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2005-06
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Assembly
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Committee on Insurance (AC-In)

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Note

*173 FOLLOWING THE DOCTOR'S ORDERS -- CAPS ON NON-ECONOMIC DAMAGES IN MEDICAL MALPRACTICE CASES

Mitchell S. Berger

I. INTRODUCTION

Courts in the United States have held physicians liable for medical malpractice since the eighteenth century, but such claims were rare until recently. [FN1] While malpractice reform may not be at the forefront of the average citizen's mind, [FN2] this subject undoubtedly affects every citizen of this country. There are indications that people recognize the present as well as potential troubles that an uncontrolled medical malpractice system could cause. [FN3] One is apt to think that this is someone else's problem, even when this is not the case. [FN4] Yet, how could the average citizen play a role in *174 the escalation or reduction of medical malpractice problems? Citizens are unlikely to envision their own role in the medical malpractice system. [FN5]

Despite the lack of involvement by the average citizen, the strong lobbies of the medical profession and the insurance industry have pushed for legislative attention to malpractice reform. One part of these reform efforts has focused on setting absolute limitations on malpractice awards. Twenty states currently have a cap on malpractice recoveries and fourteen of these caps were enacted in 1986. [FN6] The theoretical reasoning behind these statutory limitations is as follows: "[t]o the extent one limits or eliminates another's right to receive compensation for injuries, there is, of course, an equal reduction in the need for the insurance protection, which has traditionally provided the source for these compensation payments." [FN7]

This note will focus specifically on caps on non-economic damages. The state supreme courts of California [FN8] and Indiana [FN9] have upheld the constitutionality of limiting recovery for non-economic losses to a maximum award of $250,000 in actions against health care providers. Four other states with similar non-economic cap provisions are Texas, New Hampshire, North Dakota, and Ohio. [FN10]

II. MANIFESTATIONS OF THE 1970'S MALPRACTICE INSURANCE "CRISIS" [FN11]

The late 1960's saw a sudden and unanticipated increase in the *175 number of malpractice claims filed against physicians. [FN12] An unprecedented increase also appeared in the size of jury awards corresponding to an unanticipated increase in both the number of claims filed for negligent injuries and the amounts recovered. [FN13] The mid-1970's brought forth a climate of dramatically increasing malpractice insurance rates, [FN14] significantly raising the cost of liability insulation. Consequently, doctors began to experience difficulty obtaining adequate coverage and some insurance carriers even eliminated their coverage of medical malpractice liability. [FN15] In response to the rate increases and difficulties in obtaining adequate insurance coverage, physicians' associations "predicted that physicians would abandon the practice of medicine or would practice without the protection of liability insurance." [FN16] When the unavailability of medical malpractice insurance reached an apparent "crisis" level in the mid-1970's, the state legislatures tried to reduce the cost of insurance premiums *176 and increase insurance availability. [FN17] Every state except West Virginia responded to the

situation with some type of legislation. [FN18]
However, the "crisis" of the 1970's may have been an unjustified panic. The increases in insurance premiums were hardly devastating to a majority of physicians. [FN19] Malpractice premiums make up only about one percent of the nation's bill for personal health care services. [FN20] Moreover, the proportion of gross income that the average practitioner paid for malpractice insurance from 1976 to 1983 actually decreased. [FN21] There is no evidence, other than the increase of legal claims, to support a notion that medical practice standards had declined. [FN22] There is also little indication that the general public was aware of any "crisis". [FN23] Thus, depending on one's perspective, it seems that the malpractice "crisis" could be viewed as either a threat to the very fabric of our society, or as an insignificant figment of the insurance companies' and medical profession's imaginations. [FN24]

***177** III. CAUSES OF THE MALPRACTICE "CRISIS" OF THE 1970'S

The varied causes of the changing malpractice insurance climate are subject to much debate. Physicians and the insurance industry attribute the soaring malpractice costs to increases in both the number of suits filed and the size of awards. In contrast, lawyers and consumer groups question the very existence of the "medical malpractice crisis." They blame excessive insurance industry profits and the medical community's inability to eliminate substandard practitioners. [FN25] The 1970's may have seen a tremendous increase in the number of frivolous claims filed due to attorney contingency fee arrangements and the media's focus on outlandish jury awards. [FN26] Perhaps this theory is wrong and there was actually a huge increase in meritorious claims filed. The increase in claims could be attributed to a breakdown in patients' trust and admiration for their physicians, [FN27] an increase in the public's willingness to litigate as they became more aware of their legal rights, and an increased risk exposure because of the growing complexities of medical technology. [FN28] Another explanation is that the increase in claims was the product of an increase in the number of lawyers, thus allowing for the more aggressive pursuit of claims already in existence. Yet, evidence of such a phenomenon is weak and subject to much criticism. [FN29] The decline in the United States stock ***178** market in the early '70's undoubtedly contributed to the rising costs of the malpractice insurance system. [FN30] Prior liberalization of tort law and procedure also helped to precipitate the changes. [FN31]
Insurance companies unquestionably played a key role in the process. [FN32] The inability to predict and absorb the shock of sudden increases contributed to malpractice insurance problems. [FN33] Even so, some indication exists that the insurance industry is not the passive and helpless victim of market forces it would like the public to believe. [FN34] The industry's role in the malpractice system should receive much greater scrutiny in the future.

IV. RESULTS OF THE 1970'S "CRISIS"

The tremendous power of the medical lobby forged the way for ***179** legislative reform following the "crisis" of the 1970's. [FN35] Legislatures in nearly every state enacted some sort of tort reform measures. [FN36] These efforts sought to preserve the availability of health care systems at reasonable cost. [FN37] State legislatures feared doctors would refuse to practice in certain geographical areas and would be unwilling to provide services in certain high risk specialties without a reduction in the cost of insurance. [FN38] Also of concern was that if physicians practiced medicine without insurance (because of its high cost), the consequences of this practice would fall on the consumers of health care in that injured patients would be unable to hold any party financially accountable for a health care provider's negligence. [FN39]
In addition to legislative reforms, the insurance industry also emerged in a different form in the following decade. With the few large carriers abandoning the malpractice market, state medical societies and other physician groups sponsored the formation of nearly forty malpractice insurance companies between 1975 and 1982. [FN40] This alteration in the ***180** makeup of the insurance market, while contributing to the crisis at

the time, will probably prove to be beneficial to the system in the long run. [FN41] Additionally, one lingering effect of the insurance crisis of the 1970's has been an increase in the practice of defensive medicine, [FN42] despite legislative efforts at reform.

V. ARE WE NOW HEADED FOR ANOTHER MEDICAL MALPRACTICE "CRISIS"?

Malpractice insurance is now generally available. Yet, once again there is concern that large numbers of physicians will find themselves in danger of practicing without malpractice coverage. [FN43] Recently, the frequency of malpractice lawsuits and the amount of dollars paid out per ***181** claim have increased markedly. [FN44] This means that physicians are, or soon will be, facing hefty increases in the amounts they must pay for malpractice insurance. [FN45] Responding to the upward trend in claims which are once again substantially increasing insurance premium costs, the American Medical Association and health care providers have already proclaimed the existence of a new crisis. [FN46] Medical society and physician-run insurance companies [FN47] are now experiencing many of the same troubles as their nonprofessionally run counterparts. [FN48] State legislative efforts at reform have been recently revived. [FN49] The overall impact on malpractice insurance has ***182** been to reduce by more than fifty percent not only the number of companies providing malpractice coverage, but also the amount of coverage available. [FN50] Some even feel that we are now headed for a no-fault medical liability insurance system. [FN51] While there are arguments to the contrary, [FN52] there remains at least sufficient justification for concern over the current state of the medical malpractice system.

VI. TO CAP OR NOT TO CAP: SHOULD THERE BE ANY QUESTION?

One reform measure likely to have a significant impact on insurance costs and its availability is placing a limit on recovery of non-economic ***183** losses. [FN53] Such damage caps limiting recovery for non-economic loss are highly controversial. [FN54] To date they have not been an effective weapon in the malpractice insurance war, since some courts have declared this measure unconstitutional. [FN55] Nevertheless, recent state [FN56] and federal [FN57] decisions upholding California's $250,000 ceiling on non-economic loss serve as significant constitutional support for this reform and will pave the way for other states to follow California's lead. [FN58]

The American Bar Association's Commission on Medical Professional Liability recommended that no dollar limit be imposed on recoveries for economic loss, but expressly "[took] no position on whether it is appropriate to place a ceiling on the recovery of non-economic loss." [FN59] This note takes the position that limitations on non-economic losses are a desirable tort reform measure. While there are a variety of arguments pro and con, such caps only come into play in very remote situations [FN60] and their potential benefits outweigh their infringement on the rights of only a very few people to be fully "compensated" economically for their pain and suffering.

