (intangible damages) are limited to $400,000); MO. REV. STAT. § 538.210 (1986) (non-economic damages may not exceed $350,000 (adjusted annually), upheld in Adams v. Children Mercy Hosp. (Mo. Sup. Ct. May 19, 1991)); MONT. CODE ANN. § 21-1-310 (1987) (non-economic damages are not recoverable in a breach of contract action); NEB. REV. STAT. § 44-2825 (1986) (a plaintiff's total amount recoverable may not exceed $1 million, upheld in Prendergast v. Nelson, 256 N.W.2d 657 (Neb. 1977)); N.H. REV. STAT. ANN. § 508:4-d (1986) (this statute limited non-economic damages to $875,000, but was found unconstitutional in Brannigan v. Usitalo, No. 90-377 (N.H. Sup. Ct. Mar. 13, 1991)); N.M. STAT. ANN. §§ 41-5-6 to -7 (Michie 1976) (the aggregate amount recoverable is limited to $500,000; this figure increased to $600,000 in 1995); N.D. CENT. CODE § 32-03.2-09 (1987) (awards greater than $250,000 may be reviewed for reasonableness; a $300,000 limit was improper in Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978); OHIO REV. CODE ANN. § 2307.43 (Anderson 1975); OKLA. STAT. tit. 76, § 18 (1976) (damages limited to actual expenses if action is brought more than three years from the injury); OR. REV. STAT. § 18.550 (1989) (no punitive damages without proof of malice), § 18.560 (1987) (non-economic damages capped at $500,000); S.D. CODIFIED LAWS ANN. § 21.3-11 (1986) (total damages may not exceed $1 million); TEX. REV. CIV. STAT. ANN. art. 4509i, § 10.02 to .04 (West 1977); UTAH CODE ANN. §§ 78-14-12 to -16 (1985) (non-economic losses may not exceed $250,000); VA. CODE ANN. § 8.01-581.15 (1983) (total damages limited to $1 million); WASH. REV. CODE § 4.56.250 (1986) (non-economic damages may not exceed 43% of the state's average annual wage multiplied by the injured person's life expectancy (not less than 15 years), found unconstitutional in Sofie v. Fiberboard Corp., 771 P.2d 711 (Wash. 1989)); W. VA. CODE § 55-78-9 (1986) ($1 million cap on non-economic damages, upheld in Robinson v. Charleston Area Medical Center, 414 S.E.2d 877 (W. Va. 1991)). *But see* WIS. STAT. § 893.35 (1985) (limit on pain and suffering expired Jan. 1, 1991 and is now unlimited according to Jelenik v. St. Paul Fire and Casualty Ins. Co., no. 92-1858 (Wis. Sup. Ct. Mar. 14, 1994)).

quate compensation,[96] while it gives physicians additional benefits despite their negligence.[97]

The validity of damage caps has been challenged with some success in each of the four major damage award classifications: economic damages,[98] non-economic damages,[99] total damages, and punitive damages.[100] First, statutes establishing a ceiling on economic recovery have not been favored by the courts.[101] In *Duren v. Suburban Community Hosp.*, an Ohio statute restricting general damages[102] to $200,000 was held unconstitutional.[103] The court reasoned that the statute violated the constitutional right of equal protection because the limitation on damages unfairly burdened those plaintiffs least able to pay their medical and legal expenses.[104]

Alternatively, judicial treatment of non-economic damage limits has not been as clear-cut. In *Fein v. Permanente Medical Group*,[105] the California Supreme Court demonstrated that when considering legislation with potentially harsh ramifications, its duties are two-fold.[106] Specifically, the court must maintain its integrity and

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96 Corboy, *supra* note 1, at 4; STRAIGHT TALK, *supra* note 10, at 18.

97 Michael Berger, *Don't Reward Doctor's Negligence by Restricting Injured Patients*, TRIAL LAW. 65 (May 1992). Limits on damages may succeed in lowering insurance premiums, yet this savings is not passed on to the consumer. Berger stated that reform focusing on diminishing insurance premiums will never decrease overall health costs if doctors continue to pocket the savings. *Id.*

98 OTA REPORT, *supra* note 3, at app. K. "Economic damages" are those designed to compensate the plaintiff for his or her out-of-pocket expenses. These include any tangible economic loss, such as past and future medical expenses, costs of follow-up treatment, and lost wages. *Id.*

99 *Id.* Non-economic damages are the portion of the award that compensates for "pain and suffering." Because there exists no basis by which to measure the mental and physical anguish of an injury and its rehabilitation, these damages tend to be the most unpredictable. *Id.*; ANNUAL REPORT, *supra* note 12, at 294.

100 *See* RESTATEMENT (SECOND) OF TORTS § 908 (1979). Punitive damages are used to punish tortfeasors for their outrageous conduct and to deter similar future conduct. It is rarely used in malpractice cases unless the physician is found to have acted with a willful indifference to or in deliberate disregard of the patient's needs.

101 *See, e.g.*, Duren v. Suburban Community Hosp., 495 N.E.2d 51 (Ohio Misc. 1985).

102 For the purposes of this note, general damages and economic damages are synonymous terms.

103 *Duren*, 495 N.E.2d at 51.

104 *Id.* at 56. Indigent victims of torts may face a net loss if their medical and litigation expenses exceed their court awards. *Id.*

105 695 P.2d 665 (Cal. 1985).

106 *Id.* at 684.

must defer to legislative objectives that are rational.[107] In finding the law constitutional, the court pointed out that there were no limits placed on economic damages, and that an across-the-board limitation was fair, was consistent, and promoted settlements.[108]

Eight years later, in *Scholz v. Metro. Pathologists*,[109] a Colorado statute set a victim's non-economic damages at $250,000, though the jury believed he was entitled to $914,250. The court reasoned that an equal protection violation does not necessarily exist merely because legislation treats people differently.[110] Moreover, there was no due process violation because victims have no property interests in a mere expectation of compensation for pain and suffering.[111]

Other courts have attacked the premium caps as arbitrary and unreasonable barriers compensating the most seriously injured.[112] For example, in *Carson v. Maurer*, the court found the damage cap

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107 *Id.* at 679-84. If people do not agree with legislation, the proper course of action is through their representative legislature, not through the court system. Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985). *But see* Moore v. Mobile Infirmary Ass'n, 592 So.2d 156 (Ala. 1991) (illustrating how a legislature's information of the state of health care could be outdated; hence, the judicial role is to determine whether this information has changed enough to render the objective unworkable).

108 *Fein*, 695 P.2d at 683. The California legislature believed that "it was fairer to malpractice patients in general to reduce only very large non-economic damage awards, rather than to diminish the more modest recoveries for pain and suffering and the like in the great bulk of cases." *Id.*

109 851 P.2d 901 (Colo. 1993).

110 *Id.* at 906. Where no fundamental right has been infringed upon and no suspect class has been discriminated against, rational basis is the proper standard of review. *Id.* Here, in response to the legitimate governmental interest to increase the availability of health care, at a time when costs are rising nationwide, it was clearly reasonable to limit non-economic damages. *But see Moore*, 592 So.2d at 166-67 (burdening the most devastated victims for the indirect and speculative benefit that society might receive if malpractice premiums decrease is an unreasonable exercise of legislative power).

111 *Scholz*, 851 P.2d at 907; *cf.* Am. Bank & Trust Co. v. Community Hosp., 683 P.2d 670 (Cal. 1984) (stating that, "[I]t is well established that a plaintiff has no vested property right in a particular measure of damages, and [ ] the Legislature possesses broad authority to modify the scope and nature of such damages").

112 *See* Carson v. Maurer, 424 A.2d 825, 838 (N.H. 1980). The most severely injured patient's damages are likely to exceed the non-economic premium cap. ASS'N OF TRIAL LAW. OF AM., QUICK FACTS OF MEDICAL MALPRACTICE: WHAT YOU NEED TO KNOW TO PROTECT CONSUMERS 19 (1994) (compiled by ATLA-NJ). For this reason, the ATLA argues that "[a]rbitrarily capping damages is unjust and unfair and [has the effect of] further punish[ing] those who have had the misfortune of being severely injured." *Id.*

to be unconstitutional because it violated the equal protection clause.[113] The court reasoned that damage limits will have an egregious effect on those with meritorious medical claims because they will not be provided adequate compensation, but will continue to file their grievances and clog the court system.[114] Without limits on damages, the court can prevent excessive verdicts through the use of remitturs.[115]

A third classification of statutes limiting damages are those that set restrictions on all damages, irrespective of the distinctions of non-economic and economic damages. These statutes are subject to the same constitutional arguments outlined above.[116] Statutes supporting caps on damages will be upheld so long as they reasonably benefit society.[117] The reasons for striking down most caps in the various states have closely parallelled those enumerated in *Carson*.[118]

Lastly, the portion of the award designed to punish physicians are typically not favored in medical malpractice cases.[119] Punitive

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113 *Carson*, 424 A.2d at 828. In *Carson*, the plaintiffs raised constitutional challenges to New Hampshire's statute that governed medical malpractice suits after they were foreclosed from recovery. *Id.* at 829-30. *See also* Brannigan v. Usitalo, 587 A.2d 1232 (N.H. 1991) (using reasoning similar to that used in *Carson*, the same court struck down a statute limiting non-economic damages to $850,000).

114 *Carson*, 424 A.2d at 837 (*quoting* Arneson v. Olson, 270 N.W.2d 125, 135-36 (N.D. 1978)).

115 424 A.2d at 837, *citing* Reid v. Spadone Mach. Co., 404 A.2d 1094, 1099-1100 (N.H. 1979) (remitting a $150,000 award to $125,000). "Remittur" is the judicial process which reduces an excessive jury verdict. BLACK'S LAW DICTIONARY 1295 (6th ed. 1990). Using her discretion, a judge may order plaintiffs to remit a portion of their jury award, if it is grossly excessive. *Id.*

116 *See supra* notes 105-115 and accompanying text.

117 Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585 (Ind. 1980). The Indiana Supreme Court upheld a $500,000 cap on all damages. *Id.* at 600, 602; *see also* Butler v. Flint Goodrich Hosp., 607 So.2d 517 (La. 1992) (holding that limits allow a better guarantee that doctors will be insured and that payment will be made promptly); Etheridge v. Medical Ctr. Hosp., 376 S.E.2d 525, 531 (Va. 1989) (a plaintiff's substantive due process rights were not violated where she had no fundamental right to a specific tort recovery, and because the $1,000,000 cap on damages was economic in its effect, there is wide judicial deference); Robinson v. Charleston Area Medical Ctr., Inc., 414 S.E.2d 877 (W. Va. 1991).

