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)

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(1992 documents)

L. H. Otis, Medical Malpractice Reforms Eyed In N.Y., in THE NATIONAL UNDERWRITER COMPANY 1990, at 4 (Property & Casualty/Employee Benefits ed.) (LEXIS, Nexis library, Omni file).

[FN67]. THE LIABILITY SYSTEM, supra note 16.
The emphasis in the future will be on specific, narrower reforms, according to the American Tort Reform Association (ATRA). While more attention will be directed toward limiting punitive damages and to defending the tort reforms that have been achieved in recent years, innovative alternatives to traditional tort liability, especially in the medical malpractice arena, will be introduced.
Id.
In addition, in 1991, the American Law Institute ("ALI") recommended that state legislatures enact legislation limiting the circumstances under which a plaintiff may receive punitive damages and restricting awards for pain and suffering to cases in which the plaintiffs suffer permanent disabilities. Id. Many expect that the ALI report will influence state legislatures. Id.

[FN68]. See, e.g., Clark v. Container Corp. of Am., Inc., 589 So. 2d 184, 198 (Ala. 1991) (statute structuring damage awards violated right to jury trial); Brannigan v. Usitalo, 587 A.2d 1232, 1237 (N.H. 1991) ($875,000 cap on noneconomic damages violated right to equal protection); Morris v. Savoy, 576 N.E.2d 765, 772 (Ohio 1991) ($200,000 cap on general damages violated right to due process but not equal protection). In December 1991, however, the Georgia Supreme Court held a $250,000 cap on punitive damages constitutional. See Bagley v. Shortt, 410 S.E.2d 738, 739 (Ga. 1991).

[FN69]. Mark A. Hoffman, Crunch Time for Tort Reforms; Challenges Expected in 22 States this Year, BUSINESS INS., Feb. 4, 1991, at 3. In 1991, the American Tort Reform Association predicted that 22 states would attempt to repeal tort reform through judicial or legislative action. Id. Presumably, those states that did not attempt the repeals in 1991 will try again this year.

[FN70]. UNITED STATES JUSTICE DEPARTMENT, REPORT OF THE TORT POLICY WORKING GROUP ON THE CAUSES, EXTENT, AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY (Washington, D.C., Government Printing Office, 1986) [hereinafter JUSTICE DEPARTMENT REPORT].

[FN71]. Id. at 4, 62. The Justice Department reaffirmed these conclusions one year later. UNITED STATES JUSTICE DEPARTMENT, AN UPDATE ON THE LIABILITY CRISIS 96-7 (Washington, D.C., Government Printing Office, 1987).

[FN72]. Concerns Growing Over Liability Insurance Climate, AM. MED. NEWS, Apr. 11, 1986, at 2. President Reagan did not, however, explicitly endorse any of the report's specific recommendations. Id.

[FN73]. NATIONAL ASSOCIATION OF ATTORNEYS GENERAL, AN ANALYSIS OF THE CAUSES OF THE CURRENT CRISIS OF UNAVAILABILITY AND UNAFFORDABILITY OF LIABILITY INSURANCE (May 1986) (prepared by the state Attorneys General from California, Massachusetts, North Carolina, Texas, West Virginia, and Wisconsin).

[FN74]. Id. at 1.

[FN75]. Id. at 2. The figures frequently cited by the insurance industry do not account for income earned by investing premiums and the sale of capital assets and savings produced by tax credits. Id. at 10-13.

[FN76]. Id. at 23-24.

[FN77]. Id. at 39 (quoting William B. Glaberson & Christopher Farrell, Commentary, BUSINESS WEEK, Apr. 21, 1986, at 24). For an interesting analysis of the insurance industry, see generally George L. Priest, The Current Insurance Crisis and Modern Tort Law, 96 YALE L.J. 1521 (1987). The author argues that a shift in the insurance industry to the use of third party corporate insurance coverage produced a collapse of the insurance market. Id. at 1524. For further discussion of the issues Priest raises, see generally Steven P. Croley & Jon D. Hanson, What Liability Crisis? An Alternative Explanation for Recent Events in Products Liability, 8 YALE J. ON REG. 1 (1991).

[FN78]. In re Insurance Antitrust Litigation, 723 F. Supp. 464 (N.D. Cal. 1989), rev'd and remanded, 938 F.2d 919 (9th Cir. 1991). For a discussion of the case, see generally INSURANCE INFORMATION INSTITUTE ANTITRUST (Ruth Gastel ed., Dec. 1991) (LEXIS, Nexis library, IIRPTS file).

[FN79]. In 1989, the district court dismissed the case. Antitrust Litigation, 723 F. Supp. at 491. The court ruled that the insurers' conduct did not amount to an illegal conspiracy and, thus, the insurers were protected by an antitrust exemption provided by the McCarran-Ferguson Act. Id. at 472-79. On June 18, 1991, the United States Court of Appeals for the Ninth Circuit reversed the district court's judgment and reinstated the case. In re Insurance Antitrust Litigation, 938 F.2d 919, 934 (9th Cir. 1991).

[FN80]. HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (Report of the Harvard Medical Practice Study to the State of New York 1990) [hereinafter HARVARD STUDY]. For a recent summary of the HARVARD STUDY by its authors, see A. Russell Localio et al., The Relationship Between Malpractice Claims and Adverse Events Due to Negligence, 325 NEW ENG. J. OF MED. 245 (July 25, 1991). For an additional summary, see Major U.S. Study Shows Unreported Malpractice Widespread, Reuter Library Report, Feb. 28, 1990 (LEXIS, Nexis library, LBYRPT file) (28% of patient injuries suffered in hospital stays caused by negligence).

[FN81]. HARVARD STUDY, supra note 80, at 7-7. See infra notes 172-73 and accompanying text. Curiously, the New York Commissioner of Health and Human Services cited this data, before the report issued, to support a call for a no-fault medical malpractice liability legislation in New York. William Bunch, Furor on Malpractice, NEWSDAY, Jan. 30, 1990, at 21.

[FN82]. Id. The Commissioner apparently was not influenced by the percentage of those filing suits.

[FN83]. In addition to S. 489, 102d Cong., 1st Sess. (1991), introduced by Senator Orrin Hatch (RUT) on February 26, 1991, and the Bush Administration proposal, S. 1123, 102d Cong., 1st Sess. (1991)-The Health Care Liability Reform and Quality of Care Improvement Act of 1991-introduced on May 22, 1991, the following were proposed in 1991 and were still pending as of the end of 1991:
On January 3, 1991, Representative Dingell (D-MI) introduced H.R. 16, The National Health Insurance Act. The Bill proposes to direct the Secretary of Health and Human Services to conduct a study of methods to reduce the cost of medical malpractice litigation. H.R. 16, 102d Cong., 1st Sess. (1991).
On January 3, 1991, Representative Neal (D-NC) introduced H.R. 166, the Health Care Crisis Policy Commission Act. The bill proposes the establishment of a commission to study the cost of health care, including medical malpractice. H.R. 166, 102d Cong., 1st Sess. (1991).
On January 31, 1991, Senator Cohen (R-ME) introduced S. 314, The Comprehensive Health Care Act of 1991. That bill proposes grants to fund the creation of pre-litigation

screening panels. S. 314, 102d Cong., 1st Sess. (1991).
On February 20, 1991, Representative Johnson (R-CT) introduced H.R. 1004, the House companion to S. 489. The bill differs from S. 489 in the method of calculating the grants to be awarded each state for the implementation of the legislation. H.R. 1004, 102d Cong., 1st Sess. (1991).
On February 21, 1991, Senator McConnell (R-KY) introduced S. 454, the Comprehensive American Health Care Act. The bill proposes that attorney's fees be awarded the prevailing party in medical malpractice litigation. S. 454, 102d Cong., 1st Sess. (1991).
On April 11, 1991, Senator Brown (R-CO) sponsored S. 815, the Community and Migrant Health Centers Self-Insurance Act. The bill proposes the establishment of an Office of Medical Insurance and the provision of malpractice liability coverage for community or migrant health centers. S. 815, 102d Cong., 1st Sess. (1991).
On May 23, 1991, Senator Rockefeller (D-WV) introduced S. 1177 (and companion H.R. 2535), The Pepper Commission Health Care Access and Reform Act of 1991. The bill proposes that the administrator of Health Care Policy and Research conduct a study of tort reform. S. 1177, 102d Cong., 1st Sess. (1991).
On June 5, 1991, Senators George Mitchell (D-ME), Edward Kennedy (D-MA), Donald Riegle (D-MI), and Jay Rockefeller (D-WV) introduced S. 1227, HealthAmerica: Affordable Health Care for All Americans Act. The bill proposes providing state grants for the implementation of alternative dispute resolution systems for medical malpractice cases. S. 1227, 102d Cong., 1st Sess. (1991).
On June 6, 1991, Senator Pete Domenici (R-NM) sponsored S. 1232, the Medical Injury Compensation Fairness Act of 1991. That bill contains many of the same provisions as S. 489 and the Bush Administration proposal. The bill limits the recovery of noneconomic damages to $250,000, proposes the abolition of the collateral source rule, and proposes periodic instead of lump-sum payment of damage awards. S. 1232, 102d Cong., 1st Sess. (1991). S. 1232 also proposes the most radical reform of the tort system. Patients covered by Medicare, Medicaid, or federal employee health plans would be required to submit all malpractice claims to binding arbitration. In addition, employer-paid health plan premiums would no longer be tax deductible unless those covered by the plans submit claims to binding arbitration. For a discussion of S. 1232, see generally CLARK C. HAVINGHURST & THOMAS B. METZLOFF, S. 1232-A Late Entry in the Race for Malpractice Reform, 54 LAW & CONTEMP. PROBS. 179 (1991).
On June 26, 1991, Representative Bilirakis (R-FL) introduced H.R. 2783. The Bill proposes that the Secretary of Health and Human Services conduct a study on the feasibility and advisability of instituting a system for resolving medical malpractice claims similar to that used for resolving workmens' compensation claims. H.R. 2783, 102d Cong., 1st Sess. (1991).
On July 11, 1991, Senator Kerrey (D-NE) introduced S. 1446, Health USA Act of 1991. The bill proposes the formation of a national commission that will recommend the best system of alternative dispute resolution for medical malpractice cases. S. 1446, 102d Cong., 1st Sess. (1991).
On October 8, 1991, Representative Kyl (R-AZ) introduced H.R. 3516, the Medical Care Injury Comprehensive Reform Act of 1991. The Bill proposes awarding grants to states for use in developing alternative dispute resolution programs for malpractice claims. H.R. 3516, 102d Cong., 1st Sess. (1991).
On October 17, 1991, Senator Durenberger (R-MN) introduced S. 1836, the American Health Quality Act. The bill proposes providing Medicaid bonus funds to states for use in developing alternative dispute resolution programs for malpractice claims. S. 1836, 102d Cong., 1st Sess. (1991).
On October 29, 1991, Representative Campbell (R-CA) introduced H.R. 3656. The unnamed bill proposes providing grants to states with legislation limiting malpractice claims against physicians providing charity care services. H.R. 3656, 102d Cong., 1st Sess. (1991).
On October 31, 1991, Representative Johnston (R-FL) introduced H.R. 3689, the Community Health Care Act of 1991. The bill proposes to amend the Social Security Act

to provide health benefits through federally financed state programs. H.R. 3689, 102d Cong., 1st Sess. (1991).
On November 7, 1991, Senator Chafee (R-RI) introduced S. 1936, the Health Equity and Access Improvement Act of 1991. The bill proposes application of a broad range of tort reform measures to medical malpractice actions. S. 1936, 102d Cong., 1st Sess. (1991).
On November 23, 1991 Senator Kasten (R-WI) introduced S. 2036, the Access to Health Care for All Americans Act of 1991. The bill proposes to reform the procedures used in resolving medical malpractice claims. S. 2036, 102d Cong., 1st Sess. (1991).
On November 26, 1991, Representative Bilrakis (R-FL) introduced H.R. 3951, Comprehensive Health Care Access Improvement and Cost Containment Act of 1991. The bill proposes providing grants to states to assist in developing programs to reduce the cost of medical malpractice claims. H.R. 3951, 102d Cong., 1st Sess. (1991).
Finally, near the end of 1991, Senator Jay Rockefeller announced plans to convene the Senate Health subcommittee to discuss these and other proposals. McCormick, supra note 20, at 3, 19.

[FN84]. S. 489, 102d Cong., 1st Sess. (1991). See infra notes 337-74 and accompanying text for a discussion of the provisions of S. 489.

[FN85]. Milt Freudenheim, Limiting Awards in Malpractice, N.Y. TIMES, Mar. 19, 1991, at D2; Kosterlitz, supra note 20, at 1686.

[FN86]. Kosterlitz, supra note 20.

[FN87]. S. 1123, 102d Cong., 1st Sess. (1991). See infra notes 375-88 and accompanying text for a discussion of the provisions of the proposal.

[FN88]. S. 1123, 102d Cong., 1st Sess. (1991). See infra note 388 for the text of the provision.