A number of policies underlie these limitations. Caps seek to reduce the number of lawsuits in the health care industry, provide inexpensive health care, allow for affordable insurance coverage, address the insurance crisis, assure that jury awards are closely related to actual damages, and generally, reduce the cost of medical malpractice litigation. [FN61]

Initially there is a question as to whether a malpractice cap effectuates ***184** its intended purposes because most of the premium paid by the insured goes to the first $100,000 of coverage. [FN62] The cost to insure beyond this point is relatively small. [FN63] Nevertheless, limits on recovery still serve to contain health care costs in both a direct and indirect fashion.

The economic model of tort liability for medical malpractice, intending to lead to an optimal degree of care in the practice of medicine, [FN64] breaks down in the real world. [FN65] This model predicts that, "an increase or decrease in the expected liability cost of negligent patient care will result in an inversely related decrease or increase in the amount of medical negligence." [FN66] With respect to liability for medical malpractice,

"there will be no deterrent effect primarily because of a liability insurance system and medical financial care market structure which effectively erase the financial deterrent effects of damage payments." [FN67]

Many factors tend to undermine the workings of the economic model in the malpractice system. A substantial number of people negligently injured by physicians have no opportunity to bring suit. [FN68] Settlements are ***185** often made for significantly less than the actual claim value. [FN69] A defendant's negligence can be impossible to prove. [FN70] Tort doctrines may restrict or eliminate recovery, as in the case of wrongful death or emotional distress. [FN71] All of these factors shrink tort liability for culpably caused injuries. [FN72] Likewise, caps on non-economic damages would also diminish liability for culpably caused injuries. Nevertheless, this alone is hardly reason to abandon the reform measure and, given the infringements that society has come to accept, this is a relatively small intrusion. A perfect liability system would never demand intrusions on a victim's right to be fully compensated. Unfortunately, such a system does not exist in twentieth century American society.

Undoubtedly, non-economic caps will harm some individuals whose compensation will be constrained by the statutory limits. Some have argued that we are attempting to solve our insurance problems by hitting those who can least take the punch. [FN73] The caps could "have a devastating effect on the occasional individual who is seriously injured by negligent medical treatment and can prove large economic loss either because the injury occurred early in life or because the patient's substantial earning power was destroyed." [FN74] A person may receive the brunt of the statute's force merely because he is very young, or single. "The limitations are dependent on whether the victims of medical negligence are minors or legal adults, and whether or not they have dependents, regardless of the extent of their injuries." [FN75]

The seriously injured person is forced to give up the right to receive compensation for proven losses above a set amount, yet he receives nothing for this sacrifice. [FN76] The actions of doctors, hospitals, lawyers, insurance companies, and perhaps patients who press frivolous claims all contribute ***186** to the malpractice crisis. [FN77] The seriously injured patient with a valid claim is not the source of the problem, so why should he be forced to pay for the cure? [FN78] Finally, the argument can be made that it is the medical profession and insurance industry that are the true beneficiaries of malpractice caps, not the average citizen. [FN79]

Nevertheless, the vast majority of injured people will remain unaffected by caps on non-economic damages. States that have put ceilings on non-economic damages have been quite generous when setting limits. While it is true that a $250,000 ceiling will lower some potential multimillion dollar awards, it will not affect the outcome in many smaller cases. [FN80] Moreover, the impact of the few very large awards decreased to a statutory maximum would have a substantial effect on reducing the average payout. [FN81] A cap may even help the average person. The money saved by not having to pay for a share of excessive verdicts would enable people to better insure themselves. [FN82]

***187** Physicians tend to feel that a reasonable cap on non-economic damages will decrease claim severity. [FN83] Such limitations do not affect the safety of medical care. [FN84] Regardless, evidence that the cap is reducing the severity of malpractice awards has not yet been forthcoming or overwhelming, [FN85] but it does exist, and as the caps gain acceptance and momentum, their effects will undoubtedly be more pronounced.

A United States General Accounting study on the tort reform of the 1970's which limited malpractice awards, (caps on award, elimination of plaintiff's ad damnum clauses and periodic payments) found that potential verdicts had been reduced by 42 percent and settlements by 34 percent. [FN86] One study that measured the effects of damage ceilings concluded that states which enacted caps in 1975 had malpractice awards nineteen percent lower in 1977. [FN87] Another study of the period from 1975-84 revealed that the average impact of the various statutes capping all or part of plaintiff's recovery has been to reduce average claim severity by twenty-three percent. [FN88] There is little information evaluating the effect of malpractice caps on insurance

availability and affordability, [FN89] but the data that does exist suggests that "premium rate increases are not as large in states with rigorous medical malpractice statutes." [FN90] With regard to consumer medical expenses, it appears that "as physicians pay higher insurance rates the added cost will be passed on to their patients." [FN91] Yet, malpractice premiums may not be such a significant factor in driving medical cost increases or impeding access to health care. [FN92] Data of the National ***188** Association of Insurance Commissioners indicates that the caps are not likely to affect malpractice premiums greatly. [FN93]

Another potential danger of the statutory caps would arise if the dollar thresholds were not periodically revised to reflect inflation. Inflation could potentially cause the caps to have a greater limiting effect than they were intended to possess. [FN94]

It is not readily apparent that consumers of medical services care about medical malpractice caps. "Whether consumers should care depends largely on whether the reduction in frequency and severity of malpractice claims will lead to an increase in medically unsafe behavior. That, in turn, depends on the extent to which tort liability deters medical negligence." [FN95] Caps on non-economic damages do not infringe upon the deterrent aspects of the malpractice system. Malpractice award caps are not likely to reduce a physician's internal inhibitions against malpractice. The legislature is not changing "the law's statement about what kinds of behavior are bad." [FN96] A physician still has a duty to act with reasonable care and the plaintiff must still prove a breach of that duty. [FN97]

Regardless, stating that caps do not intrude on the deterrence domain of malpractice law [FN98] does not necessarily imply that this domain exists in the first place. In general, medical malpractice law can be perceived as ***189** under-deterring unsafe behavior. [FN99] The fact that an individual doctor's record of performance has little effect on his premium rates contributes to this lack of deterrence. [FN100]

Malpractice costs are relatively small when compared to other health care costs. [FN101] Some feel that the problem only exists is in the eyes of physicians and insurance companies. [FN102] Nevertheless, there is some question as to why, as a policy matter, there should be different rules for medical malpractice cases than for other personal injury cases which have no general damage ceilings. [FN103]

Another argument against a statutory limit is the idea that physicians should "absorb at least some part of the increase rather than going on strike and demanding radical changes in the rights of the injured victims of their ***190** medical negligence." [FN104] Yet, the medical profession does absorb much of the cost. Limits on damage awards only become effective in the extreme and generally unforeseeable cases. Even with a statutory cap on non-economic damages, doctors must still insulate themselves from liability in the vast majority of situations.

Isn't the purpose of insurance to protect against the remote, unforeseeably large injuries that the victim and the victim's family could not provide for? Aren't these statutes concentrating the costs of the worst injuries on a few individuals? [FN105] While these are valid concerns, it is important to realize that economic damages would still be compensated for. [FN106] The defenseless injured victim would still be offered significant compensation for his injuries. While some will argue that general damages are as real to the plaintiff as economic loss, [FN107] the latter measure is the only assessment that can be made with some degree of reliability. [FN108]

One final argument against the statutory non-economic damage cap is that this part of an award provides a means to pay for plaintiff's attorney's fees without diminishing the plaintiff's compensation. [FN109] A response to this challenge is that such costs should be taken into account when determining actual damages, and, consequently, there is no unjustified decrease in plaintiffs' awards.