118 *See* Lucas v. United States, 757 S.W.2d 687 (Tex. 1988) (striking down a statute capping all damages at $500,000, based on the combined constitutional notions of a right to court access and a right to a trial by jury). The Texas Supreme Court created an exception to *Lucas* in Rose v. Doctors Hosp., 801 S.W.2d 841 (Tex. 1990), allowing a cap to be placed in a wrongful death action, leaving open the right to move for a remitter.

119 Daniels & Martin, *Myth and Reality in Punitive Damages*, 75 MINN. L. REV. 1, 43

damages are rarely used unless a physician's negligence rises to the level of gross or wanton neglect of duty, an intent to harm, or extreme indifference to a patient's best interests.[120] Even in the few cases where a punitive award may be necessary, judges still have the authority to reduce the excessive or unjustified portion of the award.[121]

Though not addressed by most federal proposals, there are two popular reforms states use with regard to punitive damages.[122] One approach is to allocate the award towards improving the quality of care in accordance with the goal of these damages, which is to deter gross physician misconduct.[123] The rationale is that by putting the money into quality improvement programs, future injuries will be prevented.[124] The second reform considers raising the standard for proving punitive damages from a mere preponderance of proof to clear and convincing evidence.[125] Heightened scrutiny of these claims will ferret out weaker claims that rely on sympathy and not on the merits.[126]

### B. *Abolishing the Collateral Source Payments*

At trial, the collateral source rule[127] precludes admission of evidence of payments already received by an injured patient, unless

(1990). A study of 1,917 medical malpractice claims in which punitive damages were requested found only 18 cases (less than one percent) succeeded. *Id.* at 38.

120 61 AM. JUR. 2D *Physicians, Surgeons, etc.* § 371 (1981); *see* Noe v. Kaiser Found. Hosp., 435 P.2d 306 (Or. 1967) (proving mere negligence will not meet the threshold required for punitive damages); D. A. Johns, Annotation, *Allowance of Punitive Damages in Medical Malpractice Action*, 27 A.L.R.3d 1274 (1969). Determining the particular heightened standard of negligence depends on the facts and circumstances of each case.

121 ANNUAL REPORT, *supra* note 12, at 295.

122 *Id.*

123 *Id.*

124 *Id.*

125 *Id.* at 296. The PPRC is hesitant to approve such a program unless it is enforced throughout all cases. The rationale behind this is that it purports to change a well established rule of civil jurisprudence—the correct standard of proof has always been a preponderance of evidence.

126 *See* ANNUAL REPORT, *supra* note 12, at 296.

127 BLACK'S LAW DICTIONARY 262 (6th ed. 1990). The "collateral source rule" is the common-law doctrine that permits an injured person to receive compensation from each tortfeasor regardless of damages already paid by other tortfeasors. The rule does not deduct amounts already paid to the injured person (i.e. hospital expenses, related physical therapy, etc.) that he would otherwise be entitled to recover. *Id.; see also* RESTATEMENT (SECOND) OF JUDGMENTS § 50 cmt. e (1980).

it would clearly not prejudice the parties to the suit.[128] The justification for the rule is that if the recovery is offset by collateral benefits, the deterrent effect of tort liability would be rendered ineffective.[129] Moreover, the wrongdoer should not be permitted to benefit from payments made by others for damages which he or she has proximately caused.[130] Finally, it would be unjust for the wrongdoer to profit from the insurance protection that the injured party has secured under his or her own initiative.[131] Application of the rule guarantees that the injured party's medical, physical, and emotional needs are met, in essence, allowing full compensation from all liable entities.[132]

Nineteen states have passed legislation abrogating or limiting some of the duplication inherent in awards from multiple responsible sources.[133] The legal sentiment on compensation no longer

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128 MATTHEW BENDER, DAMAGES IN TORT ACTIONS § 17.00 (1994). Mention of inadmissible collateral benefits at a jury trial may produce reversible error on appeal. *Id.* at 21-24. Regardless of how the evidence has been introduced, such evidence can be highly prejudicial. *Id; but see* Eastin v. Bloomfield, 570 P.2d 744, 753 (Ariz. 1977) (stating that because evidence of collateral benefits may be easily ignored, the admission of such evidence *in no way* guarantees a reduced jury award) (emphasis added).

129 *Eastin*, 570 P.2d at 751.

130 *See* RESTATEMENT (SECOND) OF TORTS § 920A(b) (1979). "[I]t is the tortfeasor's responsibility to compensate for all harm that he causes, not confined to the net loss that the injured party receives." *Id.*

131 *See* BENDER, *supra* note 128, § 17.00 at 8.

132 *See* Wittkin, *supra* note 76, at 11. Abolishing the collateral source rule would seriously impede the victim's expectations of adequate compensation. Also, an inevitable consequence of eliminating collateral sources as potential payers will affect attorneys' willingness to accept malpractice cases. *See id.*

133 OFF. TECH. ASSESSMENT, IMPACT OF LEGAL REFORMS IN MEDICAL MALPRACTICE COSTS 40 (1993); *see also* Larry Milner, *Medical Malpractice Reform*, 18 LOY. U. CHI. L.J. 1053, 1068 (1987).

The following was originally compiled in STATE LAWS, *supra* note 95: ALA. CODE § 6-5-545 (1987) (discretionary offset in which the jury may offset the amount of an award for paid medical expenses); ALASKA STAT. §§ 9.55.547, 9.55.548, 9.17.070 (1976) (discretionary offset determined by the court); ARIZ. REV. STAT. ANN. § 12-565 (1984) (discretionary offset by jury based on evidence of economic payments); CAL. CIV. CODE § 3333.1 (West 1975) (discretionary offset may be introduced, upheld in *Fein*, 695 P.2d 665 (1985)); COLO. REV. STAT. §§ 13-21-111.6 and 13-64-402 (1992) (mandatory offset determined by the court); CONN. GEN. STAT. § 52-225a (1987) (court required to offset awards by damages already paid); DEL. CODE ANN. tit. 18, § 6862 (1976) (discretionary offset, but no evidence of life insurance, marital status, or financial circumstances is allowed); FLA. STAT. ch. 768.76 (1986) (mandatory offset, except where there are subrogation rights; offset was extended to binding arbitration cases in FLA. STAT. ch. 766.207 to .209 (1986)); IDAHO CODE § 6-1606 (1990) (mandatory collateral offset, except for federal benefits, life insurance, and subrogation rights); ILL. REV. STAT. ch. 110, para. 2-604 (1985) (reduces award by amount

favors double recovery from more than one tortfeasor for the same injury.[134] Fairness requires that a plaintiff only recover the amount that compensates him or her for actual injuries sustained, and no more.[135] To that end, evidence of supplementary benefits is used at trial, which can be more of an advantage to the defendant-physician than a detriment to the patient.[136] It assures that liability is divided among the various tortfeasors in accordance with their de-

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paid by collateral sources, but not by more than 50% of the total award); IND. CODE § 34-4-36-2 (1989) (discretionary offsets for damages, except for insurance payments paid directly to the plaintiff); IOWA CODE § 147-136 (1975) (mandatory offset for collateral sources); KAN. STAT. ANN. §§ 60-3801 to -3807 (1992) (discretionary offset); KY. REV. STAT. § 411-188 (1988) (discretionary offset, excluding life insurance); ME. REV. STAT. ANN. tit. 24, § 2902 (West 1985) (mandatory offset for collateral sources that failed to assert their subrogation rights within 10 days of the judgment); MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-05(h) (1989) (discretionary offset when action has gone before a medical review panel); MASS. GEN. LAWS ANN. ch. 231, § 60G (West 1986) (mandatory offset as determined by the court); MICH. COMP. LAWS § 600.6303 (1986) (mandatory offset, except for life insurance); MINN. STAT. § 548.36 (1986) (offsets are mandatory when the defendant shows evidence of collateral payments); MO. REV. STAT. § 490.715 (1987) (may only use collateral source evidence for special damage awards); MONT. CODE ANN. § 21-1-308 (1987) (if plaintiff is awarded a judgment greater than $50,000, then mandatory offset); NEB. REV. STAT. § 44-2819 (1976) (discretionary offset determined by the court, found constitutional in *Prendergast*, 256 N.W.2d 657); NEV. REV. STAT. § 42.020 (1985) (mandatory offset); N.J. REV. STAT. § 2A:15-97 (1987) (required offset for collateral payments, except for workers' compensation and life insurance); N.M. STAT. ANN. § 41-5-11 (Michie 1976) (mandatory offset); N.Y. CIV. PRAC. L. & R. 4545 (McKinney 1981) (mandatory offset determined by the court); N.D. CENT. CODE § 32-03.2-06 (1987) (discretionary offset, except for insurance and death or retirement benefits); OHIO REV. CODE ANN. § 2305.27 (Anderson 1975) (mandatory offsets, except for insurance already paid); OR. REV. STAT. § 18.580 (1987) (discretionary offset, excluding life insurance, disability benefits, pension plans, or social security); S.D. CODIFIED LAWS ANN. § 21.3-12 (1977) (discretionary offset, except for benefits with a right of subrogation and benefits paid for by plaintiff); TENN. CODE ANN. § 29-26-119 (1975) (mandatory offset, except for assets purchased by the parties); UTAH CODE ANN. § 78-14-4.5 (1985) (mandatory offset, except where subrogation rights exist); WASH. REV. CODE § 7.70.080 (1976) (may introduce collateral source evidence, excluding insurance of either party).

134 *See* James J. Watson, Annotation, *Validity and Construction of State Statutes Abrogating Collateral Source Rule as to Medical Malpractice Actions*, 74 A.L.R.4th 32 (1989) (providing a detailed examination of the treatment of statutes abolishing the collateral source rule).

