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The Future of Personal Injury Compensation in the USA : Current Trends in the Medical Malpractice Field

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INTRODUCTION

During the past year numerous studies and proposals at both the federal and state levels have addressed new ways of dealing with civil liability for personal injuries [1]. The impetus has arisen from concern

1. The leading study is a two year effort requested by Sen. John Heinz and Rep. John Porter in 1985 to be undertaken by the U.S. General Accounting Office (GAO). The GAO has so far issued three of a projected series of five reports : *Medical Malpractice : No Agreement of the Problems or Solutions* (GAO/HRD-86-50, Feb. 24, 1986); *Medical Malpractice : Insurance Costs Increased but Varied Among Physicians and Hospitals* (GAO/HRD-86-112, Sep. 15, 1986); *Medical Malpractice : Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms* (GAO/HRD-

about rising premium rates for commercial insurance policies for product liability, municipal liability for government services, and most noticeably, insurance for the injuries caused to patients in the course of the practice of medicine. Many have associated these problems in the insurance market with the need for changes in the laws of civil liability [2].

While most of the recent legislative activity has been stirred by medical interests, coalitions of private and public groups have been formed to promote public attention to general tort reform in the various states as well as nationally [3]. The result has been a considerable amount of pressure on both levels of government to respond.

At the federal level the Congress, Executive Agencies, the Office of the President and the Supreme Court have all addressed various aspects of the multiple issues affecting the field of medical malpractice [4]. More importantly, however, state legislatures and legislative study

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87-21, Ded. 31, 1986) (the six states are Arksansas, California, Florida, Indiana, New York, and North Carolina). The remaining two reports will provide information on the characteristics of malpractice claims closed in 1984 and the GAO recommendations concerning the medical malpractice situation.

Other governmental studies include, *Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability* (Feb. 1986) (the inter-agency working group was established by the Attorney General in Oct. 1985 and consisted of representatives from the Department of Justice, Department of Commerce and the Small Business Administration and seven other federal agencies and the White House) (hereafter, Working Group Report); National Conference of State Legislatures, *State Legislative Report — Controlling Liability Insurance Costs : State Actions and Future Initiatives in the Area of Civil Justice Reform* (Jan. 1986).

2. E.g., *The Need For Legislative Reform Of The Tort System : A Report On The Liability Crisis From Affected Organizations* (May 1986) (prepared by the Sidley & Austin law firm for 140 listed organizations); American Medical Association Special Task Force on Professional Liability and Insurance, *Professional Liability in the '80s* (Report 1, Oct. 1984; Report 2, Nov. 1984, Report 3, March 1985) (hereafter, AMA Professional Liability Reports).

3. E.g., American Tort Reform Association, a coalition of businesses and professional organizations, located in Washington, DC; Halt, Inc., an organization claiming 100,000 members and publishing a quarterly, *Americans for Legal Reform*, with headquarters in Washington, DC.

4. See, e.g., *Defensive Medicine and Medical Malpractice*, Hearing before the Senate Committee on Labor and Human Resources, 99th Congress, July 10, 1984; *Report of the Tort Policy Working Group..., supra.* n. 1; Office of Legislation and Policy, Health Care Financing Administration, *Physician Medical Malpractice* (May 1985); *Roa* v. *Lodi Medical Group, Inc.*, 695 P.2d 64 (Cal. 1985), appeal dismissed, 106 S.Ct. 421 (1985) (upholding state law limiting amount of plaintiff's attorney's contingent fee to a statutory scale, against claims of violation of the federal due process and equal protection clauses); *Fein* v. *Permanente Medical Group*, 695 P.2d 665 (Cal. 1985), appeal dismissed, 106 S.Ct. 214 (1985) (upholding state law limiting non-economic damages recoverable in medical malpractice cases to $ 250,000 against claims of violation of federal due process and equal protection clauses).

commissions have been deliberating numerous specific proposals for changing state laws governing the litigation of medical malpractice cases, regulation of the liability insurance industry, and the control of the practice of medicine [5].

Parallel to these governmental efforts has been a series of studies undertaken by the private sector to analyze the medical malpractice problem and to make recommendations for dealing with it [6]. Business coalitions have become involved since the costs of medical malpractice insurance affect the cost of employee benefit programs and also because the liability insurance crisis has struck business and industry in general [7].

Most of these public and private developments have been followed by the news media and reported to the public [8]. Both the print media and electronic media nationally have devoted considerable attention to this topic, perhaps because it appears to pit lawyers against doctors and both against the insurance industry. Local media have addressed the topic because the dramatic increases in insurance

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5. See Federation of American Hospital Systems, "State-by-State Survey." *FAHS Review* 27 (Sep./Oct. 1986); National Conference of State Legislatures, *Resolving The Liability Insurance Crisis : State Legislative Activities In 1986* (1986); The Council of State Governments, *CSG Backgrounder : Medical Malpractice* (Dec. 1985); National Conference of State Legislators and Foundation for State Legislatures, *What Legislators Need To Know About Medical Malpractice* (July 1985).

6. See BOVBJERG and HAVIGHURST (spec. eds.), "Medical Malpractice : Can the Private Sector Find Relief?" 549 *Law & Contemp. Problems* (entire issue) (Spring 1986); American Bar Association Action Commission to Improve the Tort Liability System, *Report to the House of Delegates* (Jan. 1987); American Hospital Association, *Medical Malpractice Task Force Report on Tort Reform and Compendium of Professional Liability Early Warning Systems for Health Care Providers* (May 1986); American Bar Association Special Committee on Medical Professional Liability, *Report to the House of Delegates* (Feb. 1986); Alpha Center, *Medical Malpractice Resurfacing as Issue for States*, Washington, DC (Oct. 1985); DANZON, *Medical Malpractice : Theory, Evidence And Public Policy* (1985); MANNE (ed.), *Medical Malpractice Policy Guidebook* (1985) (prepared for Florida Medical Association); AMA Professional Liability Reports, *supra*, n. 2.

7. See, e.g., The New York Business Group on Health, Inc., "Industry's Perspective on Medical Malpractice. "*Newsletter*, Vol. 6, No. 6 (1986); Peat Marwick, "Courting Disaster," *World*, Vol. 20, No. 4 (1986); GREENE, "The Tort Reform Quagmire," *Forbes* 76 (Aug. 11, 1986); Washington Business Group on Health, "Medical Malpractice : The Employers' Perspective" (Aug. 1985); BEST's "Insurance Management Report" (Dec. 30, 1985).

8. See, e.g., "The Manufactured Crisis : Liability-insurance Companies Have Created a Crisis and Dumped It On You," *Consumer Reports* 544 (Aug. 1986); "Experts Look Afar for Liability Ideas," *New York Times* 1 (Apr. 6, 1986); "Suffer the Little Children," *Wall St. Journal* 30 (Mar. 25, 1986); "Sorry, America, Your Insurance Has Been Canceled," *Time* (cover story) (Mar. 24, 1986); "The Malpractice Blues," *Time* 60 (Feb. 24, 1986); "The Malpractice Mess," *Newsweek* 75 (Feb. 17, 1986); "Sky-High Damage Suits," *U.S. News & World Report* 36 (Jan. 27, 1986).

premiums have forced many physicians to limit their practices, withdraw from certain services (especially obstetrics) or announce early retirement [9].

