A Survey of Medical Malpractice Tort Reform

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A SURVEY OF MEDICAL MALPRACTICE TORT REFORM

SHIRLEY QUAL†

The medical malpractice insurance "crisis of availability" of the seventies has resurfaced as the "crisis of affordability" of the eighties. This Article surveys the various tort reform measures which have been proposed or enacted by the federal government and various state legislatures. Ms. Qual also examines the recent Minnesota tort reform legislation and concludes that although it is a realistic solution to the problem, it falls short of its goal of fully addressing the causes of the "crisis" by neglecting the crucial issue of physician discipline.

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INTRODUCTION

The medical malpractice crisis stunned the medical community, insurers, and the public for the first time in the early 1970's. The crisis was characterized by drastically increased medical malpractice premiums for physicians, increased frequency and severity of claims, and increased damage awards.

1. See Defensive Medicine and Medical Malpractice, 1984: Hearing before the Comm. on Labor and Human Resources, 98th Cong., 2d Sess. 163 (1984) (statement of Elvoy Raines, American College of Obstetricians and Gynecologists). Mr. Raines, a professional liability expert, reported to the Senate Committee on Labor and Human Resources on July 10, 1984, that 80% of all medical malpractice lawsuits filed between 1935 and 1975 were filed in the last five years of that 40 year period. Id.

2. In mid-1975, physicians' and surgeons' insurance premiums were 100% higher than the previous year. See The Problems of Insuring Medical Malpractice: Hearing Before the Subcommittee on Health of the Committee on Labor & Public Welfare, 94th Cong., 1st Sess. 188 (1975).

3. In 1974, the St. Paul Companies estimated that the amount of claims they would receive in 1975 would increase 225% based on their annual claims growing each year from 2,538 claims logged against their company in 1970. AMERICAN MEDICAL ASSOCIATION SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE
At its peak in 1975, insurers were so shocked by this activity that they began to withdraw rapidly from the market of insuring health care providers, who had suddenly become high-risk insureds. Insurers still providing coverage in the medical malpractice area responded to this crisis by raising their premiums. Physicians and hospitals, in turn, increased their fees.

State legislatures responded quickly. From 1975 through 1976, every state legislature made some attempt at tort reform to curtail medical malpractice claims. Whether these reforms had any effect on medical malpractice litigation or insurance costs is debatable. The "crisis," however, seemed to pass out of existence by 1984-85.

1984-85; Professional Liability in the 80's, Reports 1-3, at 5. [hereinafter cited as AMA Report 1-3].


8. The following quotation summarizes the response of state legislatures: In 1975, medical malpractice problems reached crisis proportions in many states . . . . As a result, 52 states and territories passed remedial legislation in a two-year period beginning in 1975 and ending in 1976. It is difficult to recall a problem in the history of the United States which generated more state legislation in such a short period of time.


The tort reform legislation is advocated by medical societies and insurers in an effort to promote actuarial certainty for the insurance industry. The reforms allegedly reduce the number of medical malpractice suits and lower damage awards and attorneys' fees, providing additional cost savings to insurers. These cost reductions are theoretically passed on to society, resulting in lower insurance premiums for physicians and consequently, lowering health care costs to society. The reforms, however, have not proved to be effective, and have not achieved these goals. See, e.g., AMA Report 2, supra note 3, at 13; Note, California's Medical Injury Compensation Reform Act: An Equal Protection Challenge, 52 S. Cal. L. Rev. 829, 846 & n.102 (1979).
of the public eye—until today.9

This Article summarizes the history and potential causes of the medical malpractice crisis. It explores various tort reform methods employed by state legislatures attempting to alleviate pressures brought on by the 1975 medical malpractice crisis, and reviews the effects of tort reform on medical malpractice litigation. Current Minnesota law is discussed, followed by an analysis of the newly enacted legislation. Proposed national legislation is explained, followed by the author’s conclusion. The purpose of this Article is to survey the use of, and evaluate the effectiveness of, “crisis” legislation enacted by other states, in order to provide insight for future attempts to do the same in Minnesota.

I. THE “MEDICAL MALPRACTICE CRISIS”—PAST AND PRESENT

A. History

The first medical negligence suit in the United States was recorded in 1794.10 It was not until the 1930’s, however, that the number of medical malpractice suits began to grow,11 and it was not until after World War II that the volume of claims began to increase steadily.12 This increase did not achieve national attention until the early 1970’s when its growth rate was so alarming that the phenomenon was dubbed a “crisis.”13 This medical malpractice insurance dilemma became known as

9. See Wolfe, Bergman & Silver, Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform 1 (public citizen health research group report) [hereinafter cited as THE NEED FOR DISCIPLINARY REFORM]. The authors state:

Just as it did during the last malpractice crisis ten years ago, organized medicine has succeeded in diverting attention away from the issue of the dangerously inadequate discipline of doctors by going all out to pass state tort reform laws that will, in a variety of ways discipline injured patients or the families of dead patients and their lawyers instead of the doctors. Id.


11. Hirsch, supra note 4, at 5.

12. This increase coincided with the increased availability of medical care and the development of modern medicine and sophisticated technology. In post-war times, more people were able to afford medical care, which increased the number of encounters that could lead to a lawsuit. Id.

13. St. Paul Fire & Marine Insurance Company, long recognized as a leading medical malpractice carrier, reported that in 1969 it had one claim per 23 physicians, but in 1974, the ratio was one in every 10 physicians. In addition, in 1969 the average claim paid was $6,075, increasing to $12,534 in 1975—an increase of over 100%. T. Lombardi, supra note 6, at 11; see also supra notes 1-5.
the "crisis of availability" because so many insurers withdrew from the market that some physicians found it difficult to find insurance at any price.\textsuperscript{14}

The crisis reached its peak in 1975.\textsuperscript{15} State legislatures across the country reacted swiftly, passing legislation curtailing access to the courts\textsuperscript{16} and facilitating the means by which health care providers could obtain liability coverage unavailable to them on the commercial market.\textsuperscript{17} The "crisis" faded from the public eye in the late 1970's and early 1980's, although health care costs and malpractice litigation costs continued to rise.\textsuperscript{18}

Today, the public, insurance companies, and physicians are once again clamoring about a new medical malpractice crisis.\textsuperscript{19} This crisis has been entitled the "crisis of affordability"\textsuperscript{20} because, unlike the the mid-1970's, medical malpractice insurance is available, but its cost is claimed to be prohibitive.\textsuperscript{21}

\textsuperscript{14} According to an American Medical Association survey reported in the January 1976 American Medical News, a significant number of physicians in about 25 states were having difficulty obtaining liability insurance. Munch, Causes of the Medical Malpractice Insurance Crisis: Risks and Regulation, in The Economics of Medical Malpractice 128 (S. Rottenberg ed. 1978). Most notorious perhaps, was the New York experience. Employers Insurance of Wausau, Wisconsin, pulled out of the market after having underwritten the New York Medical Society's professional liability insurance for 25 years. Argonaut Insurance Company then agreed to provide coverage, after raising rates 93.5%. In late 1974, Argonaut requested an additional 200% increase, and shortly thereafter abandoned the New York market. See AMA Report 1, supra note 3, at 5.

\textsuperscript{15} AMA Report 2, supra note 3, at 13.

\textsuperscript{16} See infra notes 43-51 and accompanying text.

\textsuperscript{17} Many states passed Joint Underwriting Association (JUA) legislation to furnish insurance to health care providers unable to obtain liability insurance on the commercial market. These JUA's, usually required insurance companies registered in the state to cooperate in supplying the liability insurance for these health care providers until the open market once again made that insurance available. See Munch, supra note 14, at 128.

