THE MEDICAL MALPRACTICE CRISIS OF THE 1970'S: A RETROSPECTIVE

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I

INTRODUCTION

The recent declaration by the American Medical Association of a medical malpractice "crisis" requiring major legal reform[1] inspires a sense of *déjà vu*. We have, it seems, been here before. A decade ago tort law was widely denounced for creating a similar crisis for medical care providers.[2] The problem then was huge increases in insurance premiums and the departure of some insurance carriers from malpractice underwriting. These events sparked a general alarm over the economic viability and quality of health care[3] and caused investigations to be launched by the federal and state governments and private groups.[4] Reforms occurred in both legal rules and

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1. *See* N.Y. Times, Feb. 21, 1985, at A16, col. 4; *see also* SPECIAL TASK FORCE ON PROF. LIAB. AND INS., AM. MEDICAL ASS'N, PROFESSIONAL LIABILITY IN THE '80S, REPORTS 1, 2 & 3 (1984-1985) (originally published as supplements to AM. MED. NEWS, Oct. 1984, Nov. 1984, Mar. 1985) [hereinafter AMA TASK FORCE]. For earlier reports on the continued upward trend in claims and in insurance costs, see, for example, Stein, *The High Cost of Suing*, NAT'L J., Feb. 25, 1984, at 382; Taravella, *Physicians Faced With Ballooning Malpractice Rates*, BUS. INS., Sept. 16, 1983, at 1, 56-57.

2. The "crisis" spawned an enormous literature. Useful general discussions of the problem and references to other discussion can be found in the following: THE ECONOMICS OF MEDICAL MALPRACTICE (S. Rottenberg ed. 1978); S. LAW & S. POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE (1978); Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489 (1977); *Symposium on Medical Malpractice*, 1975 DUKE L.J. 1177. Most of the literature is roughly contemporaneous with the crisis and its immediate aftermath in the mid to late 1970's. However, an important series of studies by Patricia Danzon provide a more current perspective on the problems. Since the present article was substantially completed Danzon's studies have been partly updated and now appear, with a contemporary commentary on the on-going "crisis" in P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY (1985). References herein to her work continue to be to the earlier sources.

3. *See generally* U.S. DEP'T HEALTH, EDUC., & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE & APPENDIX (1973) [hereinafter cited as HEW REPORT].

4. The leading study on a national level was that of a special commission formed by HEW. *See id.* At the state level, more than forty groups reportedly undertook formal studies. *See* Grossman, *An Analysis of 1975 Legislation Relating to Medical Malpractice*, in A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE 4 (D. Warren & R. Merritt eds. 1976). For a sample of such studies, see, for example, BUREAU OF INS., VA. STATE CORP. COMM'N, MEDICAL MALPRACTICE INSURANCE IN VIRGINIA: THE SCOPE AND SEVERITY OF THE PROBLEM AND ALTERNATIVE SOLUTIONS (1975); MASS. SPECIAL COMM'N ON MEDICAL MALPRACTICE, ANNUAL REPORT (1978) (reported annually from 1976-1979); NEW YORK SPECIAL ADVISORY PANEL ON MEDICAL MALPRACTICE, REPORT (1976).

In addition to these official public studies, there were numerous private studies. *See, e.g.*, AM. BAR ASS'N, INTERIM REPORT OF THE COMMISSION ON MEDICAL PROFESSIONAL LIABILITY (1976); Am. Ins.

insurance practices.[5] By the end of the 1970's, the momentum for institutional change and legal reforms was spent. Whether the changes and reforms solved the underlying problems or merely appeared to do so, they did have the *immediate* effect of dissipating the crisis atmosphere that had earlier prevailed.

Renewed increases in the severity (size) and frequency (number) of malpractice claims, accompanied by new increases in insurance premiums,[6] are now causing fresh anxiety within the medical profession. New proposals for legal reform have included not only a myriad of bills in state legislatures—only a handful of which have been enacted to date[7]—but also two bills in Congress.[8] This renewed interest in the problem makes timely another look at the crisis of the 1970's and the legal and insurance changes it produced.

This article begins with a summary of the events of the early 1970's and a review of what is known of the immediate causes of those events—namely the unexpected rise in legal claims and recoveries, certain insurance practices that exacerbated the problem, and exogenous developments in the economy. Various speculations about the causes of the increase in legal claims, particularly the role of legal doctrine, are reviewed. Because liberalization of liability rules was widely blamed for producing the escalation of malpractice claims leading up to the crisis, reform of those rules became the focus of political attention. The article provides some skeptical comments on the degree to which the ostensible reforms actually changed tort law and closes with a few comments about the alleged reemergence of the crisis.

The malpractice crisis of the mid-1970's had several facets. For health care providers the immediate crisis was essentially twofold: a sudden and substantial increase in malpractice insurance premium rates and, worse, the threat that liability coverage would become unavailable at any price as a consequence of carrier withdrawal from the field.[9] For the carriers themselves, the crisis was an unanticipated increase in both the number of claims filed for negligent injuries and the amounts recovered.[10] Rising underwriting costs were compounded by investment losses that a nationwide recession inflicted on insurance companies along with other investors.[11]

If the public at large were aware of any crisis, it is unlikely that they directly felt its effects. Although patients may have paid somewhat higher medical and

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Ass'n & Ins. Servs. Office, All-Industry Committee Special Malpractice Review: 1974 Closed Claim Survey (1976); AM. MEDICAL ASS'N, MALPRACTICE IN FOCUS (1975) (collecting and reviewing data from other studies, principally by state medical associations); A. MURRAY, THE MEDICAL MALPRACTICE SITUATION IN CALIFORNIA (1976).

5. *See infra* notes 73-116 and accompanying text.
6. *See infra* notes 135-36 and accompanying text.
7. *See infra* notes 141-43 and accompanying text.
8. *See infra* notes 145-46 and accompanying text.
9. *See infra* notes 23-24 and accompanying text.
10. *See infra* notes 32-33 and accompanying text.
11. *See* Kendall, *Expectations, Imperfect Markets, and Medical Malpractice Insurance*, in THE ECONOMICS OF MEDICAL MALPRACTICE, *supra* note 2, at 167, 180-81; Roddis & Stewart, *The Insurance of Medical Losses*, 1975 DUKE L.J. 1281, 1289 (1975).

hospital bills as the costs of malpractice insurance passed through the system, the third-party payment system tends to diffuse and obscure the effect of higher costs on the patient's own purse.[12] Moreover, in a health care system already plagued by costs rising substantially faster than inflation, even a dramatic increase in liability costs would be scarcely noticeable.[13]

The people's legislative representatives, however, with the aid of lobbyists for the medical profession, could see the potential for disruption in medical services if insurance became unavailable to the profession or if its costs became too burdensome. Something had to be done, or at least something had to *appear* to the relevant constituencies to be done.[14] That "something" consisted of a considerable amount of legislative activity ostensibly directed at changing the liability rules underlying the malpractice legal system. How much the changes were substantive and how much they were cosmetic is a matter best deferred until after the nature and genesis of the underlying problem have been reviewed.

II

MALPRACTICE CLAIMS AND INSURANCE COSTS

A study conducted for the HEW Secretary's Commission on Medical Malpractice provides the most dramatic evidence of the 1970's malpractice crisis—the sudden rise in malpractice insurance premiums.[15] Illustrative of the general pattern are the data for insureds in the next-to-lowest and the

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12. *See, e.g.*, K. ARROW, ESSAYS IN THE THEORY OF RISK-BEARING, 202-04 (1971) (general discussion of the moral hazard problem in the context of health insurance); M. FELDSTEIN, HOSPITAL COSTS AND HEALTH INSURANCE 5-6, 93-94 (1981). To explain the moral hazard problem, Feldstein notes that employers pay a large fraction of the insurance cost. Thus, although insurance costs increases might lead to lower net wages, this fact may not be perceived by employees. However, the problem may not be entirely one of perception but also one of free-riding (each employee expects to externalize a disproportionate share of their health service costs to other insureds).

13. Even at its present high level, malpractice insurance costs are less than one percent of total health care expenditures. For 1984, total health care costs were reported at $387.4 billion. 7 HEALTH CARE FIN. REV. 9 (1985). For the same years, the total medical malpractice insurance premium costs have been estimated to be about $2.7 billion. MILLIMAN & ROBERTSON, INC., ACTUARIAL ANALYSIS OF AMERICAN MEDICAL ASSOCIATION TORT REFORM PROPOSALS 2 (Sept. 1985). The estimates are based on Best's reports—the leading source of insurance data—supplemented by data for insurers not reporting to Best's. Inexplicably the Milliman-Robertson report of Best's data gives a much higher figure than Best's own reports for 1984. *See* 46 BEST'S AGGREGATES & AVERAGES, PROPERTY/CASUALTY 105 (1985). Attempting to reconcile the disparate reporting would be of no real consequence in this instance. Even accepting the higher figure, the insurance costs are considerably under one percent of the total health care expenditures.

14. For legislators concerned about reelection (or comparable reward from their constituencies) the key, of course, is to *appear* responsive to demands by those constituents who are important to achieving those rewards. *See generally* D. MAYHEW, CONGRESS: THE ELECTORAL CONNECTION 13-77 (1974). Given the organized power of the medical profession, it is not surprising that legislators would be solicitous of the profession's concern about the malpractice crisis. However, the complexity of the law and its effects make measuring the true effectiveness of legislative action difficult. This monitoring problem is not unique to malpractice, but it warrants mention to counter the frequent assumption that the legal reforms in this area were in fact responsive to the problems that the medical constituency identified.

15. Kendall & Haldi, *The Medical Malpractice Insurance Market*, in HEW REPORT, *supra* note 3, at app. 494.

next-to-highest risk rating categories.[16] From 1960 to 1972, the average premium costs for the former category increased an estimated 600%, while those of the latter class increased about 900%.[17] It should be emphasized that these are nationwide averages; some states experienced even higher rates of increase.[18] Hospital insurance premiums showed a similar pattern, with an average nationwide increase of some 750% between 1965 and 1973, according to one study.[19] Again, considerable variation existed among states and among hospitals.[20]

Data on premium increases are a misleading indicator of the malpractice problem because they are not related to provider income. The HEW survey shows that premium costs relative to professional income rose just under 300% from 1962 to 1970. However, the ratio was still modest in absolute terms. Premium costs were 1.8% of income for a "class 2" physician, and 4.2% for a "class 4" surgeon.[21] Recent data show comparably low percentages.[22] These figures may still tell very little because they do not show how much of the increased premiums were passed on to patients and their health care insurers.

The rise in premium rates was only part of the crisis. Potentially more troublesome was the actual or threatened withdrawal from the malpractice market by some major insurers under the combined pressure of volatile underwriting risks, investment losses, and uncertain profits. For most of

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16. Under the rating system used by the Insurance Services Organization (ISO), physicians are classified into five categories according to the degree of liability risk associated with their practice. In general, this risk is roughly correlated to the degree of participation in surgery. The premium rates assigned the five ISO categories are multiples of the "class 1" rate. For example, in 1972, the "class 2" rate was 175 percent of the "class 1," while "class 4" was 400 percent of "class 1." *See id.* at app. 533-34. It is now common for major insurance carriers to use more than five rating categories. *See* MEDICAL LIABILITY MUTUAL INSURANCE CO., PREMIUM RATE SCHEDULES (July 1, 1983) (14 specialty categories).

17. *See* Kendall & Haldi, *supra* note 15, at app. 541. Kendall and Haldi's percentages are indexed to a 1966 base; those in the text are extrapolations.

18. The rate experience in each state over varying periods—generally, the early 1970's—is reviewed in AM. MED. NEWS, Feb. 24, 1975, *reprinted in* STAFF OF HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG. 1ST SESS., AN OVERVIEW OF MEDICAL MALPRACTICE 205-18 (Comm. Print 1975).

19. *See* M. SUMMER, THE DOLLARS AND SENSE OF HOSPITAL MALPRACTICE INSURANCE 19 (1979). The percentages presented therein are derived from aggregate earned premium volume.

20. *See id.*

21. Kendall & Haldi, *supra* note 15, at app. 541.

22. Surveys by the AMA show the mean ratios of premium costs to gross income, for all physicians, have fluctuated between 2% and 5% since 1973. For instance, the mean was 4.4% in 1976, 3% in 1981, and 3.7% in 1983. AM. MEDICAL ASS'N, 1973-80 AMA PERIODIC SURVEYS OF PHYSICIANS; AM. MEDICAL ASS'N, 1981-83 SOCIOECONOMIC MONITORING CARE SURVEYS (both AMA surveys are cited in background materials prepared for the 1985 National Medical Malpractice Conference sponsored by The Urban Institute, Medical Malpractice: Can the Private Sector Find Relief? (R. Bovbjerg & C. Havighurst eds., Working Paper 3417-01, Mar. 1985)) [hereinafter cited as AMA SURVEYS]. A recent AMA report gives a figure of 7.7% for 1984. AM. MEDICAL ASS'N, REPONSE OF THE AMERICAN MEDICAL ASSOCIATION TO THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA STATEMENTS REGARDING THE PROFESSIONAL LIABILITY CRISIS app. table 2 (1985). However, that figure is the ratio of premium costs to pretax *net* income. The appropriate measure is the ratio to *gross* income. The AMA's data show this to be about 4.2% for 1984. *See* AM. MEDICAL ASS'N, SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 110, 116, 120 (1985) (showing net income, total expenses, and premium costs).

them, malpractice was not a major line of underwriting in any case, making withdrawal in the face of uncertain future profitability relatively easy.[23] A precipitating factor in some states was the refusal of insurance commissioners to permit large premium rate hikes—often at the urging of state medical societies.[24] Conditions such as these reduced the likelihood that the place of a vacating insurer would be quickly filled by another carrier.