While the initiating force for all these actions was the medical community's alarm about rapidly rising premium rates for liability insurance coverage, the agenda has become much more far-ranging [10]. Included in the discussions are many of the matters that have some effect on the issues of medical practice accountability, legal procedures for settling disputes both in and out of court, insurance company regulation and patient advocacy. Some seemingly related issues, such as control of medical technology and cost of health care services, are not yet part of the debates on medical malpractice, but are being addressed in other forums [11].

The end results are not yet known, since much of the activity is currently in various stages of development. The work of many of the study commissions is still in progress and it will be several months before some of the state legislatures are convened for considering the legislative proposals. Even in those states which have recently taken definitive steps by enacting special legislation or issuing new regulations there will be both ongoing assessment of the impact of those steps as well as continuing consideration of other proposals being put forward.

I. States are Foci of Legislative and Judicial Activity

During 1986 thirty eight states enacted some form of legislation designed to address concerns about personal injury liability [12]. Most of these were tort reforms intended to lower insurance rates. Nine states passed comprehensive packages, 16 capped non-economic damage awards, 14 abolished or modified the joint and several liability

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9. See, e.g., "Medicine On Trial : The Malpractice Crisis," *The Orlando (Fla.) Sentinel* (eight-part series, Apr. 13-20, 1986).

10. See RODARMOR, "The Other Side of Medical Malpractice," *California Lawyer* 38 (Mar. 1986); REYNOLDS, RIZZO and GONZALEZ, "The Cost of Medical Professional Liability," a monograph published by the Center for Health Policy Research of the American Medical Association (Sep. 1985); LUDLAM, "Payment Systems, Cost Management and Malpractice," *Hospitals* 102 (Nov. 1, 1984).

11. See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "Reports" (1983); Health Policy Advisory Center, "Great Expectations : The Politics of Biotechnology,'" *Health PAC Bulletin*, Vol. 14, No. 5 (cover story) (Oct./Nov. 1983).

12. PROFFER, "Coping with a Crisis," in National Conference of State Legislatures, *Resolving The Liability Insurance Crisis : State Legislative Activities In 1986*, at p. 1 (1986).

doctrine, 13 passed legislation requiring or encouraging structured settlements and periodic payments, 11 modified the collateral source rule, 10 placed limits on punitive damages, and numerous states imposed new penalties for suits or defenses found to be frivolous. Traditionally, both tort law and regulation of the professions have been primarily a state matter [13]. Accordingly, it is not surprising that states have been the battleground.

II. POLITICAL, ECONOMIC AND LEGAL FACTORS

Complicating any analysis of the medical malpractice situation is the fast-developing public and political concern about the availability and affordability of general liability insurance for businesses and community organizations of all types. The resulting pressure from an odd amalgamation of municipalities, day care centers, ski resorts, sports equipment manufacturers and small businesses seeking to force both federal and state legislatures to solve their insurance problems has supplemented the interest in the professional liability insurance dilemmas, rather than diverting it [14]. A particularly acute and surprising aspect is the question of protecting board members of both businesses and non-profit, charitable organizations, due to the scarcity of reasonably priced Directors and Officers (D&O) insurance [15].

It can be anticipated that a settlement of the situation will not come about for an extended period due to several major factors. First, any new legislation enacted by state government is subject to constitutional challenge and is likely to be mired in litigation by those who disagree with it or, conversely, those who want to assure its validity through a court test [16]. Second, many of the legislative changes in the rules of civil liability will take some period of time to implement and even longer to assess as to their impact, requiring later adjustment and modification to achieve both workability and acceptability [17]. Third,

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13. See CHRISTOFFEL, *Health and The Law 49-104* (1982) where he discusses federal and state authority in the health field and explains the significance of *McCulloch* v. *Maryland*, 17 U.S. (4 Wheat.) 316, 4 L.Ed. 579 (1819) and *Jacobson* v. *Massachussetts*, 197 U.S. 11 (1905) for the traditional division of responsibility.

14. National Conference of State Legislatures, "State Legislative Report — Civil Justice Reform in the States," (Dec. 1985).

15. *N.Y. Times* D1 (Mar. 7, 1986) (number of claims against directors up 275 % since 1974; average total cost per claim up 84 %); Working Group Report 7, *supra* n. 1.

16. See REDISH, "Legislative Response to the Medical Malpractice Crisis : Constitutional Implications" (American Hospital Association monograph, 1977); REDISH; "The Constitutionality of Medical Malpractice Reform Legislation : A Supplemental Report" (American Hospital Association monograph, 1978).

17. See MANNE, *Medical Malpractice Policy Guidebook* (1985); Bowen, "Medical Malpractice Law in Indiana," 11 *J. of Legislation* 15 (1984); "The Pennsylvania Experience," *Maryland Bar J.* 14 (Jan. 1986).

there are market forces at work in the insurance industry which take time to develop and be acted upon. These forces are to some extent beyond the power of state legislatures to affect [18].

For example, negotiations on the terms of reinsurance [19] treaties are conducted on an international basis and hinge upon many factors external to state legislation. The impact of those decisions on the setting of medical malpractice insurance premiums is greater than the individual power of any state insurance commissioner, no matter what new regulatory authority the legislature may delegate to that official. A tightening of the reinsurance market results in "higher insurance costs, less availability of higher coverage limits, more restrictive terms and policy restrictions when limits are available, and greater assumption of losses on the part of the insurers [20]."

Underscoring this frustration felt by state legislatures and commissioners of insurance not to be able to have an immediate impact on the problem of high and rising insurance premiums and the sequelae of adverse impact on the health care system, the New York senate considered a bill which recognizes the problem as follows [21] :

> The legislature hereby finds and declares that although reforms have been enacted to restrain increases in medical and dental malpractice premiums and related costs and to prevent medical and dental malpractice, the complete effect of some of these reforms cannot be fully measured for some time, due to the considerable delay currently between the medical and dental malpractice event and its final determination.

One final overall consideration in evaluating the recent developments in this field is the inherent and continuing tension about the constitutional jurisdiction of federal and state governments in the field of health matters, coupled with historic competition for political leadership between and among all levels of government in matters affecting health and welfare [22]. Complicating these traditional factors is the new policy of the Reagan Administration to foster private sector responsibility for health care and health services, in effect promoting competitive, "free market" development of appropriate policies and

18. Working Group Report 16, *supra* n. 1.

19. "Reinsurance" is defined as "insurance for insurance companies... a spreading of risks among insurance companies" in Insurance Information Institute, *Basic Concepts Of Accounting And Taxation Of Property/Casualty Insurance Companies* (monograph, Nov. 1984).

20. GAO/HRD-86-112 at p. 18, *supra* n. 1.

21. NY Senate, S. 6770, introduced Dec. 5, 1985.

22. See WING, *The Law And The Public's Health* (2nd edition, 1985) 17-39.

solutions [23]. This political stance has a trickle down effect on promoting both state and private initiatives to address the medical malpractice issue.

