WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

(Form Updated: 11/20/2008)

COMMITTEE NOTICES ...

➢ *Committee Reports* ... *CR*
**

➢ *Executive Sessions* ... *ES*
**

➢ *Public Hearings* ... *PH*
**

➢ *Record of Comm. Proceedings* ... *RCP*
**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

➢ *Appointments* ... *Appt*
**

Name:

➢ *Clearinghouse Rules* ... *CRule*
**

➢ *Hearing Records* ... *HR* *(bills and resolutions)*
**

➢ *Miscellaneous* ... *Misc*

05hr_AC-In_Misc_pt09a

(1992 documents)

65 Temp. L. Rev. 459

Temple Law Review
Summer, 1992

*459 THE MEDICAL MALPRACTICE "CRISIS": A CRITICAL EXAMINATION OF A PUBLIC DEBATE

W. John Thomas [FNa]

*460 INTRODUCTION

Medical malpractice is perhaps the most controversial tort in the American legal system. Increases in the frequency and severity (or size) of claims in the 1960s and 1970s caused cries of outrage in the medical profession and general public alike. [FN1] The controversy has spawned debate before medical and legal professional *461 organizations [FN2] as well as state [FN3] and federal [FN4] legislatures, and has prompted the Bush Administration to propose tort-reform legislation. [FN5]

The debate probably began on this side of the Atlantic in the late 1700s in response to the first reported medical malpractice case in the United States. [FN6] By the late 1800s a leading physician, lawyer, and professor described malpractice suits as " f requent, important, and troublesome." [FN7] The frequency of malpractice claims rose at an alarming rate from 1833 to 1856, and nearly all practicing surgeons were sued. [FN8] Moreover, "the best surgeons were the most frequently sued." [FN9] The resulting insecurity in the profession led many qualified surgeons to leave the practice of surgery. [FN10] In 1875, Dr. Frank Hamilton [FN11] told the *462 Medico-Legal Society of New York that malpractice suits had become a threat to the quality of the profession:

[C]ivil suits for damages are of a frequency alarming both to the profession of medicine and to the public. Suits of this class, in some parts of the country, seem to be on the increase. So common is it for the surgical treatment of the oldest and best physicians and surgeons in general practice to be called in question and overhauled in courts of justice, that there is at this time a general feeling of uneasiness, and a conviction that the business is at best very dangerous, so far as property and reputation is concerned. The result is that some of the most thoroughly qualified men utterly refuse to attend surgical cases, confining their practice to that of medicine alone. They say the compensation usually attending the practice of surgery does not warrant a man of property in exposing himself to the probability of having, sooner or later, to defend his treatment in an action for malpractice. Victory in these cases is, in one sense, defeat, because the disgrace, vexation and cost are generally ruinous. [FN12]

Dr. Hamilton's comments, though focused on the plight of the surgeon, give voice to many of the fears of the medical profession as a whole today.

Unlike modern physicians, however, Dr. Hamilton laid the blame for the crisis on the medical profession itself:

In my early days I was disposed to lay most of the blame upon lawyers. I supposed that a certain class of pettifogging lawyers hunted up these cases and incited the people to prosecutions. But I have changed my mind upon this point. Perhaps they are in some degree responsible; but I am convinced that the responsibility rests mostly with ourselves. Many writers upon surgery, and most practical surgeons, have claimed too much. They declared that they could do many things which they could not; and their patients have simply taken them at their word, and required of them damages when they have fallen short of their own claims and promises. [FN13]

Dr. Hamilton proposed a change in medical practice to remedy this growing problem: "The profession and the world must be taught to understand that the science of surgery has not yet attained perfection .... They must be taught also, as nearly as possible, what that degree of imperfection is." [FN14]

In contrast, today's physicians have blamed the legal system for the problem and have proposed tort reform as the proper solution. Declaring the situation to be of "crisis" proportions in the 1970s, [FN15] the medical community *463 successfully lobbied nearly all state legislatures [FN16] to adopt measures designed to eliminate some claims, [FN17] limit plaintiffs' recoveries, [FN18] or make the bringing of claims more financially burdensome for plaintiffs and their lawyers. [FN19]

Despite the tort reforms of the 1970s, physicians today maintain that the situation remains critical, [FN20] arguing that the frequency and severity of claims ***464** have led malpractice insurance companies to charge prohibitive amounts for malpractice insurance premiums. [FN21] Physicians argue that the result has been two-fold. Many physicians have abandoned specialties particularly fraught with malpractice claims. [FN22] Those who have not abandoned their chosen specialties ***465** practice what they consider economically wasteful "defensive medicine," [FN23] which does not serve the patient, but functions only to provide a defense in case the patient makes a claim. [FN24]

Lawyers have, in general, reacted to physician criticism by endorsing the existing tort system and suggesting that the source of the problem lies in the medical community. [FN25] Neither physicians nor lawyers, however, have provided much data supporting or denying the existence of a "malpractice crisis." Moreover, neither group has persuasively placed the blame for the crisis, if it exists, on physicians, insurers, or a society spurred to litigation by lawyers and a litigious public sentiment. [FN26] Rather, the medical and legal professional organizations have engaged in a long-term, heated debate, each locating the "cause" of the crisis in the "adversary" professional community. [FN27]

The thesis of this article is that the adversarial dialogue between physicians and lawyers, rather than objective data, has informed the political and legislative debate over medical malpractice. The proponents of two recent federal legislative proposals have contributed to the adversarial nature of the debate. Senator Orrin Hatch has sponsored S. 489, entitled Ensuring Access Through Medical ***466** Liability Reform Act of 1991. [FN28] President Bush has proposed The Health Care Liability Reform and Quality of Care Improvement Act ("Bush Proposal"). [FN29] The objectives of both proposals, which are supported by the American Medical Association (AMA), [FN30] are rooted in the medical/legal dialogue rather than in data revealing a crisis and identifying both its cause and a workable solution. The existing data counsel against enactment of the basic provisions of either proposal. To the extent that the data are inconclusive, further study is a more appropriate response than legislation.

Part I of this Article examines the dialogue between physicians and lawyers from the peak of the "malpractice crisis" in the 1970s to the recent introduction in Congress of the Bush Proposal and S. 489. Part II summarizes the data on issues raised in the adversarial dialogue between the medical and legal communities. The data include the frequency and severity of claims, the frequency of physician negligence, the cost of malpractice insurance, and the practice of defensive medicine. Part III argues that both S. 489 and the Bush Proposal are products of the adversarial dialogue and concludes that, in light of the data discussed in Part II, neither proposal merits enactment.

I. THE ADVERSARIAL DIALOGUE BETWEEN THE MEDICAL AND LEGAL COMMUNITIES

A. Tension Between the AMA and ABA

The medical malpractice controversy has understandably produced tension between physicians and lawyers. In 1979, at the instance of the American Medical Association, the American Bar Association (ABA) undertook a study of the tort system. [FN31] The ABA report, completed in 1984, concluded that tort reform was not needed. [FN32] Indeed, the ABA praised the legal system for its adaptability and its ability to deter harmful conduct. [FN33]

***467** Reacting angrily to the ABA report, the AMA published a response in February 1985 calling for state and federal legislative relief. [FN34] The AMA proposed limiting pain and suffering awards, abolishing punitive damage awards and the collateral source rule, [FN35] limiting contingent fees, and establishing screening panels designed to eliminate frivolous lawsuits. [FN36]

In February 1986, the ABA rejected the AMA proposals, describing them as a "special-interest court system for physicians." [FN37] ABA President William Falsgraff, however, noted that the ABA's own recent study might have been based on outdated data [FN38] and that many members "simply disagreed" with its conclusions. [FN39]

Dissent to the ABA's rejection of the AMA proposal apparently formed along economic and philosophical lines. The ABA's corporate and banking law section, whose members are not dependent on the litigation system for economic survival and likely provide service to both physicians and the insurance industry, openly took issue with the action. [FN40] The section's chairman stressed that many members of the bar shared the AMA's concern over the cost of lawsuits, the delays inherent in the court system, widely disparate jury verdicts, the social utility of punitive damages, the increased expense of medical services, and the decreasing availability of malpractice insurance. [FN41]
In 1987, the AMA and thirty-two national medical specialty organizations - the AMA/Specialty Society Medical Liability Project ("the Project") - issued ***468** a report that seemed to raise the ante in the debate. [FN42] The Project's report deviated greatly from earlier AMA studies of the liability crisis. Instead of suggesting modifications to the existing tort system, the Project recommended a comprehensive alternative: [FN43] the formation of an expert administrative board that would replace the jury as the trier of fact in malpractice claims, [FN44] and even greater limitations on noneconomic damage awards. [FN45]
The proposal to abolish juries in malpractice cases represents a qualitative change in the AMA approach to this subject and a focus on long-range goals rather than the short-term goals that the organization has tended to pursue (and has often attained) in recent years. [FN46] Because the right to a jury trial is guaranteed in nearly all state constitutions, [FN47] the AMA proposal may require state constitutional amendment for its implementation. [FN48] Moreover, the proposal evidences an AMA sufficiently mobilized and confident to recommend significant societal change.
As a result of the 1987 report, the gap between the medical and legal communities has grown even wider. In 1989, the Project issued another report confirming the observations in its 1987 report and again recommending adoption of an administrative board to resolve malpractice cases. [FN49] In 1991, the Project, in conjunction with the federal government and the American College of Obstetricians and Gynecologists, funded a study of the feasibility of the 1987-89 proposal. [FN50] Bar groups refused to participate in the study, apparently because of the study's agreement "with much of organized medicine's critique of the current court-based tort system." [FN51]

***469** B. State Medical Societies Join In Lobby Efforts
Fueled by the open dispute between the AMA and ABA, the debate continued to grow. Medical societies in nearly all states lobbied successfully for tort reform legislation. [FN52] Legislative action reached a high point in the mid-1980s [FN53] and today, all states have some type of tort reform in place. [FN54]
***470** State legislative action reached a turning point in 1988. [FN55] Fewer states than in the peak years of 1986 and 1987 enacted tort reform legislation. [FN56] Most states ***471** that enacted tort reform measures in the peak years considered legislative repeal of those measures or witnessed litigation challenging the constitutionality of those reforms. [FN57] In addition, most tort reform proposals considered in 1988 were coupled with extensive insurance regulation. [FN58] Nonetheless, the march toward state tort reform continued. States amended or abolished the collateral source rule, [FN59] modified joint and several liability, [FN60] mandated periodic payment of awards, [FN61] changed punitive damages laws, [FN62] and enacted alternative dispute resolution measures. [FN63] In 1990, three states enacted some type of tort reform measure, [FN64] and four states enacted measures in 1991. [FN65] In addition, in 1991 some state legislatures considered, but did not enact, reform aimed at particular specialty fields. [FN66] The American Tort Reform Association ("ATRA") predicts that in the coming years state legislatures will concentrate their efforts on narrow reforms limiting punitive damages and encouraging alternative dispute resolution. ***472** [FN67] Finally, in 1991, the supreme courts of three states held statutes that limit the recovery of noneconomic damages unconstitutional, [FN68] and ATRA predicts a number of similar challenges this year. [FN69]

C. The Conflicting Responses of the Executive Branch and the National Association of Attorneys General

The debate recently expanded beyond medical and legal professional organizations when physicians received support from the executive branch of the federal government. A task force formed by the President and headed by an Assistant Attorney General issued a report recommending major tort reforms ("the Justice Department Report"). [FN70] The report urges limiting attorney's fees, eliminating joint and several liability for multiple tortfeasors, limiting noneconomic damages to $100,000, limiting causes of action based on product ***473** liability theories to the traditional areas of product liability litigation, paying damages in installments rather than in lump sums, greater use of arbitration panels, and rejecting findings "based on fringe scientific or medical opinions well outside the mainstream of accepted scientific or medical beliefs." [FN71] After the report issued, President Reagan announced that he supported legislation designed to benefit the liability insurance industry. [FN72]

In response to President Reagan's declaration, the National Association of Attorneys General ("NAAG") issued a report - An Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance ("NAAG report"). [FN73] The authors of the NAAG report disavowed any intention "to advocate or oppose changes in the tort system." [FN74] The NAAG report analyzes the data and assumptions on which the Justice Department Report is based and reaches three conclusions. First, when the financial condition of the insurance industry is reviewed according to standard accounting principles rather than the reserve and accounting requirements used for statutory accounting purposes, a continuing profit is revealed. [FN75] Second, the federal court data used by the Justice Department are substantially flawed and an examination of state court data reveals moderate and predictable growth in claim frequency approximately equal to population growth. [FN76] Finally, the NAAG report concludes that insurance premium increases are not related to any purported liability crisis, but "result largely from the insurance industry's own mismanagement." [FN77]

In March 1988, the states whose attorneys general prepared the NAAG report acted on its findings. They filed a lawsuit against a number of insurance companies alleging a conspiracy to increase insurance premiums that forced ***474** numerous state and municipal entities to become self-insured because they could not afford insurance. [FN78] The lawsuit is still pending. [FN79]

D. The Harvard Study

In 1989, the New York Department of Health and Human Services commissioned the Harvard Medical and Law Schools to conduct what should prove to be the most influential and controversial study of all ("the Harvard Study"). The study addresses the rate of physician negligence in New York hospitals in 1984. [FN80] The Harvard team identified cases of death and injury caused by physician negligence and concluded that approximately 12.5% of those injured asserted claims against physicians or hospitals. [FN81] Despite that conclusion, the Department of Health and Human Services and the New York legislature began calling for the adoption of no-fault medical malpractice tort legislation. [FN82]

E. Federal Legislative and Executive Proposals

The debate has now moved to the federal legislature. In 1991, twenty medical liability reform measures were introduced in Congress. [FN83] Two of the measures ***475** would effect extensive modification of the present tort system. Senator Orrin Hatch's bill, Ensuring Access Through Medical Liability Reform Act (S. ***476** 489), was the first. The bill is based on the 1987 AMA proposal and would limit recovery of "noneconomic" damages for "pain and suffering" and the amount lawyers can recover as contingent fees, and would require periodic, rather than lump-sum, payment of all judgments. [FN84]

In March 1991, President Bush expressed his dismay with the medical malpractice epidemic, stating that, "[w]e've got to restore common sense and fairness to America's

malpractice system," [FN85] and proposed legislation similar to S. 489. The Bush proposal differs from S. 489, however, in that it does not propose mandatory federal legislation. Rather, the proposal, added to the end of the administration's 1992 budget proposal and noticed by few, [FN86] seeks to encourage states to enact reform legislation. [FN87] Those states that adopt satisfactory legislation will receive federal funds equivalent to 1% of the annual increase in hospital Medicare payments and 2% of Medicaid administrative expenses. [FN88]

Evaluating these two proposals is difficult. With the exception of the reports of the NAAG, the Presidential Task Force, and the Harvard Practice Study, the data regarding the existence of a "liability crisis" have been produced by medical and legal organizations with strong economic and professional motivations for reaching particular conclusions. Moreover, the conclusions of the NAAG, the Justice Department, and the Harvard Study are inconsistent. Consequently, a legislature considering action is presented with little data, outside that generated by the medical/legal adversarial dialogue, on which to act.