Capping general damage awards will help reduce the frequency and ***191** severity of malpractice claims and will not adversely affect the safety of medical care. [FN110] Another benefit of the cap is continued availability of adequate medical malpractice insurance providers, which is essential for the protection of the providers and the general public. [FN111] Malpractice insurance protects the patient as well as the

physician. [FN112] Ultimately, it is the patient who suffers to the extent that physicians relocate to areas with lower insurance rates, withdraw from high-risk specialties, and practice defensive medicine. [FN113]
Pain and suffering are real losses, but money can not begin to compensate for them. [FN114] Even if we were to continue our current attempt to fully assess an individual victim's pain and suffering, can we say with any degree of certainty that a jury's finding in one case will have any relation to its finding in another?
Caps on non-economic loss would "contain jury awards within realistic limits, reduce the exposure of insurers (which reductions could be reflected in lowered premiums), lead to more settlements and less litigation, and enable insurance carriers to set more accurate rates because of the greater predictability of the size of judgments." [FN115] Finally, removing the extravagant awards through statutory limitations might effectively bring more order to the presently random system of compensation. [FN116]
***192** Congress has already begun proposing legislative reform in this area. The Federal Incentives for State Health Care Professional Liability Reform Act of 1985 (the "Hatch bill") [FN117] and the Medical Offer and Recovery Act of 1985 (the "Moore/Gephardt bill"), [FN118] focus on the elimination or limitation of non-economic damage awards. [FN119] Yet another reform possibility is to allow consumers to negotiate privately for their own tort reform measure. [FN120]

VII. CONSTITUTIONALITY

Presently several states have non-economic medical malpractice damage caps. [FN121] If these tort reform measures are to find greater acceptance and become truly effective, the debate as to their constitutionality must be resolved. Nevertheless, this area of the law is just beginning to evolve, and there are strong indications that limitations on non-economic damages will gain support. Besides medical malpractice law there are other situations where legislative modification of damages has been permitted by courts. [FN122] Furthermore, the United States Supreme Court ***193** has approved a federal statute limiting tort damages. [FN123] However, this information alone is insufficient to establish a statute's constitutionality.
An initial and perhaps insurmountable obstacle to placing a limit on non-economic damages is the existence of a specific state constitutional provision barring non-economic damage caps. [FN124] Yet, in most states there is no specific state constitutional bar. Judicial interpretations of basic constitutional protections vary substantially. Further, a capping provision that one state court finds unconstitutional may differ significantly from a damage limitation upheld in another state. [FN125] Courts are split on the constitutionality of statutes limiting overall compensation, economic as well as non-economic awards, or establishing other capping schemes. [FN126] However, non-economic caps by themselves have not met with such judicial scrutiny. At present New Hampshire is the only state whose supreme court has specifically invalidated a medical malpractice non-economic damage cap. [FN127]

*194 A. Equal Protection

Courts which strike down malpractice caps generally rely on equal protection analysis. The rationale behind the application of this analysis is that state legislatures, in imposing ceilings on damages, have classified individuals on the basis of the claim asserted and the amount of damages sought. [FN128] Under equal protection analysis, the first question presented for a court is what level of scrutiny to apply. The scrutiny level determines whether the cap will survive a constitutional challenge. [FN129] The United States Supreme Court has applied three tests in addressing equal protection challenges: the minimal scrutiny or rational relationship test, the strict scrutiny test, and the intermediate scrutiny test. [FN130] Strict scrutiny is generally not applicable because no suspect class or fundamental right is affected, and the intermediate test is normally not applied to economic or social welfare legislation. [FN131] Consequently, the rational relationship test is the standard most often used to assess the constitutionality of malpractice caps.

Under this test, constitutionality depends on whether the legislature's rationale has a real and substantial relationship to the objective it seeks to obtain. [FN132] In other words, whether it is rationally related to a legitimate state interest. Courts utilizing this standard have no trouble finding a rational basis for limiting the amount of non-economic damages that can be awarded to a plaintiff. [FN133] The rational relationship test received ***195** significant federal approval when the United States Supreme Court dismissed the appeal of Fein v. Permanente Medical Group [FN134] for lack of a substantial federal question. In Fein, the California Supreme Court held that a cap on non-economic damages was rationally related to the goals of reducing insurance costs and eliminating nonmeritorious claims. The United States Supreme Court's dismissal suggests that non-economic damage caps "sufficiently the same" as California's are valid under the federal constitution. [FN135] Consequently, federal courts should not object to caps on non-economic damages because they will clearly find a rational relation. As a general rule, state courts have adopted the Supreme Court's deferential rational relationship approach when reviewing malpractice caps. [FN136] Still, some courts have utilized the intermediate test to resolve equal protection issues. [FN137] Those courts which have invalidated caps ***196** invariably apply a higher degree of scrutiny than the rational relationship test. [FN138]

B. Quid Pro Quo

A less conventional due process argument advanced against malpractice recovery caps is that in many cases the right to recover medical malpractice damages in tort is a property interest which cannot be deprived unless it provides a quid pro quo in return. The "argument entails the notion that limiting a plaintiff's recovery equates into a societal quid pro quo by lower insurance premiums and medical costs." [FN139] Nevertheless, state courts have rejected this justification because the benefits derived are too remote to compensate malpractice plaintiffs awarded capped recoveries, [FN140] Consequently, this argument has not proven significant in current constitutional doctrine. [FN141] Nevertheless, many scholars advocate this doctrine, maintaining that statutes which limit malpractice awards must provide a "reasonably just substitute" for a malpractice victim's abridged common-law remedies. [FN142] At present however, the requirement of a quid pro quo is not a driving force in constitutional attacks of malpractice caps.

C. Jury Trial

Another argument attacking statutes which limit medical malpractice compensation raises the issue whether such caps violate the plaintiff's constitutional right to a jury trial. [FN143] The first case to invalidate a statute on this basis was Boyd v. Bulala. [FN144] This decision has recently been reversed ***197** by the United States Court of Appeals for the Fourth Circuit with respect to the cap's constitutionality. [FN145] This reversal should significantly weaken the validity of future attacks on this ground. Regardless, the arguments advanced by the lower court are still worthy of consideration because many courts have relied on them in their reasoning.

The reasoning of the lower Boyd court essentially stated that the right to a jury trial encompasses not only the function of the jury to determine questions of liability, but also to determine the extent of the injuries sustained by the amount of damages to be awarded. The inherent problem with this reasoning is that it denies a legislature of its power to limit a common law right of recovery. Unquestionably, a legislature has the power to completely eliminate such recovery if it desires. [FN146] While this interpretation may be inherently flawed, courts are currently battling out the constitutionality of malpractice caps on the basis of jury trial rights. [FN147] As the circuit court's decision in Boyd gains recognition, however, this argument is less likely to be successful.

VIII. CONCLUSION

The 1990's will undoubtedly prove to be a decade of innovation and reform. It is unlikely that medical malpractice insurance rates will ***198** significantly decrease in the next several years. Consistent with this notion, it is also doubtful that health care for the average citizen will become more affordable in the present decade. Nevertheless, legislative power to change our current compensatory scheme is one potential source for solutions. We must also begin to more closely scrutinize the workings of the insurance industry.

In the future, limitations on general damages in medical malpractice cases are more likely to survive constitutional scrutiny in state and federal courts. Non-economic caps, along with other tort reform measures, could effectively stabilize the health care insurance market. Eventually this would reduce the costs of health care in the United States by driving down the necessary costs of malpractice insurance and decreasing the practice of defensive medicine. While there are undoubtedly costs to statutory limitations on non-economic damages, these costs are mitigated in the face of the health care insurance industry's current problems and the potential benefits that these measures could derive.

FN1. Danzon, The Frequency and Severity of Medical Malpractice Claims: New Evidence, 49 LAW AND CONTEMP. PROBS 57 (Spring 1986).

FN2. One study found that, "[o]nly 55 percent of the voters [in Arizona] even regarded medical-malpractice liability as a potential concern, compared with 70 percent in 1985. Moreover, only one voter in ten saw the issue as affecting his own pocketbook." De Berge, Malpractice Reform is Doomed-And Doctors are to Blame, Med. Econ. Jan. 8, 1990, at 21. The following statement is also representative:

There are a few areas of legislation and court decisions which evoke primal emotions in the general public. At the present time the subject of abortion would probably head this list. But regulation of malpractice legislation is not in this category. The general public is not aroused. There are no long processions of irate citizens carrying placards and chanting slogans marching around courthouses and state capitols on this issue. The intense feelings, the anger, and the rage are there but they are in the minds of professionals who believe their livelihoods are at risk.

Kansas Malpractice Victims Coalition v. Bell, 243 Kan. 333, 354, 757 P.2d 251, 265 (1988) (McFarland, J. dissenting).

FN3. One Arizona survey found that 80 percent of the people believed that malpractice insurance costs would make health care unaffordable for some consumers, and 64 percent thought that women throughout the state would soon have trouble finding insured doctors willing to deliver babies. De Berge, supra note 2, at 22.

FN4. Id. at 22-24. Despite rising costs, the vast majority of voters surveyed in Arizona believed that medical insurance would provide for their own families, and that they would be able to obtain the obstetrical care they needed. Id.

FN5. Eighty percent of Arizona voters believed that jury awards were excessive in malpractice cases. Yet only one in ten saw a direct relationship between malpractice awards, premiums paid by physicians, and a patient's doctor bills. Id. at 24. It is this disassociation which is "critical to the issue of runaway awards, because it prevents patients from seeing that they're the ones who ultimately pay for a jury's largesse. As a

result, 70 percent of voters surveyed believe that only doctors and insurance companies -- not the general public -- would benefit from tort reform." Id.

FN6. Farrell, Virginia's Medical Malpractice Cap and the Doctrine of Substantive Due Process, 23 TORT & INS. L.J. 684, 687-88 (1988) (Table 1 lists those states which have enacted limitations, along with their amounts).