135 BENDER, *supra* note 128, § 17.00 at 1-2.

136 Watson, *supra* note 134, at 37; *see* OTA REPORT, *supra* note 3, at 29 (noting that physicians rarely pay damages beyond their policy limits, especially because other defendants' insurance covers part of the damages. In any event, the plaintiff should still receive the same amount, regardless of the number of potentially liable parties). Without the collateral source rule, evidence of supplementary benefits may be introduced at trial.

gree of culpability.[137]

Statutes abrogating the collateral source rule have been challenged as violative of the United States and state constitutions.[138] Traditionally, courts have employed a rational basis review of the legislature's presumptively legitimate purpose for the statute.[139] For example, in *Bernier v. Burris*,[140] the court determined that because the statute did not infringe on a fundamental right, the appropriate standard of review was the rational basis test.[141] Furthermore, though the statute in *Bernier* was drafted in response to a crisis later found not to exist by the court, the ultimate ruling of the case depended on the legitimate effect of the law and not on the error of original legislative purpose.[142]

Generally, the rational basis test has been applied to regulations which have an economic and social focus, provided the regu-

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137 BENDER, *supra* note 128, § 17.00 at 24-26. Specifically, admitting evidence of collateral source payments may assist determination of the proximate cause, the extent of actual injuries, and the patient's motivation for suing the particular defendant.

138 Watson, *supra* note 134, at 38. Historically, the collateral source rule has withstood due process, equal protection, and supremacy clause challenges. *Id.*

139 *Id.*; *see generally Fein*, 695 P.2d at 665 (restating the legislature's broad control over damages that plaintiffs are entitled to recover and which defendants are required to pay); Ferguson v. Garmon, 643 F. Supp 335 (D.C. Kan. 1986) (admitting evidence of collateral benefits from other payers was held constitutional based on rational basis scrutiny. The court found that the Kansas legislature's goals to prevent monumental plaintiff recoveries and the imminent decline of health care were legitimate state interests and were rationally related to the state's abolition of the collateral source rule. Such action was intended to stifle the rapidly rising cost of malpractice insurance premiums and to prevent physician flight to states with less expensive premiums and more favorable laws reducing doctors' malpractice liabilities).

140 497 N.E.2d 763 (Ill. 1986).

141 *Id.* at 768. The Illinois statute at issue, ILL. REV. STAT. ch.10, par. 2-1205 (1985), modified the collateral source rule to reduce judgments against tortfeasors. Half of the benefits received from collateral sources for lost wages could not be used as an offset, while the patient's out-of-pocket expenses already paid could still be used as an offset. *Id.* at 774-75. The court reasoned that a presumption exists whereby a low level of judicial scrutiny shall be used for medical malpractice legislation, whether in due process or equal protection challenges. *Id.* at 775; *but see generally Carson*, 424 A.2d at 825 (applying a stricter standard, one which examines such cases for a fair and substantial relation between the purpose of the legislation and the classifications made within it).

142 *Bernier*, 497 N.E.2d at 769. Though the legislature's actual purpose was to combat a growing malpractice "crisis" and none existed at the time of the trial, the statute will not be found unconstitutional on those grounds alone. Examination of this statute focused generally on the government's legitimate interest in reducing the costs of malpractice actions. *Id.* The rationality of legislative purposes depends on the reasonableness of its relationship with the "health and welfare of the people." Williamson v. Lee Optical, 348 U.S. 483, 486 (1955).

lations do not draw arbitrary or unreasonable distinctions between individuals.[143] A legislative enactment reducing malpractice insurance premiums and health care costs qualifies as an economic regulation, whether successful or not.[144] Thus, classifications between litigants in furtherance of those objectives are usually upheld.[145] Alternatively, an argument can be made for heightened scrutiny based on the fact that limitations on damages may operate to disadvantage a particular class.[146] Statutes that set ceilings on damages are likely to be found arbitrary, unreasonable, and in violation of each person's right to equal protection of the law.[147]

Application of laws abolishing the collateral payments is limited. Collateral source offsets usually apply to tangible damages which include out-of-pocket damages such as medical care, rehabilitation, or loss of earning ability.[148] Therefore, compensation for punitive and non-economic damages, such as pain and suffering, are not expenses and cannot by limited by the rule.[149] Moreover, judgments predicated on physician negligence will not be offset by payments made by collateral sources because those findings bear on personal liability, separate and apart from joint obligations.[150] Also, the rule may find refuge in preexisting contracts.[151] For instance, the right of subrogation[152] was not addressed in H.R. 3600.

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143 *See* Baker v. Vanderbilt Univ., 616 F. Supp. 330, 332 (D.C. Tenn. 1985) (the rational basis analysis governs "economic and social legislation regulating the relationship between physicians, patients, and insurance carriers, . . . absent suspect classifications or impingement[s] on fundamental rights . . .").

144 *Id.*

145 *Id.*; *Eastin*, 570 P.2d 744. *But see* Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983) (though malpractice reform acts neither infringe upon fundamental rights nor employ suspect classifications, such acts may be found unconstitutional in the future if the economic need for the regulation disappears).

146 Arneson v. Olsen, 270 N.W.2d 125, 135 (N.D. 1978) (holding that the aggregate of the North Dakota medical malpractice provisions, N.D. CENT. CODE § 26-40.1-01 et. seq. (1977), operated to the disadvantage of the most seriously injured. Though strict scrutiny was not appropriate because a "non-suspect" class was involved, an intermediate standard could be applied requiring the classification to serve an important governmental interest which bears a substantial relation to the attainment of that interest).

147 *Id.*

148 N.Y. CIV. PRAC. L. & R. 4545 cmt. 2 (McKinney 1992).

149 *Id.*

150 *Id.*

151 Watson, *supra* note 134, at 45. The invocation of the collateral source rule may be shielded from federal reforms by state laws of contract or state constitutions which may limit the amount of abrogation—making a preemption issue imminent. *Id.*

152 "Subrogation" is when a third party assumes a lawful claim of another. BLACK'S

If subrogation is permitted by federal enactment in this area, it may destroy the economic effectiveness of collateral source negation.[153] If it remains, insurers and employers are likely to be placed in the untenable position of bearing the brunt of a physician's negligence.[154] In sum, any proposal that restricts collateral benefits to injured patients will arouse federal and state constitutional suspicion.

### C. *Periodic Payments*

Section 5306 of the Health Security Act provided that, at the plaintiff's election, a court may determine the amount of the jury award it would require the defendant to pay in periodic payments.[155] Typically, there are two perceived reservations pertaining to discretionary periodic payment measures. First, the broad discretion allowed by section 5306 technically would bear no effect on the objective of reducing health care costs.[156] Also, the bill made no definitive statement whether present or future value will be applied to the periodic payments.[157]

Thirty-one states have enacted some type of periodic payment

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LAW DICTIONARY 1427 (6th ed. 1990). The third party extinguishes the debt owed to that other party and may exercise whatever rights he or she had. In malpractice actions, insurers may "step into the shoes" of the physician and provide defenses on the claim against him or her as if the claim was against itself.

153 HENRY COHEN, CONG. RES. SERVICE, MEDICAL MALPRACTICE PROVISIONS OF THE PRESIDENT'S PROPOSED HEALTH SECURITY ACT: A LEGAL ANALYSIS 9 (1994) (quoting Barry J. Nance & Virginia C. Nelson, *Plaintiff's Lawyers Have Already Seen Many of the Proposed Tort Reforms in the States and Find Them to be Disastrous for Clients*, NAT'L. L.J., Jan. 1994, at 26).

154 *Id.*

155 "Periodic payments" are payments made in the future at regular intervals after a lump sum has been paid and the immediate needs of the victim have been satisfied. Jay Zitter, Annotation, *Propriety and Effect of "Structured Settlements" Whereby Damages are Paid in Installments Over a Period of Time, and Attorneys' Fees Arrangements in Relation Thereto*, 31 A.L.R.4th 95, 96 (1984). After the final disposition of the case, these future payments are often satisfied by the defendant's purchase of an annuity or other investment. *Id.*

156 COHEN, *supra* note 153, at 11. Attorneys have always had the option to structure settlements. Section 5306 serves to affirm that a judge may assist in structuring the settlement only if the plaintiff makes that election. *See* H.R. 3600, 103d Cong., 1st Sess. § 5306 (1993).

157 *See* Zitter, *supra* note 155, at 96. There may be some confusion as to which value the defendant must pay into the annuity. Judgments based on the future value potentially may lower health care costs, while allowing the defendants to benefit by paying a much lower face value. An award starting with a present value put into an annuity will have no effect on health care costs. *Id.*

requirement.[158] These reforms of damages have been implemented in response to the legislative objective to ensure that injured patients are paid.[159] It also has the purpose of protecting insurers from enormous immediate withdrawals from their poli-

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158 The following was originally compiled in STATE LAWS, *supra* note 95: ALA. CODE § 6-5-543 (1987) (mandatory periodic payments when award exceeds $150,000); ALASKA STAT. § 9.17.040 (1986) (mandatory periodic payments when requested by the injured party); ARIZ. REV. STAT. ANN. §§ 12-581 to -594 (1984) (mandatory when elected by either party); ARK. CODE ANN. § 16-114-208 (Michie 1979) (discretionary periodic payments of awards greater than $100,000); CAL. CIV. PROC. CODE § 667.7 (West 1975) (required periodic payment for future damage awards exceeding $50,000 and demanded by a party, upheld in *American Bank*, 683 P.2d 670); COLO. REV. STAT. § 13-64-203 (1988) (mandatory periodic payments when future damages exceed $150,000); CONN. GEN. STAT. § 52-225d (1987) (election for discretionary periodic payments of damages for damages in excess of $200,000 must be taken within 60 days, or else payments must be made in a lump sum); DEL. CODE ANN. tit. 18, § 6864 (1976) (discretionary); IDAHO CODE § 6-1606 (1990) (mandatory periodic payments when future damages exceed $250,000 and demanded by either party, but the defendant may decide to pay lump sum of the award at its present value); ILL. REV. STAT. ch. 100, para. 2-1705 to -1718) (1985) (mandatory periodic payment for awards greater than $250,000, upheld in *Bernier*, 497 N.E.2d 763); IND. CODE §§ 16-9.5-2 to -2.2 (1985) (discretionary periodic payments); IOWA CODE § 668.3 (1986) (court's discretion to impose a periodic payment schedule); KAN. STAT. ANN. §§ 60-3801 to -3807 (1992) (discretionary offset); LA. REV. STAT. ANN. § 40:1299.43 (West 1984) (if judgments exceed $500,000, then there must be periodic payments for future medical care and related benefits); ME. REV. STAT. ANN. tit. 24, § 2951 (1985) (mandatory periodic payments of awards over $250,000); MD. CODE ANN. CTS. & JUD. PROC. § 11-109 (1986) (discretionary periodic payments of future economic damages); MICH. COMP. LAWS § 600.6307 (1986) (mandatory periodic payments of future economic damages, excluding future medical costs and collateral source payments); MINN. STAT. § 549.25 (1988) (discretionary periodic payments of future damages exceeding $100,000); MO. REV. STAT. § 538.220 (1986) (mandatory periodic payments of future damages exceeding $100,000); MONT. CODE ANN. § 25-9-4-3 (1987) (discretionary periodic payments of future damages exceeding $100,000); N.M. STAT. ANN. § 41-5-7 (Michie 1976) (mandatory periodic payments for future medical care); N.Y. CIV. PRAC. L. & R. 5031 to 5039 (McKinney 1985) (mandatory payments for future damages payments when the total is greater than $250,000); N.D. CENT. CODE § 32-03.2-09 (1987) (discretionary periodic payments for future medical care which will continue for two years or more, subject to periodic court review of payment adequacy); OHIO REV. CODE ANN. § 2323.57 (Anderson 1987) (mandatory periodic payments of future damages over $200,000); R.I. GEN. LAWS § 9-21-12 to -13 (1987) (requires conference on periodic payments where judgment exceeds $150,000); S.C. CODE ANN. § 38-79-480 (Law. Co-op. 1976) (discretionary periodic payments where liability exceeds $100,000); S.D. CODIFIED LAWS §§ 21-3A-1 to 3A-13 (1986) (required periodic payments of future damages over $200,000); UTAH CODE ANN. § 78-14-9.5 (1986) (mandatory for future damages greater than $100,000); WASH. REV. CODE § 4.56.260 (1986) (mandatory payments for future economic damages over $100,000); WIS. STAT. § 655.015 (1975) (required periodic payments where future economic damages exceed $25,000).