II. MALPRACTICE CLAIMS, PHYSICIAN NEGLIGENCE, AND MALPRACTICE INSURANCE COSTS: HAVE THEY REACHED CRISIS PROPORTIONS?

Claims of a "malpractice crisis" usually speak to the frequency and severity of malpractice claims and the increasing cost of malpractice insurance premiums. ***477** [FN89] On the one hand, many physicians state that fear of malpractice suits, many of which they believe are unwarranted, has led them to practice "defensive medicine" which makes the patient, or the patient's insurer, pay for unnecessary, costly procedures. [FN90] On the other hand, lawyers frequently claim that endemic physician negligence is the root of the "crisis." [FN91]

Frequently, the speaker in the debate fails to identify which of the foregoing - claim frequency or severity, the cost of defensive medicine, or physician negligence - has reached crisis proportions. This has led to difficulty in both determining whether a crisis exists and identifying its causes and potential solutions. This section will attempt to separate and identify the variables that may contribute to a "crisis."

A. Claim Related Costs

1. Claim frequency

a. The data

The Insurance Service Office ("ISO"), the central rating bureau for the liability insurance industry, collects data from member companies, identifies and projects trends in liability claims, and computes advisory premiums for its members. [FN92] The ISO has been collecting medical malpractice data since 1966. [FN93] The ISO reports of claims made against physicians [FN94] were the major data source for ***478** determining malpractice litigation trends in the 1970s. [FN95]

ISO data reveal what has been characterized as a "mild increase in frequency" of medical malpractice claims made (but not necessarily resolved) from 1966 to 1970, [FN96] but depict rapid growth in the early 1970s. [FN97] Based on information available as of April 1975, the ISO reported a 19% average annual increase in claims from 1971 to 1973, resulting in a 12% increase for the entire period from 1966 to 1973. [FN98] The ISO's graphic representation of the data then projected a skyrocketing increase in claims for the mid-to-late 1970s. [FN99]

The ISO disproved its own projections for the mid-to-late 1970s when new information became available for that time period in May 1980. The new data reflected a smaller increase in claims than initially projected for 1971 to 1975 and then showed a dramatic decrease in claims from 1976 to 1978. [FN100] As a result, the average growth rate for claims from 1971 to 1978 was 0.3%, a slight overall decrease. [FN101] Early projections seemingly greatly exaggerated claim frequency.

An analysis of claims closed or resolved, as opposed to claims made but not necessarily resolved, reveals a similar trend. Between 1970 and 1975, the median rate of increase in claims closed, as reported from state to state, was between 20% and 30%. [FN102] In 1976, the number of claims closed decreased by 27%. [FN103] In 1977 they decreased 9% and in 1978 they increased 2%. [FN104] The data suggest that these figures reflect either a decrease in the filing of small claims, which close quickly, or an increase in the time lag from filing to disposition. [FN105]

An analysis of more recent data, although limited to lawsuits brought as opposed to insurance claims filed, reveals a different picture. The Justice Department has analyzed product liability claims in federal court in an effort to identify recent litigation trends for all types of litigation, including medical malpractice. ***479** [FN106] From 1974 to 1985, those claims rose 758%. [FN107] Based on those figures, the Justice Department concluded that " t here is no reason to believe that the states' courts have not witnessed a similar dramatic increase in the number of product liability claims." [FN108]

The Justice Department Report is of limited import for four reasons. First, the data on which it relied are not limited to medical malpractice claims, but are concentrated in the area of products liability litigation, which is not comparable to other forms of litigation in other courts. [FN109] Second, although not disclosed in the report, federal court litigation comprises only 2% of the total litigation in this country. [FN110] Recent studies of the state litigation that composes the other 98% have found no dramatic increases in tort litigation. [FN111] The Justice Department's attempt to extrapolate from the federal data therefore, is flawed. [FN112] Third, the increase in federal litigation is probably due to a recently emerging preference for the federal court as a forum for litigation. [FN113] Fourth, changes in corporate and business structures have increased diversity of citizenship between ***480** corporations and, consequently, have produced more federal litigation between corporations. [FN114]

Moreover, other studies that cite data for all litigation cast doubt on the Justice Department's conclusions. The National Center for State Courts has released data demonstrating that state courts have not witnessed this "dramatic increase." From 1978 to 1984, tort claims increased 8%. [FN115] During the same time period, the population increased only 9%, virtually the same rate. [FN116] Although more recent data from the same organization show a 26% increase from 1984 to 1989, [FN117] tort filings did not increase annually in any state during that period [FN118] and tort claims constituted a "small component" of all civil cases. [FN119] Furthermore, the total number of civil cases in state trial courts increased only 10% from 1986 to 1989. [FN120] Thus, the data do not support the Justice Department's conclusion that society is becoming more litigious or that we are presented with a "crisis" of litigation. [FN121]

Finally, although recent data are somewhat sketchy, most insurance carriers and other observers have concluded that the number of medical malpractice claims stabilized and, perhaps, began to decline in the mid to late 1980s. [FN122] The ***481** nation's largest medical malpractice insurance carrier [FN123] reported that from 1980 to 1984 the frequency of claims increased 56% against physicians and 71% against hospitals. [FN124] That same insurance carrier has reported 10.6 claims per 100 physicians in 1980, [FN125] 11.4 in 1981, [FN126] 13.3 in 1982, [FN127] 15.1 in 1983, [FN128] 16.5 in 1984, [FN129] 17.9 in 1985, [FN130] 13.0 in 1988, [FN131] and 12.4 in 1989. [FN132] In 1990 the claims increased to 13.6, the first increase reported by the carrier since 1984, but claims are still substantially below the mid-1980s levels. [FN133]

b. Conclusions supported by the data

The frequency data, then, indicate that cries of a "malpractice crisis" and a ***482** generalized crisis of all types of litigation have been exaggerated or, at the least, have been based on erroneous projections of pre-1980 evidence. At present, there is no evidence to suggest that there is a litigation crisis in this country and there is good reason to believe that the number of malpractice cases has at least stabilized. [FN134] Indeed, though the Bush Administration has publicly called for medical malpractice tort reform, it has privately conceded that the malpractice litigation "crisis" is "on the wane."

[FN135]

2. Physician negligence

Regardless of whether medical malpractice claims are increasing as rapidly as the medical community and some members of the public have stated, the foregoing data fail to make clear the relationship between the number of claims and the incidence of physician malpractice. Whether claims exceed the number of negligently inflicted injuries should reveal whether the crisis, if crisis it is, is a reflection of litigious patients or poor physician performance.

a. The Danzon Study

In 1985, Patricia Danzon published a pioneering study on just this point. [FN136] She based her study on a comparison of two data pools. First, she analyzed a 1974 California report on the number of injuries caused by physician negligence in California hospitals ("the CMA Report"). [FN137] The CMA Report, then the only available study of physician caused injuries, [FN138] was jointly sponsored by the California Medical Association and the California Hospital Association. [FN139] The two groups formed a team of four experts in legal medicine who examined patient records in twenty-three California hospitals. [FN140] The team selected hospitals according to size, location, and teaching status to produce a sample representative of hospitals across the state. [FN141] The team selected patient records ***483** according to patient age, race, sex, and source of payment. [FN142]

The team evaluated patient injuries to determine the likelihood that a jury or court would hold the treating physicians liable under California negligence law. [FN143] In so doing, the team considered the state of the hospital records, the severity of the patient's injury, and whether the injury was preventable by the practice of ordinary medical care. [FN144]

The CMA report did not include a finding on the number of injured patients who filed claims. [FN145] Danzon, however, was able to obtain "reasonably complete" claim data from a second data pool supplied by the National Association of Insurance Commissioners ("NAIC"). [FN146] The NAIC had published a survey reporting claims closed by private insurers between 1975 and 1978. [FN147] By comparing the NAIC claim data with the CMA report, Danzon was able to obtain "a crude measure ... of injuries by age of the plaintiff, severity of the injury, and the type of medical error." [FN148] As Danzon states, " t he results are striking." [FN149]

Only 10% of all negligently injured patients filed claims against the hospitals or physicians. [FN150] Only 40% of the claimants received any compensation. [FN151] Consequently, only 4% of negligently injured patients received any compensation. Claimants under the age of forty-four were more than twice as likely to recover compensation as those over sixty-five. [FN152] Those who suffered permanent injuries were more likely to file claims than those who suffered temporary injuries, while fatal injuries were most infrequently the subject of claims. [FN153]

Although they are striking, Danzon's findings are somewhat limited. She sampled only one state, and she has stated in other publications that there is great claim frequency variation among states. [FN154] Because actual claim data are unavailable, the comparison of CMA and NAIC information results in only a "crude measure." [FN155] Finally, the determination whether a physician would be held liable is a product of the judgment of the CMA "malpractice experts" - a judgment that inevitably is subjective. This factor is compounded because 90% of all claims, with and without payment, were resolved pursuant to pre-trial ***484** settlements. [FN156] Consequently, legal evaluation of liability is not available for most of the compensated injuries.

The limitations of Danzon's data do not deprive her study of national significance. At the time of the study, California had the second highest claim frequency rate of any state in the United States. [FN157] Assuming physicians in other states caused injuries no more frequently than California physicians, the claim per injury rate in most other states was even lower. [FN158] In addition, hospital records may not reveal all injuries. [FN159]

Thus, one can conservatively apply Danzon's conclusions regarding physician negligence and malpractice claims to other states.

Danzon reached two broad conclusions regarding physician negligence and malpractice claims. First, the risk of negligently inflicted medical injury is substantial - approximately one in one hundred twenty six patients are negligently injured. [FN160] Second, because claim frequency is low, "the cost of malpractice - the cost of injuries due to negligence - is probably several times greater than the cost of malpractice claims." [FN161]

b. The Harvard Study

Danzon's findings recently received support from the Harvard Study. [FN162] Moreover, unlike the Danzon study, which had to compare two separate bodies of data to reach conclusions regarding the incidence of medical malpractice, the Harvard Study directly addressed that issue.

The Harvard Study analyzed the 1984 records of over 30,000 patients at fifty-one New York hospitals. [FN163] Members of the study screened the records ***485** and submitted 7,743 records to physicians for further review. [FN164] The reviewing physicians then determined that "adverse events," defined as "an unintended injury caused by medical management," [FN165] had occurred in 1,133 of those cases. [FN166] Of that number, 280 were caused by negligent care. [FN167] After the study weighted the figures to account for the size of the total sample, [FN168] it concluded that "1% of all hospitalized patients experienced negligent injury that led to some prolongation of the hospitalization and/or disability at the time of discharge." [FN169]

The Harvard Study then compared the incidence of negligence with the number of malpractice claims made by lawsuit or written or oral demand [FN170] and concluded that "the number of negligent adverse events was eight times the number of tort claims." [FN171] That is, approximately 12.5% of negligently injured patients made claims. [FN172] History indicated that approximately one-half of all claimants were eventually compensated. Thus, the incidence of negligence is approximately sixteen times greater than the number of paid claims. [FN173] That "litigation gap" shrinks for more severe injuries to a two-or-three-to-one ratio of injuries to claims. [FN174] But even as to these injuries for which patients are most likely to make claims, the Harvard Study's findings indicate that "we do not now have a problem of too many claims; if anything, there are too few." [FN175] In addition, although not observed by the Harvard team, New York now has a ***486** claim frequency even higher than that of California. [FN176] Thus, like the California data, the New York data can be conservatively generalized to the rest of the nation.

The Harvard Study supports Danzon's first broad conclusion - patients do face a substantial risk of negligently inflicted medical injury. The Harvard Study found this risk to be approximately one in one hundred, [FN177] as compared with Danzon's finding of one in one hundred twenty-six.

The Harvard Study purports not to support fully Danzon's second broad conclusion - the cost of malpractice exceeds the cost of malpractice claims. The Harvard Study compared the sum of potentially compensable patient losses - $894 million for the sample year - with the sum cost of malpractice liability insurance for the same time period [FN178] - more than $1 billion. [FN179] Thus, with some caution, the Harvard Study concluded that the cost of negligence does not exceed the cost of malpractice claims. [FN180] That conclusion, however, is substantially undermined when the values the Harvard Study assigned to the claims are compared to the values malpractice insurance carriers would likely assign the claims. The Harvard Study based its estimate of the claims' value on awards that would be provided by a hypothetical, no-fault compensation system. [FN181] Consequently, the assigned value of $894 million does not account for at least several categories of damages that are awarded in the present tort system and that should be reflected in malpractice insurance costs calculated by insurance carriers to pay for those awards. [FN182]

First, the Harvard Study did not assign a value to pain and suffering and other

noneconomic losses of injured patients. [FN183] Because noneconomic losses may account for as much as 50% of the damages awarded in the tort system, [FN184] ***487** the value of the claims the Harvard Study assessed may be as high as $1.8 billion, or twice the estimated value of $894 million.