FN7. Aitken, Medical Malpractice: The Alleged "Crisis" in Perspective, 637 INS. L.J., 90, 91 (1976).

FN8. See Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368, appeal dismissed 474 U.S. 892 (1985).

FN9. Johnson v. St. Vincent Hosp., 273 Ind. 374, 404 N.E.2d 585 (1980).

FN10. See Baptist Hosp. v. Baber, 672 S.W.2d 296, 298 (Tex. Ct. App. 1984); Carson v. Maurer, 120 N.H. 925, 941-43, 424 A.2d 825, 836-38 (1980); Arneson v. Olson, 270 N.W.2d 125, 135-36 (N.D. 1978); Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 166, 355 N.E.2d 903, 906-07 (1976).

FN11. See generally Robinson, The Medical Malpractice Crisis of the 1970's: A Retrospective, 49 LAW & CONTEMP. PROBS. 5 (Spring 1986) for a detailed look at the malpractice insurance situation in the 1970's.

FN12. See e.g., Department of Health and Human Services, REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE, at 121 (August, 1987) [hereinafter Report on Medical Liability]; Robinson, supra note 11, at 6.

FN13. See e.g., Report on Medical Liability, supra note 12, at 121; Robinson, supra note 11, at 6. One study by Jury Verdict Research, Inc., revealed a 363 percent increase in average jury verdict awards from $220,018 in 1975 to $1,017,716 in 1985. Farrell, supra note 6, at 696-697. This statistic is of limited value however, because the majority of malpractice awards arise from settlements rather than verdicts. Id.

FN14. See e.g., Note, Limitation on Recovery of Damages [sic] Medical Malpractice Cases: A Violation of Equal Protection?, 54 U. Cin. L. Rev. 1329, 1331 (1986) [hereinafter Note, Limitation on Recovery]; Note, Legislative Limitations on Medical Malpractice Damages: The Chances of Survival, 37 MERCER L. REV. 1583 (1986) [hereinafter Note, Legislative Limitations]. Between 1960 and 1970 malpractice premiums rose 540.8 percent for physicians other than surgeons and 949.2 percent for surgeons. Learner, Restricting Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties, 18 HARV. J. ON LEG. 143 fn. 1 (1981), citing Blaut, The Medical Malpractice Crisis--Its Causes and Future, 44 INS. COUNSEL J. 114 n.3 (1977). The economy of the period undoubtedly contributed to the magnitude of the problem. Insurance rates rose not only due to

higher underwriting costs, but also because of investment losses resulting from a nationwide recession. Robinson, supra note 11, at 6.

FN15. See, e.g., Posner, Trends in Medical Malpractice Insurance, 49 LAW AND CONTEMP. PROBS. 37, 38 (Spring 1986); Note, Legislative Limitations supra note 14, at 1583. Insurers that had previously underwritten medical malpractice insurance policies responded to increasing claims and decreasing profits by abandoning the malpractice market. Kansas Malpractice Victims Coalition v. Bell, 243 Kan. 333, 335, 757 P.2d 251, 254 (1988). Malpractice was not a major form of underwriting for most insurance companies. Consequently, withdrawal in
the face of a questionable profit future was relatively easy. Robinson, supra note 11, at 9. In some states this withdrawal was instigated by an insurance commissioner's refusal to allow a large rate hike. Id.

FN16. Note, Limitation on Recovery, supra note 14, at 1331.

FN17. Report on Medical Liability, supra note 12, at 121; Note, Limitation on Recovery, supra note 14, at 1331.

FN18. Note, Limitation on Recovery, supra note 14, at 1331.

FN19. Compared to the average income of the medical profession, these premium rates are not excessive. "The average doctor pays proportionately less of his income for malpractice insurance than does the average citizen for his car insurance." Aitken, supra note 7, at 92. One study which analyzed the distribution of physician premium increases from 1974 to 1976 concluded that the increases were financially manageable for most physicians and that only a small number of specialties in selected states were "bearing a financial burden." Zuckerman, Koller, and Bovbjerg, Information on Malpractice: A Review of Empirical Research on Major Policy Issues, 49 LAW AND CONTEMP. PROBS. 85, 92 (Spring, 1986).

FN20. Law, A Consumer Perspective on Medical Malpractice, 49 LAW AND CONTEMP. PROBS. 305, 308 (Spring 1986).

FN21. The decrease was from 4.40% in 1976 to 3.69% in 1983. Id.

FN22. Robinson, supra note 11, at 11.

FN23. As one commentator stated:

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 hospital bills as the cost 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. 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.

Robinson, supra note 11, at 6-7.

FN24. Compare, for example, statements made by the American Medical Association (AMA) with those of the Association of Trial Lawyers of America (ATLA). The AMA pronounces:

The problem of medical professional liability has already been the subject of much study and analysis and the need for tort reform is well documented. There is proven need for reform of the tort system in general-the AMA seeks no special protection for physicians. Together, the AMA and ABA could design modifications of the existing tort system that would preserve its fundamental process and goals while, at the same time, eliminate the windfalls, waste and unfairness.

Farrell, supra note 6, at 694. ATLA's statement to the contrary is as follows:

There is no medical malpractice crisis today. Medical malpractice companies are profitable, even if they won't admit it. Malpractice insurers are doing better than they would have the public, or the doctors they insure, believe. The proposals of the medical industry are simply special interest legislation.

Id.

FN25. Farrell, supra note 6, 684.

FN26. Note, Legislative Limitations, supra note 14, at 1583.

FN27. Evidence that increased malpractice litigation is attributable to a loss in public confidence in the medical profession is difficult to evaluate and mostly anecdotal. Robinson, supra note 11, at 12-13. Public confidence in the medical profession is still generally high according to public opinion polls. Id. at 13.

FN28. Note, Legislative Limitations supra note 14, at 1583. The increased risk exposure stemming from the growing complexity of modern medicine can be attributed to the use of more dangerous, but generally more beneficial treatment methods. Robinson, supra note 11, at 11.

FN29. Robinson, supra note 11, at 14-15. One study analyzing the frequency and severity of tort claims between 1970 and 1978 concluded that the increase in claims over time could not be attributed to differences in the number of attorneys per capita. Danzon, The Frequency and Severity of Medical Malpractice Claims, 27 J.L. & ECON. 115, 143-144 (1984). However, another study of malpractice insurance premiums paid by doctors from 1974 to 1978 concluded that "the notion that a ten percent increase in a state's lawyer/ population ratio leads to an almost like percentage increase in premiums . . . is a distinct possibility." Sloan, State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment, 9 J. HEALTH POL.,

POL'Y & L. 629, 643 (1985). For a discussion of the difference between the Sloan data and the Danzon data, see Danzon, supra note 1, at 58-59. Danzon repeated her study for the period of 1975-1984, and again concluded that "there is no evidence that a high density of lawyers per capita has any systematic impact on the frequency of claims filed . . . ." Id at 70. Danzon's second study suggests that the high correlation "between number of claims per physician and number of attorneys per capita appears to reflect the tendency of attorneys to migrate to areas where litigation rates are high . . . rather than reflecting an independent effect of attorneys on litigation rates." Id.

FN30. Posner, supra note 15, at 38.

FN31. As one commentator notes:

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 relaxation of the locality rule, standards for informed consent, and the scope of the doctrine of respondent superior. Procedurally, the main alterations have been the elimination of charitable immunity, relaxation of the statute of limitations, . . . and the loosening of proof requirements . . . .
Robinson, supra note 11, at 17.

FN32. The erratic and large damage awards made accurate rate prediction impossible for the insurance companies. Learner, supra note 14, at 144-145. The poor investment practices of the insurance companies also contributed to the "crisis". Id.

FN33. Posner, supra note 15, at 49-51.

FN34. As one commentator observed:

To date, no one knows whether the insurance companies are overcharging. They have repeatedly refused to make their books available, and their premium costs are not subject to regulation by the Department of Insurance. With these facts-or lack of facts-in mind, it seems even more incredible that substantial revisions of our existing compensatory system are being proposed without any plausible scheme for insurance regulation and without a dispassionate development of those facts that triggered the alleged 'crisis'.

Aitken, supra note 7, at 96. There is surprisingly little empirical research on the interaction of the insurance system with medical malpractice. Zuckerman, Koller, & Bovbjerg, supra note 19, at 110-111.

FN35. It is doubtful that such legislation would have gained momentum throughout the country, had it not been for the powerful lobbies of the American Medical Association and the American Hospital Association. As one author noted: "Although premiums for health insurance, both public and private, often rise at rates comparable to rising medical malpractice premiums, the people who bear these costs do not have the political clout of the doctors and hospitals who bear the immediate costs of rising malpractice

premiums." Law, & Polan, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE 147 (1978).