There is not much dispute about these basic events. Nor is there much dispute about their immediate causes. The insurer's investment losses were traceable to general economic conditions. Their underwriting losses reflected unexpected increases in both the frequency and the severity of insured claims. The hard questions are why claims and costs suddenly increased and why these increases were not anticipated.

The conventional insurance explanation for underwriting losses stresses the difficulties of actuarial prediction of future claims exposure.[25] Part of the problem is said to arise from the small number of insureds in any particular risk category or geographic region, which creates a "credibility" problem with the data from which claims exposure is estimated.[26] The credibility problem was compounded by the scant attention that the companies gave to risk and rate loss evaluations for this relatively minor line of insurance.[27] In part, the steep climb reflected years of insurer neglect of the changing legal and social environment affecting malpractice claims. This neglect, followed by the carriers' rude awakening, precluded a more gradual premium adjustment.[28] When the increases came, they were greater in percentage terms than recent claims increases appeared to explain, as insurers projected the trends they were seeing into the future and sought premiums sufficient to cover losses incurred at even higher rates. Many observers were unconvinced that the new premium levels were a fair reflection of anticipated claims experience, a skepticism applied with equal force to current premium levels.

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23. For a mid-1975 survey of carriers withdrawing from one or more markets, see AM. MEDICAL ASS'N, MALPRACTICE IN FOCUS 19-20 (1975). Personal correspondence with insurance carriers shows withdrawal from the malpractice line by such major companies as Wausau, Hartford, Fireman's Fund, United States Fidelity and Guarantee, and Travelers. The impact of withdrawal by major carriers was enhanced by the fact that insurance is commonly written, on a group basis, for the medical society in a particular area.

24. *See* Danzon, *An Economic Analysis of the Medical Malpractice System*, 1 BEHAV. SCI. & L. 39, 49 (1983).

25. For a good, concise description of the actuarial process as applied to malpractive insurance, see Roddis & Stewart, *supra* note 11, at 1290-97.

26. *See id.* at 1294.

27. *See* Kendall, *supra* note 11, at 175 (prior to 1970 medical malpractice was less than 0.5% of total property and liability insurance premium volume).

28. The failure of insurers to collect better information about changes affecting their underwriting risks was not necessarily negligent. *See* Roddis & Stewart, *supra* note 11, at 1289. Insurers have traditionally offset unexpected underwriting losses with investment earnings. In fact, the general pattern was that the very economic cause of loss on one side of the ledger usually produced gain on the other. Since many carriers abandoned malpractice lines in the 1970's, it appears that underwriting losses were not fully offset by investment returns derived from malpractice premiums.

The difficulty that figures most prominently in all explanations of the insurers' problems is the "long tail" of malpractice claims. In contrast to some other forms of indemnity, where claims are filed and losses fully developed within a short period after the insured event, medical malpractice claims, relating to injuries that may not come immediately to light and that take time for claimants to investigate, may not mature for as much as a decade.[29] Slowness in the development of claims increases the uncertainty inherent in the "development" of losses and in the "trending" of loss experience (that is, adjusting projections for anticipated alterations in conditions affecting future payouts).[30]

Uncertainty in general and the "long tail" in particular provide an incomplete explanation of the 1970's malpractice crisis because they leave out the instability of the underlying events. The "long tail" on claims exposure would be irrelevant in a steady-state environment or if the rate of change in the incidence of claims were constant.[31] To create an actuarial problem, the long tail must be accompanied by unpredictable changes affecting claims payments. Although unanticipated inflation, reflected in damage awards, might be one example, the surge of inflation in the 1970's is unlikely to have had more than a slight effect on tort recoveries during that period because the contested injuries were sustained earlier, during a period of more gradual and predictable price rises. Analyses of the long-tail problem typically emphasize that the uncertainty confronting underwriters resulted from changes in the *inflation-adjusted* severity of claims.

The rise in the number and size of malpractice claims over the decade preceding the crisis was striking. For example, industry data on malpractice claims in the late 1960's and early 1970's showed an annual increase in claims frequency (defined as claims per 100 doctors) of more than twelve percent and an increase in severity (defined as average cost per claim) of more than ten percent.[32] Although there was considerable variation,[33] virtually every professional specialty and virtually every state experienced increases of such magnitude and duration as to compel a search for causes other than pure chance. What would produce such a severe and sudden change in claims? The usual answers consist of a mixture of generalizations about changes in health care, in public attitudes, and in the legal system.[34]

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29. For a good discussion of the problem, see Kendall, *supra* note 11, at 181-89.

30. *See id.* On development and trending generally, see *Hearing Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare, Continuing Medical Malpractice Insurance Crises*, 94th Cong., 1st Sess. 183, 196-209 (1975) (report of the All-Industry Medical Malpractice Insurance Committee); Roddis & Stewart, *supra* note 11, at 1294-97.

31. *See* Mann, *Factors Affecting the Supply Price of Medical Malpractice Insurance*, in THE ECONOMICS OF MEDICAL MALPRACTICE, *supra* note 2, at 155, 156-57.

32. *See* Kendall, *supra* note 11, at 187.

33. Scattered data on claims frequency and severity are given in AM. MED. NEWS, *supra* note 18.

34. *See, e.g.*, VA. STATE CORP. COMM'N, *supra* note 4, at 54.

III

THE SEARCH FOR CAUSES

One speculation is that the increase in malpractice claims in the early 1970's reflected a decline in standards of medical practice. This assertion can be dismissed fairly easily. No reliable evidence, other than the incidence of legal claims, supports the implausible notion that there had been, in absolute or relative terms, a decline in medical practice standards. Moreover, the suggestion does not correlate well with the fact that the incidence of claims was highest and rising most rapidly in heavily urbanized areas, where intuition suggests that professional standards are highest.[35]

Although it is implausible that greater sophistication in medical science would be matched by a sharp decline in practice standards, it is possible that advances in medical procedures and technology increased the risk of iatrogenic injury.[36] One possibility is that the costs of iatrogenic injury brought on by new procedures and technology exceeded the therapeutic benefits, implying that use of these innovations was legally negligent under Judge Learned Hand's familiar test.[37] More likely, however, there was not a higher incidence of negligence but simply increased risk exposure attributable to the use of more dangerous but generally beneficial methods. It is plausible that malpractice suits increased in relation to these new iatrogenic risks, either because inevitable injuries triggered claims without regard to actual negligence or because the new complexity made an increase in negligence inevitable. In any event, the seemingly paradoxical result was that an increase in medical sophistication produced more claims for malpractice.

The judgment that increasing medical sophistication results in greater malpractice losses is consistent with the fact that malpractice claims most often result from surgical and related treatments,[38] the type of higher-risk

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35. *See* Reder, *Medical Malpractice: An Economist's View*, 1976 AM. B. FOUND. RESEARCH J. 511, 526 (1976).

36. *See* L. LANDER, DEFECTIVE MEDICINE: RISK, ANGER, AND THE MALPRACTICE CRISIS 36-56 (1978).

37. *See* United States v. Carroll Towing Co., 159 F.2d 169 (2d Cir. 1947); Brown, *Toward an Economic Theory of Liablity*, 2 J. LEGAL STUD. 323 (1973); Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29, 32-33 (1972). Strictly speaking, the suggestion in the text goes beyond the Hand-Posner-Brown negligence formulation insofar as it implies that the level of activity is another factor in the calculus. The conventional interpretation of that calculus does not include activity level as a variable. *See* Shavell, *Strict Liability Versus Negligence*, 9 J. LEGAL STUD. 1 (1980). There is no reason for this result, however. Where iatrogenic risk exposure is correlated to level of health care services, the Hand-Posner-Brown test could determine whether the increased risk of additional health care was cost-justified—quite independent of any reasonableness assessment of precautions taken in connection with those services.

38. Dietz, Baird & Berul, *The Medical Malpractice Legal System*, in HEW REPORT, *supra* note 3, at app. 87, 150. Their survey of appellate cases between 1950 and 1971 found that over 57% of claims involved surgical treatment. Other studies corroborate their findings, although the data are not all precisely similar. *See, e.g.*, NAT'L ASS'N OF INS. COMM'RS, MALPRACTICE CLAIMS 65 (1977) (59.5% of claims paid between July 1975 and June 1976 involved surgical or related procedures); ST. PAUL FIRE & MARINE INS. CO., MALPRACTICE DIGEST, December 1982, at 3 (a list of 20 most-often-cited allegations of malpractice in claims made against physicians insured by St. Paul Marine and Fire Co.; surgical treatment implicated in over half of the claims classified on the list).

procedures that have burgeoned in recent years.[39] In addition, more than seventy-five percent of claims arise from injuries suffered in hospitals,[40] which are the site of the most sophisticated therapies and which came to be used more intensively during the period when the malpractice crisis was brewing.[41] Another high-risk treatment that ranks near the top in generating malpractice claims is pharmaceutical therapy,[42] which also has increased significantly in use in recent years just as, coincidentally, drugs and their effects have become more complex.[43] Not only does the increase in "high tech" health care plausibly increase patients' exposure to the risk of "mistakes" (that is, injuries for which there is a credible legal claim for malpractice), but it may also produce more serious injuries than older forms of treatment, increasing the size of awards and making malpractice claims more attractive investments for patients and lawyers.

Admittedly, among the procedures or treatments frequently cited in malpractice claims are several that do not on their face appear to involve new or complex treatments. These include failure to diagnose fracture, improper treatment of fracture, improper treatment of infection, and birth-related problems.[44] Despite the continued prominence of such claims, however, the greater exposure to iatrogenic injury from the high-risk procedures could alone increase the claims rate significantly.

The search for explanations of increased malpractice litigation has provoked considerable sociological speculation that changing public attitudes contributed to the change. Although greater public unhappiness with medical care in general and with conspicuously affluent medical practitioners has been often mentioned as a factor,[45] this claim is hard to evaluate.[46] A related explanation attributes this alleged public disaffection to the increased

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39. L. LANDER, *supra* note 36, at 50-51 (hospital statistics showed an increase from 61 to 95 in number of operations performed per 1000 people over the period from 1949 to 1975—a jump of over 50%).

40. An HEW sponsored study of claims closed in 1970 reported 80% of claims and 84% of dollars awarded involved injuries occurring in hospitals. OFFICE OF STATISTICAL RESEARCH, NAT'L CENTER FOR HEALTH STATISTICS, MEDICAL MALPRACTICE CLOSED CLAIM STUDY—1976, at 4-7 (1978). Other studies report somewhat smaller percentages. *See id.* at 4-2; S. LAW & S. POLAN, *supra* note 2, at 53.

41. *See* L. LANDER, *supra* note 36, at 17 (annual rate of admissions to hospitals increased 50% during 1950-1974). It should be emphasized that a significant percentage of injuries in hospitals do not arise directly from medical treatment, but from various institutional factors (such as patients falling as a consequence of neglect or equipment failure). The 1976 closed claim study sponsored by the National Center for Health Statistics reported that 47% of hospital injury claims involving awards of $500 or more cited institutional factors as causes. OFFICE OF STATISTICAL RESEARCH, NAT'L CENTER FOR HEALTH STATISTICS, *supra* note 40, at 4-9. Other cited causes were: drug related, 11%; procedure related, 54%; anesthetic related 6%; and diagnostic related, 20%. The aggregate percentages exceeded 100% because more than one factor was cited for some claims. *Id.*

42. *See* ST. PAUL FIRE & MARINE INS. CO., *supra* note 38, at 3 ("drug side effect" and "incorrect drug" list respectively as the 10th and 18th most common allegations of malpractice claims).

43. *See* L. LANDER, *supra* note 36, at 44-50.

44. *See* ST. PAUL FIRE & MARINE INS. CO., *supra* note 38, at 3.