Second, the Harvard Study included in the estimated value of claims only the portion of medical expenses that patients would pay and did not include the portion that insurance carriers would pay. [FN185] The Harvard Study reported the total cost of unreimbursed medical expenses to be $103 million. [FN186] The unreimbursed expenses represent approximately 13% of total medical costs. [FN187] In many jurisdictions the collateral source rule prevents deduction from malpractice awards of some, if not all, of the uncounted 87%. [FN188] Therefore, in those jurisdictions the total value of medical costs awarded in the tort system will likely be substantially higher than the value the Harvard Study assigned for purposes of evaluating its no-fault hypothesis.

Third, the Harvard Study excluded some losses for which working adults would be compensated in the tort system. The Harvard Study excluded lost "fringe benefits" totalling $55 million because "[p]rivate and social insurance plans in the U.S. do not now compensate for workers' loss of fringe benefits." [FN189] In addition, the reported $231 million [FN190] loss of wages reflects only 19% [FN191] of wages that likely would be compensable by the tort system. [FN192] Thus, by adding the uncounted 81% back into the equation, one can estimate the value of those lost wages to be as high as $1.2 billion.

***488** Finally, the Harvard Study's estimate also excluded "economic losses suffered in the first six months from the date of hospitalization." [FN193] The Harvard Study reasoned that these costs would be compensated by employer-supplied sick leave and other programs. [FN194] Moreover, the Harvard Study excluded in their entirety the claims of patients who would recover from their injuries within six months. [FN195] These cases account for 50% of all claims. [FN196] Again, because the tort system would compensate these losses, their value should be reflected in malpractice liability insurance costs.

Once the Harvard Study's figures are adjusted to account for all the damages awarded in the tort system, [FN197] the study appears to confirm Danzon's second broad conclusion. The cost of malpractice in New York likely exceeds, by several times, the $1 billion value of currently prosecuted malpractice claims.

3. Claim Severity (or Size)

a. The data

The data Danzon and the Harvard Study gathered fail to account for the amount of compensation paid successful claimants (claim severity). [FN198] On the one hand, many physicians claim that payments by either jury verdict or settlement over-compensate claimants. This would tend to increase the cost of claims in relation to the cost of negligence. On the other hand, to the extent that payments undercompensate claimants, the figures may underestimate the discrepancy between the cost of negligence and the cost of malpractice claims.

According to all studies, the amount of damages that successful plaintiffs receive pursuant to verdict or settlement has increased at a rate considerably in excess of inflation. [FN199] Danzon, for example, reports a steady upward trend in ***489** claim severity from 1971 to 1978. [FN200] During that period, the mean payment in satisfaction of a claim against a physician increased 12.4%. [FN201] During the same period, the mean payment in satisfaction of claims against hospitals increased 18.9%. [FN202] From 1975 to 1984, mean claim severity increased approximately twice as quickly as did the consumer price index. [FN203]

A comparison of state-specific data reveals great variation in claim severity among states in the early years of the "crisis," but then a rapid erosion of that variation. The state median for payment of claims increased approximately 30% from 1971 to 1978. [FN204] The mean payment, however, increased 60% during the same period. [FN205]

The data suggest that the mean of state means increased significantly more rapidly than the national claim mean. This reflects a more rapid increase in mean severity in states with few claims than in those states that account for a large portion of the nation's claims. [FN206] In addition, mean severity grew most rapidly in states where severity was initially quite low. [FN207] As a result, the data reflect a national trend toward uniform malpractice verdict and settlement payments.

More recent data, limited to reports of jury verdicts, reveal a continuation of this trend. [FN208] The mean medical malpractice jury verdict was $228,818 in 1975, $192,344 in 1976, $666,123 in 1984, and $1,017,716 in 1985. [FN209] Overall, ***490** then, the data depict an increase in the mean jury verdict. [FN210]

Again, analysis of the median produces a surprisingly different picture. The same service reports that the median jury verdict remained approximately the same from 1980 to 1984 - $200,000. [FN211] Insurance company data confirm this evidence. As of 1986, the median medical malpractice claim payment by either jury verdict or settlement was approximately one-fifth the mean. [FN212] As a result, while large verdicts and settlement payments have progressively increased, [FN213] an equal number of verdicts and settlement payments remain at small or moderate amounts. Moreover, the median is more indicative of the "typical" verdict or settlement payment received by a medical malpractice claimant. [FN214]

Finally, data currently available from insurance carriers confirm the upward trend in verdict and settlements. Mean claim severity, adjusted for inflation, increased 14% annually from 1980 to 1986. [FN215] The nation's largest provider of medical malpractice insurance has reported that the mean cost of reported claims was $12,802 in 1980, $30,279 in 1984, [FN216] $31,000 in 1988, $32,700 in 1989, and $36,400 in 1990. [FN217]

b. Conclusions supported by the data

The foregoing data dispel a number of myths regarding the current medical malpractice "crisis." First, because the median claim severity has remained relatively unchanged in recent years, resulting in an unchanged percentage of claims receiving small or moderate awards, there is no reason to believe that plaintiffs who sustain minor injuries are now receiving greater compensation. Rather, one must conclude that juries are awarding greater sums for the more serious injuries. Thus, there is no reason to believe that patients filing "nuisance suits" are receiving substantial compensation.

Similarly, assuming that litigants and their lawyers are generally aware of these data, there is no reason to believe that many patients bring claims for minor injuries with hopes of receiving large awards. That is, allegations of a ***491** "lotto mentality" [FN218] motivating the filing of malpractice claims appear misplaced. [FN219] At a minimum, those motivated by such hopes are mistaken.

What is apparent is that juries are awarding significantly more money for severe injuries. That trend continues in the most recent data. For example, juries nationwide awarded 92 verdicts in excess of $1 million in 1986, 62 in 1987, [FN220] 97 in 1988, and 107 in 1989, the most recent year for which data are available. [FN221]

At least five factors may have contributed to the trend toward larger verdicts. First, in some respects the increase in large verdicts can be explained by the homogenization of the United States. Increased mobility and communication have apparently worked to standardize jury responses regarding appropriate compensation for comparable injuries. Those areas where juries once awarded smaller verdicts have now produced verdicts comparable to those awarded in the urbanized areas of the country.

Second, the erosion of the "localized standard of medical practice" may have contributed to this phenomenon. In the early jurisprudence of most states, physicians were judged by the standard of care of localized practice. [FN222] Whereas physicians in major metropolitan areas may have used more modern techniques, practices, or equipment, physicians outside those areas were not held liable if their conduct complied with local standards. [FN223]

In the 1960s, most states abandoned the localized standard of practice. [FN224] As a

result, not only were physicians subjected to a different standard of care, but the testimony of experts from other communities became admissible at trial. ***492** One effect was simply that plaintiffs prevailed who would have lost under the old rules. Another may have been that the attitude of testifying physicians accustomed to a more rigorous standard of practice increased jury disapproval of negligent physicians, resulting in larger verdicts.

Third, large verdicts have traditionally received widespread publicity. The result may be an increase over time in jury expectations regarding appropriate compensation, producing an upward trend in claim severity.

Fourth, the existence of the defendant's liability insurance has traditionally been hidden from juries. The rule is based on the theory that, knowing the defendant will not personally be responsible for paying a judgment and perhaps fueled by antipathy toward insurance companies, juries will be willing to award a plaintiff a money judgment despite little evidence of the defendant's culpability. [FN225] As the existence of medical malpractice liability insurance has received publicity and come to public attention, assuming the rationale supporting the exclusion of such evidence is valid, juries may have become more willing to award larger verdicts. According to the same logic, of course, recent publicity regarding a liability insurance crisis may eventually produce smaller verdicts.

Finally, the increase in verdict amount may simply reflect jury disapproval of negligent physicians. This phenomenon may in turn reflect changing medical practices. Group and HMO practice may not create sympathy for the "trusted, family physician." [FN226]

4. Medical and Demographic Factors Affecting Claim Frequency and Severity

A number of medical and demographic factors may impact on both severity and frequency of claims. Danzon has observed that the per capita number of physicians in a community is positively correlated to claim frequency. [FN227] An increase of 100 physicians per population of 100,000 corresponds to an increase of thirty-six claims. [FN228] The number of physicians is not, however, related to claim severity. [FN229] The number of lawyers per capita, however, does not affect claim frequency once the data are controlled for urbanization and for the number of physicians per capita. [FN230] The data, therefore, undermine the physicians' assertion that ***493** claim frequency increases when the number of lawyers available to prosecute suits increases. After controlling for per capita numbers of physicians and lawyers and changes in tort law, [FN231] "urbanization remains a highly significant determinant of claim frequency and severity." [FN232] This remains so even after controlling for per capita income, unemployment, capital-intensive medical services, and frequency and severity in other areas of tort litigation. [FN233]

Rapid equipment advances and highly publicized technological triumphs, such as heart transplants and the implantation of artificial organs, may have raised patient expectations regarding appropriate medical care. The failure of medical treatment to meet these expectations may produce more frequent lawsuits when patients perceive the outcome of their medical treatment as unsatisfactory. Finally, jury reaction to injured patients may also be more sympathetic.

This conclusion is supported by a 1976 study that reported a positive correlation ***494** between claim frequency and the availability of technologically complex medical facilities. [FN234] The study concluded that complex facilities generate more injuries. [FN235] However, when corrected for urbanization and for per capita numbers of physicians and lawyers, the conclusion made in the 1976 study becomes questionable. [FN236] Yet because urbanization remains a factor, [FN237] and because urban areas tend to employ the most recent technological advances, the study may actually show that urbanization is a determinant of claim frequency, [FN238] and may suggest that patient expectation is also a relevant factor.

B. Costs Not Directly Related to Claim Payment

1. Medical Malpractice Insurance

Although claim frequency data may be unclear, it is undisputed that medical malpractice insurance rates increased steadily until recent years. From 1976 to 1984, the average annual charge to physicians for medical malpractice insurance increased 79%, from $4,700 to $8,400. [FN239]

Medical malpractice rates, however, stabilized in 1988 and 1989. [FN240] Physicians in the United States paid a total of $1.9 billion for medical malpractice premiums in 1984, $4 billion in 1987, and $3.9 billion in 1988. [FN241] In 1989, one company that insures physicians in thirty-two states reduced premiums by an average of 14%. [FN242] Other insurance companies implemented similar reductions ***495** across the country in 1989, [FN243] and premiums were reduced in two-thirds of all the states. [FN244] This trend continued in 1990. [FN245]

Some medical community observers have described the leveling off as the "light at the end of the tunnel." [FN246] The observers have attributed the change in medical malpractice insurance rates to a reduced number of malpractice claims produced by "tort reform, more public awareness about medical liability and how the cost is passed on to patients, improved risk management among physicians and improved technology." [FN247] Others have cautioned that the data represent only "a temporary blip" in a continuing trend. [FN248] Although 1991 data are ***496** still incomplete, they nevertheless indicate that premium rates did not change. [FN249] Indeed, in late 1991 the nation's largest provider of medical malpractice insurance announced a rate freeze in all forty-two states in which it provides insurance until January 1992. [FN250]

Even in New York, where insurance carriers have claimed to be particularly hard-hit by the medical malpractice crisis, [FN251] premiums have leveled off. Before 1989, the New York State Insurance Department generally granted insurance carriers "substantial" premium increases. [FN252] In 1989, however, for the first time in six years, the rates did not change, [FN253] and in 1991 they decreased 5%. [FN254] The Harvard Study concluded that "the medical liability insurance system has reached a point of stability." [FN255] However, the Harvard Study cautioned that, because we may not know for some years the value of claims made on physician conduct insured by premiums being paid now, "we should not be unduly optimistic about the future." [FN256]

These figures appear even less alarming when compared with other data. For example, although malpractice insurance premiums increased 79% from 1976 to 1984, physicians experienced an 89% increase in income during the same time period. [FN257] Thus, while physicians paid an average of 4.4% of their income for malpractice insurance premiums in 1976, they paid an average of 4.2% of their income for insurance premiums in 1984. [FN258] Moreover, while medical ***497** malpractice insurance premiums represented 2% of the United States' total medical care costs in 1975, that percentage decreased to 1% in 1982 [FN259] and to less than 1% in 1989. [FN260] These data, therefore, suggest that medical malpractice insurance premiums constitute a serious problem only for those medical specialties and geographic locations that are particularly fraught with malpractice litigation. [FN261]

Finally, concerns regarding insurance premiums are of equal significance to both those physicians frequently sued and to those infrequently sued. Unlike insurers generally, most medical malpractice insurers do not adjust premiums to account for physician claim records:

> [T]here was a short-lived trend to put a surcharge on premiums for doctors who have claims paid against them, but that's largely been abandoned. It was too cumbersome .... They set up peer review committees, but they got too bogged down .... Maybe a handful of companies do it for a handful of people .... Sometimes, companies will refuse to protect a guy altogether, but that, too, is very, very rare.... [FN262]

As a result of this practice, a physician's insurance rate is unaffected by performance, claim record, or reputation. In one state, as few as 1% of all the physicians were responsible for over one-half of the medical malpractice claims ***498** brought. [FN263] Frequently, medical speciality and geographic locations are the principal and only factors considered in determining premiums. [FN264] Concern about premium cost is,

therefore, compounded by the physicans' inability to reduce that cost by improving practice techniques, improving patient relations, or practicing defensive medicine. [FN265] Similarly, insurance rates do not benefit the public by providing an incentive for competent medical practice.