[FN89]. 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.
Nowhere has the problem been felt more acutely than in the health care field. While the general expansion of negligence and other legal theories has provided greater compensation for injury, medicine has borne the added burden of increasingly high expectations from patients and their families. Dramatic gains in treatment and prevention have led, unfortunately to an increased level of unrealistic expectations by patients.
Id.; see also Lacayo, supra note 27, at 60 ("Convinced of their diagnosis that crippling malpractice insurance rates have been caused by a malignant surge of lawsuits, physicians prescribe legislative relief, and lots of it.").

[FN90]. See, e.g., AMA Center for Health Policy Research, Recent Trends in Medical Professional Liability, 49 CONN. MED. 475, 475 (1985) ("There is growing evidence that these trends have lead [sic] physicians to attempt to reduce the risk resulting from claims through the practice of defensive medicine."); Brill, supra note 23, at 9 (cost of defensive medicine constitutes 30% of cost of all medical treatment); Lehman, supra note 21, at 4 (fear of lawsuits has prompted obstetricians to perform more tests and document care more meticulously).

[FN91]. See, e.g., Lacayo, supra note 27, at 60 ("Lawyers hold to their brief that doctors, like manufacturers or architects, should be liable for mistakes.").

[FN92]. DANZON (1982), supra note 1, at 4.

[FN93]. Id. at 5.

[FN94]. "These estimates are based on frequency of claims incurred for policy years 1966-73 and basic limits of paid loss per claim, excluding loss-adjustment expenses for calendar years 1969-73." DANZON (1982), supra note 1, at 1 n.1.

[FN95]. DANZON (1982), supra note 1, at 1 n.1. "The only data available for comparing trends in different lines of tort litigation are those on claims incurred ... reported by the ISO." Id. "The advantage of these data over claims-closed data by calendar year ... is that incurred claims include both closed and open claims, and an estimate of claims not yet filed ("incurred but not reported")." Id.

[FN96]. Id. at 5.

[FN97]. Id.

[FN98]. Id.

[FN99]. Id.

[FN100]. Id.

[FN101]. Id. Similar trends occurred in other fields of tort litigation. Product liability claims show a similar, though less extreme, peak in the mid 1970s, with an otherwise essentially stable rate throughout the measured time period. Id. at 5-6. Automobile injury claims were also stable throughout the decade, although the data do not reflect a mid-decade peak. Id. at 6. As a result, medical malpractice claim frequency was not "statistically" distinct from the frequency of other tort claims. Id.

[FN102]. Id. at 7.

[FN103]. Id.

[FN104]. Id.

[FN105]. Id. n.5. The average time from filing to resolution increased from 18 months in 1975 to 25 months in 1978. Id.

[FN106]. JUSTICE DEPARTMENT REPORT, supra note 70, at 45.

[FN107]. Id.

[FN108]. Id.

[FN109]. Nearly all of the tort litigation increase cited by the Justice Department involved products liability. Marc Galanter, The Life and Times of the Big Six; or, the Federal Courts Since the Good Old Days, 1988 WIS. L. REV. 921, 937 (1988) [hereinafter Good Old Days]; Marc Galanter, The Day After the Litigation Explosion, 46 MD. L. REV. 3, 16, table 2 (1986) [hereinafter Day After]; Eliot M. Blake, Comment, Rumors of Crisis: Considering the Insurance Crisis and Tort Reform in an Information Vacuum, 37 EMORY L.J. 401, 416-18 (1988).
Although products liability litigation did increase by 758% from 1974 to 1985 in federal court, that data should not be generalized to all litigation in all courts for two reasons. First, "[t]his frequently cited 758% rise is 30 times as great as the rise in the rest of the

torts category [in federal court], even discounting for some exaggeration in this figure." Second, although the data are sketchy, there is little reason to believe that products liability and other forms of tort litigation have witnessed similar increases in state courts. Good Old Days, supra, at 938. See supra notes 70-71 and accompanying text for a discussion of the Justice Department Report.

[FN110]. Day After, supra note 109, at 6 (1986) (at least 98% of all civil cases filed in state courts); Cf. David M. Trubeck et al., The Costs of Ordinary Litigation, 31 UCLA L. REV. 72, 81 (1983) (federal court cases "probably comprise less than 3% of all civil cases filed in courts of general jurisdiction in the United States.").

[FN111]. NATIONAL CENTER FOR STATE COURTS REPORT (Feb. 1991), in Roxanne B. Conlin, Litigation Explosion Disputed: Studies Refute the Critics, NAT'L. L.J., July 29, 1991, at 26. From 1984 to 1989, tort filings increased by 26.7% while contract filings increased by 21.6% and real property filings increased by 44.2%. Id. Tort filings did not increase annually from 1984 to 1989 in any state. Id. Moreover, the study observed that "torts are a small component of civil filings in most general-jurisdiction trial courts." Id. See infra notes 115-19 and accompanying text for a discussion of the National Center for State Court's findings concerning litigation costs.

[FN112]. "Hence, there is ample ground for skepticism about the use of federal court product liability filing figures as an indicator of the propensity to bring product liability claims, or of the general effects of such claims on business enterprise, or as a portent of the general growth of litigation." Good Old Days, supra note 109, at 941-42 (1988). For other discussions of the fallacy of generalizing from federal court data, see Marc Galanter, Reading the Landscape of Disputes: What We Know and Don't Know (and Think We Know) About Our Allegedly Contentious and Litigious Society, 31 UCLA L. REV. 4, 36-41 (1983) [hereinafter Landscape of Disputes]; Blake, supra note 109, at 416-18.

[FN113]. See, e.g., Kristin Bullimer, Choice of Forum in Diversity Cases: An Analysis of a Survey and Implication for Reform, 15 LAW & SOC'Y REV. 749, 759-60 (1980-81).

[FN114]. A recent study by Professors Galanter and Rogers of the University of Wisconsin Law School examined federal court data from 1960 to 1988 and expanded on Professor Galanter's findings that were published in Marc Galanter, The Life and Times of the Big Six; or, the Federal Courts since the Good Old Days, 1988 WIS. L. REV. 921 (1988). The professors concluded that the most significant change in federal litigation was due to changes in corporate structure, resulting in more frequent diversity of citizenship between corporate litigants. Conlin, supra note 111, at 26 (citing Marc Galanter et al., A Transformation of American Business Disputing? Some Preliminary Observations (pre-publication draft)). "These changes far outstrip increases in tort filings in the same courts." Id.

[FN115]. STATE CASELOAD STATISTICS, ANNUAL REPORT 1984, 182 (June 1986).

[FN116]. Id.

[FN117]. From 1984 to 1989 tort filings increased by 26.7%. Conlin, supra note 111, at 26 (citing NATIONAL CENTER FOR STATE COURTS (Feb. 1991)). The 7.6% increase from 1988 to 1989, however, represents the largest increase in four years. See THE LIABILITY SYSTEM, supra note 16.

[FN118]. Conlin, supra note 111, at 26 (citing NATIONAL CENTER FOR STATE COURTS (Feb. 1991)).

[FN119]. Id.

[FN120]. A REPORT FROM THE PRESIDENT'S COUNCIL ON COMPETITIVENESS, AGENDA FOR CIVIL JUSTICE REFORM 4 (Aug. 1991) [hereinafter REPORT OF THE PRESIDENT'S COUNCIL], reporting data prepared by the National Center for State Courts. The Council, chaired by Vice President Dan Quayle, id. at 6, opens the report by stating that "America has become a litigious society" and citing federal court data. Id. at 1. The state court data, however, indicate a 2% increase in civil caseloads from 1986 to 1987, a 5% increase from 1987 to 1988, and a 2% increase from 1988 to 1989. Id. at 4.

[FN121]. See generally Landscape of Disputes, supra note 112, at 122-23.

[FN122]. See, e.g., MEDICAL MALPRACTICE, supra note 16 ("The most significant change was in the number of claims, which peaked in 1985 and fell through 1989."); P. Wish, REVIEW AND PREVIEW: 1990 AND 1991, Jan., 1991 (LEXIS, Nexis library, Omni file) ("Experiencing a continued decline of medical malpractice suits, stock insurers offering the line continued to reduce premiums in 1990, but not as much as in the prior two years."); Tami Bradley, One Year Later, Malpractice Crisis Fades With Lower Insurance Rates, WICHITA BUS. J., June 18, 1990, at 1; Milt Freudenheim, Costs of Medical Malpractice Drop After 11-Year Climb, N.Y. TIMES, June 11, 1989, at A1; James R. Schiffman, Medical Malpractice Rates Fall: Drop in Number of Claims Cuts Insurers' Costs, WALL ST. J., Apr. 28, 1989, at B1 (frequency of malpractice claims decrease for first time in decade).
After steadily rising for 11 years, the torrent of medical malpractice lawsuits that has added at least $12 billion annually to the nation's health spending has begun to ease, insurers and physicians say.
They pointed to a sharp decline in the number of multimillion-dollar jury awards for medical negligence, a drop in the number of malpractice claims and a reduction in overall spending for settling claims.
Freudenheim, supra at A1. The data from a particular state support this conclusion:
According to information from the Kansas Insurance Department, which administers the stabilization [insurance] fund, the number of cases reported to the fund has dropped since fiscal year 1987, when the number peaked at 317. In fiscal year 1988 there were 285 reported and 252 in 1989. Through April 30, 1989, 178 cases were reported, according to the statistics. The fiscal year ends June 30.
Bradley, supra at 1. Recently, the New York State Bar observed that "a consensus has emerged that in the last several years there has been in fact a rather dramatic moderating trend in both the frequency and severity of malpractice claims. The committee credits the 1985-86 [New York] legislation with initiating this trend." L.H. Otis, supra note 66.

[FN123]. Mike Mitka, Cost, Frequency of St. Paul Claims up in '90, AM. MED. NEWS, Aug. 5, 1991, at 11. St Paul provides insurance to approximately 30,000 physicians in 42 states. Id.

[FN124]. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE, SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS 4 (1986) [hereinafter GAO SIX STATE STUDY].

[FN125]. Id. at 17.

[FN126]. Id.

[FN127]. Id.

[FN128]. Id.

[FN129]. Id.

[FN130]. Mitka, supra note 123, at 11, table 1.

[FN131]. WEILER, supra note 1, at 168 n.6 (citing PHYSICIANS' AND SURGEONS' UPDATE 1 (St. Paul, 1989)).

[FN132]. Mitka, supra note 123, at 11, table 1. For other discussions of claim frequency trends in the 1980s, see generally two reports prepared by the General Accounting Office: GAO SIX STATE STUDY, supra note 124; GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION (1987). For a detailed study of claims against obstetricians, see a report prepared by the INSTITUTE OF MEDICINE, MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE (1989).

[FN133]. Mitka, supra note 123, at 11, table 1. A Pennsylvania insurance carrier that insures 6,900 physicians also reported a claim increase in 1990. Id. at 17. See also MEDICAL MALPRACTICE, supra note 16 ("Now data published in mid-1991 indicates that the number of claims filed is rising for the first time in five years.").

[FN134]. To some extent, the decrease in the number of recently filed cases and especially the number of large awards may reflect the impact of pre-1975 tort reforms. See, e.g., Bradley, supra note 122, at 1 (decrease in medical malpractice insurance rates due in part to legislative reforms); Freudenheim, supra note 122, at A1 (tort reform laws convey message that public wants recovery system to be based on fault); Schiffman, supra note 122, at B1 (post 1986 laws governing medical malpractice claims had "chilling effect" on number of claims filed). On the other hand, while a five year study prepared by the Washington (State) Liability Reform Coalition also concluded that claim frequency (as well as insurance rates) had recently decreased as a result of tort reform measures, the study also opined that "the process of evaluating the reforms was made more complicated by the expansion of liability by the courts." THE LIABILITY SYSTEM, supra note 16 (discussing WASHINGTON LIABILITY REFORM COALITION STATUS REPORT OF THE TORT REFORM ACT OF 1986 - A FIVE YEAR REPORT). See supra note 54 for a discussion of tort reforms enacted by many states.

[FN135]. Glazer, supra note 20, at 10 ("[p]rivately, Bush administration officials agree that the malpractice crisis appears to be on the wane").

[FN136]. PATRICIA DANZON, MEDICAL MALPRACTICE, THEORY, EVIDENCE, AND PUBLIC POLICY (1985).

[FN137]. Id. at 18-19.

[FN138]. Id. at 18.

[FN139]. Id. at 19.

[FN140]. Id.

[FN141]. Id.

[FN142]. Id.

[FN143]. Id.

[FN144]. Id.

[FN145]. Id. at 18.

[FN146]. Id.

[FN147]. Id.

[FN148]. Id. at 19. The Harvard Study observed that, "the estimated number of claims coming out of medical care in California in 1974 is possibly low because of incomplete coverage of the claims data bases. NAIC gathered its data from commercial insurers in California. There is no evidence on the number of claims filed in California but not reported to NAIC." HARVARD STUDY, supra, note 80, at 7-3.

[FN149]. DANZON (1985), supra note 136, at 19.

[FN150]. Id. at 24.

[FN151]. Id.

[FN152]. Id.

[FN153]. Id.

[FN154]. DANZON (1982), supra note 1, at 7-8.

[FN155]. DANZON (1985), supra note 136, at 19.

[FN156]. Id. at 23.

[FN157]. DANZON (1982), supra note 1, at 8 n.7. "Washington was an extreme outliner in 1975, with a claim frequency over twice that of California, the second-ranked state." Id.