III. FEDERAL ATTEMPTS TO PROVIDE LEADERSHIP IN SEEKING SOLUTIONS

At the federal level several key persons and organizations have emerged and become significant exponents of one approach or another. In Congress, Representative John Porter (Republican — Illinois) has assumed a leadership role in attempting to define federal responsibilities in this field. He requested the U.S. General Accounting Office (GAO) to conduct a large scale national study of the medical malpractice problem [24] and has assisted in promulgating the results of the GAO study through press conferences and interagency seminars in Washington.

House Resolution 386 introduced by Representative Porter and nine others on March 3, 1986, is an attempt to foster multiple solutions and promote state initiatives. It cites the increased costs of medical malpractice claims and insurance, gives recognition to the primary jurisdiction of states but notes the federal government interest inasmuch as it pays 30 % of the total health care costs in the nation and has the power to "require States that do not undertake necessary reforms... to pay the Social Security taxes which they collect on behalf of their employees in a more timely fashion." Specifically, the resolution states that, in order to improve the availability of medical care, to limit the incidence of medical malpractice, to control the direct and indirect costs of malpractice insurance and their impact on the Medicare Trust Funds, to validate alternative procedures for quickly resolving malpractice claims, and to strengthen the regulation of insurance, the States should adopt the following measures.

1) Reforming State Tort Law

(a) Caps should be placed on the recovery of non-economic losses in medical malpractice suits.

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23. "In sum, tort law appears to be a major cause of the insurance availability/affordability crisis which the federal government can and should address in a variety of sensible ways. But significant, long-term reform cannot and should not come solely from the federal government. Ultimately, state governments and courts must address the current excesses of tort law. Their active participation is essential to finding workable solutions to the increasing debilitating problems of tort law." Working Group Report, 80, *supra* n. 1.

24. See GAO reports, *supra* n. 1.

(b) The financial liability of parties bearing less than half the fault in a medical malpractice action should be proportionate to their degree of fault.
(c) The use of structured payouts should be required in cases involving large settlements or judgments.
(d) Duplicate payments from tort recoveries and collateral sources should be eliminated.
(e) Statutes of limitation and allowable discovery periods should be short in order to balance the need to protect the victims of latent injuries and the need to reduce the high costs of insuring against uncertain risks far into the future.

2) Reforming The Monitoring And Regulation Of Unprofessional And Negligent Conduct By Health Care Professionals

(a) State agencies which license, certify, and discipline health care professionals should be strengthened by having access to information on malpractice actions for the purpose of identifying practitioners with aberrant practice patterns and by other means.
(b) Risk management programs acceptable to these State agencies should be implemented.
(c) Relevant State authorities should be granted access to insurance settlement information, with proper protection for individual patient confidentiality.
(d) State medical societies should be authorized to review malpractice complaints and actions, to take such responsible action as they deem appropriate in light of such review, and to report on such actions to State authorities.
(e) State medical societies should be allowed to perform the actions described in subparagraph (d) in confidence and should be exempted from antitrust prosecution for those actions.
(f) Hospital staffs should be authorized to review malpractice settlements and awards involving staff physicians and required to make a report of recommended action to the State medical board.
(g) Hospitals should be required to confirm the professional credentials and work history of physicians seeking staff privileges and should be granted immunity from antitrust and antidiscrimination suits should they deny staff privileges on the basis of unacceptable malpractice records.

3) Reforming State Contract Law

Contractual agreements entered into knowingly and willingly between health care providers and their patients to forego malpractice litigation in favor of alternative dispute resolution and claims settlement procedures should be enforceable and presumed valid under State law.

4) Regulating Insurance

Insurance regulation should be strengthened by the States to protect consumers through assuring continued availability of commercial, pooled, or self-insured coverage at the fair price consistent with solid underwriting practices.

IV. Recent State Legislative Responses

More direct approaches are visible in the bills introduced by various Congressmen during the past several months.

In October 1985 Senator Orrin Hatch (Republican — Utah) introduced S.1804 (identical to HR 3865 in the House), the *Federal Incentives for State Health Care Professional Liability Reform Act of 1985*, which embodies the recommendations of the American Medical Association. It would provide financial incentives (totalling $ 222,875,000 over the next 6 years) to States to take legislative steps to adopt specified tort reforms ($ 250,000 cap on non-economic damages, periodic payments for future damages in excess of $ 100,000, elimination of collateral source rule, sliding scale restrictions on contingent fees, with a proviso that fees may be increased for good cause), medical disciplinary procedures (including investigatory responsibilities by local medical societies), and insurance reporting requirements (information about awards). The bill also requires providers to have approved risk management programs and to participate in insurer-sponsored risk management education programs every 3 years. Further, the bill states that any peer review activities undertaken by professional societies shall not be subject to state or federal antitrust law enforcement. The provisions of this bill have received considerable attention through support from the medical community.

On January 6, 1986, Representative Henson Moore (Republican — Louisiana) and Richard Gephardt (Democrat — Missouri) introduced HR 3084, the *Medical Offer and Recovery Act*, a novel mechanism for alternative dispute resolution which promotes rapid settlement of economic damages and avoids payment of non-economic damages to an injured party. This bill, which gathers more interest and

support when it is explained as an additional alternative to the traditional tort system, is designed to serve as a model act for state legislatures. While there are no financial incentives and no direct penalties attached for non-adoption, the bill would apply to all beneficiaries of federal health care programs in states which do not enact similar provisions. The mechanics of the scheme include the following major points :

(1) A health care provider would, within 180 days of an occurrence, have the option of making a commitment to pay the patient's economic loss. Payments from collateral sources such as private health insurance and workers' compensation would offset the amount.
(2) The provider's offer to pay would foreclose the patient's right to sue, except for cases where the provider intentionally caused the injury or a wrongful death occurred.
(3) The payment would be for all economic losses but not non-economic losses, and would be paid periodically as the patient's loss occurred.
(4) The provider may join other third parties; any disagreement between the joined parties as to responsibilities for injury will be settled by arbitration.
(5) Patients may sue for enforcement of the commitment, if necessary. Physicians are required to carry insurance or to post bond to participate.
(6) If a patient's demand for compensation for economic loss is denied by the provider, the patient may sue in traditional tort or may request arbitration, which forecloses the patient's right to sue.

On March 12, 1986, Representative Ron Wyden (Democrat — Oregon) introduced HR 4390, the *Health Care Quality Improvement Act of 1986*[25], which encourages state medical licensing agencies to establish special review committees to validate the actions taken by individual hospitals which deny or limit medical staff privileges for physicians. If the review committee judges that the hospital's decision was a good faith process, the hospital is immune under federal liability laws. Second, the bill establishes a national data bank to collect and collate settlement and judgment information from insurers and licensure actions from state license boards. This information about individual physicians is to be made available only to hospitals and state licensure boards.

Numerous other bills have been introduced to address the problem in various ways. Among them are bills which would facilitate

25. H.R. 4390 was enacted as P.L. 99-660.

self-insurance by physicians[26], permit patients to sue military physicians[27], provide financial incentives for states to establish screening panels and to conduct studies[28], and apply tort law reforms to federal courts, preempting state laws inconsistent with those reforms[29].

It can be expected that bills will continue to be generated in the Congress, since constituency pressure for relief from increasing insurance rates seems to be mounting, according to news media releases.