\textsuperscript{18} Medical liability premiums increased by more than 80% between 1975 and 1983, reaching as much as $80,000 per year for physicians practicing high risk specialities. Hirsch, supra note 4, at 8.

\textsuperscript{19} See Middleton, The Medical Malpractice War, Nat'l. Law J., Aug. 27, 1984, at 1, col. 1.

\textsuperscript{20} See AMA Report 1, supra note 3, at 8.

\textsuperscript{21} In Minnesota, for example, the Minnesota Medical Insurance Exchange has just published the projected average percentage increases for 1985 to be 28%. This percentage has risen from 22% in 1984, 11.6% in 1983, 15% in 1982, and 15% in 1981. Minnesota Medical Insurance Exchange is a physician-owned insurance company founded in 1980. Minneapolis Star & Tribune, July 24, 1985, at 1A, col. 3-4. Physician owned insurance companies were created in mid-1975, by doctors frustrated...
B. Causes

A great deal of controversy surrounds the cause and existence of the current medical malpractice insurance crisis.22 One theory is that insurance companies have orchestrated the phenomenon by manipulating the medical malpractice insurance market to eliminate competition among insurers.23 The

with the alternatives—exorbitant premiums or the lack of available insurance. See AMA Report 1, supra note 3, at 5.

Specialists are considering not practicing their specialties as a result of the expensive premiums and the likelihood of lawsuits. Young physicians are reportedly not entering those fields for the same reasons. A Florida medical association survey indicated that 25% of obstetricians in the state no longer deliver babies presumably as a result of the risk. AMA Report 1, supra note 3, at 11. Wisconsin reports that 18% of obstetricians have stopped accepting high risk patients. State Medical Society of Wisconsin, Report to the Legislative Council Special Committee on Medical Malpractice 65 (Sept. 4, 1984) (copy on file at the William Mitchell Law Review office).

22. As Senator Edward M. Kennedy said about the crisis of 1975: “It is all too reminiscent of what happened to gas and oil prices during the Arab embargo.” See T. Lombardi, supra note 6, at 1. An illustration of the theory that the insurance industry has fabricated the “crisis” for its own profit is exemplified in a California incident. See Carlova, How Doctors Forced a Malpractice Carrier to Refund $50 Million, Med. Econ. 171-72 (1981). In 1976, physicians who obtained their medical malpractice insurance through Travelers Insurance Company on a contract with Southern California Physicians Council, were forced to pay a 486% increase to cover the higher losses Travelers expected in the future years. The physicians continued to pay high rates through 1978 when it was discovered that Travelers had made an enormous profit on its contract with the physicians. The Southern California Physicians Council demanded return of the excess premiums and ended up filing suit, resulting in a return of $50,000,000 in premiums. Id. Cf. Jones v. State Bd. of Medicine, 97 Idaho 859, 872, 555 P.2d 399, 412 (1976) (“It is argued that the Act is a necessary legislative response to a ‘crisis in medical insurance’ in Idaho, but the record does not demonstrate any such ‘crisis’”), cert. denied, 431 U.S. 914 (1977). But see T. Lombardi, supra note 6, at 2, “[d]espite serious misgivings about the [insurance] industry’s response to the medical malpractice issue, the author in all fairness must state that there is little evidence to substantiate the point of view that the crisis was contrived for the benefit of the insurance company.” Id.

23. “What we are witnessing is a manufactured crisis intended to bloat insurer profits and reduce victims’ rights.” Perlman, Don’t Confuse Me with the Facts, 22 Trial, 1986 at 5 (quoting J. Robert Hunter, former Federal Insurance Administrator).

Major liability carriers stopped writing medical malpractice insurance in some states during the 1975 crisis. See supra note 14. This selective withdrawal allocated the medical malpractice market and eliminated competition among insurers, thus causing rates to rise dramatically. Londrigan, The Medical Malpractice “Crises,” 21 Trial, 1985, at 23-24. See Bernier v. Burris, No. 85CH6627, slip. op. (Cook Co. Cir. Ct. Ill. Dec. 19, 1985), in which the Illinois circuit court for Cook County struck down the major portions of a statute which limited malpractice awards, stating “[t]here is no empirical data to support the claim that a medical malpractice insurance crisis exists in the state of Illinois.” Id. at 2. The court found that the cause of the crisis was that insurance companies were raising their rates to recoup bad investments. Id.
insurance industry’s power to accomplish this arises not only from the unique immunities that it enjoys from federal antitrust laws, but also from the absence of any effective state rate regulation.

The insurance industry denies this accusation, blaming the crisis on liberal doctrines adopted by the courts. These doctrines include: discarding the locality rule, adopting the

The court stated, "[a] sharp decline in the value of investments resulted in a reduction of 'reserves' for the payment of claims. The funding problems now asserted by the insurers, are of their own making, not the outgrowth of 'unforseeable' [sic] increases in the number (frequency) and size (severity) of malpractice claims." Id. at 3. See also Med-Mal Insurance "Crisis" is a Sham; State Statute Struck Down, 5 LAW ALERT 114 Jan. 27 (1986).

25. See Londrigan, supra note 23, at 25. The insurance industry advised its insureds to demand immediate "crisis" legislation to reform the tort system. Id.

26. See Blair v. Eblen, 461 S.W.2d 370, 372-73 (Ky. 1970) ("that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances"). The locality rule requires that a physician's conduct be judged by the standard of care which is acceptable in that particular community. The rule is criticized as being unreconcilable with the realities of modern medical practice, immunizing doctors from malpractice liability if they are the sole practitioner in their community, and preventing any possibility of obtaining expert testimony due to the "conspiracy of silence" in the plaintiff's locality. See Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 194, 349 A.2d 245, 249 (1975).

Some courts have wholly rejected the locality rule in favor of using a national standard to guage a physician's acceptable standard of care. Courts adopting a national standard have both raised the standard of care, and have made it easier to prove cases by expanding the pool of potential expert witnesses to include those who are not doctors from that particular community. See, e.g., Blair, 461 S.W.2d at 372-73; Pederson v. Dumouchel, 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967) ("that degree of care and skill which is expected of the average practitioner in the class to which he belongs, acting in the same or similar circumstances").

Other courts relax the strict locality rule and apply the "same or similar locality" rule, enabling plaintiffs to obtain expert witnesses from other communities similar to their own. See, e.g., Sinz v. Owens, 35 Cal. 2d 749, 754, 205 P.2d 3, 5 (1949) ("same locality" or 'vicinity'); McGulpin v. Bessmer, 241 Iowa 1119, 1129, 43 N.W.2d 121, 126 (1950) ("under like circumstances and in like localities"); Karrigan v. Nazareth Convent & Academy, Inc., 212 Kan. 44, 50, 510 P.2d 190, 195 (1973) ("in the community where he practices, or similar communities").