45. *See, e.g.*, BUREAU OF INS. VA. STATE CORP. COMM'N, *supra* note 4, at 54; L. LANDER, *supra* note 36, at 92-100; James, *Medical Malpractice Insurance: A Consideration of Some of the Factors*, 128 RADIOLOGY 837, 838 (1978).

commercialization, and corresponding depersonalization, of medical care. By one account,

> [t]he developing character of modern medical practice has made the doctor-patient dyad less and less a healing relationship and more and more a market transaction; thus, the commodification of healing. The process involves both discrete exchanges replacing ongoing associations and technocrats engaged in commerce replacing healers engaged in a calling, both things replacing human relatedness and economics replacing ethics. Aspects of commodification attach to the patient, to what happens to the patient in the name of medical treatments, and even to the doctor. . . . Just as a commercial for a car or a detergent is selling both a product and the lure of success and happiness, or just as a hairdresser is selling both a service and an aura of beauty, so the modern doctor is selling both medical treatment and the expectation of that amorphous quality we call health. . . . Health becomes a thing rather than a way of living, and the doctor becomes a purveyor (and the patient a consumer) of things—pills and procedures—rather than a participant in a way of relating.[47]

Although exaggerated, this complaint is a fair sample of a genre of criticism leveled at modern health care. Evidence supporting this explanation is heavily anecdotal, and the anecdotes are somewhat at odds with the relatively high rating of public confidence in the medical profession reported by general public opinion polls. Although such polls show some decline in the absolute level of public confidence in the profession during recent years, this appears merely to mirror disaffection with all public institutions; relative to other groups or institutions, the medical profession is still highly rated in confidence surveys.[48]

The general public may, of course, be the wrong universe to measure. A more discriminating approach would be to survey the attitudes of those who have had repeated or significant encounters with the profession. Some surveys have gathered such evidence, with rather paradoxical results. On the one hand, the surveys show considerable dissatisfaction with hospital and medical treatment; yet even persons who believed they had been injured as a consequence of their poor treatment seldom contemplated filing a malpractice claim.[49] This latter fact is consistent with other studies showing

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46. *See* Reder, *supra* note 35, at 528-29 (explanation must be relegated to the category of "interesting but unusable" variables because there is no practicable way of measuring this shift in patient attitudes).

47. L. LANDER, *supra* note 36, at 92-95. For more in this vein (although not specifically in the context of malpractice), see I. ILLICH, MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH (1975); Fox, *The Medicalization and Demedicalization of American Society*, in DOING BETTER AND FEELING WORSE: HEALTH IN THE UNITED STATES 9-22 (J. Knowles ed. 1977).

48. *See* N.Y. Times, June 12, 1977, at 55, col. 1 (reporting the results of a Louis Harris poll showing a decline in the percentage of people expressing a "great deal" of confidence in the medical profession from 73% in 1966 to 43% in 1977 but also reporting similar decline in public confidence in the federal government and interpreting both trends as disaffection with public institutions generally). It is noteworthy that, relative to other public institutions, the medical profession apparently enjoys a higher degree of public confidence than virtually any other. A 1978 Harris poll reported a much higher degree of public confidence in the medical profession than in the President, the press, the Supreme Court, the military, big business, local government, state government, law firms, Congress, organized labor, and advertising agencies. N.Y. Times, Jan. 8, 1978, at 15, col. 1.

49. *See* Peterson, *Consumers' Knowledge of and Attitudes Toward Medical Malpractice*, in HEW REPORT, *supra* note 3, at app. 653, 669, 674-75 (of the surveyed population who reported "negative medical care experience," only eight percent even *considered* seeking legal advice on the possibility of legal action, and of the number who considered it, fewer than half actually did seek advice).

that malpractice claims represent only a small percentage of iatrogenic injuries—even of iatrogenic injuries probably caused by negligence.[50]

It seems more plausible, and more consistent with the attitudes just reported, that the propensity to file claims is associated not with public disaffection in some absolute sense but with modern expectations. This explanation reinforces, and is reinforced by, the comments made earlier about the increasing sophistication of medical care; greater regard for medical science would naturally generate increased reliance, which in turn would intensify the degree of disappointment whenever therapy was injurious.[51] Moreover, rising expectations with regard to medical care were also implicit in the political climate of the 1960's, which produced the Medicare and Medicaid programs and prompted a widespread belief in a so-called "right to health care." It is not implausible that the social and political attitudes of that era, which included a loss of public respect for professional and other elites, would translate into a greater willingness of patients to sue their doctors and a greater receptivity of judges and juries to their claims.

A common assertion, especially in the medical community, is that the increase in malpractice claims in the 1960's or 1970's was the product of more aggressive pursuit of these claims by lawyers.[52] To distinguish it from the "demand-side" explanations for the malpractice crisis that were examined above, this one can be labeled a "supply-side" explanation. Although the "supply-side" argument is typically presented in a polemical fashion that does not invite a studied response, it should not be dismissed out of hand. The "supply side" does require attention, because lawyer services are an essential factor in the production of malpractice claims. As with any factor of production, the quantity of legal inputs provided is a function of both demand and supply. The contingent-fee system in particular makes the lawyer not merely a supplier of services but also an investor. As such, he adjusts his

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50. The HEW Secretary's Commission estimated that in 1970 there was one incident of malpractice per 158,000 patient visits, but only one claim per 226,000 visits. HEW REPORT, *supra* note 3, at 12. Other studies show similar disparity between potentially compensable events and claims made. *See, e.g.*, CAL. MEDICAL ASS'N AND CAL. HOSPITAL ASS'N, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY 103-05 (D. Mills ed. 1977) (of potentially compensable events in California in 1974, only about one-fourth resulted in tort liability); Pocincki, Dogger & Schwartz, *The Incidence of Iatrogenic Injuries*, in HEW REPORT, *supra* note 3, at app. 50 (a study of injuries in two hospitals: out of 517 cases of negligently caused injuries, only 31 claims were filed). *See generally* Schwartz & Komesar, *Doctors, Damages and Deterrence*, 298 NEW ENG. J. MED. 1282, 1286 (1978) (estimating that the ratio of claims to incidents of malpractice "could be as high as 0.3 or less than 0.1").

51. Rising public expectations for medical treatment is commonly cited as a causal factor underlying modern malpractice litigation. *See, e.g.*, HEW REPORT, *supra* note 3, at 70; Rubsamen, *Medical Malpractice*, SCI. AM., Aug. 1976, at 18. The recital of public expectations in both of the above reports adds that they are "exaggerated" and "unjustified" in relation to the capabilities of modern medicine. This sentiment is common in the medical literature on the subject. *See, e.g.*, Am. Surgical Ass'n, *Statement on Professional Liability*, 295 NEW ENG. J. MED. 1292, 1294 (1976). However, the characterization of rising expectations as "exaggerated" or "unjustified" presupposes the existence of some determinate number of justifiable malpractice claims that has been exceeded. There is no basis for such an assumption.

52. *See, e.g.*, Pabst, *A Medical Opinion Survey of Physicians' Attitudes on Medical Malpractice*, in HEW REPORT, *supra* note 3, at app. 83, 84.

investment in a particular project (malpractice cases, products liability cases, corporate takeovers, and so forth) according to his expected returns relative to the effort called for and the attractiveness of other opportunities.[53]

However, this economic commonplace, in itself, cannot explain the increase in malpractice claims in the absence of some credible evidence of exogenous changes in the supply of lawyers or in their investment opportunities. With regard to the supply of lawyers, one possibility is that a general increase in the number of lawyers during this period made lawyers more willing to take marginal cases. There is, however, no evidence linking the substantial increase in lawyers per capita to increased entry into medical malpractice, prompting more vigorous pursuit of marginal claims.[54] With regard to altered investment opportunities, it was occasionally suggested that tort lawyers targeted the medical malpractice field when the passage of no-fault insurance in the later 1960's and early 1970's deprived them of litigation opportunities in the auto accident field.[55] However, fewer than half the states adopted no-fault in any form, and it is unlikely that malpractice claims in other states would have been influenced by those enactments.[56] Moreover, in all of the no-fault states tort remedies were only partially displaced, and most no-fault limits were set so low that they would displace only minor liability claims of little or no interest to entrepreneurial lawyers.[57] Finally, California, a leading state in the production of malpractice claims,[58] never adopted an automobile no-fault plan.

In any event, looking for explanations of the malpractice crisis in exogenous events affecting lawyers' behavior neglects the question of why they shifted their attention disproportionately to malpractice cases.[59] To

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53. *See* Reder, *supra* note 35, at 529. Reder observes that, at the margin, the returns from the different opportunities will be equalized (after allowance, for example, for the frictional costs of adjusting from one practice to another).

54. Despite the reported 70% increase in the number of lawyers between 1950 and 1980, lawyers' earnings *increased* relative to other salaried male workers. P. DANZON, THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS 12 n.6 (The Rand Corp., Report No. R-2870-ICJ/HCFA, 1982). This would seem to imply the absence of strong financial pressure to pursue marginal claims.

55. *See id.* at 28-29 (reporting and rejecting the claim).

56. Of those states adopting no-fault plans, about half do not materially affect tort law since they do not displace tort actions but merely provide for additional first-party insurance coverage (so-called "add-on" schemes). For a survey of the plans, see Henderson, *No-Fault Insurance for Automobile Accidents: Status and Effect in the United States*, 56 OR. L. REV. 287 (1977).

57. *See, e.g.*, FLA. STAT. ANN. §§ 627.731, 627.736 (West 1984) (benefits up to $10,000); MASS. ANN. LAWS ch. 90, § 34M (Michie/Law. Co-op. 1985) (no-fault benefits up to $2,000). In addition, the tort action typically is preserved for pain and suffering in cases where medical expenses exceed a certain set amount or where the injury results in death, disfigurement, or dismemberment. *See, e.g.*, N.J. STAT. ANN. § 39:6A-8 (West 1985) (tort action for noneconomic loss where medical costs exceed $200); N.Y. INS. LAW, §§ 5102(d), 5104 (McKinney 1985) (tort action for noneconomic loss in case of "serious injury" defined as death, disfigurement, loss of use of internal organ, etc.).

58. *See* AM. MEDICAL ASS'N, MALPRACTICE IN FOCUS 13-15 (1975).

59. One thinks particularly of products liability actions as an alternative investment of energies. To be sure, products liability suits have grown apace—to the point where they have evoked cries of "crisis" from industry and led to a national study commission. *See* J. HENDERSON & R. PEARSON, THE TORTS PROCESS 800-801 (2d ed. 1981). However, the increased investment by lawyers in products liability actions apparently has not been at the expense of medical malpractice actions. One possible reason concerns the different investment costs for the two types of cases.

answer that question one must consider factors affecting the relative earnings from investments in such claims.[60] The increased attractiveness of malpractice claims could have resulted either from a reduction in the costs of pursuing such claims or from an increase in the expected payout. Attention is thus directed to the legal developments of the 1960's and early 1970's that facilitated the bringing of malpractice suits and increased both the likelihood and the expected amount of recoveries.

The central target of critics and reformers in the 1970's was the liberalization of legal rules that was perceived to have occurred and to have facilitated the initiation of claims and improved the prospects for recoveries. Despite the common belief among health care professionals that the legal system is hostile to their interests, however, the procedural and substantive rules that evolved under the common law have been extraordinarily protective of health care professionals, interposing exceptional impediments to tort litigation and liability. Before the 1960's, absolute immunities for nonprofit providers blocked some suits altogether, and restrictive statutes of limitations made no allowance for latent injuries, which are characteristic of many malpractice cases. The plaintiff who survived these obstacles faced, and to a considerable degree still faces, the formidable hurdle of a standard of care that is especially advantageous to health care providers.

With certain exceptions, the law allows the medical community to establish its own liability standards. Plaintiffs must prove, through expert testimony, that the care or skill exercised by a defendant physician was below that customarily exercised by comparable professionals in the community.[61] This protective, provider-defined standard of care was traditionally conjoined with a narrow definition of "community."[62] One effect of this traditional "locality rule" was to insulate local professionals from forced adherence to higher standards prevalent in other areas. However, that effect could be significant only where a whole community of practitioners lagged behind current medical learning. The rule's greater importance lay in its constriction of the pool of professionals qualified to testify as to the relevant standards of practice. In addition, requiring expert witnesses to be drawn from the particular community meant that the eligible professionals might be reluctant to testify, fearing that they would antagonize local colleagues or incur censure from local medical groups. The locality rule thus reinforced general medical

60. It appears that no one has attempted to obtain the requisite empirical information to measure the returns from malpractice cases relative to other liability actions. For a general investigation of the economic dynamics of malpractice litigation, see Danzon & Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. LEGAL STUD. 345 (1983). *See also* Dietz, Baird & Berul, *supra* note 38, at 113-20 (analysis of contingent fees and their effect).

61. *See generally* McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959).

