Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card

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INTRODUCTION

Even casual observers of the 1980s "crisis"[1] in medical malpractice insurance recall the not dissimilar events of the mid-1970s. Both eras have experienced insurance problems and have generated waves of legislative reform.[2] Parallels between the eras abound, and, although in-depth examinations seem to be lacking, commentators routinely remark on the similarities between the decades.[3] However, the situation today

[1] The quotation marks reflect the lack of consensus about the precise extent of problems and their social import; however, readers are spared any further use of the quotes.

[2] For discussion of the first wave of the 1970s reforms, see generally P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY (1985); S. LAW & S. POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE (1978); Danzon, *The Medical Malpractice Insurance Crisis Revisited: Causes and Solutions*, HOOVER INSTITUTE PUBLICATION NO. E-83-11, July 1983; Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, LAW & CONTEMP. PROBS., Spring 1986, at 5. For discussion of the 1980s reforms, see Harrington & Litan, *Causes of the Liability Insurance Crisis*, 239 SCIENCE 737 (1988); Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521 (1987).

[3] *See, e.g.*, Grad, *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, 36 CASE W. RES. L. REV. 1058, 1059 (1986) (calling 1980s "carbon copy" of 1970s); Robinson, *supra* note 2, at 5-7 (remarking on sense of "*dejá vu*").

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differs from a decade ago. More is known today about the nature of problems, the affected insurance markets have changed, and the public responses, though similar, have hardly been identical. The present need for thoughtful reform probably is also greater.

The interrelated insurance and legal developments of the last fifteen years have greatly affected medical malpractice coverage. This Article traces those interactions, especially the legal reforms meant to alleviate the insurance crises. Part I covers the problems that provoked reforms. Next come the responses: Part II covers the 1970s, and Part III the 1980s. The discussion considers the nature and extent of reforms, the patterns that emerged, and the respective state and federal roles. Part IV compares and contrasts the two decades of reform. Part V attempts to assess the reforms' success, and a conclusion considers future improvement. Although this Article focuses on medical malpractice, it necessarily also discusses more generic tort and insurance reforms.

I. Crisis and the Coming of Tort Reform

Historically, most tort law "reform" has occurred through case-by-case, common-law judicial development. These trends have traditionally favored plaintiffs.[4] More recently, prompted by fears about the availability and price of liability insurance, legislatures have been asked to intervene, thus overriding or otherwise modifying the common law of tort and its attendant systems of dispute resolution and insurance. This trend is usefully seen through the prism of malpractice developments — the first reform to achieve prominence at either the state or the national level.

A. *The Story of Malpractice*

The story of the malpractice insurance crisis is well-known.[5] The American Medical Association (AMA) estimated that as recently as the late 1950s only one doctor in seven had ever faced a malpractice claim in her entire professional career.[6] Moreover, large recoveries were exceedingly rare, and malpractice insurance premiums were accordingly

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[4] *See, e.g.*, Dietz, Baird & Berul, *The Medical Malpractice Legal System*, in Dep't of Health, Education, and Welfare, Report of the Secretary's Commission on Medical Malpractice app. at 50 (1973) [hereafter Secretary's Commission Report]; Robinson, *supra* note 2, at 16-18.

[5] *See* F. Sloan & R. Bovbjerg, Medical Malpractice: Crises, Response, and Effects on Health Care and Coverage (1989).

[6] American Medical Association (AMA), *Opinion Survey on Medical Malpractice*, 164 J. A.M.A. 1583 (1957).

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priced.[7] Policymakers first took note of malpractice insurance in the late 1960s, as insurance and medical professionals became concerned about the rising frequency of claims and costs of insurance.[8] Congressional hearings were held,[9] and an executive study commission was convened,[10] but found no crisis.[11]

Crisis was not declared until 1974-1975. For poorly understood reasons, the frequency of malpractice claims, which had risen only moderately through the 1960s, turned sharply upward in the early 1970s.[12] Moreover, in the early 1970s insurers' investment earnings unexpectedly fell because of the first oil crisis and the decline in the stock and bonds markets.[13] Throughout this period, average jury awards and insurance claims payments were steadily rising, but premium increases lagged behind, followed later by more wrenching adjustments.[14] The

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[7] In 1962 the typical physician paid about half of one percent of gross income for coverage. SECRETARY'S COMMISSION REPORT, *supra* note 4, at 13.

[8] In the 1960s rates rose even faster than physicians' incomes. *Id.* at 13. During the 1970s, malpractice premiums tripled, to some 1.8% of the typical physician's gross income. *Id.* The insurance market simultaneously reorganized, as companies became more specialized and rating categories more sophisticated. Marketing focused more on quasi-group sales through selected plans sponsored by state medical societies than on completely decentralized sales of innumerable company policies by individual agents.

[9] *See* STAFF OF SENATE COMM. ON GOVERNMENT OPERATIONS, 91ST CONG., 1ST SESS., MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN (Comm. ed. 1969).

[10] In February 1971 President Nixon directed the Secretary of Health, Education, and Welfare (now Health and Human Services) to create a study commission, which in turn commissioned the first collection of empirical information about all facets of malpractice. *See* SECRETARY'S COMMISSION REPORT, *supra* note 4, at xv & xvi, app. at ix.

[11] The Secretary's Commission had concluded in late 1972 that no crisis then existed, since insurance was readily available. However, the Commission recommended creating stand-by mechanisms to provide coverage should it become unavailable through normal market channels. *Id.* at 38-39. Not long after the report appeared, the much more serious crisis began in 1974.

[12] *See generally* P. DANZON, THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS 4-5 (1982). Social factors (especially degree of urbanization), medical activity (especially physicians per population), and legal ones (number of proplaintiff changes in doctrine prior to 1970) all helped predict the frequency of claims per population in the states. *Id.* at 16-29. But most of the variation in frequency among states remains unexplained, as does and the rapidity of the upsurge in the early 1970s.

[13] Law & Polan emphasize this factor as contributing to companies' requests for rate hikes or to leave the market. *See* S. LAW & S. POLAN, *supra* note 2, at 163-70. Danzon cites the surge in risk of insolvency as the result of simultaneously adverse experiences both in investments and in underwriting. *See* Danzon, *supra* note 2, at 4-2.

[14] Danzon's analysis blames this delay mainly on price-cutting competition by new entrants to the insurance market and on the reluctance of state regulators (pressured by

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situation peaked in 1974 and 1975. Especially in the leading states of New York and California, major insurers refused to continue writing coverage.[15] Few other states faced such stark problems of availability, but by 1975 requests for very high premium increases were nearly universal.[16] The reaction of affected physicians was to seek regulatory relief from rate hikes as well as reform of the entire tort law and liability insurance system. The mid-1970s saw a blossoming of such legislation across the states.[17]

In the 1980s, however, medical malpractice problems re-emerged. Many believed that the new problem was more one of "affordability" than of availability,[18] in good measure because many medical providers had themselves banded together to make coverage available. Physicians' own insurance companies underwrote at least half the market, and these companies, unlike a commercial carrier, were committed to maintaining coverage.[19] In the 1980s it was problems of non-medical insureds that held center stage. Day care centers, liquor stores, city council members, and, indeed, most ordinary seekers after liability insurance — all were finding coverage expensive and difficult to obtain, if by 1984 and 1985 it could be had at all.[20] Lobbyists sought both state and federal reforms, numerous task forces were convened, and additional

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insureds) to allow the actuarily indicated rates. *See* P. DANZON, *supra* note 2, at 6-13. She does not support explanations of insurers' ignorance or federal price controls during 1971-1974. *See id.*

[15] *See* AMA SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE, PROFESSIONAL LIABILITY IN THE '80S 4-6 (1984) [hereafter AMA TASK FORCE]. For contemporary background discussion, see SELECT COMM. ON MEDICAL MALPRACTICE, CALIFORNIA STATE ASSEMBLY, PRELIMINARY REPORT (1974) [hereafter CALIFORNIA ASSEMBLY REPORT]; SPECIAL ADVISORY PANEL, STATE OF NEW YORK, REPORT ON MEDICAL MALPRACTICE (1976).

[16] *See* Danzon, *supra* note 2, at 10. Danzon reports that the leading national rating bureau recommended increases averaging 52% in 29 states for 1973, 92% in 32 states for 1974, and fully 197% in 48 states in the peak crisis year of 1975. *Id.*

[17] *See* A LEGISLATOR'S GUIDE OF THE MEDICAL MALPRACTICE ISSUE (D. Warren & R. Merrit eds. 1976) [hereafter A LEGISLATOR'S GUIDE]; Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489 (1977); Robinson, *supra* note 2; *Symposium on Medical Malpractice*, 1975 DUKE L.J. 1177.

[18] *See, e.g.*, AMA TASK FORCE, *supra* note 15, REP. NO. 1, at 8.

[19] Moreover, most sizable hospitals either self-insured or used "captive" insurers they controlled. *See* Posner, *Trends in Medical Malpractice Insurance, 1970-1985*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 37, 39; *see also infra* notes 77-81 and accompanying text.

[20] *See* Hilder, *Small Firms Face Sharp Cost Hikes for Insurance — If They Can Get It*, Wall St. J., Aug. 5, 1985, at 23, col. 4; *Sorry, America, Your Insurance Has Been Cancelled*, TIME, Mar. 24, 1986, at 16 *passim.*

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legislation ensued. So the 1980s crisis and responses differ from those of the 1970s.[21]

B. *The Nature of Problems*

Both "malpractice" crises have been first and foremost crises of insurance, and most of the impetus for tort reform comes from problems in the insurance markets. Other motivations for reform come from perceived legal problems, not so much from a sense of crisis as from a growing sense that tort law simply does not work "right," or achieve fairness, especially from the defendant's viewpoint.

Many reformers also worry about medical quality, though from different perspectives. Some contend that quality is "too low" and thus exacerbates the crisis, while others argue that crisis-induced fears of lawsuit change medical practice to the detriment of doctors and patients alike.

What evidence supports these different views? The next three subparts examine evidence in insurance, law, and medicine.

1. Insurance Events Precipitated the Crises

How bad have insurance problems been? This question is highly relevant for legislators and lawyers, because some courts have sought to judge tort reforms' validity by whether the crisis was "bad enough" to justify curtailing plaintiffs' remedies.[22] The question is difficult to answer not only because data are less than comprehensive but also because a "crisis" is in the eye of the beholder. The 1970s availability problems are well-described for several states in anecdotal fashion,[23] but systematic national data on the extent of insurance availability are not available.[24] Sharp increases in physicians' insurance premiums are better documented: Premiums for a constant dollar amount of coverage

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[21] *See infra* Section IV.

[22] *See, e.g.*, Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976) (remanded for determination of whether crisis existed); Boucher v. Sayeed, 459 A.2d 87, 91-92 (R.I. 1983) (stating that no crisis existed in 1981 to justify mandate for nonjudicial screening of malpractice claims).

[23] For sources on New York and California, see *supra* note 15; *see also* A LEGISLATOR'S GUIDE, *supra* note 17, at 27-55 ("Case Studies from Five States").

[24] Unfortunately, systematic data on malpractice insurance and who was writing what type of insurance, for how many insureds, and in what states are not available for the pre-crisis period. One of the beneficial reactions to crisis was that standard insurance reporting began to separate medical malpractice from general liability coverage as a statistical and regulatory category. *See, e.g.*, INSURANCE INFO. INST., FACT BOOK ON PROPERTY AND CASUALTY INSURANCE (1985).

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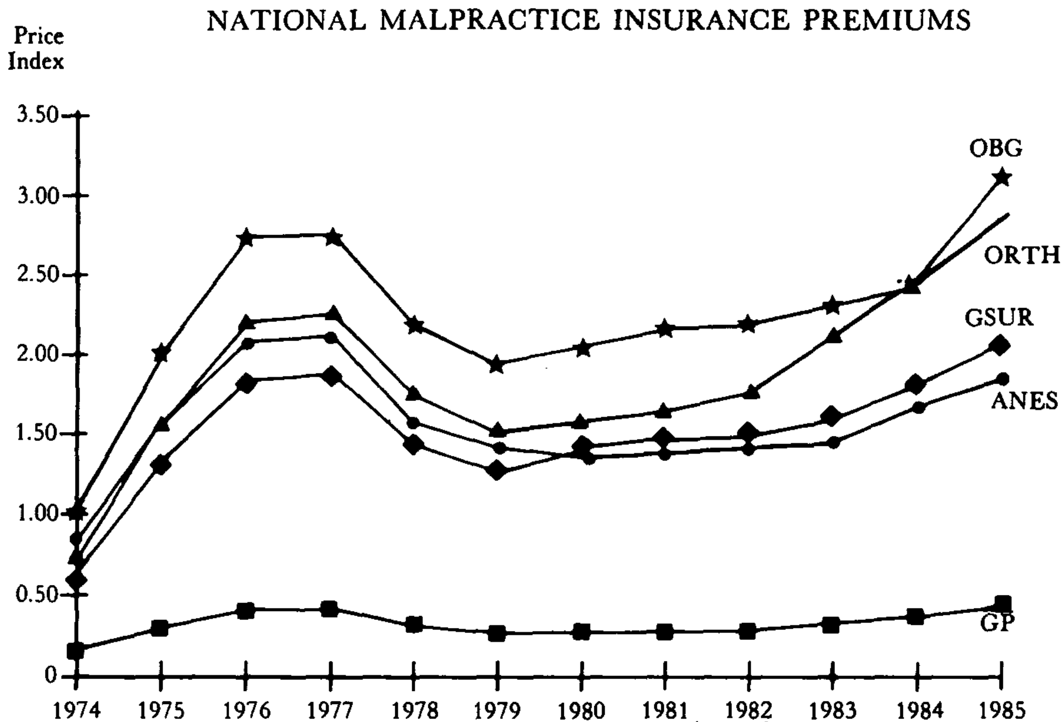
rose sharply in the 1970s and in the 1980s, but with a decline in "real," inflation-adjusted prices in between.[25] Figure 1 graphically depicts that obstetrician-gynecologists paid three times as much for the same nominal dollar coverage in 1985 as in 1974.

FIGURE 1

NATIONAL MALPRACTICE INSURANCE PREMIUMS



Source: Urban Institute/Vanderbilt University calculations, using data from annual HCFA survey

Note: OBG = Obstetrician-Gynecologist; ORTH = Orthopedic Surgeon; GSUR = General Surgeon; ANES = Anesthesiologist; GP = General Practitioner

1974 premium level for OBG indexed as 1.00; other values stated as relative prices, in "real" terms (inflation adjusted).

That cycles occur in insurance pricing and availability is not disputed. It is far from clear, whether in the industry itself, among academic investigators, or in state legislatures and the popular mind, exactly why these surges in insurance prices occur (with resulting

[25] This Figure is based on a 51 jurisdiction survey of price quotations for "mature" claims-made coverage of $100,000 per occurrence and $300,000 per year. Prices are presented on an index basis, with 1974 obstetrician-gynecologist as 1.00. This presentation fails to capture the reality that $100/300 coverage buys much less protection now than before. In fact, physicians buy considerably more coverage today than before the first crisis. *See* F. SLOAN & R. BOVBJERG, *supra* note 5.

political-legal complaints). Continuing rises in claims and payments are the underlying cause, but the dynamics of the insurance market seems to be the precipitating factor, and no consensus exists on how much each is to blame. Most accounts can only speculate on why claims and awards have risen. Reasons commonly listed include an erosion in physician-patient relationships, higher patient expectations, more expert and numerous attorneys for malpractice plaintiffs, greater willingness of physicians to testify, a more compensation-oriented worldview among judges and juries, and changes in legal doctrine favorable to malpractice plaintiffs — sometimes called part of a more general "legal rights explosion."[26]

Policymakers proclaim crisis when complaints are widespread or when a vital activity seems threatened. Most recently, the apparent withdrawal of numerous obstetricians from the delivery of babies because of liability concerns has received the most attention.

2. Festering Complaints About Law Also Contributed

Developments in legal doctrines and legal procedures are thus only partly tied to increased claims payouts and more specific worries about the insurance crisis. However, general objections about how law handles malpractice and other personal injury claims also underlie the push for reform. These complaints are not so much about a legal "crisis" as they are about gradually worsening problems.

Most complaints came from a provider-defendant's viewpoint. It has been said that a social conservative is a liberal who has been mugged. In that case, a tort reform crusader is perhaps a conservative executive or professional who has been sued. Complaints are legion,[27] but three main objections predominate: First, reformers say that the law encourages too many lawsuits. Ignoring how many constitutes too many, it is clear that a general "liberalization" of common-law doctrines and processes in recent decades has favored plaintiffs.[28] In addition, the re-

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[26] *See, e.g.*, P. HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES (1988); CALIFORNIA ASSEMBLY REPORT, *supra* note 15, at 3-4; TORT POLICY WORKING GROUP, REPORT ON THE CAUSES, EXTENT, AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY (Feb. 1986 & Mar. 1987 Update).

[27] *See, e.g.*, Havighurst, *Reforming Malpractice Law Through Consumer Choice*, 4 HEALTH AFFAIRS 63, 66-67 (1984); O'Connell, *Neo-No Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 125, 125-27.

[28] *See, e.g.*, Dietz, Baird & Berul, *supra* note 4, app. at 87-167.

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formers argue that numerous claims are merely "frivolous" and that unfairly "stale" cases are brought many years after the allegedly negligent act. This trend, while especially noticeable in toxic torts and in other environmental or products liability claims, is also prevalent in medical malpractice, in which discovery of the tort may take years and in which birth defects are often involved.