Finally, some courts have adopted a national standard which only applies to specialists. See, e.g., Kronke v. Danielson, 108 Ariz. 400, 403, 499 P.2d 156, 159 (1972) ("the standard of care required of physicians in the same specialty practiced by the defendant"); Brune v. Belinkoff, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968) ("standard of care and skill of the average member of the profession practising the specialty"); Christy v. Saliterman, 302 Minn. 144, 166 & n.1, 179 N.W.2d 288, 302 & n.1 (1970) (standard of care is "the nationally recognized professional standard"); RESTATEMENT (SECOND) OF TORTS, § 299A comment d (1976).
discovery of the injury rule,\textsuperscript{27} tolling minors' statutes of limitations pending the age of majority,\textsuperscript{28} adopting the tort of emotional distress,\textsuperscript{29} allowing recovery for pain and suffering,\textsuperscript{30} accepting the lack of an informed consent as an independent tort,\textsuperscript{31} and adopting the doctrine of the loss of a chance.\textsuperscript{32}

Other commentators blame the medical malpractice crisis on advances in technology that began in the 1960's and which have dramatically changed the character of the physician-pa-
Doctors no longer treat all the needs of their patients, but rather, focus only on one aspect of the patient's care, usually an area in which they specialize. The doctor's changing role causes a breakdown in the physician-patient relationship which alters the character of the relationship from one of a family confidant, to that of an anonymous technician. As a result, suing one's doctor has become much less of a personal affront than it was in the past. This problem is compounded by another byproduct of advanced technology—unreasonably high expectations of cure from medical treatment. Yet, another commentator explains the crisis as a social phenomenon, claiming that the health care industry simply passed through phases in the 1960's and early 1970's which reflect the climate of American politics.

Physicians have not escaped blame for causing the crisis. Malpractice is widespread, but there still is no effective discipli-
nary process to prevent incompetent physicians from practicing. 37 It is estimated that at any given time, up to fifteen percent of the nation’s physicians are incompetent and unfit to practice medicine, yet these physicians continue to practice and to harm their patients. 38 Despite these statistics, state medical licensing boards revoked only 255 licenses in 1984, one for every 1,701 practicing physicians. 39 The lack of a uniform approach to this problem among the states, their use of disjointed disciplinary systems, and the medical profession’s own reluctance to demand or to enforce the disciplining of their brethren, has helped to create and perpetuate the problem. 40

Of course, lawyers are also blamed for the state of the medical malpractice climate. Plaintiffs’ lawyers have been characterized as greedy, and exploitative, and wholly unethical in pursuing large damage awards. 41 Some commentators claim that contingency fees cause plaintiffs’ attorneys to have too

37. Physicians are regulated by hospitals, medical societies, state licensing boards, and federal peer review organizations. Since there is no coordination of these efforts, however, incompetent physicians are able to move freely from hospital to hospital, or state to state as problems arise. See Brinkley, U.S. Industry and Physicians Attack Medical Malpractice, N.Y. Times, Sept. 2, 1985, at 10, col. 1. The Public Citizen Health Research Group reports that of nearly 400,000 nonfederal patient care doctors in the United States in 1983, only 563 had their licenses revoked, suspended, or were put on probation. The Need for Disciplinary Reform, supra note 9, at 1. This is true even though the HEW Malpractice Commission estimates that in 1983 203,000 people were injured while hospitalized due to doctors’ negligence. Id. at 4.

38. The New York Times reports that an Illinois doctor, who had already been sued for malpractice at least 13 times, was ordered by a jury to pay a woman $9 million for rendering her a quadriplegic after performing plastic surgery on her nose. Brinkley, supra note 37, at 1, col. 1.

39. Id. This is equal to .05 percent. “More than one-half of the disciplinary actions nationwide are reprimands or administrative actions that have little or no effect on a physician’s right to treat patients.” Id. at 10, col. 1.

40. Incompetent physicians increase medical costs. Errors lead to readmissions, longer hospital stays, expensive additional surgery and medications, as well as other unforeseen treatment, including malpractice lawsuits. Id. at 10, col. 1; Brinkley, Medical Discipline Laws: Confusion Reigns, N.Y. Times, Sept. 3, 1985, at 1, col. 3.

41. Anthony J. De Vito, a prominent New York medical malpractice defense lawyer, described his opposition as “plaintiff’s attorneys who, while tenaciously guarding their lucrative turfs, react like a marauding [sic] school of piranhas, tearing glutonously at the body which sustains them while, at the same time, pretending to pursue a course of justice!” De Vito, Abuse of Litigation: Plague of the Medical Profession, N.Y. St. Bar J., July 1984, at 23, 24. This attack did not go without response from the plaintiff’s bar. See, e.g., Magner, Medical Malpractice: The Answers to Mr. De Vito, N.Y. St. Bar J., Nov. 1984, at 10.
large a stake in the outcome of lawsuits.\textsuperscript{42}

\section*{II. Tort Reform Legislation}

The Lord giveth and the Lord taketh away. With respect to medical malpractice litigation, the courts giveth and the state legislatures taketh away.\textsuperscript{43}

Legislative tort reforms evolving in the area of medical negligence focus on curtailing medical negligence claims by modifying access to the courts, shifting the costs and burdens of litigation from the insurance and the medical industries to plaintiffs and their attorneys, and modifying evidentiary and procedural requirements. Nearly every state has enacted some type of tort reform, with certain states passing comprehensive packages of legislation.\textsuperscript{44} This section identifies the various types of statutes enacted to accomplish tort reform. The tort reforms that are analyzed cause medical malpractice lawsuits to be a more complicated and burdensome procedure for the plaintiff, while implementing no procedure to regulate the insurance industry or to reduce the incidence of malpractice. Moreover, many of these tort reforms have been invalidated by courts as violative of both the federal and state constitutions.\textsuperscript{45}

\subsection*{A. Modifying Access to the Courts}

\subsubsection*{1. Statute of Limitations}

The most frequently utilized legislative tort reform is shortening statutes of limitation for medical malpractice causes of action.\textsuperscript{46} Forty-one states have enacted legislation establishing a specific statute of limitations for medical liability cases. The majority of these statutes provide that the period of limitations begins to run and the cause of action accrues when the negligence occurs.\textsuperscript{47} Recently, however, several courts have

\begin{footnotesize}
\begin{enumerate}
\item See, e.g., F. MacKinnon, \textit{Contingent Fees for Legal Services} 4, 5 (1964); Comment, \textit{Are Contingent Fees Ethical Where Client is Able to Pay a Retainer?} 20 \textit{Ohio St. L.J.} 329, 339 n.53 (1959).
\item AMA Report 2, \textit{supra} note 3, at 13.
\item See \textit{infra} notes 93 to 151 and accompanying text.
\item The states which have \textit{not} established a separate statute of limitations for medical liability cases are Alaska, Arkansas, Connecticut, Idaho, New Jersey, Pennsylvania, Vermont, Virginia, West Virginia.
\end{enumerate}
\end{footnotesize}
adopted the “discovery rule,” which provides that the period begins to run from the time at which plaintiff discovered or should have discovered the injury through the use of reasonable diligence. A few state courts have gone one step further by declaring that the statute does not begin to run until the plaintiff discovers the negligence that caused the injury. These decisions lengthen the insurer’s period of risk. To insure that interpretations of this type do not unreasonably extend the period of limitations, over half of these states have incorporated provisions with a maximum time limitation in which a claim may be brought.

The extended period of risk or “long tail” for insurers in medical malpractice claims is especially evident in the limitation statutes for minors, which, in most states, traditionally did not begin to run until the child reached the age of majority. In an effort to limit the risk period, several states have reduced the tolling period of the statute from when a child reaches the age of majority, to an arbitrarily chosen younger age.