62. The locality rule has been variously defined. In some jurisdictions, it means the required standard of care is measured by customary practice in the "same" community; in others it denotes the "same or similar" community. *See id.* at 569-75. The "similar community" standard is capable of more flexibility than the "same community" standard, depending on the size and characteristics of the community of practice.

opposition to legal intervention in health care matters and facilitated the infamous "conspiracy of silence."[63]

Modern times—beginning roughly in the 1960's—witnessed liberalization of substantive standards and procedural rules governing medical malpractice cases. Substantively, the principal modifications involved negligence standards, particularly the elimination or relaxation of the locality rule,[64] standards for informed consent,[65] and the scope of the doctrine of respondeat superior.[66] Procedurally, the main alterations have been the elimination of charitable immunity,[67] relaxation of the statute of limitations (most notably by incorporating a discovery rule to cover latent injuries),[68] and the loosening of proof requirements, including the necessity for expert testimony and the availability of the principle of res ipsa loquitur.[69]

The degree of change in legal doctrine in the decade before the first appearance of the malpractice crisis may have been exaggerated in the crisis commentary of the 1970's. A mere listing of modifications in legal rules is misleading without some empirical assessment of their actual importance in triggering additional malpractice litigation. At least some rules that were clearly liberalized appear not to have been significant factors in cases

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63. *See* S. LAW & S. POLAN, *supra* note 2, at 99-100.

64. There has been a perceptible trend towards further liberalization of the locality rule, particularly for medical specialists. *See, e.g.*, Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 IND. L.J. 528, 538-40 (1976). However, some states have resisted. *See, e.g.*, Butler v. Berkeley, 25 N.C. App. 325, 213 S.E.2d 571 (1975). On the effect of crisis legislation, see *infra* notes 95-96 and accompanying text.

65. The rule that a patient must consent to treatment necessitates at least minimal information disclosure about the nature and consequences of a treatment. However, except for the unusual case where the patient is totally informed about the character or scope of the procedure, the physician's obligation to disclose is defined by negligence principles—that is, whether the degree of disclosure (or nondisclosure) is reasonable in the circumstances. Under traditional rules, reasonableness is governed by the standards of professional custom as measured by expert medical testimony—just as for adjudications of the reasonableness of medical treatment. *See* Pearson, *supra* note 64, at 542. Beginning in the 1970's, courts in several states eliminated the professional custom standard (and its concomitant expert testimony requirement) in favor of more general standards based on what a reasonable patient would want to know to make an informed choice. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). Although this change has been cited widely as significant, *see, e.g.*, Deitz, Baird & Berul, *supra* note 38, at 126, two qualifications must be noted: (1) many states have refused to make the change, and (2) virtually all of the cases instituting this reform occurred in the 1970's—too late to have generated the claims increase precipitating the "crisis." *See* Pearson, *supra* note 64, at 540-45. On the effect of recent legislation, see *infra* notes 97-101 and accompanying text.

66. The changes in the respondeat superior doctrine consist of a narrowing of the independent contractor exception and an expansion of the "borrowed servant" rule. However, in some cases the hospital is held liable for its own violation of duty, not via respondeat superior. *See, e.g.*, Deitz, Baird & Berul, *supra* note 38, at 125.

67. Most states have abolished or substantially curtailed charitable immunity for hospitals. *Id.* at 138.

68. The critical change had been judicial interpretation of the limitations statutes to toll the running of limitations until a latent injury was or should have been discovered. *Id.* at 126-27.

69. The principal relaxation of evidentiary standards involved liberalized locality rules. The ostensible change in the use of res ipsa loquitur is more problematical. The usual authorities cited to demonstrate this modification are pro-plaintiff California decisions which were not widely followed in other jurisdictions. Moreover, res ipsa loquitur was not a dominant factor in a majority of sample appellate decisions studied by Deitz, Baird & Berul. *Id.* at 137, 142.

contributing to the surge in malpractice claims in the 1960's;[70] unfortunately, no empirical examination of the 1970's crisis adequately addresses this point. Also, many of the cited legal changes developed gradually so that their impact should have been less sudden than the sharp spike in claims suggested it was.

Until there are better empirical studies or a workable theoretical model of how changes in legal rules affect litigation rates, one must be satisfied with an intuitive assessment. On this basis, it seems certain that liberalization of tort law and procedure did indeed contribute importantly to the malpractice crisis of the 1970's. The dramatic changes in the frequency and severity of claims could not have occurred unless the costs of suing providers were appreciably reduced or the probability of winning or of winning a large award was increased. Without such changes in the value of a potential lawsuit, malpractice victims and their lawyers would not have increased their aggregate investments in pursuing claims.[71] Certainly the nonlegal factors canvassed above—such as more serious injuries associated with high tech medical care and changing attitudes on the part of patients, judges, and juries—also contributed to making malpractice claims more attractive, but legal doctrine must have had the greatest impact. Indeed, the liberalization of tort doctrine that occurred was, in the last analysis, a direct manifestation of the revolution in social attitudes toward medicine and the medical profession that occurred in the period preceding the malpractice crisis. Law is, after all, a product of a social milieu. Just as the malpractice crisis of the 1970's was the result of abrupt changes in social attitudes, the reform efforts that followed, first in the mid-1970's and now in the 1980's, may best be understood as a backlash of sorts against what may now be seen as excesses of the 1960's.

IV

RESPONSES TO THE CRISIS

The malpractice crisis of the mid-1970's, perceived as stemming from flaws in insurance practices, legal rules, and medical practice, produced apparent reforms in at least the first two areas. As to medical practice, it is hard to find reliable evidence of significant alteration in therapeutic procedures.[72] Nevertheless, "risk-management" programs in hospitals may

70. For an attempt to measure the significance of legal rules (based on the frequency with which they are applied in appellate decisions, or their importance to appeal initiation), see *id.* at 128-49. Some of the most controversial legal rules, such as those governing informed consent and res ipsa loquitur, were more important to plaintiff success in the 1950-1960 time period than in the 1961-1971 period. This fact suggests that the liberalization of these rules during the period most relevant to the crisis was not significant. *See id.* at 137.

71. *See id.* at 95-102, reporting the results of two surveys. One, a random sampling of private practice lawyers, showed a 50% rejection rate for cases brought to them. The other, a survey of lawyers specializing in malpractice litigation, showed a rejection rate of just under 30%. In both surveys, the most commonly given reason for rejection was the probable absence of liability. A significant number also reported "economic reasons" for rejecting cases. *Id.* at 97. Presumably "economic reasons" translates to a probability that liability would not yield a recovery for damages sufficient to justify investment in pursuing the claim.

72. The "defensive medicine" claim is examined in Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, LAW & CONTEMP. PROBS., Spring 1986, at 173, 175-80.

have improved patient care in some respects, and peer review and regulatory mechanisms have been strengthened in many places, often as a result of statutory tightening aimed at improved quality assurance.

One important development in malpractice insurance was the withdrawal, noted earlier, of some companies from the malpractice market.[73] Although this development contributed to the crisis at the time, the departure of marginal firms not fully committed to this line of insurance reflected efficient market discipline. The gap left by their departure was filled by newly formed mutual insurance companies owned and operated by medical groups. These provider-owned companies now hold a considerable share of the malpractice market.[74]

As an emergency measure, most states also authorized the creation of either special "joint underwriting associations" (JUA's) or "reinsurance exchanges" to provide coverage for health care professionals unable to obtain it from the private market.[75] Under the typical JUA legislation, all companies writing liability insurance of any kind within the state were required to form a cash reserve pool for underwriting malpractice risks.[76] Generally conceived as temporary measures, most JUA plans have since expired by the terms of their creation. However, a few are still active and remain an important source of underwriting in some states.[77] A reinsurance exchange is similar to the JUA except that the administration and underwriting responsibilities remain with individual malpractice insurers, which are reinsured by the exchange for risks beyond a certain amount.[78]

Mere changes in the underwriting entity did not, and could not, address the critical underlying problems of malpractice insurance practices. Shifting from a for-profit to a nonprofit form of enterprise was simply an expedient means of temporarily absorbing the losses from underwriting; it could not eliminate the losses, or correct for the problem of unanticipated cost increases. Focusing on the "long tail" problem and its effect on the reliability of actuarial predictions of future liability,[79] insurers began to reconsider their practice of writing policies on an "occurrence" basis, covering all claims, whenever filed, arising out of care rendered during the policy year. By shifting to "claims-made" policies covering the insured only for claims filed in the policy year, the "long tail" problem would be alleviated. In contrast to occurrence policies, which require the carrier to forecast risk exposure as far as a decade into the future, the claims-made policy can more safely base rates

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73. *See supra* notes 23-24 and accompanying text.

74. Since 1975, professionally-sponsored insurance companies have captured more than 50% of the malpractice business nationwide and rank among the top three underwriters in 26 of 51 jurisdictions. *General Liability/Medical Malpractice Insurance Marketing—1982*, BEST'S REV., Oct. 1983, at 4-5.

75. For a list of states enacting legislation through 1976, see 5 AM. MEDICAL ASS'N, STATE HEALTH LEGISLATION REPORT 11 (1977).

76. For a more extended description, see Grossman, *supra* note 4, at 4-5.

77. *See, e.g.*, N.Y. INS. LAW § 5501-15 (McKinney 1985).

78. *See* Grossman, *supra* note 4, at 5.

79. *See, e.g.*, HEW REPORT, *supra* note 3, at 42; Roddis & Stewart, *supra* note 11, at 1295.

on current claims experience. The increase in actuarial accuracy promotes rate stability and, by reducing reserve requirements, permits lower current rates.

Following the lead of the St. Paul Fire and Marine Insurance Company, most carriers switched to claims-made policies in the 1970's.[80] The medical profession initially opposed the change, primarily because it required physicians to purchase a costly "reporting endorsement" for claims filed after their retirement from active practice. That opposition was overcome, however, when many carriers refused to offer malpractice insurance on any other basis. Today, claims-made policies have been widely adopted even among provider-owned carriers,[81] although occurrence policies are still available in some places.[82]

Innovations in insurance practices alone could not, of course, alter the incidence or the severity of claims, the driving force behind increased underwriting costs. Because the crisis involved long-run trends in insurance costs as well as the availability of insurance, attention was directed at ways of reducing the frequency and severity of claims. The medical profession urged state legislatures across the country to halt or reverse the liberalization trend by shoring up or imposing new constraints on malpractice actions. A first glance at the flood of legislation enacted nationwide makes it appear that the legislatures were responsive to the doctors' *cris du coeur.* Yet the torrent of legislative words is not an accurate indication of their actual effect. An examination of the significance of the reforms will follow a summary of the types of measures taken.[83]

It should be noted at the outset that in many states reform legislation has been held unconstitutional in whole[84] or in part[85] on substantive due process

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80. *See* S. LAW & S. POLAN, *supra* note 2, at 186-88.

81. *Id.* at 187.

82. A 1982 breakdown of provider-owned carriers shows a nearly even split between companies writing claims-made and those writing occurrence policies. *See* BEST'S INSURANCE MANAGEMENT REPORTS, PROPERTY/CASUALTY RELEASE No.9 (Apr. 4, 1983).

83. There are several summaries of reforms taken; unfortunately, they differ somewhat in their lists of states enacting reforms. Also, some inaccuracies exist in all of them. The most extensive summary is given in the AMA's periodic survey of legislation. The main "crisis" legislation is summarized in 5 AM. MEDICAL ASS'N, AMA STATE HEALTH LEGISLATION REPORT (1977). It was supplemented in December 1977, and has been periodically updated since then. A more limited, but still very useful summary is found in P. DANZON, *supra* note 54, app. A.

84. *See* Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976) (remanding for trial court findings on whether a crisis existed), *cert. denied,* 431 U.S. 914 (1977); Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) (minor features of the statute upheld); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978) (a separate screening panel law was not challenged).

85. The following is a partial listing of decisions holding particular reforms unconstitutional, exclusive of the cases in *supra* note 84. *Collateral Source Rule Modification:* Doran v. Priddy, 534 F. Supp. 30 (D. Kan. 1981); Graley v. Satayatham, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (1976). *Damages Limitations:* Wright v. Central DuPage Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977); Simon v. St. Elizabeth's Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (1976). *Limitation on Contingent Fees:* Heller v. Frankston, 76 Pa. Commw. 294, 464 A.2d 581 (1983). *Pretrial Screening Panels:* Aldana v. Holub, 381 So. 2d 231 (Fla. 1980); Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980); Boucher v. Sayeed, —— R.I. —— —, 459 A.2d 87 (1983). *Required Posting of Bond:* Eastin v. Broomfield, 116 Ariz. 576, 570 P.2d 744 (1977); Nork v. Superior Court, 33 Cal. App. 3d 997, 109 Cal. Rptr. 428 (1978). *Shorter Statutes of*

or equal protection grounds.[86] The constitutional cases do raise the interesting, and largely unanswered, question whether the alleged malpractice crisis was sufficiently real in the particular state to justify extraordinary legislative measures; a similar issue was whether problems constituting the malpractice crisis were distinct enough from problems afflicting other fields of personal injury law to warrant singling it out for special, arguably discriminatory, attention. To explore these questions would take us rather far afield. It must suffice to observe that most states have rejected constitutional challenges, at least implicitly giving an affirmative answer to both questions.[87]

Legislation in the malpractice area can be classified according to its immediate thrust: rules directed at the initiation of claims, those affecting the standard of care and proof of breach, and those affecting the amount recoverable. This classification is somewhat arbitrary because the different rules are interactive. Obviously, a limit on the amount recoverable will discourage the bringing of claims and a limit on bringing claims affects the amount recoverable.