[FN158]. DANZON (1985), supra note 136, at 24.

[FN159]. Id.

[FN160]. Id. at 25.

[FN161]. Id.

[FN162]. HARVARD STUDY, supra note 80. In 1984, the Harvard Medical and Law Schools pooled members of their faculties to form the Harvard Medical Practice Study. Id. at Preface 1. The group contracted with the State of New York to conduct a study of "medical injuries and malpractice." Id. at 1.
The Practice Study Group included physicians, lawyers, economists, statisticians, risk managers, computing specialists, and others. Id. at Preface 1-3. Members were selected from the Harvard School of Public Health, the Harvard Law School, the Risk Management Foundation, Boston University, Syracuse University, the University of Massachusetts, the University of Michigan, the New England Medical Center and other institutions. Id. The study has come to be known in the literature as the Harvard Study.

[FN163]. Id. at 3. "The basic sampling design of the Study was an implicitly stratified, systematic, two-stage cluster sample of discharges." Id. The Practice Study selected hospitals on the basis of the number of non-psychiatric discharges. Id. The Practice Study then selected records from all of the 51 hospitals on the basis of age and diagnosis related group. Id. The Practice Study selected 31,429 records and examined 30,121 of

those records. Id.

[FN164]. Id. Apparently, the lay staff was able to establish that adverse events had not occurred in nearly 23,000 of the 30,121 cases and referred the remaining 7,743 for physician review.

[FN165]. Id. at Glossary 1. "The injury [must be] sufficiently serious to lead to prolongation of hospitalization or temporary or permanent impairment or disability in the patient." Id.

[FN166]. Id. at 3. "The majority of adverse events (57%) resulted in minimal and transient disability, but 14% of patients died at least in part as a result of their adverse event, and in another 9% the resultant disability lasted longer than 6 months." Id.

[FN167]. Id.

[FN168]. Id.

[FN169]. Id. at 11-1. The risk of adverse injury was higher for the elderly and for Black patients. Id. The Practice Study opined that the higher incidence of injury for Blacks was "likely due to the kind of care provided in many hospitals with a high proportion of minority patients." Id.

[FN170]. The Harvard Study defines "claim" as "a demand for tort compensation for injury and financial loss arising out of medical care." Id., Glossary, at 1. Thus, the data reflect both suits and oral or written demands (by the patient, his or her family or attorney) to the physician, hospital, or insurer. Id. at 7-7. Moreover, the data reflect those cases in which the insurer identifies negligence and approaches the patient or his or her family regarding settlement. Id.

[FN171]. Id. at 11-4.

[FN172]. A summary of the Harvard Practice Study was published in the New England Journal of Medicine. Localio, supra note 80, at 248. The summary reported that 1 in 7.6, or approximately 13%, of negligently injured patients made claims. Id. All discussion in the text refers to the original Harvard Study and not to the Summary.

[FN173]. HARVARD STUDY, supra note 80, at 11-4.

[FN174]. Id. "Minimal impairment" is defined as an injury from which the patient can recover within one month. Id. at 6-21, table 6.5. "Moderate impairment" requires greater time for recovery. Id. The textual statement apparently refers to all injuries greater than "minimal." See id. at 11-4.

[FN175]. Id. Elsewhere, the Harvard Study emphasized, "Our analysis of malpractice claims, both all claims reported to the DOH and those involving our sample patients, suggests that while malpractice premiums have increased substantially in the past decade, the incidence of litigation remains far below the incidence of injuries caused by medical negligence." Id. at 7-41.

[FN176]. DANZON (1982), supra note 1, at 8 n.7. In 1982 Danzon reported California as the state with the second highest claim frequency based on 1975 data. See supra note 157. As of 1984, the predominate New York and California insurer reported 35.7 claims per 100 physicians in New York and 26 per 100 physicians in California. GAO SIX STATE STUDY, supra note 124, at 26, 36.

[FN177]. HARVARD STUDY, supra note 80, at 11-1.

[FN178]. Id. at 8-79. The Harvard Study did not actually compare the same time periods. The study compared malpractice costs (premiums and self-insured expenses) for 1988 with an analysis of 1984 injuries. Id. at 8-79 n.44. The study then adjusted the 1984 figure to account for inflation. Id. n.45.

[FN179]. Id. at 8-79.

[FN180]. Id.

[FN181]. Id. at 11-7.

[FN182]. Id. The authors of the Harvard Study conceded that the value assigned by the Study for malpractice injuries could not be compared with the value of those injuries as compensated by the tort system: "Still, one cannot directly compare those numbers. Not only does the tort system now pay benefits for some important harms (in particular, pain and suffering) that are not incorporated into our no-fault program, but one must add to the latter's cost a sizable allowance for administration expense." Id. at 11-7. The authors then estimated that administrative costs would exceed 20% of the value of benefits paid. Id. See infra note 198 for a discussion of administrative costs.

[FN183]. HARVARD STUDY, supra note 80, at 8-81.

[FN184]. Id. at 8-81. "These items [noneconomic losses] are major components - some scholars believe around 50% - of the damages being awarded in the tort system." Id.

[FN185]. Id. at 8-38, 8-45.
Our results on the patients' share of health care costs are based on the assumption that their shares equaled national averages for hospital care and physician visits, and that the payments for therapy and home health visits can be represented by the national averages for "other" health care services. Since the services consumed by the patients in the survey sample are distributed over several years, we used the average patients' shares of costs for the years 1984 through 1987.
Id. at 8-38 (citing Suzanne W. Letch, et al., National Health Expenditures 1987, HEALTH CARE FINANCING REV. 109-122 (1988)).

[FN186]. HARVARD STUDY, supra note 80, at 8-78, table 8.13.

[FN187]. Id. at 8-62. "We estimate that 87% of the medical care costs of adults were paid by third parties." Id.

[FN188]. See, e.g., N.Y. CIV. PRAC. L. & R. § 4545 (McKinney 1991). The New York legislature has extensively modified the collateral source rule in medical malpractice cases. See supra note 54 for a survey of various states' treatment of the collateral source rule. See supra note 18 for a general discussion of the collateral source rule. Depending on the degree to which the rule has been modified in various states, the "value" of injuries as determined by the tort system will exceed the value assigned by the Harvard Study.

[FN189]. HARVARD STUDY, supra note 80, at 8-67.

[FN190]. Id., table 8-13, at 8-78.

[FN191]. Id. at 8-68. The Harvard Study uses the 19% figure in reference to the $168 million loss of adult wages. Id. I have generalized that percentage to the total lost wages

of $231 million reflected in table 8.13, p. 8-78.

[FN192]. Id. at 8-68 to 8-69:
We estimate the ratio of total compensation payments to net total wage losses both past and future to be equal to 19%. Thus, the uncompensated portion of the wage losses caused by medical injuries equals $168 million, the amount that would need to be paid our hypothetical no-fault plan for wage loss benefits for the medical injuries that occurred among persons hospitalized in 1984. Id.

[FN193]. Id. at 11-6.

[FN194]. Id.

[FN195]. Id. at 8-63.

[FN196]. Id. at 8-63 to 8-64.

[FN197]. This, of course, can be done in two ways. The Harvard Study's $894 million estimate of the value of claims can be increased, possibly two-fold, to account for the discussed elements of damages. Alternatively, the Harvard Study's $1 billion insurance figure can be decreased to measure the value of currently made claims as if they were processed in the hypothetical no-fault system.

[FN198]. The data also fail to account for administrative costs incurred in processing claims, including attorney's fees and insurance costs, and the increased cost of medical care due to physician practice of "defensive medicine." See infra notes 266-306 and accompanying text for a discussion of defensive medicine. Both administrative costs and defensive medicine costs may be reduced through alternative dispute resolution. See HARVARD STUDY, supra note 80, at 2-11 to 2-12; 2-21 to 2-23. The Harvard Study authors observed that workers compensation "expends roughly 20% of its revenues on administration." Id. at 11-7. The authors then concluded, "our experience with a number of difficult cases suggests that no-fault patient compensation would likely have a somewhat higher administration cost ratio than does present-day workers compensation." Id. Although the costs may be reduced through alternative dispute resolution, they will be present regardless of whether the injuries are valued in that system or in the tort system. Thus, the ratio identified by the Harvard Study between the cost of the injuries and the cost of malpractice claims should remain useful despite this omission. See infra note 409 for further discussion of the merits of alternative dispute resolution.

[FN199]. See, e.g., DANZON (1982), supra note 1, at 25.

[FN200]. Id.

[FN201]. Id. at 7.

[FN202]. Id. During the same period, product liability claim payments increased 19.4%, while automobile physical injury claim payments increased 15.6%. Id.

[FN203]. PATRICIA M. DANZON, NEW EVIDENCE ON THE FREQUENCY AND SEVERITY OF MALPRACTICE CLAIMS 23 (Rand. 1986) (also published as Patricia M. Danzon, The Frequency and Severity of Medical Malpractice Claims: New Evidence, 49 LAW AND CONTEMP. PROBS. 57 (1986)).

[FN204]. DANZON (1982), supra note 1, at 9.

[FN205]. Id.

[FN206]. Id.

[FN207]. Id.

[FN208]. White House Working Group, Report Backs Tort Law Changes, AM. MED. NEWS, Apr. 4, 1986, at 2, [hereinafter White House Group] (citing data prepared by Jury Verdict Research, Inc.) Jury Verdict Reports, Inc. released data for the 10 year period from 1975 to 1985, with the most recent year being based on incomplete information. Id. See MEDICAL MALPRACTICE, supra note 16 (January 1991 report by Jury Verdict Research, Inc., shows trend of rising costs and increasing claims filed).

[FN209]. White House Group, supra note 208, at 2 (citing data prepared by Jury Verdict Research, Inc.) See Randall R. Bovbjerg et al., Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?, 54 LAW & CONTEMP. PROBS. 5 (1991) (analysis of data concerning medical malpractice jury verdicts). The authors compared jury verdicts for malpractice, products liability, and suits against the government (the "deep pocket" personal injury defendants) with automobile litigation defendants and reached six conclusions. First, the authors concluded that malpractice verdicts are three times higher than verdicts in automobile cases. Id. at 36. Second, that disparity did not grow over time. Id. at 36-37. Third, the "plaintiffs' win rate" is sufficiently lower in malpractice cases to render the "net expected value" of malpractice cases equal to automobile cases. Id. at 37. Fourth, the authors rejected one hypothesis supporting the disparity-"plaintiffs' attorneys' argument that they select cases for trial that have suffered legitimately more severe injuries." Id. Fifth, juror sympathy for malpractice plaintiffs may explain the disparity. Id. at 37-38. Sixth, "there is no direct evidence on just how sympathy (or other similar factors) affects awards." Id. at 38. The authors then postulate that the disparity may be produced by lawyer selection of cases according to the sympathy appeal of the case to potential jurors. Id. at 38-39.

[FN210]. See MEDICAL MALPRACTICE, supra note 16 (analysis of recent data from January 1991 report by Jury Verdict Research, Inc.).

[FN211]. Lacayo, supra note 27, at 60. (citing data prepared by Jury Verdict Research, Inc.).

[FN212]. DANZON (1990), supra note 1, at 48. The mean was approximately $100,000 while the median was approximately $20,000. Id.

[FN213]. Indeed, while the number of verdicts exceeding $1 million peaked in 1985 at 590 and then dropped to 410 in 1986 and 1987, the number increased in 1988 and increased by 22.4% to 588 in 1989. MEDICAL MALPRACTICE, supra note 16 (reporting data compiled by the Institute for Civil Justice.).

[FN214]. See A. Russell Localio, Variations on $962,258: The Misuse of Data on Medical Malpractice, 13 LAW, MED. & HEALTH CARE 126, 127 (1985) ("An appropriate indicator of the typical medical malpractice verdict should probably be the median.").

[FN215]. Danzon (1990), supra note 1, at 48, 56, table 1.

[FN216]. GAO SIX STATE STUDY, supra note 124, at 19. The value of the average paid claim increased by 137% from 1980 to 1984. Id.

[FN217]. MEDICAL MALPRACTICE, supra note 16. The data exclude settlements in excess of $200,000 to avoid "skewing" the data. Id.; see also Mitka, supra note 123, at 11.

[FN218]. See, e.g., MCNEIL/LEHRER NEWSHOUR TRANSCRIPT, McNeil/Lehrer Report (PBS television broadcast Feb. 28, 1990, transcript, Interview with Dr. David Axelrod, New York Health Commissioner) (LEXIS, Nexis library, Omni file) ("There is no clear indication that our system is geared to one of social responsibility with respect to payment for medical malpractice injury and it leads more to an event that looks like entering a lottery with respect to a return with a medical malpractice suit."); Jill Andresky, Mary Kuntz & Barbara Kallen, A World Without Insurance?, FORBES, July 15, 1985, at 40 ("Americans now seem to look on a civil suit against a corporation or municipality as a kind of lottery-a lottery to be played whenever they can."); Bradley, supra note 122, at 1. ("Nowadays its a lottery system, but when your number comes up you [a physician] lose instead of winning."); Monetary Cap on Malpractice, L.A. TIMES, Oct. 19, 1987, Metro, part 2 ("[Tort reform] helps bring some sense to a tort system that in our litigious state threatens to surpass the California Lottery as a path to riches, but which causes Californians to suffer higher costs for medical care."); The $65 Million Malpractice Question, N.Y. TIMES, July 24, 1986, A24 ("All New York loves a lottery, and the best game in town takes place in the courtroom. That's what Agnes Mae Whitaker, a victim of medical malpractice, discovered recently.").