49. See supra notes 27, 28 and accompanying text.


51. See, e.g., ALA. CODE § 6-5-482 (1975) (minor under age four has until age eight to file claim for medical negligence); CAL. CIV. PROC. CODE § 340.5 (West 1985) (minor under age six has three years or until his eighth birthday to file claim); DEL. CODE ANN. tit. 18, § 6856 (1974 & Supp. 1984) (minor under age six has three years
2. Arbitration

Several states have experimented with arbitration in the medical malpractice arena.\textsuperscript{52} Arbitration is usually a voluntary alternative to litigation.\textsuperscript{53} Patients and health care providers enter into an agreement providing for arbitration of any dispute arising from the health care transaction. This agreement is a substitute for a jury trial, not a condition to one. The procedure attempts to assure a fast and efficient decision by an expert fact finder without the publicity or potential for an astronomical jury verdict. It is usually subject to only limited judicial review by a court on appeal.

Arbitration has been an unsuccessful alternative to the traditional court system because the parties are precluded from having "their day in court."\textsuperscript{54} Patients are reluctant to give up this right and, therefore, this procedure is rarely used.\textsuperscript{55}

\textsuperscript{52} Although medical malpractice claims may be arbitrated in at least 30 states under their general arbitration statutes, the following states have enacted arbitration legislation specifically for medical malpractice claims: ALA. CODE § 6-5-485 (1975); ALASKA STAT. § 09.55.535 (1985); CAL. CIV. PROC. CODE § 1295 (West 1982); GA. CODE ANN. § 9-9-112 (1982); ILL. REV. STAT. ch. 10, § 201 (1985); LA. REV. STAT. ANN. §§ 9:4230-:4236 (West 1983); ME. CODE ANN. tit. 24, §§ 2701-2715 (repealed by ch. 492, § 1 (1977)); MICH. COMP. LAWS ANN. § 600.5040 (West Supp. 1985); N.D. CENT. CODE 32-29.1 (repealed by ch. 358, § 1, 1981); OHIO REV. CODE ANN. §§ 2711.21-2711.24 (Page 1981); PA. STAT. ANN. tit. 40, § 1301.101 (Purdon 1985); S.D. CODIFIED LAWS ANN. § 21-25B-1 to 21-25B-26 (1979 & Supp. 1985); VT. STAT. ANN. tit. 12, § 7001-08 (1985); VA. CODE §§ 8.01-581.1 to 581.12 (1984).

Minnesota has an arbitration plan drafted by the Minnesota State Bar Association in 1975, entitled "An Experimental Arbitration Plan for Medical Liability Claims." This is to be used in conjunction with MINN. STAT. § 572 (1984), the general arbitration statute. For a discussion of its use, see Orwoll, \textit{Medical Malpractice Arbitration, Bench & Bar of Minn. Aug. 1985, at 31.}

53. Courts have not imposed mandatory arbitration schemes due to the potential conflict with the constitutional right to a civil jury trial. \textit{See Redish, supra note 28, at 765.}


55. In Minnesota, for instance, as of August, 1985, only 14 medical malpractice cases have been filed since September of 1975. Orwoll, \textit{supra} note 43, at 31. Michigan has had a similar experience with their Medical Malpractice Arbitration Act of 1975, which, as of 1983, has been utilized for only 2-3\% of the medical malpractice cases in that state. \textit{Evaluation: State of Michigan Medical Malpractice Arbitration Program, Technical Report, Vol. I, Analysis of Closed Medical Mal-
3. Pre-trial Screening

Pretrial screening panels designed to screen out nonmeritorious claims prior to trial have been adopted by many states. Pretrial screening generally requires a mandatory pretrial hearing to be conducted before a panel composed of physicians and attorneys. The panel's decision is not binding on the parties, and therefore, does not preclude a plaintiff from subsequently bringing a lawsuit. Consequently, these panels may not achieve the intended result of decreasing malpractice claims. States are split as to whether the panel's decision should be admissible in court.

Wisconsin, for example, has mandatory pretrial screening

56. See, e.g., Wis. Stat. Ann. § 655.17-.18 (West 1980). Wisconsin's formal panels are composed of two health care providers, one attorney, and two public members appointed by the governor. See id. § 655.03. The panel determines negligence, causation, and awards compensation. Id. § 655.065. These findings, however, are not binding on the parties unless the parties have agreed in writing to be so bound. Id. § 655.07. In Wisconsin, if either party commences a court action after the hearing, findings of formal panels are admissible in court, while findings of an informal panel are not. Id. § 655.19.

57. In at least one state, the fact that the panel decision was not binding was crucial to upholding the statute against constitutional attack based on the right to a trial. See State ex. rel. Strykowski v. Wilkie, 81 Wis. 2d 491, 261 N.W.2d 434 (1978) (Wisconsin statute providing for panel hearings as exclusive means for prosecution of medical malpractice claims not unconstitutional because it does not impair right to jury trial).


panel hearings in all medical malpractice cases. Wisconsin's experience, however, has proven that pretrial screening panels do not reduce the number of claims brought or the amount paid on claims. Moreover, Wisconsin's system has not been effective in maintaining low medical malpractice insurance premiums.

The Illinois Legislature recently enacted yet another pretrial screening procedure. In Illinois, a plaintiff is required to file a Certificate of Merit within 90 days of bringing an action for medical negligence. The Certificate of Merit consists of an affidavit stating the facts of the case, and a written report by a knowledgeable health care professional who has reviewed the case and deems it meritorious. Failure to comply results in dismissal of the suit.

The pretrial screening panels have proven ineffective. Since plaintiffs are not bound by the panel's decision, and they are not precluded from using the court system despite having received an unfavorable panel decision. Therefore, pretrial screening frequently increases the costs of, and further delays, the final resolution of the dispute. On the other hand, the pretrial screening method, which requires a Certificate of Merit, will not delay or increase the costs of litigation since a medical expert is necessary to prove most claims.

59. See Wis. Stat. Ann. § 655.001-27 (West 1980 & Supp. 1985), which also incorporates a patient compensation fund to be used in conjunction with the panels.
60. State Medical Society of Wisconsin, Medical Liability in Wisconsin: Problems and Recommendations for Change, UPDATE 2 (Feb. 1985). Wisconsin State Medical Society reports on statutes from 1980 to 1984 show that the number of claims paid increased in those years 142% (from 66 to 160) and the average payments increased 65% (from $24,889 to $40,660). Minnesota has not had a pretrial screening mechanism, yet it has had a better experience with insurance claims. From 1981 to 1984, the two major Minnesota Medical malpractice insurers, St. Paul Fire & Marine, and Minnesota Medical Insurance Exchange (accounting for 85-90% of all medical malpractice insurance written in Minnesota) had an increase in the number of claims paid from 128 to 200 (56.2%), and the average claim paid increased only 14%, to over $54,000. Statement by David Corum, Minn. Dept. of Commerce to the Minn. Medical Ass'n Commission on Medical Professional Liability, July 24, 1985, at 5.
61. See supra note 60 and accompanying text.
62. Act of June 25, 1985, ch. 110, ¶ 2-1018(3) 1985 Ill. Legis. serv. 8-10 (to be codified at Ill. Rev. Stat. ch. 110, ¶ 2-622(3)).
63. Id. (1) (to be codified at Ill. Rev. Stat. ch. 110, ¶ 2-622(1)).
64. Id. (3)(g) (to be codified at Ill. Rev. Stat. ch. 110, ¶ 2-622(3)(g)).
B. Shifting Costs and Burdens of Litigation

1. Awarding Costs

In order to deter frivolous claims and defenses, some states have enacted legislation providing for the payment of reasonable attorney and expert witness fees against the unsuccessful party in addition to the usual court costs. This type of statute varies the procedure from the usual civil trial in which the prevailing party may have court costs paid by the opposing party, but must still incur the expense of his own expert witness and attorney fees. The statutes vary from state to state; some are mandatory, and others are at the court's discretion when a party has shown bad faith or has brought a frivolous claim or defense.