Second, reformers argue that the system in many cases pays too much. Occasional reports of very large verdicts support the observation that damage awards can seem extravagant.[29] Most commentators mainly object that awards are growing too fast instead of addressing the appropriateness of particular results. Third, complain reformers, judges and juries can make poor decisions about fault. All defendants complain that sympathy for plaintiffs can color results. Doctors particularly are concerned that lay jurors and judges do not appreciate when a bad medical outcome is simply unfortunate as opposed to faulty, especially when the case is very old and when medical knowledge has advanced in the interim. Some critics even characterize results as "haphazard" and the process as a "game of chance" or "lottery."[30]

Other complaints about the performance of the legal system concern plaintiffs as well as defendants, most notably that the system costs too much and takes too long. Lawyers' fees are frequently deemed too costly, particularly on the plaintiff's side, when contingency fee arrangements can result in very large awards that seem disproportionate to the amount of effort involved.[31] On the other hand, defense legal costs are also high, especially for complex cases like medical malpractice.[32] Malpractice cases are not quickly resolved. Once filed, claims

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[29] The best known example comes not from malpractice or other tort law but from the Texaco-Pennzoil dispute, in which Pennzoil obtained a $10 billion judgment against Texaco. *E.g.*, *Jury Awards $10.53 Billion to Pennzoil in Texaco Case*, Wash. Post, Nov. 20, 1985 at A1, col. 2. Note that many seemingly extravagant jury awards also seem extravagant to judges and the parties. Many large awards are reduced by judges or compromised on appeal. About one-quarter of jury verdict awards are eventually reduced by almost one half, such that the total payout is only 71% of the total awarded. M. SHANLEY & M. PETERSON, POSTTRIAL ADJUSTMENTS TO JURY AWARDS (1987).

[30] *E.g.*, O'Connell, *supra* note 27, at 127.

[31] Most malpractice claims, however, are not paid, so that plaintiffs' lawyers get no fees at all. In addition, unlike products liability cases, it is rare that the same defendant can be repeatedly sued on essentially the same grounds; each case must be researched and proved on its own.

[32] According to an analysis from the Rand Corporation, plaintiffs' net compensation was 52% of total costs for auto tort cases. J. KAKALIK & N. PACE, COSTS AND COMPENSATION PAID IN TORT LITIGATION 74 (1986). For all other civil cases (including

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average twenty-five months to close, and sixteen percent average more than five years to adjudicate.[33]

Most of these objections to legal-insurance practice apply alike to malpractice and other injuries. Some complaints simply reflect commonsense judgment, grounded more in anecdotes than in careful documentation and argument. In tort reform debates it is easy to be emotional and hard to be analytical, for key questions are whether claims or awards are "too high." Finally, one important complaint is seldom heard: that too few injured patients actually seek and receive payment, as discussed in the next subpart.

3. Medical Quality Is Also at Issue

Tort reformers and their opponents argue from understandably different perspectives about the quality of medical care. Like the complaints about law, however, alleged quality problems seem to pose not a crisis but rather a general, continuing concern. One argument is that medical quality is "too low," causing the large increase in claims. Even physicians concede that malpractice does occur,[34] and many observers blame the "bad apples" among physicians — those practicing beyond their competence — for a large share of malpractice woes.[35] However, no credible evidence exists that medical quality has declined in recent years, much less that any such decline has caused an upsurge in malpractice claims.[36]

In fact, little is known about what prompts people injured by malpractice to bring a claim; what evidence exists suggests that unlitigated incidents of substandard care far outnumber malpractice claims.[37] One

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malpractice), claimants received only 42%. *Id.* Unsubstantiated assertions in this area abound, such as that each dollar given to injured patients costs four dollars to deliver. *E.g.*, Grad, *supra* note 3, at 1072.

[33] GENERAL ACCOUNTING OFFICE (GAO), MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984, at 33-35 (1987).

[34] *E.g.*, Rubacky, *Let's Not Kid Ourselves About Who Causes Malpractice Suits*, MED. ECON., Dec. 7, 1981, at 84 (practicing orthopedic surgeon reports finding "obvious deviations from accepted standards of medical care in more than 40 percent of the cases" reviewed for plaintiffs' attorneys over three years); *see also* AMA TASK FORCE, *supra* note 15, REP. NO. 3, at 3.

[35] Some writers assert that 5% to 15% of physicians are not fully competent. *E.g.*, Feinstein, [letter to editor], 313 NEW ENG. J. MED. 390 (1985). Such very high estimates are not well-supported. *See* Bovbjerg, *Medical Malpractice on Trial: Quality of Care Is the Important Standard*, LAW & CONTEMP. PROBS., Spring 1986, at 321, 345.

[36] For discussion, see F. SLOAN & R. BOVBJERG, *supra* note 5.

[37] Claims not brought may outnumber those brought by five to one — or even more

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plausible explanation for this evidence is that patients' (and their families') expectations for good outcomes have grown even more rapidly than quality. Thus, the rise in frequency of claims could be due to increasing litigiousness about an unchanged or reduced number of bad outcomes. Of course, low quality deserves public and professional attention regardless of whether it "caused" the insurance crisis, and legislatures have responded.

A second quality concern relates more directly to tort reform: that liability fears prompt physicians to practice "defensive medicine," which is not good medicine and certainly not cost-effective medicine. This term mainly means that doctors order procedures or undertake a practice style for legal defense rather than for medical benefit. Some believe that defensive practices are extensive; the AMA estimates that extra defensive procedures cost $12 billion in 1984.[38] Almost certainly, this figure considerably overstates the actual amount, in part because some defensiveness presumably helps prevent injury, and extra attention often pleases patients. Indeed, defenders of expansive tort rules point to their presumed deterrent effect as a major plus, though they lack even weak empirical estimates.[39]

A more troublesome complaint is that doctors may curtail their practice out of fear of suit. Obstetricians, for example, often report that they have withdrawn from delivering babies.[40] This contention is hard to assess,[41] and even harder to quantify in terms of its damage to health care. However, the concern is a major support for tort reform to ease physicians' fears of unfair treatment.[42]

— according to extrapolations from hospital chart reviews; larger cases seem more likely to be filed. *See generally* F. SLOAN & R. BOVBJERG, *supra* note 5 (citing the work of Don Harper Mills and his doctor-lawyer colleagues); Zuckerman, Koller & Bovbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 85, 94-95.

[38] Reynolds, Risso & Gonzalez, *The Cost of Medical Professional Liability*, 247 J. A.M.A. 2776 (1987).

[39] For critiques of this research and other estimates, see F. SLOAN & R. BOVBJERG, *supra* note 5; Zuckerman, Koller & Bovbjerg, *supra* note 37, at 106-09.

[40] *See* OPINION RESEARCH CORP., PROFESSIONAL LIABILITY AND ITS EFFECTS: REPORT OF A 1987 SURVEY OF ACOG'S MEMBERSHIP (Report prepared for AM. COLL. OF OBSTET. & GYNEC.), Mar. 1988, table 36; F. SLOAN & R. BOVBJERG, *supra* note 5.

[41] *See supra* note 40.

[42] Unfortunately, it is unclear how much reassurance would be needed to reduce significantly whatever amount of defensiveness has affected health care. It would be surprising if any legislature would enact tort reform to take malpractice claims or insurance premiums back to 1960s levels. Even at that time, a Senate Report and AMA

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That doctor-patient relations suffer from insurance crisis is a final medical concern that supports tort reform. This argument is that an atmosphere suffused with liability concerns has hurt the quality of medical care. Patient trust in physicians, which has traditionally been seen as an important element in healing, is said to have eroded (from litigation as well as other developments). On the physician side, doctors' defensiveness may make them less sensitive to patients' legitimate medical concerns. Ironically, many physicians assume that poor patient relations may in turn also encourage litigation.[43]

Another medical issue is seldom mentioned by reformers, namely that far more instances of medical malpractice occur than ever come to light. Some evidence exists that valid malpractice claims greatly outweigh actual filings by a factor of perhaps five or ten to one.[44] A related worry is that a certain number of incompetent physicians is not being found and weeded out, whether through the liability-and-insurance mechanism, by professional peer review, or by state disciplinary authorities.[45]

C. *The Limits of Knowledge and Solutions*

Because the dynamics of malpractice are so poorly understood, one must discuss these problems with some modesty. The key deficiency is perhaps that no one truly understands what governs trends in claims. Both of the insurance crises for medical malpractice have been attended by run-ups in claim frequency, followed by downturns in the trend lines. Claims frequency for medical malpractice fell considerably in the latter part of the 1970s, much to the surprise of insurers.[46] It appears that a similar drop has followed the 1984-1986 crisis, at least for malpractice claims.[47] Given that no one really understands why such large

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survey report concluded that considerable defensiveness existed. *See* COMMITTEE ON PROFESSIONAL LIABILITY, AMA, PROFESSIONAL LIABILITY SURVEY 12 (1970) (stating that 60% of doctors surveyed agreed that extra tests were prompted in part by liability concerns).

[43] SECRETARY'S COMMISSION REPORT, *supra* note 4, at 67-68.

[44] *See supra* note 37.

[45] It is possible to find extraordinarily high estimates of the number of "incompetent" doctors — up to 15% of physicians, which strains credulity. *See supra* note 35. More frequently, it may be the case that competent physicians practice beyond the bounds of their competence, and so should be encouraged to retrain or cut back.

[46] F. SLOAN & R. BOVBJERG, *supra* note 5.

[47] *See* Voelker, *Leveling Trend in Premium Rates Seen Continuing*, Am. Med. News, Jan. 13, 1989, at 13, col. 4 (observing that St. Paul, the largest nationwide physicians' insurer, has had drop in claims frequency from 17 or 18 claims per 100

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changes occur, one should be modest in projecting how reforms can affect future crises.

As one might expect, legislative enactments deal with the three areas of concern — insurance, law, and medicine. Legislatures make little attempt to address potentially more important social expectations that underlie behavior of claimants, who may or may not seek recovery, and of jurors and judges, who may or may not grant it. They may make some indirect attempt to influence such expectations through study commissions, reports, and other legislative efforts.

II. Understanding the Responses to Crisis — The 1970s

The 1974-1976 crisis received considerable attention from both the media and legislatures. Every state responded in some manner. Most discussions lump all legislative reforms together as "tort reforms." However, the statutes addressing insurance availability and quality of medical care should properly be considered separately from reforms of legal rules or processes. This Part addresses the reactions to crisis, both legislative and nonlegislative — first insurance developments, then medical developments, and finally legal changes.

Contemporary chronicles and legal scholarship were quick to address malpractice reform,[48] sometimes in more detail than can be given here. Most of this Article's information about reforms comes from a comprehensive new review of the legislative record.[49] Each enactment found was characterized, along with its effective date and termination (in case of legislative "sunset," active repeal, or invalidation on judicial review). Most findings were cross-checked against available listings distributed by trade associations[50] and other sources.[51] This statutory compilation

insureds in 1983-1985 to 15 per 100 in 1987).

[48] *See, e.g.*, A LEGISLATOR'S GUIDE, *supra* note 17; Abraham, *supra* note 17; Webb, *Recent Medical Malpractice Legislation — A First Checkup*, 50 TULANE L. REV. 655 (1976) (more thorough than Duke Note); Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759 (1977). Tort reforms are more often discussed than insurance or quality reforms.

[49] This Project conducted an exhaustive search during 1987-1988 of state codes and statute books. All fifty states and the District of Columbia were canvassed for all enactments relevant to medical malpractice from 1970 through 1987. All together, as Table 1 indicates, over thirty different types of enactments were identified (plus an "all other" category) and checked for every jurisdiction for every year. The study of which this legal research was part is described *infra* note 52. Numerous law students and recent graduates helped in this search — too many to acknowledge by name, which does not diminish the service they performed.

[50] Two sources were the most useful. The first was the reasonably comprehensive

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was undertaken for a larger study of medical malpractice insurance.[52] In addition to providing information for this Article, this legal research enabled empirical analyses to address the effectiveness of reforms in previously unavailable detail.[53]

This Part discusses the 1970s enactments, while Part III discusses the 1980s. Each considers in turn reforms of insurance practice, regulation of medical quality, and legal rules and processes. Table 1 lists the major reforms.

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listing compiled by the American Insurance Association. *See* AMERICAN INSUR. ASSOC. (AIA), MEDICAL MALPRACTICE INSURANCE REPORTS (SELECTED STATE STATUTES) (1984) (unpaginated) [hereafter AIA REPORT]. This Report lists insurance and related legislative reforms in standardized format for each jurisdiction. The compilation almost always gives citations, though not usually dates or much detail, and sometimes notes judicial decisions. Not surprisingly, detail is best for insurance enactments, next best for tort reform, and least comprehensive for medical issues.

The second very useful source was reports on individual types of statutes from the Department of State Legislation of the American Medical Association. These began during the mid-1970s, *see, e.g.*, 5 STATE HEALTH LEGISLATION REPORT NO. 1, at 1-72 (1977) (containing "A Special Update and Review on Medical Malpractice Legislation and Related Court Decisions"), and have continued periodically since that time, *see, e.g.*, 14 STATE HEALTH LEGISLATION REPORT NO. 2, at 18-32 (1987) (covering "Attorney Fee Regulation," "Limits on Recovery," Collateral Source Rule," and "Periodic Payments"). These write-ups are reprinted as pamphlets available from the AMA and will hereafter be cited as "AMA REPORT." The AMA compilations cover fewer types of reforms than the AIA's and without legislative citation or dates, but in more substantive detail, including some information on judicial rulings. The AMA also made available its more complete home office files, with state-specific enactments in chronological order, for which the Author is most grateful.

[51] Though far less comprehensive, other listings, articles, manuscripts, and case studies were often very useful. *See, e.g.*, GAO, MEDICAL MALPRACTICE: NO AGREEMENT ON PROBLEMS OR SOLUTIONS app. II (1986) ("Status of State Tort Reforms"); A LEGISLATOR'S GUIDE, *supra* note 17, at 3-21; Doll, *Medical Malpractice Legislation — The Kentucky Experience*, 1985 J. KY. MED. ASS'N 505; Tobin, *The Current Status of Tort Reform in Iowa*, 35 DRAKE L. REV. 859 (1986-1987).

[52] The grant is entitled National Center for Health Services Research, *Empirical Analyses of Medical Malpractice Insurance*, No. NCHSR #1RO1 HSO5683 (Feb. 1987-July 1989) (Ira E. Raskin, project officer). The study has also done a survey of leading malpractice insurers, conducted numerous interviews, compiled insurance statistics, and otherwise addressed malpractice insurance issues.

[53] *See, e.g.*, Sloan, Mergenhagen & Bovbjerg, *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis* (1989) (forthcoming).

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TABLE 1

CATEGORIZING THE MAJOR LEGAL REFORMS OF THE 1970s AND 1980s

A. Insurance reforms
1. Joint Underwriting Associations (JUAs)
2. Limits on insurance cancellation
3. Mandates for liability coverage
4. Patient Compensation Funds (PCFs)
5. Reporting requirements

B. Reforms Aimed at Medical Quality
1. Peer review requirements, protection from lawsuits
2. Powers of disciplinary boards increased
3. Reporting requirements, data compilation
4. Requirements for continuing medical education

C. Tort Reforms

Aimed at the number of lawsuits (insurance "frequency"):
1. Arbitration
2. Attorney fee controls
3. Certificate of merit
4. Costs awardable
5. Pretrial screening panels
6. Statutes of limitations

Aimed at size of recoveries ("severity"):
1. Ad damnums restricted
2. "Caps" on awards (non-economic, total)
3. Collateral source offset (permissive, mandatory)
4. Joint & several liability changes
5. Periodic payments of damages ("structured" awards)
6. Punitive damage limits

Aimed at plaintiffs' difficulty (or costs) of winning:
1. Expert witness requirements
2. Informed consent limits
3. Professional standard of care reasserted
4. Res ipsa loquitur restrictions
5. Statute of frauds for medical promises

Aimed at functioning, cost of judicial process:
1. Mediation
2. Notice of intent to sue
3. Precalendar conference required
4. Preferred scheduling for malpractice cases

Miscellaneous:
1. Extension of Good Samaritan statutes
2. Immunity for school athletic injuries
3. All other

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A. Insurance Reforms

1. Legislative Enactments

Understandably, state legislatures reacted to the mid-1970s crisis with numerous reforms meant to make malpractice insurance more available or more reasonably priced, especially for individual physicians but also for hospitals and other providers.[54] Very often, legislatures mandated *Joint Underwriting Associations* (JUAs) or authorized their insurance commissioners to do so upon finding that conventional coverage was insufficiently available.[55] Some statutes were explicitly made temporary, a reasonable reaction to temporary crisis.[56]

JUAs were the single most common insurance response to the 1970s crisis.[57] The typical JUA is a state-overseen insurance pool in which all of the state's liability insurers are required to participate but for which a single lead carrier conducts business much like a conventional company — issuing policies, collecting premiums, and settling claims.[58] Unlike a conventional insurer, however, a JUA has special statutory guarantees of solvency that enable it to accept all or nearly all applicants for coverage (and hence to alleviate any crisis of availability); if losses exceed the premiums collected, JUAs can assess all participating insurers *pro rata* for the operating deficit[59] and can often also assess policyholders.[60] Some JUAs were designed to cover all physicians in a state,[61]

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[54] This review focuses upon physicians, who received the most legislative attention.

[55] *See, e.g.*, IOWA INS. CODE § 655 (1975) (authorization); MASS. GEN. L. ANN. ch. 175A, § 5A (West 1987 & Supp. 1988) (mandate).

[56] *See, e.g.*, DEL. CODE ANN. tit. 18, § 6830(e) (Supp. 1988) (authorization not to exceed two years from enactment); *id.* § 6830(g) (Supp. 1988) (any JUA to end upon commissioner's finding of availability).

[57] For a "scorecard" on reforms in the 1970s and 1980s, see *infra* notes 187-91 and accompanying text, especially Table 2.

[58] Alternative insurance mechanisms exist to accomplish JUA goals of making coverage available to all while spreading the risk among insurers. In Kansas, for example, the state's "Health Care Insurance Availability Plan" would have allowed participating insurers to agree to apportion among themselves all would-be insureds unable to obtain coverage "through ordinary means." KAN. STAT. ANN. § 40-3413(a) & (a)(1) (Supp. 1987). The Kansas Supreme Court held this statute constitutional in Schneider v. Liggett, 223 Kan. 610, 576 P.2d 221 (1978). In practice, however, the plan seems to operate as a JUA. AIA REPORT, *supra* note 50; ALLIANCE OF AMERICAN INSURERS, FINANCIAL CONDITION OF MEDICAL MALPRACTICE JUAs (1987) (prepared for the National Coordinating Committee on Medical Malpractice JUAs); *see also infra* note 64 (discussing reinsurance exchanges).

[59] *See, e.g.*, N.Y. INS. CODE § 550-7(a) (McKinney 1985).