[FN219]. See, e.g., Thomas B. Metzloff, Resolving Malpractice Disputes: Imaging the Jury's Shadow, 54 LAW & CONTEMP. PROBS. 43, 105 (1991): "The results described here give little support to the popular image of the jury system in malpractice cases as being some sort of lottery; there is no evidence suggesting that the jury's liability determinations are random." Id.

[FN220]. MEDICAL MALPRACTICE, supra note 16.

[FN221]. Id. "A January 1991 report by Jury Verdict Research, Inc. showed that of the 423 medical malpractice awards reported to the service in 1989, 107 or 25% totaled $1 million or more. In 1988, 97 awards amounted to a million or more dollars." Id.

[FN222]. DANZON (1982), supra note 1, at 45-46.

[FN223]. Id.

[FN224]. Id.

[FN225]. See, e.g., Fed. R. Evid. 411. The rule generally prohibits evidence of insurance coverage. Id. The Advisory Committee's note states that "knowledge of the presence or absence of liability insurance would induce juries to decide cases on improper grounds." Id. advisory committee's note.

[FN226]. One study revealed that more claims are made against physicians who practice in groups. E. KATHLEEN ADAMS & STEPHEN ZUCKERMAN, Variation in the Growth and Incidence of Medical Malpractice Claims, 9 J. OF HEALTH POL., POL'Y & LAW 475, 485 (1985). A "reason patients may receive (or may feel they receive) lower quality care from group physicians is that these doctors spend less time with each individual patient." Id.

[FN227]. DANZON (1982), supra note 1, at v.

[FN228]. Id.; see also id. at 23-24.

[FN229]. Id. at vi.

[FN230]. Id. at v. Danzon confirmed this conclusion in 1986. See DANZON (1986), supra note 203, at 3; see also Patricia M. Danzon, The Effects of Tort Reforms on the Frequency

and Severity of Medical Malpractice Claims, 48 OHIO ST. L.J. 413, 415 (1987). Danzon distinguished a 1985 study that found a positive relationship between the number of attorneys per capita and claim frequency. Sloan, supra note 1, at 643 [T]he lawyer variable has a positive impact on premiums ...."). Danzon observed that the Sloan study did not control for urbanization. See DANZON (1986), supra note 203, at 3.

[FN231]. Danzon states that, in some states, pro-plaintiff changes in common law doctrines contributed to the increase in both frequency and severity of claims in the early 1970s. See DANZON (1982), supra note 1, at vi. Such legislation included abolition of charitable immunity, abolition of the locality rule, adoption of informed consent measures, and adoption of respondeat superior. Id. Informed consent appears to have been one of those measures which had the greatest impact. Id.
Post-1975 tort reforms have included monetary limits on judgments, abolition of the collateral source rule, screening panels, contingency fee limits, abolition of res ipsa loquitur, and shortening statutes of limitation. Id. at 30-31. In 1982 Danzon reported that only those reforms designed to limit awards have had their intended effect. Id. at 30. Specifically, only absolute limits on awards and mandatory set-off of compensation received from collateral sources have limited awards. Id. None of the post-1975 reforms has reduced the frequency of medical malpractice claims. Id. at 31. Danzon confirmed these conclusions in 1986. See DANZON (1986), supra note 203, at 28. Danzon added in 1986 that shortening statutes of limitations also reduce claim frequency. Id. See infra notes 428-29 and accompanying text for a more detailed discussion of the impact of tort reform on claim frequency and severity.
The data were corrected for the impact these reform measures have had on the frequency and severity of claims. DANZON (1986), supra note 203, at 28.

[FN232]. See DANZON (1982), supra note 1, at vii. Danzon confirmed this conclusion in 1986, with two qualifications. DANZON (1986), supra note 203, at 17. First, Danzon observed that "urbanization is positively related to the total number of claims filed but negatively related to the number of claims paid." Id. This result may be explained by a disproportionate filing of frivolous claims in urban areas. Id. Second, Danzon observed that urban areas may have a particularly high number of late claim filings that skew the data. Id.; see also DANZON (1982), supra note 1, at 415.

[FN233]. See DANZON (1982), supra note 1, at 27:
We were unable to identify any other characteristics of urban environments that influence claim frequency and severity. The urban coefficient is essentially unaffected by the inclusion of number of lawyers and specific laws. Per capita income was also insignificant, after controlling for physician and lawyer densities, although the simple correlations between per capita income and frequency and severity are high. This suggests that income has little net effect on the expected payoff and propensity to sue, given the medical and legal characteristics associated with high income.
Other variables that proved insignificant and were therefore not used include the percent of the population on welfare, the unemployment rate, and court delay.

[FN234]. Id. at 25 (citing Mueller, THE ECONOMICS OF MEDICAL MALPRACTICE: CLAIMS, AWARDS AND DEFENSIVE MEDICINE, paper presented at American Economic Association Meetings, 1976).

[FN235]. See DANZON (1982), supra note 1, at 25.

[FN236]. Id. at 25-26.

[FN237]. Id. at 26.

[FN238]. Id.

[FN239]. Lacayo, supra note 27, at 60; see also GAO SIX STATE STUDY, supra note 124, at 4. ("From 1980 to 1986, the cost of malpractice insurance increased much more than the consumer price index and the medical care index, which increased 41 and 65 percent, respectively.").

[FN240]. See Christine Woolsey, Medical Malpractice Cover for Hospitals Stages Recovery, BUS. INS., Nov. 20, 1989, at 1 (LEXIS, Nexis library, Omni file):
The medical malpractice insurance crisis is in remission.
Medical malpractice insurance rates for hospitals that buy commercial coverage now are in stable condition, with prices either holding steady or declining for institutions with good loss records.
....
The rates charged to hospitals by Continental Corp. units peaked in 1986 and early 1987 and have been declining since, though not dramatically, noted Timothy P. Mitchell, president of New York-based Continental Insurance HealthCare, a division of Continental Corp.
Currently, "the average rate decrease in all medical malpractice business, including doctors and hospitals, is about 20% countrywide," he explained.
Id.

[FN241]. See Bradley, supra note 122, at 1.

[FN242]. See Freudenheim, supra note 122, § 1, at 31: "The St. Paul Fire and Marine Insurance Company, which insures 31,000 physicians, reduced malpractice premiums by an average of 14 percent in 32 states, effective July 1 [1989]." Id.

[FN243]. Id. Carol Galin, publisher of Medical Liability Monitor, a Chicago Newsletter, stated "'We are seeing a significant moderation in the rates all across the country. This is the first time I have been encouraged in 14 years.'" Id.
One insurer reported that 1989 marked the first time since 1979 that rates decreased, on average, for the entire nation:
Medical malpractice insurance rates decreased 10 to 15 percent nationally in 1989, says Judy Hart, deputy director of the National Healthcare Division of Alexander and Alexander, Inc., St. Louis. "It's a good market. It's positive," Hart says.
St. Paul Companies, St. Paul, the country's largest medical liability insurer, decreased its rates by an average of 2 percent nationally in 1989 compared with an average increase of 7.5 percent in 1988. In 23 of the 47 states in which St. Paul writes policies, the company's 1989 rates decreased from 5 to 16 percent.
The 1989 decrease was the first drop in the company's average national rate in almost a decade .... "It was 1979 the last time we saw any decrease," says Richard Pfeiffer, vice-president of the Medical Services Division of St. Paul Companies.
Paula Eubanks, Medical Malpractice Rates Decreased in 1989, J. OF THE AM. HOSP. ASS'N (Dec. 20, 1989).

[FN244]. "Overall, two-thirds of the U.S. jurisdictions (including the District of Columbia) experienced premium decreases from 1988 levels." See Lawrence J. Stern, MEDICAL MALPRACTICE, FIDELITY AND SURETY - 1989 (Best's Review-Property-Casualty Ins. ed., Nov. 1990) (LEXIS, Nexis library, Omni file).

[FN245]. See Bradley, supra note 122, at 1.
During the past few months the medical malpractice insurance rates in the state have fallen, with the most significant cut reported by St. Paul Fire and Marine Insurance Co. at an average of more than 20 percent. That decrease quickly was followed by more reduction requests from other major insurers, as well as a drop in the surcharges of the state's Health Care Stabilization Fund.

[FN246]. Id. "'They [the Kansas Medical Society] were saying maybe there's a light at the end of the tunnel and it's not a train coming our way....'" Id.

[FN247]. Id. An insurance industry publication succinctly summarized the discussion:
Does the current stability in the medical malpractice insurance market represent a permanent trend or is it only a temporary lull in a volatile marketplace?
While many market observers say rising medical malpractice insurance rates are inevitable, some say the current rate stability is an indication that the market's peaks and valleys are leveling.
These observers point to a decline in medical malpractice lawsuits, more tort reform, improved hospital risk management programs and a commitment to higher standards of quality in health care as the foundations for a more stable marketplace.
Christine Woolsey, Observers Split Over Longevity of Malpractice Market Stability, BUS. INS., Nov. 20, 1989, at 16 (LEXIS, Nexis library, Omni file).

[FN248]. See Freudenheim, supra note 122, § 1, at 32.
To be sure, some doctors believe that the drop in claims may not last. Dr. Brad Cohn, a California pediatrician who is president of the Physician Insurers Association of America, a group of doctor-owned companies that insures 173,000 physicians, said the decline was "a temporary blip."
Dr. Cohn expects a new crisis for the industry in two to three years. "It is a cyclical phenomenon," he said. "As business conditions improve, insurers get money from premiums and income from investments. They begin to lower rates until the premiums become inadequate to cover claims a few years down the line, when the investment income climate changes."
Id.

[FN249]. See Mitka, supra note 123, at 11; see also MEDICAL MALPRACTICE, supra note 16.

[FN250]. Mitka, supra note 123, at 11. See also MEDICAL MALPRACTICE, supra note 16.

[FN251]. See Freudenheim, supra note 122, § 1, at 32. "Even in New York, where a year ago the largest medical insurer was on the brink of financial insolvency, that [the increase in malpractice insurance premiums] has turned around ...." Id.

[FN252]. See HARVARD STUDY, supra note 80, at 1-1.

[FN253]. Id. The New York State Insurance Department granted increases up to 5% for insuring "physicians in the high litigation risk counties in and around New York City." Id. at 1-1 n.1.

[FN254]. MEDICAL MALPRACTICE, supra note 16.
Rates for medical malpractice insurance in New York State are down an average of 5 percent statewide, beginning July 1991. In its announcement, the Department of Insurance attributed the improvement to reforms instituted in 1985 and 1986 in New York State, among other things. The reforms included reducing attorney contingency fees, periodic payments, disclosure of collateral sources and penalties for frivolous suits. The disciplinary process for medical professionals was also streamlined.

[FN255]. HARVARD STUDY, supra note 80, at 1-2.

[FN256]. Id. at 1-6.

[FN257]. See Lacayo, supra note 27, at 60.

[FN258]. Id. Danzon's most recent study cautions that more research must be done to definitively establish the relationship between malpractice premiums and physician income:
To measure the real effect of malpractice premiums requires knowing what physicians' net incomes would have been in the absence of malpractice costs. Answering this counterfactual question from actual data is difficult, because physicians change their fees and practice patterns in response to the expected costs of liability, including both insurance costs and uninsurable costs of litigation, thereby affecting net income.
Danzon (1990), supra note 1, at 56. Moreover, specialty-specific mean premiums vary from 2% to 6%. DANZON (1985), supra note 136, at 186-87. The U.S. General Accounting Office has reported that malpractice insurance costs accounted for 8% of physician average gross business expenses in 1983 and 10% in 1985. See GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION 2 (1987); see also GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE, INSURANCE COSTS INCREASED BUT VARIED AMONG PHYSICIANS AND HOSPITALS 24 (Sept. 1986) [hereinafter GAO INSURANCE COSTS] (average malpractice premiums increased from 7% to 9% of "total professional expenses" from 1982 to 1984 for those physicians who were self-employed).

[FN259]. Id.

[FN260]. Freudenheim, supra note 122, § 1, at 32 (discussing "direct costs" of malpractice, presumably reflected in insurance premiums).

[FN261]. Obstetricians have suffered some of the largest premium increases. For a detailed account of obstetricians and malpractice, see generally MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE (Washington, D.C. National Academy Press, 1989). See also 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."); Lehman, supra note 21, at 4 (Obstetricians in Maine and Massachusetts leave obstetrics when faced with increasing malpractice premiums.). Physicians in some states, such as Florida and New York, have also suffered particularly large malpractice premium increases. See also WEILER, supra note 1, at 4.
The Nation's six hundred community health clinics have experienced 30% to 40% increases in premiums in the past year, forcing many to limit services. See, e.g., Robert Pear, Community Health Clinics Cut Back as Malpractice Insurance Costs Soar, N.Y. TIMES, Aug. 21, 1991, at A18.
For a detailed discussion of the geographical and specialty variation of malpractice insurance costs, see GAO INSURANCE COSTS, supra note 258.