2. Limiting Attorneys' Fees

The contingent fee arrangement has long been criticized as creating a conflict of interest for attorneys. Critics of the contingent fee argue that it manifests in the attorney a personal interest in the outcome of the case. This personal interest creates incentive for an attorney to encourage the public to litigate and seek excessive damages. To counteract this perceived problem, several states have enacted statutes which either authorize court approval of reasonable attorneys' fees or set limits as to the maximum amount attorneys may collect. Some states provide for a sliding fee scale, whereby the percentage of the contingent fee collected by the attorney decreases incrementally as the amount of the award increases.

Other states have enacted legislation which authorizes a court to approve or disapprove the reasonableness of the


66. See supra note 65.

67. See F. Mackinnon, supra note 43, at 5.

68. See Comment, supra note 42, at 339 n.53.

fees. Another scheme restricts fees to a certain percentage of the plaintiff's award. Wisconsin, for example, restricts attorneys' fees by excluding all amounts reflecting previously paid medical expenses and future medical expenses in excess of $25,000 from the amount upon which the contingency fee is based.

3. Altering the Collateral Source Rule

The collateral source rule prevents the value of any benefits received by the injured party from sources other than the tortfeasor to offset the damage recovery. This rule is attacked as causing a windfall to plaintiffs, who may receive a double recovery of their claimed damages by receiving insurance benefits and a damage award for the same injury. Since many insurers have a subrogation right against a judgment in a plaintiff's favor, which includes reimbursement for costs paid by the insurer, proponents of the rule argue that few plaintiffs ever actually receive overcompensation. Moreover, proponents argue that the rule prevents a tortfeasor from capitalizing on the good fortune and foresight of the plaintiff who has paid the premiums to insure his risk. With the advent of the medical malpractice crisis, however, the collateral source rule has been criticized as contributing to inflated damage awards and unnecessary overcompensation.

State legislatures have taken two approaches to limit the effect of the collateral source rule. Some statutes allow the trier
of fact to hear testimony regarding collateral source payments and to decide whether to offset any of the damage award. A second type of statute actually abolishes the collateral source rule by requiring that the damage award be offset by the amount of collateral source payments without informing the jury of collateral sources.

4. Limiting Damages

Several states have enacted legislation restricting recovery of particular types of damages. These measures are implemented by either statutes placing caps on the amount of damages a plaintiff may recover, or by statutes which limit the liability of physicians or other health care providers participating in state patient compensation funds. Damage caps typically affect only the severely injured person, since damages awarded to those with lesser injuries do not reach the ceiling amounts. Thus, the most helpless party among those involved in medical malpractice litigation is burdened with the cost of malpractice. This is fundamentally unfair. Moreover, severely injured patients, such as paraplegics, quadriplegics, or brain damaged patients will undoubtedly require financial help from public


assistance programs unless they are adequately compensated since the amount necessary for their lifetime maintenance can easily surpass statutory limits. In that case, the cost of malpractice shifts from the private sector of the insurance and health care industries to the public sector.

5. Creating a Patient Compensation Fund

Some states have established funds to pay the portion of a judgment or settlement in excess of statutory ceilings. In order to limit its liability through this fund, a health care provider must be insured up to the statutorily designated amount. The funds are usually financed through annual surcharges assessed against health care providers, and held in trust to be invested by the insurance commissioner. This reform attempts to ensure compensation for malpractice victims and to spread the risk among health care providers.

6. Mandating Periodic Payments

Plaintiffs have traditionally received their damage awards in lump sum payments. Recently, however, such payments have become the subject of tort reform because they are more burdensome to insurers than periodic payments. Damages may include payments for anticipated future medical care, loss of future earning capacity, and future pain and suffering. A lump sum, which includes payment for future damages, may overcompensate the plaintiff who recovers or dies sooner than expected. In addition, an award that may be paid out over time is financially favorable for insurance companies, since the plaintiff's award may be used to generate income over the payment period. Consequently, a number of states have enacted legislation which permits or requires medical liability judgments to be paid in installments.

81. See supra note 80.
82. See id.
C. Modifying Evidentiary and Procedural Requirements

1. Limiting Res Ipsa Loquitur

Res ipsa loquitur is a common law doctrine permitting a plaintiff to prove negligence by circumstantial evidence. The doctrine requires the plaintiff to prove that the injury occurred while the instrumentality which caused the injury was under the exclusive control of the defendant, and that the cause of injury was one that ordinarily would not have occurred in the absence of negligence. Perceived as a boon to increasing medical liability claims, the use of res ipsa loquitur has been limited or modified in some states. These changes are an attempt to limit the number of res ipsa loquitur claims by raising the standard of proof in medical negligence cases above that required in other tort cases.

2. Modifying Expert Witness Standards

Expert witnesses play an important role in establishing liability in medical negligence cases. Due to the technical nature of these suits, and the particular standard of care required in certain circumstances, physicians are best judged by fellow physicians. Attempting to curtail medical malpractice claims, some states have enacted legislation which restricts the qualifications and use of expert witnesses. These statutes vary from making expert testimony mandatory in order to prevail in a medical negligence case, to modifying the necessary qualifications of the expert, such as requiring the expert to practice within the state in which the claim is brought, to have practiced a certain percentage of his profession in the defendant’s specialty, or to have practiced within the past year.
By enacting such legislation, states are not reducing the incidence of malpractice or its cost to patients, the medical community, or the public. These statutes also do not reduce the number of claims that can be brought. Rather, such measures simply frustrate the plaintiff's attempt to find a qualified expert who supports the position that his injuries resulted from medical negligence. The task of finding a doctor to testify against another doctor has always been difficult. This type of legislation makes that task more formidable.

3. Limiting the Standard of Care

In order to prevail in a medical negligence action, the plaintiff must establish that the health care provider departed from accepted standards of medical practice. Each state has its own standard with which the defendant must comply. Some states have enacted legislation that limits or modifies the standard of care required by health care providers within that state. These statutes generally codify the "locality rule."

4. Ad Damnum Clause

The ad damnum clause is the part of the plaintiff's complaint which sets forth the recovery sought. Many states have enacted legislation that either excludes or limits the monetary

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Some statutes provide standards for specific circumstances. For instance, the Florida statute states that the discovery of a foreign object left in a plaintiff's body is prima facie evidence of negligence. See Fla. Stat. Ann. § 768.45(4). The statute also provides that the failure of a health care provider to administer "supplemental diagnostic tests" is not actionable if the provider acted in "good faith and with due regard for the prevailing professional standard of care." Id.

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amount claimed in an ad damnum clause. This reform seeks to reduce publicity surrounding medical malpractice suits. This tort reform is based on the theory that requests for large damage awards in the ad damnum clause contributes significantly to the medical malpractice crisis by inflaming emotion and encouraging other members of the public to seek similar large recoveries.

III. Constitutional Challenges

Every major category of tort reform has been found unconstitutional by at least one state supreme court. Courts have declared entire acts void, finding that the tort reform measures are so interrelated that it is impossible for any part of the law to stand if one provision is declared unconstitutional, despite severability clauses in the acts. Commentators have questioned whether courts, in invalidating these statutes on constitutional grounds, have strained the meaning of the relevant constitutional provisions beyond all legitimate bounds.


92. See Medical Malpractice Committee Report, Wis. Bar Bulletin, June 1975, at 19, where the committee recommends that Wisconsin abolish the ad damnum clause to "keep gamesmanship and emotionalism out of the litigation process." Id. The committee further stated that "it is inappropriate, and emotionally devastating to some physicians to have the news media report that doctors are being sued for huge sums of money." Id.