One set of legislative enactments modified applicable statutes of limitations. Prior to the 1970's, courts in most states had adopted the "discovery rule," under which the statute of limitations was tolled for latent injuries that could not have been discovered by reasonable effort. Because this rule exposed providers to suits based on old evidence and possibly to new standards of liability not in effect when care was rendered, a majority of states put limits on the discovery principle. In a few states the discovery rule was eliminated altogether, so that the limitations period commenced with the act or omission exclusively.[88] Most states enacted either a general discovery

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Limitations: Kenyon v. Hammer, 142 Ariz. 69, 688 P.2d 961, (1984); Aldana v. Holub, 381 So. 2d 231 (Fla. 1980); Sax v. Votteler, 648 S.W.2d 661 (Tex. 1983).

86. Most of the courts have employed an ordinary "rational basis" test to determine whether medical malpractice cases warranted special treatment because of the "malpractice crisis." However, some courts have applied a more rigorous test, or at least have applied the rational basis test more rigorously than the Supreme Court would have done. For example, in Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980), the court explicitly adopted a "more rigorous" test that required a "fair and substantial relation" between the legislative purpose and the special treatment of medical malpractice claims. *Id.* 120 N.H at 932, 424 A.2d at 830-31. In Graley v. Satayatham, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (1976), the court appears to have employed the even more rigorous test which requires the classifications to be justified by a "compelling governmental interest." *Id.* 74 Ohio Op. 2d at 319, 343 N.E.2d at 837. In Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976), *cert. denied,* 431 U.S. 914 (1977), the Idaho Supreme Court remanded the constitutional issue to the trial court to make findings on the key factual assumptions underlying the legislation. On remand the trial court held that, applying a rational basis test, the legislation did not violate due process or equal protection. However, it interpreted the remand order to require a more rigorous "means scrutiny" test under which there was insufficient factual basis for the reforms adopted. Jones v. State Bd. of Medicine, Nos. 55527, 55586 (4th Dist. Idaho, 1980).

87. For a list of decisions, see American Bank & Trust Co. v. Community Hosp. of Los Gatos-Saratoga, Inc., 36 Cal. 3d 350, 370 n.10, 683 P.2d 670, 677 n.10, 204 Cal. Rptr. 671, 678 n.10 (1984).

88. *See* DEL. CODE ANN. tit. 18, § 6856 (1984) (two years from injury, unless injury could not have been discovered within two years, in which case three years from injury; exception for child under six); IND. CODE ANN. § 16-9.5-3-1 (Burns 1983) (two years from injury; exception only for child under six); N.M. STAT. ANN. § 41-5-13 (1978) (three years from injury; exception only for child under six); S.D. CODIFIED LAWS ANN. § 15-2-14.1 (1984) (two years; no exceptions).

rule,[89] or a special discovery rule for cases involving a foreign substance in the body or fraudulent concealment.[90] However, in all but a few instances, the discovery rule was given a fixed outer time limit, ranging between three and ten years, with a special provision usually made for minors.[91] Although these reforms were ostensibly directed at the "long-tail" problem, one would expect them also to curtail the number of claims, discriminating particularly against cases involving failure to diagnose and cases involving latent injuries.

Another reform designed principally to curb claims initiation involved regulation of lawyers' contingent fees. Contingent fees have been the eternal nemesis of those who consider themselves victims of aggressive lawyering. Although regulation of prices has traditionally been adopted to offset the absence of price competition in a market, the purpose of contingent fee regulation is not to protect consumers against monopolistic price gouging but to protect defendants and their insurers against malpractice suits. The perception inspiring such regulation was that contingent fees induce lawyers to bring unwarranted lawsuits, to seek exaggerated damages, and not to settle claims for reasonable amounts. Most states responding to that notion simply authorized judicial control of fees, although some went further and adopted limits on the percentage of the award that the lawyer could claim; the statutorily prescribed percentages generally diminish as the size of the award increases.[92]

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89. *See, e.g.*, ALA. CODE § 6-5-482 (1975) (two years from injury or six months from discovery, but no later than four years from act); CAL. CIV. PROC. CODE § 340.5 (West 1982) (three years from injury or one year from discovery); COLO. REV. STAT. § 13-80-105 (1984) (two years from injury or from discovery; no later than three years from injury except in cases involving foreign substances in body, knowing concealment, or a suit brought by a child); FLA. STAT. ANN. § 95:11 (West 1982) (two years from injury or discovery, but no later than four years except for concealment or misrepresentation, in which case two years from discovery, but no later than seven years); HAWAII REV. STAT. § 657-7.3 (1968) (two years from injury or discovery, but no later than six years from injury except for failure to disclose); ILL. ANN. STAT. ch. 110, § 13-212 (Smith-Hurd 1984) (two years from injury or discovery, but no later than four years from injury); MD. CTS. & JUD. PROC. CODE ANN. § 5-109 (1984) (five years from injury or three years from discovery, whichever first occurs); MICH. COMP. LAWS ANN. §§ 600.5805(4), 600.5838 (1985) (two years from period treatment is discontinued or six months from discovery); MISS. CODE ANN. § 15-1-36 (1984) (two years from injury or discovery); MONT. CODE ANN. § 27-2-205 (1984) (three years from injury or discovery, but no later than five years from injury, except for failure to disclose); NEB. REV. STAT. § 25-222 (1979) (two years from injury or one year from discovery, but no later than ten years from injury); OKLA. STAT. ANN. tit. 76, § 18 (West 1984) (two years from injury or discovery, but no later than three years from injury); TENN. CODE ANN. § 29-26-116 (1980) (one year from injury or discovery, but no later than three years from injury except for concealment or foreign substance in body); WASH. REV. CODE § 4.16.350 (1985) (three years from injury or one year from discovery, but no later than eight years from injury).

90. *See, e.g.*, ARIZ. REV. STAT. ANN. § 12-564 (1982); ARK. STAT. ANN. § 34-2616 (1983); GA. CODE § 9-3-72 (1982); N.Y. CIV. PRAC. LAW § 214-a (McKinney 1984).

91. *See* statutes cited *supra* note 89. Exceptional statutes which impose no outer limit include: ARIZ. REV. STAT. ANN. § 12-564 (1982); ARK. STAT. ANN. § 34-2616 (1983); R.I. GEN. LAWS § 9-1-14.1 (1984). Some states that did not modify or enact new statutes of limitation for malpractice retain an open-ended discovery rule. *See, e.g.*, Franklin v. Albert, 381 Mass. 611, 411 N.E.2d 458 (1980); Stein v. Richardson, 302 Pa. Super. 124, 448 A.2d 558 (1982).

92. *See, e.g.*, ARIZ. REV. STAT. ANN. § 12-568 (1982) (court, on request for either party, shall determine reasonableness of both contingent and fixed fees); CAL. BUS. & PROF. CODE § 6146 (West 1985) (fixed limits ranging from 40% on first $50,000 to maximum of 10% on recoveries over $200,000); DEL. CODE ANN. tit. 18, § 6865 (1984) (fixed limits: 35% on first $100,000 damages, 25%

A similar desire to curb artificial stimulation of lawsuits also probably underlay another common legislative reform, the elimination of the ad damnum clause in complaints alleging medical malpractice.[93] The ostensible rationale for this measure was the elimination of harmful and often misleading publicity. In fact, the real concern was probably that the publicity given to large but as yet unsubstantiated claims encouraged more claims to be filed and encouraged larger jury awards.[94]

In regard to standards of care and proof of breach, there were three principal reform targets: the locality rule, the standard for informed consent, and the use of the doctrine of res ipsa loquitur as a substitute for affirmative evidence of negligence. Each targeted reform ostensibly attempted to reverse, or at least to freeze, liberalization of the law by common law courts.

As observed earlier, the principal effect of judicial expansion of the locality rule was to widen plaintiffs' access to expert witnesses, particularly to witnesses who were not subject to sanctions by the local medical community. Despite its salience, however, statutory reform of the locality rule was not widespread. Fewer than a dozen states dealt with the geographical standard generally, and these states usually did no more than codify the common law standards prevailing in the jurisdiction. In most instances, the "same or similar community" standard was adopted, albeit with some variation in phrasing.[95] The vagueness of this formulation permits a wide range of judicial discretion both in defining the standard and in qualifying witnesses. It appears that courts have responded with expansive interpretations.[96] The medical profession has not been given the opportunity to reestablish the once notorious "conspiracy of silence."

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on second $100,000, 10% on remainder). In Florida, the statute allows the court to award "reasonable" attorney's fees to the prevailing party. FLA. STAT. ANN. § 768.56 (West 1985). This solution would seem to have a more powerful effect than merely constraining contingent fees to correct any propensity to pursue speculative claims.

93. *See, e.g.*, MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-02(b) (1984); MASS. GEN. LAWS ANN. ch. 231, § 60C (West 1985).

94. P. DANZON, *supra* note 54, at 39.

95. *See, e.g.*, ALA. CODE § 6-5-484 (1975) ("same general neighborhood"); ALASKA STAT. § 09.55.540 (1973) ("similar communities"); ARK. STAT. ANN. § 34-2614 (1983) ("similar locality"); FLA. STAT. ANN. § 768.43 (West 1985) ("same or similar community"); LA. REV. STAT. ANN. § 9-2794A (West 1985) ("similar community"); TENN. CODE ANN. § 29-26-115 (1980) ("same or similar community"); WASH. REV. CODE § 7.70.040 (1974) (average practitioner in "same or similar circumstances"). In Arizona, the statute confines the geographical reference to the state. ARIZ. REV. STAT ANN. § 12-563 (1983). In Virginia, the statute requires reference to the state standard except where "same or similar community" would be more appropriate. VA. CODE § 8.01-581.20 (1984). In Delaware, the statute limits expert testimony to those *familiar* with local standards, but this has not apparently restricted the prior "similar community" standard. *See* Butler v. Alatur, 419 A.2d 938 (Del. 1980). Only one statute sought to reinstate the strict "same" community standard for the older common law. IDAHO CODE § 6-1012 (1979). It has been held unconstitutional. Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976).

96. *See, e.g.*, May v. Moore, 424 So. 2d 596, 602 (Ala. 1982) (same general neighborhood refers to "national medical community"); Butler v. Alatur, 419 A.2d 938, 939-40 (Del. 1980) (qualified experts not limited to state practitioners despite statutory requirement that experts be familiar with local standards); Mitchell v. Angelo, 416 So.2d 910, 912-13 (Fla. 1982) ("same or similar community" embraces a national standard for specialists).

Informed consent reforms were more widespread, though quite variable. Approximately twenty-two states enacted provisions dealing in some way with the issue.[97] Most of the statutes essentially codified the traditional standard of disclosure, which defines appropriate disclosure by reference to professional custom.[98] The more modern, liberal standard, allowing the jury to assess the patient's need for information in order to make an informed choice, was enacted in several states.[99] In still other instances, the statute simply prescribes information to be included in written consent forms, leaving the effect for liability purposes unspecified.[100] Finally, there are some statutes that defy easy categorization.[101]

The use of the principle of res ipsa loquitur has long been one of the most controversial issues in the law of medical malpractice. Hence, it is a little surprising that it was the subject of reform legislation in only a few states—probably less than ten. Cataloging pertinent statutes is problematic given the ambiguity of some of them in addressing the general issue of proof burdens without obviously or necessarily affecting the use of res ipsa loquitur. For example, several states that are cited as having legislated on the subject merely enacted statutes specifying that the plaintiff has the burden of proving the absence of customary care or skill.[102] Such provisions do not necessarily affect the use of res ipsa loquitur because that doctrine alters neither the general standard of care nor the plaintiff's burden of proof. Instead, res ipsa loquitur affects the character and sufficiency of evidence necessary to make a

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97. One source, P. Danzon, *supra* note 54, at 42, lists 23 states. However, in one of them, California, no pertinent statute could be found.

98. On the common law of informed consent *see supra* note 65. The following statutes are illustrative: ALASKA STAT. § 09155.556 (1973) (physician must disclose "common risks and reasonable alternatives"); DEL. CODE ANN. tit. 18, § 6852 (1984) (reasonable physician/medical custom); FLA. STAT. ANN. § 768.46 (West 1985) (same); IDAHO CODE § 39-4304-5 (1977) (same); ME. REV. STAT. ANN. tit. 24, § 2905 (Supp. 1985) (reasonable physician); NEV. REV. STAT. § 41A.110 (1979) (consent presumed if physician generally explains risks and alternatives); N.H. REV. STAT. ANN. § 507-C:2 (1983) (medical custom); N.Y. PUB. HEALTH LAW § 2805(d)(1) (McKinney 1977) (reasonable physician); N.Y. CIV. PRAC. LAW § 4401-(a) (McKinney 1984) (requires expert testimony); TENN. CODE ANN. § 29-26-118 (1980) (reasonable physician/custom); TEX. REV. CIV. STAT. ANN. art. 4590i:602 (Vernon Supp. 1986).