[FN262]. Brill, supra note 23, at 9.

[FN263]. See Freudenheim, supra note 122, § 1, at 32. "'[I]n Maryland, over a 10-year period, 1 percent of the doctors accounted for 51 percent of malpractice payouts."'

[FN264]. DANZON (1985), supra note 136, at 94.

[FN265]. For an examination of an alternative method for determining malpractice insurance premiums, see John E. Rolph, Merit Rating for Physicians' Malpractice Premiums: Only a Modest Deterrent, 54 LAW & CONTEMP. PROBS. 65 (1991). The author concludes that a merit rating system based on physicians' past claim history "is only moderately accurate" in predicting future claims. Id. at 79. In addition, measuring the "deterrent effect" of such a premium practice "is usually a daunting task." Id.

[FN266]. See generally AMA Center for Health Policy Research, No. 7, Recent Trends in

Medical Professional Liability, 49 Conn. Med. 475, 475 (July 1985) [hereinafter AMA Center]; Will, supra note 23, at B7 (most recent reference to 30% figure). For another 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, at 54. For a more recent discussion, see Kosterlitz, supra note 20, at 1.

[FN267]. See generally Brill, supra note 23, at 1; see also Will, supra note 23, at B7 (most recent reference to 30% figure).

[FN268]. Brill, supra note 23, at 9.

[FN269]. Glazer, supra note 20, at 11.

[FN270]. See supra notes 257-61 and accompanying text for a discussion of how the increase in physicians' salaries from 1976 to 1984 has impacted on their ability to pay malpractice premiums during this same period.

[FN271]. 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.").

[FN272]. See AMA CENTER, supra note 266, at 475.

[FN273]. Id.

[FN274]. Id. at 475-76.

[FN275]. Id. at 476.

[FN276]. Id.

[FN277]. Id.

[FN278]. Id.

[FN279]. Id.

[FN280]. Id.

[FN281]. Id.

[FN282]. Id.

[FN283]. See Brill, supra note 23, at 9.

[FN284]. Indeed, a malpractice insurer in Kentucky reduced premiums for physicians who adopted a computerized record system because "participating physicians are expected to improve their documentation of patient encounters and enhance the quality of care rendered." See Lower Malpractice Premiums for Doctors Using High Tech, Pr Newswire, Nov. 20, 1989 (LEXIS, Nexis library, Omni file). See also WILLIAM O. ROBERTSON, MEDICAL MALPRACTICE, A PREVENTATIVE APPROACH (1985). Dr. Robertson writes that communication errors in medical records can lead to treatment errors. Id. at 20, 21. Dr. Robertson reports two cases in which treatment errors occurred when verbal and written orders were not followed properly by staff and patients. Id. To improve treatment and avoid malpractice suits, Dr. Robertson recommends improved record keeping. Id. at 25;

see also GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE, CHARACTERISTICS OF CLAIMS CLOSED IN 1984 (April 1987) [hereinafter GAO 1984 CLAIMS]. 3.9% of all claims alleged improper "[m]edication administration." Id. at 39. The errors included giving improper drugs or improper dosages, treating the wrong patient, and other errors. Id. at 23. Presumably, some of those errors could be avoided through improved record keeping.

[FN285]. See ROBERTSON, supra note 284, at 42. Dr. Robertson writes that "doing too little-failure to diagnose" is the "most common cause of liability actions." Id. at 40, 42; see also GAO 1984 CLAIMS, supra note 284, at 39 (24.1% of 1984 claims alleged failure to diagnose).

[FN286]. Brill, supra note 23, at 1,9.

[FN287]. DANZON (1985), supra note 136, at 221. See infra notes 288-300 and accompanying text for an examination of whether the tort system does deter conduct.

[FN288]. DANZON (1985), supra note 136, at 187.

[FN289]. Id.

[FN290]. Id. For a detailed discussion of defense costs in medical malpractice cases, see Metzloff, supra note 219, at 54-59.

[FN291]. DANZON (1985), supra note 136, at 187.

[FN292]. Id.

[FN293]. Id. at 221. Many have criticized the malpractice system for its high "transaction costs" that are a function of the delay inherent in the system and the time spent selecting and educating a lay jury. See, e.g., Metzloff, supra note 219, at 53.

[FN294]. DANZON (1985), supra note 136, at 221.

[FN295]. HARVARD STUDY, supra, note 80, at 9-67:
[M]ost physicians perceive their suits as arising from circumstances beyond their control. Many physicians report that they are being unfairly and unjustly punished, a situation which might detract from the deterrent effects of the tort system. The long delays ... indicate that physician recount [sic] that the so-called punishment is not particularly swift. Finally, as discussed in connection with the mailed survey, the reported certainty of punishment for negligence was only about 60%. All three findings explain why physicians seem to believe that the net of the tort system is cast too broadly and lacks specificity. The diffuse nature of the perceived tort incentives may mean that physicians have a difficult time identifying what actions should be taken to prevent accidents.
Id. at 9-66, 9-67 (emphasis in original).

[FN296]. Id. at 9-68.
Given this set of professional attitudes, physicians are quite likely to downplay the specific deterrent effect of malpractice litigation. They tend to characterize malpractice litigation as an irritating nuisance rather than something that affects the way they practice medicine. Results of the mailed survey indicate, however, that the tort system may have a deterrent effect as evidenced by physicians overestimating being sued.
Id.

[FN297]. Id. at 10-4. This would be especially likely if physicians are aware of this "litigation gap."

[FN298]. Id. at 10-1.

[FN299]. Id. at 10-44.

[FN300]. Id. at 10-45.

[FN301]. Id.

[FN302]. Id.

[FN303]. Id. at 10-45, 10-46. The Study added, "Thus, our study of the empirical relationship between claims rates and injury rates cannot directly determine the magnitude of any deterrence. One might ask whether any study could determine this magnitude." Id. at 10-46.

[FN304]. Id. at 9-4:
A priori, the tort system appears to have a deterrent impact. The aim of the litigation is to identify those providers who have engaged in negligent behavior and to require any parties at fault to pay for damages that they have inflicted on their victims. The prospect that one's unduly risky behavior will be penalized in this fashion should give everyone a real incentive to be more careful and conscientious in their actions. In that respect tort law rests on the same commonsense notions of deterrence that influence fields of human behavior ranging from child rearing to criminal justice to defense policy.
Id.

[FN305]. Id. In a recently published article, the authors of the Harvard Study confirmed this conclusion.
[S]everal reasons ... lead us to believe that the tort system exerts a deterrent effect. First, the self-reported behavior of New York physicians interviewed by us is consistent [with this conclusion]. Second, our finding of increased negligence among the elderly and among the uninsured may be attributed, at least in part, to reduced economic losses in those groups, and therefore, a smaller likelihood of their bringing claims. Finally, there is evidence of fewer workplace injuries because of the workers' compensation program.
Paul C. Weiler, et al., Proposal for Medical Liability Reform, 267 JAMA 2355, 2356 (1992) (footnotes omitted).

[FN306]. DANZON (1985), supra note 136, at 222.

[FN307]. See supra notes 42-46 and accompanying text. It does however, stop short of proposing radical reform for the civil jury. See id.

[FN308]. 137 CONG. REC. S2325 (daily ed. Feb. 26, 1991). Senator Hatch stated:
The legislation I am introducing today builds on legislation I introduced last session. It was developed with the help of a broad coalition representing health care provider organizations, the business community, health insurers, and other groups. This coalition came together at my request, and I am grateful to them for their efforts. In particular, I want to thank Kathy Bryan from the American College of Obstetrics and Gynecology for her capable counsel.
Id. (Statement Sen. Hatch).

[FN309]. David G. Duff, Compensation for Neurologically Impaired Infants: Medical No-Fault in Virginia, 27 HARV. J. ON LEGIS. 391, 398 (1990); see also INSTITUTE OF MEDICINE, MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 2 (1989); see also sources cited supra note 261.

[FN310]. 137 CONG. REC. at S2325.

[FN311]. Id. In light of these events, Senator Hatch observed: "The time has come to stop debating whether there is a medical liability problem. It is time to admit that medical liability has had a decidedly negative impact on American's access to quality health care. Instead, we must move forward to enact solutions." Id. Senator Hatch added:
We know that it is a crisis; there are 900 new malpractice lawsuits every day. The average award for cases amounts at a minimum to $300,000.
This crisis is not only affecting the cost but also the quality and availability of health care. Physicians are refusing to do high risk procedures and to accept high risk patients. They have stopped delivering babies because of liability concerns. Women today do not have to worry merely about finding affordable pregnancy-related care; they have to worry about finding care at all. For example, in Utah, more than half of the general and family practitioners have quit delivery babies. Expectant mothers from our rural areas and small communities must often travel an extra 100 to 150 miles for care. This legislation is an access to health care legislation.
Id. (Statement Sen. Hatch).

[FN312]. For a recent publication of Senator Hatch's views on medical malpractice, see generally Hatch, supra note 20 ("Since the mid-1970s the increase in medical malpractice litigation has sparked growing public and professional concern.").

[FN313]. See supra notes 211-18 and accompanying text for a discussion of the increase in average awards and the increase in large awards.

[FN314]. 137 CONG. REC. at S2331. Jeffords added, "[t]his fear, resulting in the availability of fewer physicians, has become an especially serious problem in many rural areas." Id. (Statement Sen. Jeffords).

[FN315]. Id. Jeffords added, "And when doctors do deliver care, they will be less likely to engage in defensive medicine provided mostly to protect themselves in the event that they should ever be sued. Such changes in physician behavior should result in significant medical cost savings for the American public." Id. (Statement Sen. Jeffords).

[FN316]. S. 489, § 2(a), reprinted in 137 CONG. REC. at S2325. The findings state that malpractice actions have reduced patient access to health care, have increased the cost of healt care, and have impaired the ability of physicians "to practice in high risk areas of health care treatment." Id. § 2(a)(1), reprinted in 137 CONG. REC. at S2325. The findings further state that the "Federal Government has a major interest in these problems as a direct provider of health care to many Americans through the Public Health Service." Id.

[FN317]. Id. § 2(a)(1)(D), reprinted in 137 CONG. REC. at S2325.

[FN318]. Id. § 2(a)(1)(E), reprinted in 137 CONG. REC. at S2325.

[FN319]. Id. § 112(a), reprinted in 137 CONG. REC. at S2327; see infra note 410 and accompanying text for a discussion of this provision.

[FN320]. 137 CONG. REC. S6356 (daily ed. May 22, 1991):
Mr. President, I rise today to introduce legislation at the request of President Bush that addresses one of the major problems with our health care system - medical liability. Medical liability reform is an important step in improving access to reasonably priced health care for all Americans. By becoming involved early in this Congress, the President is recognizing the importance of this issue. His leadership will be critical to expanding the dialogue and passing this legislation.

[FN321]. Id.

[FN322]. S. 1123, § 101(a), reprinted in 137 CONG. REC. at S6357. In addition, the S. 1123 findings refer to a pilot project the Federal Government is designing "to promote alternative dispute resolution procedures on a voluntary basis." Id.

[FN323]. Id. § 101(a)(f), reprinted in 137 CONG. REC. at S6357.

[FN324]. 137 CONG. REC. at S6356. The study actually found that only approximately 12.5% of those negligently injured make any type of claim, whether by oral or written demand or lawsuit. See supra note 172 and accompanying text. Senator Hatch referred to these figures to emphasize that "[o]ur current medical liability system rewards a few individuals and their attorneys with settlements while denying remedy to the majority of injured patients." 137 CONG. REC. at S6356.

[FN325]. 136 CONG. REC. S556-558 (daily ed. Jan. 30, 1990) (remarks of Sen. Cohen) (quoting Nicholas E. Davies, M.D. & Louis H. Felder, M.D., Applying the Brakes to the Runaway American Health Care System-A Proposed Agenda, 263 JAMA 73 (1990)).

[FN326]. Id. at S556.

[FN327]. Id. at S555 (remarks of Sen. Cohen).

[FN328]. Id. at S556 (remarks of Sen. Cohen) (quoting Nicholas E. Davies, M.D., & Louis H. Felders, M.D., Applying the Brakes to the Runaway American Health Care System - A Proposed Agenda, 263 JAMA 73, 73 (1990)). The entire proposal called for a study of several issues:
We recommend that President Bush appoint a blue-ribbon commission to study our present system in depth, then offer alternative solutions for its many problems. He should look closely at, at least, the following nine issues: controlling medical technology, instituting a resource-based relative value system for physician reimbursement, establishing an ongoing national medical ethics commission, instituting national malpractice reform, implementing universal medical coverage with Medicare/Medicaid reform, establishing a national health services research and planning institute, reducing the nation's health care facilities, reducing physician supply, and improving health promotion/disease prevention education.
Id.

[FN329]. Id. Medical malpractice may not be a large factor in that cost. Malpractice premiums account for less than 1% of total national health care costs. When the AMA's estimate of the cost of defensive medicine is added to that cost, the total accounts for approximately 3% of national health care costs. See supra notes 270-71 and accompanying text.

[FN330]. Glazer, supra, note 20, at 210.
Privately, Bush administration officials agree that the malpractice crisis appears to be on the wane. They credit growing conservatism by judges and juries in setting malpractice awards as well as limits on damage awards passed by many states, including Virginia and Maryland. Many of these caps were imposed in response to publicity about multi-million dollar malpractice awards and a resulting exodus of doctors, particularly obstetricians.
Id.