[60] *See, e.g.*, *id.* § 316(g)(6).

[61] *See, e.g.*, TENN. STAT. ANN. § 56-33-103(c) (1980) (exclusive except for doctors

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while others were designed merely to cover those not insured with their own conventional insurer.[62] In fact, JUAs vary greatly in the proportion of the market that they command.[63] In lieu of enacting JUAs, a few states allowed or required insurers to operate a "reinsurance exchange"[64] or intervened on behalf of the relatively few physicians totally unable to find private coverage.[65]

Another major intervention is the running of state *Patient Compensation Funds* (PCFs).[66] PCFs, sometimes given other names,[67] cover losses above a basic (or "primary") level of insurance bought privately by participating medical providers. PCF revenues come from a surcharge on the basic coverage (*e.g.*, ten percent of primary premium), usually "backstopped" by the ability to retroactively assess providers or,

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employed by state).

[62] *See, e.g.*, TEX. INS. CODE ANN. art. 21.49-3 (Vernon 1989).

[63] *See* ALLIANCE OF AMERICAN INSURERS, *supra* note 58.

[64] In brief, this term means that primary insurers join together to reinsure large losses and to allow high-risk policies written by participants to be "ceded" to the exchange, with profits and losses shared pro rata. *See, e.g.*, N.J. STAT. ANN. § 17:30D-4 (West 1985). If only large losses are involved, such reinsurance may resemble a PCF. *See infra* notes 66-69 and accompanying text. North Carolina's statute would have required all liability insurers to issue malpractice policies, with the exchange to reinsure high-risk policies and to spread any losses pro rata among insurers, but with no recourse to assess policyholders. N.C. GEN. STAT. § 58-1 to -404 (1982 & Supp. 1988), held unconstitutional in Hartford Accident Indem. Co. v. Ingram, 290 N.C. 457, 226 S.E.2d 498 (1976). For Alabama, in addition to creating a JUA, *see* ALA. CODE § 27-26-20 to 27-26-43 (1975 & Supp. 1988), Alabama mandated that any casualty insurer in the state that offered malpractice coverage elsewhere also offer it in Alabama. *See id.* § 27-26-3 (1975).

[65] This approach resembles states' "assigned risk" plans familiar in auto insurance. For example, Michigan ran a residual fund, called the "Brown McNeely Insurance Fund." *See* MICH. LAWS ANN. § 24-12500 to -12517 (Callaghan 1987). This was terminated as of July 1, 1981, with its obligations assumed by the physicians' mutual insurers. *See* AIA REPORT, *supra* note 50. A very few other states also had such provisions; however, very few physicians were evidently affected.

[66] *See, e.g.*, IND. CODE ANN. § 16-9.5-4-1 to -4 (West Supp. 1988). The Indiana Supreme Court found this statute constitutional in Johnson v. St. Vincent Hosp., 273 Ind. 374, 404 N.E.2d 585 (Ind. 1980); KY. REV. STAT. ANN. §§ 304.40-250 to -330 (Michie/Bobbs-Merrill 1988). The Kentucky Supreme Court found this statute unconstitutional in McGuffey v. Hall, 557 S.W.2d 401 (Ky. 1977).

[67] *See, e.g.*, COLO. REV. STAT. § 10-4-801 to -808 (1987) ("Medical Liability Extraordinary Loss Fund"; never made operational); KAN. STAT. ANN. § 40-3401 to -3423 (1986 & Supp. 1987); ("Health Care Stabilization Fund"); NEB. REV. STAT. § 44-2837 to -2839 (1984) ("Excess Liability Fund"); PA. STAT. ANN. tit. 40, § 1301.701-.705 (Purden Supp. 1988) ("Medical Professional Liability Catastrophe Loss Fund" or CAT Fund).

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in one unusual instance, by state revenues.[68] PCFs thus protect primary insurers against large losses, presumably encouraging them to continue making coverage available in the state. They also ensure the availability of funds to compensate severely injured claimants.[69]

Lesser insurance reforms include ***limits on insurance cancellation***.[70] These provisions are designed to enable medical providers to obtain and keep coverage that insurers might not otherwise provide; however, the provision may backfire if as a result insurers decide not to continue writing coverage.

Occasionally, states also ***mandate liability coverage*** to assure that injured patients could collect. This mandate may be imposed directly[71] or indirectly, through saying that only insured providers can avail themselves of the financial protection of a PCF.[72] Legislatures are not the only entities to impose insurance requirements. Of perhaps more practical consequence, many hospitals began to require that physicians carry a certain level of coverage to maintain hospital privileges, without which doctors are hard put to practice medicine.[73] At least one legislature has supported such measures.[74]

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[68] Kentucky sought to have general revenues pay for PCF losses. *See* KY. REV. STAT. ANN. § 304.40 to 330(8)(c) (Michie/Bobbs-Merrill 1988). This feature was part of what led the state supreme court to declare the statute unconstitutional. *See* McGuffey v. Hall, 557 S.W.2d 401, 409-10 (Ky. 1977).

[69] A few states gave conventional malpractice insurers not dissimilar financial protection by creating a state-run reinsurance fund to cover very large losses. *See, e.g.*, N.J. STAT. ANN. § 17:30D-4 (West 1985) ("New Jersey Medical Malpractice Reinsurance Association"). The New Jersey statute was deactivated in 1982. *See* AIA REPORT, *supra* note 50.

[70] Some limits are not especially stringent. *See, e.g.*, LA. REV. STAT. ANN. § 40:1299.45 (West 1987 & Supp. 1988) (requiring companies to give insurance commissioner 30-days advance written notice of cancellation. Other statutes are more stringent. *See, e.g.*, COLO. REV. STAT. § 10-4-107 to -109.5 (1987) (allowing no cancellation except for nonpayment of premiums, revocation of insured's license, or false representations to obtain policy). California also provides that companies may not refuse to insure because of a valid arbitration agreement. CAL. INS. CODE § 11589.5 (West 1988). Insurance commissioners may also use regulatory means to dissuade companies from ceasing to write coverage.

[71] *See, e.g.*, IDAHO CODE § 39-4201 to -4213 (repealed 1981) (held constitutional in Jones v. State Bd. of Med., 97 Idaho 859, 555 P.2d 399 (1976)); KY. REV. STAT. ANN. § 304.40-250 to -330 (Michie/Bobbs-Merrill 1988) (held unconstitutional in McGuffey v. Hall, 557 S.W.2d 401 (Ky. 1977)).

[72] *See, e.g.*, IND. CODE ANN. § 16-9.5-2-6 (West Supp. 1988).

[73] *See* Renforth v. Fayette Memorial Hosp. Ass'n, 178 Ind. App. 475, 383 N.E.2d 368 (1978) (en banc) (upholding a wholly private requirement), *cert. denied*, 444 U.S. 930 (1979).

[74] *See* CAL. HEALTH & SAFETY CODE § 1319 (West 1979). This statute opposed

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A final type of insurance reform is new *reporting requirements* placed on insurers. Some call for reports of aggregate statistics, meant to give somewhat more warning to authorities about impending crises.[75] Others provisions require information about practitioners' individual claims closed with payment — more in the interests of quality control.[76]

2. Other Adjustments

Legislatures were not the only entities to react to the crisis. The most major shift in medical malpractice insurance was probably the entrance of provider-owned insurers. Most of these were mutual insurance companies or so-called "reciprocals" or insurance exchanges. State legislation specifically authorized some of these,[77] but most plans simply began under existing statutory or regulatory authority. Most operate intrastate, but some are interstate.[78] The first provider-organized companies were established in 1975 in Maryland, California, and New York. Within a few years fifteen or more such companies existed[79] and by the early 1980s, they had claimed half the market for physicians' coverage.[80] Such companies take as their *raison d'être* promoting stability in the physicians' malpractice insurance market. Because they are capitalized and run by physicians in each state, physicians can have more confidence that the companies will not precipitously withdraw

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challenge of unconstitutional delegation of authority. *See* Wilkinson v. Madera Community Hosp., 144 Cal. App. 3d 436, 192 Cal. Rptr. 593 (1983).

[75] *See, e.g.*, CAL. INS. CODE § 11555.2 (West 1988) (providing data on exposure and claims experience).

[76] The requirements are largely to report *closed* claims, which because of their "long tail" come far too late to consider for review of premiums or to warn of availability problems. *See, e.g.*, CAL. BUS. & PROF. CODE § 801(b) (West Supp. 1989) (requiring insurers to report to Board of Quality Insurance any settlements over $30,000 against physicians). Florida and Indiana have unusually detailed requirements. *See* FLA. STAT. ANN. § 627.912 (West 1984 & Supp. 1988) (requiring all dispositions of claims within one year); IND. CODE ANN. § 16-9.5-6-1 (West 1984 & Supp. 1988) (same but on 60-day basis).

[77] *See, e.g.*, MD. INS. CODE ANN. § 48A-550 (Supp. 1988) (authorizing Liability Insurance Society of Maryland as non-stock corporation).

[78] South Dakota's provision specifically contemplates mutual insurers formed by licensed providers from "any or all of the states of Montana, Nebraska, North Dakota, South Dakota and Wyoming." S.D. CODIFIED LAWS ANN. § 58-5B-1(4) (1978).

[79] AMA TASK FORCE, *supra* note 15, REP. NO. 1, at 5.

[80] Posner, *supra* note 19, at 39 (observing that nearly 40 physician companies were in operation by 1982). Hospital developments are harder to track, but most large hospitals either moved to self-insurance or to hospital-controlled "captive" insurance companies. *Id.* At least 11 state hospital associations also formed companies. *Id.*

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from the market as commercial companies had done (and would do again in the 1980s to a lesser degree).[81] Secondary goals include promoting tort reform, fairly pricing insurance, and encouraging quality initiatives like risk management.

Another important development was the appearance of a new "policy form" called "claims-made" coverage, pioneered during the 1970s crisis by the St. Paul Group, the leading commercial malpractice carrier. Traditional "occurrence" policies pay for any claim resulting from an occurrence in the policy year, no matter how long afterwards the claim may be brought. Such policies thus allow a "long tail" of hard-to-predict claims payments to continue for many years after premiums are collected,[82] which means that insurers must accept considerable risk in rate making. By contrast, premiums collected from "claims-made" policies, as the name implies, cover only claims brought during the policy year. This means that premium adjustments can be made much more smoothly, because the long tail is considerably shortened. Little uncertainty remains about outstanding claims incurred but not yet reported; this helps rate-making projections, although uncertainty remains about how long it will take to settle cases and at what values. Initially, physicians and some insurance regulators understandably resisted this form of coverage, because some risk is shifted from insurers to future policy holders. Today, however, "claims-made" coverage is almost universal, even among physician companies, and its acceptance clearly makes insurers more willing to sell coverage.[83]

Another development (and one not to be minimized) is that many insurers ultimately succeeded in significantly increasing their rates,[84] which naturally tended to improve their ability to stay in the market as

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[81] Previously, state medical societies had organized "group" insurance plans — standardized individual policies available from an insurer selected by the society. *See* Kendall & Haldi, *The Medical Malpractice Insurance Market*, in SECRETARY'S COMMISSION REPORT, *supra* note 4, app. at 494, 512-21. These plans, however, were vulnerable to sudden withdrawal by the carrier, as occurred for example in New York.

[82] For malpractice claims closed during 1975-1978, only about half closed within three years of occurrence, and time to closure lengthened over the four years. *See* NAT'L ASS'N OF INS. COMMISSIONERS, MALPRACTICE CLAIMS: FINAL COMPILATION table 1.2, at 27 (1980). For claims closed in 1978, only 48% closed within three years, accounting for only 19% of all payments (large claims take longer than small ones). *See id.* In addition, 21% took over five years (and 40% of payments); about half of 1% took over 20 years. *See id.*

[83] *See* PHYSICIAN INSURERS ASS'N OF AM., 1987 MEMBERSHIP DIRECTORY (1987) (listing types of policies sold by each member).

[84] *Cf.* Danzon, *supra* note 2, at 9-13 (noting that increases were not approved as fast as needed).

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well as to make subsequent increases seem more reasonable. Finally, to everyone's surprise, the real end of the crisis was marked by a tapering off of claims frequency — a development still not adequately explained.[85]

B. Reforms Aimed at Medical Quality

1. Legislative Enactments

Virtually every state in the mid-1970s passed some form of legislation directed at medical quality and its relationship to malpractice.[86] These numerous and idiosyncratic statutes almost defy categorization, but several groupings are discernable. One group encourages *peer review* by protecting the participating "peers" from lawsuits by disappointed reviewees.[87] The theory here is that doctors and hospitals should frequently oversee the work of their peers, so that problems can be prevented or at least ameliorated before injuries occur and lawsuits follow. Licensure and accreditation rules encourage and require such review. However, because peer reviewers themselves may either unfairly tarnish the reputation of someone being reviewed or fail to discover the problem physician who later injures someone, peer reviewers themselves have often feared to participate because of potential liability.[88] The statutes addressed that fear by giving immunity from civil liability to peer review done in good faith.

In another quality reform, almost all states increased the power of their *boards of medical discipline*, which were traditionally very

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[85] *See* P. DANZON, *supra* note 12, at 4-8; Danzon, *supra* note 2, at 12 n.22; *see also* Voelker, *supra* note 47 (observing similar drop-off in the 1980s).

[86] According to this Project's research, only three states seem not to have made changes that became effective in 1975-1977. For another survey of bills and statutes considered or enacted in the prime crisis year of 1975, see Brook, Brutoco & Williams, *The Relationship Between Medical Malpractice and Quality of Care*, 1975 DUKE L.J. 1197, 1230-31 (table).

[87] *See, e.g.*, GA. CODE ANN. § 31-7-130 to -143 (Harrison 1982 & Supp. 1987). Many of these enactments predated the malpractice crisis, then were strengthened in the mid-1970s. *See, e.g.*, OHIO REV. CODE ANN. § 2305.25 (Anderson 1981 & Supp. 1987) (originally effective Dec. 14, 1967). For a detailed review, see Note, *Discovery of Peer Review Records*, 53 UMKC L. REV. 663 (1985). For a jaundiced view of the fairness and effectiveness of peer review immunity, see Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. & MED. 151 (1984).

[88] For a recent discussion in the context of federal antitrust law, see Curran, *Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws*, 316 N. ENG. J. MED. 597 (1987).

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weak.[89] The legislatures not only upgraded the boards' powers,[90] but also provided the board with greater access to information about problem areas by mandating the reporting of malpractice actions.[91] Boards' staffing and financing were also often enhanced.[92] Other provisions frequently mandated included more elaborate ***continuing medical education*** beyond initial licensure,[93] and, very rarely, ***hospital risk management***,[94] again on the theory that adverse incidents could be avoided and thus malpractice litigation reduced.

2. Other Developments

Obtaining high quality results is the central purpose of seeking health care. Medical professionals and institutions, patients and con-

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[89] *See, e.g.*, Derbyshire, *Disciplining the Incompetent Physician*, HOSP. PRAC., June 1971, at 140-47 (stating that only 18 states find that professional incompetence justifies revoking license); Derbyshire, *Medical Ethics and Discipline*, 228 J. A.M.A. 59 (1974) (noting that, in prior 10 years, only 0.66% of physicians were investigated, mainly for drug or alcohol abuse or for advertising).

[90] Sometimes, legislatures added new grounds for disciplinary action. *See, e.g.*, MO. ANN. STAT. § 334.100 (Vernon 1966 & Supp. 1989) (especially subsection (21) on lack of professional skill). Requirements to investigate complaints also appeared. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 112, § 5 (West Supp. 1988) (requiring all complaints to be investigated). Boards' powers to investigate were also expanded. *See, e.g.*, NEV. REV. STAT. § 630.140 (1985) (1977 amendment added subpoena powers and hearing procedures). Legislatures enacted additional sanctions so that boards could take intermediate action besides merely embarrassing a physician and removing her license — neither very effective in the majority of cases. *See, e.g.*, FLA. STAT. ANN. § 458.331 (West 1981 & Supp. 1988) (1979 amendment conferred power to refuse, revoke, or suspend licenses, to restrict a practice, to impose fines up to $1000 per violation, to issue reprimand, and to place physician on probation).

[91] Sometimes reporting requirements were put on hospitals or other provider groups. *See, e.g.*, OR. REV. STAT. § 677 (1988). Sometimes reporting requirements were also placed on malpractice insurers (or the insurance department that received an insurer's report. *See also supra* notes 75-76 and accompanying text.

[92] *See, e.g.*, WASH. REV. CODE § 18.72.020-.300 (repealed 1986).

[93] In 1971, before the crisis years, New Mexico appears to have been the first state to enact continuing medical education (CME) and periodic relicensure. *See* N.M. STAT. ANN. § 61-6-3(E) (1978). A number of states followed during the crisis. *See, e.g.*, MICH. STAT. ANN. § 14.542 (10) (repealed 1979) (mandating 50 hours of CME per year). Medical societies also acted to require their members to have CME. *See* Ruhe, *Recent Event of Special Interest to Medical Education*, 234 J. A.M.A. 1326 (1975).

[94] "Risk management" by hospitals is a more insurance-oriented process. While many approaches exist, the basic idea is to identify problem areas and intervene promptly to prevent injuries or to forestall lawsuits after injury. A few states introduced it by statute. *See, e.g.*, ALASKA STAT. § 18.20.075 (1986).

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sumer advocates, health insurers (both public and private), and state legislatures therefore all have ample independent reasons other than malpractice concerns to "reform" medical quality. Indeed, several states enacted many of the quality reforms noted above before the malpractice crisis.[95]

Other efforts to improve quality are far too numerous and varied to catalogue here, but concerns about how to define and measure quality have moved increasingly higher on public and private health care agendas.[96]

C. *Tort Reforms*

Although the 1970s and 1980s reforms are often lumped together as "tort" reforms, true tort reforms are those that directly address legal doctrine or process. They are central to the idea of legislative reform, since they mediate between adverse outcomes of medical care and insurance claims (and hence premiums). Most discussions of reform have given these true reforms the most attention,[97] so this Article provides only a summary treatment.