99. PA. CONS. STAT. ANN tit. 40, § 1301.103 (Purdon 1985); WASH. REV. CODE § 7.70.050 (1974); *see also* statutes cited *infra* note 100.

100. IOWA CODE ANN. § 147.137 (West 1985); LA. REV. STAT. ANN. § 40:1299.40 (West 1977); OHIO REV. CODE ANN. § 2317.54 (Baldwin 1984). The Louisiana statute has been interpreted to incorporate the patient needs standard. LaCaze v. Collier, 434 So. 2d 1039, 1048 (La. 1983).

101. *See, e.g.*, R.I. GEN. LAWS § 9-19-32 (1984) (issue of informed consent a preliminary question for the court); UTAH CODE ANN. § 78-14-5 (1977) (patient must prove he was not informed of "substantial and significant risk").

102. For example, of the 15 states identified in P. DANZON, *supra* note 54, at 45, as having enacted legislation on res ipsa loquitur, six enacted statutes of this broad character. ALA. CODE § 6-5-484 (1975); ARIZ. REV. STAT. ANN. § 12-563 (1982); ARK. STAT. ANN. § 34-2614 (1983); MICH. COMP. LAWS ANN. § 600.2912(a) (1985) (specifically construed in Sullivan v. Russell, 417 Mich. 398, 338 N.W.2d 181 (1983), not to affect res ipsa loquitur); VT. STAT. ANN. tit. 12, § 1908 (Supp. 1985); WASH. REV. CODE ANN. § 7.70.040 (1974). ALASKA STAT. § 09.55.540 (1973) may be construed to limit res ipsa loquitur because it provides that there shall be no presumption of negligence. *See* Priest v. Lindig, 583 P.2d 173 (Alaska 1978) (dictum). However, since res ipsa loquitur is usually treated not as a presumption, but as a circumstantial inference from certain proved facts, it is a bit strained to interpret this statute as affecting res ipsa loquitur.

prima facie case, an issue that the described provisions do not explicitly address. Of those statutes that do mention res ipsa loquitur, two abolish it,[103] three restrict its use to specified cases,[104] and four either explicitly ratify the common law doctrine or address minor procedural aspects.[105]

In addition to legislating on the standard of care or the burden of proof, many states established a scheme for expert review or mediation of claims as a prerequisite for judicial trial.[106] The features of these pretrial schemes vary, but the statutes typically call for a review of the evidence by a panel comprised of medical-legal experts and sometimes lay persons. The panel's report and opinion on the claim is sometimes made admissible in evidence, but it is never conclusive.[107] The goal in establishing such screening panels was to improve the quality of fault-finding by the system and thus both to discourage the bringing of questionable claims and to encourage the settlement of valid ones.

Increases in damages recovered were often cited as dramatic evidence of the malpractice crisis. Several states attempted to deal with this problem by fixing ceilings on amounts recoverable.[108] Some states limited the amount to

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103. *See* IDAHO CODE § 6-1012 (1979); N.H. REV. STAT. ANN. § 507-C:2(III) (1983). New Hampshire's statute was held unconstitutional, as was a predecessor to the Idaho statute. *See supra* note 84.

104. In three states, Delaware, Florida, and Nevada, the statutes explicitly limit the use of res ipsa loquitur to specified exceptional cases. DEL. CODE ANN. tit. 18, § 6853 (1984); FLA. STAT. ANN. § 768.45 (West 1984); NEV. REV. STAT. § 41A.100 (1979). Each of the three statutes allows the doctrine's use where a foreign object is left in the body during surgery; Delaware and Nevada allow its use in cases where injury is caused by a fire or explosion in a substance used in treatment, or injury to a part of the body not involved in treatment. Nevada is slightly more expansive, including injury to a part of the body not involved in treatment. Although these limitations possibly curtail an expansive use of res ipsa loquitur, they do incorporate the principal applications of res ipsa loquitur in malpractice cases, and it is not clear that these applications are affected. *See, e.g.*, Borghese v. Bartley, 402 So.2d 475, 477, (Fla. 1981) (statute codifies common law); Stepien v. Bay Memorial Medical Center, 397 So. 2d 333, 334 (Fla. Dist. Ct. App. 1981) (citing pre-statute res ipsa loquitur decision without any mention of the statute in a case concerning negligent custodial care; expert testimony held not required).

105. *See* CAL. CIV. PROC. CODE § 411.30(d) (West 1985) (exempting res ipsa loquitur cases from requirement that plaintiffs consult with medical professional before filing suit); OKLA. STAT. ANN. tit. 76,§ 21 (West 1984) (incorporating res ipsa loquitur and making it a presumption); R.I. GEN. LAWS § 9-19-33 (1984) (merely requires the court to make a preliminary finding of fact that res ipsa loquitur inference would be reasonable); TENN. CODE ANN. § 29-26-115 (1980) (codifying res ipsa loquitur); TEX. REV. CIV. STAT. ANN. art. 4590i, § 7.01 (Vernon 1986) (expressly codifying common law, but forbidding any expansion in the scope of its application).

106. For a list of states enacting such legislation see P. DANZON, *supra* note 54, at 43.

107. For a review of the different screening panel schemes and how they have performed, see P. CARLIN, MEDICAL MALPRACTICE PRE-TRIAL SCREENING PANELS: A REVIEW OF THE EVIDENCE 15-41 (George Washington Univ. Intergovernmental Health Policy Project 1980). Reports on the performance of these schemes are mixed. In some states there has been criticism that the panels promote delay without promoting greater settlement than would have been achieved without them. *See, e.g.*, Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980) (holding mandatory panels unconstitutional on this ground); *see also* Curran, *Screening Panels in Malpractice Cases: Some Disturbing Progress Reports*, 302 NEW ENG. J. MED. 954 (1980) (reporting findings of a survey showing widespread dissatisfaction with screening panels even among groups that originally sponsored them); Comment, *A Practical Assessment of Arizona's Medical Malpractice Screening System*, 1984 ARIZ. ST. L.J. 335 (1984). In other states opinion has been more favorable. *See* Curran, *supra*, at 954-55. Until more rigorous investigations are conducted as to the effect of panels measured against prepanel outcomes, panel performance must be considered an unknown.

108. *See* P. DANZON, *supra* note 54, at 48. Again, several of these statutes have been overturned on constitutional grounds. *See supra* notes 84-85.

be paid by defendants, with amounts over that ceiling (up to a specified limit) to be paid from a special fund established by the state and supported by special surcharges on health care providers.[109] Other states limited damages recoverable from any source, some fixed ceilings on total amounts recoverable, others limited only noneconomic losses such as pain and suffering and loss of consortium.[110]

Several states sought to limit recoveries by modifying the collateral source rule, which permits plaintiffs to recover amounts that they have already been reimbursed under health, life, or disability insurance or under an employer's sick-pay plan.[111] Reforms have either required collateral source payments to be offset against awarded damages[112] or allowed defendants to introduce evidence of such payments, leaving the jury to decide whether to take those benefits into account in fixing damages.[113]

Some states sought to reduce the cost of claims by allowing or mandating periodic payments in lieu of lump-sum awards.[114] Although periodic payments are sometimes rationalized on paternalistic grounds—as a means of preventing plaintiffs from squandering their awards[115]— the main purpose of such measures is plainly to save contingent future damages by allowing defendants or their insurers to retain and invest the unpaid damages and by cutting off payments in the event of the patient's death.[116]

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109. *See, e.g.*, IND. CODE ANN. § 16-9.5-2-2 (Burns 1983) (limit of $500,000 for death of patient; liability of any physician limited to $100,000, remainder payable from fund); LA. REV. STAT. ANN. § 40:1299.42(B) (West 1985) (same as Indiana); N.M. STAT. ANN. § 41-5-6 (1982) (same as Indiana but exclusive of punitive damages and medical costs).

110. *See, e.g.*, CAL. CIV. CODE § 3333.2(b) (West 1985) ($250,000 limit for "noneconomic" loss); VA. CODE § 8.01-581.15 (1984) (total recovery limit of $1 million).

111. Abolition or modification of the collateral source rule is a popular target of contemporary reform efforts. *See infra* text accompanying notes 142-43.

112. *See, e.g.*, FLA. STAT. ANN. § 768.50 (West 1985); IOWA CODE ANN. § 147.136 (West 1985); OHIO REV. CODE ANN. § 2305.27 (Baldwin 1984) (collateral sources other than those paid for by claimant or employer); PA. CONS. STAT. ANN. tit. 40, § 1301.602 (Purdon 1985) (*public* collateral sources only); R.I. GEN. LAWS § 9-19-34 (1984); TENN. CODE ANN. § 29-26-119 (1980).

113. *See, e.g.*, CAL. CIV. CODE § 3333.1 (West 1985); DEL. CODE ANN. tit. 18, § 6862 (1984) (*public* collateral sources); N.Y. CIV. PRAC. LAW § 4010 (McKinney 1984); S.D. CODIFIED LAWS ANN. § 21-3-12 (1984) (collateral sources not paid for by claimant); WASH. REV. CODE ANN. § 7.70.080 (1974) (collateral sources not paid, or bargained for, by plaintiff).

114. *See, e.g.*, CAL. CIV. PROC. CODE § 667.7 (West 1980) (periodic payments in lieu of lump sum at option of either party); MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-08(b) (1984) (claimant's option only); WIS. STAT. ANN. § 655.015 (West 1980) (periodic payments mandatory for sums over $25,000). Illinois and New York recently enacted elaborate periodic payment schemes. Medical Malpractice Act, 1985 Ill. Legis. Serv. 84-7, §§ 2-1705 to -1719 (codified at ILL. ANN. STAT. ch. 110, §§ 2-1705 to -1719 (Smith-Hurd 1986)); Act of April 15, 1985, 1985 N.Y. Laws, ch. 294, § 9 (codified at N.Y. CIV. PRAC. LAW §§ 5031-5039 (McKinney Supp. 1986)).

115. American Bank & Trust Co. v. Community Hosp. of Los Gatos-Saratoga, Inc., 36 Cal. 3d 359, 369, 683 P.2d 670, 676, 204 Cal. Rptr. 671, 677 (1984). *See generally* Elligett, *The Periodic Payment of Judgments*, 46 INS. COUNS. J. 130, 131 (1979).

116. This purpose was acknowledged by the California Supreme Court in American Bank & Trust Co. v. Community Hosp. of Los Gatos-Saratoga, Inc., 36 Cal. 3d 359, 683 P.2d 670, 204 Cal. Rptr. 671 (1984), which rationalized it as eliminating a "windfall" to plaintiff's heirs. *Id.* 36 Cal. 3d at 369, 683 P.2d at 676, 204 Cal. Rptr. at 677. Just why economic losses are any more a "windfall" than any other asset of the decedent was not explained.

V

WHAT DID THE REFORMS OF THE 1970's ACCOMPLISH?

Although changes in insurance underwriting practices and in legal rules and standards had the immediate effect of dissipating the crisis atmosphere, a closer look at these reforms suggests they were less substantive and important than they first appeared.

Among the changes in the field of malpractice insurance, the general shift by insurers to claims-made policies was significant only if the "long tail" phenomenon was an important problem. Although claims-made policies do reduce actuarial uncertainty, this effect is likely to be slight; only about two percent of claims are filed more than five years after the event,[117] and this number is likely to be reduced by the new statutes of limitations. The more important insurance development of the 1970's was the appearance of provider-owned insurers. These plans, being noncommercial and under the control of physicians anxious to reduce malpractice costs, have the potential at least to identify dangerous providers and rectify dangerous situations. They face the risk, however, that, in order to keep premiums down for the benefit of their provider-owners, they will adopt overly optimistic assumptions, undercharge providers, and face bankruptcy if trends disappoint their expectations.[118]

As to the actual impact of legal reforms, Patricia Danzon has attempted to analyze how several major reforms affected the frequency and severity of claims in enacting states.[119] Her study shows that limitations on recoverable damages and abolition of the collateral source rule were both positively correlated with near-term reductions in the severity of claims. Limits on contingent fees showed "some sign" of having reduced claim severity, but no other significant positive correlations between the legislation and changes in claim frequency or severity were found.[120]

The absence of observable effects for most of the legal reforms of the 1970's may simply reflect the absence of reliable current data to measure long-term effects, particularly on claims frequency.[121] However, another

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117. A 1974 study by the Insurance Services Office of closed claims found that over 98% of claims were reported within five years of malpractice occurrence. As Kenneth Abraham put it, "although the tail is long, it may not be very wide." Abraham, *supra* note 2, at 503; *see also* HEW REPORT, *supra* note 3, at app. 254 (88% to 95% of all claims reported within first 24 months after mishap; 97% within 48 months).