Last year the Attorney General of the United States created an interagency study group to make recommendations for federal action. This group issued its report in February 1986 with primary contributions from the Department of Justice, Department of Commerce and Small Business Administration[30]. The principal reforms recommended are these :

(1) Return to a fault-based standard for liability.
(2) Base causation findings on credible scientific and medical evidence and opinions.
(3) Eliminate joint and several liability in cases where defendants have not acted in concert.
(4) Limit non-economic damages (such as pain and suffering, mental anguish, or punitive damages) to a fair and reasonable maximum dollar amount.
(5) Provide for periodic (instead of lump-sum) payments of damages for future medical care or lost income.
(6) Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery.
(7) Limit attorneys' contingency fees to reasonable amounts on a "sliding scale".
(8) Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

The report details reasons why government insurance or indemnification would be undesirable. "Such a federal... program would not only be extremely expensive, but also could exacerbate the problems of tort law by making the 'deep pocket' of the taxpayer available in many cases. In addition, such a program could undermine public health and safety, require more extensive government regulation of private sector activities, involve the government in substantial litigation, lead to

26. S. 1357, H.R. 2261, H.R. 3761 (99th Cong.).
27. H.R. 3174 (99th Cong.).
28. S. 175, H.R. 2659 (99th Cong.).
29. S. 2046 (99th Cong.).
30. Working Group Report, *supra* n. 1.

increased federal involvement in state insurance regulation and inhibit the ability of the private sector to adapt insurance services to changing economic and social conditions [31]."

The report was promptly acted upon by the President's Domestic Council which announced in March that it was preparing legislation for Congress to modify tort law as it affects suits against the federal government [32].

Some of the concern about medical liability of the federal government stems from an audit by the Inspector General of the Veterans Administration which revealed that the Veterans Administration medical system paid out nearly $ 35 million in claims in fiscal years 1983 and 1984 [33].

Another concern at the federal level was whether Medicare should include in its reimbursement of hospital costs an amount for the expense of purchasing hospital liability insurance. A 1979 regulation from the Health Care Finance Agency limited reimbursement to the national loss ratio for liability claims paid to Medicare patients (about 5 % then, now 13 %), or higher if an institution could show a different loss ratio for its Medicare patients. That "apportionment rule" was challenged repeatedly in the federal courts and found to be invalid in eight separate appellate judgments across the country. Unless the federal government adopts a different rule, hospitals will be entitled to more than $ 400 million in back payments during the period of the flawed regulation. The Agency is now in fact in the process of promulgating a new regulation as a compromise, hoping that hospitals will not bring further court challenges. Under it the back payments would total only $ 200 million. The new rule divides liability insurance costs into two components : an "administrative component" and a "risk component." The former is based on the assumption that overhead costs, commission and taxes are used proportionately by Medicare and non-Medicare patients. The latter uses the national Medicare loss ratio and scales the individual hospital's Medicare utilization rate to it. This seemingly technical controversy, ranging over the past seven years, manifests the tension between the hospital industry and the federal Medicare agency and also reflects hospitals' fears about absorbing the fast-rising costs of insurance [34].

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31. *Id.* at 76-77.

32. *N.Y. Times News Service, The News & Observer* (Raleigh, NC) 1 (Apr. 5, 1986).

33. Hospital Risk Management (Feb. 1986).

34. "HCFA Prepares to Issue Revised Medical Malpractice Apportionment Rule," *Health L. Vigil* 1 (Mar. 28, 1986).

V. ORGANIZATIONAL CONFRONTATION IN THE PRIVATE SECTOR

Private organizations at the national level which have recently addressed the medical malpractice issue are the ones which have the greatest stake in any changes that may be made which affect medicine, law or insurance.

The American Bar Association in December 1984 released a 1000-page report entitled, "Towards a Jurisprudence of Injury : The Continuing Creation of a System of Substantive Justice in American Tort Law [35]." Resulting from a five year study, the report concludes that the tort liability system is generally effective in its present form, although state and federal courts should "experiment vigorously" with procedures for more effective alternative dispute resolution, litigation efficiency should be improved, frivolous suits should be penalized, and special procedures should be devised to deal with catastrophic occurrences. It allows that while the tort system is not a perfect way of dealing with medical malpractice cases, there is "no evidence that alternative general approaches would be superior," either as a matter of economics or justice.

The American Medical Association responded with a series of three reports in 1985, entitled *Professional Liability in the '80s*, which described the problem, including compilations of supporting data and opinions, and put forward a series of proposed modifications affecting primarily tort reform, and also changes in medical disciplinary mechanisms [36].

The American Bar Association countered with the adoption in February 1986 of a report from the Special Committee on Medical Professional Liability which carried these 12 recommendations [37] :

(1) Medical malpractice regulation is a state matter, not federal.
(2) Frivolous suits and defenses should be penalized.
(3) Medical licensure and hospital risk management should be strengthened.
(4) Medical malpractice actions should not be exempted from punitive damage awards.
(5) Disclosure of the financial worth of the defendant should generally not be required.
(6) Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary.

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35. Griffin Bell, former Attorney General of the United States, chaired the special committee which issued the report, authored by Prof. Marshall Shapo.
36. AMA Professional Liability Report, *supra* n. 1.
37. *Supra*, n. 1.

(7) No special rule is justified for allowing malicious prosecution.
(8) Trial courts should scrutinize qualifications of expert witnesses.
(9) Collateral source rule should be retained; third parties should be permitted to seek reimbursement from the recovery.
(10) Contingent fees should have no special restrictions.
(11) Structured settlements are encouraged.
(12) Data should be collected on the cost and causes of professional liability claims and studies should be undertaken; loss prevention programs should be developed.

The National Insurance Consumers Organization, headed by former federal insurance administrator Robert Hunter, has maintained repeatedly over the last several months that the insurance industry has not been examined closely enough to verify whether rates and conditions of coverage are fair to the public; it has urged state insurance commissioners to be more aggressive in regulating the industry [38].

The American Trial Lawyers Association and state chapters have been active in defending the current civil justice system both publicly and at legislative hearings across the country, countering the lobbying efforts of the AMA and state medical societies. The trial lawyers have blamed the problem on the insurance industry, attacking in particular the poor investment decisions made by the companies in the early 1980s and new signs of profitability [39].

Supplying some credence to the lawyers' charges was a report published in *Review and Preview*, January 1986 by A.M. Best Co., an independent insurance analyst in New York, which states, "Despite higher underwriting loss, the insurance industry seems to be well into its first phase of recovery." It reported a $ 71 billion year-end surplus in 1985, a $ 7 billion gain over 1984 for liability and casualty insurers [40].

VI. Insurance Industry Response

The principal actors in the insurance industry are St. Paul Insurance Company (the largest commercial carrier) and the 33 physician-owned mutual insurance companies. St. Paul has increased

38. Hector, "The Insurance Industry Is To Blame," *Washington Post* C7 (Apr. 13, 1986).

39. See Saks, "In Search of the 'Lawsuit" Crisis," 14 *Law, Medicine & Health Care* 77 (1986) (defending the present civil justice system); Knapp, "Who's to Blame? Insurers or Courts?" *State Gov't News* 4 (Mar./Apr. 1986). But see, O'Connell and Kelly, *The Blame Game : Injuries, Insurance And Injustice* (1987) (highly critical appraisal of the present tort system).