2. Defensive Medicine.

a. Definitions

Many physicians contend that the recent increases in medical malpractice claims have led them to practice "defensive medicine" in an attempt to protect themselves from medical malpractice suits. [FN266] Indeed, the AMA states that defensive medicine may account for 30% of all medical care costs in the United States. [FN267] In an apparent recognition of a lack of corroborative evidence, however, the AMA calls the 30% figure "the most frequently quoted estimate." [FN268]

The AMA also estimates the cost of defensive medicine to be $15 billion. [FN269] When that sum is combined with the cost of medical malpractice premiums paid by physicians, [FN270] the total cost of medical malpractice is equal to 3% of this nation's total health care costs. [FN271]

Defensive medicine consists of both "positive" and "negative" practices. [FN272] Positive practice "occurs when a physician performs additional tests or procedures in order to avoid being accused of negligence." [FN273] In contrast, negative ***499** practice occurs when a physician avoids tests or procedures perceived as legally risky. [FN274]

In 1984, the Socioeconomic Monitoring System, directed by the AMA, surveyed physicians regarding "positive defensive medicine." [FN275] The survey described the following as positive defensive medical practices: (1) maintenance of more detailed patient records; (2) prescribing more diagnostic tests and/or treatment procedures; (3) increasing follow-up visits; and (4) spending more time with patients during examinations. [FN276]

Of physicians surveyed, 42% reported that they had increased defensive medical practices in the last year, [FN277] 31% had begun maintaining more detailed patient records, [FN278] 20% prescribed more diagnostic tests, [FN279] 17% scheduled more follow-up visits, [FN280] and 17% reported that they increased the duration of patient examinations. [FN281] Overall, general practitioners reported the greatest increase in defensive medical practices, followed by surgeons, and, then, by physicians practicing internal medicine. [FN282]

Most physicians contend that defensive medical practices do not contribute to the quality of medical practice. The following is a prototypical response:

Maybe out in small towns somewhere they need lawsuits to practice quality medicine - I doubt it, but maybe - but here at New York Hospital all the law suits do is cause us to practice defensively with a lot of unnecessary paperwork and tests. We have our own checks on the quality of our work, and lawsuits don't help us one bit. [FN283]

b. Benefits and disbenefits

In the first two categories - improved record keeping and increased diagnostic testing - the data may support the physicians' position. Improved record keeping, for example, may indeed be wasteful from a physician's viewpoint. Maintaining improved patient records requires physician time, but does not directly contribute to patient treatment. However, improper treatment can occur because critical information has been omitted from the patient's records. [FN284] As ***500** a result, while some information is undoubtedly entered on records only for retrieval in the event of a lawsuit, improved record keeping can improve care. The question the data pose, then, is whether the cost to patients of improved record keeping exceeds the benefits it produces in some cases. The data do not yet provide a clear answer.

Analysis of the testing and procedures category produces a similar conclusion. Avoiding procedures may deprive patients of valuable medical treatment. On the other hand, if we assume that physicians act rationally in avoiding certain procedures, the avoidance is

a result of a determination that the benefits of a procedure are outweighed by the likelihood of a successful patient lawsuit if the procedure is performed. While one may argue that decisions may result at least in part from fear of unpredictable juries, doctors must also endeavor to predict the views of expert witnesses. The decisions on testing and procedures therefore represent, at least in part, physicians' assessments of their own compliance with the requisite standard of care.

The evidence in the testing and procedures category is, on the whole, more supportive of the physicians' position than is evidence in the medical records category. Additional procedures are costly, probably entail some risk, and if physicians are correct, are of little benefit to patients. Yet the failure to diagnose and perform the proper procedure is the most common basis for malpractice suits. [FN285] An evaluation of defensive medical practice is therefore again dependent on unavailable data regarding the relationship between the cost of performing additional procedures and the benefit that the procedures provide.

Although the first two categories of positive defensive medical practice provide some support for physicians' contentions, however ambiguous, it is difficult to argue that increased follow-up visits and longer patient examinations are detrimental to patients. As one lawyer put it, these changes in practice are welcome in today's world of mass medical treatment:

Last year I had to take my baby daughter to the emergency room ... because she'd hit her head falling out of a chair. After her X-rays were examined by a first-year resident and found to be routine, I asked if I could take the X-rays with me to send to our family doctor. I was told that they would not be available until the next morning because a radiologist on the staff had to double-check them first. "You know, we need to avoid legal problems," the resident said, as he asked for my phone number, so the radiologist could call if he found anything wrong when he looked at the X-rays within the next hour. If that's defensive ***501*** medicine, I'll take it. [FN286]

c. The tort system

That physicians attribute the practice of defensive medicine to the tort system may, in itself, constitute a defense of that system, which arguably exists only to deter negligent conduct. [FN287] In 1985, Danzon published a report discussing the merits of the tort system. [FN288] She noted that sixty-six cents are spent on litigation for every dollar that reaches the plaintiff in compensation. [FN289] Overall, plaintiffs and defendants spend approximately the same amounts. [FN290] Defense costs exceed plaintiff costs on small claims, while plaintiff costs exceed defense costs on large claims. [FN291] Insurer expenses account for 28% of all sums paid in premiums. [FN292]

The large sums spent in processing claims led Danzon to contend that "the medical malpractice system makes no sense if its sole function is compensation." [FN293] It can be justified only on the ground of deterring negligent conduct. [FN294]

The Harvard Study was unable either to confirm or to refute Danzon's conclusions regarding the efficacy of the fault-based tort system. Harvard Study personnel conducted interviews of physicians to discern whether the physicians believed that the system deters potentially negligent conduct. Although respondents tended to "downplay" the deterrent effect of the tort system, [FN295] the Harvard Study concluded that "the tort system may have a deterrent effect as evidenced by physicians overestimating the risk of being sued." [FN296]

The Harvard Study then compared these physician perceptions with empirical ***502*** evidence, but did not reach any conclusive findings. That so few injured patients bring suits suggests that the tort system, regardless of its impact on the individual physician, may not function as a deterrent. [FN297] In addition, the study was unable to demonstrate the premise of deterrence theory, that any increase in claims produces a decrease in negligent conduct: [FN298] " O ur findings are at best weak evidence of no deterrence." [FN299]

Two factors buttressed this equivocal stance. First, the Harvard Study concluded that an increase in the tort claim rate leads to an increase in costs per patient, [FN300] perhaps

indicative of defensive medical practice. Second, the Harvard Study found a positive relationship between claim rates and negligent adverse events. [FN301] That is, hospitals with higher claim rates tend to have a greater frequency of negligence. [FN302] Because of the small sample size and the possibility that "high injury hospitals or physicians" generating these claim rates are actually being deterred, the study concluded that the findings can be read to support both advocates and opponents of the tort system. [FN303] The equivocal nature of the data and an apparent reluctance to confront the "a priori" proposition that the tort system has a deterrent impact, [FN304] led the study to sound a cautionary note: "It would be imprudent to conclude on the basis of these findings that there would be no change in medical injuries if the tort system were abolished and no comparable incentive structure put in its place." [FN305] ***503** The conclusion of the Harvard Study, then, lends at least some support to Danzon's overall assessment of the efficacy of the tort system as a deterrent mechanism:

> [T]he tort system deserves serious consideration. Although most physicians may well act in their patients' best interests most of the time, even without the threat of liability, nevertheless the incidence of medical malpractice is too common to be ignored.... [T]he cost of negligent injuries is several times larger than the cost of malpractice premiums. ....
> In practice, as we have seen, the malpractice system departs significantly from this theoretical ideal [of providing an ongoing system of quality control], but the most extreme criticisms are unfounded. Far from being excessive, the number of claims falls far short of the number of incidents of malpractice. The deposition process follows the precepts of the law to a significant degree. Court awards are strongly influenced by the economic loss of the plaintiffs and by the law of compensable damages. [FN306] Although far from perfect, the tort system has a positive effect on the practice of medicine. It is presently impossible to evaluate to what extent the defensive measures taken appropriately correct actual practices to conform to the standard of care, or whether the cost of defensive medicine exceeds the benefit that patients receive. Yet, because injuries substantially outnumber claims, there is little justification for fears that defensive medicine is more costly than the injuries and the claims it prevents.

III. FEDERAL LEGISLATIVE ACTION - S. 489 AND THE BUSH ADMINISTRATION PROPOSAL: THE ADVERSARIAL DIALOGUE REVISITED

A. Findings and Goals of the Proposed Legislation

1. S. 489

On February 26, 1991, several months before the Bush Administration's proposal ("Bush Proposal"), Senator Orrin Hatch introduced S. 489, which closely modeled the AMA's 1987 proposal. [FN307] In his introductory remarks, Senator Hatch openly admitted that the legislation was "developed with the help of a broad coalition representing health care provider organizations, the business community, health insurers, and other groups." [FN308] In addition, he gave special ***504** thanks to a representative of the American College of Obstetrics and Gynecology, the group of physicians most frequently sued. [FN309] Senator Hatch focused on the "fear of litigation" [FN310] that has prompted physicians to leave the practice or to practice "defensive medicine" and that has "adversely affect ed Americans' access to quality and affordable health care." [FN311] Senator Hatch based his conclusions on the number of lawsuits filed and average awards received. He did not cite data regarding the frequency of malpractice or the relationship between the commission of malpractice and the frequency of claims. [FN312] Moreover, he did not differentiate between the increase in average awards and the increase in awards in specialty specific-litigation. [FN313]

Co-sponsor Senator Jeffords departed even farther from the data base discussed earlier, stating that "[u]nder our current system, many physicians will not perform high risk procedures due to fear of becoming victim to an expensive lawsuit of dubious merit." [FN314] He added that Congress should enact the bill "to provide physicians the security

they need to deliver care in such critical areas as ***505** obstetrics and gynecology." [FN315] Like Senator Hatch, Senator Jeffords failed to cite any data indicating that a substantial number of meritless lawsuits are filed.

The findings cited in S. 489 mirror Senator Hatch's opening remarks [FN316] and omit any reference to the incidence of medical malpractice in this country. In addition to addressing Senator Hatch's concerns, the findings address the "inefficiency of the civil judicial system." [FN317] The only recognition of the possibility that the "crisis" is one of physician negligence is contained in a curious reference to "the inefficiency of State disciplinary systems in restricting the activities of health care professionals who endanger patient safety." [FN318] The proposal contemplates remedying this "inefficiency" by providing grants that states may use "to develop and implement improved mechanisms for monitoring the practices of health care professionals or for conducting disciplinary activities." [FN319]

2. The Bush Administration Proposal

Introduced on May 22, 1991, the Bush Administration proposal ("Bush Proposal") in many ways mirrors the objectives and perspectives of S. 489. Indeed, at President Bush's request, Senator Hatch introduced the Bush Proposal in the Senate. [FN320] Hatch again maintained that the "high cost of medical malpractice insurance and the fear of litigation" were operating to produce defensive medicine and were driving physicians from practice. [FN321]

The findings reported in the Bush Proposal, for the most part, closely resemble those of S. 489 and focus on the rising cost of insurance, litigation, and fear of liability. [FN322] The Bush Proposal, however, contains one finding strikingly different from any formally presented in S. 489. The finding echoes Senator ***506** Jefford's comments in support of his co- sponsorship of S. 489: "improving the civil judicial system" would "deter frivolous actions." [FN323] The Bush Administration does not cite any data indicating that frivolous actions are common. Indeed, one cursory reference points to data that belie the finding. Senator Hatch, in apparent recognition of the 1990 Harvard Study, observed that fewer than 15% of injured patients file suit [FN324] - an implicit acknowledgement that unjustified lawsuits do not pose a threat to the practice of medicine.

Rather than citing or reporting objective data, the Bush Administration simply allied itself with physicians in the medical/legal dialogue. Indeed, an appeal for tort reform in the American Medical Association Journal may have prompted the proposal. [FN325] On January 30, 1990 Senator Cohen spoke in the Senate in support of an amendment to the Internal Revenue Code to provide a credit for health insurance expenses. Senator Cohen quoted extensively from an article in the Journal of the American Medical Association ("JAMA") [FN326] that called for "a radical overhaul of our entire health care system." [FN327] As part of the overhaul, the authors of the article and Senator Cohen requested that President Bush "appoint a blue-ribbon commission" to study, among other issues, "instituting national malpractice reform." [FN328] Neither the JAMA authors nor Senator Cohen offered any data regarding the incidence of malpractice, claim frequency or severity, or insurance industry practice. Rather, they rested their case solely on the observation that the cost of health care has become problematic in our society. [FN329]

***507** In contrast to Senator Cohen, the Bush Administration privately conceded that the "malpractice crisis" had abated. [FN330] Publicly, however, and perhaps motivated by Senator Cohen's appeal, President Bush expressed "concern over the rising cost of liability insurance for physicians and its implications for the practice of medicine." [FN331] He requested that the Domestic Policy Council study medical malpractice liability. [FN332] Shortly thereafter, and apparently in advance of any report by the council, a reporter who had spoken with an Administration official disclosed the President's position on the issue:

One issue the administration has to grapple with in this area is whether to step in and help those states that are 'under the gun of trial lawyers,' the official said, noting a wide diversity in the size of damage awards. Before suggesting changes in an area that has

long been left to the states, the administration must reconcile those recommendations with its overall federalism policy of respecting states rights, he added. Nevertheless, the administration is considering tying federal aid to states to reforms of their medical liability laws, such as caps on damages. [FN333]
The President then assigned his assistant for economic and domestic policy to discuss "with members of Congress possible approaches to reform of the medical liability system." [FN334]
Neither the Bush Administration nor the members of Congress with whom it consulted produced the data on which the proposal is based. The President did, however, make clear his reasons for the proposal. "Too many of our medical dollars are going to [p]ay off lawyers." [FN335] That money should "pay for healing, not suing." [FN336]