To consider their genesis and likely effects, one can group reforms into five categories, according to apparent legislative intent in enacting the provisions, as in Table 1 above: (1) the first group addresses the number of lawsuits or insurance claims brought (insurance "frequency"); (2) another group targets the size of recoveries ("severity" in insurance jargon); (3) a third set addresses plaintiffs' likelihood of win-

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[95] *See, e.g.*, *supra* note 87.

[96] Notable mid-1970s efforts include the Federal Professional Standards Review Organizations (PSROs) which were mandated to assess the care given Medicare and Medicaid patients. *See generally* Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 Nw. U.L. REV. 6 (1975). The PSRO legislation contained an interesting analogue of the peer review immunity. To help effectuate PSROs' utilization and quality review, it immunized from malpractice suits for underservice providers who acted in reliance on PSRO norms or directives. *See* former 42 U.S.C. § 1320c-6(c) (Supp. II 1972) (repealed); *see also* Note, *Professional Standards Review and the Limitation of Health Services: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 B.U.L. REV. 931 (1974). But this era's state of the art was not high. In the early 1970s, methods of quality measurement and assessment were "rudimentary," according to an authoritative overview. INSTITUTE OF MEDICINE, ADVANCING THE QUALITY OF HEALTH CARE (A POLICY STATEMENT) (1984). Matters had not much improved by the end of the decade. A. DONABEDIAN, NEEDED RESEARCH IN THE ASSESSMENT AND MONITORING OF THE QUALITY OF MEDICAL CARE (1978) (ending with comment on "extent of ignorance" at 28).

[97] *See, e.g.*, Robinson, *supra* note 2; *supra* note 50.

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ning (or the costs of building successful cases); (4) other reforms target the functioning or cost of the judicial process; (5) finally, a miscellaneous set of largely minor reforms also exists. The next five subparts discuss these groups.

1. Reforms Addressing the Number of Lawsuits Brought

One of the 1970s reforms which addressed the number of lawsuits brought was *arbitration*. This method of resolution aims to substitute a less formal, less expensive, and more expeditious private process for the conventional courtroom procedures, thus easing access to dispute resolution.[98] The major question here is whether a malpractice reform statute allows agreements to arbitrate *signed before* an injury occurs.[99] Under the Uniform Arbitration Act[100] or other state law, post-injury disputes that already exist as claims can normally be arbitrated or settled in any other mutually agreeable manner. Almost all states only permit voluntary arbitration; they do not positively encourage it.[101] Various provisions typically try to protect patients from unthinkingly signing away their right to a traditional trial.[102]

Attorney fee controls were very common enactments, since many medical observers blamed excessive contingency fees for encouraging unwarranted lawsuits and for depriving injured patients of a reasonable share of awards. Fee controls take two basic forms — regulation of

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[98] *See, e.g.*, MICH. STAT. ANN. § 27A.5040-.5065 (Callaghan 1968) (declared constitutional in Morris v. Metriyakool, 418 Mich. 423, 344 N.W.2d 736 (1984)). Some pretrial screening procedures are statutorily mislabeled "arbitration." *See, e.g.*, HAW. REV. STAT. § 601-20 (1988) (establishing nonbinding process, with trial de novo available).

[99] Most reform statutes allow such agreements, *see, e.g.*, VA. CODE ANN. § 8.01-581.12 (1984), but a few do not, *see, e.g.*, VT. STAT. ANN. tit. 12, § 7001 (Supp. 1988).

[100] 7 U.L.A. 1 (1985 & Supp. 1989).

[101] Michigan's statute uniquely mandates that malpractice insurers in turn require that their insured hospitals offer all their patients the option of arbitration. *See* MICH. COMP. LAWS ANN. § 500.3051-.3062 (West 1983).

[102] These provisions include requirements about clear notice in arbitration agreement of waiver to jury trial, requirements that treatment may not be conditioned on a patient's agreement to arbitrate, and, most importantly, requirements that allow patients to repudiate the pre-injury agreement within 30 or 60 days after treatment. *See, e.g.*, VA. CODE ANN. § 8.01-581.12 (1984) (allowing repudiation within 60 days of terminating health care). Some provisions, however, provide for only a contractual "cooling off" period. *See, e.g.*, LA. REV. STAT. ANN. § 9:4230 to :4236 (West 1983) (providing 30 days from execution of contract, but not if alleged malpractice occurred in interim).

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awards in percentage terms[103] and enhanced judicial oversight.[104]

Two related reforms attempted to deter claimants from bringing frivolous lawsuits (presumably in hopes of coercing an early settlement). At least one state in the 1970s required plaintiffs' attorneys to provide *certificates of merit* that their suit was meritorious.[105] Similarly, some states adopted provisions making more than the usual *costs allowable* in frivolous cases — a sanction meant to deter attorneys and their clients from bringing such suits. This procedure is an expansion of the traditional practice of awarding court costs to the winning party.[106]

Pretrial screening panels were very commonly enacted in the

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[103] Most provisions created a sliding scale of maximum fees graduated by size of award. *See, e.g.*, CAL. BUS. & PROF. CODE § 6146 (West Supp. 1989) (establishing fees of 40% of first $50,000, down to 10% over $200,000). The California Supreme Court held this statute constitutional in Roa v. Lodi Medical Group, 36 Cal. 3d 920, 695 P.2d 164, 211 Cal. Rptr. 77 (1985), *appeal dismissed*, 474 U.S. 990 (1985). Another example of this scale is N.H. REV. STAT. ANN. § 507-C:8 (1983) (establishing fees from 50% of first $1000 to 20% over $100,000). The New Hampshire Supreme Court held this statute unconstitutional in Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980). Some provisions set flat maximum percentages. *See, e.g.*, IND. CODE § 16-9.5-5-1 (1984) (establishing fees of 10% on PCF recoveries — amounts over $100,000). The Indiana Supreme Court held this statute constitutional in Johnson v. St. Vincent Hosp., 273 Ind. 374, 404 N.E.2d 585 (1980). *See generally* Annotation, *Validity of Statute Establishing Contingent Fee Scale for Attorneys Representing Parties in Medical Malpractice Actions*, 12 A.L.R.4th 23 (1982) (discussing such statutes' fate in court).

[104] Such statutes allow or require judges in particular cases to review the reasonableness of attorneys' fees. *See, e.g.*, NEB. REV. STAT. § 44-2834 (1984) (requiring review, but only if requested by a party). This statute was held to be constitutional in Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977). Occasionally, state supreme courts also adopt rules on attorneys' fees as part of their inherent control over the bar, as did Florida in the 1980s. *See* Florida Bar RE Amendment to Code of Professional Responsibility, 494 So. 2d 960 (Fla. 1986). These rules, however, were adopted under pressure from the state legislature. *See* FLA. STAT. ANN. § 768.595 (West 1986) (stating only legislative recommendations, to be superseded by any future supreme court schedule).

[105] *See* CAL. CIV. PROC. CODE § 411.30 (repealed 1989) (not enacted until 1978). More states acted in the 1980s.

[106] *See, e.g.*, MINN. STAT. ANN. § 549.21 (West 1988) (providing that bad faith, fraud, and frivolous claims punishable by award of court costs, disbursements, and reasonable attorney and witness fees). Florida was apparently unique in providing for some time in which all losing parties were to pay the attorneys' fees of winning parties. *See* FLA. STAT. ANN. § 768.56 (1982) (repealed 1986). This statute was upheld in Florida Patient's Compensation Fund v. Rowe, 472 So.2d 1145 (Fla. 1985). However, apparently only the relatively well-to-do losers (largely defendant medical providers) were in fact paying, and the legislature repealed the provision.

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1970s.[107] Such panels offer either a voluntary or a mandatory process for informally hearing a case prior to its coming to trial. The goal is to weed out frivolous cases and speed settlement of meritorious ones.[108] Many believe, however, that such panels add delay,[109] extra cost, and merely another layer of discovery for plaintiffs in serious cases who expect in any event to go to trial.[110] Finally, almost all states changed *statutes of limitations*, which directly affect the number of suits likely to be filed. One change shortens the basic statute of limitations, either for medical malpractice cases or general civil cases.[111] Many states codified a form of the "discovery rule" to limit the number of years that undiscovered medical malpractice lawsuits could toll the statute.[112] States also sought to shorten the tolling period for minors in malpractice cases from the traditional eighteen or twenty-one years of minority to some shorter period.[113]

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[107] *See generally* P. CARLIN, MEDICAL MALPRACTICE PRE-TRIAL SCREENING PANELS: A REVIEW OF THE EVIDENCE (1980).

[108] *See, e.g.*, LA. REV. STAT. ANN. § 40:1299.47 (West 1977 & Supp. 1988) (held constitutional in Everett v. Goldman, 359 So. 2d 1256 (La. 1978). The statute will typically specify the panel's nature. Some of the statutes necessitate findings on both liability and damages, while others require findings only on liability. Pretrial screening panels may make findings as to liability or also as to damages. Their findings may or may not under various circumstances be admissible at trial, and they may or may not provide expert testimony for the party that won on screening.

[109] Pennsylvania and Florida courts initially found panels constitutional, but later they found the panels as applied unconstitutional because of delays in application. *See* Aldana v. Holub, 381 So. 2d 231 (Fla. 1980); Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980).

[110] Some states have amended their statutes to provide that if the parties agree, they may go directly to trial. This procedure seems a sensible response in larger, hotly contested cases when it is clear to everyone that no settlement is possible.

[111] In the early 1970s a number of states added special statutes for medical malpractice, typically with longer periods than the basic tort statute. In the mid-1970s these statutes of limitations tended to be shortened, often while also addressing the "discovery" exception. *See infra* text accompanying note 112. California, for example, reduced its medical malpractice statute of limitations as of Dec. 15, 1975, from four years to three years (having previously raised it above the basic statute of one year) while simultaneously adding other restrictions. *See* CAL. CIV. PROC. CODE § 340.5 (1982) (held constitutional in Kite v. Campbell, 142 Cal. App. 3d 793, 191 Cal. Rptr. 363 (1983)).

[112] These efforts often met with problems in court. *See, e.g.*, ARIZ. REV. STAT. ANN § 12-564 (1982) (repealed 1985) (found unconstitutional in Kenyon v. Hammer, 142 Ariz. 69, 688 P.2d 961 (1984)).

[113] These provisions also caused problems in court. *See, e.g.*, *id.* (found unconstitutional in Barris v. San Manuel Div. Hosp., 143 Ariz. 101, 692 P.2d 280 (1984)).

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2. Reforms Addressing the Size of Recoveries

Six types of statutes address the size of recoveries. One type of statute restricts claimants' ability to list a specific (allegedly over-large) dollar amount sought in the *ad damnum* clauses of their initial complaint.[114] Most states enacted such changes. Their goal was two-fold: to limit the publicity obtainable by a malpractice claimant even before any evidence was presented and to limit potential or actual jury members' hearing about unsubstantiated general dollar amounts. Most statutes simply provide that the initial claim may not allege anything beyond a statement that the jurisdictional amount is met. Rarely, the statutes say that only economic damages may be listed by dollar amount. The statutes often provide that jurors may not hear general statements of the overall amount being sought, only specific amounts stated by expert witnesses.

Specific dollar *"caps" on awards* were probably the most significant reform in this area. They can be of two general sorts: First, many states have restricted an award's intangible, or noneconomic portion, namely that share not supported by specific amounts of medical bills, wage loss, and other costs.[115] In general, these statutes have simply put a flat cap on the amount of noneconomic damages, ranging from $250,000 to $1 million.

The second type of cap limits total awards or the entire amount that can be collected against one type of defendant or all defendants. The strongest version of this type of cap is the overall cap on all recoveries against medical practitioners by a claimant from an individual occurrence. The Indiana statute is the leading example; it restricts recovery from all medical defendants to $500,000 (the last $400,000 of which come from the state PCF).[116] The operation of caps is complicated by the presence or absence of PCFs. In Indiana, the "cap" perceived by

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[114] *See, e.g.*, IND. CODE ANN. § 16-9.5-1-6 (West Supp. 1988) (held constitutional in Johnson v. St. Vincent Hosp., 273 Ind. 374, 404 N.E.2d 585 (1980); WYO. STAT. § 1-1-114 (1988) (held unconstitutional in White v. Fisher, 689 P.2d 102 (Wyo. 1984)).

[115] *See, e.g.*, CAL. CIV. CODE § 3333.2 (West Supp. 1989) ("noneconomic" loss; held constitutional in Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (1985), *appeal dismissed*, 474 U.S. 892 (1985); OHIO REV. CODE ANN. § 2307.43 (Anderson 1981) ("general damages" not involving death; held unconstitutional in Simon v. St. Elizabeth Medical Center, 3 Ohio St. 3d 164, 355 N.E.2d 903 (1976)). More specialized limits also exist. *E.g.*, VA. CODE ANN. § 8.01-581 (1984) (limited liability of charitable hospital for any one occurrence to $100,000 — $500,000 since 1983).

[116] IND. CODE ANN. § 16-9.5-2-2 (West 1984 & Supp. 1988) (held constitutional in Johnson v. St. Vincent's Hosp., 273 Ind. 374, 404 N.E.2d 585 (1980)).

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individual physicians and their primary insurance policies is not the $500,000 total cap but rather the $100,000 level beyond which the state PCF covers all damages. All states with PCFs demarcate between the responsibility of primary coverage and the PCF.[117] Not dissimilarly, one state in the 1970s restricted its courts' ability to award *punitive damages*, not in dollar terms but by restricting judicial discretion.[118]

Many states' provisions for *collateral source offset* modified the common-law rule that tort damages do not account for other recoveries, such as life insurance, health insurance, or disability coverage. Mandatory offsets direct either the judge or the jury under the judge's instructions to subtract any payments from health insurance or similar plan from the liability award.[119] It is common for these requirements to allow plaintiffs to show that they paid or that their employers paid for the coverages being offset, in which case they can be reimbursed for those payments. Permissive statutes, on the other hand, merely allow the jury, given other sources of payment and any premiums paid for those other sources, to draw inferences about the appropriate level of damages.[120] Government programs that have paid a claimant are often allowed subrogation rights, and, perhaps because it is traditionally an individual rather than a collective purchase, life insurance is frequently excepted as a collateral offset.

One state seems the first in the latter 1970s to have modified *joint*

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[117] One should further note that some of these PCF states have an overall cap, as in Indiana; other states have no cap on total recovery, even though there is a PCF. In some of this last group, PCF liability is unlimited — in which case physicians' underlying responsibility ceases at the point when the PCF takes over. Other states limit the PCF liability, in which case the medical providers' underlying responsibility can reappear above the level at which the PCF stops paying. In Pennsylvania, for example, the first $100,000 is the responsibility of the primary coverage. Damages from $100,000 to $1 million will be paid by the PCF, and above $1 million is again the medical provider's responsibility.

[118] *See* DEL. CODE ANN. tit. 18, § 6855 (Supp. 1988) (requiring separate finding of malicious intent or wilful or wanton misconduct and specifically not including cases when a physician applies the intended treatment to the wrong patient or organ or when unforeseen injuries result from intended treatment).

[119] *E.g.*, IOWA CODE ANN. § 147.136 (West Supp. 1988) (held constitutional in Rudolph v. Iowa Methodist Medical Center, 293 N.W.2d 550 (Iowa 1980)); N.H. REV. STAT. ANN. § 507-C:7I (1983) (held unconstitutional in Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980)).

[120] *See, e.g.*, ARIZ. REV. STAT. ANN. § 12-565 (1982 & Supp. 1988) (held constitutional in Eastin v. Broomfield, 116 Ariz. 576, 570 P.2d 744 (1977); KAN. STAT. ANN. § 60-471 (1986) (held unconstitutional in Wentling v. Medical Anesthesia Servs., 237 Kan. 503, 701 P.2d 939 (1985)).

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and several liability;[121] like punitive-award laws, such reforms became much more popular in the 1980s. Finally, "structured" awards have been encouraged by statutes mandating or permitting *periodic payment of damages*, rather than traditional "lump sum" payments.[122] This approach allows an insurance company or other payer of an indemnity to purchase an annuity to pay a fixed periodic payment to a winning claimant. Thus, market forces determine the appropriate discount rate rather than the jury.[123] Another goal of periodic payments is paternalistic — not to allow successful plaintiffs to fritter away their award and subsequently become wards of the state.

3. Reforms Addressing the Likelihood of Winning

Many 1970s reforms shifted the relative burdens of litigation — and the likelihood that the plaintiff would prevail — presumably in response to the earlier history of proplaintiff liberalization. Several types of enactments deserve mention. Many medical malpractice reform statutes sought in some manner to restrict the judicially created doctrine of *informed consent* as a method to establish liability.[124] Many reform statutes have merely codified a relatively "liberal" version of judicial

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[121] *See* MINN. STAT. ANN. § 604.02 (West 1988) (limiting liability of states and municipalities in general).

[122] *See, e.g.*, CAL. CIV. PROC. CODE § 667.7 (West 1988) (mandating structured award at request of party for future damages above $50,000; held constitutional in American Bank & Trust Co. v. Community Hosp. of Las Gatos, 36 Cal. 3d 359, 683 P.2d 670, 204 Cal. Rptr. 671 (1984)); N.H. REV. STAT. ANN. § 507-C:7 (1983) (providing discretionary plan; held unconstitutional in Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980)); *see also* Annotation, *Liability of Repairer for Unauthorized, Unnecessary, or Fraudulent Repairs of Motor Vehicle*, 23 A.L.R.4th 265. Lawyers' fees and expenses typically come off the top before the remainder of the award is structured.

[123] The jury also no longer needs to estimate the claimant's expected life, because the periodic award normally terminates with the payee's death. Occasionally, however, as in Florida, the balance of a lump sum that has not been paid out on a period basis is payable to the payee's estate.

[124] For an overview of the doctrine, see Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413. On the 1970s reforms, see Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407 (1980). For a state-by-state review of judicial and legislative rules, with citations to statutes and leading cases, see *The Law of Informed Consent*, in PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL RESEARCH, 3 THE ETHICAL AND LEGAL IMPLICATION OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 193 (1982).