40. See A.M. Best Co., "Review and Preview" (Jan. 1986).

the pressure on state legislatures to take some sort of action; in January 1986 the company declared a nationwide moratorium. Company officials stated it was not taking any new medical malpractice business, although promising to service existing policyholders and to cover new members of medical groups already holding policies. Their announced rationale was to take time to analyze the market. The result has been increased focus on the physician mutual companies to absorb the new applications. A somewhat surprising additional result has been the entry into the market in some states of a few new companies. Medical Protective Insurance Co. of Ft. Wayne, Indiana, has decided to expand its market into some other states, including North Carolina, on a selective basis. At this time no existing companies have left the market entirely and none have gone bankrupt, although there are some reports that several of the physician mutual companies are under-reserved and unstable[41].

VII. PROPOSALS PUT FORWARD IN STATE LEGISLATURES

The following listing of proposals in state legislature are grouped by tort reforms (alternatively termed "civil justice reforms," or "changes in civil liability laws"), insurance regulation, medical practice regulation, and alternative dispute resolution. This is a comprehensive listing, but not necessarily complete since new proposals are continuously being made[42].

In most of these areas there had been proposals developed and legislation enacted during the earlier "malpractice crisis" in 1975–77. Currently, many of the same or similar proposals are being considered and those earlier enactments are being reviewed. Thus, proposals are being made for both new laws and modifications of existing laws. An

41. In a case of first impression in Chapter 11 proceedings involving a hospital which had set up a self-insurance trust fund, the court ruled that the fund be transferred by the bankrupt hospital for distribution to all general unsecured creditors, giving medical malpractice plaintiffs no special priority. *In the matter of Kirwood General Hospital*, Case No. 85-03590-G, U.S. Bankruptcy Court, E.D. Mich. (Apr. 28, 1986).

42. The information in this section about new or pending state legislation was obtained generally from Intergovernmental Health Policy Project at The George Washington University, "State Health Notes," (Jan.–Dec. 1986); National Conference of State Legislatures, *Resolving The Liability Insurance Crisis : State Legislative Activities In 1986* (July 1986); and "American Medical News," (Jan.–Dec. 1986); and about constitutional challenges to legislation from KOPIT, "Constitutionality of Medical Malpractice Reform Statutes," in American Hospital Association, *Medical Malpractice Task Force Report On Tort Reform* (Appendix) (May 1986). See also, SIOAN, "State Responses to the Medical Insurance 'Crisis' of the 1970s : An Empirical Assessment," 9 *J. of Health Politics, Pol. and Law* 626 (1985).

important additional consideration is that some of these proposals are being made to apply only to medical malpractice litigation while others are changes to all civil liability litigation.

1) Attorneys' fees

Numerous proposals have been designed to modify the current practice of plaintiffs' attorneys using the contingent fee system. Under this type of arrangement (in use all across the US but only in a few other countries, or parts of countries) the attorney accepts a case on the basis of his or her fee being paid from the proceeds of an award or settlement. If there is none, then no fee is paid or expected. If the case is won or settled, the attorney is paid an agreed percentage of that amount. That percentage varies from 25 % to perhaps 50 %, depending on area, type of case, and the attorney-client relationship.

General practice is difficult to document, since the arrangement is considered in most states a private contractual matter between the lawyer and the client. It is often stated that the percentage in medical malpractice cases is usually 40 % for jury verdicts and 33⅓ % for pre-verdict settlements.

Practice varies too on how much of the expenses of case preparation are paid by the client. Generally clients are expected to pay out-of-pocket costs of medical record copying and professional review (this upfront cost may range from $ 500 to $ 3000 or more). The costs of other consultants, deposing witnesses and expert witnesses, copying other documents, performing tests, and other investigatory and pre-trial expenses are usually borne by the client at the time of the service, unless billing for them is deferred by the persons performing the services. Attorneys are not ethically allowed to advance clients any funds for expenses. Payment on either an hourly basis or a contingent basis is considered ethical in all 50 jurisdictions.

No serious proposals have been made to eliminate the contingent fee system for medical malpractice cases, only to restrict it. Two arguments are commonly put forth for continuing it : social and political. The social argument is that the present system provides a measure of access by citizens to legal services and to the courts and promotes vigorous representation of deserving clients. The political argument is that the system has served justice well for many years and change may bring forth unknown inequities; additionally, it is recognized that plaintiffs' lawyers are well organized and politically difficult to counter. Nevertheless, the arguments against the contingent fee system cite the very high fees that some attorneys fortuitously receive in high verdict cases which are based more on sympathy for the client's

misfortune than a measure of the amount or value of work effort by the attorney. Also, it has been suggested that potential clients with deserving cases but injuries which are minor (perhaps under $ 10,000–20,000) are turned away by plaintiff's attorneys, since the contingent fee might be minor as well, compared to the possible difficulty of preparing even a small suit.

Proposals fall into two categories : (a) establishing a variable schedule for maximum fees that can be paid on a contingent basis, using a sliding scale of percentages compared to the size of the award or settlement, and (b) limiting the maximum percentage. At least 23 states received proposed legislation limiting attorneys fees during 1985-86.

Here are examples of types of enacted legislation :

(a) California sliding scale [43]

Up to	$ 50,000	40 %
"	" $ 100,000	33⅓ %
"	" $ 200,000	25 %
Over	$ 200,000	10 %

(b) Indiana — 15 % above $ 100,000 [44]
9.5-5-1 par. 2-611.1)

(c) Hawaii — "reasonable amount as approved by a court of competent jurisdiction" [45] (Hawaii Rev. Stat. sec. 671-2)

Proposals affecting attorneys' fees seem to be among the most controversial. There has been, however, more interest in pressing for contingent fee schedules in the wake of the U.S. Supreme Court decision in *Roa* v. *Lodi Medical Group* [46] which let stand the California Supreme Court approval of a statutory sliding fee schedule. The state court decision found the statute was not unconstitutional as a denial of due process, violation of equal protection or violation of separation of powers doctrine.

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43. Cal. Bus. & Ins. Code, sec. 6146.

44. Ind. Code Ann., sec. 16-9.5-5-1, para. 2-611.1.

45. Hawaii Rev. Stat. sec. 671-2.

46. 695 P.2d 164 (Cal. 1985), appeal dismissed, 106 S.Ct. 421 (1985). See also *DiFilippo* v. *Beck*, 520 F.Supp. 1009 (D.Del.1981) and *Johnson* v. *St. Vincent Hospital, Inc.*, 404 N.E.2d 585 (Ind. 1980) (both cases upholding statutory scale of contingent fees); *Florida Patient's Compensation Fund* v. *Rowe*, 472 So.2d 1145 (Fla. 1985), reaffirmed in *Florida Patient's Compensation Fund* v. *Von Stetina*, 474 So.2d 783 (Fla. 1985) (upholding provision directing trial court to award a "reasonable" attorney's fee to the prevailing party); *Attorney General* v. *Johnson*, 385 A.2d 57 (Md. 1978) (upholding provision requiring that attorney's fees associated with arbitral and judicial proceedings be approved by panel and court, respectively); *Prendergast* v. *Nelson*, 256 N.W.2d 657 (Neb. 1977) (upholding provision that medical malpractice plaintiffs have a right to agree to pay their attorney on a mutually agreed per diem basis, rather than contingent fee basis). But see, *Carson* v. *Maurer*, 424 A.2d 825 (N.H. 1980) and *Heller* v. *Frankston*, 475 A.2d 1291 (Pa. 1984) (holding statutory contingent fee scales unconstitutional).