FN36. The most common legislative proposals included capping plaintiffs' recoveries, limiting liability of individual health care providers, reducing the statute of limitations applicable to medical malpractice actions, abrogating the collateral source rule in medical malpractice actions, establishing medical-legal screening panels and establishing either compulsory or voluntary arbitration plans. Redish, Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications, 55 TEX. LAW REVIEW 759, 761 (1977). See also, Comment, Recent Medical Malpractice Legislation -- A First Checkup, 50 TUL. L. REV. 655 (1976); Probert, Nibbling at the Problems of Medical Malpractice, 28 U. FLA L. REV. 56 (1975); Comment, An Analysis of State Legislative Responses to the Medical Malpractice Crisis, 1975 DUKE L.J. 1417 (1975).

FN37. Note, Legislative Limitations, supra note 14, at 1584.

FN38. Id.

FN39. Id. There is some question as to whether the rights of the individual patient really was a concern. As one observer noted:

If you look at the medical malpractice reform litigation-legislation, rather-of the middle 1970's, a very substantial portion of it was doctors' legislation. It was designed to protect the health care system from the onslaught of malpractice litigation . . . patients' rights have to be respected, too, in any proposed change."

Defensive Medicine and Medical Malpractice, S. Hrg. 98-1039, Hearing Before the Committee on Labor and Human Resources, 98th Cong. 2nd Sess. 26 (1984) [hereinafter Hearing] (Statement of Arnold J. Rosoff, Associate Professor, Wharton School, University of Pennsylvania).

FN40. Posner, supra note 15, at 39. These professionally sponsored companies were founded on the notion that the physicians and hospitals could manage their insurance needs better than lay companies. These professionally sponsored companies now account for over one-half of the two billion dollar
annual malpractice premium volume. Id.

FN41. Robinson, supra note 11, at 19. "Departing companies only marginally committed to the area of malpractice were replaced with newly formed mutual insurance companies owned and operated by medical groups." Id.

FN42. Defensive medicine refers to "physicians' behavior in response to a perceived threat of future malpractice litigation, including such activities as performing extra procedures, ordering additional diagnostic tests, or even refusing to treat certain high risk patients." Hearing, supra note 39 at 4. (statement of Sen. Orrin G. Hatch).

The American Medical Association (AMA) Committee on Professional Liability recently estimated that the total cost of defensive medicine was $15.1 billion in 1983 alone, a

very large proportion fo [sic] total medical treatment costs. Also, the AMA surveyed a sample of 1240 of its members in 1983 to determine how physicians have changed their usual patterns of practice in response to rises in professional liability premiums. Of the 1240 doctors surveyed, 40.8 percent reported prescribing additional diagnostic tests, 27.2 percent provided additional treatment procedures, 35.9 percent spent more time with patients, 56.7 percent kept more detailed patient records, 44 percent refer more cases to other doctors, 34.6 percent
no longer accept certain types of cases, and finally, 31.4 percent reported increasing their fees for services to recover their increased cost of professional liability insurance.

Id. at 5. Nevertheless, there is some indication that overuse of procedures in some cases may actually benefit patients, is not expensive, and probably does not contribute to the rising costs of medical care. Bell, Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts about the Deterrent Effect of Tort Liability, 35 SYRACUSE L. REV. 939, 972 (1984).

FN43. MEDICAL MALPRACTICE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, 39 (January 16, 1973). Physicians are now raising charges for services, and may stop providing those medical services that have high litigation rates. WINDOM, A HEALTHY NATION, MALPRACTICE REFORM: THE DEVELOPING CONSENSUS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (November 1987). Yet at least one author predicts that for the next two to three years the malpractice climate will remain fairly stable, with no dramatic increases in the number of claims. This commentator, however, does not see the present system as financially acceptable, claiming that, "the severity of awards will remain a problem unless tort reform is enacted in certain states." STUART, MALPRACTICE IN THE 1990'S: A FORECAST, PHYSICIAN'S MANAGEMENT, 67 (January 1990). One court viewed the concern over physicians' inability to obtain
coverage as the primary reason for the legislature's statutory intervention:

After careful and deliberate study, the General Assembly determined that health care providers faced increasing difficulty in obtaining affordable malpractice insurance in excess of $750,000 and that this situation would tend to reduce the number of health care providers available to serve Virginia's citizens.

Etheridge v. Medical Center Hospitals, 237 Va. 87, 102, 376 S.E. 525, 533 (1989). See infra note 50.

FN44. Bell, supra note 43, at 939. Before 1981 there were 3.2 malpractice claims for every 100 physicians. By 1985, that figure had grown to 10.1 claims per 100 physicians. WINDOM, supra note 44. The St. Paul Fire and Marine Insurance Company, which has been the leading writer of malpractice insurance for many years, reports a fifty-five percent increase in claim frequency since 1980, from 10.5 claims per 100 physicians in 1980 to 16.3 in 1984. Claim severity increased faster than the rate of inflation throughout the 1970's, and this trend appears to have continued into the 1980's. St. Paul reports that paid claim severity increased ninety-five percent during the five year period from 1979 to 1983, from $27,408 in 1979 to $53,482 in 1983. The average malpractice jury award is reported to have risen from $404,726 in 1980 to $954,858 in 1984. Danzon, supra note 1, at 57-58.

FN45. Total compensation paid by insurers for medical malpractice claims has increased at an average annual rate of 25 percent from 1979 to 1985. WINDOM, supra note 44. Moreover, the average compensation paid per malpractice claim increased

approximately 54 percent between 1982 and 1985. By contrast, the Consumer Price Index increased just eleven percent during that same period. Id.

FN46. Robinson, supra note 11, at 31.

FN47. See supra note 40 and accompanying text.

FN48. In the mid-1980's these companies were encountering many of the same pressures as traditional multiline carriers; many instances of severe losses, the need to add to loss reserves, and poor financial results requiring the infusions of new capital and large rate increases. Posner, supra note 15, at 40. The current crisis may be more of a dilemma; insurance industry's natural behavior contributes to the continuing cycles of "crisis" and "remission". Id. at 48.

FN49. See supra note 6 and accompanying text. One court's statement of the legislature's reasoning for enacting a malpractice reform statute in the 1980's is representative:

[T]he Legislature was acting in a situation in which it had found that the rising cost of medical malpractice insurance was posing serious problems for the health care system in California, threatening to curtail the availability of medical care in some parts of the state and creating the very real possibility that many doctors would practice without insurance, leaving patients who might be injured by such doctors with the prospect of uncollectible judgments.

Fein v. Permanente Medical Group, 38 Cal.3d 137, 158, 695 P.2d. 665, 680 211 Cal. Rptr. 368, 383 appeal dismissed 474 U.S. 892 (1985). The California legislature chose to cap non-economic damages because it was

[f]aced with the prospect that, in the absence of some cost reduction, medical malpractice plaintiffs might as a realistic matter have difficulty collecting judgments for any of their damages-pecuniary as well as nonpecuniary - the Legislature concluded that it was in the public interest to attempt to obtain some cost savings by limiting non-economic damages.

Id. 38 Cal.3d at 160, 695 P.2d. 681, 211 Cal. Rptr. at 384, 368.

FN50. Posner, supra note 15, at 52. "The malpractice market has shifted from an extreme 'buyer's market' to a 'seller's market' in which a few insurance companies are swamped with business and can be extremely selective about what coverage they will offer, to whom, and at what price." Id.

FN51. One commentator compared the situation with the federal no-fault vaccine law, where the federal government capped all awards for pain and suffering arising from the use of the DPT vaccine at $30,000. Dr. Barry Manuel, president-elect of the Massachusetts Medical Society advocates a no-fault system saying that it would pay for all costs of a medical maloccurrence. Dr. Manuel states: "Unfortunately, we'll have to be hurting a little bit more before the government enacts that type of legislation. But when the government's back is forced to the wall, it will resort to exactly this type of

legislation . . . ." STUART, supra note 49, at 76-79. Dr. Manuel advances the following example in favor of a no-fault system:

[I]f a patient undergoes coronary artery bypass surgery, there is a 1/10 of 1% chance he will have a cerebrovascular accident. It may not mean the physician involved was negligent, because in the best of series it does happen. Why, if that patient is disabled, should he or she have to prove that the doctor did something wrong? Society has clearly indicated it would like to be compensated for every maloccurrence. Consequently, plaintiffs should not have to prove fault. But consumers will pay for it. The costs must be on the backs of those who will receive the benefits as in every other form of insurance.

Id. at 79. See also O'Connell, Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives, 49 LAW AND CONTEMP. PROBS. 125 (Spring 1986) for a discussion of the advantages and disadvantages of a no-fault system.