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doctrine,[125] encouraged consent to be in writing,[126] or made other non-"reform"-oriented changes.[127]

However, most enactments attempted in various ways to restrict plaintiffs' ability to sue.[128] Numerous enactments sought to reassert that malpractice is a matter of medical standards and expertise and intended to limit plaintiffs' ability to recover without traditional types of expert testimony. Provisions setting *requirements for expert witnesses* and reasserting the traditional *professional standard of care* for judging the negligence of medical providers are closely interrelated. The traditional standard of medical liability was whether a defendant departed from the "customary practice" of like physicians, which departure must be shown by expert testimony.[129] Both the standard and the witnesses were those of the locality where the alleged injury occurred. However, by the

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[125] *See, e.g.*, ALASKA STAT. § 09.66.556 (1988) (stating that action lies for failing "to inform the patient of the common risks and reasonable alternatives . . . and that but for that failure the claimant would not have consented").

[126] *E.g.*, IOWA CODE ANN. § 147.137 (West Supp. 1988) (providing presumption of validity to written consent form containing general description of procedure and its risks and acknowledgement of disclosure).

[127] One example of this sort is the requirement that specific disclosures be made for particular procedures, especially mastectomies for breast cancer and voluntary sterilization. *See, e.g.*, FLA. STAT. ANN. § 458.324 (West Supp. 1988). Another example is the listing of which decisionmakers may supply surrogate consent. *See, e.g.*, GA. CODE ANN. § 88-2901 to -2907 (Harrison 1986 & Supp. 1988). A third is allowing treatment of those unable to consent and lacking a guardian, with written assurance of necessity from two or more doctors. *See, e.g.*, ALA. CODE § 22-8-1 to -8 (1984).

[128] One approach was to limit the duty to disclose by statute. *See, e.g.*, GA. CODE ANN. § 31-9-6 (Harrison 1986) ("[C]onsent to . . . treatment which discloses in general terms the treatment or course of treatment . . . shall be conclusively presumed to be valid consent."). Another approach limited disclosure by reasserting a professional standard, so that whether to disclose and the extent of the disclosure were governed by customary medical practice rather than by patient expectations. *See, e.g.*, ME. REV. STAT. ANN. tit. 24, § 2905 (repealed 1973) ("No recovery [lies] where . . . the action of the physician in obtaining the consent . . . was in accordance with the standards of [peer] practice."). Alternatively, statutes reassert the so-called objective-claimant standard of causality, namely that one must show the needed causal relationship to an injury by proving that a reasonable patient would have made a different treatment decision had she been properly informed and not merely by claiming after the fact that this particular plaintiff would have made a different decision had she been properly informed. *See, e.g.*, NEB. REV. STAT. § 44-2820 (1984) (providing "reasonably prudent person" standard). *But see, e.g.*, ALASKA STAT. § 09:55.556 (1988) (standard is "but for that failure [to disclose] the claimant would not have consented").

[129] *See* W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON TORTS 185-89 (5th ed. 1984) [hereafter PROSSER & KEETON]; McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959).

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mid-1970s, the traditional "locality rule" had greatly eroded.[130]

Physician reformers were very concerned that jurors may "second guess" expert opinion, especially in sympathetic cases or when standards have advanced since the time of treatment, thus holding defendants to a higher standard ex post facto. Accordingly, many statutes reaffirm that the appropriate standard is what professionals in good standing do (rather than what laymen think they should do).[131] These statutes often reassert a state or locality rule as well.[132] The other side of this reform coin is a reassertion that the professional standard and its breach must be demonstrated through expert rather than lay testimony.[133] Most expert witness requirements also attempt to limit the type of person who can qualify as an expert. In response to complaints that out-of-state, "professional" witnesses unfairly impugn in-state practitioners, states have limited the locality from which an expert can come and have set other requirements for experts' qualifications.[134]

Legislatures in the mid-1970s very frequently enacted similar restric-

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[130] *See* Dietz, Baird & Berul, ***supra*** note 4, at 134 table III-62; Comment, *Standard of Care for Medical Practitioners — Abandonment of the Locality Rule*, 60 KY. L.J. 209 (1971).

[131] *See, e.g.*, IDAHO CODE § 6-1012 (1979) (upheld as constitutional in LePelley v. Grefenson, 101 Idaho 422, 614 P.2d 962 (1980)); N.D. CENT. CODE § 26-40.1-08 (1978) (held unconstitutional as nonseverable in Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978)). More rarely, the standard may also be stated as that of a "reasonably prudent" provider. *See, e.g.*, Harris v. Groth, 99 Wash. 2d 438, 663 P.2d 113 (1983) (citing WASH. REV. CODE § 7.70.040 (Supp. 1989)).

[132] *See, e.g.*, ARK. STAT. ANN. § 16-114-206(a)(1) (1987) (same or similar locality for trials). However, Arkansas's pretrial panels, since repealed, were "not bound or limited by . . . any particular geographical area or locality." *Id.* § 34-2601 to -2612; *see also* VA. CODE ANN. § 8.01-581.20 (1984) (establishing statewide standard unless shown that local standard more appropriate). ***But see also*** Zills v. Brown, 382 So. 2d 528 (Ala. 1980) (interpreting statutory standard of "same general neighborhood" as liberalizing strict locality rule and thus demanding reference to national medical neighborhood of reasonably competent physicians).

[133] *E.g.*, OHIO REV. CODE ANN. § 2743.43 (Anderson 1981) (held constitutional in Denicola v. Providence Hosp., 57 Ohio St. 2d 115, 87 N.E.2d 231 (1979)). Only a few states enacted expert standards without standard-of-care provisions or vice versa.

[134] *See, e.g.*, FLA. STAT. ANN. § 768.45(e) (West 1986) (requiring active involvement in practice or in teaching medicine within five-year period before incident giving rise to claim); N.H. REV. STAT. ANN. § 507-c:3 (1983) (requiring medical provider to be qualified to render or to supervise equivalent care to that at issue and to be expert at contemporaneous time; held unconstitutional because time requirement invalid in Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980)); TENN. CODE ANN. § 29-26-115 (1980) (requiring medical provider to be licensed in Tennessee or contiguous state and to be in practice during year preceding alleged wrongful act; court may waive if appropriate witnesses not otherwise available).

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tions on the doctrine of *res ipsa loquitur*. This doctrine seems particularly unpopular with the medical profession because it undercuts the need for expert testimony and seems at least superficially to subject medical activities to lay standards.[135] Many states thus sought to limit the use of the doctrine in malpractice cases in several ways. A few imposed a total ban.[136] Some restated the doctrine in its form as a burden-shifting rule of evidence, apparently to limit subsequent judicial expansion.[137] A number restricted its use in medical cases to particular circumstances.[138]

Fewer states enacted a special *statute of frauds* for medical lawsuits. This provision allows recovery for "promises to cure" or obtain specific results only when made in writing.[139] Legislatures directed these provisions at claimants who allege after the fact (and again without medical testimony) that their doctor had promised a better result than obtained, thus seeking to show liability in the absence of negligence.[140]

Finally, *advance payment* statutes enacted in many states provide that no interim payment made by a defendant may be introduced to admit responsibility in subsequent proceedings.[141] Statutes typically

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[135] For the classic exposition of the doctrine in the context of malpractice, see Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944).

[136] *See, e.g.*, N.H. REV. STAT. ANN. § 507-c:2 III (1983) (overturned as nonseverable from unconstitutional reform chapter in Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980)).

[137] *See, e.g.*, OKLA. STAT. ANN. tit. 76, § 21 (West 1987) (establishing rebuttable presumption with defendant bearing burden of proof); *see also* Turney v. Anspaugh, 581 P.2d 1301 (Okla. 1978) (discussing statute § 21 *supra*).

[138] *See, e.g.*, NEV. REV. STAT. § 41A.100 (1985) (restricting use unless foreign substance left in body, explosion or fire during treatment, unintended burn, injury to body part not involved in treatment, procedure performed on wrong patient, organ, or limb, or other listed exceptions that may reestablish the rule); N.D. CENT. CODE § 26-40.1-07 (1978) (providing slightly shorter list such as foreign substance or surgery on wrong patient, organ, limb, or body part). The North Dakota Supreme Court held the statute unconstitutional in Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978). While the statute possibly did not violate due process as an individual provision, the court determined that along with the rest of the reform it did violate due process. *Id.* at 137.

[139] *See, e.g.*, UTAH CODE ANN. § 78-14-6 (1982).

[140] However, even without a statute most courts will apparently not imply a warranty of result in the absence of a written agreement. *See* PROSSER & KEETON, *supra* note 129, at 186. For a review of cases, see generally Annotation, *Recovery Against Physician on Basis of Breach of Contract to Achieve Particular Result or Cure*, 43 A.L.R.3d 1221 (1972) (discussing liability issues); Annotation, *Measure and Elements of Damages in Action Against Physician for Breach of Contract to Achieve Particular Result or Cure*, 99 A.L.R.3d 303 (1980) (discussing issues of damages).

[141] *E.g.*, NEB. REV. STAT. § 44-2826 (1984) (enacted as part of comprehensive malpractice act). One should note that a number of such provisions came before the mid-

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provide that any subsequent recovery shall be reduced by the amount of the advance payment and often that excess payments are refundable to the defendant.[142]

4. Reforms Aimed at the Functioning or Costs of Judicial Process

Most 1970s reforms aimed to *reduce the expansion of plaintiffs' prerogatives.* One should also note that some enactments were meant to improve the *functioning of the judicial process* from a more neutral perspective, changes from which all parties might hope to gain. (However, this was the smallest substantive reform category). One such reform previously discussed is *arbitration.* Arbitration is popular among defendants because they perceive that arbitrators are more expert, more neutral, and less emotional, particularly regarding damages to sympathetic plaintiffs. Plaintiffs, likewise, may gain from more informal procedure, speedier process, and lower costs such as attorneys' fees. In theory, both parties can gain and in practice, because arbitration is voluntary, both parties presumably find it beneficial (assuming knowledge and lack of coercion).

Some states have required would-be plaintiffs to give defendants *notice of intent to sue*, evidently to encourage early negotiations to resolve medical problems, before costly court proceedings begin.[143] Especially when coupled with a requirement for certification of meritorious suit, as in California,[144] the provision might also tend to discourage lawsuits. Another similar idea is to require a *precalendar conference* in medical cases (as judges are in any case free to do), to encourage settlement and to simplify issues for trial. But the few such enactments came only later, in the 1980s. Finally, malpractice cases have occasionally been given *preferred scheduling* for trial to shorten the "long tail" a bit at the far end.[145]

1970s crisis as part of more general civil procedure concerns. *See, e.g.*, *id.* § 25-222 (1985) (establishing generic rule).

[142] *See, e.g.*, KY. REV. STAT. ANN. § 304.40-280 (Michie/Bobbs-Merrill 1988).

[143] *E.g.*, CAL CIV. CODE § 364 (1982) (requiring 90-days notice in malpractice cases, but failure to comply is not jurisdictional, *id.* § 365); TEX. REV. CIV. STAT. ANN. art. 4590i, § 4.01 (Vernon Supp. 1989) (requiring 60-days notice before suit, that pleadings state compliance, and allowing court to require verification).

[144] *See supra* note 105.

[145] *See, e.g.*, N.Y. CIV. PRAC. L. & R. 3403 (McKinney 1964 & Supp. 1989). Nonetheless, it is said that waiting for trial in New York can easily take ten years.

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5. Miscellaneous Provisions

Any statutory search discovers miscellaneous provisions that may somehow potentially affect certain medical malpractice cases. Some clearly were not part of conscious malpractice reform efforts. Most commonly, "*Good Samaritan*" statutes originally written to immunize physicians from liability for emergency care have added nurses, paramedics, volunteer firefighters, emergency personnel, and others.[146] Medical practitioners have sometimes also been given immunity from liability when acting as team doctor for *school athletics*.[147] Many provisions also deal with public liability or the liability of public employees — either for malpractice or general liability — or add additional provisions that can only be categorized as "all other."[148]

III. Understanding the Responses to Crisis — The 1980s

Not surprisingly, a second "wave" of legal reform followed the 1980s insurance crisis, as in the 1970s. Between 1977 and 1982 the impetus if not the need for reform ebbed along with claims frequency. Relatively few reforms occurred during this hiatus, although many amendments altered pre-existing, more comprehensive reform statutes.[149] The plausi-

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[146] Perhaps the broadest statute was enacted in Arizona. *See* ARIZ. REV. STAT. ANN. § 32-1471 (1986). This statute covers ambulance attendants, drivers or pilots, or any other person gratuitously and in good faith rendering emergency care at an emergency occurrence. *Id.* Like several others, this statute was added in 1972, before the separate liability crisis.

[147] *See, e.g.*, OHIO REV. CODE ANN. § 2305.231 (Anderson 1982 & Supp. 1987).

[148] *E.g.*, LA. REV. STAT. ANN. § 40:1299.39 (West Supp. 1988) (declaring that state-employed doctors are not personally liable for malpractice, state is); MASS GEN. L. ANN. ch. 71, § 55A (1981) (granting immunity to public school personnel from liability for emergency transportation or first aid to injured students); S.C. CODE ANN. § 44-7-50 (Law Co-op. 1985) (abolishing charitable and sovereign immunity for hospitals and medical facilities but retaining it for religious organizations; liability capped at $100,000); *see, e.g.*, ARIZ. REV. STAT. ANN. § 12-569 (1982) (evidence that party has interest in operation of health care insurer is inadmissable); CAL. BUS. & PROF. CODE § 2262 (altering medical records with fraudulent intent subject to disciplinary action and $500 civil penalty).

[149] Consider, for example, that after three years of major coverage, the AMA's 1978 review of state legislation devoted only one page to tort reform, listing only two enactments for the year — California provisions on expert witnesses' qualifications and certificates of merit for malpractice filings. *See A Capsule Review of State Health Legislation Enacted in 1978*, 7 STATE HEALTH LEGIS. REP. NO. 1, at 17 (1979) (under "Malpractice"). The next year's review did not even address malpractice. *See A Capsule Review of Selected State Health Legislation Enacted in 1979*, 7 STATE HEALTH LEGIS. REP. NO. 2 (1979).

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ble explanation is that squeaky wheels get the grease. This Part discusses 1980s developments affecting insurance, medical quality, and law. The next section, Part IV, compares the two decades, including an overall "scorecard" of enactments to date.

A. *Insurance Reforms*

In the 1980s, malpractice insurance reforms were uncommon at the state level. This striking drop in legislative activity reflects the improved malpractice insurance market with physician-run (and hospital-run) companies. Insurance availability was generally more of a problem for other professions and businesses than for medicine. Despite the new crisis, no new PCFs seem to have been founded and only a handful of JUAs; far more JUAs were terminated as unneeded or, in the case of Florida's troubled PCF, insolvent. Among other reforms this Project tracked, mandates for liability coverage appeared in a very few states, and some half a dozen jurisdictions limited insurance cancellation or imposed new reporting requirements.

The main 1980s insurance reform addressing insurance availability related only tangentially to malpractice and came at the federal level rather than in the states. Congress first passed the Risk Retention Act[150] in 1981 to assist insureds seeking product liability coverage.[151] The statute allowed purchasers to band together to buy group policies or to self-insure. In 1986 Congress expanded the statute to include liability coverage more generally, including medical malpractice.[152] In brief, the Act allows insureds with similar interests to "pool" and "retain" their liability risks as a "risk retention group," to be chartered in at least one state.[153] Such groups are an alternative to conventional insurers' creating and underwriting a group of insureds. "Purchasing groups" formed to acquire commercial coverage are also included within the Act's ambit.[154] The Act encourages forming these new enti-

[150] Product Liability Risk Retention Act of 1981, Pub. L. No. 97-45, 95 Stat. 949 (codified as amended at 15 U.S.C. § 3901-06 (1982 & Supp. IV 1986)).

[151] The Risk Retention Act responded to specific concerns about manufacturers' ability to purchase coverage, even prior to the full-blown 1980s crisis. *See* H. Rep. No. 97-190, 97th Cong., 2d Sess., 1981 U.S. Code Cong. & Admin. News 14,532.

[152] *See* Risk Retention Amendments of 1986, Pub. L. No. 99-563, 100 Stat. 3170 (1986) (codified at 15 U.S.C. § 3901-06 (Supp. IV 1986)). Congress concluded that insurance markets had a shortfall in capacity of billions of dollars, thus directly curbing availability of coverage and indirectly allowing great upswings in prices. H. Rep. No. 99-865, 99th Cong., 2d Sess., 1986 U.S. Code Cong. & Admin. News 5303.

[153] *See* 15 U.S.C. § 3901(a)(4) (1982 & Supp. IV 1986).

[154] *See id.* § 3903.

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ties by federally preempting most state insurance regulation outside the state that charters a group.[155] Congress found that prior regulation had inhibited the entry of new firms into the insurance market.[156] This foray into insurance is an unusual departure for the federal government. Still, the topic of whether more state insurance regulation should be federalized remains on the nearly permanent discussion agenda in Washington. Proposals of various degrees of seriousness are periodically made to require federal chartering of insurers or other forms of federal intervention.[157] To date, however, federal legislation has carefully avoided active regulation. Indeed, unlike the 1970s state mandates for JUAs or PCFs, the 1980s Federal Act was notably *de*regulatory.

The main insurance problem in the 1980s for medical providers has not been availability but price. This Project did not track state provisions on insurance prices, since states typically address pricing issues through insurance regulation rather than through statutes. In general, however, the trend seems to be away from competitively set insurance

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[155] The 1986 Amendments added to the list of allowable state regulation; states may regulate solvency, trade practices, and certain other matters. *See id.* § 3902(a) (Supp. IV 1986).

[156] Prior to the Act, an individual physician or institution could of course "self insure" by not buying any coverage at all (assuming no state mandate for coverage). However, groupings of individuals might easily run afoul of state laws against unlicensed sales of insurance, even if not selling to the public at large. Some states had already explicitly allowed medical providers to form their own insurance companies, *see supra* notes 77-78, or to self-insure formally, although still subject to some regulatory requirements. *See, e.g.*, FLA. STAT. ANN. § 627.357 (West 1984 & Supp. 1988). Thus, the Federal Act mainly reduces in-state regulation and allows the self-insurance pool to charter itself in the state it deems most favorable, then to operate nationwide. As a result, it is now easier for physicians and others to form an insurance entity without facing the full extent of state insurance regulation felt by the physician companies. There has not been the same rapid influx of risk retention entities that there were of physician mutuals in the 1970s. Nonetheless, it appears that a number of them are selling in various states.