93. AMA REPORT 2, supra note 3, at 14.


95. See, e.g., Redish, supra note 28, at 763.
A. Standard of Review

Equal protection\textsuperscript{96} and special legislation\textsuperscript{97} arguments are the most common challenges to tort reform legislation.\textsuperscript{98} Medical malpractice legislation has an unequal impact on one class of tort claimants—victims of medical malpractice. Thus, these statutes discriminate among classes of injured tort claimants.\textsuperscript{99} Whether the legislation will be upheld often depends upon which standard of review the court utilizes in analyzing the legislation.\textsuperscript{100}

When analyzing suspect legislation under an equal protection challenge, courts use one of three standards of review—a rational basis, an intermediate, or a strict scrutiny standard.\textsuperscript{101} The strict scrutiny standard is applied if the court deems that a fundamental right\textsuperscript{102} or a suspect classification\textsuperscript{103} is at issue. States differ as to whether the right to receive adequate medi-

\textsuperscript{96} The United States Constitution provides: "No state shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1.

\textsuperscript{97} Many state constitutions contain provisions which prohibit the enactment of special laws to benefit a particular class. The Illinois Constitution provides: "The General Assembly shall pass no special of local law when a general law is or can be made applicable." Ill. Const. art. IV, § 13.

\textsuperscript{98} AMA REPORT 2, supra note 3, at 14. The North Dakota Supreme Court invalidated its entire medical malpractice act on primarily equal protection grounds. See Arneson, 270 N.W.2d at 136.

\textsuperscript{99} Redish, supra note 28, at 769. In Graley v. Satayatham, 343 N.E.2d 832 (Ohio Ct. Com. Pleas 1976) the court stated:

There is no satisfactory reason for this separate and unequal treatment. There obviously is "no compelling governmental interest" unless it be argued that any segment of the public in financial distress be at least partly relieved of financial accountability for its negligence. To articulate the requirement is to demonstrate its absurdity, for at one time or another every type of profession or business undergoes difficult times, and it is not the business of government to manipulate the law so as to provide succor to one class, the medical, by depriving another, the malpracticed patients, of the equal protection mandated by the constitution.

\textit{Id.} at 320, 343 N.E.2d at 837.


\textsuperscript{101} \textit{Id.}

\textsuperscript{102} The United States Supreme Court has limited the fundamental rights category to rights "explicitly or implicitly guaranteed by the Constitution." San Antonio Independent School Dist. v. Rodriguez, 411 U.S. 1, 28 (1973).

\textsuperscript{103} A classification is "suspect" when the "class is . . . saddled with such disabilities or subjected to such a history of purposeful unequal treatment, or relegated to such a position of unequal powerlessness as to command extraordinary protection from the majoritarian political process." San Antonio Independent School Dist., 411 U.S. at 28.
cal care is a fundamental right. If the court finds that a fundamental right is at stake, the state must show that the statute is necessarily related to a compelling governmental interest. If no fundamental right is involved, the rational basis standard is applied and, a statute is valid if it is rationally related to a legitimate state objective.

A third, intermediate, standard has been applied to invalidate medical malpractice legislation challenged on an equal protection basis. This test applies to "suspect classifications," or "near fundamental" rights. Although the Supreme Court has limited the application of the intermediate standard test to cases involving classifications based on gender and illegitimacy, some state courts have expanded the classifications to which this standard applies to include the right to recover for personal injuries. Using this standard, a court determines whether the classification substantially furthers the asserted purpose for the classification. In contrast to the rational basis standard, the intermediate standard requires a state to provide a greater justification for its classification. It entails a close scrutiny of the legislative means and ends, with

104. Id. The Nebraska Supreme Court stated that the right to receive adequate medical care is a fundamental right. Prendergast, 199 Neb. 97, 114, 256 N.W.2d 657, 668 (1977). But cf. Carson, 120 N.H. at 931, 424 A.2d at 830 ("right to recover for one's injuries is not a fundamental right"); accord Jones v. State Bd. of Medicine, 97 Idaho 859, 870, 555 P.2d 399, 410 (1976), cert. denied, 431 U.S. 914 (1977).


106. For states applying a rational basis test, see State ex rel Schneider v. Liggett, 223 Kan. 610, 618, 576 P.2d 221, 227-28 (1978), appeal dismissed, 439 U.S. 808 (1978); Prendergast, 199 Neb. at 113, 256 N.W.2d at 667; State ex rel Strykowski v. Wilkie, 81 Wis. 2d 491, 508, 261 N.W.2d 434, 442 (1978).

107. See, e.g., Jones, 97 Idaho at 865, 555 P.2d at 411; Johnson v. Saint Vincent Hosp. Inc., 273 Ind. 374, 397, 404 N.E.2d 585, 600 (1980) (fair and substantial relationship between classification and purpose of legislation); Carson, 120 N.H. at 933, 424 A.2d at 831 ("whether challenged classifications are reasonable and have a fair and substantial relation to the object of the legislation"); Arneson, 270 N.W.2d at 133 ("close correspondence between statutory classification and legislative goals"). This intermediate standard has been called a "means scrutiny" test. Woods v. Holy Cross Hosp., 591 F.2d 1164, 1172 (5th Cir. 1979)


110. See Jones, 97 Idaho at 865-67, 555 P.2d at 413-16.

111. See id.
less deference accorded to legislative judgments. Instead of determining the merits of the asserted legislative goal of ameliorating the medical malpractice crisis, the court asks whether a crisis, does in fact exist, and then, whether the challenged legislation substantially furthers the goal of alleviating that crisis. Continued use of this standard to determine the validity of malpractice legislation may result in a proliferation of "suspect classifications" or an expansion of fundamental rights.

Courts have also applied special legislation arguments in testing the validity of tort reform. Many state constitutions provide that a special law benefitting a class of persons may not be passed when a general law is, or can be, applicable.

B. Modifying Access to the Courts

Critics of pretrial screening panels argue that the panels violate the due process and equal protection clauses of the Constitution, as well as unconstitutionally providing for the performance of judicial functions by nonjudicial entities. These panels have also been found to deny a claimant's fundamental right of access to the courts. The most critical factor in upholding the constitutionality of a pretrial screening panel is whether the review is mandatory or voluntary. If mandatory, it may be struck down as violating the right of ac-

112. See id.
113. See Redish, supra note 28, at 773.
115. See Redish, supra note 28, at 773.
116. See supra note 97.
120. See Cardinal Glennon Memorial Hosp., 583 S.W.2d 107, 110 (Mo. 1979). But see Comiskey v. Arlen, 55 A.D.2d 304, 390 N.Y.S.2d 122 (1976), aff'd, 43 N.Y.2d 696, 401 N.Y.S.2d 200, 372 N.E.2d 34 (1977), in which the court held that the statute providing for a medical malpractice panel did not deny the fundamental right of access to the courts. The screening panel, however, was convened after the court proceedings were commenced.
121. See AMA REPORT 2, supra note 3, at 16.
cess to courts, the right to a jury trial, or the separation of powers doctrine. Arguably, if the panel determines liability, or if its decision is seen as a form of expert evidence relied upon at a later trial, this is an improper usurpation of judicial power. This argument lacks substance, however, due to the non-binding nature of the panel’s findings. If the panel is voluntary, it will escape these challenges. In complying with these constitutional requirements, however, a panel is unlikely to achieve the goals of efficiency and screening out nonmeritorious claims.