FN52. One observer notes that recently the number of claims is down and insurance rates have levelled off and even slightly declined in some states. Stuart, supra note 49, at 67. One should also consider the notion that we are not in the midst of another malpractice "crisis" just because medical costs are increasing. Studies have shown that the public perceives increasing medical costs to be the result of physician greed rather than skyrocketing malpractice premiums. De Berge, supra note 2, at 21.

FN53. Non-economic damages are awarded to compensate for pain, suffering, inconvenience, and physical impairment. Note, Legislative Limitations supra note 14, at 1585.

FN54. The constitutionality of such caps is discussed infra. See supra notes 121-145 and accompanying text.

FN55. See infra notes 121-145 and accompanying text.

FN56. Fein v. Permanente Medical Group, 38 Cal 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368, appeal dismissed 106 S.Ct 214 (1985).

FN57. Hoffman v. United States, 767 F2d 1431 (9th Cir. 1985)(interpreting California law).

FN58. Robinson, supra note 11, at 32.

FN59. The Commission stated that "it is unconscionable to preclude a plaintiff, by an arbitrary ceiling on recovery, from recovering all his economic damages, even though some lowering of medical malpractice premiums may result from the enactment of such a ceiling." Note, Legislative Limitations supra note 14, at 1586-1587 cited in REPORT OF THE COMMISSION ON MEDICAL PROFESSIONAL LIABILITY, 102 Rep. A.B.A. 786, 849 (1977).

FN60. "The probability of a serious mistake that leads to damages over one million dollars is about one in 100,000 hospital patients, and even lower in the doctor's office." Posner, supra note 15, at 53. It is important to note that this statistic accounts for both economic harm (lost wages, future income
lost, child support, etc.), which would still be fully compensable, and non-economic damages.

FN61. Wagner & Reiter, Damage Caps in Medical Malpractice: Standards of Constitutional Review, 187 DET. C.L. REV. 1005, 1006 (1987).

FN62. Harlan, Jr., Virginia's New Medical Malpractice Review Panel and Some Questions it Raises, 11 U. RICH. L. REV. 51, 66 (1976).

FN63. Id.

FN64. The model can be illustrated as follows:

The practitioner faces the prospect of a financial sanction if he negligently causes injury to a patient. That sanction, in the form of a damage award, is the monetary equivalent of the injury caused. The doctor will, as a result, act to avoid causing patient injuries so long as the expected costs of those actions are less than the expected costs of the patient injuries that will occur if he doesn't take those actions. If the expected safety costs are greater than the cost of the injuries they are expected to avoid, the doctor will not be given a tort incentive to take the safety measures. Accordingly, the effect of the tort sanction will be to
cause the doctor to behave efficiently. There will be no incentive to spend more on safety than is saved in expected injury costs, because in such a case the doctor would be spending more to prevent liability than he expects to pay for that liability.

Bell, supra note 43, at 950-51.

FN65. Most people injured by another's negligence fail to make a damage claim. A 1972 study conducted for the Department of Health, Education and Welfare projected that, "only six percent of patients injured by medical negligence in two typical hospitals would bring claims for their injuries." Id. Furthermore, while a higher percentage of negligently injured patients may make a damage claim, studies project a claim rate for malpractice victims no higher than one in four. Id. at 951-52.

FN66. Id. at 949.

FN67. Id.

FN68. Id. at 952. The potential plaintiff may need to have upwards of $30,000 in injuries before a lawyer will take his or her case on a contingency fee basis. Id. Other malpractice victims have no incentive to sue; persons
on welfare, who are more likely than most people to be subjected to malpractice, are required as a condition of receiving public assistance to sign over to the welfare

department any damages awarded in a personal injury action. Id. Moreover, given the difficulty of obtaining expert medical testimony and the fact that many patients do not even know when they have sustained a compensable injury, fewer lawsuits are being filed than would be justified. Aitken, supra note 7, at 93.

FN69. Bell, supra note 65, at 952.

FN70. Id.

FN71. Id. at 952-53.

FN72. Id. at 953.

FN73. Learner, supra note 14, at 147.

FN74. Law, and Polan supra note 35, at 144.

FN75. Aitken, supra note 7, at 95. As one judge observed: "Spread out over the expected lifetime of a young person, $250,000 shrinks to insignificance." Fein v. Permanente Medical Group, 38 Cal.3d 137, 171, 695 P.2d 665, 689, 211 Cal. Rptr. 368, 392, appeal dismissed 474 U.S. 892 (1985) (Bird, C.J. dissenting). Yet, this same amount given to a relatively older person may be adequate compensation.

FN76. As one writer observed: "Never before in American legal history has a legislature abolished the right of the most seriously injured to receive full compensation for personal injuries caused by the unreasonable action of another, without providing any substitute remedy." Law & Polan, supra note 35, at 140.

FN77. Id. at 139.

FN78. Id. at 139-140.

The crisis will not be solved by forcing the most seriously injured into dependency on friends, families, or welfare. Although we all ultimately pay for soaring malpractice premiums through rising health-care costs, it seems grossly unjust to impose a disproportionate share of these costs on people who are unfortunate enough to be seriously injured as a result of negligent medical treatment.
Id.

FN79. Professor Law advances the view that most malpractice reforms do not help consumers. "[R]eform is typically designed simply to reduce premiums. Reform efforts that see reduced malpractice premiums as the 'bottom line' will almost inevitably injure patients." Law, supra note 20, at 315.

FN80. Robinson, supra note 11, at 30.

FN81. Danzon, supra note 1, at 77. "Large awards account for a disproportionate fraction of total dollars . . . . [Currently] over fifty percent of dollars are paid on five percent of cases." Id.

FN82.

A cap on non-economic damages obviously reduces the chances that malpractice victims will receive full compensation. Those reduced chances of full compensation for injuries probably will not, and perhaps should not, concern the ordinary consumer of medical services. A reduction in the frequency or severity of malpractice claims can be expected to lead to a reduction in malpractice insurance cost increases, or costs period. That, in turn, should lead to a reduction in medical care prices or to lesser price increases . . . With his savings in lower medical fees, the medical consumer could probably buy first-party insurance which would provide monetary compensation if he were injured in a manner or to an extent that would have resulted in greater compensatory damages being awarded to him under the old rules than under the reform legislation. Since first-party insurance generally pays out a higher percentage of the premium dollar in benefits than does malpractice liability insurance, the medical consumer probably could afford to buy enough "compensation insurance" with his savings in lower medical fees to more than make up for any reduction in compensation that would occur under the new legal regime.

Bell, supra note 43, at 941-42 n. 13.

FN83. Stuart, supra note 49, at 69.

FN84. Bell, supra note 43, at 990-91.

FN85. Farrell, supra note 6, at 684.

FN86. Id. at 695. "[I]n the eight states which have enacted such ceilings, there were only 36 cases in which more than $50,000 was paid to an injured patient in 1975-76." Law & Polan, supra note 35, at 144. See also Report on Medical Liability supra note 12, at 122.

FN87. Bell, supra note 43, at 946. "These reductions probably occurred not because the ceilings on damages reduced the number of malpractice claims, but because they reduced . . . overall amounts paid out in those malpractice actions . . . brought." Id.

FN88. Danzon, supra note 1, at 76. This percentage represents the average impact of the various forms of caps, during the period between 1975 and 1984, when some statutes were still under challenge. Id. at 71.

FN89. Kansas Malpractice Victims v. Bell, 243 Kan. 333, 355, 757 P.2d 251, 265 (1988).

FN90. Report on Medical Liability, supra note 12, at 122.

FN91. Learner, supra note 14, at 144. Most evidence indicates that physicians do pass on the costs of malpractice insurance increases to their patients. Bell, supra note 43, at 958-60.

FN92. Law, supra note 20, at 309.

FN93. Law & Polan, supra note 35, at 144. "According to an American Bar Association study of recently enacted laws, the only change in tort law which is likely to have a measurable impact on premium costs is the repeal of the collateral-source rule." Id. at 148. Perhaps most significant and worthy of further investigation is the testimony of the National Insurance Consumer Organization, that after studying some of the states that have enacted limits on non-economic damages, insurers did not reduce rates, but increased them. Farrell, supra note 6, at 697.

FN94. Danzon, supra note 1, at 78. Juries however, may be able to "find ways of implicitly circumventing the limits by increasing allowances for uncapped components of the award." Id.

FN95. Bell, supra note 43, at 941-42.

FN96. Id. at 991. "The social stigma, loss of prestige, embarrassment, time, anxiety and the like which physicians now expect to result from a malpractice action and subsequent liability judgment should not be perceived differently." Id. at 992.

FN97. Law & Polan, supra note 35, at 140. One court stated:

While H.B. 2661 made sweeping changes in the amount injured patients could recover, it did not change the underlying obligation of a health care provider toward his patients. Every health care provider has a duty to use reasonable and ordinary care and to exercise that reasonable degree of learning, skill, and experience which is ordinarily possessed by other health care providers in the same location.