[157] Since United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944), insurance has been recognized as commerce, potentially subject to federal regulation, but delegated to the states under the McCarran-Fergusson Act of 1945, Pub. L. No. 79-15, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. § 1011-15 (1982 & Supp. IV 1986)). Federal concerns periodically surface about the seeming inadequacy of state regulation, *e.g.*, GAO, ISSUES AND NEEDED IMPROVEMENTS IN STATE REGULATION OF THE INSURANCE BUSINESS (1979), or about the need for "tougher" antitrust enforcement, *e.g.*, U.S. DEP'T OF JUSTICE, A REPORT TO THE TASK GROUP ON ANTITRUST IMMUNITIES: THE PRICING AND MARKETING OF INSURANCE (1977). In the aftermath of the insurance initiatives in the 1988 California elections, see *infra* note 160, there may be further federal efforts to regulate insurers.

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rates toward more regulatory control.[158] The most significant reaction arguably came not from legislatures but from California's voters. Their rate-cutting initiative, Proposition 103, was approved in the November 1988 election.[159] Fueled mainly by voters' concerns about automobile insurance rates, the measure applies more broadly to casualty coverage, including medical malpractice. It calls for an immediate twenty percent reduction in insurance rates below 1987 levels and strong regulation by an elected insurance commissioner (California previously had "competitive" rate making and an appointed commissioner). Whether the cuts will be implemented as voted remains unclear, since the provisions faced immediate challenge in court.[160] In any event, other states are expected to consider similar proposals.

B. Quality of Medical Care

In the 1980s the quality of medical care has moved much closer to the top of health policy agendas for several reasons little related to malpractice concerns.[161] Medical professions naturally strive actively to improve their competence and care. State regulators and "patients' rights" advocates are increasingly active,[162] even though complaints remain about regulatory effectiveness.[163] Both public and private payers now realize that they cannot control health care spending without understanding quality effects, and they are trying to develop standards for

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[158] *See 1987 Was "As Predicted" for Tort Reform*, J. OF AM. INS., First Quarter 1988, at 23. Many states, however, loosened rate regulation by adopting "flex" rating — subjecting to regulatory review only rate increases above a certain range.

[159] *See, e.g.*, *Insurance: Voters' Revenge*, ECONOMIST, Nov. 19, 1988, at 33; Stevenson, *California Insurers In Turmoil*, N.Y. Times, Nov. 11, 1988, at A1, col. 6.

[160] *See, e.g.*, Stevenson, *California Court Delays Cuts By Voters in Insurance Rates*, N.Y. Times, Nov. 11, 1988, at A1, col. 1. Many companies have raised constitutional challenges; pending their resolution, physicians' insurers are also seeking an exemption from the law. *See* McGinn, *Fla. Rejects Damage Cap; Calif. Insurers Fight Rate Cut*, Am. Med. News, Nov. 18, 1988, at 3, col. 1.

[161] Assessment efforts have "mushroomed." OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, THE QUALITY OF MEDICAL CARE: INFORMATION FOR CONSUMERS 20 (1988).

[162] *See, e.g.*, Brinkey, *State Medical Boards Disciplined Record Number of Doctors in '85*, N.Y. Times, Nov. 8, 1986, at 6, col. 1; Murray, *Tightening the Patrol for Incompetents*, Med. World News, Dec. 9, 1985, at 54.

[163] *See* DEP'T OF HEALTH & HUMAN SERVS., REPORT OF THE INSPECTOR GENERAL (June 5, 1986); *see also* Wolfe, Bergman & Silver, *Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform*, in PUBLIC CITIZEN HEALTH RESEARCH GROUP REPORT (issued 1985).

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guidance.[164]

States continue to enact quality-oriented legislation in the 1980s, and as for insurance or tort reforms, quality enactments are generally of the same types as in the 1970s. Unlike the other reform areas, however, quality did not take a holiday between the crises; statutes continued to pass even after the end of the 1970s crisis, and the 1980s statutes have brought no renewed upsurge in laws.

Regarding specific reforms, states now almost universally require peer review, at least for hospital care.[165] All states have now enacted protections for peer reviewers and witnesses, although states increasingly make exceptions when a disciplined physician is challenging the review in court.[166] The U.S. Supreme Court has recently undercut the state legislative rationale by holding that federal antitrust actions can lie for improper peer review, despite contrary state immunities.[167]

As for insurance, the major new 1980s legislative initiative on malpractice and quality occurred at the federal level. The main federal interest in quality derives from its stewardship of Medicare and Medicaid. Good program administration has naturally sought to address the quality of care purchased, although these efforts are conceded to need considerable improvement.[168] In 1986 Congress went much further, for the first time directly addressing quality in the malpractice context. The particular concern was "bad docs," in the unfortunate jargon of Capitol Hill.[169] For some time, many have complained that states insuf-

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[164] *Cf.* McClure, *Buying Right*, BUS. & HEALTH, Sept. & Oct. 1985, at 43 (two-part article); *The Year in Review: Medicine by the Book*, Am. Med. News, Jan. 6, 1989, at 1, col. 1.

[165] *See, e.g.*, CAL. BUS. & PROF. CODE § 2282(c) (West Supp. 1989). The Joint Commission on Accreditation of Health Care Organizations requires peer review as a condition of accreditation, which means that Medicare and Medicaid hospitals (almost all) must also comply. *See generally* Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. & MED. 151 (1984).

[166] *See State Peer Review Statutes: Non-Discoverability and Confidentiality*, 15 STATE HEALTH LEGIS. REP. 13 (1987).

[167] *See* Patrick v. Burget, 108 S. Ct. 1658 (1988). The Court held that the conduct of the hospital peer review committee was required. *Id.* The Court added that under Oregon law, such conduct was not state action shielded from antitrust scrutiny because the state was insufficiently involved in the process. *Id.* The decision overturned Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986), which had held that the proceedings were immune, even though defendants had acted in bad faith. *Id.*

[168] *See, e.g.*, GAO, MEDICARE: IMPROVING QUALITY OF CARE ASSESSMENT AND ASSURANCE (1988).

[169] One can fault the expression for undue levity, but it at least goes beyond prior concern about the "sick doctor" or "impaired" physician in recognizing that lack of medical competence, not merely illness, addiction or senility, poses quality problems. Of

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ficiently regulate the continuing competence of medical practitioners beyond initial licensure.[170] A particular concern is that practitioners who even lose their license in one state could move to another state and begin anew, with no restrictions or other oversight of their practice. To their credit, the AMA and other medical groups have been vocal in calling for, among other quality-oriented reforms, interstate coordination of information about discipline.[171] A number of states, as already noted, have "beefed up" their medical licensure provisions, often including reporting of medical malpractice claims or settlements. The Federation of State Medical Boards also runs a computerized (since 1984) clearinghouse for such reports.[172]

The Federal Health Care Quality Improvement Act of 1986[173] advocated creating a federal data bank to maintain records on physicians, including reports on all malpractice settlements with payment and all significant hospital and state licensing board disciplinary actions.[174] The Act left much to the implementing regulation (*e.g.*, precisely what information was to be reported, what right the affected practitioner would have to submit for the record, and who should have access to the information).[175] Regulations were slow to appear, and funding problems delayed implementation. Solicitation of bids for a contractor to run the data bank went through two cycles,[176] and the final contract

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course, neither formulation addresses occasional mistakes by competent doctors.

[170] Thus, the earlier emphasis on continuing medical education. *See supra* note 93.

[171] *See* AMA REPORT, *supra* note 50, Rep. No. 3, at 16. In the mid-1970s, the AMA emphasized a two-part program of reinsurance pools for availability and tort reform for cutting claims and awards. *Id.* They also supported on general principles so-called "sick doctor" provisions to remove from practice those who might harm patients because of drug addiction, senility or emotional illness. *See, e.g.*, Todd, *Medical Malpractice: A Physician's View*, in A LEGISLATOR'S GUIDE, *supra* note 17, at 59.

[172] B. FURROW, S. JOHNSON, T. JOST & R. SCHWARTZ, HEALTH LAW: CASES, MATERIALS AND PROBLEMS 27 (1987).

[173] Pub. L. No. 99-660, 100 Stat. 3784 (1986) (codified at 42 U.S.C.A. §§ 11,101, 11,111-11,152 (West Supp. 1988)). Technical amendments were contained in the Public Health Service Amendments of 1987, Pub. L. No. 100-177, 101 Stat. 986 (1987) (to be codified at 42 U.S.C.A. § 11,137), and the Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, 101 Stat. 680 (1987) (to be codified in scattered sections of 42 U.S.C.).

[174] *See supra* note 173. The Medicare and Medicaid Patient and Program Protection Act of 1987's § 5, codified at 42 U.S.C.A. § 1396r-2 (1988), requires that states report on disciplinary actions by licensure authorities. *Id.*

[175] *See generally* Curran, *supra* note 88.

[176] In response to the first request, the federal government evidently received two serious bids. One was from the AMA, which subsequently withdrew, alleging that the ground rules had been changed and that there was insufficient clarity about how much

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was not awarded until early 1989.[177]

The Act seems likely to affect only one aspect of malpractice problems — the severe or repeat offender, who is meant to be curtailed in her career prospects. All hospitals or other entities hiring a physician are required to check the data bank for information about that physician; what they do with the information is up to them. This duty means that, should a problem develop, employers who do not check may face a lawsuit at some future date for negligent failure to monitor physicians. State regulators presumably will also check when doctors newly seek licensure in their state. Otherwise, the Act contains no enforcement mechanisms. The Act may very indirectly affect quality more broadly through its encouragement of hospital peer review; it gives limited immunity from liability for participation in review activities.[178]

C. Tort Reforms

Almost every 1980s state tort reform first surfaced in the previous decade: the provisions simply spread to more states a decade later. Reformers and legislators in the 1980s seek a similar roll-back of plaintiffs' prerogatives and seem naturally to have turned to the methods already "on the table" from other states' prior experiences. Thus, Table 1 still serves to characterize almost all legislation. In both eras, reform statutes most commonly targeted the size of recoveries.[179]

Different states enacted the 1970s reforms in the 1980s, and different emphases emerged. For example, through 1987 legislatures very seldom addressed ad damnums, arbitration, informed consent, res ipsa loquitur, notice of intent to sue, and statute of frauds — all much more "popular" in the 1970s. Some reforms were well represented in both eras, such as collateral source offset (increasingly enacted as a permissive rather than mandatory offset in the 1980s), expert witness, professional

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work was required. Gianelli, ***Data Bank to Chronicle Licensing, Malpractice Actions***, Am. Med. News, Jan. 13, 1989, at 11, col. 1; Robinson, *M.D. Malpractice Data Bank: Nobody's Happy*, HOSPITALS, Sept. 5, 1988, at 28.

[177] The Department of Health and Human Services awarded a five-year contract to Unisys Corp. in January 1989. *Id.* at 11, col. 1; *Unisys Corp. to Set Up A Data Bank on Doctors*, Wall St. J., Jan. 3, 1989, at B4, col. 3.

[178] *See* 42 U.S.C. §§ 11,111-11,115 (Supp. IV 1986). Civil rights actions are excepted, as are those by the Federal Trade Commission, the U.S. Department of Justice, and state or federal Attorneys General.

[179] One seemingly new reform idea in the 1980s — not widespread — has been to offset damages for loss or impairment of earning capacity by probable future income taxes. *See* HAW. REV. STAT. § 663-8.3 (1986); N.Y. CIV. PRAC. L. & R. 4546-c (McKinney 1988).

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standard of care, and periodic payment (with a trend to permissive statutes here as well). Many more states in the 1980s adopted the following reforms: awarding costs in frivolous cases, limiting non-economic and punitive damage awards, requiring certification of meritorious suits, and changes in joint and several liability. The last two reforms went from being rare to being relatively common.

It thus appears that the 1980s have no wholly new "magic bullet" to cure tort ailments. More states did enact apparently "strong" reforms, such as caps on awards, collateral source offsets, periodic payment, and changes in joint and several liability. State legislatures and to a certain extent federal policymakers were also far more likely than a decade before to pass generic reform statutes. For example, provisions were quite likely to apply across the board to all tort suits, all civil litigation, or all personal injury suits, rather than simply to cases of medical malpractice. Two practical realities were surely influential. First, medical reformers very often chose to form coalitions with business groups and others hurt by the wider crisis to seek broader reform. Second, state supreme courts had not infrequently objected to the 1970s malpractice-only statutes.[180] Nonetheless, even in the 1980s, concerted efforts continue to address malpractice as a separate problem, and a number of states have passed comprehensive reforms specifically oriented to malpractice.[181]

Finally, although most 1980s reforms had previously been enacted, two apparently novel and significant ideas are worth noting. One notable development, thus far visible in only two states, concerns severely deformed newborns. These laws seek to remove cases of severe neurological birth injuries from the tort-law-and-liability-insurance system into a purely social-insurance scheme. This scheme is one version of a "no fault" approach, which trades an easier finding of responsibility for a far more structured approach to damages.[182]

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[180] New Hampshire's reform efforts, for example, suffered perhaps the 1970s' most thoroughgoing court reversal. *See* Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980). The most probable reason was that it singled out malpractice from other types of injury. Most of the state's more recent enactments have been generic. *See* N.H. REV. STAT. ANN. § 508:4, :4-c, :4-d, :4-e (Supp 1988) (concerning, respectively, statute of limitations, elimination of ad damnum, cap on non-economic loss, and contingent fees). *But see id.* § 507-E:2 (Supp. 1988) (establishing burden of proof in medical injury cases).

[181] *See, e.g.*, 1985 Fla. Laws ch. 85-175.

[182] Passed in early 1987, The Virginia Birth-Related Neurological Injury Compensation Act, VA. CODE ANN. § 38.2-5000 to -5021 (Supp. 1988), substitutes a panel judgment for tort recovery. The statute automatically compensates any newborn

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A second development also seeks wholly to replace one part of the current liability system with a new approach. The National Childhood Vaccine Injury Act of 1986[183] authorized a "no fault" system to handle victims of vaccine-related accidents.[184] The Act calls for compensation to all who suffer adverse reactions during vaccinations, but it limits the amount of available damages. Vaccines pose a particular need to act, for public health calls for universal vaccination of certain kinds. Allowing patients or providers or both to decide not to undergo vaccination because of liability or personal fears would not be acceptable. The same rationale does not necessarily apply to all of tort reform.

IV. Reform Eras Compared: The 1970s and the 1980s

A. *Some General Observations and a "Scorecard"*

To recapitulate: there were two distinct "waves" of legal reforms in insurance and in tort law, responding to the two insurance crises, although a few legal changes occurred prior to the initial crisis. Quality reforms seem to march to a more consistent drummer — not a bad idea, given the social consensus of a considerable need to improve. The same substantive provisions introduced in the 1970s were also enacted (in more states) in the 1980s, though often with new "wrinkles"[185] and

deemed to have had "injury to the brain or spinal cord caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living." *Id.* The provisions are clearly geared to one limited type of case that is very expensive under the current system. Payments under the new regime are to be financed by assessment of $5000 per year on participating doctors who perform obstetrical services, a $250 assessment on all other licensed physicians, and $50 per infant delivered from hospitals. *Id.* Later that year, the Florida Birth-Related Neurological Injury Compensation Plan of 1987 similarly barred lawsuits against participating doctors for such injuries, referring such claims instead to a medical advisory panel.

[183] Title III of the Omnibus Health Act of 1986, Pub. L. No. 99-660, 100 Stat. 3743 (1986) (codified at 42 U.S.C. § 300aa-1 to -33 (Supp. IV 1986)).

[184] *See id.* Evidently, funding for compensation is not yet in place. North Carolina's statute is not dissimilar to the federal law, and passed earlier in 1986. *Cf.* N.C. Gen. Stat. § 130A-422 to -434 (1987). Payment is automatic before the state industrial commission, and benefits are limited. *Id.* Interestingly, the state attorney general is subrogated and can sue a doctor or manufacturer for negligence to recover payments. *Id.* California has also addressed the issue of liability for vaccinations, legally immunizing providers who give state-mandated immunizations, except for gross negligence or willful misconduct. *See* Cal. Health & Safety Code § 429.36 (West 1979). However, the statute has not provided compensation to victims. *See id.*

[185] An unusual development comes from Florida, whose medical providers suffered

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with considerable shifts in the "popularity" of particular provisions. Notably, far fewer states addressed availability of insurance through JUAs, PCFs, and similar entities; their increasing interest in regulating prices charged by insurers was more significant. The major development on the "supply side" of the market was federal — the previously discussed Risk Retention Act.

Tort reforms attracted far more attention at the state level (and at least discussion at the federal level). In both decades, the most obvious characteristic of these reforms was that almost all were defense oriented, a reaction to the continuing pro-plaintiff trends in judicial development.[186] Casual empiricism suggests that more states enacted apparently strong reforms in the 1980s (caps, collateral source offsets, structured awards, changes in joint and several liability), while fewer new states enacted seemingly less consequential efforts (bars on dollar ad damnums, informed consent changes, statutes of frauds, res ipsa loquitur modifications). Arbitration and pretrial screening almost disappeared as reforms, perhaps reflecting concerns that they do not cut system costs.[187] Indeed, very few states sought by statute to reform judicial processes.

Overall, after the 1987 legislative sessions (the end of this Project's systematic review), reform was widespread but remained far from unanimous in the fifty states and the District of Columbia. Table 2 gives a comprehensive "scorecard."

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perhaps the most in the 1980s crisis. This development is encouraging settlements by mandating a settlement conference, FLA. STAT. ANN. § 768.58 (1988) (renumbered FLA. STAT. ANN. § 766.108 (West Supp. 1988)). The statute used to also provide that if either side held out for a trial after receiving an offer to settle, that party must pay full costs and attorneys fees unless the trial yields a result 25% more favorable. *Id.* § 768.585 (repealed 1986). Florida also provided for a very limited form of arbitration — encouraging post-litigation arbitration by allowing defendants to concede liability if and only if plaintiffs agree to accept arbitration for damages. FLA. STAT. ANN. § 768.575 (West Supp. 1988). States also continue to address how expert medical testimony is delivered. A new concern has emerged with national witness-brokering firms that accept contingency fees from plaintiffs' attorneys and pay experts flat fees to appear. Courts themselves have begun to set new standards. *See generally* Richards, *Doctors Seek Crackdown on Colleagues Paid for Testimony in Malpractice Suits*, Wall St. J., Nov. 7, 1988, at B1, col.2.