159 Zitter, *supra* note 155, at 96; *American Bank*, 683 P.2d at 674. Traditional large

cies, instead allowing them to defray their payments over time.[160]

State courts determining the constitutionality of periodic payment statutes have encountered the same due process, equal protection, and trial-by-jury challenges mentioned above.[161] For the most part, these provisions are constitutional based on the presumption of reasonableness that all economic legislation enjoys in the courts.[162] For example, in *American Bank & Trust Co. v. Community Hosp.*,[163] a California provision that provided for periodic payments of future damages exceeding $50,000 was declared valid.[164] The statute allowed the jury to determine the portion of the award designated as "future damages" indirectly by allowing them to calculate the victim's past and present needs.[165] As for the amount exceeding $50,000 in future damages, the court stated that it has retained the sole authority to determine the form and method of disbursement of awards.[166] Therefore, because the statute did not conflict with jury powers and was not a substantial impairment of any other feature of the trial, there was no legitimate constitutional claim against the statute.[167]

After *American Bank*, the Illinois Supreme Court, in *Bernier v. Burris*,[168] used similar reasoning to illustrate how the jury's function was not impaired by the imposition of a periodic payments schedule.[169] First, the court refuted the argument that a plaintiff

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lump-sum awards are often spent long before the future medical expenses are incurred.

160 Zitter, *supra* note 155, at 96. Mandatory periodic payments of damages allow insurers to maintain fewer liquid reserves, while increasing the amount available for savings. 683 P.2d at 678.

161 Russell G. Donaldson, Annotation, *Validity of State Statute Providing for Periodic Payment of Future Damages in Medical Malpractice Action*, 41 A.L.R.4th 275, 276 (1985).

162 *American Bank*, 683 P.2d at 676. It is the function of the legislature to measure the effects of economic rights. *Id.*

163 *Id.* at 670.

164 *Id.* at 680-81.

165 *Id.* at 681. The jury maintained its authority and ability to determine the portion of the award to be designated as past, present, and future damages, but was not given the authority to determine the type or form of these payments. *Id.*

166 *Id. But see* Kansas Malpractice Victims v. Bell, 757 P.2d 251, 258 (Kan. 1988) (allowing the court to arbitrarily determine the award without jury ratification infringes on a victim's constitutional right to a remedy by due course of law).

167 *American Bank*, 683 P.2d at 680. Chief Justice Traynor wrote that, "[N]ew procedures better suited to the efficient administration of justice may be substituted if there is no impairment of the substantial features of a jury trial." *Id.*

168 497 N.E.2d 763 (Ill. 1986).

169 *Id.* at 772.

has a right guaranteed by due process or equal protection to a particular format of future payments.[170] Next, the court declared that the legislature, using its economic powers, could establish a formula with which to calculate the present lump sum value.[171] Though it did not provide for annual adjustments, the court found that this process was reasonable because it could only be applied when making future damages available in a lump sum.[172]

On the other hand, some jurisdictions have not found it necessary to address the problems that periodic payments pose with respect to the right to a trial by jury. In *Carson v. Maurer*,[173] a periodic payment statute was struck down for being unreasonable and discriminatory in its effect.[174] The court grappled with the issue of how to treat periodic payments being made to a victim of malpractice who had recently died.[175] Here, the statute eliminated the "bonus element," which is the amount that the defendant no longer pays on future damages when the victim dies before he has been completely compensated.[176] Also, the court reaffirmed the notion that once a final judgment has been rendered, the claimant takes a property interest in the award decreed.[177] The court could not ignore the plaintiff's rights to the future payments created by the final judgment.[178] Additionally, the arbitrarily set limit for mandating periodic payments deprived the most seriously injured victims

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170 *Id.* The complainant has no "indefeasible interest" in the format of recovery. *Id.* at 771. Thus, statutes may properly regulate the timing of future payments. *Id.*

171 *Id.* at 771.

172 *Id.* at 772-73. It operates as a minimal deterrent to early withdrawal of the cash award placed in an annuity.

173 *Bernier*, 424 A.2d 825 (N.H. 1980).

174 *Id.* at 838.

175 *Id.*

176 *Id.* The eradication "bonus element" allowance decreases the cost of medical malpractice, but has the effect of barring the plaintiff's full recovery and gives a windfall to defendants. *But see American Bank*, 683 P.2d 670, 676 (the defendant's obligation to compensate a victim for expected medical expenses ceases when the payee dies. Thus, continuing payments would amount to a windfall to heirs who have no claim to the money); *contra Bernier*, 497 N.E.2d at 773-74 (surviving beneficiaries are at least entitled to receive the balance of periodic installments not yet paid); *see also* RESTATEMENT (SECOND) OF JUDGMENTS § 48 (1980) (recognizing a right to seek compensation for harm done to family members).

177 *Bernier*, 497 N.E.2d at 774. A litigant has a something of a property right in a final judgment. *See* RESTATEMENT (SECOND) OF JUDGMENTS § 64 cmt. a (1980) ("According finality to judgments gives efficacy to the adjudicative process." Final judgments are not to be disturbed by additional claims or defenses raised later).

178 *Id.*

of the benefit of their winnings.[179] Therefore, the court held that the statute terminating the plaintiff's right to future payments could not be reasonably enforced.[180]

### D. *Limits on Attorney Fees*

Depending upon whether injured plaintiffs are successful, their attorneys may receive a predetermined percentage of the award as compensation for their services.[181] Typically, fee arrangements have been a flat rate, but recently there has been a trend in personal injury and medical malpractice law towards a sliding scale approach.[182] This approach seeks to deter frivolous suits, en-

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179 *Id.*

180 *Id.*

181 *See* BLACK'S LAW DICTIONARY 614 (6th ed. 1990) (defining "contingent fees"). STATE LAWS, *supra* note 95, lists state laws that focus on attorney fees in medical malpractice cases. They are: ARIZ. REV. STAT. ANN. § 12-568 (1976) (when requested, a court will review the reasonableness of attorney fees); CAL. BUS. & PROF. CODE § 6146 (West 1987) (sliding scale); CONN. GEN. STAT. § 52-251c (1986) (sliding scale); DEL. CODE ANN. tit. 18, § 6865 (1976) (sliding scale); FLA. STAT. ch. 766.109 (1986) (sliding scale that varies according to when the case is settled); HAW. REV. STAT. § 607-15.5 (1986) (limited to those fees that are reasonable); ILL. REV. STAT. ch. 110, para. 2-1114 (1985) (sliding scale allowing attorneys to apply for additional compensation when extraordinary services are rendered); IND. CODE § 16-9.5-1 (1985) (15% cap on fees for awards from Indiana's Patient Compensation Fund); IOWA CODE § 147.138 (1975) (court may review fees); KAN. STAT. ANN. § 7-121b (1988) (court may review fees for reasonableness); ME. REV. STAT. ANN. tit. 24, § 2961 (West 1987) (sliding scale); MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-07 (1986) (panel reviews disputed fees); MASS. GEN. LAWS ANN. ch. 231, § 601 (Law Co-op 1986) (sliding scale); MICH. COMP. LAWS § 8.121(b) (1981) (ceiling on fees set at 33⅓%; NEB. REV. STAT. § 44-2834 (1976) (court may review fees for reasonableness); N.H. REV. STAT. ANN. § 508:4-e (1986) (court must review fees for actions with settlements exceeding $200,000); N.J. REV. STAT. § 1-2107 (1976) (sliding scale); N.Y. JUD. LAW § 474a (McKinney 1985) (sliding scale); OKLA. STAT. tit. 5, § 7 (1953) (maximum attorney fee may be 50% of judgment); 40 PA. CONS. STAT. ANN. § 1301.604 (1975) (sliding scale); TENN. CODE ANN. § 29-26-120 (1975) (fees capped at 33⅓% of damages awarded); UTAH CODE ANN. § 78-14-7.5 (1985) (33⅓% fee ceiling); WASH. REV. CODE § 7.70.070 (1976) (court determines reasonableness of fees); WIS. STAT. § 655.013 (1986) (sliding scale); WYO. COURT RULES GOVERNING CONTINGENT FEES, Rule 6 (1977) (upon plaintiff's request, the court will review the reasonableness of fee arrangements).