Kansas Malpractice Victims Coalition v. Bell, 243 Kan. 333, 339, 757 P.2d 251, 256 (1988).

FN98. One commentator takes the extreme view that any limitation on the patient's right to recover full damages may remove an important deterrent to negligent conduct. Aitken, supra note 7, at 95.

FN99. Bell, supra note 43, at 953. "Acting as risk-neutral wealth maximizers, doctors facing a reduced expected liability cost of their negligent behavior may choose to continue that behavior and pay the liability judgment, rather than change to safer

behavior that would have avoided the accident at a cost lower than the actual injury costs." Id.

FN100. Id. at 962. A doctor's liability insurance premium rates are independent of the expected costs of his behavior. Such rates generally depend on specialty and location. Id. at 955.

FN101. As of 1984, malpractice costs were in the range of two to four billion dollars a year, whereas total costs of hospital and physician care exceeded 300 billion dollars per year. Posner, supra note 15, at 49. Based on estimates of the number of injuries occurring in California hospitals, one researcher estimated that the costs of injuries due to medical negligence are at least ten times the costs of malpractice insurance premiums, which are currently approximately 24 billion dollars. Hearing, supra note 39, at 12 (Statement of Patricia Danzon, Ph.D., professor at the center for Health Policy at Duke University). A 1974 study by the California Hospital Association and California Medical Association showed that roughly 1 in 126 hospital admissions results in an injury due to medical negligence. One can estimate that at most one in ten of these injured patients filed a claim, and at most one in twenty-five received compensation through the tort system. Id. at 11.

FN102. One critic launched the following attack: "A crisis seen through the eyes of doctors and measured in premium dollars naturally generates responses evaluated in terms of effect on premiums. The needs of patients and consumers never even enter the debate." Law, supra note 20, at 305.

FN103. See e.g. Law & Polan, supra note 35, at 148. One author assessed the following reason for not capping malpractice awards: "Our system of justice expects nothing more from the members of the medical profession than it does from any other professional or skilled group." Aitken, supra note 7, at 96. A possible explanation for our willingness to preferentially treat the medical profession is the political prowess of the profession:

In medical malpractice, one very powerful class of people creates and imposes risks on another, relatively powerless class. In many other types of personal-injury cases, risks are created and borne by all those participating in the activity on a relatively equal basis, as, for example, the risks involved in use of the highways. As a practical matter, severely injured patients are not an identifiable or organized interest group that can assert its claims in the legislature.

Law & Polan, supra note 35, at 145.

FN104. Aitken, supra note 7, at 93. Doctors take home more income than any other class of workers in this society, an average of $106,300 in 1983. Law, supra note 20, at 309.

FN105. One dissenting judge commented: "Insurance is a device for spreading risks and costs among large numbers of people so that no one person is crushed by misfortune. In a strange reversal of this principle, the statute concentrates the costs of the worst injuries on a few individuals." Fein v. Permanente Medical Group, 38 Cal.3d

137, 173, 695 P.2d. 665, 690, 211 Cal. Rptr. 368, 393-94 appeal dismissed, 474 U.S. 892 (1985) (Bird,C. J. dissenting).

FN106. See infra note 145 and accompanying text.

FN107. It is true that the burden on victims is no less real, simply because the uncompensated injury is non-economic. Fein v. Permanente Medical Group, 38 Cal.3d 137, 173, 695 P.2d. 665, 689, 211 Cal. Rptr. 368, 392 appeal dismissed 474 U.S. 892 (1985) (Bird, C.J. dissenting). "For a child who has been paralyzed from the neck down, the only compensation for a lifetime without play comes from non-economic damages. Similarly, a person who has been hideously disfigured receives only non-economic damages to ameliorate the resulting humiliation and embarrassment." Id. at 173, 695 P.2d at 689, 211 Cal. Rptr. at 392. An Ohio court made an equally compelling argument: "[T]he legislative scheme of shifting responsibility for loss from one of the most affluent segments of society to those who are most unable to sustain that burden, i.e., horribly injured or maimed individuals, is not only
inconceivable, but shocking to this Court's conscience." Duren v. Suburban Community Hosp., 42 Ohio Misc. 2d 25, 482 N.E.2d 1358, 1362-63 (1985).

FN108. See infra notes 114-116 and accompanying text.

FN109. Fein v. Permanente Medical Group, 38 Cal.3d 137, 160, n. 17, 695 P.2d. 665, 681, 211 Cal. Rptr. 368, 385, appeal dismissed 474 U.S. 892 (1985) (Bird, C.J. dissenting).

FN110. See e.g. supra note 43 at 990-91.

FN111. Report on Medical Malpractice, supra note 12, at 38.

FN112. See e.g. De Berge, supra note 2, at 24. (Malpractice insurance protects patient even more than physician).

FN113. Windom, supra note 45; Learner, supra note 14, at 144. Surveys indicate that 50 to 70% of doctors say they practice defensive medicine. Bell, supra note 43, at 971. See also supra notes 42-44 and accompanying text.

FN114. One suggestion has been to restructure damage awards so they more closely parallel insurance that we buy voluntarily. Hearing supra note 39, at 12. A more desirable system might come out of such a restructuring:

After all, in its compensation function, the tort system is simply a form of compulsory insurance, which we are all required to buy when we buy health care. When faced with the choice--and the bill--most of us do not buy insurance against pain and suffering. The tort system should provide compensation for loss of earning capacity (after tax) and for reasonable medical expenses, rehabilitation and other monetary costs. Pain, suffering and other nonmonetary losses are very real losses, but money cannot replace them.

That is precisely why most of us do not choose to insure against them, and the tort system should not force us to.

Id.

FN115. Fein v. Permanente Medical Group, 38 Cal.3d 137, 160 n. 17, 695 P.2d 665, 689, 211 Cal. Rptr. 368, 385, appeal dismissed 474 U.S. 892 (1985) (Bird, C.J. dissenting).

FN116. As noted:

Many injured patients go uncompensated even when their injuries were actually caused by negligence; a few patients are compensated extravagantly. Review of the numerous reasons why some potential lawsuits are brought while
many others are not leaves the impression that the system is not serving any clear function well. Instead, like lightning, it seems to strike almost at random.

Hearing, supra note 39, at 22.

FN117. S. 1804, 99th Cong., 1st Sess., 131 CONG. REC. S14, 356-59 (daily ed. Oct. 29, 1985).

FN118. H.R. 3084, 99th Cong., 1st Sess., 131 CONG. REC. H.6353 (daily ed. July 25, 1985).

FN119. The Hatch bill was introduced on behalf of the AMA and contains provisions for limitation on non-economic loss up to $250,000. Robinson, supra note 11, at 32-33. The Moore/Gephardt bill would eliminate non-economic damages. Id. See also Moore and Hoff, H.R. 3084: A More Rational Compensation System for Medical Malpractice, 49 LAW AND CONTEMP. PROBS. 117 (Spring 1986).

FN120. "Private parties could be expected to bargain for more flexible ceilings that are better related to the type of damage, the age, and other circumstances of the injured person. There could also be provision for certain payment
without regard to fault. Reasonable and flexible limitations freely bargained for by the parties should be enforceable." Ginsburg, Kahn, Thornhill, and Gambardella, Contractual Revisions to Medical Malpractice Liability, 49 LAW AND CONTEMP. PROBS. 253, 262-263 (Spring 1986). See also Havighurst, Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles, 49 LAW AND CONTEMP. PROBS. 143, 156-70 (Spring 1986) (advocating private ability to contract). But see Robinson, Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers, 49 LAW AND CONTEMP. PROBS. 173, 183-197 (Spring 1986) (examining the case against contract).

FN121. See e.g. Cal. Civil Code § 3333.2 (West Supp. 1990); N.H. Rev. Stat. Ann. § 507-C:7 (1983 & Supp. 1989); Ohio Rev. Code Ann. § 2307.43 (Anderson 1981 & Supp. 1989); S.D. Codified Laws Ann. § 21-3-11 (1987 & Supp. 1990).

FN122. The list includes: automobile no-fault legislation, worker's compensation, treble damages, government tort immunity, and dramshop laws limiting vendor liability. Wagner & Reiter, Damage Caps in Medical Malpractice: Standards of Constitutional Review, DET. C.L. REV. 1005, 1016-17 (1987).

FN123. Duke Power Co. v. Carolina Environmental Study Group, 438 U.S. 59 (1978). Duke Power involved a federal statute which placed a cap on tort damage recovery. The Supreme Court refused to strike the statute down. The Court stated in dicta: "'[a] person has no property, no vested interest, in any rule of the common law.' 'The Constitution does not forbid the creation of new rights, or the abolition of old ones recognized by the common law, to attain a permissible legislative object,' despite the fact that 'otherwise settled expectations' may be upset thereby. Indeed, statutes limiting liability are relatively commonplace and have consistently been enforced by the courts." Id. at 88 n.32.