118. The problem is most dramatically illustrated by the experience in Florida where the Florida Physician's Insurance Reciprocal was placed in receivership in 1984. New management and surplus contributions from insureds have since rehabilitated the carrier. Medical Liability Monitor, Jan. 29, 1985, at 2-3.

119. P. DANZON, *supra* note 54.

120. *Id.* at 30-32; *see also* Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J. HEALTH POL., POL'Y & L. 629 (1985) (an econometric study of the effect of reforms on insurance premiums; reforms did not have intended effect of curbing rise in premiums).

121. Danzon analyzed closed claims for the 1975-1978 period. Since many of the claims in this data pool would have been filed before the effective dates of the reforms (most of which appeared in 1975), the ramifications of the reforms on claims frequency could not be fully manifest. However, as Danzon observes, a sharp reduction in the amount recoverable should have a somewhat sudden

possible problem is the specification of the measured variable—legal change. The mere fact that a legislature enacted a law relevant to a legal doctrine does not necessarily imply a change in the law.[122] It is hardly unknown for legislatures to seek the appearance, but not the reality, of effective legislative response to what some of the legislators' constituents perceive to be a serious problem.[123] There is some evidence that this is precisely how most legislatures responded to the malpractice crisis and that legislators got credit for affirmatively responding to the medical profession's concerns without delivering very much actual relief. One might question whether a truly sophisticated constituency could have been taken in by reforms with little substance, but in fairness to the medical profession, it would not have been a simple matter to predict the effects of some reforms which, superficially at least, seemed to promise much.

It would be enormously difficult to ascertain the precise extent to which each of the enacted statutes altered preexisting law within each state. However, some of the major enactments were more codifications than modifications of the common law. For example, a perusal of the legislation relating to general standards of care and proof requirements in malpractice cases reveals little or no change in the common law of the enacting state. The statutes dealing with standards of care typically incorporate the general common law requirement of compliance with customary norms and some version of the locality rule, usually without important changes.[124] With respect to burden of proof, the doctrine of res ipsa loquitur appears wholly unaffected by pertinent statutes in most states that addressed the doctrine at all.[125] Of course, codification of existing law might serve the medical profession's interests by curbing further judicial liberalization, but even this goal would be accomplished only if the statute explicitly freezes the specific

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effect on claims initiated. Given that claim severity was shown to be affected in this time period, it is odd that no effect was seen on claim frequency. *See* P. DANZON, *supra* note 54, at 29-30.

122. *See* P. DANZON, *supra* note 54. Danzon's study is unclear as to "change." It appears that all of the enactments identified in her Appendix A are treated as pertinent changes in the model.

123. *See supra* note 14.

124. Without providing an exhaustive reference list, the following comparisons of statutes and cases will illustrate the point. First, the following illustrate the general care standards and the locality rule. *Compare* ALA. CODE § 6-5-484(a) (1977) *with* Parrish v. Spink, 284 Ala. 263, 224 So. 2d 621 (1969), *and* May v. Moore, 424 So. 2d 596 (Ala. 1982) (post statute case; standard permits reference to national standard of physicians in same or similar circumstances); *compare* FLA. STAT. ANN. § 768.43(a)(3) (West 1985) *with* Brooks v. Serrano, 209 So. 2d 297 (Fla. 1968), *and* Mitchell v. Angelo, 416 So.2d 910 (Fla. 1982) (post statute case; national standard); *compare* WASH. REV. CODE ANN. § 7.7-.040 (1974) *with* Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967). In at least one case, the "reform" statute was construed to liberalize the prior common law, even though the court acknowledged that the statute's purpose in general was to garner protection for the medical profession. *See* Ardian v. Hartford Accident & Indemnity Co., 360 So. 2d 1331 (Tenn. 1978).

Second, the following regard the informed consent issue. *Compare* FLA. STAT. ANN. § 768.46a (West 1985) *with* Ditlow v. Kaplan, 181 So. 2d 220 (Fla. 1965); *compare* TENN. CODE ANN. § 29-26-118 (1980) *with* German v. Nichopoulous, 577 S.W. 2d 197 (Tenn. 1978); *compare* PA. CONS. STAT. ANN. tit. 40, § 1301.103 (Purdon 1985) *with* Cooper v. Roberts, 220 Pa. Super. 260, 286 A.2d 641 (1971). *See also* Nelson v. Patrick, 58 N.C. App. 546, 293 S.E.2d 829 (1982) (explicit interpretation of statute as codification of common law); Robinson v. MROZ, 433 A.2d 1051 (Del. 1981) (same).

125. *See supra* notes 102-05.

point of law.[126] In most instances, the codification is in such general terms that judicial discretion is not much curbed. Moreover, the reception given the legislation to date suggests that the judiciary will not easily yield its law-creating authority and traditional autonomy in this area.[127]

One might expect legislation directly affecting the initiation of claims to have greater effects, but changes in statutes of limitations and the discovery rule usually left unaffected the largest category of latent-injury cases—those involving foreign substances in the body after surgery. Statutes requiring pretrial screening of claims cause delay, which may increase claimants' litigation costs and thereby discourage marginal suits. However, although there is evidence of delay,[128] its costs may not be entirely borne by plaintiffs. Thus, the availability of prejudgment interest in a growing number of states partially offsets the cost to claimants, and, even where such interest is not authorized explicitly, juries apparently make an implicit allowance for it in setting general damages.[129] Although the necessity for incurring the additional costs of the screening process might discourage suits, much of this cost would have to be incurred anyway in preparing for trial.

Danzon's study indicated that limits on contingent fees may have had some effect on claim severity, though no effect on claim frequency was shown. It is puzzling that a marginal reduction in the amount recoverable by attorneys would not also yield a reduction in claim frequency. Perhaps the statutory fee limits were equal to or higher than market-determined rates and thus did not interfere with attorneys' incentives to take cases. In those states that gave courts the discretion to set limits on fees,[130] lawyers may have expected the judges to be liberal. Moreover, most courts probably already possessed some power over fees as part of their inherent supervisory authority over the bar.[131]

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126. *See* TEX. REV. CIV. STAT. ANN. art. 4590i, § 7.01 (Vernon 1986) (forbidding future expansion of the scope of the res ipsa loquitur doctrine).

127. Aside from cases that invalidate the statutes, *see supra* notes 84-85, a sampling of cases interpreting statutes governing standards of care and burdens of proof indicates a disposition to view them as not curbing the common law. *See* cases cited *supra* notes 96, 104, 124.

128. *See supra* note 107.

129. *See* Hammitt, Carroll & Relles, *Tort Standards and Jury Decisions*, 14 J. LEGAL STUD. 751 (1985).

130. For a sample of statutes, see *supra* note 92. Of the seventeen states identified in Danzon's study, only five enacted *fixed* limits. P. DANZON, *supra* note 54, at 41. Several states have more recently enacted fixed limits on fees. *See* Florida Comprehensive Medical Malpractice Reform Act of 1985 § 17, 1985 Fla. Laws ch. 85-175 (to be codified at FLA. STAT. § 768.575 (1986)); Ill. Pub. Act 84-7, § 2-1114 (to be codified at ILL. ANN. STAT. ch. 110 § 2-1144 (Smith-Hurd 1986)); UTAH CODE ANN. § 78-14-7.5 (Supp. 1985). Utah's provision is noteworthy for its liberality. It places a ceiling of 33 1/3% of all damages, which is the percentage standard now commonly used.

131. *See, e.g.*, Schlesinger v. Teitelbaum, 475 F.2d 137, 139-40 (3d Cir.), *cert. denied*, 414 U.S. 111 (1973); *In re* Chow, 656 P.2d 105, 110-11 (Hawaii Ct. App. 1982) (statute allowing court to limit contingent fees codifies common law); American Trial Lawyers Ass'n. v. New Jersey Supreme Court, 66 N.J. 258, 262, 330 A.2d 350, 352 (1974); Gair v. Peck, 6 N.Y.2d 97, 105-07, 160 N.E.2d 43, 47, 188 N.Y.S.2d 491, 496-97 (1959), *cert. denied*, 361 U.S. 374 (1960); Heller v. Frankston, 76 Pa. Commw. 294, 303-04, 464 A.2d 581, 586 (1983) (statute limiting contingent fees unconstitutional as an interference with inherent judicial authority to regulate fees), *aff'd*, 504 Pa. 528, 475 A.2d 1291 (1984). *Contra* Thatcher v. Industrial Comm., 115 Utah 568, 574-75, 207 P.2d 178, 181 (1949). Despite judicial authority existing independently of statutes, the legislation might still have had some effect as a signal to the courts to give special attention to the fee problem.

Logically, the greatest effect on claims would be expected to come from limitations on recoverable damages—through ceilings on awards, the offsetting of collateral source payments, and the substitution of periodic payments for lump-sum payments. Although Danzon's econometric study detects some early effects on claims severity from the first two of these reforms, there are some reasons why the long-term effect of these legislative limitations might be limited. First, many of the most draconian limits were struck down by the courts, and one might ask whether some legislators, anxious to appear to assist the doctors, may have voted for the limitation while anticipating precisely this result. Second, the states that modified the collateral source rule frequently provided that only collateral payments from public, not private, sources should be taken into account; also, most states leave it the jury's discretion whether to deduct the collateral source payments,[132] and it is possible that juries will ignore the invitation to offset such payments or will adjust noneconomic damages upward to ensure that the negligent provider is appropriately punished. Third, the states that have put ceilings on noneconomic damages have been fairly generous in their allowances; although a $250,000 ceiling (a typical amount) will undoubtedly lower some potential multimillion-dollar awards, it will not affect the outcome in many smaller cases.

As Danzon's studies show, absolute dollar limits on total recoveries or on specific items of damages (noneconomic losses) did indeed reduce the severity of claims and thus the total cost of the tort system for compensating victims of medical malpractice. This result is not surprising because a very small number of cases involving especially serious injuries account for a large percentage of the system's dollar costs.[133] Thus, putting effective ceilings on "megabuck" recoveries should significantly lower actual payments and improve the predictability of insurers' risks. The actual effect of partially repealing injured patients' malpractice rights in this fashion would naturally depend upon the ceilings set, but several states set limits (for example, Indiana's $500,000 ceiling for total damages) that were calculated to have a real impact.[134] Whether many other legislatures (or courts) will tolerate such low ceilings on awards for actual medical expenses and lost wages (as opposed to noneconomic losses) is questionable.

VI

CONCLUSION

Examination of individual reforms adopted by the states in the malpractice crisis of the mid-1970's thus indicates that most of the flurry of legislative activity was just that—more show than substance. Recent resumption of the

132. *See supra* notes 112-13 and accompanying text.

133. *See* P. DANZON & L. LILLARD, THE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS, RESEARCH RESULTS AND POLICY IMPLICATIONS xiv (The Rand Corp., Report No. R-2793-ICJ, 1982) (study of claims paid in 1974-1976 period; 5% of all paid claims accounted for 49% of total dollars paid).

134. *See supra* note 109.

upward trends in both the frequency and the severity of malpractice claims tends to confirm this judgment.[135] As the upward trend in claims is again substantially increasing premium costs,[136] declarations of a new crisis have been issued by the AMA, and other provider organizations.[137] Although the new crisis is widely said to be more a problem of affordability than availability of liability insurance, that distinction is of questionable usefulness. If insurance is truly "unaffordable," it is, perforce, "unavailable" as a practical matter. But whether insurance is in fact unaffordable remains to be demonstrated. It is noteworthy that despite the continued increase in premium costs, the ratio of such costs to average provider income has not changed substantially. The AMA's own surveys show that average premium costs as a percentage of physicians' gross income were about 3.7% in 1983, down from 4.4% in 1976 and about the same as in 1979.[138] Such averages do not, however, reveal the significant deviations from the mean for particular subcategories of providers. For example, obstetricians, not a high-rated insurance class in the 1970's, have become one in the 1980's.[139] Also, very rapid premium increases in such places as New York and Florida make the affordability problem more serious, at least for the high-risk specialties.[140]

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135. A recent AMA survey reports that the average annual incidence in the number of claims per 100 physicians increased from 3.3 to 8 in the period from 1978 to 1983. *See* AMA TASK FORCE, *supra* note 1, REPORT 1 (1984), at 15. Increase in the severity of claims also is reported. For example, provider-owned companies tied to medical societies reportedly experienced an increase in average paid losses of over 254% between 1979 and 1983. *Id.* at 17. There is no indication that the figures were adjusted for inflation, however. Interestingly, the leading commercial underwriter, St. Paul Fire and Marine, reports a rise in claim severity of less than half this amount over the longer period 1975 to 1983. Letter from St. Paul Fire and Marine Insurance Co. to author (Aug. 15, 1983).