182 *See supra* note 181 (giving examples of state laws governing attorney's fees). Today, eleven states use sliding scale arrangements to apportion the plaintiff's award. *Id.* These arrangements are regressive, permitting attorneys to collect a greater percentage of the award when the recovery is small, but that percentage declines as the size of the award grows. In practice, legislators believe that the sliding scale system will ensure court access for those with smaller claims, who under the flat-rate system would have been avoided by lawyers more interested in "big ticket" cases. *See* Falcon, *supra* note 15, at 17.

courage prompt settlement, and assure fair distribution of awards.[183]

At best, those goals are tenuous or speculative. The legislative goal to cut malpractice costs cannot be achieved by rationing the plaintiff's award, especially where the amount that the plaintiff's attorney receives has no impact on the amount that the insurer must pay upon decree of the court.[184] Capping only plaintiff's attorney fees favors the opponent: it effectively allows the defense to use unlimited resources and attain unfair advantages.[185] Moreover, the establishment of rate schedules could violate the plaintiff's fundamental right to obtain meaningful court access.[186] Additionally,

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183 *See* DiFilippo v. Beck, 520 F. Supp. 1009, 1016 (D.C. Del. 1981) (upholding a Delaware law limiting the plaintiff's attorney's recovery on the finding that "the limitation is [ ] related to reducing malpractice insurance costs and, consequently, medical costs"). Because compensation is conditioned on a favorable verdict, attorneys who accept cases based on large anticipated returns will be persuaded to carefully select only those claims in which they can prevail. *See* ANNUAL REPORT, *supra* note 12, at 294 (health care costs will decline when frivolous suits are avoided); *but see* Roa v. Lodi Medical Group, Inc., 695 P.2d 164, 183 (Cal. 1985) (Bird, C.J., dissenting) (arbitrary classifications dissuading attorneys from representing the most seriously injured malpractice victims conflicts with the individual's right to equal protection of the laws).

184 *Roa*, 695 P.2d at 185 (Bird, C.J., dissenting) (suggesting that insurance premiums could be more effectively contained by restricting defense counsel fees, because these attorneys are paid *directly* out of insurance liability accounts). Because attorney fees are paid out of the plaintiff's final award and because juries may not consider attorney fees when computing awards, the plaintiff will always receive the same payment from the insurance company regardless of its ultimate apportionment. *Id.* at 178, 185; *contra Carson*, 424 A.2d at 839 (quoting R. Scott Jenkins & William C. Schweinfurth, Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 S. CAL. L. REV. 829, 943 (1979)) (there is no "direct evidence that juries consider attorneys fees in coming to a verdict")).

185 STRAIGHT TALK, *supra* note 10, at 19. *Accord Roa*, 695 P.2d at 183, 185 (Bird, C.J., dissenting) (restrictions that unreasonably favor defending physicians should be struck down as violative of the equal protection clause).

186 *Roa*, 695 P.2d at 176 (Bird, C.J., dissenting)."It is evident that the First Amendment protects individuals' rights to obtain the adequate legal representation necessary to ensure their rights of petition, access to the courts, and association . . . ." *Id.* The freedom to contract and to be represented by counsel are fundamental to the right of court access. It follows that laws must not discriminate against those who wish to prove medical negligence. *Id.* at 176-77 (Bird, C.J., dissenting). Conversely, the majority in *Roa* viewed the restriction as simply a limitation, not a prohibition. *Id.* at 168 n.5. Plaintiffs who desire to obtain the best representation, without the potential impediment of a sliding scale, may elect to pay their attorneys on a *per diem* basis. *See Johnson*, 404 N.E.2d at 602-03 (the sliding scale system reasonably curbs abuses of contingent fee contracts without affecting smaller claims (e.g. claims less than $100,000), which are usually not affected by such legislation). *See also* ANNUAL REPORT, *supra* note 12, at 294 (fee restrictions seem to discourage attorneys from ac-

promoting early settlement restricts the patient's ability to receive the most appropriate award.[187]

As lobbying efforts are made by proponents on each side, the debate over whether attorney fees should be limited rages onward.[188] The end result must contain provisions that can limit boiler-plate plaintiff factories and reduce insurer payments to the insured, while assuring court access to all claimants and special protection to the most seriously injured.[189]

## *V. Reform of Claim Procedures*

### A. *Alternative Dispute Resolution Mechanisms*

During recent years, courts have been inundated with medical malpractice litigation.[190] Prolonged resolution has produced a significant backlog of unsettled claims.[191] In response, Congress has

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cepting claims with small or uncertain expected recoveries, thus leaving many claimants without adequate legal representation. The regressive nature of fee scales, however, minimizes this effect).

187 *Carson*, 424 A.2d at 839 (stating that contingent fee scales unfairly burden plaintiffs and their attorneys by making cases appear less attractive, thereby serving as an impediment to court access). Generally, the greater the expected award, the more likely an attorney will accept the additional risks. Because malpractice cases are so difficult to prove, there are many costs that a plaintiff's attorney must expend, and with each additional outlay a decision must be made determining if the mounting expenses are worthwhile. *Roa*, 695 P.2d at 174 (Bird, C.J., dissenting) (quoting Keene, *California's Medical Malpractice Crisis*, LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE 29-30 (1976)). For this reason, attorneys may opt not to take a case to trial where their expected return cannot significantly offset their costs, even when doing so would greatly improve the plaintiff's financial position. *See Roa*, 695 P.2d at 177 (Bird, C.J., dissenting).

188 *See* Peter Brimelow & Leslie Spencer, *The Attorney's Great Honey Rush*, FORBES, Oct. 16, 1989, at 197, 199 (pointing out ATLA's tremendous lobbying power in Congress).

189 *See, e.g.*, Heller v. Frankston, 464 A.2d 581, 586 (Pa. Commw. Ct. 1983). Additionally, any federal enactment defining attorney fee scales must account for the need to provide a state law preemption clause to avoid conflicts of law. In some states, regulation of attorney conduct is exclusively within the power of the judiciary, while in other states the legislature controls. *Id.*

190 Sohn, *supra* note 47, at 688. Overburdened courts have had a negative effect on claims which could have been worthwhile but for the long delays that discourage the institution of suits. *Id.* The extraordinary costs force claims out of the process when the expected remedy will not cover those costs. *Id.*

191 *See* Mattos v. Thompson, 421 A.2d 190, 194-95 (Pa. 1970). Between April 6, 1976 and December 31, 1979, 2,909 medical malpractice claims were filed in Pennsylvania. Of those 2,909 claims, only 134 cases had filed certificates of readiness. Such long delays threaten to be a considerable burden on one's right to a jury trial. *Id.* at 195.

made attempts to carry forward the growing trend in state medical malpractice tort legislation to use Alternative Dispute Resolutions[192] (hereinafter ADR), which are mechanisms that include

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192 Alternative Dispute Resolutions consist of processes which settle disputes outside the traditional judicial system. Decisions are rendered by dispute resolution specialists, such as arbitrators and mediators. BLACK'S LAW DICTIONARY 78 (6th ed. 1990).

Nearly all Federal statutes addressing medical malpractice tort reform include a form of ADR. *See supra* note 20 listing bills introduced during the 103d Congress. The following is a list of various state statutes which contain arbitration or medical review panel requirements for malpractice claims; the list was originally compiled in STATE LAWS, *supra* note 95: ALA. CODE § 6-5-485 (1975) (voluntary binding arbitration); ALASKA STAT. §§ 9.55.535 (1976) (voluntary arbitration); ARIZ. REV. STAT. ANN. § 12-150 *et seq.* (1968) (parties may agree in writing to arbitrate); ARK. CODE ANN. §§ 16-108-210 to -224 (Michie 1969) (voluntary arbitration in medical cases); CAL. CIV. PROC. CODE § 1295 (West 1975) (voluntary arbitration); COLO. REV. STAT. § 13-64-403 (1988) (voluntary arbitration), § 13-22-402 (1990) (establishes mandatory demonstration program); CONN. GEN. STAT. §§ 38-19c, 38-19f (1977) (voluntary pretrial screening decisions are admissible at later trial); DEL. CODE ANN. tit. 18, §§ 6801 to 6814 (1976) (submission to medical review panel upon either party's demand and results are admissible as evidence at trial); D.C. CODE ANN., SUPER. CT.—CIVIL ARBITRATION PROGRAM, RULE I (1993) (binding arbitration); FLA. STAT. ANN. §§ 766.106, 766.107 (West 1985) (court may require submission to screening panel), § 766.207 (West 1988) (voluntary binding arbitration); GA. CODE ANN. §§ 9-9-61 to -63 (1987) (voluntary arbitration made binding based on prior agreement); HAW. REV. STAT. §§ 671-11 to -20 (1987) (mandatory submission to medical review panel for claims under $150,000, recommendations not admissible at trial); IDAHO CODE §§ 6-1001 to -1011 (1976) (mandatory submission to panel, results not admissible at trial); ILL. REV. STAT. ch. 10, para. 201 (1977) (voluntary arbitration is valid if made revocable); IND. CODE §§ 16-9.5-9-1 to -10 (1987) (mandatory submission to review panel, result is admissible at subsequent trial; upheld in Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585 (Ind. 1980)); IOWA CODE § 679A.1 (1981) (arbitration agreement may be valid and irrevocable); KAN. STAT. ANN. § 65-4901 (1976) (voluntary submission to panel if requested), §§ 60-3501 to -3509 (1987) (decision may be accepted as evidence at trial); KY. REV. STAT. ANN. § 417-050 (Baldwin 1984) (arbitration agreement is fully enforceable and irrevocable); LA. REV. STAT. ANN. §§ 9:4230 to 9:4236 (West 1975) (voluntary revocable arbitration), § 40:1299.47 (West 1988) (mandatory submission of medical injury claim to pretrial screening panel); ME. REV. STAT. ANN. tit. 24, § 2851 (West 1989) (mandatory submission to panel unless parties agree otherwise, findings of panel are admissible at trial); MD. CODE ANN., CTS. & JUD. PROC. §§ 3-2A-03 to -06 (1989) (mandatory use of claims review panel, results are admissible at trial); MASS. GEN. LAWS ANN. ch. 231, § 608 (1975) (requires mandatory submission to a medical tribunal, upheld in Paro v. Longwood Hosp., 369 N.E.2d 993 (Mass. 1977); MICH. COMP. LAWS § 600.5040 (1975) (voluntary revocable arbitration; upheld in Morris v. Metriyakool, 344 N.W.2d 736 (Mich. 1984)); in 1993, the law was amended to require written binding arbitration for claims short of $75,000); MONT. CODE ANN. §§ 27-6-101 to -704 (1977) (mandatory submission to screening panel unless sent to arbitration, results are admissible at trial; upheld in Linder v. Smith, 629 P.2d 1187 (Mont. 1981)); NEB. REV. STAT. §§ 44-2840 to -2841 (1976) (mandatory review, except if waived by the plaintiff, report is admissible at trial; upheld in *Prendergast*, 256

programs for arbitration,[193] mediation,[194] and no-fault.[195] These alternatives to traditional litigation can provide claimants with easier access to compensation and to various standards for