Permitting the panel’s decision to be admitted into evidence at a subsequent trial is challenged as diluting the right to a jury trial. Although the panel’s decision is not binding at the later trial, its decision may unduly influence a jury, and thus preclude the plaintiff’s right to receive a meaningful jury trial. Courts have rejected this argument, finding that the panel merely provides the jury with the opinion of an expert panel, which the plaintiff may rebut at trial. This controversy does not arise in jurisdictions in which the panel’s findings are not admitted into evidence at a later trial.

Administration of pretrial screening or arbitration panels may also lead to constitutional challenges. The pre-litigation burden requiring a plaintiff to undergo the cost and delay of a pretrial process as a condition to trial may effectively deprive a plaintiff of state guaranteed access to the courts.

122. Cardinal Glennon Memorial Hosp., 583 S.W.2d at 109-10.
124. See Wright, 347 N.E.2d at 739-40.
125. But see Redish, supra note 28, at 795 (stating that this is a strained concept of separation of powers).
126. Id.
129. Redish, supra note 28, at 792.
130. See Comiskey, 390 N.Y.S. 2d at 125-26; see also Eastin v. Broomfield, 116 Ariz. 576, 580-81, 570 P.2d 744, 748-49 (1977) (admissibility of panel findings is merely rule of evidence, not violation of right to jury trial); Prendergast, 199 Neb. at 110, 256 N.W.2d at 665-66 (mere rule of evidence does not usurp judicial function).
131. See Redish, supra note 28, at 793; Comment, supra note 8, at 1461 & n.222.
133. See Aldona, 381 So. 2d 231, 236-38 (medical malpractice statute ten month jurisdictional period unconstitutional as applied); Simon, 355 N.E.2d at 907-08 (statute providing for compulsory arbitration before medical malpractice screening panel found unconstitutional). But see Johnson, 282 Md. at 299, 385 A.2d at 71 (additional
The Florida Supreme Court invalidated its pretrial procedures, finding them to be arbitrary and capricious and violative of a plaintiff's due process rights. In support of this conclusion, the court stated that the procedure had "proven unworkable and inequitable in practical operation." 134

Courts have struck down special statutes of limitation for minors on the grounds that such limitations violate equal protection 135 or arbitrarily deny minors their right to seek redress for injuries. 136 Measures to shorten the statutes of limitation for all medical malpractice victims have been unsuccessfully attacked as special legislation or as violating the equal protection clause of the fourteenth amendment. 137

Limitation statutes have also been altered so that the discovery rule applies only to situations where a foreign object is discovered in a plaintiff's body. 138 This type of statute has been successfully challenged as discriminating between different members of the class of medical malpractice claimants. 139 Curtailing or limiting the discovery rule in medical malpractice cases may violate state constitutional right of access provisions as well. 140

134. Aaldona, 381 So. 2d at 237.
140. Redish, supra note 28, at 791.
C. Shifting the Costs and Burdens of Litigation

State statutes abolishing the collateral source rule only in medical malpractice cases have been successfully challenged on equal protection grounds for discriminating against medical malpractice claimants.141 Other courts, however, have held that this legislation is constitutional, finding that it bears a reasonable relationship to the legitimate state interest of ensuring the availability of adequate medical care.142

Fixed caps on the amount of damages that victims can recover have been vulnerable to constitutional challenges. Courts have found these limitations void for arbitrarily limiting the rights of injured plaintiffs to recover.143 Other courts have found that the limitations deny patients equal protection by precluding the most seriously injured victims from fully recovering for their injuries.144 Still, other courts have rejected limitations on recovery, stating that the asserted general societal *quid pro quo* provided by the limitation, in the form of reduced insurance premiums and lower medical costs, did not extend to the seriously injured malpractice victim.145 Similarly, courts have found that allowing a court to order periodic payments to eliminate the "bonus element of a judgment," such as when a judgment includes future damages and a patient dies prematurely, unreasonably discriminates in favor of health care providers, and unduly burdens seriously injured plaintiffs.146

Statutes limiting contingent fee agreements have also been

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143. See, e.g., Wright, 63 Ill. 2d 313, 330, 347 N.E.2d 736, 742-43.


145. See Wright, 63 Ill.2d at 328, 347 N.E.2d at 742. But see Prendergast, 199 Neb. at 120-21, 256 N.W.2d at 671 ("there is no merit to the argument that if a common law right is taken away, something must be given in return").

146. See Carson, 120 N.H. at 944, 424 A.2d at 838.
challenged. Arguably, this type of reform aggravates the problem by acting as an incentive for attorneys to advise their clients to seek higher verdicts and settlements in order to maximize their own fees. The New Hampshire Supreme Court has held that this reform violates equal protection by discriminating between one class of plaintiffs and their attorneys. The court also stated that sliding scale attorneys' fees interfere with the freedom to contract between an attorney and his client, and unfairly make medical malpractice cases unattractive to attorneys. Contingent fee limitations create a potential impediment to injured plaintiff's access to the courts, since a plaintiff's ability to sue is often dependent upon the contingency fee system.

IV. MINNESOTA'S RESPONSE

Prior to 1986, the Minnesota Legislature had been relatively dormant with respect to crisis medical malpractice tort reform. During the 1986 legislative special session, however, strong tort reform measures were enacted, which affect all civil actions, as well as some measures directed specifically at medical negligence actions.

147. See id. at 944-45, 424 A.2d at 838-39.
148. AMA REPORT, supra note 3, at 15.
150. Id. Contra Johnson, 273 Ind. at 401-02, 404 N.E.2d at 602-03; Roa v. Lodi Medical Group, Inc., 37 Cal. 3d 920, 925-34, 211 Cal Rptr. 77, 79-85, 695 P.2d 164, 164-72 (1985) (limit on attorneys' fees does not violate equal protection, due process, or separation of powers doctrine).
151. Cf Carson, 120 N.H. at 945, 424 A.2d at 839.

Neither the Minnesota Session Law Service, nor the Laws of Minnesota for 1986 were published at the writing of this Article. Consequently, the citations to the new legislation will refer to the House file number (S.F. No. 2078) as indicated above.

153. The Minnesota Medical Association initiated a Commission in Professional Liability in 1985. From the Commissioner's report, several proposed bills were drafted. The most substantial by Kathleen Blatz, (Rep. I.R. Bloomington) which would have implemented, among other things, a mandatory pretrial certification of expert review, a five-year limit on the tolling of the statute of limitations for minors, elimination of punitive damages, a $250,000 limit on non-economic damages, abolition of the collateral source rule, and a provision for periodic payments of damages exceeding $100,000. See MINNESOTA MEDICAL ASSOCIATION, REPORT OF THE MINNESOTA COMMISSION ON PROFESSIONAL LIABILITY (Nov. 1985) (copy on file at the William Mitchell Law Review office).
A. Modifying Access to the Courts

1. Statute of Limitation

Until just recently, Minnesota's medical malpractice statute of limitation had remained essentially unchanged since its adoption in 1945. This statute provides that an action based on negligence by physicians or hospitals must be brought within two years of the negligent act.\(^{154}\) Prior to 1986, the most significant change in the limitations statute was in its breadth. The statute was expanded to include not only physicians, surgeons and dentists, but also "all other health care professionals."\(^{155}\) With respect to the limitation statutes, the 1986 legislation affects only plaintiffs under the age of 18 who are victims of medical negligence.\(^{156}\) The new statute applies to all medical malpractice actions commenced on or after January 1, 1987, and provides that the period of limitations may not be suspended for more than seven years or for no more than one year after the age of minority ceases.\(^{157}\)

2. Arbitration

There is no specific arbitration statute for medical malpractice cases in Minnesota, however, an arbitration plan was developed by a subcommittee of the Minnesota State Bar Association in 1971.\(^{158}\) This procedure utilizes the general

\(^{154}\) Minnesota Statutes section 541.07 provides:
Except where the uniform commercial code or this section otherwise prescribes, the following actions shall be commenced within two years:

(1) for libel, slander, assault, battery, false imprisonment, or other tort, resulting in personal injury, and all actions against physicians, surgeons, dentists, other health care professionals as defined in section 145.61, and veterinarians as defined in chapter 156, hospitals, sanitoriums, for malpractice, error, mistake, or failure to cure, whether based on contract or tort.