***508** B. The Substance of the Proposed Legislation

1. S. 489
S. 489 contains mandatory provisions and elective provisions. The mandatory provisions seek to limit the amount plaintiffs can recover; [FN337] the time when suits can be brought; [FN338] and the fees that lawyers representing plaintiffs, but not defendants, can charge. [FN339] Adoption of the elective provisions is a requisite for the receipt of federal grants. [FN340] The elective provisions seek to eliminate jury trial of malpractice claims [FN341] and to educate the public about the "limits" of medical science. [FN342]

a. Mandatory provisions
The mandatory provisions - Federal Reform of Civil Actions - apply to "any health care malpractice action brought in any federal or state court," [FN343] and consist of five modifications of existing tort law. The first requires periodic rather than lump-sum payment of damage awards in excess of $100,000. [FN344] The periods are to be "determined by the court, based upon projections of ... future losses." [FN345]
The second modification abrogates the collateral source rule. [FN346] A plaintiff's recovery will be reduced by the amount of any other "source of payment intended to compensate" the plaintiff for the injury, including payments from ***509** governmental [FN347] or private [FN348] disability programs, governmental or private health insurance, [FN349] and "employer wage continuation programs." [FN350]
The third measure limits the recovery of an injured patient to $250,000 for damages for noneconomic losses such as pain and suffering. [FN351] The limitation applies regardless of the number of health care defendants named in the action. [FN352]
The fourth provision limits the contingent fees attorneys representing plaintiffs may recover. Lawyers are limited to "33% of the first $100,000 of any award or settlement," "15% of the next $100,000," and "10% of any additional amounts in excess of $200,000." [FN353] The bill does not impose any limitation on the fees lawyers representing defendants may charge.
The final mandatory provision of S. 489 establishes a two year statute of limitations, running from the date the injury "should reasonably have been discovered" [FN354] with an outside limit of four years from the date of the injury [FN355] unless the injury occurred before the patient attained the age of six. In the latter case, the lawsuit must be brought before the later of "4 years after the date of the alleged occurrence of the injury or the date on which the minor attains 8 years of age." [FN356]

b. Elective provisions
After mandating limitation of the liability of health care professionals, S. 489 then purports to provide a safeguard against negligent practices. In order to receive Public Health Service Act funds, a state medical review agency must enter into an agreement with the professional society in its state. [FN357] The agreement will require the society to investigate all claims of malpractice to identify "the practice patterns of a health care practitioner." [FN358] The investigation must ***510** be confidential and expeditious, and must be reported to the state agency. [FN359]

The efficacy of these elective Health Service Act provisions is questionable for two reasons. First, unlike the tort reform provisions, these provisions are elective. A state need not comply, although by failing to do so it will risk loss of its Public Health Service Act funds. [FN360] Second, review of physician actions, including those subject to pending malpractice suits, is placed in the hands of professional review boards rather than an independent state agency.

S. 489 contains two other sets of elective provisions, the adoption of which entitles the state to receive grants that S. 489 creates. The first set of these "elective-grant" provisions is a proposal to replace the current trial process with some form of alternative dispute resolution. [FN361] S. 489 defines alternative dispute resolution as a system that is "enacted or adopted by a state to resolve health care malpractice claims other than through a health care malpractice action." [FN362] S. 489 authorizes the Secretary of Health and Human Services to make grants to each state [FN363] and mandates that a state use its grant funds to implement one of four authorized systems for resolving malpractice disputes. [FN364]

First, a state may create an administrative agency to resolve claims. [FN365] Agency decisions will be subject to judicial review which "may not extend to de novo consideration of the underlying facts." [FN366]

Alternatively, a state may adopt a Catastrophic Injury Compensation System to compensate "malpractice" victims regardless of fault. [FN367] The system ***511** would apparently resemble workmen's compensation. [FN368]

Third, a state may adopt an Early Offer and Recovery Mechanism, pursuant to which hospitals and physicians could avoid lawsuits by offering to compensate injured patients for economic losses. [FN369] Disputes concerning the amount of the loss would be resolved by arbitration. [FN370]

Fourth, a state may establish "binding arbitration" to resolve malpractice disputes. Arbitration would take place as a result of either the parties' choice to submit an existing dispute to a panel or the state's unilateral determination that, upon receiving medical treatment, all patients "have entered into an agreement to arbitrate health care malpractice claims." [FN371]

The second set of "elective-grant" provisions provides for grants for physician discipline and public education. [FN372] Educational grants will fund programs to inform the public of "realistic expectations of medical intervention" and of the existence of professional licensing and disciplinary boards. [FN373] The grants may also be used to educate health care professionals regarding "quality assurance, ***512** risk management, and medical injury prevention." [FN374]

2. The Bush Administration Proposal

Like S. 489, the Bush Proposal abolishes the collateral source rule [FN375] and limits recovery of noneconomic damages to $250,000. [FN376] Unlike S. 489, however, it abolishes joint liability for noneconomic damages. [FN377] Instead, " e ach defendant shall be liable only for the amount of non-economic damages allocated to that defendant in direct proportion to that defendant's percentage of fault, and a separate judgment shall be rendered against that defendant for that amount." [FN378]

The Bush Proposal mandates periodic rather than lump-sum payment of damage awards. [FN379] Instead of requiring periodic payment of awards in excess of specific amounts, the Bush Proposal simply provides that a court should direct that payments be made at the time damages are "likely to occur" or when they actually "accrue." [FN380] The court may require the defendant to purchase an annuity to fund payment. [FN381] In the absence of fraud, the judgment may not be adjusted or modified at a later time. [FN382] In contrast to the strict prohibition against lump-sum payment contained in S. 489, the Bush Proposal allows parties to settle for a lump-sum payment. [FN383]

Like S. 489, the Bush Proposal encourages resolution of malpractice disputes by means other than traditional trial. But unlike S. 489, the Bush Proposal does not outline any alternative dispute resolution systems. Rather, the legislation delegates to the Secretary of Health and Human Services the authority to develop alternative dispute resolution

mechanisms. [FN384] A state need only provide "one mediation or pretrial screening panel alternative dispute resolution mechanism specified in regulations issued by the Secretary." [FN385]
The principal difference between the Bush Proposal and S. 489 lies in the method of implementation. S. 489 proposes federal legislation that supersedes inconsistent state law. Because the Bush Administration was concerned with ***513** "its overall federalism policy of respecting states rights," [FN386] all tort reform under its proposal would be enacted, if at all, by state legislatures. [FN387] As an incentive, the federal government will withhold 2% of a state's share of Medicaid administrative expenses and 1% of the annual increases in hospital Medicare prospective expenses if the state fails to enact the reforms. [FN388]

C. Evaluation in Light of Existing Data
Shortly after Senator Hatch introduced the Bush Proposal, Professor Paul C. Weiler of the Harvard Law School - a member of the original study group that produced the Harvard Practice Study - commented on both S. 489 and the Bush Proposal: "My concern [with these proposals] is that they respond only to one side of the problem, the doctor's side, and they don't respond to the patient's side." [FN389] For the most part, Professor Weiler is correct. The Proposals both discourage claims and do nothing for those who presently receive no compensation from the tort system.

***514** 1. Provisions that Discourage Claims
A number of provisions in both proposals seek to discourage lawsuits either directly or indirectly. Because only 12.5% of those negligently injured claim damages by way of lawsuit or written or oral demand, these provisions clearly address the "doctors' side" of the issue.

a. The statute of limitations in S. 489
The statute of limitations contained in S. 489 is the provision that is most clearly designed to discourage lawsuits. Although the two/four-year rule for adults does not depart much from many existing statutes, [FN390] the proposal will certainly decrease claim frequency in jurisdictions that presently have longer statutes of limitations. [FN391] The provision barring children injured before the age of six from bringing suits after the age of twelve will also bar some litigation, so that even fewer than 12.5% of all patients negligently injured will bring suits if the legislation is enacted.

b. The fee limitation provision of S. 489
Close analysis of S. 489's fee limitation provision reveals that it too will either discourage litigation or produce unfairness in the litigation process. [FN392] Because the provision limits the contingent fees plaintiffs' lawyers may charge but not the approximately equal amounts that defendants' lawyers charge, [FN393] enactment will produce an asymmetry. Defendants' lawyers will, on average, receive more compensation than plaintiffs' lawyers. Enactment can only make representing plaintiffs less economically attractive and result in dissuading the plaintiffs' personal injury bar from engaging in this field of law practice. [FN394]

***515** c. Provisions in both proposals mandating periodic payments
Two other provisions contained in both proposals will arguably have the same effect. On its face, the provision mandating periodic payment of awards for future damages should have little impact. Traditionally, all awards for future damages are reduced to present value and awarded in lump-sum. [FN395] Awarding the damages at the time the loss is suffered, but obviously without reduction to present value, should have the same economic consequences to the plaintiff. However, for two reasons periodic payment of awards may make plaintiffs' cases less valuable and thus less likely to be brought. First, neither statute provides for adjusting the future payments for inflation. As a result, the periodic payment may reduce the overall value of the award. [FN396] Second, continued

payment is subject to the defendants' continued economic viability - a risk that the plaintiff need not suffer under the lump-sum system. While neither factor may seem substantial, the data do not support any discouragement of suits and therefore the periodic payment provisions are at least questionable. [FN397]
Both S. 489 and the Bush Proposal contain provisions that should in part ameliorate these effects. S. 489 mandates periodic payment only for awards that exceed $100,000. This exception should avoid making even less attractive the small claims that Senators Hatch and Jeffords already believe are unappealing to plaintiffs' lawyers. [FN398] The Bush Proposal allows the court to require that the defendant purchase an annuity to provide for future payments. This should eliminate some of the plaintiff's risk.

***516** d. Provisions in both proposals that limit recovery of noneconomic damages
The $250,000 limit on noneconomic damages that both proposals contain will certainly make some lawsuits less attractive to lawyers charging contingent fees. Of course, one third of $250,000 should still attract competent counsel in most cases. Moreover, while claim frequency and average claim severity may not have increased as much as the lay press report, there certainly has been a dramatic increase in the size of large awards. [FN399] Regardless of its other merits, [FN400] then, this damage limitation does address a concern that has some factual basis.
***517** This damage limitation may be problematic, however, precisely because it affects only large awards. A recent study attempted to quantify the economic losses in birth and emergency room cases in Florida ("the Florida Compensation Study"). [FN401] The study interviewed families that had filed medical malpractice claims, closed at the time of the study, based on incidents occurring in the 1980s. [FN402] Based on the interviews, the study authors estimated the past and future medical, wage, and "home production" losses of the claimants. [FN403] The authors then concluded that the compensation the claimants had actually received was "inadequate on average" and that the shortfall was most striking for the more severe injuries. [FN404] While the authors themselves question "generalizing conclusions from a detailed analysis of 187 closed claims from one state to the nation as a whole," [FN405] Congress should at least be concerned about limiting the noneconomic losses of the group of claimants most likely to be undercompensated for their economic losses.

e. Provisions in both proposals abolishing the collateral source rule
The provisions abolishing the collateral source rule may be similarly analyzed. To the extent that the size of awards is problematic, even though only 12.5% of possible claims are made, reducing large awards to net losses will reduce the size of awards without leaving plaintiffs with uncompensated losses. [FN406] ***518** Yet, abolition of the rule may have little impact because most private insurance policies now provide for subrogation or refund in the event of a tort recovery, [FN407] and much public compensation is subject to the same limitations. [FN408] Moreover, to the extent that compensation on average, and especially in the larger cases, is inadequate, any attempt to reduce that compensation may be ill-advised.

f. The educational provisions of S. 489
The educational provisions of S. 489 may be the most curious in light of claim frequency data. The legislation directs states to educate the public about the limitations of medical science. This plainly seems intended to persuade patients not to complain about less than ideal results - a goal that is unnecessary when nearly 90% of those injured fail to complain.

2. Alternative Dispute Resolution Provisions that Do Not Provide Economic Efficiency Nor a Forum for Claims Not Presently Redressed by the Tort System
Both S. 489 and the Bush Proposal encourage, but do not mandate, alternative dispute resolution ("ADR") as a more cost-efficient compensation mechanism. Both could cite the Harvard Study in support of this approach. For a number of reasons, however, the

Harvard Study is of little use to the proposals' sponsors in their present form.
First, Senator Hatch has repeatedly advocated tort reform to provide a forum for small, meritorious claims that for some reason are not redressed in the ***519*** tort system. To accomplish his goal, Senator Hatch would have to include in his ADR proposal all patient injuries regardless of severity. Because the Harvard Study excluded all injuries from which patients recover within six months, it does not address this concern. Because claims from which patients recover in six months account for 50% of all claims, their inclusion in Senator Hatch's ADR proposal would severely impair economic advantage of the ADR the Harvard Study proposed. Similarly, the Harvard Study excludes any recovery for noneconomic loss for which both the Bush Proposal and S. 489 allow recovery of up to $250,000. Again, inclusion of these damages would severely impair the economic efficiency of the Harvard model.
Without these limitations on small claims and noneconomic damages proposed by the Harvard Study, most commentators have concluded that ADR would cost the medical community significantly more than the current tort system because most proposals, including the Harvard proposal, do not require a claimant to prove fault and thus would compensate more claimants. [FN409] That ***520*** result is clearly at odds with the goals of both the Bush Proposal and S. 489.
Oddly enough, S. 489 may avoid some of these problems. States are given an option of adopting one of four ADR systems, only one of which, like the Harvard Study model, is no-fault. The other three alternatives would apparently retain fault determination, but would "streamline" the process by arbitration or similar mechanisms. On the one hand, while such a system may produce a less expensive process, it would not address Senator Hatch's concern for those injured patients who never take legal action. On the other hand, the no-fault model would likely be more expensive than the current tort system. In either case, the result probably would not satisfy Senator Hatch.
Finally, even the authors of the exhaustive Harvard Study were unwilling to declare the likely deterrent impact of the tort system expendable. Neither S. 489 nor the Bush Proposal reflects any concern for the loss of this benefit. The only reference in either proposal to anything resembling deterrence is S. 489's proposal for peer review of malpractice claims, with a special emphasis on patterns of claims against individual physicians.
The only difference between this provision and current state licensing review is that S. 489 removes the authority to review claims from independent officials and places that authority in the hands of physicians themselves. Most physicians have long wanted to limit review of their actions to panels of peers. [FN410] In light of the medical view of the malpractice "crisis" (including "dubious" and "frivolous" claims) this proposal may serve only to reduce the number of claims filed - a result that available data do not support.