2) Awards

Enacting legislation which limits the amount of the award that a court may permit in verdicts and settlements has been a common proposal. There are many variations on the concept. The two basic categories are (a) limits on economic and non-economic awards, (b) limits on non-economic awards, and (c) limits or modifications on punitive damage awards.

Non-economic damages include those for pain and suffering, loss of consortium, disfigurement, mental anguish, inconvenience, lessened quality of life and other factors which are not deemed compensation for out-of-pocket losses by the plaintiff.

Several states have enacted statutory limitations, or caps, on total recovery. Some like Indiana have a cap which is coupled with state-administered compensation fund. In Indiana the physician must have commercial insurance for the first $ 100,000 and the state fund pays the next $ 400,000, with a total cap of $ 500,000. It has been observed that such an arrangement is more constitutionnally defensible than a total cap without a compensation fund. Virginia last year raised its total cap from $ 750,000 to $ 1,000,000, but has no compensation fund. Proposals range from $ 500,000 in South Dakota to $ 3,300,000 in Wisconsin. Variations include $ 3,000,000 each case, $ 6,000,000 annually for each provider (Kansas); $ 1,000,000 individual, $ 5,000,000 group (Nebraska); $ 500,000 limit exclusive of future medical care costs (Louisiana); limit exclusive of punitive damages (Florida); judicial review of damages which are either inadequate or excessive and judicial authority to order additur or remittitur (Georgia, Florida).

During the past few months Missouri and Maryland enacted limitations of $ 350,000 on non-economic awards. The proposal of the Governor's study commission in New York recommended a $ 250,000 cap on non-economic damages, but it has been reported that while Governor Cuomo favors the remainder of the commission's recommendations, he is not supporting the cap. Pending in numerous other states are recommendations for limitations, ranging from $ 250,000 (the figure suggested by the AMA through the state medical societies) to $ 500,000.

The array of proposal affecting the award of punitive damages is even wider. Some states have proposals before them to eliminate punitive damages in medical malpractice cases (New Hampshire, Illinois), others to limit it to 25 % of the annual gross income of the guilty party (Kansas), others to direct any amount over $ 100,000 to be paid to the state treasury (North Carolina), some to limit them to 3 times actual damages (Mississippi) or 2 times (Pennsylvania). In North Carolina, unlike most states, punitive damages are insurable.

Like the contingent fee schedule, a cap on awards has stirred considerable controversy but increased interest has been recently stimulated by judicial approval of the California statute. The California Supreme Court in *Fein* v. *Permanent Medical Group*[47], upheld the constitutionality of the California statute which imposed a $ 250,000 limit on non-economic damages in medical malpractice cases. The U.S. Supreme Court on October 15, 1985, dismissed an appeal for want of a federal question. Indiana and Nebraska had previously upheld the constitutionality of medical malpractice damage awards[48]. Five other states have invalidated state statutory damage limitations on federal constitutional grounds[49]. In addition, two other states have reviewed damage caps on state constitutional grounds[50].

3) Burden of proof

There have been various proposals to change the burden of proof from a "preponderance of the evidence" to "clear and convincing evidence" (New York, Wisconsin, Pennsylvania, South Dakota). Some proposals suggest elimination of the *res ipsa loquitur* doctrine, or severely limiting it to certain surgical procedures (e.g., sponges left in abdominal cavity).

4) Collateral Source Rule

The collateral source rule is a traditional rule of evidence which makes inadmissable any evidence of collateral sources of payment.

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47. 695 P.2d 665 (Cal. 1985), appeal dismissed, 106 S.Ct. 214 (1985).

48. *Johnson* v. *St. Vincent Hospital, Inc.*, 404 N.E.2d 585 (Ind.1980) and *Prendergast* v. *Nelson*, 256 N.W.2d 657 (Neb. 1977) (both upholding $ 500,000 total cap).

49. *Boyd* v. *Bulala*, U.S. District Court, Charlottesville, Va., Nov. 5, 1986 (American Medical News 7, Nov. 21, 1986) (Va. $ 1 million limitation is unconstitutional infringement on right to trial by jury in both federal and state constitutions); *Carston* v. *Maurera*, 424 A.2d 825 (N.H. 1980) ($ 250,000 limit on non-economic damages); *Arenson* v. *Olsen*, 270 N.W. 125 (N.D. 1978) ($ 300,000 on total damages); *Simon* v. *St. Elizabeth Medical Center*, 355 N.E.2d 903 (Ohio Com.Pl.1976) ($ 200,000 limit on "general damages"); *Baptist Hospital of Southeast Texas* v. *Barber*, 672 S.W.2d 296 (Tex. App. 1984) ($ 500,000 limit on damages other than medical expenses). See also, *Duren* v. *Suburban Comm. Hospital*, 482 N.E.2d 1358 (1985) and *Hoffman* v. *United States*, 767 F.2d 1431 (9th Cir. 1985).

50. *Wright* v. *Central DuPage Hospital Association*, 347 N.E.2d 763 (Ill. 1976) (struck down limit on award for both economic and non-economic damages); *Jones* v. *State Board of Medicine*, 555 P.2d 399 (Idaho 1976), cert. denied 431 U.S. 914 (1977) (remanded for factual determination on whether medical malpractice crisis actually existed to justify measure).

It in effect prevents a set off against the plaintiff's award of other amounts from health and disability insurance which the plaintiff may be entitled to receive for his or her injuries. While the intent is to not permit the defendant to escape the full consequences of the negligent act, the effect is sometimes to produce a windfall for the plaintiff through multiple payments.

Proposed reforms take the form of eliminating the collateral source rule by declaring that evidence of payment from collateral sources is admissable and that either (a) the jury should consider such evidence in its determination of damages, or (b) the collateral source payments directly reduce the amount the damages. Variations include allowing plaintiff full or partial credit for any insurance premiums paid to obtain the benefits, exempting governmental payments and preserving the subrogation rights for payors of collateral benefits [51].