FN124. In Wright v. Central Du Page Hospital Association, 63 Ill.2d 313, 347 N.E.2d 736 (1976), the Illinois Supreme Court invalidated a $500,000 malpractice damage cap because it violated a state constitutional provision against "special legislation". See also Ariz. Const. art. 18, § 6; Ky. Const. § 54; Okla. Const. art. XXIII, § 7.

FN125. Note, Medical Malpractice Damage Caps: Navigating the Safe Harbors, 65 WASH. U.L.Q. 565, 566 (1987).

FN126. For example, the following courts have found damage limitations unconstitutional: Kansas Malpractice Victims v. Bell, 243 Kan. 333, 757 P.2d 251 (1988); Waggoner v. Gibson, 647 F.Supp. 1102 (N.D. Tex. 1986); Baptist Hospital of Southeast Texas v. Baber, 672 S.W.2d 296 (Tex. App. 1984); Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980). By contrast, the following courts have found such limitations constitutional: La Mark v. N.M.E. Hospitals, Inc., 542 So.2d 753 (La. App. 4 Cir. 1989); Davis v. Omitowoju, 883 F.2d 1155 (3rd Cir. 1989); Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, appeal dismissed 474 US 892 (1985); Johnson v. St. Vincent Hospital, Inc., 273 Ind. 374, 404 N.E. 2d 585 (1980); Prendergast v. Nelson, 199 Neb. 97, 256 N.W. 2d 657 (1977). It is significant to note that while a federal court may invalidate decisions upholding malpractice caps, decisions finding caps unconstitutional are usually final. Note, Medical Malpractice Damage Caps: Navigating the Safe Harbors, 65 WASH. U.L.Q. 565, 567 (1987).

FN127. Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980). The court objected to the cap because it considered pain and suffering "a very material element of damages in tort cases." Id. at 942, 424 A.2d at 837.

FN128. Wagner & Reiter, supra note 122, at 1007.

Most often, parties challenge medical malpractice caps by asserting that the caps favor a particular class in at least one of the following ways: (1) medical malpractice victims with moderate damages enjoy full recovery, while medical malpractice victims with damages above the cap do not; (2) plaintiffs in medical malpractice actions are entitled only to limited recovery, while plaintiffs in all other tort actions may receive full compensation . . .; or (3) defendants in malpractice actions

enjoy limited liability, while defendants in all other tort actions do not receive such protection.

Note, supra note 126, at 570-71.

FN129. A court could apply some form of heightened scrutiny and look to the record and interest involved. In this case the damage cap will usually be found unconstitutional. Alternatively, a court could use a lower level of scrutiny, and defer to the legislature. In this situation damage caps generally will be upheld. See Note, Legislative Limitations, supra note 14, at 1602.

FN130. Wagner & Reiter, supra note 122 at 1007.

FN131. Richards, Statutes Limiting Medical Malpractice Damages, 32 FED'N. INS. COUNS. Q. 247, 252 (1982).

FN132. Note, supra note 126, at 567.

FN133. As one commentator noted:

When the rational relation test is applied, a court is certain to sustain the challenged statute. In light of rising health costs and the perceived litigiousness of American society, courts have no difficulty finding a rational or conceivable relation between the perceived crisis situation and a legislature's attempt to rectify a problem that is both complex and somewhat overwhelming.

Note, Legislative Limitations, supra note 14 at 1602. The following circuit court decisions all survived due process and equal protection attacks: Davis v. Omitowoju, 883 F.2d 1155 (3rd Cir. 1989); Lucas v. United States, 807 F.2d 414 (5th Cir. 1986); Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985). For examples of the language courts use note the following: ("Legislature may expand or limit recoverable damages so long as its action is rationally related to a legitimate state interest.") Fein v. Permanente Medical Group, 38 Cal.3d 137, 695 P.2d 665, 680, 211 Cal. Rptr. 368 appeal dismissed, 474 U.S. 892, (1985) ("A limitation on a common law measure of recovery does not violate a fundamental right or create a suspect classification.") Boyd v. Bulala, 877 F.2d 1191 (4th Cir. 1989).

FN134. 38 Cal.3d 137, 695 P.2d 665, 211 Cal. Rptr. 368, appeal dismissed, 474 U.S. 892 (1985).

FN135. Note, supra note 122, at 574. "The Supreme Court considers such a dismissal to be an adjudication on the merits, although its precedential effect only applies to subsequent issues that are 'sufficiently the same'. Id. at 574 n.72, citing Hicks v. Miranda, 422 U.S. 332 (1975). The power of the Fein dismissal is perhaps most aptly reflected in the following: "At the very least, the dismissal signifies that in Fein the Supreme Court did not find a constitutional violation worthy of plenary consideration . . . After Fein, a lower federal court will find it difficult, though perhaps not impossible, to

distinguish Fein sufficiently to allow the application of a higher level of scrutiny." Note, Limitation on Recovery, supra note 14, at 1347.

FN136. Note, supra note 122, at 567.

FN137. Note, Legislative Limitations supra note 14, at 1594. See also Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) which involved a challenge to a state limitation on recovery of non-economic damages to $250,000. The Supreme Court of New Hampshire applied intermediate scrutiny, noting that the court could apply a more rigorous standard of review than that applied by the United
States Supreme Court. The court's test to determine whether the restriction on the plaintiff's individual rights was justified asked whether the statute was reasonable and not arbitrary, whether it had a fair and substantial relationship to the objective of the legislation, and whether, based on the facts surrounding the statute's enactment it could reasonably be conceived that the legislation's purpose was to benefit society. Id. at 932, 424 A.2d at 831.

FN138. Note, supra note 122, at 569.

FN139. Farell, supra note 6, at 692.

FN140. Id.

FN141. [T]he majority of the courts generally have acknowledged the argument, expressed reservations about the vitality of the theory, noted that the law in question does provide a quid pro quo, and decided the case on other grounds." Richards, supra note 131, at 259. See also White & McKenna, Constitutionality of Recent Malpractice Legislation, 13 FORUM 312, 329 (1977) ("where due process is in question, the quid pro quo element is rightfully criticized as being the illegitimate offspring of dictum, in view of the economic and social welfare character of malpractice legislation.").

FN142. See Learner, supra note 14, at 143. Note, Legislative Limitations supra note 14, at 1583. ("Requirement of a quid pro quo is an additional tool available to assist courts. Even when the granting of a quid pro quo is not required, the lack of such a compensatory provision can be detrimental to a statute if it is subjected to constitutional analysis.").

FN143. This right is provided for in the Seventh Amendment to the United States Constitution which states "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law." U.S. Const. Amend. VII.

FN144. 647 F. Supp. 781 (W.D. Va. 1986). The case involved Virginia's constitutional right to a jury trial which was the same as the United States Constitution's Seventh Amendment right to a jury trial.

FN145. Boyd v. Bulala, 877 F.2d 1191 (4th Cir. 1989).

FN146. One commentator noted the fundamental flaw of the Boyd court's rationale:

Through strict adherence to the Boyd holding, a legislature may abolish the common law right of action for medical malpractice, yet it cannot take the less drastic course of limiting damages. Similarly, a legislature could eliminate categories of damages, which would affect a plaintiff's recovery virtually the same as an absolute damage cap. Merely by modifying its statutory mechanism, therefore, a legislature could circumvent the jury trial problems cited in Boyd and still severely curtail a plaintiff's recovery in medical malpractice actions.

Note, supra note 122, at 580.

FN147. See, Kansas Malpractice Victims v. Bell, 243 Kan. 333, 343, 757 P.2d 251, 258 (1988). ("The determination of damages is an issue of fact. Therefore, it is the jury's responsibility to determine damages . . . . When the trial judge enters judgment for less than the jury verdict . . . he clearly invades the province of the jury. This is an infringement on the jury's determination of the facts, and, thus, is an infringement on the right to a jury trial.") Id. at 343, 757 P.2d at 258; Etheridge v. Medical Center Hospitals, 237 Va. 87, 96, 376 S.E.2d 525, 529 (1989). ("Without question, the jury's fact-finding function extends to the assessment of damages. Once the jury has ascertained the facts and assessed the damages, however, the constitutional mandate is satisfied. Thereafter, it is the duty of the court to apply the law to the facts.") Id. at 96, 757 P.2d at 529; Franklin v. Mazda Motor Corp. 704 F. Supp. 1325, 1331 (D. Md. 1989) (legislatures have always shaped the issues that are given to the jury by shaping the law. Capping the damages is simply just another means of shaping the law).

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