3. Legislation that Discourages Claims and Does Not Serve Those Whose Claims Are Not Redressed by the Tort System
In sum, both the Bush Proposal and S. 489 appear to go too far and at the same time not far enough: too far by seeking to discourage the bringing of claims, and not far enough by doing nothing for those injured patients who receive no compensation from the present tort system. The proposals nicely serve the interests of physicians in reducing the cost of liability insurance but do not address the underlying issues of physician negligence and the failure to compensate a majority of those who are negligently injured.

521 D. Impact of the Adversarial Dialogue and Recommendations for Congress

1. The Adversarial Dialogue - One Last Look
The member of President Bush's Administration who opined that many states are "under the gun of trial lawyers" [FN411] gave voice to the bias that underlies both the Bush Proposal and S. 489. Despite the public statements of President Bush and Senators

Hatch and Jeffords, "frivolous" litigation and "dubious" claims cannot be problematic when the data suggest that almost ten times as many suits should be brought. [FN412] The speakers apparently were not aware of the data. Or, more pointedly, the speakers may not have cared about the data. Indeed, Senator Hatch still spoke of the fear of litigation after apparently discovering the Harvard Study. [FN413] In either case, one must wonder why anyone would propose legislation targeting an institution as central to our culture as the civil litigation system without consulting and, to the extent possible, implementing the available data.

The answer may lie in the alliance of the medical community and the sponsors of the legislation. As the quote that opened this article indicates, physicians have always been alarmed by the frequency of lawsuits, regardless of cause and/or the relationship of lawsuit frequency to the frequency of malpractice. Their "prescribed" solution has always been "legislation, and plenty of it," [FN414] and they participated extensively in drafting the proposals.

Although this simplistic explanation may be closer to the truth than advocates of the proposed legislation would like to admit, it confirms only that the legislation does reflect the wishes of one participant in the adversarial dialogue. We cannot and should not ask our legislators to refuse to hear the views of constituents who report what they regard as a crisis in a vital profession. Moreover, the assertion that legislation can represent victory for one side in a debate ***522** is neither new nor startling. [FN415]

That legislation may favor one segment of the population over another is likewise neither new nor startling. [FN416] In recent years Public Choice theorists have argued that much legislation is largely a product of the influence that special interest groups assert over the political process. [FN417] Thus, "the lawmaking process has been transformed into a series of accommodations among competing elites." [FN418] Legislation serves the interests of these groups rather than the public at large. [FN419] The Public Choice theorists' indictment of the legislative process has even led them to advocate that courts faced with the need to interpret statutes should freely deviate from the implications of legislative history [FN420] and strict statutory construction when doing so will result in enforcement of "truly-held majoritarian values." [FN421] These assertions have produced a spirited debate in ***523** which some scholars have branded the Public Choice model as "immoral" [FN422] while others have simply described the model as overly generalized. [FN423]

Regardless of whether one sides with the Public Choice theorists or their critics, one can, at a minimum, include S. 489 and the Bush Proposal within the body of empirical evidence that the theorists cite in order to demonstrate the influence of particular interest groups. [FN424] Moreover, because neither the Bush Proposal nor S. 489 has been enacted, we need not be concerned with the impact of Public Choice theory on the interpretation of enacted legislation. Instead, we can ask Congress to view the current proposals in light of the revelations of Public Choice theory and to consider only that legislation that will implement the available data without overtly favoring any particular interest group.

2. Recommendations for Congress: The Data Do Not Support Enacting Legislation that Will Discourage Malpractice Claims

The data regarding the frequency of physician negligence and malpractice claims clearly indicate that Congress should not enact legislation designed to discourage or bar malpractice claims. Thus, Congress should not enact the fee limitation or the statute of limitations provisions in S. 489. [FN425] Similarly, Congress should not enact any educational or grant provisions designed to dissuade patients from complaining about their treatment. [FN426]

The claim severity data, however, do support enactment of two provisions of both proposals. First, limiting recovery of noneconomic damages [FN427] will ***524** ameliorate the dramatic increase in the severity of large awards. Second, abolishing the collateral source rule [FN428] will also limit recovery, yet should not unduly discourage claims. Moreover, these two provisions are the only tort reform measures that have proven

effective. In 1986, Patricia Danzon published yet another pioneering study in which she analyzed claim data supplied by insurers for forty-nine states for the years 1975 through 1984. [FN429] The data demonstrated that of all tort reform measures, including alternative dispute resolution provisions, contingent fee limitations, and mandatory periodic payment of awards, only damage caps and abolition of the collateral source rule significantly reduced the severity of malpractice claims. [FN430]

Although effective in addressing the dramatic increase in claim severity, the propriety of enacting these measures has been substantially undercut by the Florida Compensation Study. [FN431] If the conclusions of that study can be generalized across the nation, "overcompensation is more nearly the exception than the rule," [FN432] and these provisions that propose to limit "payment for total loss and noneconomic loss are inappropriate." [FN433]

The other provisions of S. 489 and the Bush Administration Proposal require further study before Congress should even consider enactment. Chief among these provisions are the proposals for ADR. Senator Hatch's twin goals of making the compensation system more efficient and at the same time more effective in compensating those who do not now receive compensation are admirable. The system probably can be made both more efficient and more effective by eliminating fault. That change, however, will thwart Senator Hatch's and ***525** President Bush's goal of reducing the overall cost of malpractice compensation. [FN434] The President, Senator Hatch, and Congress must choose between compensating the "missing 90%" and reducing the overall cost of malpractice awards. They cannot have both.

Congress must also decide whether we can do without the possible deterrent impact of the tort system. The Harvard Study's authors, for example, conceded that they could not "directly determine the magnitude of any deterrence" produced by the existing tort system. [FN435] This gap in our knowledge can be filled only by broadening the study to include more hospitals inside and outside New York. [FN436] In addition, more sophisticated techniques must be employed to measure the "threat of a claim" being filed against a physician. [FN437]

Perhaps Congress should also consider whether the malpractice insurance system can provide the requisite deterrence. [FN438] When as few as 1% of physicians are responsible for as many as 50% of all claims, mandating that premiums be based, at least in part, on claim history may well be justified.

Finally, many share the view of President Bush, Senator Hatch, and the medical community that ours is a more litigious society than we would like. [FN439] Regardless of the relationship between injuries and claims, many would prefer ***526** less litigation. [FN440] Because the only accurate predictor of the rate of litigation is urbanization, perhaps the only answer to those who are concerned is that we must learn to live with the consequences of our own social evolution. In 1875, Dr. Hamilton advised that the medical profession and society must accept the imperfection of medicine. [FN441] Perhaps the best one can do today is to add that we must also accept the resulting litigation.

CONCLUSION

Times may have changed since Dr. Hamilton spoke in 1875, but the nature of the dialogue between physicians and lawyers has not. Physicians continue to identify the practice of law and the litigious nature of our society as the cause of a problem that clearly burdens the thoughts of many, if not most practitioners. In response, lawyers have almost uniformly questioned the existence of any problem or, alternatively, have cited physician negligence as the root of the cause. Moreover, the data to which both camps refer are in most cases anecdotal. As one observer recently put it, "That is precisely the problem - almost everyone is an extremist of one stripe or another when it comes to debating the legal system." [FN442]

There have been, however, two major changes since 1886. First, legislators have now acted on the basis of these anecdotal accounts, providing physicians with "legislation, and

plenty of it." Second, and in striking contrast to the first change, we are no longer limited to anecdotal evidence. The two wide-ranging studies of Danzon and Harvard contradict in many ways the accounts that the medical and legal communities present in their adversarial dialogue. Both studies recognize their own limits - limits that can be redressed only by broadening the studies and employing more sophisticated research techniques. [FN443] Thus, the process of empirical study has only begun.

At the very least, however, the data now available have demonstrated two propositions. First, the present tort system is not likely, by itself, to cause the economic failure of health care in this country. After all, only approximately 12.5% of those injured assert any type of claim. Moreover, the premiums that cover those claims account for less than 1% of our health care costs. When combined with AMA estimates of the cost of defensive medicine, the total still accounts for only 3% of health care costs. Second, the deterrent effect of the tort system, supported by "common sense" perceptions, has not been disproven and even studies calling into question its efficacy have cautioned against abandoning it wholesale. The only prudent course serving "truly-held majoritarian values" lies in attempting to implement existing data and conducting further study of the problem.

Finally, those who advocate immediate legislation may urge enactment of the provisions of the Bush Proposal and S. 489 that are supported by claim ***527** severity data - the cap on noneconomic damages and the abolition of the collateral source rule. Those provisions, however, are at odds with the recent Florida Compensation Study that indicates that undercompensation rather than overcompensation is the norm in medical malpractice claims. That is, although claim severity has increased dramatically in recent years, the claims, especially large claims, may not yet be "severe" enough. Without further and broader study, any present attempt at "remedial" legislation is simply inappropriate and may well prove counterproductive.

[FNa]. Associate Professor of Law, Bridgeport Law School at Quinniplac College. J.D., 1982, University of Arizona; LL.M., 1988, Yale Law School. The author thanks his colleague Alexander Meiklejohn for comments on earlier drafts, Jay Katz, M.D., of the Yale Law School for direction and support in early research, and Suzanne Krudys and Shuli Graham for research assistance.

[FN1]. PATRICA M. DANZON, THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS iii (1982). For two detailed symposia published by the same journal only five years apart, see generally Symposium, Medical Malpractice: Can the Private Sector Find Relief?, 49 LAW & CONTEMP. PROBS. 5 (1986) and Symposium, Medical Malpractice: Lessons for Reform, 54 LAW & CONTEMP. PROBS. 5 (1991). For discussions of the "medical malpractice crisis of the 1970s," see generally PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (1991); Glen O. Robinson, The Medical Malpractice Crisis of the 1970s: A Retrospective, 49 LAW & CONTEMP. PROBS. 5 (1986); Frank A. Sloan, State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment, 9 J. HEALTH POL., POL'Y & L. 629 (1985). For other, more recent discussions of medical malpractice, see generally Randall R. Bovbjerg, Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card, 22 U.C. DAVIS L. REV. 499 (1989); Patricia M. Danzon, The "Crisis" in Medical Malpractice: A Comparison of Trends in the United States, Canada, the United Kingdom and Australia, 18 LAW, MED. & HEALTH CARE 48 (1990); David J. Nye et al., The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances, 76 GEO. L.J. 1495 (1988).

[FN2]. See infra notes 31-88 for a discussion of the medical malpractice debate between the medical and legal professions.

[FN3]. See infra notes 15-19 and accompanying text for a discussion of state legislative tort reform in the 1970s. See infra notes 52-69 and accompanying text for a discussion of

state legislative tort reform in the 1980s. See infra note 54 and accompanying text for a current summary of state tort reform.

[FN4]. S. 489, 102d Cong., 1st Sess. (1991). See infra notes 337-74 and accompanying text for a detailed discussion of the provisions of S. 489. See infra note 83 for a summary of 1991 federal legislative action concerning medical malpractice.

[FN5]. S. 1123, 102d Cong., 1st Sess. (1991). The Administration added the proposal to the end of its 1991 budget proposal. See infra notes 375-88 and accompanying text for a detailed discussion of the proposal's provisions.

[FN6]. See Cross v. Guthery, 2 Root 90 (Conn. 1794). Dr. Guthery, a surgeon, was sued by the husband of one of his patients who had died as a result of allegedly "unskillful, ignorant, and cruel" surgery. Id. at 90- 91. The jury awarded the plaintiff damages of 40 pounds. Id. at 91.

[FN7]. JOHN J. ELWELL, MEDICO-LEGAL TACTICS ON MALPRACTICE AND MEDICAL EVIDENCE 7 (1871).

[FN8]. Frank H. Hamilton, Malpractice in Surgery, in MEDICO-LEGAL PAPERS, at 98-99 (New York, The Medico-Legal Journal Ass'n, First Series 3d ed. 1889).

[FN9]. Id. at 99.

[FN10]. Id. at 98-99.
During the period of time extending from the year 1833; when, on admission to the practice of medicine and surgery, I first became aware of the condition of matters in my profession, down to the year 1856, or thereabouts, suits for malpractice were so very frequent in the Northern States - they were always less frequent in the Southern States - that many eminent men who had acquired reputation as surgeons, in order to escape the danger which seemed to threaten all alike, abandoned the practice of surgery, leaving it to those who, with less skill and experience, had less reputation and property to lose.

[FN11]. Frank H. Hamilton, A.M., M.D., L.L.D., practiced surgery in New York State at the time he presented the referenced speech. See id. at 97. Dr. Hamilton claimed to be the first in the history of surgery to compile statistics regarding the success rates of surgical procedures. Id. at 104. He published a series of articles reporting on over 1000 cases of treatment of broken bones. Id. at 105. To support the observations that he presented to the Medico-Legal Society of New York, Dr. Hamilton quoted sources describing his research efforts as "herculean, and ... of great practical importance to the surgeon," id.; JOHN J. ELWELL, ELWELL ON MALPRACTICE 86 (New York, Baker, Voorhis & Co., 3d ed. 1871), and "one of the most valuable contributions ever made to American surgery." Hamilton, supra note 8, at 106 (quoting NEW YORK JOURNAL OF MEDICINE (1858)).

[FN12]. Hamilton, supra note 8, at 100 (quoting JOHN J. ELWELL, ELWELL ON MALPRACTICE 7, 8 (New York, Baker, Voorhis & Co., 3d ed. 1871)). Dr. Hamilton added that, despite the crisis, he had not been sued: "The best surgeons were the most frequently prosecuted; and the speaker has always felt that he, perhaps, had some reason to complain, inasmuch as he had never been prosecuted, and he could not, therefore, claim for himself this title to respectability." Id. at 99-100.

[FN13]. Id. at 103.

[FN14]. Id. at 108.

[FN15]. DANZON (1982), supra note 1, at iii.