5) Expert witnesses

Proposals in this area are designed to address the concern about expert medical witnesses who devote a considerable portion of their practice to making appearances in medical malpractice litigation. These persons are considered by many to be "hired guns," or professional witnesses who may not be promoting the best interests of the medical profession. Trial lawyers claim that they resort to this type of witness, usually from out of state and charging high witness fees, because of the unavailability or unwillingness of local physicians to serve as expert witnesses. The most common proposal, backed by state medical societies is to limit expert witnesses to the field of specialty of the defendant physician, but not limit the expert geographically. A variation imposes a

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51. See *Fein* v. *Permanente*, 695. P.2d 665 (Cal. 1985), appeal dismissed, 106 S.Ct. 214 (1985) (upholding under federal due process and equal protection clauses state statute providing that medical malpractice defendant may introduce evidence of any amount received by or payable as a benefit to the plaintiff as a result of his or her injury which, according to the court, may influence the jury to set the plaintiff's damages at a lower level, but that the plaintiff may introduce evidence of the amounts he or she paid to secure the benefits); *Barme* v. *Wood*, 689 P.2d 446 (Cal. 1984); *Pinillos* v. *Cedars of Lebanon Hospital Corp.*, 403 So.2d 365 (Fla. 1981) (upholding provision requiring any judgment in medical malpractice action to be reduced by amount which the plaintiff received from collateral sources); *Rudolph* v. *Iowa Methodist Medical Center*, 293 N.W.2d 550 (Iowa 1980) (upholding statute mandating that damages awarded to malpractice claimants exclude actual economic losses to the extent that those losses were replaced or indemnified by insurance, governmental employment or service benefit programs, or by any other source except the assets of the claimant or his immediate family); *Eastin* v. *Broomfield*, 570 P.2d 744 (Ariz. 1977) (permitting consideration of all amounts received from collateral sources). See also, *Prendergast* v. *Nelson*, 256 N.W.2d 657 (Neb. 1977).

further limitation that the witness shall not devote more than 20 % or 25 % of his or her time to serving as an expert witness; in Kansas, 50 % of time must be in clinical practice [52]. A corollary proposal made by trial lawyer groups is to require the medical society or licensing board to furnish a list of able and available witnesses for plaintiff to call to testify, as a direct means of overcoming the "conspiracy of silence."

6) Frivolous suits

A central element of the debate between the medical and legal communities is the prevalance and significance of suits brought without sufficient grounds. Trial attorneys maintain that there are very few frivolous suits, while some physicians believe that every case in which a plaintiff is unsuccessful constitutes a manifest groundless suit which should be penalized. In fact, both sides agree in principle that frivolous suits should be discouraged, regardless of any agreement on their definition of prevalance. Therefore, several proposals have been made to address this matter. While some states already have given courts the authority to award costs and attorney fees to the prevailing party if the other party brings a groundless suit (e.g., NC Gen. Stats. 6-21.5 [1984] provides for awarding attorney's fees if "the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party in any pleading.") Proposals include court costs and attorney's fees to be awarded in any frivolous action (NY, IN, MI, WY), requirement for attorney to present certification from a similar health care professional that the suit is meritorious (FL, MD), posting of bond by plaintiff (FL). Already enacted in Florida are provisions for mandatory pre-trial court hearings, 90 days notice of plaintiff's intent to file a claim, and possible penalties for refusing an offer or demand for judgment, in the *Comprehensive Medical Malpractice Act of 1985.* These are designed to restrict unfounded tactics by attorneys on both sides.

52. See *LePelley* v. *Grefenson*, 614 P.2d 962 (Idaho 1980) (upholding requirement of expert testimony in medical malpractice cases and standard of care based on local community); *Denicola* v. *Providence Hospital*, 387 N.E.2d 231 (Ohio 1979) (upholding requirement that medical malpractice expert witness must spend three-fourths of their professional time in the active clinical practice of medicine or in university instruction). See also, *Beeler* v. *Downey*, 442 N.E. 2d 19 (Mass. 1982). But see, *Arneson* v. *Olson*, 270 N.W.2d 125 (N.D. 1978) and *Carson* v. *Maurer*, 424 A.2d 825 (N.H.1980).

7) Funds

At least four states operate special compensation funds for medical malpractice claims : Hawaii, Indiana (claims over $ 100,000 up to $ 500,000), Kansas (claims over $ 200,000) and Louisiana. At least one other state (NC) has authorized but not funded such a fund. Proposals for various types of funds have been made in NY, MI, WI.

8) Joint and Several Rule

In most states a plaintiff who has successfully sued two or more defendants may require any of them to pay the full amount of the award. The paying defendant may have a right of contribution from the co-defendants but they may be insolvent or uninsured. In some cases a defendant who is only slightly involved in the case may end up with the whole liability. This is sometimes called the "deep pocket" phenomenon and often is a disadvantage for hospitals. Even in jurisdictions where the contributory negligence rule has been replaced with the more equitable comparative negligence rule, the joint and several rule is often still in effect [53].

Six states have abolished the joint and several rule by statute (Kan., La., N.H., Ohio, Pa., Vt.) and some states (e.g., Oklahoma) have created a modified several rule. At least 12 states are considering proposals for elimination or modification of the rule.

9) Limits on liability; immunity provisions

While most states in the 1960s enacted various types of good samaritan legislation for emergency medical care and in the 1970s many adopted special immunity provisions for blood transfusions, there are now several proposals for extending those statutes or providing immunity or statutory defenses in other situations : AR (drawing blood to determine alcohol or substance abuse), ND (free care for amateur athletes), VA (drug administration in patient's home), NY (good faith failure to order supplemental tests), FL (administering prenatal care in health departments).

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53. At the end of 1985, six states (Ala., Del., Ky, Md., N.C., Va.) and the District of Columbia still retained the doctrine of contributory negligence. By April of 1987 only N.C. retained it and was then considering legislation to replace it with comparative negligence.

10) Statute of limitations

Most states modified their statutes of limitations in various ways during the 1975–77 reform period. Now there are proposals to shorten the periods from 3 to 2 years in several states (e.g., AZ, IN, NY [2-½]) and reduce the maximum period for minors [54].

11) Structured awards and periodic payments

Traditionally judgment and settlement awards have been distributed in lump sum amounts, even when a large part of the award is intended to compensate the plaintiff for uncertain costs of medical expenses or lost wages anticipated to be incurred in the future. Some state statutes now allow a court to structure awards attributable to future losses by instructing that arrangements be made for payment at regular intervals of costs actually incurred or a set amount as agreed. Upon the death of the plaintiff, payments or a portion thereof will cease, thus precluding a windfall to heirs and an unnecessary expense for the payors.

One version of periodic payments has been found unconstitutional [55]. California upheld its statute which requires the trial court in

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54. See *Brubaker* v. *Cavanaugh*, 741 F.2d 318 (10th Cir. 1984) (upholding four year statute of limitations in Kansas for medical malpractice actions); *Houk* v. *Furman*, 613 F.Supp. 1022 (D. Me. 1985) (upholding two year Maine statute); *Hill* v. *Fitzgerald*, 501 A.2d 27 (Md. 1985) (upholding five years after time of injury or three years after date when injury is discovered); *Morrison* v. *Chan*, 699 S.W.2d 11 (Tex. 1985) (upholding two year statute where plaintiff was provided with a reasonable opportunity to discover the injury and bring suit within the two year period); *Opalko* v. *Marymount Hospital, Inc.*, 458 N.E.2d 1337 (Ohio 1983) (distinguishing provisions of statute applying to adults and minors, respectively); *McCarroll* v. *Doctors General Hospital*, 664 P.2d 382 (Okla. 1983) (upholding two years from date plaintiff knew or should have known of injury). See also *Tucker* v. *Nichols*, 431 So.2d 1263 (Ala. 1983); *Bowlin Horn* v. *Citizens Hospital*, 425 So.2d 1065 (Ala. 1982); *Colton* v. *Dewey*, 321 N.W.2d 913 (Neb. 1982), reaffirmed in *Smith* v. *Dewey*, 335 N.W.2d 530 (Neb. 1983); *Stephens* v. *Snyder Clinic Association*, 631 P.2d 222 (Kan. 1981); *Allen v. Intermountain Health Care, Inc.*, 635 P.2d 30 (Utah 1981); *Anderson* v. *Wagner*, 402 N.E.2d 560 (Ill. 1980), reaffirmed in *Moore* v. *Jackson Park Hospital*, 447 N.E.2d 408 (Ill. 1983); *Mishek* v. *Stanton*, 616 P.2d 135 (Colo. 1980); *Ross* v. *Kansas City General Hospital and Medical Center*, 608 S.W.2d 397 (Mo. 1980); *Dunn* v. *St. Francis Hospital, Inc.*, 401 A.2d 77 (Del. 1979); *Harrison* v. *Schrader*, 569 S.W.2d 822 (Tenn. 1978); *Owen* v. *Wilson*, 537 S.W.2d 543 (Ark. 1976).
But several courts have invalidated statutes of limitations and repose applicable to medical malpractice cases. See, e.g., *Kenyon* v. *Hammer*, 688 P.2d 961 (Ariz. 1984), *Shessel* v. *Stroup*, 316 S.E.2d 155 (Ga. 1984); *Austin* v. *Litvak*, 682 P.2d 41 (Colo. 1984), 961 (Ariz. 1984).