136. For example, St. Paul Fire and Marine Insurance Co., the nation's leading malpractice underwriter, reports representative premiums that show increases in each of its rating classes from 1975 to 1983 of between 87% and 226% (unadjusted for inflation). Letter from St. Paul Fire & Marine Insurance Co. to author, *supra* note 135. Medical Liability Mutual Insurance Co., a New York provider-owned carrier and the nation's second largest malpractice underwriter, reports premiums that show increases of between 37% and 230% (unadjusted for inflation) over the same time period. (Unlike St. Paul, Medical Liability Mutual Insurance Co. continued to write occurrence-based policies exclusively until 1982, when it began to offer claims-made policies.) Letter from Medical Liability Mutual Insurance Co. to author (August 31, 1983).

137. *See* sources cited *supra* note 1.

138. *See* AMA SURVEYS, *supra* note 22.

139. *See* N.Y Times, Feb. 12, 1985, at A1, col. 1 (large numbers of ob-gyn specialists were reportedly giving up obstetrics as a consequence of increased premium costs). The change in the frequency of claims against ob-gyn physicians is striking. AMA survey data show an average annual incidence of claims in the 1976-1981 period of 15.5 per 100 physicians, more than three times the frequency of claims prior to 1976. *See* Adams & Zuckerman, *Variation in the Growth and Incidence of Medical Malpractice Claims,* 9 J. HEALTH POL., & POL'Y L. 475, 477 (1984).

140. The Florida controversy has involved highly publicized campaigns by the Florida Medical Association to obtain, and the Academy of Florida Trial Lawyers to oppose, a constitutional amendment to limit malpractice awards. *See* Nat'l L.J., Oct. 22, 1984, at 3, col. 1. The Florida Supreme Court removed the proposed limitation from the election ballot on procedural grounds. Evans v. Firestone, 457 So. 2d 135 (Fla. 1984). However, in 1985, legislation was enacted making a number of more or less incidental reforms, such as mandatory periodic payments on awards over $500,000, limits on contingent fees, and penalties for rejecting settlement offers within $25,000 of an ultimate award. Florida Comprehensive Medical Malpractice Reform Act of 1985, 1985 FLA. LAWS ch. 85-175 (to be codified at FLA. STAT. § 768.575 (1986)).

The new "crisis" has prompted renewed efforts to obtain legislative reforms. In 1985, nearly every state legislature considered some change in substantive or procedural rules affecting malpractice claims.[141] To date, only a few have enacted any reforms,[142] but it is premature to predict the long-term results of continued lobbying by the medical profession.

The nature and importance of the reforms proposed and enacted in this latest legislative round is highly variable. The single most common reform proposed or enacted is abolition or modification of the collateral source rule. Other changes include mandatory periodic payments, ceilings on contingency fees, arbitration provisions, abolition of or limits on punitive damages, and various procedural matters. The most striking feature of the reforms is that most are targeted at marginal features of the tort system where changes seem unlikely to have an important effect on either the frequency or severity of claims.[143]

The one proposed reform most likely to have a significant impact is limiting recovery of noneconomic losses. To date, this reform has been blocked—except in a handful of states that enacted it in the 1970's—but it could yet gain significant support. Recent state and federal decisions upholding California's $250,000 ceiling on noneconomic loss[144] no doubt will be taken as important constitutional support for this reform. The reform also may gain some additional visibility from federal legislation.

Congress has recently entered the picture with two legislative reform proposals: the Federal Incentives for State Health Care Professional Liability Reform Act of 1985 (the "Hatch bill")[145] and the Medical Offer and Recovery Act of 1985 (the "Moore/Gephardt bill").[146] The Hatch bill, introduced on behalf of the American Medical Association, would enact a model for state

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141. For a list of states and summary of reforms proposed and enacted, see Medical Liability Monitor, Special Report, July/Aug. 1985.

142. *See, e.g.*, CONN. PUB. ACT No. 85-574 (1985); Florida Comprehensive Medical Malpractice Reform Act of 1985, 1985 Fla. Laws, ch. 85-175 (to be codified at FLA. STAT. § 768.575 (1986)); Medical Malpractice Act, 1985 Ill. Legis. Serv. 84-7 (codified in scattered sections of ILL. ANN. STAT. ch. 110, (Smith-Hurd 1986)); Act of April 15, 1985, 1985 N.Y. Laws, ch. 294, § 9 (codified at N.Y. CIV. PRAC. LAW §§ 5031-5039 (McKinney Supp. 1986)); Act of July 1, 1985, 1985 Utah Laws ch. 67, § 1 (codified at UTAH CODE ANN. § 78-14-7.5 (Supp. 1985)).

143. The Florida and Illinois statutes, *supra* note 142, are particularly striking illustrations of the propensity to legislate *around* the subject. Though both statutes purport to be a comprehensive reform, each is filled with minutiae on such matters as requirements for advanced notice of claims, affidavits for nonbinding arbitration, and incidental provisions for risk management procedures in health care facilities. The Florida statute does contain provisions dealing directly with the standards of recovery. Florida Comprehensive Medical Malpractice Reform Act of 1985, 1985 Fla. Laws ch. 85-175 § 10 (to be codified at FLA. STAT. ANN. § 768.45). However, the provisions make only the most trivial changes in the prior statutory provision. The changes consist, for example, of such modifications as substitution of "prevailing professional standard of care" for "accepted standard of care" as the relevant norm that plaintiff must show was breached. Only a legal metaphysician would believe that something important could turn on this type of verbal filigree.

144. Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985); Fein v. Permanente Medical Group, 38 Cal.3d 137, 695 P.2d 665 211 Cal. Rptr. 368, *appeal dismissed*, —— U.S. ——, 106 S. Ct. 214 (1985).

145. S. 1804, 99th Cong., 1st Sess. 131 CONG. REC. S14,356-59 (daily ed. Oct. 29, 1985).

146. H.R. 3084, 99th Cong., 1st Sess. 131 CONG. REC. H.6353 (daily ed. July 25, 1985).

legislation and would provide financial incentives in the form of grants to states enacting reforms described in the model bill. The reforms are focused on those subjects just mentioned as having been commonly targeted by state legislatures: mandatory periodic payments for future damages over $100,000, mandatory offset for collateral source payments, limitation on noneconomic loss to $250,000, and sliding scale limitations on contingent fees. The bill also contains certain other measures relevant to disciplinary action and creation of risk management systems by hospitals.

The Moore/Gephardt bill also is designed primarily as a model for state legislation. In the absence of state legislation, however, it would have independent effect within the scope of health care provided to beneficiaries of health programs, such as Medicare, Medicaid, and federal employee health plans. The central thrust of the Moore/Gephardt bill is to eliminate noneconomic damages and damages compensated by collateral sources whenever the provider offers (within a specified time period) to make periodic payments covering *all* economic losses (as they accrue) suffered because of adverse results from medical treatment. Once the offer is made, the plaintiff is foreclosed from pursuing conventional tort actions except where the provider intentionally caused the injury or wrongful death has occurred.

In important respects the two reform bills are similar insofar as they focus on elimination of the collateral source rule and the elimination or limitation of noneconomic damages awards. The Moore/Gephardt bill, unlike the Hatch bill, does extract a kind of quid pro quo for these curtailments of tort liability to the extent that the promised payment of economic costs is not conditioned on a determination of fault. Indeed, the basic idea originated, independently of any concern with excessive or unwarranted medical malpractice liability, with Jeffrey O'Connell as one of several permutations on no-fault proposals that he has developed over the past twenty years.[147] Despite this initial purpose, however, it is not certain that Moore/Gephardt would achieve no-fault compensation.

There are two competing speculations. One is that because the offer to pay economic losses is a purely voluntary choice of the provider (or the provider's insurer), payments would only be made in those cases where the plaintiff had a solid case for liability based on negligence and a significant probability of recovering substantial noneconomic damages. In all other cases the provider would resist the claim in court. On this speculation, it is curious that the AMA has refused to endorse the Moore/Gephardt bill, because it seems to be a no-lose proposition for health care providers: limited liability for high-risk cases with a preserved tort option for low-risk cases. The AMA's resistance to the Moore/Gephardt bill gives rise to the second speculation about its effects: insurers would be too quick to settle claims that the providers believed to be "nonmeritorious" but which could be settled for

147. *See* Moore & O'Connell, *Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss*, 44 LA. L. REV. 1267 (1984); *see also* O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendant's Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U.L. REV. 589 (1982).

an amount less than the costs of litigation plus the expected value of an award if plaintiff does recover (for example, such a claim might entail a low probability of recovery but a high probability of substantial noneconomic loss if there is a recovery). Of special concern here is the possibility that paying full economic losses in such cases would lead to an increase in claims frequency and, thus, increased premium costs.

This latter effect is an inherent risk of no-fault schemes generally, although it is not obvious why it should be a substantial risk of an optional no-fault scheme, where payments are in the control of the insurer. Perhaps the fear of the AMA is that insurers will not be adequately sensitive to the general moral hazard of no-fault payments even when the payment option remains in the hands of the insurers. In addition, the AMA may fear that optional no-fault would be the camel's nose in the tent, leading to a more general form of no-fault compensation.

In any event, the AMA's legislative strategy seems somewhat confused. At the very least, it is hard to match with its strong rhetoric about the flawed character of the tort system. If the tort system is as deeply and systemically flawed as AMA pronouncements have claimed, one can only wonder why they have endorsed such marginal reforms as those proposed in the Hatch bill. By the AMA's own analysis, those reforms would yield a quite modest reduction in annual premium costs even if they were fully implemented.[148]

Be that as it may, both the Hatch bill and the Moore/Gephardt bill do perform a valuable service in calling attention to what some observers (this author included) regard as a serious flaw in the present liability system: the absence of effective restraint on awards for noneconomic loss. One can accept the legitimacy of compensation for pain and suffering, in terms of efficient deterrence as well as "fair" compensation, and even accept punitive damages in limited cases, yet still be concerned about the lack of any limits on the discretion of juries.[149] In the absence of economic guidelines for measuring noneconomic damages, some form of ceiling is probably the only workable remedy.

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148. An AMA-commissioned study of the expected premium cost savings that would result from enactment of four major reforms proposed by the Hatch bill estimated savings for a "typical state" adopting all four reforms to be 28%. The savings could, however, vary greatly from state to state depending on the accuracy of the various assumptions applied to each state. One particularly important assumption is that claims settlements would be reduced by the same amount as awards, an assumption the basis for which does not appear in the report. *See* MILLIMAN & ROBERTSON, INC., *supra* note 13. Although a 28% reduction in premium costs cannot be dismissed as trivial, it certainly does not match the reported premium increases in recent years. Moreover, 28% approximates the maximum expected reduction (the range is estimated at 28%-33%). As the report indicates, a change in certain assumptions could reduce the estimates substantially. For example, if claims settlements were not influenced by the limitations on awards the savings would fall from 28% to 5%. *Id.* at 3.

149. For an illustrative debate on pain and suffering as a compensable loss, compare Jaffe, *Damages for Personal Injury: The Impact of Insurance*, 18 LAW & CONTEMP. PROBS. 219 (1953) with W. BLUM & H. KALVEN, PUBLIC LAW PERSPECTIVES ON A PRIVATE LAW PROBLEM 35-36 (1964). On the role of punitive damages, see Cooter, *Economic Analysis of Punitive Damages*, 56 S. CAL. L. REV. 79 (1982); Ellis, *Fairness and Efficiency in the Law of Punitive Damages*, 56 S. CAL. L. REV. 1 (1982).

Aside from damage ceilings, any array of other legal reforms might be considered, including alternatives to the tort system such as enforceable private agreements for risk allocation or alternative methods of dispute resolution.[150] Conceivably, some form of true noncontractual no-fault compensation mechanism might be considered for certain kinds of iatrogenic injuries. Past proposals along these lines[151] have not attracted many supporters, even among legal academics, let alone among politicians; yet the possibility of a modest experiment, over a limited range of medical injuries, deserves studied attention.

Of course, all such reforms pose the question whether there are principled reasons for singling out health care accidents from the universe of accidents in general. However, even if that question is answered in the negative, one could argue that the controversary over medical malpractice is a useful and appropriate occasion for taking a hard look at general features of the tort system, as applied to all accidents. Unfortunately, it is probably unrealistic to expect the medical profession, presently the most organized political force actively pressing for tort reform, to concern itself with principles of accident law in general rather than medical malpractice in particular. Such an expanded vision of the problem would enable the medical profession to take a more principled stance on reform, but it would also risk diffusing its political influence over a wider arena of controversy and opening up the possibility of changes not in its interest.

If, as the saying goes, past is prologue, it is difficult to foresee any major tort reform arising out of the 1980's update of the malpractice crisis of the 1970's. A continuation of political wrestling between the medical profession and the plaintiff's bar, accompanied by state legislatures' fitful intervention to convey their "concern" to both constituencies by making some marginal adjustments in liability-related rules, is more likely to occur.

150. *See generally* Robinson, *Rethinking the Allocation of Medical Malpractice Risk Between Patients and Providers*, LAW & CONTEMP. PROBS., Spring 1986, at 173.

151. *See, e.g.*, Havighurst, *"Medical Adversity Insurance"—Has Its Time Come?*, 1975 DUKE L.J. 1233.