[FN16]. Id. at 39-48. "Aggressive campaigns to reform state laws governing medical liability lawsuits began in the 1970s. Every state except West Virginia passed reforms." MEDICAL MALPRACTICE INSURANCE INFORMATION INSTITUTE, (Ruth Gastel ed., Feb. 1992), [hereinafter MEDICAL MALPRACTICE] (LEXIS, Nexis library, IIRPTS file). Despite recent premium reductions, West Virginia physicians still call for tort reform. "The president of the state Medical Association said malpractice rates in West Virginia remain higher than in neighboring states. Dr. Derrick Latos of Wheeling renewed a call for legal reforms that would give doctors more protection against costly litigation." Medical Malpractice Premiums Lowered in West Virginia, UPI, Sept. 19, 1990 (LEXIS, Nexis library, OMNI file). In apparent reaction, the West Virginia legislature recently enacted a $1 million cap on noneconomic damages in medical malpractice cases. See infra note 54. For an even more recent account of state legislative and judicial reaction to medical malpractice litigation, see THE LIABILITY SYSTEM INSURANCE INFORMATION INSTITUTE (Nov. 1991) (LEXIS, Nexis library, IIRPTS file) [hereinafter THE LIABILITY SYSTEM].

[FN17]. DANZON (1982), supra note 1, at 43-48. Thirty states enacted legislation authorizing the use of screening panels, designed to eliminate some malpractice claims. Id. at 43. Thirty-eight states enacted more restrictive statutes of limitations for medical malpractice actions. Id. at 46-47 (citations omitted). See infra note 54 for a summary of current state tort reform legislation.

[FN18]. Seventeen states enacted legislation directly limiting plaintiff recovery. DANZON (1982), supra note 1, at 48. Sixteen states modified, in some respect, the collateral source rule. Id. at 40-41. The collateral source rule prohibits the introduction into evidence of any payments the plaintiff has received for his or her injury from a source other than the defendant. See, e.g., Lee R. West, The Collateral Source Rule Sans Subrogation: A Plaintiff's Windfall, 16 OKLA. L. REV. 395, 395-97 (1963) (plaintiffs' recovery against defendant is not reduced by payments from plaintiff's own insurance, worker's compensation, or similar sources). See infra note 54 for a summary of current state tort reform legislation.

[FN19]. Seventeen states enacted legislation limiting contingent fees, making litigation more costly to lawyers. DANZON (1982), supra note 1, at 41. Screening panels may make litigation longer, require duplication of expert witness time at the panel hearing and at trial, making litigation more costly to plaintiffs. See supra note 17 for a discussion of screening panels.
In addition to the measures mentioned in notes 17-18, thirty-one states enacted legislation prohibiting lawyers from mentioning the dollar amount demanded in damages. DANZON (1982) supra note 1, at 39. Fourteen states enacted legislation prohibiting or modifying the use of the res ipsa loquitur doctrine. Id. at 44-45. That doctrine allows the plaintiff to shift the burden of proof of negligence (actually, non-negligence after the burden has shifted) to the defendant when the plaintiff's injury would not likely have occurred absent the defendant's negligence, and the injury was caused by an instrumentality in the exclusive control of the defendant. Id. See infra note 54 for a summary of current state tort reform legislation.

[FN20]. See, e.g., Concerns Growing Over Liability Insurance Climate, AM. MED. NEWS, Apr. 11, 1986, at 4:
There can be little question of the need for change. While in the past the civil tort system has worked reasonably well in assuring proper compensation for those who are injured by the negligent or wrongful conduct of another, that tort system is not working well today. It has become erratic, unfair, and expensive.
For a recent citation to the "crisis," see Orrin Hatch, The Medical Malpractice Crisis: Physicians' Concern Over Future Liability Costs is Adversely Affecting Access To Health Care for All Americans. What Can We Do to Solve the Problem?, LEVITT

COMMUNICATIONS, INC., ROLL CALL, Mar. 26, 1990 (LEXIS, Nexis library, Roll Call file) ("Since the mid-1970s the increase in medical malpractice litigation has sparked growing public and professional concern."). Most recent discussions indicate that the "crisis," if it ever existed, is over. See, e.g., Sarah Glazer, Whatever Happened to the Malpractice Insurance Crisis?, THE WASH. POST, July 9, 1991 (Weekly Journal of Medicine, Health, Science and Society), at 10.

Until recently, when President Bush proposed new legislation aimed at reforming the nation's patchwork of medical malpractice laws, many experts believed that the crisis of the mid-1980s, which had been characterized by a spate of lawsuits against doctors and skyrocketing insurance premiums, had largely abated.... Privately, Bush administration officials agree that the malpractice crisis appears to be on the wane.

Id.

In light of growing evidence of the abatement of the "crisis," physicians still urge their cause, but with a different focus:

This rising interest in Washington [in tort reform legislation] has come in large part from doctors' success in reframing the debate. As the number of malpractice claims and the cost of premiums have recently declined, doctors have shifted from their traditional complaints that malpractice insurance is too costly and hard to obtain. The real problem, they argue, is the cost added to the nation's whopping health care tab, not only from malpractice insurance premiums but - much more important - from doctors' practice of "defensive medicine." They must offer superfluous tests and services, they say, to protect themselves from malpractice lawsuits.

Julie Kosterlitz, Malpractice Morass, NAT'L J., July 6, 1682. Even American Medical Association (AMA) Executive Vice President James S. Todd, M.D., concedes to a change in the focus of the AMA's position: "'The economic impact may have stabilized or even lessened for the moment, but the psychological toll the current system takes on physicians and the affect of all this on the doctor/patient relationship hasn't lessened one whit."' Brian McCormick, Congress Studies More Tort Reform Plans; No Consensus, AM. MED. NEWS, Oct. 14, 1991, at 3, 19.

[FN21]. See, e.g., SEARCH FOR ANSWERS FRUSTRATING: LAWSUITS NOW A WAY OF LIFE FOR ORTHOPEDISTS, AM. MED. NEWS, Mar. 14, 1986, at 2:

I'm 52, still competent, and easily could continue to perform surgery for another 10 years. But my liability premiums are $42,000 a year without doing spine surgery, $56,000 with spine surgery. This year, the rates are scheduled to increase by 50%, and effective July 1 the coverage will be reduced to claims-made. I simply choose not to afford it any longer. After 23 years of solo practice, I have joined a group, and last March I quit doing surgery. Now, I only do consulting.

See also MEDICAL MALPRACTICE, supra note 16 (severe threats of medical malpractice suits exist in field of obstetrics); Betsy Lehman, The Cost of Doing Business, BOSTON GLOBE, Aug. 26, 1985, at 4 (rising cost of malpractice insurance and fear of being sued above limits of insurance policies causing many obstetricians to quit obstetrics).

[FN22]. See, e.g., MEDICAL MALPRACTICE, supra note 16.

Another aspect of the medical malpractice crisis is its impact on obstetrics, a high-risk specialty where premiums are especially high. An American College of Obstetricians and Gynecologists survey showed that one out of eight physicians specializing in pregnancy has stopped delivering babies due to the threat of malpractice suits, and predicted that there will be more physicians leaving obstetrics at the height of their professional ability. The survey showed that two-thirds of those who had stopped delivering babies ceased practicing before age 55. In 1985, only 54 percent stopped delivering babies before that age. Previous studies have shown that this trend hits rural areas of the nation hardest. See also Lehman, supra note 21, at 4 (many obstetricians in Maine and Massachusetts leave obstetrics when faced with increasing malpractice premiums).

[FN23]. "Defensive medicine" refers to medical practices in which physicians engage

merely for the purpose of avoiding malpractice suits, or for the purpose of providing a defense in the event a suit is filed. See Steven Brill, Curing Doctors, 12 CONN. L. TRIB., Jan. 27, 1986, at 1, 9 ("threat of malpractice suits causes doctors to practice 'defensive medicine"'). The AMA contends that "defensive medicine" constitutes 30% of all current medical practice. For the most recent reference to the 30% figure, see id.; George F. Will, Rockefeller: Mining the Health-Care Issue, THE WASH. POST, June 16, 1991, at B7 ("30 percent of health-care costs result from unnecessary or inappropriate procedures"). For an account of the defensive medicine at the peak of the "malpractice crisis," see generally Susan Squire, The Doctors' Dilemma!, NEW YORK MAG., Mar. 18, 1985. For more recent discussions of defensive medicine, see Glazer, supra note 20, at 11 ("Even assuming that an additional $15 billion is spent on "defensive medicine" in the form of unnecessary tests and procedures, as the AMA estimates, malpractice costs account for only about 3 percent of the nation's total health care bill"); Kosterlitz, supra note 20, at 1685 (AMA estimates that defensive medicine costs $19 billion a year). See also infra notes 267-71 and accompanying text.

[FN24]. See Kosterlitz, supra note 20, at 1685 (AMA estimates that defensive medicine costs $19 billion a year).

[FN25]. See infra notes 31-33 and accompanying text for a discussion of ABA's 1979 study of the tort system.

[FN26]. See infra notes 31-88 and accompanying text for a discussion of the medical malpractice debate between the medical and legal professions.

[FN27]. An AMA senior deputy executive vice president once stated that allowing lawyers to review legislation proposed by physicians is "like sending the wolves to watch the chicken coop." Tony Mauro, Lawyers, Doctors Clash on Malpractice, USA TODAY, Feb. 12, 1986, at 1 (quoting Dr. James S. Todd). The American Bar Association (ABA) replied that "[l]awyers are speaking for the injured parties of this country." Id. (quoting William Falsgraf, President, American Bar Association). By 1986, the "bitterness between the two professions [was] deeply felt." Richard Lacayo, The Malpractice Blues, TIME, Feb. 24, 1986, at 60.
The cost of this debate has been enormous: "The amount spent on the state tort wars is hard to determine. But at the federal level, political action committees seeking to sway opinion on a sweeping products liability bill have contributed more than $2 million to Senate Commerce Committee members since 1983." Andrew Blum, The Hundred Years' (Tort) War, NAT'L L.J. Oct. 15, 1990, at 1.

[FN28]. S. 489, 102d Cong., 1st Sess. (1991). See infra notes 337-74 and accompanying text for a discussion of the provisions of S. 489.

[FN29]. S. 1123, 102d Cong., 1st Sess. (1991). See infra notes 375-88 and accompanying text for a discussion of the provisions of the proposal.

[FN30]. The AMA "deeply appreciates" the Bush Administration proposal and "continues to strongly support" S. 489. (MEMBER MATTERS, (American Medical Association, Chicago, Illinois) July 1991)).

[FN31]. Lacayo, supra note 27, at 60.

[FN32]. Spec. Comm. on the Tort Liability System, Towards A Jurisprudence of Injury: The Continuing Creation of A Law 1-13 (ABA 1984) ("We have found the tort system to be vital and responsive as a working process, based in legal concepts, for dealing with injuries alleged to be wrongs.") The report was compiled by the ABA Special Committee on the Tort Liability System, and presented to the ABA House of Delegates. Id.,

Committee's Preface. The report does not constitute ABA policy. Id., title page.

[FN33]. Id. at 12-1-12-6. The ABA was extravagant in its praise. It stated that the tort system "provides a grassroots response to ... injuries," id. at 12-1, "provides the incremental wisdom of the common law," id. at 12-2, "provides a forum," id., "plays an important role in knitting together, and mediating, the goals of compensation statutes and regulatory laws," id. at 12-3, "reduc[es] social friction," id. at 12-4, "serves as a reflector, as well as a positive agent, in the ongoing identification of the moral basis of the social contract," id. at 12-5, and "provides justice in a pluralistic society." Id. (emphasis omitted).

[FN34]. Mark Rust, ABA Rejects AMA Tort Plan, Asks Study, AM. MED. NEWS, Feb. 21, 1986, at 33 (quoting James Todd, M.D., AMA Senior Deputy Executive Vice President).

[FN35]. Id. See supra note 18 and accompanying text for a brief discussion of the collateral source rule.

[FN36]. Lacayo, supra note 27, at 60. The proposal has now been incorporated, in substantially identical form, into S. 489, and is currently pending before Congress. See infra notes 337-74 and accompanying text for a discussion of the provisions of S. 489.

[FN37]. Lacayo, supra note 27, at 60 (quoting Talbot D'Alemberte, Dean of Florida State University Law School and chair of the ABA committee that recommended rejecting the AMA proposal). The AMA found the ABA's refusal to address the AMA report in any detail "distressing": "Despite the extensive research that went in to our report, they failed to even mention it, let alone study it." Rust, supra note 34, at 33 (quoting James Todd, M.D., AMA Senior Deputy Executive Vice President).

[FN38]. Rust, supra note 34, at 33 (ABA President William Falsgraf "acknowledged that a new study was needed because of dissatisfaction with the old one"). The report, which was released in December of 1984, took five years to complete and is approximately 500 pages in length. Id.

[FN39]. Id. (quoting ABA President William Falsgraff).

[FN40]. The members of the section likely serve physicians by providing legal assistance in the formation of professional corporations and counsel regarding other commercial transactions.

[FN41]. Id. The chairman of the corporate and banking law section stated: "'[The public] could misconstrue the action and [interpret it] as a commitment to the status quo and to all-out war with the AMA.'" Id.
The corporate and banking law section also introduced an amendment requiring the ABA to join with the AMA, state and federal governments, and "appropriate segments of the public" in order to obtain a "broader consensus on how more equitably to compensate persons injured in our society." Id. at 33. In addition, the amendment, which passed unanimously, called for cooperation between the AMA and ABA to "avoid any efforts to polarize discussion of these problems." Id. at 33.

[FN42]. A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based, Administrative System, reprinted as the 1987 AMA ANNUAL REPORT in AM. MED. NEWS, Apr. 1, 1988, at 18.

[FN43]. Id.

[FN44]. Id.

[FN45]. Id.

[FN46]. See supra notes 17-19 and accompanying text for a discussion of tort reform measures enacted in the 1970s. See infra note 54 for a summary of current state tort reform.