N.W.2d 657); NEV. REV. STAT. § 41A.003-069 (1985) (must submit claim to a review panel, findings are not admissible at trial); N.H. REV. STAT. ANN. §§ 5198-A:1 to A:20 (1972) (voluntary panel hearing, not admissible at trial); N.J. CIV. PROC. R. §§ 4:21A-1 to -8 (1985) (voluntary arbitration for claims over $20,000); N.M. STAT. ANN. §§ 41-5-94 to -20 (Michie 1976) (mandatory submission to medical review panel, conclusions not admissible at trial); N.Y. JUD. LAW § 148-a (McKinney 1974) (mandatory pretrial conference before medical malpractice claims), N.Y. CIV. PRAC. L. & R. 3045 (McKinney 1991) (if plaintiff agrees to arbitrate, the defendant may concede liability); OHIO REV. CODE ANN. § 2711.21 (Anderson 1987) (all parties may voluntarily submit claims to arbitration, upheld in Beatty v. Akron City Hosp., 424 N.E.2d 586 (Ohio 1981), §§ 2711.22 to .24 (1975) (before treatment there may be an irrevocable agreement to arbitrate future claims); PA. STAT. ANN. tit. 40, § 1301.308 (1975) (mandatory panel review, admissible at trial; made voluntary review in Mattos v. Thompson, 421 A.2d 190 (Pa. 1980)); S.D. CODIFIED LAWS ANN. § 21-25B-1 (1976) (voluntary arbitration, agreements may be rescinded for future services); UTAH CODE ANN. § 78-14-15 (1994) (mandatory review by a medical panel, not admissible at subsequent trial), § 78-14-16 (decision of panel deemed binding arbitration if the parties agree); VT. STAT. ANN. tit. 12, §§ 7001 to 7008 (amended 1991) (mandatory arbitration which is binding upon agreement by the parties, admissible as evidence at trial); VA. CODE ANN. § 8.01-581.1 (Michie 1976) (voluntary panel review, admissible at trial; upheld in Speet v. Bauaj, 377 S.E.2d 397 (Va. 1989)); WYO. STAT. §§ 9-2-1701 to -1712 (1989) (mandatory submission to professional review panel, not admissible at trial).

Additionally, the following states adhere to the Uniform Arbitration Act: Arizona, Arkansas, Delaware, Idaho, Indiana, Kansas, Maryland, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, and Texas. STATE LAWS, *supra* note 95.

193 "Arbitration" is a formalized resolution process in which an arbitrator, who is a neutral third party, renders his decision after hearings on a dispute. OTA REPORT, *supra* note 3, at 160 app. K. The arbitrator concludes all issues of fact, then formulates a binding opinion based on the law's applications to those facts. *Id.* Arbitrators are typically objective, logical, and technical evaluators of fact, as they remain removed from the dispute. ABRAHAM P. ORDOVER ET AL., ALTERNATIVES TO LITIGATION: MEDIATION, ARBITRATION, AND THE ACT OF DISPUTE RESOLUTION 105 (1993). Arbitrations may be voluntary or mandatory, depending upon the jurisdiction and the agreement existing with the health care provider. *Id.*

194 "Mediation" is an informal resolution process made prior to filing suit. ORDOVER, *supra* note 193, at 105. The mediation is supervised by a panel consisting of health care experts, legal professionals, and sometimes consumers. *Id.*; BLACK'S LAW DICTIONARY 981 (6th ed. 1990). Mediators, as distinguished from arbitrators, use a more intuitive and conceptual analysis to arrive at their conclusions of fact. ORDOVER, *supra* note 193, at 105. Mediation is not binding on the parties and further litigation can be expected. *Id.*

195 "No-fault" programs, modeled after no-fault automobile insurance, avoid the difficult task of proving the negligence or liability of the health care provider. ALTERNATIVES TO LITIGATION, *supra* note 8, at 2. This Note does not discuss the implications of no-fault insurance for physicians.

compensation.[196]

There are many perceived benefits from the use of voluntary ADR. The benefits associated with ADR conform with the relevant tort policy considerations; mainly, relieving court congestion, limiting time to resolution, reducing total costs, and lessening the emotional trauma of seeing a case through to trial.[197] In addition, a greater number of claimants, who would not have stood behind their case in a court, are more likely to take their case to arbitration.[198] Additionally, because ADR is a less formal process, plaintiffs play a more significant role in reaching a settlement.[199] Also, the creation of a "multi-door courthouse"[200] permits the parties to choose between various methods of dispute resolution.[201] At the

196 ANNUAL REPORT, *supra* note 12, at 301. The Commission believes that the fate of ADR lies in an effective administrative system to process claims. *Id.* Enhanced access for valid claims may only be attained by lowering economic barriers and by collecting data about potential injuries which receive compensation. *Id.* at 292. Additionally, the data collected should be reported to remove patient uncertainty as to when and what injuries deserve compensation. *Id.* Increased patient awareness and lowered costs will make the system administratively sound. *See id.*

197 ABA SPECIAL COMMITTEE, *supra* note 36, at 14. The Committee approves expanding voluntary ADR where the public may benefit. *Id.*

198 *See* OTA REPORT, *supra* note 3, at 86. *But see* THOMAS E. CARBANNEAU, ALTERNATIVE DISPUTE RESOLUTION: MELTING LANCES AND DISMOUNTING THE STEEDS 219 (1989) (the increased volume of cases may prolong resolutions and a claimant's unwillingness to accept less than an expected recovery may generate greater harm to the plaintiff than benefit).

199 *See* CARBANNEAU, *supra* note 199, at 219. For instance, in mediation the introduction of intelligent neutral third party suggestions for resolution stimulates each party to view his or her claim rationally. *Id.* This empowers a plaintiff to participate in the resolution process by allowing them to explore alternatives which would have been unavailable in court. Instead of feeling like a victim in a legal process they cannot understand, the plaintiff's participation in resolution gives them back a sense of control, which is usually lost at the outset of the litigation. *See* Rifkin & Sawyer, *Alternative Dispute Resolution—From a Legal Services Perspective*, NLADA BRIEFCASE 20, 22 (1982), *quoted in* NANCY H. ROGERS & CRAIG A. MCEWEN, MEDIATION: LAW, POLICY, AND PRACTICE § 4.2 at 36 (1989).

200 *See generally* ABA BLUEPRINT, *supra* note 10 (the ABA maintains that the civil justice system must be reformed to provide multiple routes of claim resolutions, even if not accomplished in the traditional manner through the courts).

201 *Id.* at 64. Parties must be given the opportunity to select the forum most appropriate to their particular dispute, such as early conferences, arbitration, mediation, mini-trial, or summary jury trial. *Id.* at 64-65. The ABA primarily encourages early settlement through regular conferences with the court. *Id.* at 67. Specifically, the purposes of the conferences are to dispense with the costly and timely delays of discovery during trial. *Id.* at 68. Improper discovery of the relevant medical standard and of patient records can be the most expensive and burdensome factor in a medical malpractice action. *See id.*

completion of voluntary ADR, parties with unfavorable settlements may proceed to a traditional judge or jury trial.[202] In effect, voluntary arbitration or mediation is merely practice for trial and may not be taken as seriously if not binding.[203] If mandatory, the parties would be bound to accept the administrative ruling.

The imposition of a mandatory ADR system raises questions about the validity of the administrative authority and trustworthiness of the professional judgment over the layman's knowledge that juries possess.[204] ADR places the responsibility of complex decision-making in the hands of medical and legal professionals, who usually have had previous experience with malpractice cases.[205] Not only do these professionals apply higher standards of knowledge to their verdicts but, unlike juries, they must demonstrate their understanding in a written report to the court.[206] This requirement increases the quality of arbitration and results in more consistent verdicts because decisions made by professionals who are responsible for their outcome nullifies the unpredictable juror sympathy factor.[207] In fact, arbitration decisions carry presumptive validity on issues of fact and may only be challenged for erroneous applications of law.[208]

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202 STRAIGHT TALK, *supra* note 10, at 18. The use of voluntary ADR may be counterproductive to the goal of reducing claim volume, as it encourages double litigation. *See* Sohn, *supra* note 40, at 684.

203 *See* Keller, *supra* note 72, at 13.

204 *See* Vidmar, *supra* note 16, at 121-22. Juries are often confused when too many experts testify as to the required standard of care. *Id.* at 121. "[A]n adversarial courtroom is not the best place to determine medical facts, and [ ] when the process is made more objective through the use of administrative procedures, both patient and physician are better served—to say nothing of the public purse." Todd, *supra* note 21, at 1734. Unless the factual conclusions are clearly within the realm of a layman's comprehension, medical situations are best established by experts. *See* Krandra v. Houser-Norborg Med. Corp., 419 N.E.2d 1024, 1037-38 (Ind. 1981) (demonstrating that Bartholin Cyst surgery is not a matter of common knowledge; thus, whether or not there should have been informed consent prior to surgery was most appropriate for the mediation panel experts). Also, if a mandatory ADR system is imposed, it must be one that does not place onerous burdens or conditions on one's right to a jury trial. *Cf. Smith's Case*, 112 A.2d 625, 629 (Pa. 1955) (the right to an appeal of a mandatory arbitration must be practically available in all instances).

205 OTA REPORT, *supra* note 3, at 85.

206 *See* ANNUAL REPORT, *supra* note 12, at 301.

207 *See id.* Decisions will be established by applying the standard of care known or easily learned by the expert arbitrator. This eliminates the costly retention of multiple experts by each party necessary to clarify standards to a jury. *Id.*

208 61 AM. JUR. 2D *Physicians, Surgeons, etc.* § 372 (1981).