[186] Not all enactments favored the defense. In addition to arbitration and other reforms aimed at judicial process, *see supra* notes 98-102 & 144-45, some tort reforms in some states favored plaintiffs as well. Many states codified the discovery rule for the malpractice statute of limitations, while simultaneously attempting to limit its reach. However, some enacted an expansive version of the rule.

[187] *See* text accompanying *infra* notes 221-23.

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TABLE 2
SELECTED LEGISLATIVE REFORMS: AN OVERALL SCORECARD

Type of Enactment Specific Provisions	Frequency of Enactment in States Few (<10)	 Numerous (10-25)	 Majority (26-39)	 Vast Majority (40 & over)
A. Reforms of Insurance				
1. Joint Underwriting Associations (JUAs)				X
2. Limits on insurance cancellation		X		
3. Mandates for liability coverage		X		
4. Patient Compensation Funds (PCFs)		X		
5. Reporting requirements		X		
B. Aimed at Medical Quality				
1. Peer review requirements, protection from lawsuits				X
2. Powers of disciplinary boards increased			X	
3. New reporting requirements				X
4. Requirements for continuing medical education		X		
C. Reforms of Tort Law and Process				
Aimed at frequency of lawsuits				
1. Arbitration		X		
2. Attorney fee controls		X	X	
3. Certificate of merit		X		
4. Costs awardable				
5. Pretrial screening panels			X	
6. Statutes of limitations			X	
Aimed at size of recoveries ("severity"):				
1. Ad damnums restricted				X
2. "Caps" on awards (non-economic, total)			X	
3. Collateral source offset (permissive, mandatory)		X		
4. Joint & several liability changes			X	
5. Periodic payment of damages ("structured" awards)		X		
6. Punitive damage limits	X			
Aimed at plaintiffs' difficulty (or costs) of winning:				
1. Expert witness requirements		X		
2. Informed consent limits			X	
3. Professional standard of care reasserted		X		
4. Res ipsa loquitur restrictions		X		
5. Statute of frauds for medical promises		X		
Aimed at functioning, cost of judicial process:				
1. Mediation	X			
2. Notice of intent to sue	X			
3. Precalendar conference required	X			
4. Preferred scheduling for malpractice cases	X			

Note: Table 1's "Miscellaneous" category dropped from statute-by-statute count
Source: Urban Institute Survey.

Not all changes in approach for Table 2's reforms can be discussed at any length, but it is helpful to add some detail. Thus, caps on awards are discussed as an illustrative and very important reform — generally seen as the "strongest medicine" available. Experience with these reforms exemplifies several of the 1980s trends, as Table 3

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demonstrates.

TABLE 3

"CAPS" ON AWARDS, 1975 Through 1987

	1975-1977	1986 & 1987
enacted in:	16 states	21 states
of which:		
	4 noneconomic damages only	19 noneconomic damages only
	12 total damages	3 total damages
	15 med mal only	12 med mal only
	1 generic	10 generic
	3 held constitutional	0 held constitutional
	6 unconstitutional	2 unconstitutional

N.B. Many "caps" have significant exceptions; totals include a few double-counted states

Source: Urban Institute Survey

One should first observe that all the caps took effect either in 1975 through 1977 or in 1986 and 1987.[188] Moreover, more states acted in a two-year period in the 1980s than in the three-year period of the 1970s — twenty-one states versus sixteen. A shift occurred from those seeking to cap all damages awardable (often with exceptions for medical damages) to those capping only intangible or "noneconomic" damages.[189] Another shift was from an almost exclusive focus in the 1970s on medical malpractice to a nearly even split in the 1980s between malpractice and generic caps. The Table also indicates that a substantial share of the 1970s legislation was held unconstitutional (not typical for less stringent enactments); for the 1980s caps, the jury is still out, although

[188] This Table tracks legislation's effective date, most commonly the same as the enactment date because the legislation was given emergency status, but often some months after the enactment date.

[189] In an interesting 1980s development, some states have specifically provided that the cap shall grow over time to be "indexed" for inflation. *See, e.g.*, MO. ANN. STAT. § 538.210 (Vernon 1988). One state has taken the unusual step of "scheduling" the ceiling on noneconomic awards. *See* WASH. REV. CODE § 4.56.250 (1988) (using limit of 0.43 times the average annual wage times the life expectancy or 15 years, whichever smaller).

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their more generic focus should make them less susceptible to equal protection attacks.

B. *Three Particularly Notable Developments*

Three changes in the 1980s statutes deserve special emphasis. The first change is a shift toward generic enactments from malpractice-specific legislation. The 1970s crisis was truly one of malpractice, whereas 1980s legislatures faced a general liability crisis, which naturally focused the legislative reaction.[190] An open question is to what extent malpractice problems and dynamics are different from other personal injuries and ensuing litigation.

The second change is that the federal government took a far more active stance in the 1980s than in prior years.[191] Throughout the late 1960s and early 1970s, malpractice drew federal attention, but action was limited to generating information.[192] The 1980s saw far more federal activity, including for the first time, significant legislative enactments. Like the states before it, the federal government first addressed insurance problems (the Risk Retention Act), then quality of medical care (the Quality Improvement Act) and tort reform (to date only through reports and exhortations to states,[193] except for the Vaccine In-

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[190] Iowa's Act Relating to Liability and Liability Insurance, S.F. 2265, 71st G.A. (1986), is a good example at the "macro" level of a broad reform. It enacted a mix of provisions aimed at medical malpractice, all professional liability, products liability, and all suits for personal injury or wrongful death. *See generally* Tobin, *The Current Status of Tort Reform in Iowa*, 35 DRAKE L. REV. 859 (1986-1987). At the "micro" level of one specific reform provision, consider the evolution of New York's collateral source statute: N.Y. CIV. PRAC. L. & R. 4545 (McKinney Supp. 1987) (section first applied collateral source offset to medical malpractice in 1975, then to actions against public employers and employees in 1984; in 1985 and 1986 added dental and podiatric suits; and in 1986, added all actions for personal injury; *see also* supp. pract. commentaries).

[191] An interesting observation is that Washington, D.C., atypically for the 1980s saw far more intervention from federal lawmakers than from lawmakers of the District of Columbia, which had no substantial tort reform at any time. Presumably this reflects the "conservative" nature of this style of reform.

[192] This tendency included not merely the normal legislative hearings but also the farsighted effort to assess problems in the HEW's SECRETARY'S COMMISSION REPORT, *supra* note 4. In the mid-1970s, although there were proposals for federal action, no legislative or administrative initiatives went very far. *See, e.g.*, HEALTH SYSTEMS RES. INST., NAT'L CENTER FOR HEALTH SERVS. RES., INTERMOUNTAIN MEDICAL MALPRACTICE SEMINAR 1-9 (1976) (remarks of Utah's Gov. Rampton and Sen. Moss).

[193] *See, e.g.*, DEPARTMENT HEALTH & HUMAN SERVS. (DHHS), REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE (1977) [hereafter DHHS TASK FORCE REPORT]; GAO, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION

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jury Act). Traditionally, insurance regulation, medical regulation, and the running of judicial systems and tort rules have all been left to the states, although ample justification exists for federal involvement in insurance, medical quality, and liability law.[194] However, Congress has addressed malpractice rules only indirectly — by immunizing medical providers from lawsuits for failure to provide care held inappropriate by federal controls on utilization and quality.[195] Especially in tort reform, what division of function between levels of government is most appropriate is not clear.[196]

Third, state and federal lawmakers alike seem far more receptive in the 1980s to much more novel and far-reaching tort reforms. The quasi-no-fault concept is once again being taken seriously, at least partly because of the Virginia and Florida obstetrical statutes. One approach is to delimit the scope of reform by covering only "designated compensable events."[197] Another approach is to allow defendants to make plaintiffs "offers they cannot refuse" to settle for out-of-pocket economic losses without trial on liability.[198] The American Medical Association has produced a proposal to replace the entire tort-based

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(1987); TORT POLICY WORKING GROUP, REPORT ON THE CAUSES, EXTENT AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY (1986). The DHHS Task Force even produced model legislation, which staffers have sought to persuade states to adopt. *See* DHHS TASK FORCE REPORT, *supra* ("Model Health Care Provider Liability Reform Act of 1988"). The model included many of the existing tort reforms, but went further to stress improvements in judicial administration and other measures. *See id.*

[194] For example, insurance markets are arguably national, even international in scope, and liability costs may affect international competitiveness of U.S. industry. Federal involvement in health care is thoroughgoing, though deferential to state regulation, and Medicare and Medicaid pay for their share of malpractice premiums, plus whatever increment results from defensive medicine.

[195] This statutory shield appeared first for the 1970s PSRO program, *supra* note 96, then for its 1980s successor of PROs. For discussion of PROs, see 42 U.S.C. § 1320c-6(c) (1982).

[196] One can argue that federal action is needed because state legislatures will not take strong enough action for political reasons or cannot because of their courts' constitutional rulings on tort reform. *Cf.* Smith, *Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws*, 38 OKLA. L. REV. 208, 229 (1985) ("vulnerability" of reform to state judicial attack "suggests the wisdom of federal tort reform"). Such a conclusory argument seems insufficient; sorting out appropriate roles necessitates more systematically matching means and ends. For one treatment, see Blumstein, *Medical Malpractice: Thinking About the Federal Role* (unpublished policy paper, Vanderbilt Univ. 1987).

[197] Tancredi, *Designing a No-Fault Alternative*, LAW & CONTEMP. PROBS., Spring 1986, at 277, 277, 281-83.

[198] O'Connell, *supra* note 27, at 131-34.

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system of litigation with an administrative tribunal modeled in many ways on the processes of the National Labor Relations Board.[199] The proposal takes a worker's compensation-like approach but nonetheless retains a fault standard for determining liability, albeit with a slightly modified standard of care. Fault would be judged by national standards of "good practice," a change which would help some claimants. The AMA holds that its system's simplicity, ease of access to a state-paid lawyer and a state administrative apparatus, and tightening of the standard of care would promote the filing of more valid claims, thus offsetting the "losses" of claimants' traditional rights to potentially larger recoveries. However, the proposal would clearly curtail access to the courts.

Private contracting has also received attention, although less in legislatures than in journals. Contracting would allow doctors and patients to "opt out" of the tort-law-and-insurance system of resolving medical misadventures, instead fashioning their own system through mutually satisfactory private agreements.[200]

V. Assessing the Reforms

It is easier to give a scorecard than a report card. The following observations are necessarily preliminary. This Part considers first reforms of insurance and medical quality.

A. *Reforms of Insurance and Medical Quality*

The insurance-oriented legislation of the 1970s (mainly JUAs and PCFs) seems to have "worked" in helping to assure availability of medical malpractice coverage — the 1970s legal reforms' highest priority. If insurance crisis was the problem, however, legal change has been only part of the solution. It is uncertain how influential legislative reforms were compared to the emergence of provider-insurers and the other private developments.[201] The 1970s successes seem to have ameliorated the 1980s crisis for medical providers relative to other businesses — they

[199] *See* Specialty Soc'y Medical Liability Project, AMA, A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based, Administrative System (1988).

[200] For a thorough debate on the merits and demerits of such a system, both from practical and legal standpoints, see *Medical Malpractice: Can the Private Sector Find Relief?*, Law & Contemp. Probs., Spring 1986, at 1.

[201] It is instructive that most 1970s "stand by" JUAs were never activated by insurance commissioners' findings of inadequate private coverage — even in California, a leading "crisis" state. In the 1980s, JUAs and PCFs have seemed little needed.

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could at least get coverage, albeit at sharply higher prices. It is too soon to gauge the impact of the Risk Retention Act.

The quality reforms were targeted more at incompetent practitioners than at mistakes by competent ones. Assessing the legislation on medical quality must also await further research. "Quality" is a poorly understood term; neither agreed upon standards of measurement nor national data exist to help assess the functioning of the 1970s many and varied enactments.[202]

B. *Tort Reforms*

Of the three types of reform, tort reform is the most important to assess and in the past has received the most attention. Tort law is central to bringing and resolving claims for medical injury and underlies long-term insurance pricing and availability, if not short-term crises.

1. Tort Reforms Are Succeeding on Their Own Terms

Evidence of several kinds is accumulating that many tort reforms "work" as intended. What defines "success" for tort reforms? One can begin by reiterating that increasingly more state legislatures have enacted them. The record is certainly one of political success,[203] which seems to be continuing, as business and other groups continue to press for tort reforms.[204]

Judicial success is also important. Here, reforms' record seems considerably better than their reputation. Considerable publicity has gone to judicial decisions invalidating the entire statutory reform schemes in New Hampshire and North Dakota,[205] and to the overturning of selected reforms, especially caps on awards.[206] Less attention has gone to

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[202] Data on medical effectiveness remains rudimentary, and data on quality are even more so. *See, e.g.*, Roper, Winkenwerder, Hackbarth & Krakauer, *Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice*, 319 NEW ENG. J. MED. 1197 (1988). This lack of data prevails even in seemingly the most obvious case — allegedly incompetent physicians. The federal data bank just begun, *see supra* note 177, offers a unique new source of national data on the results of state licensure systems, hospital disciplinary actions, and malpractice settlements.

[203] *See generally* Table 2 and text accompanying *supra* notes 185-87.

[204] *See, e.g.*, AMERICAN TORT REFORM ASS'N, LEGISLATIVE RESOURCE BOOK (1987) (containing model bills and explanations; updated periodically).

[205] *See* Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980); Arneson v. Olson, 270 N.W.2d 125, 131 (N.D. 1978).

[206] Even without a thorough constitutional review, one may note that these most drastic of reform solutions seem to have fared worst in court. As already noted, states' highest courts invalidated nearly half of these mid-1970s caps. The main constitutional

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the thoroughgoing success of arguably the two most comprehensive sets of reform, those in California and Indiana.[207] In fact, most reforms in most states have survived — either by being upheld or from lack of challenge leading to reported decision.[208] This general success of reforms in court is greatly underappreciated.

The question remains whether even these successfully passed and upheld reforms work as intended by reform advocates. Some legal scholarship has sought to address just what difference particular versions of reforms make. Legal scholars apply common-sense judgment about the strength of provisions and about how well proposed solutions match perceived problems. One can note, for example, that some apparent reforms actually codify common-law rights rather than significantly curtailing them[209] (though such enactments may forestall further

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objection to caps and other provisions is essentially equal protection, however phrased — an objection that medical malpractice had been singled out for differential treatment. *See, e.g.*, *Carson*, 120 N.H. 925, 424 A.2d 825. *See generally* Jenkins, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 S. CAL. L. REV. 829 (1979); Redish, *supra* note 48, at 759. Other objections include substantive-due-process-sounding objections that no quid pro quo was given for curtailing common law rights. *See* Fein v. Permanente Medical Group, 474 U.S. 892 (1985) (J. White, dissenting). Courts also factually question whether any crisis existed to justify legislative cutbacks in rights. *See, e.g.*, Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976) (remanding for trial court finding on existence of crisis); Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983) (invalidating 1981 screening-panel reform). Particular state constitutional prohibitions of "special legislation" echo the equal protection concerns. *See, e.g.*, *Jones*, 97 Idaho at 859, 555 P.2d at 416-17. Other special state constitutional provisions mandate open access to courts, *see, e.g.*, Smith v. Department of Ins., 507 So. 2d 1080 (Fla. 1987), or no legislative interference in injury awards, *see, e.g.*, Kenyon v. Hammer, 142 Ariz. 69, 688 P.2d 961 (1984). *See generally* Smith, *supra* note 196, at 208-16. Some courts also held that legislatures had unconstitutionally entered the appropriate sphere of judicial authority conferred under the constitution. *See, e.g.*, *Arneson*, 270 N.W.2d 125, 131. In other cases, reform provisions have been invalidated not on their own merits but as part of an entire statutory scheme whose main provisions were held unconstitutional, as in New Hampshire and South Dakota. *See, e.g.*, *Carson*, 120 N.H. 925, 424 A.2d 825; *Arneson*, 270 N.W.2d 125.

[207] *See, e.g.*, Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (upholding limits on damages), *appeal dismissed*, 474 U.S. 892 (1985); Roa v. Lodi Medical Group, 37 Cal. 3d 920, 695 P.2d 164, 211 Cal. Rptr. 77 (1985) (upholding limits on attorney fees); Johnson v. St. Vincent Hosp., 273 Ind. 374, 404 N.E.2d 585 (1980) (upholding whole reform statute).

[208] This judgment comes from this Project's reading of annotations to reform state code sections and the AMA's compilations. *See supra* notes 49-50; *see also* Robinson, *supra* note 2, at 21 n.87.

[209] Thus, many enactments about expert witnesses, the professional standard of care to be applied, informed consent, res ipsa loquitur, and similar provisions do not signifi-

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pro-plaintiff liberalization), that reforms also contain limiting exceptions or exclusions[210] (though such caps still offer defendants more protection than no caps), and that reforms may address minor or even nonexistent problems.[211] Given such formalistic analysis of the thoroughness of reform, it has been suggested that legislatures meant to effect very little change.[212] This assessment seems unduly cynical, especially when states have repeatedly acted over time to strengthen reforms (as in New York) or to re-enact new versions in the wake of judicial invalidation (as in Kansas and New Hampshire).

But the proof of the effectiveness pudding is in the eating. Most importantly, the growing body of empirical evidence about the effects of tort reforms is increasingly positive for the reformers.[213] Researchers have assessed success according to the second main goal of reformers — not just ensuring the availability of liability coverage but also lowering premiums, at least relative to what these would have been without reform.[214] Many other reformers' goals are very hard to define and to assess empirically.[215] Support for the effectiveness of reforms comes

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cantly vary from the traditional "black letter" law. In other cases, courts have reinterpreted statutory provisions to reassert liberalized common-law doctrine, thus undercutting reformers' goals. *See* Robinson, *supra* note 2, at 29 n.127 (stressing this point regarding both standards of care and burdens of proof).