[FN47]. Paul B. Weiss, Comment, Reforming Tort Reform: Is There Substance to the Seventh Amendment?, 38 CATH. U. L. REV. 737, 739 n.11 (1989) (constitutions provide for right to jury trial). See, e.g., Cal. Const. art. I, § 16 (amended 1980); Conn. Const. art. I, § 19 (amended 1972); Fla. Const. art. I, § 22; Mass. Const. pt. I, art. 16; N.Y. Const. art. I, § 2 (amended 1938); Pa. Const. art. I, § 6.

[FN48]. For a discussion of the constitutionality of tort reform measures that mandate resolution of cases without juries, see generally Weiss, supra note 47, at 766. See also infra note 400 and accompanying text for cases discussing the constitutionality of a variety of tort reforms.

[FN49]. See Harris Meyer, Alternative Malpractice Plan Moving in States, AM. MED. NEWS, Sept. 23/30, 1991, at 3 (summarizing AMA/Speciality Society Medical Liability Project's 1989 report).

[FN50]. See Harris Meyer, AMA Liability Plan is Worth a Try, Study Says, AM. MED. NEWS, Sept. 23/30, 1991, at 34 (project model needs some fine-tuning but deserves a test). See infra note 409 for a discussion of the conclusions of the study.

[FN51]. Id. Apparently conceding that ABA cooperation will not be forthcoming, the AMA recently sought other allies to broaden its political base when it formed with health, business, and consumer groups the Alliance for Medical Liability Reform. Janice Perrone, AMA Proposes New Alliance in Renewed Tort Reform Push, AMA NEWS, Mar. 2, 1992, at 2. The Washington Business Group on Health, the National Association of Manufacturers, the American Hospital Association, the American Health Care Systems Institute, and the American College of Obstetricians and Gynecologists have joined as charter members. Id. Representatives of the charter members will immediately approach more than 60 other groups to request they join in the AMA's campaign for tort reform. Id.

[FN52]. See sources cited supra note 16 for a summary of legislative action in the 1980s. See supra notes 17-19 and accompanying text for a summary of legislative action in the 1970s.

[FN53]. See generally MEDICAL MALPRACTICE, supra note 16, at 39-48.

[FN54]. Id. The cited source reports that West Virginia is the lone hold-out in the race for tort reform. Id. The West Virginia legislature has now remedied that deficiency by enacting a $1 million cap on noneconomic damages in medical malpractice cases. W.VA. CODE § 55-7B-8 (Supp. 1991).
By the end of 1991, the legislatures of eight states had enacted caps on noneconomic damages. THE LIABILITY SYSTEM, supra note 16. See infra note 400 for cases discussing the constitutionality of these statutes. For examples of legislation, see, e.g., Alaska Stat. § 09.17.010(b) (Supp. 1991) ($500,000 cap on noneconomic damages in actions to recover damages for personal injury); Colo. Rev. Stat. § 13-21-102.5(3) (1987) ($250,000 cap on noneconomic damages); Haw. Rev. Stat. § 663-8.7 (Supp. 1991) (repealed, effective Oct. 1, 1993) ($375,000 cap on noneconomic damages in tort actions); Idaho Code § 6-1603 (1990) ($400,000 cap on noneconomic damages in all personal injury cases); Mass Gen. Laws Ann. ch. 231, § 60H (West Supp. 1991) ($500,000 cap on noneconomic damages in medical malpractice cases).

By the end of 1991, the legislatures of 27 states had enacted statutes limiting recovery of punitive damages. THE LIABILITY SYSTEM, supra note 16. See, e.g., Alaska Stat. § 09.17.020 (1990) (punitive damages available only upon proof by clear and convincing evidence); Colo. Rev. Stat. § 13-21- 102(1)(a), -102(4) (1987) (amount of reasonable exemplary damages shall not be greater than compensatory damages); Fla. Stat. Ann. § 768.73(1)(a) (West Supp. 1992) (punitive damages shall not exceed three times amount of compensatory damages); Haw. Rev. Stat. § 671-15(b) (1988) (medical liability review panel cannot recommend punitive damages); Iowa Code Ann. § 668A.1 (West 1987) (jury must answer special interrogatories before awarding punitive damages).

By the end of 1991, the legislatures of 20 states had abrogated the collateral source rule. THE LIABILITY SYSTEM, supra note 16. See supra note 18 for a discussion of the collateral source rule. See infra note 406 for cases discussing the constitutionality of abrogating the rule. For examples of legislation see, e.g., Alaska Stat. §§ 09.17.070 (1990) (defendant may introduce evidence of amounts received by claimant from collateral sources in all civil actions); Alaska Stat. § 09.55.548(b) (1990) (collateral source reduction in claimant's award in medical malpractice cases); Cal. Civ. Code § 3333.1 (West Supp. 1992) (defendant may introduce evidence of plaintiff's receipt of collateral source benefits in medical malpractice actions); Colo. Rev. Stat. §§ 13-21-111.6 (1987) (personal injury and property damages reduced by amount plaintiff is indemnified or compensated), § 13-64-402 (Supp. 1991) (plaintiff must provide notice of any amount of medical compensation in medical malpractice actions); Conn. Gen. Stat. Ann. § 52-225a (West 1991) (reduction in damages in personal injury and wrongful death actions for collateral source payments); Fla. Stat. Ann. § 766.202(8)(a) (West Supp. 1992) (payments in medical malpractice actions shall be offset by collateral source payments); Mass. Gen. Laws Ann. ch. 231, § 60G (West Supp. 1991) (damage awards in medical malpractice cases reduced by plaintiff's collateral source benefits); N.Y. Civ. Prac. L. & R. § 4545 (McKinney Supp. 1992) (collateral source rule applies in loss and damages medical malpractice cases); 40 Pa. Cons. Stat. Ann. § 1301.602 (Supp. 1991) (loss and damages reduced by any public collateral source of compensation in medical malpractice actions).

By the end of 1991, 33 state legislatures had abolished or limited joint and several liability. THE LIABILITY SYSTEM, supra note 16. The common law doctrine of joint and several liability renders a defendant liable for the plaintiff's entire loss even though other defendants may have contributed to that loss. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 47, at 328 (5th ed. 1984). In most cases, the statutes apportion liability for damages according to the percentage of fault assessed against the defendant. For examples of legislation, see Alaska Stat. § 09.17.080 (1990) (liability is based on each party's percentage of fault); Colo. Rev. Stat. § 13-21- 111.5 (Supp. 1991) (defendant liable for amount no greater than percentage of fault); Conn. Gen. Stat. Ann. § 52-572o (West Supp. 1991) (repealed effective Oct. 1, 1993) (joint and several liability for joint tortfeasors applies for recovery of economic damages in actions involving injury or death); Fla. Stat. Ann. §§ 766.112(2) (comparative fault applies in medical malpractice cases), 768.81 (comparative fault applies in all negligence cases) (West Supp. 1992); Haw Rev. Stat. § 663-10.9 (Supp. 1991) (repealed effective Oct. 1, 1993) (joint and several liability for joint tortfeasors applies for recovery of economic damages in actions involving injury or death); Idaho Code § 6-803 (1990) (joint and several liability in exceptional cases, otherwise liability allocated according to percentage of fault); N.J. Stat. Ann. § 2A:15-5.2 (West Supp. 1991) (in all negligence cases, trier of fact determines each person's percentage of negligence).

Many state legislatures have also mandated periodic payment of damages awarded for future losses. See, e.g., Alaska Stat. § 09.55.548(a) (court may enter judgment that future damages be paid by periodic payments in medical malpractice cases); id. § 9.17.040(d) (court may enter judgment that future damages be paid in periodic payments in other personal injury cases) (Supp. 1990); Cal. Civ. Proc. Code § 667.7 (West 1980) (damages paid in periodic payments for awards exceeding $50,000 in medical malpractice cases); Colo. Rev. Stat. §§ 13-64-201 to -213 (Supp. 1991)

(periodic payments for awards exceeding $150,000 in medical malpractice cases); Conn. Gen. Stat. Ann. § 52-225d (West 1991) (periodic or lump sum payment of damages for awards exceeding $200,000 in all personal injury actions); Fla. Stat. Ann. § 768.78(1)(a)(2) (periodic payments mandated for awards exceeding $250,000 in personal injury cases); id. § 768.78(2) (awards exceeding $250,000 in medical malpractice cases) (West Supp. 1992); N.Y. Civ. Prac. L. & R. § 5031(b) (installment payments permitted for awards exceeding $250,000 in medical malpractice cases); id. § 5041(b) (periodic payments for awards exceeding $250,000 in all other personal injury cases) (McKinney Supp. 1992).
Many state legislatures have limited the contingent fees that plaintiffs' lawyers can charge. See, e.g., Cal. Bus. & Prof. Code § 6146 (West 1990) (sliding scale in medical malpractice cases for collection of contingency fees); Conn. Gen. Stat. Ann. § 52-251c (West 1991) (sliding scale limitation on attorney contingency fees in personal injury, wrongful death, and property damage cases); Mass. Gen. Laws Ann. ch. 231, § 60I (West Supp. 1991) (in malpractice cases all fees must be "fair and reasonable" and contingent fees subject to sliding scale); Utah Code Ann. § 78-14-7.5 (1987) (attorney's contingency fees limited to 33.3% of the amount recovered in malpractice cases).
Finally, the legislatures of two states have enacted no-fault compensation systems that apply to claims that infants have been neurologically impaired. See generally Fla. Stat. Ann. § 768.78(1) (1991); Va. Code Ann. § 38.2- 5000-5021 (1991). To date, fewer than 10 claims have been filed under those statutes. The Liability System, supra note 16. In June 1991, the New York Governor proposed similar legislation. Id.
See supra notes 17-19 and accompanying text for a summary of state tort reform legislation in the 1970s.

[FN55]. See generally Blum, supra note 27, at 1, 26.
[Robert] Lembo [American Trial Lawyers Association director of state relations] says the tort reform movement peaked between 1986 and 1987, when there was an identifiable crisis from a legislative viewpoint, and many states passed bills. "Since then, there have been attempts to take a bite out of the apple in states where they were not successful," he says. "More often than not it's nibbles rather than bites."
Id.; see also Lenore S. Marema, Public Regulation of Insurance Law: Annual Survey, 24 TORT & INS. L. J. 472, 472 (1989) ("1988 was the turning point for civil justice reforms.").

[FN56]. Blum, supra note 27, at 26.

[FN57]. MEDICAL MALPRACTICE, supra note 16.

[FN58]. Id.

[FN59]. Id. Kansas, Kan. Stat. Ann. § 60-3801 (1990), and Kentucky, Ky. Rev. Stat. Ann. § 411.188 (Michie/Bobbs-Merrill 1991), modified the collateral source rule.

[FN60]. MEDICAL MALPRACTICE, supra note 16. Minnesota enacted a provision basing liability, in part, on percentage of fault. Minn. Stat. Ann. § 604.01 (West 1992). Florida maintained its limitation on joint and several liability by repealing a sunset provision on that part of its general tort reform legislation modeled after the 1987 AMA proposal. Fla. Stat. Ann. § 768.81 (West 1991).

[FN61]. MEDICAL MALPRACTICE, supra note 16. Florida repealed another sunset provision, thus continuing its periodic payment mandate. Fla. Stat. Ann. § 768.78 (West 1991). South Dakota limited its periodic payment legislation to medical malpractice actions. S.D. Codified Laws Ann. § 21-3A-1 (1991).

[FN62]. MEDICAL MALPRACTICE, supra note 16. Florida, Fla. Stat. Ann. § 768.73 (West

1991), Kansas, Kan. Stat. Ann. § 60-3402 (1990), Kentucky, Ky. Rev. Stat. Ann. § 411.186 (Michie/Bobbs-Merrill 1991), and South Carolina, S.C. Code Ann. § 15-33-135 (Law. Co-op. 1990), enacted or modified existing laws limiting recovery of punitive damages.

[FN63]. MEDICAL MALPRACTICE, supra note 16. Virginia enacted legislation enabling parties to elect a summary trial. VA. CODE. ANN. § 8.01-576.1 (Michie 1991). Michigan enacted a plan to provide conciliation, mediation and other alternative dispute resolution mechanisms. Mich. Comp. Laws Ann. § 600.4901-4923 (West 1991). Georgia broadened the scope of its arbitration legislation. Ga. Code Ann. ch. 7-1 to 7-3 (Michie 1991).

[FN64]. MEDICAL MALPRACTICE, supra note 16:
In 1990, three states legislated tort reform measures: Colorado amended its Good Samaritan statute for emergency care immunity to include hospitals and now prohibits punitive damages against doctors in certain cases. Maine

Next Part

Next Part | First Part

reformed collateral source rules for medical malpractice cases, established a five-year medical liability project to develop practice guidelines, and established a Rural Medical Access program to increase obstetrical care. Arizona limited the liability of doctors and hospitals in cases of births under emergency situations.
Id.

[FN65]. THE LIABILITY SYSTEM, supra note 16. The Colorado legislature prohibited punitive damage awards in cases arising from the prescription of FDA-approved drugs, the Nebraska legislature abolished joint and several liability for noneconomic damages, the Washington legislature authorized courts to impose sanctions for filing frivolous lawsuits, and the North Carolina legislature expanded the application of North Carolina's Good Samaritan statute and established a pilot mediation program. Id. In addition, the Governor of Colorado signed into law the Good Samaritan measure. Id.

[FN66]. MEDICAL MALPRACTICE, supra note 16 ("In 1991, states are focusing on specific problem areas, such as claims against obstetricians and no-fault type compensation programs for neurologically-impaired infants. Massachusetts, Utah and Vermont will consider alternative compensation systems.").
The New York Bar Association recently recommended that the New York legislature consider tort reform aimed at obstetrics:
Obstetricians in the state have been hit with frequent law suits, and correspondingly escalating premiums, resulting from the delivery of brain damaged or "neurologically impaired" infants, according to the bar association report. Many have chosen to give up the practice of obstetrics in the state as a result.
"There is something very wrong with the current system" for obstetricians says Linda Lamel, chair of the ad hoc committee. "We have to do something," she emphasizes.