1. Admissibility at Trial of the Administrative Record

When a recommended settlement is challenged and the dispute moves forward to trial, courts struggle with the admissibility of the administrative record. Generally, a panel's conclusions will be admissible at a subsequent trial to encourage the public's acceptance of settlement from ADR systems.[209] Admission of panel findings has been contested, rather unsuccessfully, as a violation of the Seventh Amendment right to a jury trial.[210] Because the jury is the final arbiter of the relevant issues and facts of a case, state statutes that treat medical panel findings as *merely evidence* are routinely validated.[211]

Plaintiffs receiving an unfavorable panel decision are entitled to attack and impeach it.[212] In *Meeker v. Lehigh Valley R.R. Co.*,[213] the U.S. Supreme Court rejected a petitioner's claim that presenting the jury with a finding of the Interstate Commerce Commission violated the right to a trial by jury.[214] The Court noted that the findings established only a rebuttable presumption whereby the petitioner retained the freedom to demonstrate error in the panel's

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209 Milner, *supra* note 133, at 1064. If the findings are admissible and not favorable to the party, he or she will probably decide against proceeding with the case to trial. Sohn, *supra* note 40, at 683; Simon v. St. Elizabeth Medical Ctr., 355 N.E.2d 903, 908 (Ohio Common Pleas 1976) (the unusual burden of overcoming panel testimony coerces parties to remain out of litigation, though they would continue to participate if the testimony was not considered at trial).

210 U.S. CONST. amend. VII; Lacy v. Green, 428 A.2d 1171 (Del. Super. Ct. 1981). Although the right to a jury trial in the federal constitution does not explicitly apply to state court proceedings, most states have constitutional jury trial guarantees of the same substance. *Id.* at 1176 n.1. The Seventh Amendment has never been interpreted to prohibit the introduction of new rules of evidence. *Ex Parte* Peterson, 253 U.S. 300, 307-09 (1920) (the nonjudicial factual determinations of court officers may be introduced as prima facie evidence); *see also* Prendergast v. Nelson, 256 N.W.2d 657, 666 (Neb. 1977) (the admissibility of the findings of the medical panel is "a two-way street which equally affects the parties on both sides"); Comisky v. Arlen, 55 A.D.2d 304, 390 N.Y.S.2d 122, 126 (1976) (at most, the panel's recommendation is an expert opinion that the jury must give the same standard of evaluation as other expert opinions); *Eastin*, 570 P.2d at 749; Gronne v. Abrams, 793 F.2d 74 (2d Cir. 1986).

211 *Meeker*, 236 U.S. at 430 (emphasis added). There is no guarantee that a jury will accept or reject the testimony of the panel. *Eastin*, 570 P.2d at 748-49. Jurors are active participants in the determination of guilt and liability; they do not merely "proofread" the panel's record and stamp it "approved by the jury." *Lacy*, 428 A.2d at 1175.

212 *Lacy*, 428 A.2d at 1176.

213 236 U.S. 412 (1915).

214 *Id.* at 430.

conclusions.[215] It follows from this judgment that submission of a medical liability panel's decision to the jury should also be rebuttable and should constitute only a rule of evidence.[216]

Alternatively, in *Simon v. St. Elizabeth Medical Ctr.*,[217] the Ohio Court of Common Pleas reasoned that, although it may be rebutted, the use of the medical panel review as expert testimony substantially reduces a person's likelihood of prevailing.[218] A party that must defeat such prejudicial testimony has his or her right to a fair jury trial significantly impaired.[219]

2. Denial of Court Access

Additionally, claims required to proceed to an ADR system have been challenged as a denial of the constitutional right to court access. The legitimacy of these actions rest on the strength of their due process challenge to the statute that has delayed or restricted the patient's access to the courts.[220] The constitutional

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215 *Id.* The parties may introduce to the jury the same witnesses and evidence presented to the medical liability panel. *Lacy*, 428 A.2d at 1176. The use of the prior findings "cuts off no defense, interposes no obstacle to a full contestation of all the issues, and takes no question of fact from either court or jury." *Meeker*, 236 U.S. at 429.

Traditionally, the legislature has been able to establish rules that affect the burden of proof without infringing on the plaintiff's Seventh Amendment right. Attorney Gen. v. Johnson, 385 A.2d 57, 69 (Md. 1978) (citing Bonaparte v. M. & C.C., 101 A. 594, 596 (Md. 1917)) (where the legislature validly allowed the Commissioner for Opening Streets to make a ruling of a monetary award which could have the effect of prima facie evidence at a subsequent trial). "States are under no constitutional obligation to neutralize the economic disparities which inevitably make resort to the courts different for some plaintiffs than others." Strykowski v. Wilkie, 261 N.W.2d 434, 444 (Wis. 1978).

216 *See Strykowski*, 261 N.W.2d at 444. *Eastin*, 570 P.2d at 748-49 (enforcing a statute which allows a court to consider the findings of the medical review panel, because such laws are simply rules of evidence and do not violate the right to a jury trial); *contra Simon*, 355 N.E.2d at 908 (the legislature's power to prescribe rules of evidence does not extend to limit the constitutional right to trial by jury; therefore, no testimony of the ultimate fact in issue is admissible).

217 355 N.E.2d 903 (Ohio Common Pleas 1976).

218 *Meeker*, 236 U.S. at 430. The disadvantaged party must persuade the jury that the decision below was incorrect—an enormous task, considering the jury's traditional acceptance of expert testimony as gospel. *Id.*

219 *Id.*

220 *See* Jiron v. Mahlab, 659 P.2d 311, 312 (N.M. 1983). All persons have a constitutional right not to be deprived of court access without due process of law. In *Jiron*, a plaintiff with strict time constraints was unlawfully deprived of her right to bring a medical negligence action to court under a New Mexico statute requiring application of all claims to a medical review commission. *Id.* Yet, most courts have upheld stat-

problems arise where additional delays and expenses, though normally expected, become so excessive as to deny claimants court access.[221] In general, patients can prevail when arbitration requirements produce unnecessary delays or unusually short limitations periods that substantially impairs their right to a full and fair trial.[222] For the same reason, statutes that cause additional, or even unnecessary, costs are usually upheld and found not violative of the right to court access.[223]

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utes limiting expeditious court access in deference to mediation's goal of ferreting out frivolous claims. *See, e.g.*, Paro v. Longwood Hosp., 369 N.E.2d 985, 990 (Mass. 1977) (Massachusetts' mediation requirement that judges set a bond price in order to proceed from an arbitration hearing to trial was found valid when the judge's discretion did not unreasonably bar meritorious claims); Keyes v. Humana Hosp. Alaska Corp., 750 P.2d 343, 359 (Alaska 1988) (plaintiff unsuccessfully petitioned to avoid submission of her claim to a medical review panel. So long as there is a rational basis for the imposed restraint, access may be hindered); Everett v. Goldman, 359 So.2d 1256, 1269 (La. 1978); Linder v. Smith, 629 P.2d 1187, 1190-91 (Mont. 1981); *Comisky*, 390 N.Y.S.2d at 130.

221 *See Attorney Gen.*, 385 A.2d at 71 (the plaintiff accrued many expenses during extensive discovery at the arbitration proceeding in attempting to prove the negligence of hospital physicians. The Maryland Court of Appeals held that minimal expenses and delays resulting from a malpractice claim statute are reasonable when in accordance with appropriate legislative goals). To prevail, injured patients must demonstrate that the mandatory arbitration obstructed the jury's determination of the facts. *Id.* at 72.

222 Cardinal Glennon Memorial Hosp. v. Gaertner, 583 S.W.2d 107, 111 (Mo. 1979) (Simeone, J., concurring). The unreasonableness of the additional time to claims resolution depends upon the particular circumstances of the case. *See Jiron*, 659 P.2d at 313. Claimants that spend too much time awaiting the recommendation of the mediation panel are likely to be able to show that the delay prejudiced their case. *Id.* In *Jiron*, the plaintiff raced to get her claim to trial, fearing that the negligent physician would not be available for trial in the future. *Id.* at 312. The requirement that the claim first go before a medical review panel prejudiced her ability to retain the parties (or witnesses) necessary for trial and, therefore, caused an impermissible delay. For this reason, the court held that a claim must be provided access to the judicial process prior to its submission to a panel. *Id.* at 313. *See Mattos*, 421 A.2d at 195 (holding that a three-year delay resulting from an arbitration requirement was unconscionable and harmful to the public's confidence in judicial efficiency); *but see Keyes*, 750 P.2d at 346 n.1, 358-59 (a delay due to panel review less than 80 days was reasonable).

On the other hand, statutes that set rigid jurisdictional periods between filing, mediating, and litigating a case may be unconstitutional if they are "arbitrary and capricious in operation." Aldana v. Holub, 381 So.2d 231, 238 (Fla. 1980) In *Aldana*, a patient was unlawfully impeded from bringing her claim to trial pursuant to a ten month mediation limitations statute. *Id.* at 234. The Florida Supreme Court struck down the statute as defective, incapable of repair, and violative of the Due Process clauses of the United States and Florida Constitutions. *Id.* at 238.

223 *See, e.g., Johnson*, 404 N.E.2d at 592. Expenses incurred in preparation of trial are not easily distinguished from those made in advance of a mediation hearing. Many of

Valid federal policy requiring submission to medical review panels must not make access to the courts practically unavailable.[224] The right to court access only becomes available when a patient has a specially protected right and there is no other alternative forum to enforce that right.[225] Courts review these types of statutes against a rationality standard because they are designed to benefit the general welfare.[226]

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the expenses from mediation overlap and are useful for trial purposes. The panel submission requirement produces discovery that is admissible at the future trial. The expenses made for mediation "do[ ] not alter or change the substantial elements and incidents of [ ] trial right for either party." *Id.* at 592.

Any additional costs on the patient bringing suit can be the equivalent to the cost of bringing an appeal. *See Attorney Gen.*, 385 A.2d at 73. Because the arbiter's decision may be accepted as final, any election to proceed further in the judicial process is taken at the risk of that party. The ability to bring the action to trial is preserved, but at an increased cost. *Id.* at 73. *But cf.* Boddie v. Conn., 401 U.S. 371, 375 (1971) (requiring the payment of court fees prior to court access is unconstitutional when applied to the indigent. Such a requirement deprives people of their property rights without due process of law. States must not tailor the procedures of conflict resolution to benefit those who have the funds to gain access. Adequate access to the judicial process may be the only available dispute settlement technique that satisfies due process). *But cf.* Lucas v. United States, 757 S.W.2d 687, 715 (Tex. 1988) (Culver, J., concurring) ("[S]tates require [ ] a judicial balancing of the individual right to assert a recognized remedy with the public necessity for abrogating or restricting that right . . . [T]he balance may be satisfied in favor of the restriction only if the legislature has created [a reasonable] alternative remedy, or *quid pro quo*, in place of the abolished right"). *See also Mattos*, 421 A.2d at 196 (holding that the alternative remedial process must be effective in its enforcement for it to viable).