[210] For example, provisions that limit total damages to a fixed cap often exclude future medical expenses from that cap on the realistic theory that these are not bounded. Likewise, requirements that collateral sources be offset against otherwise payable malpractice recoveries typically exclude certain collateral sources (especially life insurance) and also reduce the offset by premiums paid for the benefit over some period of time.

[211] For example, despite the very large concern over excessive punitive awards, one may conjecture that at least for malpractice cases, punitive awards are seldom a factor. This Project's preliminary analysis of almost 500 jury verdicts in the state of Florida and in Kansas City for 1975-87 has found only a few punitive awards. *See supra* note 52.

[212] *See* Robinson, *supra* note 2, at 28-30. Robinson stated that the "flurry of legislative activity was . . . more show than substance." *Id.* at 30.

[213] For a more detailed summary, see F. SLOAN & R. BOVBJERG, *supra* note 5.

[214] This last point is seldom appreciated. The common-sense, political viewpoint is that "reduction" means a true drop in premiums rather than a change in the rate of growth. An actual drop is much to ask in today's litigious climate. Similar misunderstandings arise, for example, in policy discussions of social security spending, which continues to grow despite true "cuts" in entitlements.

[215] As noted, these goals include cutting back frivolous lawsuits, reducing the frequency of extravagant awards, improving the accuracy of legal decisions, reducing the costs of going to court, lessening defensive medicine, and even stemming the erosion of doctor-patient relations. These goals all seem laudable on the surface, but it is very hard to define terms (much less to find data relevant to those definitions), to make

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from opinion surveys,[216] actuarial estimation,[217] and claims evaluation.[218] Moreover, one can hardly avoid noticing that California, a leading crisis state in the 1970s and among the first to enact strong reforms, experienced no real crisis in the 1980s. Indiana also did not. By contrast, New York and Florida had far less sweeping tort reforms and suffered during both decades in crises.

The most credible assessments in the public domain are probably those of independent empirical researchers who have statistically assessed tort reforms' effects on claims frequency and severity and on insurance premiums.[219] After conducting several analyses over some years, Patricia Danzon concluded that some reforms have affected claims frequency and severity, which underlie premiums.[220] Specifically, she concluded that reductions in the statute of limitations reduce

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causal connections, and to conduct an assessment. All assessments would inherently be intuitive and judgmental.

[216] According to a General Accounting Office survey, many opinion leaders in six representative states feel that reforms have already had or will soon have an influence, although the opinions were quite mixed. Only in Indiana, a state with perhaps the most stringent regime in the country, was there near-unanimity that reform had significantly reduced claims experience. *See* GAO, MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS (1986).

[217] A leading firm's assessment of consulting actuaries estimated through actuarial judgment that a package of leading reforms would save 28% in malpractice insurance costs. *See* MILLIMAN & ROBERTSON, INC., ACTUARIAL ANALYSIS OF AMERICAN MALPRACTICE ASSOCIATION TORT REFORM PROPOSALS (1985).

[218] The Insurance Services Office (ISO), the leading national property casualty insurance rating bureau, had 1200 claims assessors at insurance companies across the country evaluate specific personal injury scenarios under various assumptions about the state of generic tort law and reforms. *See* HAMILTON, RABINOWITZ, & ALTSCHULER, INC., CLAIM EVALUATION PROJECT (1987). They estimated that implementing the "pure" forms of eight tort reforms could save over 40% in claims values of personal injury, although the study had no malpractice-specific scenarios. *Id.* When asked about the reforms actually enacted in their own states, however, the assessors were generally much more pessimistic, citing the considerable "loopholes" in existing reforms. *Id.*

[219] The researchers' technique is multivariate regression analysis, which essentially measures separately the impact of each specified tort reform, while holding constant other reforms and numerous background variables also thought to influence claims or premiums. *See generally* Rubinfeld & Steiner, *Quantitative Methods in Antitrust Litigation*, LAW AND CONTEMP. PROBS., Autumn 1983, 69, 88-104 (1983).

[220] P. DANZON & L. LILLARD, THE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS: RESEARCH RESULTS AND POLICY IMPLICATIONS (1982); Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW AND CONTEMP. PROBS., Spring 1986, at 57 [hereafter, Danzon, *New Evidence*]; Danzon, *The Frequency and Severity of Medical Malpractice Claims*, 27 J.L. & ECON. 115 (1984).

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claims frequency, as do collateral source offsets; screening panels had no effect, and arbitration slightly increased claims.[221] Claims severity is reduced most by caps on awards (some 23 percent over some years), but it is also reduced by collateral source offset and possibly by arbitration.[222] Many reforms, however, either were not tested or showed no statistically significant effects. In a more recent study, using more detailed data from a longer time period, Sloan and colleagues found stronger effects of reforms than Danzon on claims payment — specifically including caps on awards, mandatory collateral source offset, arbitration, and costs awardable provisions.[223]

Thus, reforms on average are increasingly being shown to succeed on their own terms. However, the workings of reforms remain only partly illuminated. How do particular reforms achieve their savings? What features make some versions of a reform more consequential than others? Moreover, it is less well documented that malpractice premiums have dropped to the extent that claims and awards have.[224] Perhaps most importantly, no empirical assessment has yet been able to explain the ups and downs of malpractice claims: the crisis-associated rise and subsequent fall in claims frequency in both the 1970s and 1980s. This development perhaps reflects the tort reform climate created nationwide, almost independent of particular reforms enacted in individual states. The crisis-generated publicity about liability problems may subtly have altered the general attitudes of claims adjusters, judges, and

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[221] *See supra* note 220.

[222] *See id.*

[223] Sloan, Mergenhagen & Bovbjerg, *supra* note 53. This study used the very much more detailed data base on reforms described in this Article, *supra* note 49.

[224] The only published multivariate analysis of premiums found virtually no impact of any reforms through 1978, though it may have been too early to find effects. *See* Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment*, 9 J. HEALTH POL., POL'Y & L. 629 (1985). Danzon so argues, asserting that insurers will not adjust rates downward until reforms have demonstrated an effect on claims, which takes considerable time. *Cf.* Danzon, *New Evidence*, *supra* note 220, at 58-59. How quickly insurers adjust is an unresolved empirical issue. Theoretically, insurance premiums should "discount" well into the future experts' best guess about the eventual effects of any tort reform. However, insurers may not have confidence in reforms' being upheld and may thus take a "show me" attitude about recognizing effects in premiums. Alternatively, insurers may expect savings, but they may not immediately pass them through to policyholders, preferring instead to build surplus against a time when claims might again rapidly rise. According to a survey of 14 companies by The Urban Institute and Vanderbilt University, insurers vary in their reports about what credibility they give tort reform in their rate making. *See supra* note 52. This Project is also undertaking additional study of insurance premiums, although results are not yet available.

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jurors about liability cases and thus discouraged plaintiffs and their attorneys from bringing some claims. If so, the effectiveness of tort reforms is even stronger than supposed, even if less direct and possibly not sustainable over time.

On the other hand, changes in social attitudes could bring forth far more claims — for much more malpractice seems to exist than now surfaces as claims.[225] Considerable leeway thus seems to exist for claims frequency to change, both in reacting to tort reform (or common-law development) and in responding to underlying social trends not yet understood. Thus far, tort reforms have mainly tinkered with the basic tort-law-and-insurance system. It is unclear how much (if at all) such laws can influence root causes like the extent of negligent injury, the willingness of injured parties to seek legal redress, and the underlying attitudes of potential and actual jurors about tort compensation. Thus, absent other changes, one suspects that claim trends in the long run will continue to rise, after the one-time reductions achieved by some reforms. That the AMA is seeking a wholly new compensation system — not settling for the tort reforms it also wants for the judicial system — indicates that physicians, for one group, may share this expectation of renewed expansion.

In the long run, however, much depends on how the common law of tort continues to evolve. If past pro-plaintiff developments have brought us to the current state of affairs, future ones more sympathetic to defense could move us back.[226] Different approaches to judicial adminis-

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[225] *See* text accompanying *supra* note 37.

[226] On one hand, judges and juries may continue to take an ever more expansive view of rights and damages. New causes of action are continuing to evolve even as old doctrines are legislatively reduced. *See* Wickline v. California, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986) (stating in dictum that health insurer is potentially liable for cost controls' impact on patients, posing possibility of new conflicts with providers and encouragement of dissatisfied patients suing everyone). One should also consider the potential impact of two developments in the academic literature: first, most economists are now convinced that people value risks of injury and death at far higher levels than now prevail in personal injury litigation. *See, e.g.*, Miller, *Willingness to Pay: Pandora's Box or Palliative for Liability Problems*, 7 J. POL'Y ANALYSIS & MGMT. 363 (1988). This theory and its economic findings may enter courtrooms as evidence of new and higher "hedonic" damages that may circumvent tort-reform limits on "non-economic" damages. *See* Barrett, *New Legal Theorists Attach a Dollar Value To the Joys of Living*, Wall St. J., Dec. 12, 1988, at 1, col. 1. Second, demographers can testify that currently accepted estimates of life expectancy (*e.g.*, from life insurance death tables or published census tables) are much too conservative. *See, e.g.*, Vaupel & Owen, *Anna's Life Expectancy*, 5 J. POL'Y ANALYSIS & MGMT. 383 (1986). This testimony could ratchet up jury awards for the value of lost life or for future pain and suffering and medical bills.

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tration might also be influential.[227]

2. Judging Reforms on a Broader Basis

The case for tort reform has mainly been built on the need to resolve insurance crises, curbing claims and awards so as to keep premiums affordable and doctors in their offices and emergency rooms.[228] Crisis and large jumps in prices make good reform politics — but bad legal strategy. First of all, some courts have taken legislatures at their word and inquired into the reality of insurance crisis.[229] Unfortunately for reformers, crisis can be in the eye of the beholder,[230] especially if

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On the other hand, not all common-law developments have to be pro-plaintiff. One should note that an Illinois appellate court has just expansively construed that state's Good Samaritan law to protect gratuitously rendered emergency care to a new patient, even in a hospital setting. *See* McGinn, *Illinois Appellate Court Rules: Good Samaritan Law Covers MDs in Hospitals*, Am. Med. News, Dec. 9, 1988, at 6, col. 1. If convinced by good policy arguments, not just that insurance premiums are "too high," courts could introduce into tort law other new defense-oriented doctrines. For example, the high cost of a diagnostic or other procedure could become a legitimate element of the standard of care. In addition, when a defendant has caused only the "loss of a chance" of survival (as by misdiagnosing a cancer patient), a plaintiff might be entitled to damages, but the damages would need to be scaled to the size of the chance lost.

[227] In New Jersey, for example, medical malpractice cases apparently account for a disproportionate share of very old lawsuits, fully 18.2% of cases more than three years old — in part because very few defense attorneys handle almost all the work of the leading insurers. One attorney was solely responsible for trying a backlog of 269 cases awaiting trial as of the end of 1987. The state Supreme Court is considering use of its power over the bar to stop allowing more than two continuances in cases where the defense asserts that only one attorney can represent the client. Meyer, *Report: N.J. Insurer Policies Delaying Malpractice Trials*, Am. Med. News, Dec. 9, 1988, at 10, col. 4.

[228] *See, e.g.*, Preamble to the Florida Medical Malpractice Reform Act of 1975, FLA. STAT. ANN. § 768.40-.56 (West Supp. 1985). This Preamble states:

> WHEREAS, the cost of purchasing medical professional liability insurance for doctors and other health care providers has skyrocketed in the past few months; and WHEREAS, it is not uncommon to find physicians in high-risk categories paying premiums in excess of $20,000 annually; and WHEREAS, the consumer ultimately must bear the financial burdens created by the high cost of insurance; and WHEREAS, without some legislative relief, doctors will be forced to curtail their practices, retire or practice defensive medicine at increased cost to the citizens of Florida; and WHEREAS, the problem has reached crisis proportion in Florida, NOW THEREFORE. . . .

Id.

[229] *See* cases cited *supra* note 22.

[230] One can easily argue that the crisis is not as bad as interested parties allege. *See, e.g.*, Dunningham & Lane, *Malpractice — The Illusory Crisis*, 54 FLA. B.J. 114

problems have faded as a test case works its way through the courts. Claims experience clearly affects the level of insurance prices over time, and reforms can affect claims experience. As the 1970s and 1980s have demonstrated, however, insurance crisis can occur at any given *level* of claims and premiums, in low- as well as high-premium jurisdictions — given a sufficiently unpredicted *change* in experience and other factors.

Moreover, it is very unclear whether tort reforms can generally be demonstrated to avert short-run crisis.[231] Conceptually, one would expect legal changes to change behavior over time, not suddenly, and other developments seem more plausibly related to the rapid shifts in insurance markets. Empirically, a considerable time period elapsed before clear demonstration of past tort reforms' impacts. Finally, a crisis orientation prevents serious consideration of fundamental reform between crises[232] and undermines the case for considering whether different types of personal injuries (notably, medical injuries) should have different rules when crisis has become more general.

A better rationale is that the current tort-law-and-insurance system does not do what "we" want it to, regardless of crisis or noncrisis.[233] In

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(1980); Goddard, *The AMA Is Wrong: There Is No Malpractice Insurance Crisis* (issued in 1985 by American Trial Lawyers Ass'n).

[231] Certain reforms that curb the upper levels of risk of insurers may help maintain insurability by reducing the worst uncertainties in rate making: statutes of repose that truly prevent "surprise" injuries from being discovered and caps on awards that prevent sudden fluctuations in total payouts because of a few extraordinarily large verdicts or settlements in expectation of verdict.

[232] Crises seem an increasingly poor rationale for reform since insurance markets have now been seen to survive crisis twice in a decade, despite less sweeping tort reform than advocated. Considerable danger seems to exist that legislators and judges will see further calls for reform as crying wolf at the expense of court-protected claimants, especially now that the 1980s crisis has ended. *See* Holthaus, *Insurance Crisis Is Over — At Least for Now*, HOSPITALS, Apr. 20, 1988, at 46 (noting improved insurance availability and overall growth in premiums for physicians and hospitals in range of 10 percent or lower for 1988); Holthaus, *Malpractice Insurance Rates Continue Stabilizing*, HOSPITALS, Dec. 20, 1988, at 30 (observing that insurers began to break even as early as 1987 and that rates rose less in 1988).

[233] One should consider The Model Act, *supra* note 193. Like Florida's Act, *supra* note 228, and others, it speaks of "unacceptably high" insurance premiums but of other problems as well, without calling it a "crisis":

> It is the purpose of this Act to modify the current medical malpractice liability system to ensure that the system operates to compensate fairly and efficiently persons injured by the wrongdoing of a health care provider, to reduce any unacceptably high transaction costs and delays which harm both plaintiffs and defendants, to establish greater predictability, to ensure that vital medical services are not curtailed as a result of unacceptably high liability insurance costs and to establish a system of arbitration which

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this larger sense, observing that tort reforms increasingly seem to "work" to cut claims and awards really only begins to assess their desirability. The real issue is what social judgment should be drawn from this observation, or, in other words, whether the observed levels are the "correct" ones. At this stage, there are more questions than answers. Whether tort reform is desirable quickly devolves into a judgment about the overall performance and fundamental fairness of today's liability systems in each state. Through its legislatures, courts, and other mechanisms, society ultimately needs to decide how best to resolve medical injuries, including whether they, like workplace injuries before them, should be separated from other personal injuries.

It is not clear what "we" want from this system. Do we want a liability system that mainly attempts to send appropriate signals to providers and individual risk-takers, or do we prefer a compensation system primarily concerned with the needy claimant? Do we want more or fewer claims brought? Do we think that liability assessments made in the current system by judges, juries, and claims settlers are accurate? Do we feel that awards are high enough but not excessive? Are there good reasons to consider malpractice separately from other types of torts? How much are we willing to pay for a system that must make difficult, sophisticated judgments about liability and damages? Do we want a more uniform, national system or continuing state-by-state variation? No social consensus exists on these issues, so a true assessment is not possible. The continuing social and political ferment surrounding liability law and insurance shows that this process is continuing.

CONCLUSION

The legal reforms affecting malpractice have achieved some successes by a number of different yardsticks — in legislatures, in courts, in common-sense legal appraisals, and in empirical analyses of their effects. However, society has yet to arrive at ultimate social or legal judgments on what we want from our system for dealing with medical injuries and consequently in what direction reforms should move.

Reaching such political and legal decisions will eventually require much more agreement about the flaws of today's partly reformed liability system (some of which hurt plaintiffs and some, defendants) and the

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> would enable parties to swiftly and economically resolve their disputes without resorting to expensive and time-consuming litigation.

Model Act, *supra* note 193, § 2(b).

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likely effects of further reform. Neither consensus on goals nor good information on means is currently at hand. To date, such debates about values have been conducted largely on an anecdotal basis, in notable contrast to the welter of numbers generated about insurance prices and empirical estimates about reforms' effects. Because so much opinion on so many important issues is almost wholly a matter of personal judgment, considerably more detailed information seems needed to illuminate choices. Otherwise, many advocates and legislators will continue to operate on a visceral level, and reforms will continue mainly to reflect the balance of political "clout" between claimants' lawyers and defendant medical providers and business people.

We need more information on problems across the medical-legal spectrum. How much injury occurs from malpractice and from nonnegligent medicine? Precisely in what types of cases do physicians or others feel that the liability system has treated them unfairly? When do plaintiffs lack effective redress? In which types of cases are causation and responsibility clear or not so clear? In which types are injuries relatively avoidable or relatively less so? How should one assess extent of damage by different measures? What investment of lawyers' time and judicial expense is optimal? To what extent does the tort system deter low quality care or promote low-value defensive posturing? We also need more information on the performance of potential solutions — from further tinkering with the tort system to more thoroughgoing reforms.

This Article began by remarking on the similarities between the 1970s and 1980s insurance crises. One difference is that today's concern arises when liability costs claim a far higher proportion of available resources than before, yet apparently without reaching the majority of deserving medical injuries. Another difference is that there seems to be more ongoing interest in malpractice and other liability issues today. One can hope that reform issues will not now ebb in the late 1980s as they did in the 1970s; it would be encouraging to meet — or even to preempt — the next crisis with more information and a better game plan.

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