[FN331]. BNA PENSIONS AND BENEFITS DAILY (Dec. 17, 1990) (LEXIS, Nexis library, Omni file) [hereinafter BNA DAILY]. When he later proposed legislation, President Bush reiterated these sentiments:

This legislative proposal would assist in stemming the rising costs of health care caused by medical professional liability. During recent years, the costs of defensive medical practice and of litigation related to health care disputes have skyrocketed. As a result, the access to quality care for significant portions of the population has been threatened. Health Care Liability Reform and Quality of Care Improvement Act-Message from the President, 137 CONG. REC. S5897 (daily ed. May 15, 1991).

[FN332]. BNA DAILY, supra note 331.

[FN333]. BNA WASHINGTON INSIDER (June, 1991) (LEXIS, Nexis library, Omni file). The official reported that President Bush had only "recently" requested action by the Domestic Policy Council. Yet, the administration had already determined that some states were "under the gun of trial lawyers." Id.

[FN334]. Id.

[FN335]. Id.

[FN336]. Id. President Bush recently echoed these sentiments when he called upon the public to "stop America's love affair with lawsuits" and opined, "Health costs would be an awful lot lower if we didn't have a lot of frivolous lawsuits going after those doctors for malpractice." Editorial, Bashing Lawyers Also Justice, N.Y. TIMES, Feb. 15, 1992, at 22.

[FN337]. S. 489 § 201(a)(2) (periodic payment of damages); id. § 201(a)(3) (abrogation of collateral source rule), and id. § 201(a)(4) (cap on noneconomic damages)), reprinted in 137 CONG. REC. S2329 (daily ed. Feb. 26, 1991).

[FN338]. Id. § 201(a)(6), reprinted in 137 CONG. REC. at S2329.

[FN339]. Id. § 201(a)(5), reprinted in 137 CONG. REC. at S2329.

[FN340]. Id. § 101(a) & (b), reprinted in 137 CONG. REC. at S2326.

[FN341]. Id. § 102 (alternative dispute resolution systems), reprinted in 137 CONG. REC. at S2326-2327.

[FN342]. Id. § 112(c)(1), reprinted in 137 CONG. REC. at S2327.

[FN343]. Id. § 201(a)(1), reprinted in 137 CONG. REC. at S2328-2329. S. 489 does not apply to "any action for damages arising from a vaccine-related injury or death for which a petition was filed under section 2111 of the Public Health Service Act." Id. S. 489 preempts inconsistent state law:
[S. 489] supersedes any State law only to the extent that State law establishes higher payment limits, permits the recovery of a greater amount of damages or the awarding of a greater amount of attorneys' fees, or establishes a longer period during which a health care malpractice claim may be initiated.
Id., § 201(b)(1), reprinted in 137 CONG. REC. at S2329.

[FN344]. Id., § 201(a)(2), reprinted in 137 CONG. REC. at S2329. "No person may be required to pay more than $100,000 in a single payment for future losses, but such person shall be permitted to make such payments on a periodic basis." Id.

[FN345]. Id.

[FN346]. Id. § 201(a)(3)(A) & (B), reprinted in 137 CONG. REC. at S2329. See supra note 18 for a discussion of the collateral source rule.

[FN347]. Id. § 201(a)(3)(A)(i), reprinted in 137 CONG. REC. at S2329.

[FN348]. Id. § 201(a)(3)(A)(iii), reprinted in 137 CONG. REC. at S2329.

[FN349]. Id. § 201(a)(3)(A)(ii), reprinted in 137 CONG. REC. at S2329.

[FN350]. Id. § 201(a)(3)(A)(iv), reprinted in 137 CONG. REC. at S2329.

[FN351]. Id. § 201(a)(4), reprinted in 137 CONG. REC. at S2329. "The total amount of damages which may be awarded to an individual and the family members of such individual for noneconomic losses resulting from an injury which is the subject of a health care malpractice claim may not exceed $250,000." Id.

[FN352]. Id. The limitation applies "regardless of the number of health care professionals and health care providers against whom the claim is brought or the number of claims brought with respect to the injury." Id.

[FN353]. Id. § 201(a)(5)(A-C), reprinted in 137 CONG. REC. at S2329.

[FN354]. Id. § 201(a)(6)(A), reprinted in 137 CONG. REC. at S2329.

[FN355]. Id.

[FN356]. Id. § 201(a)(6)(B), reprinted in 137 CONG. REC. at S2329.

[FN357]. Id. § 202(e)(1), reprinted in 137 CONG. REC. at S2329.
Each State agency responsible for the conduct of disciplinary actions for a type of health care practitioner shall enter into agreements with State or county professional societies of such type of health care practitioner to permit the review by such societies of any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of any such health care practitioner.

[FN358]. Id. § 202(e)(2), reprinted in 137 CONG. REC. at S2329.

[FN359]. Id.
Any agreement entered into under paragraph (1) for the review of any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of a health care practitioner shall - (A) provide that the health care professional society conduct such review as expeditiously as possible; (B) provide that after the completion of such review, such society shall report its findings to the State agency with which it entered into such agreement and shall take such other action as such society considers appropriate; and (C) provide that the conduct of such review and the reporting of such findings be conducted in a manner which assures the preservation of confidentiality of health care information and of the review process.

[FN360]. Id. § 202(a), reprinted in 137 CONG. REC. at S2329.

[FN361]. Id. § 102, reprinted in 137 CONG. REC. at S2326-2327.

[FN362]. Id. § 3(1)(A), reprinted in 137 CONG. REC. at S2335.

[FN363]. Id. § 101(a), reprinted in 137 CONG. REC. at S2326: "A State shall use a grant made under this section to develop or implement, and evaluate the effectiveness of such a system." Id. S. 489 further provides:
(1) IN GENERAL.-The amount of a grant made to each State under this section shall be

equal to 1/52 of the amount appropriated and available under section 123(a)(1).
(2) DEFINITION OF STATE.-For purposes of this section, the Commonwealth of Puerto Rico, Guam, and the Virgin Islands shall be considered as a single State.
Id. § 101(c), reprinted in 137 CONG. REC. at S2326.

[FN364]. Id.

[FN365]. Id.

[FN366]. Id. § 102(b)(3)(A), reprinted in 137 CONG. REC. at S2326.

[FN367]. Id. at 102(c)(1), reprinted in 137 CONG. REC. at S2326-2327:
(1) ESTABLISHMENT. - A State may establish a system under which the State establishes a compensation fund to compensate all individuals who incur a certain injury (as defined by the State) in the course of receiving health care services. The State shall provide that if an individual incurs such an injury, the individual may only receive compensation for such injury by filing a claim with the State for compensation from such fund, and that such individual may not file a health care malpractice action in any State or Federal court for damages resulting from such injury.

[FN368]. Workmen's compensation provides compensation for work related injuries regardless of fault. See generally 1 ARTHUR LARSON, THE LAW OF WORKMEN'S COMPENSATION ch. 1 §§ 1-2 (1990).

[FN369]. S. 489, 102d Cong., 1st Sess. § 102(d) (1991), reprinted in 137 CONG. REC. S2327. The section further provides:
(1) ESTABLISHMENT. - The State may establish a system under which health care providers and professionals have the option to offer, within a specified time period after an injury or (in certain circumstances determined by the State) after the initiation of a health care malpractice action, to compensate an individual for economic losses in accordance with this subsection.

[FN370]. Id. § 102(d)(4), reprinted in 137 CONG. REC. at S2327:
If, after an offer is made under the system established under paragraph (1), the individual alleging an injury disputes the amount of the economic losses for which the offerors propose to provide compensation, or the participants dispute the relative contributions of the health care providers or professionals to the payments to be made to the individual, such disputes shall be resolved by binding arbitration in accordance with rules and procedures established by the State.

[FN371]. Id. § 102(e)(1), reprinted in 137 CONG. REC. at S2327:
The State may establish a system under which - (A) prior to treatment, health care providers and professionals may offer their patients an opportunity to enter into an agreement to arbitrate any health care malpractice claims relating to such treatment; or (B) each individual receiving health care services in the State and the health care providers and professionals providing such services shall be deemed to have entered into an agreement to arbitrate any health care malpractice claims relating to such services.

[FN372]. Id. § 112(a), reprinted in 137 CONG. REC. at S2327:
The Secretary shall make grants to States from amounts appropriated and available under section 123(a)(3) to assist States in improving the State's ability to license and discipline health care professionals. A State may use a grant awarded under this subsection to develop and implement improved mechanisms for monitoring the practices of health care professionals or for conducting disciplinary activities.

[FN373]. Id. §§ 112(c)(1) & (2), reprinted in 137 CONG. REC. at S2327.

[FN374]. Id. § 112(c)(3), reprinted in 137 CONG. REC. at S2327.

[FN375]. S. 1123, 102d Cong., 1st Sess. § 205, reprinted in 137 CONG. REC. S6357 (daily ed. May 22, 1991): "[D]amages received by a plaintiff shall be reduced ... by any other payment which has been made or will be made to such plaintiff to compensate such plaintiff for an injury." Id. Compare with text and notes supra 346-50.

[FN376]. Id. § 204, reprinted in 137 CONG. REC. at S6357. Compare with text and notes supra 351-52.

[FN377]. Id. § 203, reprinted in 137 CONG. REC. at S6357. See supra note 54 for a brief discussion of joint and several liability.

[FN378]. Id. § 203(a), reprinted in 137 CONG. REC. at S6357.

[FN379]. Id. § 206, reprinted in 137 CONG. REC. at S6357-6358.

[FN380]. Id. § 206(a), reprinted in 137 CONG. REC. at S6357.

[FN381]. Id. § 206(b), reprinted in 137 CONG. REC. at S6357.

[FN382]. Id. § 206(c), reprinted in 137 CONG. REC. at S6357-6358.

[FN383]. Id. § 206(d), reprinted in 137 CONG. REC. at S6358.

[FN384]. Id. § 207(b)(1), reprinted in 137 CONG.REC. at S6358. The Secretary is to develop the mechanisms "in consultation with the Attorney General." Id. Compare with text and notes supra 361-71.

[FN385]. S. 1123, 102d Cong., 1st Sess. § 270(b)(1), reprinted in 137 CONG. REC. at 6358.

[FN386]. See supra note 333 and accompanying text.

[FN387]. The proposal does contain one section proposing revision of federal tort law: SEC. 301. LIMITATIONS ON LIABILITY. - (1) Section 2674 of Title 28, United States Code, is amended by inserting "(a)" at the beginning of the section, and by adding at the end of the section the following new subsections: "(b)(1) Except as provided in paragraph (2) of this subsection, in any health care liability action the United States shall not be found jointly and severally liable for non-economic damages, but shall be liable, if at all, only for those non-economic damages directly attributable to its pro-rata share of fault or responsibility for the injury, and not for non-economic damages attributable to its pro-rata share of fault or responsibility of any other person (without regard to whether that person is a party to the action) for the injury, including any person bringing the action. (S. 1123, 102d Cong., 1st Sess. § 301 (1991)), reprinted in 137 CONG. REC. S6359 (daily ed. May 22, 1991).

[FN388]. Id. § 209(f), reprinted in 137 CONG. REC. S6358:
INCENTIVE PROGRAM - DISTRIBUTION OF FUNDS. - The Secretary shall establish an administrative process to -
(1) withhold from each State 2 percentum of the amount computed under 42 U.S.C. 1396b(a)(7) and from each hospital 1 percentum of the total amounts computed under 42 U.S.C. 1395ww(d)(1) for each fiscal year beginning after the initial three-year period after the enactment of this Act; and (2) distribute that part of the withheld funds comprising 2 percentum of the amount computed under 42 U.S.C. 1396b(a)(7) on a

proportional basis among States whose notifications have been approved by the Secretary pursuant to this section, and that part of the withheld funds comprising 1 percentum of the total amounts computed under 42 U.S.C. 1395ww(d)(1) on a proportional basis among hospitals otherwise entitled to those funds in States whose notifications have been approved by the Secretary pursuant to this section. "Proportional basis" means (i) with respect to funds withheld from amounts payable under 42 U.S.C. 1396(a)(7), in proportion to the average Medicaid payments made to a State for the last three preceding fiscal years for which data is available to such payments to all States whose notifications have been approved by the Secretary, and (ii) with respect to funds withheld from amounts computed under 42 U.S.C. 1395ww(d)(1), in proportion to the hospital's share of payments made under that section to all payments to hospitals operating in States whose notifications have been approved by the Secretary.

[FN389]. Phillip J. Hilts, Bush Enters Malpractice Debate With Plan to Limit Court Awards, N.Y. TIMES, May 13, 1991, at A1.

[FN390]. In 1984, Danzon reported that 34 states had enacted statutes requiring that suits be brought within 4 years or less of the alleged act of malpractice. Patricia M. Danzon, The Frequency and Severity of Medical Malpractice Claims, 27 J. L. & ECON. 115, 146-47, table A2 (1984). Remaining states allowed 5 to 20 years for the bringing of suit. Id. In addition, 20 states had enacted statutes requiring that suit be brought within 1 year of discovery of the alleged act of malpractice. Id.