55. See *Carson* v. *Maurer*, 424 A.2d 825 (N.H. 1980) (provision for periodic payment of damages over $ 50,000 unreasonably discriminates in favor of health care provider defendants and unduly burdened seriously injured malpractice plaintiffs).

cases of $ 50,000 or more in future damages to enter judgment for periodic payment at the request of either party [56].

Structured awards anticipate the purchase of an annuity, bank trust or other secured form of payment mechanism. Such a purchase costs less than payment of a lump sum because of investment and actuarial factors.

At least 17 states by 1986 provided for structured awards. A frequent proposal by state medical societies would require periodic payments for future damages in excess of $ 100,000. Proposals include provisions for paying attorney fees in a lump sum, continuation of payments for lost wages past the time of death, and various threshold amounts ranging fron $ 50,000 (WA) to $ 500,000 (FL).

12) Itemized verdicts

Sometimes specifically required in proposals for structured awards, itemized verdicts are expected to force the jury to produce a designated dollar amount for specified categories of damages : general and special, or in more detail, each type of economic damage (medical expenses, lost earnings, other out-of-pocket expenses), each type of non-economic damage (pain and suffering, lessened quality of life, inconvenience, mental anguish, disfigurement, etc.), and punitive damages.

VIII. Changes in Laws Governing Medical Practice

A variety of changes in state laws governing licensure, review and discipline of physicians and other health care professionals and new licensure requirements for hospitals have been proposed [57], including these :

(1) Adding lay members to licensure boards (KA).
(2) Require insurers and providers to report to the licensure boards any suspected acts of physician incompetence, with fines levied for non-compliance ($ 5,000 to $ 10,000 in KA).
(3) Requiring hospitals to implement approved risk management programs (FL; in KA, must institute peer review within 30 days of suspected physician negligence).

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56. *American Bank and Trust Co.* v. *Community Hospital of Los Gatos*, 683 P.2d 670 (Cal. 1984).

57. See DERBYSHIRE, "Malpractice, Medical Discipline, and the Public," *Hospital Practice* 209 (Jan. 1984).

(4) Increase license renewal fees to improve capacity of licensure board (NC, NY).
(5) Guidelines, criteria, and protocols for credentialing of physicians by hospitals (NY, MD, FL).
(6) Licensure criteria : revocation or suspension in another state considered grounds for revocation or suspension (NY), cooperation with peer review is condition of licensure (FL), proof of financial responsibility to pay claims (FL), failure to pass examination 3 times will require 1 year of postgraduate training before sitting, uniform penalties for practicing without a license (CT).
(7) Misconduct : commissioner of health authorized to conduct demonstration programs on monitoring and probation (NY), misconduct hearing panels with 2 MDs and 1 layman (NY), board review allegations of negligence in treatment (WI), copies of hospital credentialing committees be sent to state board (WA), "repeated negligence" is defined as misconduct (FL), state notify all health facilities about license disciplinary actions (CT).
(8) Required continuing medical education (60 hours in 3 years, plus 5 hours risk management education, FL).
(9) Board meet minimum of 12 times per year (WI).
(10) Risk management requirements : variations include exceptions for some facilities, guidelines established by state, reports required to be sent to state for studies.
(11) Expanded immunity from civil and criminal liability for members of medical peer review committees.

IX. NEW REQUIREMENTS FOR INSURANCE REGULATION

Insurance regulations vary widely among the states and many minor, technical proposals for modifications have been made. Some of them are described here.

(1) Premiums : delays in effective date of increases, advance notice to policyholders and insurance commissioner about increases, insurance commissioner set rates for mandatory excess coverage.
(2) Claims made policies : transferability when insurer is liquidated, required tail coverage by claims made insurer.
(3) JUA : new authorization (MT, ID, NY).
(4) Non-renewal or cancellation notices : extended to 60 days (FL), 90 days (NC, ND); notify professional licensure boards (FL).

(5) Insurance exchange : study feasibility (MD).
(6) Experience rating : for physicians (FL), to set surcharges on premiums (KA), merit rating (NY).
(7) Proof of insurance required for licensure (KA).
(8) Insurance company reporting : claims and actions (AZ, WA, WI), financial information (premiums, income, losses) (WA, VA, OH, WI), more frequent reporting (FL), reports open to public (CA).
(9) Insurers required to cover arbitration awards (NY).
(10) Insurer can offer settlement without approval of insured (FL).

X. Other Miscellaneous Proposals

(1) *Arbitration* : prescribes or modifies panel composition (full-time salaried chairman with other two chosen by parties, NY), mandatory arbitration for claims under $ 15,000 (ME), under $ 50,000 (NJ), guidelines (FL), modification of procedures, such as mutual waiver, depositions of MDs admissible, hospital records admissible, minimum of 2 experts in a designated specialty per party, procedures for selection of alternate arbitrators (MD).
(2) *Pre-trial activities* : mandatory pre-calendar conference (NY), mandatory settlement conference 3 weeks before trial (FL), cooling off period (60 days, PA ; 90 days, CA, FL), mandatory filing within 60 days after issues are joined (NY), claimant must notify provider of pending action by registered or certified mail (FL).
(3) *Validation of private contractual arrangements for arbitration.* [58]

While this does not exhaust the variety or nuances of proposals which have been made (or which will inevitably be proferred), it is a realistic listing of ideas which have been or will become the agenda for the political, as well as the academic, discussions of the next several months and years in the halls of federal and state governments.

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58. No state has yet adopted special legislative provisions to validate private contractual arrangements for both alternative dispute resolution and changing the substantive rules of tort, as proposed in HAVIGHURST, "Altering the Applicable Standard of Care," 49 *Law & Contemporary Problems* 265 (1986). One legislative study commission is, however, considering a draft bill embodying proposals for allocating rights and responsibilities by private agreement. See N.C. Medical Malpractice Study Commission, *Report And Recommendations To The 1987 N.C. General Assembly* (Mar. 25, 1987).