224 *Attorney Gen.*, 385 A.2d at 74. So long as the statute does not completely close the courts to prospective litigants, it could withstand judicial review. *Id.* at 73 (citing Knee v. City Passenger R.R. Co., 40 A. 890 (Pa. 1898)).

225 *Keyes*, 750 P.2d at 359. There can be no constitutional violation where no fundamental right is at stake and where claims with merit are not unreasonably excluded from the judicial process. The ability to bring a malpractice claim without an impediment is not a protected or enforceable property right. *See Attorney Gen.*, 385 A.2d at 71. "[T]here is [ ] no violation of the due process right of access to the courts by the addition of a mode of procedure which merely causes some delay and increases the expense for a litigant who takes his claim to court, since there is no deprivation of any vested property right." *Id.*

226 *See Attorney Gen.*, 385 A.2d at 71-72. Restrictions promulgated by the legislature are presumed to be reasonable and conducive to the general welfare. Limiting access can be a valid exercise of police power when the goal of reducing the cost of litigation and malpractice insurance is accomplished and the public benefits. *Id.* at 71. "In the area of economic or social welfare, legislation not involving suspect classifications or touching on fundamental interests is presumed constitutional, and the courts require only that the distinctions drawn by the challenged statute be rationally related to a legitimate state interest or purpose." *Gronne*, 793 F.2d at 77 (upholding New York's malpractice law, despite its perceived invalidity, because the legislature is the most appropriate authority to determine the social worth of its laws); *see also* Woods v. Holy

3. Delegation of Judicial Power in the Panel

Many claims challenging requirements for medical claim review before trial question whether the non-judicial members of the panel have been given the power to make procedural or substantive rulings of law.[227] If made, these decisions can be unconstitutional delegations of "judicial power."[228] Therefore, mediation panels should not make their recommendations binding upon the parties[229] nor should they enforce their findings.[230]

To be upheld, statutes must create panels that issue opinions on fact or law that are not deemed conclusive at trial. Otherwise, the powers of the judge will be diluted.[231] There can be no blending of non-judicial and judicial opinion in the final judgment.[232] So long as the statute establishing the panel gives no binding effect to its recommendations, there will be no usurpation of judicial

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Cross Hosp., 591 F.2d 1164, 1174 (5th Cir. 1979) (the burden is on the one who challenges the statute to show its unreasonableness and arbitrariness).

227 *Eastin*, 570 P.2d at 750.

228 BLACK'S LAW DICTIONARY 849 (6th ed. 1990). Only the courts have the power to adjudicate issues of law and fact, protect and enforce personal rights, pronounce a final judgment, and enforce its ruling on the losing party. *Id.* "The judicial Power of the United States, shall be vested in the Supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish." U.S. CONST. art. III, § 1, cl. 1.

229 *Attorney Gen.*, 385 A.2d at 63; *Eastin*, 570 P.2d at 750 (the parties must be able to accept or reject the panel's recommendation as they wish. The panel's finding may only have the weight of other evidence at trial.) *See also Keyes*, 750 P.2d at 356 (there is no unconstitutional vesting of judicial power when "the actions of the panel are at most advisory and its decision has no more weight than an expert opinion").

230 *Attorney Gen.*, 385 A.2d at 63. To withstand constitutional muster, the arbitration decision must only be enforceable upon confirmation of its findings by an established court of law; only then does the decision become final. *Id.*

231 Wright v. Central Du Page Hosp. Assoc., 347 N.E.2d 736, 739 (Ill. 1976). In *Wright*, the panel was composed of a judge, a physician, and an attorney, each of whom had the ability to make findings of facts or substantive legal issues. *Id.* at 738. The panel's judgment was binding and conclusive upon the party's agreement. The Illinois Supreme Court held that "the applications of principles of law is inherently a judicial function, and [ ] the constitution vests the exclusive and entire judicial power in the courts." *Id.* at 739.

232 *See Bernier*, 497 N.E.2d at 770-71 (to render an enforceable judgment there can be no sharing of fact-finding or decision-making functions between the judicial and non-judicial members of the panel. Where non-judicial members of the panel are empowered to exercise any judicial role, there is a violation of the constitutional provision against delegating judicial authority); *but see Paro*, 369 N.E.2d at 992-93 (the judge on the panel need only have a preeminent role in the mediating process and must have the sole authority over questions of law).

authority.[233]

### B. *Certificates of Merit*

Proposals to reduce the number of frivolous claims include provisions requiring a qualified expert to submit an affidavit stating that the claimant's cause of action is a reasonable one.[234] These certificates of merit may result in a denial of court access if drafted in such a way as to impose significant burdens on individuals seeking to sue their health care provider.[235] Because these pretrial filing procedures threaten to abrogate the rights of individuals who should have court access and limit the courts' ability to dispose of claims in an orderly fashion, increased federalization in this area must be strictly scrutinized.[236]

### C. *Reducing the Statute of Limitations*

Many states have enacted laws that reduce the limitations period for filing claims and for filing suit.[237] Reductions in the statutes of limitations benefit all parties involved.[238] Victims will not be induced to accept unfavorable settlements forced upon them by

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233 *See Attorney Gen.*, 385 A.2d at 63-67.

234 *See, e.g.*, H.R. 3600, *supra* note 27, at § 5303 (defining "qualified specialist" as a health professional who is knowledgeable of, and has expertise in, the same specialty area of practice that is the subject of the action.)

235 Keller, *supra* note 72, at 6. First, if qualified experts are not limited in what they may charge for their services, high prices may bar low-income individuals from asserting meritorious claims. Effective federal action in this area must contain the costs of attaining these affidavits of merit, for example, by setting a ceiling on costs which denies the ability of market forces to operate.

Second, proposals that require a cause of action to be reasonable and meritorious before the claim may proceed may deny due process. *See id.* Meritorious claims may be screened out based upon apparent insufficient information that could only have been attained after a full and fair review of the facts and circumstances through the judicial process. *Id.* Federal legislation in this area should be drafted with an eye towards guaranteeing court access to any potentially reasonable claims, so as to avoid constitutional due process objections.

236 *See* ABA BLUEPRINT, *supra* note 10, at 5 (barriers to court access can distort the process by promoting the adoption of assembly-line tactics and procedural shortcuts). Alternatively, certificates of merit can be practical if the only effect is to lessen the frequency of frivolous claims.

237 *See generally* STATE LAWS, *supra* note 95 (listing states with statutes of limitations that specifically apply to medical malpractice cases).

238 *But see* ANNUAL REPORT, *supra* note 12, at 295 (the effects of restricting the limitations period may be especially harsh for claims with merit).

the threat of long, drawn-out proceedings.[239] But, physicians will be protected from the unfairness of defending against old lawsuits.[240] Moreover, enacting a uniform statute of limitations may reduce claim frequency and unnecessary delays in their resolution and should eradicate certain insurance expenses that had been reserved for protecting against older claims.[241]

### *VI. Conclusion*

No one can deny that federal reform of the medical malpractice claims process is necessary. Yet, there is no similar agreement as to what form these changes should take. Of the proposals, most address either limiting liability or forcing claims through the system in small amounts of time. Generally, these types of legislation are reasonable and could fit into a federal format so long as these limits are fair, consistent, and encourage settlements.

At first glance, these suggestions do not seem to account for patient needs, and appear to set harsh limits on the route a claim must take and on the ultimate award. While the above may appear to be true, in fact the proposals create new avenues through which injured claimants may benefit. By allowing claimants to actively participate in informal arbitration or mediation, those injured by medical negligence will control their own destiny. As a result, the emotional strain of a long, formal judicial proceeding can be minimized, allowing the plaintiff to feel less like a victim and more like an empowered individual entitled to compensation.

Much of the blame for high malpractice costs falls on patients who bring frivolous lawsuits. Realistically speaking, however, the most needed area of reform lies in our inefficient and often ineffective administrative procedures. This is, perhaps, the most needed area of reform. It is necessary for reform to focus on streamlining the process by eliminating unnecessary or duplicative discovery, restricting the time to claim resolutions, and screening claims before they have an opportunity to clog the court system.

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239 Wittkin, *supra* note 76, at 2-3.

240 O'SULLIVAN, *supra* note 3, at 6.

241 *See* ANNUAL REPORT, *supra* note 12, at 295. However, reducing claims frequency may have the opposite effect, by encouraging claimants to file suits with uncertain merits in order to avoid being excluded from court. Furthermore, it is not clear whether the insurer will reduce its rates because less time to claim disposition may force insurance companies to cover their liabilities sooner rather than later.

It is important to remember that malpractice litigation is not necessarily a bad thing. Fear of litigation stimulates better quality of care, as physicians are forced to make conscious efforts to avoid practices that are likely to result in negligence. In those respects, malpractice must not be reformed.

However, to the extent that physicians perform unnecessary treatment, there must be incentives not to act. To this end, practice guidelines have been proposed—the success of which has yet to be determined. Defining how much care physicians will be held responsible for reduces the incentive to provide wasteful procedures for the sole purpose of limiting liability.

Successful federal regulation in this area, whether enacted by the present Congress or the next, should define the standard of care. Such standards should include an allowance for flexibility depending on locality, an accounting for medical science imperfections, and an effortless amendment process for new technological advancements or discoveries. As a linchpin to any guideline proposal, there is no empirical evidence that use of guidelines will eliminate the probability that litigation trends may remain the same or will even increase. It is foreseeable that while costs may remain unchanged as actual malpractice declines, new expenditures will arise when litigants dispute the medical standard applied. For instance, doctors may challenge the applicability of the guideline to their particular circumstance and may assert that good medical care comes, not from the pages of a statute, but rather from experience.

The above example hones in on the most serious concern facing medical malpractice legislation: the tort reform ultimately enacted must be sensitive to the legislative goals of allowing court access and limiting malpractice costs, while ensuring that the quality of health care in America remains the same. For now, Congress should look to the states as laboratories of tort reform, and frame future proposals from the successful state enactments.