[FN391]. Danzon has observed that a reduction by one year of the statutes governing adults produces an 8% reduction in total claim frequency and a 6-7% reduction in the frequency of paid claims. DANZON (1986), supra note 203, at 20.

[FN392]. For a discussion on the constitutionality of statutes limiting contingent fees, see generally Richard M. Birnholz, Comment, The Validity and Propriety of Contingent Fee Controls, 37 UCLA L. REV. 949 (1990).

[FN393]. Danzon has reported that defense lawyers, on average, charge the same as plaintiffs' lawyers. DANZON (1985), supra note 136, at 187. Defendants' fees exceed plaintiffs' fees in small cases while plaintiffs' fees exceed defendants' fees in large cases. Id.

[FN394]. Opponents of the California tort reform legislation contend that a similar provision in California law has caused some lawyers to stop accepting medical malpractice cases. Harris Meyer, Calif. Tort Reform Law Faces Showdown, AM. MED. NEWS, Feb. 17, 1992, at 3, 52-54. Proponents of the law contend that only the less capable lawyers have ceased taking medical malpractice cases. Id. at 54. The state's largest medical malpractice insurance carrier possesses data demonstrating which of these positions is correct but, like other California insurers, has refused to release its data. Id. at 51-52.

[FN395]. Dan B. Dobbs, HANDBOOK ON THE LAW OF REMEDIES 570 (1973). Some courts, however, do not reduce to present value because any excess value in a lump sum payment will be offset by future inflation. See, e.g., Beaulieu v. Elliot, 434 P.2d 665, 671 (Alaska 1967) (plaintiff more likely to be restored to original condition if trier of fact computes loss of future earnings without reduction).

[FN396]. If the loss is calculated in today's dollars but paid in the future, the award will undercompensate the plaintiff. Therefore, the statute should provide for an inflation adjustment. See Roger C. Henderson, Designing a Responsible Periodic Payment System for Tort Awards: Arizona Enacts a Prototype, 32 ARIZ. L. REV. 21, 34 (1990) (legislatively determined inflation factor or formula would simplify trial).

Similarly, the concomitant periodic payment of attorney's fees would reduce the present value of those fees and thereby further erode the economic incentive for lawyers to represent plaintiffs in medical malpractice. See supra notes 392-94 and accompaning text for a further discussion of the impact of both legislative proposals on attorneys fees.

[FN397]. But see Henderson, supra note 396, at 31. (periodic payment beneficial to plaintiffs because it obviates "complex investment and budgetary choices" posed by a lump sum). In addition, Professor Henderson observes that "some" believe that awards will be larger under a periodic payment system because plaintiffs will not face juror reluctance to award large sums in lump payment. Id. at 33.

[FN398]. See 137 CONG. REC. S2325 (daily ed. Feb. 26, 1991) ("There are many Americans who have a difficult time gaining recovery even when there is medical care negligence.") (remarks of Sen. Hatch); ("Under our current system, those with small legitimate claims usually have a hard time finding an attorney to take their case.") (remarks of Sen. Jeffords). Id. at S2331-2332.

[FN399]. See supra notes 199-221 and accompanying text.

[FN400]. Damage caps have been especially criticized for placing the burden of tort reform on a limited number of plaintiffs. "The problem with the cap is it says the only people who are going to pay the price for controlling malpractice insurance premiums are the people who are the most catastrophically injured ... It's a totally regressive form of tort reform." Glazer, supra note 20, at 10, 11 (quoting Paul C. Weiler, one of the authors of the Harvard Study). Weiler favors a sliding scale that places a partial limit on the recovery of noneconomic losses regardless of the size of the award. WEILER, supra, note 1, at 61.

Moreover, a number of courts have held damage caps unconstitutional under a variety of theories. Some courts have held that caps violate due process guarantees in state constitutions. See, e.g., Kansas Malpractice Victims Coalition v. Bell, 757 P.2d 251, 264 (Kan. 1988) ($1 million cap on general damages violated a state constitutional provision that guarantees "remedy by due course of law"); Morris v. Savoy, 576 N.E.2d 765, 772 (Ohio 1991) ($200,000 cap on general damages violated due process provision but did not violate equal protection provision). But cf. Samsel v. Wheeler Transp. Servs., 789 P.2d 541, 558 (Kan. 1990) ($250,000 cap on noneconomic damages did not violate Kansas constitution), overruled on other grounds, Bair v. Peck, 811 P.2d 1176 (Kan. 1991). Other courts have held that caps violate equal protection provisions of state constitutions. See, e.g., Carson v. Maurer, 424 A.2d 825, 830 (N.H. 1980) ($250,000 cap on noneconomic damages unconstitutional); Arneson v. Olson, 270 N.W.2d 125, 136 (N.D. 1978) ($300,000 cap on general damages unconstitional). Other courts have held that caps violate provisions in state constitutions guaranteeing the right to a jury trial. See, e.g., Sophie v. Fibreboard Corp., 771 P.2d 711, 712-13 (Wash. 1989) (age-based formula that caps noneconomic damages violated constitutional right to jury trial). Still other courts have held that caps violate a variety of other state constitutional provisions including right to access to courts. See, e.g., Lucas v. United States, 757 S.W.2d 687, 692 (Tex. 1988) ($500,000 cap on general damages in medical malpractice cases violated "open courts" provision in state constitution). But cf. Smith v. Department of Ins., 507 So. 2d 1080, 1087-89 (Fla. 1987) ($450,000 cap on noneconomic damages violated "open courts" guarantee); Wright v. Central Du Page Hosp. Ass'n, 347 N.E.2d 736, 743 (Ill. 1976) ($500,000 cap on general damages constituted "special law" in violation of state constitution); Rose v. Doctor's Hosp., 801 S.W.2d 841, 846 (Tex. 1990) (same cap not an unconstitutional limit in wrongful death cases).

Other courts have upheld damage caps in the face of challenges under both state and federal constitutional provisions. See, e.g., Davis v. Omitowoju, 883 F.2d 1155, 1165 (3d Cir. 1989) ($250,000 cap on noneconomic damages did not violate Federal Constitution); Boyd v. Bulala, 877 F.2d 1191, 1195 (4th Cir. 1989) ($1 million cap on general damages

in medical malpractice actions did not violate either Virginia or Federal Constitutions); Franklin v. Mazda Motor Corp., 704 F. Supp. 1325, 1333, 1337 (D. Md. 1989) ($350,000 cap on noneconomic damages did not violate Federal or Maryland Constitutions); Fein v. Permanente Medical Group, 695 P.2d 665, 686 (Cal. 1985) ($250,000 cap on noneconomic damages in medical malpractice suits did not violate either California or Federal Constitution), appeal dismissed, 474 U.S. 892 (1985); Williams v. Kushner, 549 So. 2d 294, 296-97 (La. 1989) ($400,000 cap on damages available from state funded patient compensation fund was constitutional; $500,000 cap on damages recoverable against private hospital violated equal protection provision of state constitution); Etheridge v. Medical Ctr. Hosps., 376 S.E.2d 525, 531-32 (Va. 1989) ($750,000 cap on general damages did not violate Virginia Constitution).
See generally Martin H. Redish, Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications, 55 TEX. L. REV. 759, 759-65 (1977); David Randolph Smith, Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws, 38 OKLA. L. REV. 195, 208 (1985); Mixed Record On Tort Caps, NAT'L. L. J., Oct. 15, 1990; James F. Tiu, Comment, Challenging Medical Malpractice Damage Awards on Seventh Amendment Grounds: Attacks in Search of a Rationale, 59 U. CIN. L. REV. 213 (1990); R. Kyle Gavin, Note, The Constitutionality of Florida's Cap on Noneconomic Damages in Tort Reform and Insurance Act of 1986, 39 UNIV. FLA. L. REV. 157 (1987); Todd M. Kossow, Note, Fein v. Permanente Medical Group: Future Trends in Damage Limitation Adjudication, 80 NW. U. L. REV. 1643, 1674 (1986).

[FN401]. Frank A. Sloan & Stephen S. Van Wert, Cost and Compensation of Injuries in Medical Malpractice, 54 LAW & CONTEMP. PROBS. 131, 135 (1991). The survey selected Florida because substantial information regarding malpractice claims is available in that state. Id. at 136.

[FN402]. Id.

[FN403]. "Home production," losses consist of the loss of "meals, transportation, child care, and home tutoring, for example." Id. at 138 n.30.

[FN404]. Id. at 158-59. Only one-fifth of the claimants were overcompensated. Id. The authors added that they had likely "seriously underestimated future medical and related expenses of survivors of emergency room incidents, especially in cases involving severe injuries." Id. at 158.

[FN405]. Id. at 164. The authors also cautioned that the findings are subject to the limitations of interview-based estimates. Id. at 161. In addition, the payments may have been reduced to account for the comparative negligence of the claimants or the questionable liability of the claims. Id. at 159. The authors did, however, buttress their conclusions by observing that earlier empirical studies were consistent with their conclusions. Id. at 164 & n.108, citing Robert L. Bombaugh, The Department of Transportation's Auto Insurance Study and Auto Accident Compensation Reform, 71 COLUM. L. REV. 207 (1971); Ted R. Miller, Willingness to Pay Comes of Age: Will the System Survive?, 83 NW. U. L. REV. 876 (1989); E. KING & J. SMITH, ECONOMIC LOSS AND COMPENSATION IN AVIATION ACCIDENTS (1989).

[FN406]. One commentator recently questioned the assertion that application of the collateral source rule to government benefits results in double compensation to the plaintiff that is in part subsidized by taxpayers who fund the government compensation programs: "Implicit in this [view] is the assumption that the consumer, not the tortfeasor, pays for negligence. Empirical evidence to support this conclusion is lacking. In the medical malpractice area, there is some evidence that malpractice premiums are shifted forward to patients by more than the premium increase." Sloan & Van Wert, supra note 401, at 134 n.11.

In addition, even if, on balance, the data support abolition of the collateral source rule, the U.S. Constitution and applicable state constitutions may not. Two state supreme courts recently considered this question. In Carson v. Maurer, 424 A.2d 825, 830 (N.H. 1990), the New Hampshire Supreme Court held that abolition of the collateral source rule in medical malpractice actions violated plaintiffs' rights of equal protection guaranteed by the New Hampshire Constitution. Id. at 836. In Morris v. Savoy, 576 N.E.2d 765, 788 (Ohio 1991), on the other hand, the Ohio Supreme Court held that abolition of the collateral source rule is constitutional. See also Fein v. Permanente Medical Group, 695 P.2d 665, 686 (Cal. 1985), appeal dismissed, 474 U.S. 892 (1985) (abolition of collateral source rule, among other tort reform measures, upheld against a variety of constitutional challenges); Pinillos v. Cedars of Lebanon Hosp. Corp., 403 So.2d 365, 368 (Fla. 1981) (abolition of collateral source rule did not violate equal protection guarantee); Farley v. Engelken, 740 P.2d 1058, 1068 (Kan. 1987) (abolition of collateral source rule in medical malpractice cases violated equal protection guarantee); Bernier v. Burris, 497 N.E.2d 763, 779 (Ill. 1986) (abolition of the collateral source rule did not violate equal protection guarantee); Rudolph v. Iowa Methodist Medical Ctr., 293 N.W.2d 550, 561 (Iowa 1980) (abolition of collateral source rule was not unconstitutional).

[FN407]. See, e.g., John G. Fleming, The Collateral Source Rule and Loss Allocation in Tort Law, 54 CALIF. L. REV. 1478, 1479 (1966).

[FN408]. Most state statutes provide that tort awards are subject to a subrogation claim for workmen's compensation received by the plaintiff. 2A ARTHUR LARSON, THE LAW OF WORKMEN'S COMPENSATION § 74.00, at 14-365 (1990).

[FN409]. Danzon, for example, has observed that although arbitration decreases claim severity, it sufficiently increases claim frequency to produce a net increase in claim cost. DANZON (1986), supra note 203, at 27. In another study Danzon opined that distinguishing between compensable and noncompensable claims based solely on causation might not be any easier than discriminating between negligent and non-negligent care. DANZON (1985), supra note 136, at 214. Therefore, she concluded that "it seems unlikely that no-fault liability for medical injuries would realize a significant saving in litigation cost per case." Id. In addition, Danzon observed the likelihood that a no-fault plan would compensate more claimants and might lead to even greater practice of defensive medicine. Id. at 215-16; see also HARVARD STUDY, supra note 80, at 2-13, 2-14, 2-20 (no-fault would cost considerably more than the present tort system) (citing California Medical Association, Medical Insurance Feasibility Study (1977)). See supra notes 136-45 and accompanying text for a brief discussion of the CMA report. On the other hand, the RAND Institute for Civil Justice recently issued a report concluding that arbitration reduced legal fees but did not affect the duration of litigation. LIABILITY SYSTEM, supra note 16.
Participants at public hearings conducted by the New York State Departments of Health and Insurance provided widely diverse opinions of the cost of the no-fault plan even with the limitations proposed by the Harvard Study. Perhaps not surprisingly, the New York State Bar Association contended that the study "seriously underestimates the cost of no-fault," and opined that "the cost of no-fault will be at least 50 percent higher than the present system." NEW YORK STATE DEPARTMENTS OF HEALTH AND INSURANCE, HARVARD MEDICAL PRACTICE STUDY PUBLIC HEARINGS, HEARING OFFICERS' REPORT at 5-7 (Jan. 1991). A number of medical and insurance organizations agreed. The Medical Liability Mutual Insurance Co. stated that no-fault "might well be more costly than the system which we have today." Id. at 10. The Medical Professional Liability Agency, Ltd. stated that "[a] no-fault system would not be affordable. Administrative expenses would be very high due to causation determination." Id. The Hospital Trustees of New York State cautioned that "[i]t is unknown ... what the projected costs would be and whether premiums would be raised or lowered." Id. at 4. Finally, the Nassau Suffolk Hospital Council cautioned against the adoption of a no-fault system without further study and

stated that, "[a] broad based no-fault liability system would potentially diminish the ability to identify frivolous claims and leaves many questions open." Id. at 5.
Similarly, groups examining the 1987 and 1989 AMA proposal to resolve medical malpractice claims with a no-fault administrative board reached inconsistent conclusions. See supra notes 42-51 and accompanying text. The Utah Medical Association examined 500 closed malpractice claims and 500 potential claims disclosed in incident reports to simulate the outcome of the no-fault plan. The Association concluded that claim severity would be reduced but that claim frequency would increase sufficiently to increase total costs by as much as one-third, resulting in a possible doubling of insurance premiums. Meyer, supra note 49, at 3, col. 1 & 3-4. Thus, the Utah Medical Association opposed adoption of the proposal unless the legislation also protected physicians from the potentially higher premium costs. Id. at 3, col. 2-3. On the other hand, a study funded by the AMA/Specialty Liability Project, the federal government and the American College of Obstetricians and Gynecologists concluded that the proposal has sufficient merit to be tested. Meyer, supra, note 49.
Finally, a number of commentators have criticized the existing jury system as leading to delay and unpredictability that would not exist in a no-fault system administered by professional decisionmakers. See, e.g., Metzloff, supra note 219, at 43; George L. Priest, The Role of the Civil Jury in a System of Private Litigation, 1990 U. CHI. LEGAL F. 161, 198-200.

[FN410]. HARVARD STUDY, supra note 80, at 9-67. Physicians define "peer" as "another physician from their own specialty." Id.

[FN411]. See supra note 333 and accompanying text.

[FN412]. In a recently published article, the authors of the Harvard Study reported on the results obtained by "[m]atching tort claims filed ... with our independent appraisal of hospital records." Paul C. Weiler, et al. Proposal for Medical Liability Reform, 267 JAMA 2355, 2355 (1992). The match revealed that "a substantial majority of the tort claims filed appear not to have had a positive basis in iatrogenic injury." Id.
If one limits "meritorious" claims to those in which the authors discovered "pervasive evidence of negligence," 5 in 6 tort claims, or 83%, are not meritorious. Id. Because 87.5% of those injured, however, do not assert claims, the number of non-meritorious claims (83% of the 12.5% of those who do assert claims) is approximately equivalent to 10% of those injured. Moreover, for three reasons even this number overestimates the burden of these "false positive" claims. First, one can assume that a disproportionate number of the non-meritorious claims are casualties in the process that results in compensation for only 50% of all claimants. See id. Second, a "modest number" of negligence cases are probably not revealed in the hospital records. Id. Third, although this high rate of "false positive" claims may impose a "sizable financial burden" on physicians and insurers, id., it also indicates that the number of "'false negative,' that is, those cases in which negligent injuries did not lead to tort claims," was even greater than the Harvard Study first reported. Id. at 2356. "Thus, although the tort system appears quite erratic, there is no basis for the charge that the amount of malpractice litigation is excessive. On the contrary, there seems to be a major 'deficit' of litigation." Id.

[FN413]. See supra note 324 and accompanying text.

[FN414]. See supra note 12 and accompanying text.

[FN415]. See, e.g., James T. O'Reilly, Deregulation and Private Causes of Action: Second Bites at the Apple, 28 WM. & MARY L. REV. 235, 243 n. 38 (1987):
In a legislative struggle for the creation of a new statutory set of rights, for example rights for consumer product safety or chemical regulation, proponents of the legislation, typically including private rights advocates and adversaries representing an established

constituency, advocate inclusion of private enforcement remedies. Because the adversaries usually concentrate their efforts on substantive issues, procedural issues routinely do not attract attention. An exception was the 1980 passage of the Comprehensive Environmental Response, Compensation, and Liability Act ('Superfund'), in which the bill's opponents eliminated a private enforcement provision.
Id. (citing Fredrick R. Anderson, Negotiation and Informal Agency Action: The Case of Superfund, 1985 DUKE L.J. 261, 270 n.21 (1985)). Anderson observed that a personal injury recovery provision was deleted from the Comprehensive Environmental Response Compensation Liability Act (CERCLA) shortly before final passage. Id.

[FN416]. Martin H. Redish, Judicial Parity, Litigant Choice, and Democratic Theory: A Comment on Federal Jurisdiction and Constitutional Rights, 36 UCLA L. REV. 329, 362 n.129 (1988):
In a number of ways, the empirical insights of the public choice theorists on this point amount to something less than a news flash. It was, after all, Bismarck - hardly a pioneer of public choice theory - who warned us that the two things one should not witness being made are sausages and legislation.

[FN417]. See generally Abner J. Mikva, Foreword to Symposium on the Theory of Public Choice, 74 VA. L. REV. 167 (1988); Cass R. Sunstein, Interest Groups in American Public Law, 38 STAN. L. REV. 29 (1985), for a discussion of Public Choice theory.

[FN418]. Sunstein, supra note 417, at 29.

[FN419]. Of course, Public Choice theorists are not without their critics. For example:
The "public choice" tradition ... expresses an unbending contempt for legislative and agency action that represents a quite radical departure from the centrist [Legal] Process tradition. ... [T]he public choice literature ... is an effort to demonstrate that ... the democratic sphere is, at its core, an arena of theft, an unmitigated disaster that should be limited carefully, tolerated only if fundamentally powerless.
Redish, supra note 416, at 370. (quoting Mark Kelman, On Democracy-Bashing: A Skeptical Look at the Theoretical and "Empirical" Practice of the Public Choice Movement, 74 VA. L. REV. 199, 201-02 (1988)). Kelman goes on to say, "Of course, one could ultimately interpret all these public choice scholars as they interpret the rest of us: they're just trying to make a buck." Kelman, supra, at 269; see also infra notes 422-23 for a discussion of sources criticizing Public Choice.

[FN420]. Redish, supra note 416 (citing Frank H. Easterbrook, Statutes' Domains, 50 U. CHI. L. REV. 533, 551-52 (1983)).

[FN421]. Redish, supra note 416, at 362 n.133 (citing Daniel A. Farber & Philip P. Frickey, The Jurisprudence of Public Choice, 65 TEX. L. REV. 873, 908 (1987); Jonathan R. Macey, Promoting Public-Regarding Legislation Through Statutory Interpretation: An Interest Group Model, 86 COLUM. L. REV. 223, 226 (1986)).

[FN422]. See, e.g., Mark Kelman, "Public Choice" and Public Spirit, 87 PUB. INTEREST 80 (1987).

[FN423]. Mikva, supra note 417. Judge Mikva, who sits on the United States Court of Appeals for the District of Columbia Circuit, comments that his five terms in the Illinois State legislature and five terms in the United States Congress, id. at 167, revealed some "crooks" in office, id. at 169, but that "the motivations of politicians are far too mixed to be understood through the generalizations that ... the public choice theorists formulate about political behavior." Id.

[FN424]. See Kelman, supra note 419, at 217-23 (discussion of Public Choice view of

elected officials). Kelman summarizes Public Choice theory regarding re-election campaigns, "selling" "rents" Congressmen create by voting to allow campaign contributors to collect "rents," maximizing government budget and size, and maximizing employment opportunities. Id. Kelman then evaluates four empirical studies: id. at 238-60; Peter Linneman, The Effects of Consumer Safety Standards: The 1973 Mattress Flammability Standard, 23 J. L. & ECON. 461, 462-71 (1980) (Mattress Flammability Standard does not benefit public); Sam Peltzman, The Effects of Automobile Safety Regulation, 83 J. POL. ECON. 677, 717-18 (1975) (Regulation did not promote safety); Ann Bartel & Lacy Glenn Thomas, Direct and Indirect Effects of Regulation: A New Look at OSHA's Impact, 28 J. L. & ECON. 1, 25 (1985) (OSHA does not serve public interest); W. Kip Viscusi, Consumer Behavior and the Safety Effects of Product Safety Regulation, 28 J. L. & ECON. 527, 537-38 (1985) (aspirin bottle safety caps did not benefit public). Kelman then concludes, "In the final analysis, then, we hardly seek either selfish gain or some abstract public good when we work for rent control or write a public choice article; what we largely do is to help define ourselves in the only context that ever provides us definition, a social and collective one." Kelman, supra note 419, at 273 (emphasis in original).

[FN425]. See supra notes 353-56 and accompanying text.

[FN426]. See supra notes 372-74 and accompanying text.

[FN427]. See supra notes 351-52 & 376 and accompanying text.

[FN428]. See supra notes 346-50 & 375 and accompanying text.

[FN429]. DANZON (1986), supra note 203, at 28; see also generally DANZON (1982), supra note 1. Danzon advised that the conclusions are limited by the incomplete availability of data, the inability to isolate the effects produced by each provision in a state that simultaneously enacts several provisions, the unknown impact of judicial challenges to the measures, and the relatively short time span of the study. DANZON (1986), supra note 203, at v-vii. Danzon's

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study is still viewed as the leading study regarding the effect of tort reforms. See Walter J. Waldington, Legal Responses to Patient Injury: a Future Agenda for Research and Reform, 54 LAW & CONTEMP. PROBS. 200, 204 (Spring 1991).

[FN430]. DANZON (1986), supra note 203, at 28. Damage caps reduced claim severity by an average of 23% while abolition of the collateral source rule reduced severity by 11% to 18% and frequency by 14%. Id.
Modifying the statute of limitations also reduced frequency by up to 8%. Id. Reducing the time for bringing a claim will reduce the number of claims and, therefore, should not be considered by Congress. See supra note 391.

Arbitration statutes increased frequency and decreased severity. DANZON (1986), supra note 203, at 28. The net result was an overall increase in claim costs. Id.
See also GAO SIX STATE STUDY, supra note 124, at 5. Four of six groups that the GAO surveyed believed that a cap on malpractice awards had a "major effect" in reducing the size of awards. Id. Three groups also believed that pretrial screening had a "major effect" on the number of claims going to trial. Id.

[FN431]. See generally Sloan & Van Wert, supra note 401. See supra notes 401-05 and accompanying text.

[FN432]. Sloan & Van Wert, supra note 401, at 157.

[FN433]. Id.

[FN434]. See supra notes 307-15 & 321-36 and accompanying text.

[FN435]. HARVARD STUDY, supra note 80, at 10-46.

[FN436]. Id. at 10-46, 10-47.

[FN437]. Id. at 10-47. The Study states:
Simply expanding the number of hospitals and broadening the range of claims, however, would do nothing to address the possible upward bias in the coefficient of the claims variable. The better way would be to measure the likelihood of a claim conditional on an adverse event or negligent adverse event. This would convert the explanatory variable to one that measured purely the threat of a claim rather than, as in our case, the product of an injury rate (per discharge per physician) times the likelihood of a claim's being filed conditional upon an injury. We could not implement such a measure because of the small number of claims that we could match to patients.
Id.

[FN438]. One study suggested that: "If hospital premiums can be adjusted for ... risk factors, there would be incentives for hospitals to avoid services and activities associated with increased risk and premiums, and to undertake efforts to reduce risk." Harold S. Luft et al., Risk Factors for Hospital Malpractice Exposure: Implications for Managers and Insurers, 54 LAW & CONTEMP. PROBS. 43, 64 (1991). Another author, on the other hand, has concluded that measuring the deterrent effect of such a premium practice "is usually a daunting task." John E. Rolph, Merit Rating for Physicians' Malpractice Premiums: Only a Modest Deterrent, 54 LAW & CONTEMP. PROBS. 65, 79 (1991) (footnote omitted).

[FN439]. See, e.g., Do We Have Too Many Lawyers?, TIME 54, Aug. 26, 1991 at 54 [hereinafter Too Many Lawyers]. When addressing the August 1991 American Bar Association Convention, Vice President Dan Quayle opined that the United States population is too litigious and asked, "Does America really need 70% of the world's lawyers?" Id. The Vice President based his remarks on a report recently issued by a council that he chaired. REPORT OF THE PRESIDENT'S COUNCIL, supra note 120. The report relied extensively on federal court data and concluded that the "America has become a litigious society" and that "[u]nrestrained litigation necessarily exacts a terrible toll on the U.S. economy." Id. at 1. See supra notes 109-21 for a critique of the report. See supra notes 73-77 and accompanying text for a more general critique of the use of federal court data to identify litigation trends.

[FN440]. Too Many Lawyers, supra note 439.

[FN441]. See supra note 16 and accompanying text.

[FN442]. Too Many Lawyers, supra note 439.

[FN443]. HARVARD STUDY, supra note 80, at 10-47.
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