\(^{155}\) 1984 MINN. LAWS ch. 608 § 4. This change shortened the time in which a plaintiff was required to file suit against nurses, dental hygienists, and other health care professionals who previously could have been found to fall under the six-year statute of limitations.

\(^{156}\) S.F. No. 2078, supra note 152, § 79 (to be codified as amended at MINN. STAT. § 541.15(a)(1) (1986)).

\(^{157}\) Id. § 79 (to be codified as amended at MINN. STAT. § 541.15(b) (1986)). This provision has been interpreted by those who drafted it to provide that the two-year statute of limitations does not begin to run until seven years after the cause of action arises. Therefore, the child has nine years within which to bring a claim, unless he reaches the age of 18 first, and then the child must bring the claim by his 19th birthday. Under no circumstances may the period of limitation be less than two years.

\(^{158}\) See Orwoll, Medical Malpractice Arbitration, BENCH & B. MINN., Aug. 1985, at
Minnesota Arbitration Statute, and specifically provides for a voluntary agreement between patients and health care providers to arbitrate their claims. The procedure has been so seldomly used, however, that it is difficult to evaluate its effect on medical malpractice litigation other than to surmise that, as a result of its infrequent implementation by practitioners, it has had no effect whatsoever.

3. Certificate of Review

The 1986 reform measures include a statute which requires that a certification of expert review accompany the service of summons and complaint in all medical malpractice cases commencing on or after August 1, 1986. The certifying affidavit must be signed by the plaintiff’s attorney and state that the case has been reviewed by “an expert whose qualifications provide a reasonable expectation that the expert’s opinions could...
be admissible at trial." The expert must be of the opinion that one or more of the defendants has deviated from the applicable standard of care, thereby causing the plaintiff’s injury.

In addition to the certifying affidavit, a plaintiff must provide the defendant with an affidavit identifying the expert witnesses upon whose testimony the plaintiff will rely at trial within 180 days after commencement of the suit. The affidavit must include the identity of each expert, the substance of the facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. These new requirements must be met only in cases and to issues in which expert testimony is necessary to prove a prima facie case of medical negligence. The statute also provides that the parties can agree to extensions of the time limits or that the court may extend these time limits upon a showing of good cause. The penalty for noncompliance with these requirements is harsh—upon motion, those issues in the case requiring expert testimony will be dismissed with prejudice.

Although the implementation of this statute will likely expedite the pretrial discovery process and reduce the frequency of frivolous claims, it may also cause the dismissal of meritorious

164. Id. § 60 (to be codified at MINN. STAT. § 145.682, subd. 3(a) (1986)). See Cornfeldt v. Tongen, 262 N.W.2d 684, 699 (Minn. 1977), rev’d on other grounds, 295 N.W.2d 638, 640 (Minn. 1980) for a description of an expert who is qualified to testify.

165. S.F. No. 2078, supra note 152, § 60 (to be codified at MINN. STAT. § 145.682, subd. 3(a) (1986)).

166. Id. § 60 (to be codified at MINN. STAT. § 145.682, subd. 4 (1986)). Plaintiff must disclose the expert’s name, substance of facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. This may be provided in an affidavit executed by plaintiff or his attorney, or by answer to expert interrogatories. Id. Minnesota Rules of Civil Procedure require that answers to expert interrogatories be based upon the same criteria prior to trial, therefore, this portion of the new law changes only the time frame within which this requirement must be completed.

167. Id. § 60 (to be codified at MINN. STAT. § 145.682, subd. 2 (1986)). Evidently, excluding the rare res ipsa loquitur cases where lay persons are able to grasp the issues and determine negligence without the help of an expert.

168. Id. § 60 (to be codified at MINN. STAT. § 145.682, subd. 4 (1986)).

169. Id. § 60 (to be codified at MINN. STAT. § 145.682, subd. 6 (1986)). Upon motion, the action will be dismissed with prejudice if plaintiff’s attorney fails to comply within 60 days of defendant’s demand for the certifying affidavit. Failure to comply with the expert identification requirement results in mandatory dismissal with prejudice upon motion of the defendant. Note that pro se plaintiffs must also comply with this provision.
claims, since plaintiffs may be unable to comply with the arbitrary time frame. Thus, the already difficult task of locating a qualified physician willing to testify against the defendant physician will be further complicated by a short time frame.

B. Shifting the Costs and Burdens of Litigation

Shifting the costs and burdens of litigation has been the most popular response to rising insurance costs in other states. Until the recent legislation, Minnesota had not invoked any of the mechanisms used to achieve the goal of this type of tort reform. All civil actions commenced on or after August 1, 1986, however, will be subject to collateral source calculations, a $400,000 limit on intangible losses, a requirement that juries allocate damages as past, future, and intangible, and a discounting of future damages to present value.

1. Collateral Source Rule

The new collateral source rule provides that in any civil action where liability is admitted or determined, a party may file a motion for determination of collateral sources within ten days of the verdict if damages include an award for losses compensable by collateral sources up to the date of the verdict. Once the motion is filed, the parties must submit written evidence of the amount of collateral sources paid to benefit the plaintiff, except those for which subrogation rights have been asserted. Amounts incurred by or on behalf of the plaintiff or his immediate family to secure the right to payment from a collateral source for the two years prior to accrual of the cause of action shall also be submitted as evidence. The court shall then offset these two values and reduce the verdict accordingly. The jury will not be informed of the plaintiff's collateral sources.

170. *Id.* § 80 (to be codified at *Minn. Stat.* § 548.36 (1986)).
171. *Id.* § 88 (to be codified at *Minn. Stat.* § 549.23, subd. 2 (1986)).
172. *Id.* § 89 (to be codified at *Minn. Stat.* § 549.24 (1986)).
173. *Id.* § 86 (to be codified at *Minn. Stat.* § 604.07, subds. 2, 3 (1986)).
174. *Id.* § 80 (to be codified at *Minn. Stat.* § 548.36, subd. 2 (1986)).
175. *Id.* § 80 (to be codified at *Minn. Stat.* § 548.36, subd. 2(1) (1986)).
176. *Id.* § 80 (to be codified at *Minn. Stat.* § 548.36, subd. 2(2) (1986)).
177. *Id.* § 80 (to be codified at *Minn. Stat.* § 548.36, subd. 3 (1986)).
178. *Id.* § 80 (to be codified at *Minn. Stat.* § 548.36, subd. 5 (1986)).
2. Limiting Damages

The new tort reform legislation provides that in all civil suits, "intangible damages" shall not exceed $400,000. Intangible damages are defined as embarrassment, emotional distress, and loss of consortium, and do not include pain, disability, or disfigurement. Again, the jury is not informed of this limitation. A plaintiff’s verdict is further discounted in all civil cases claiming personal injury, wrongful death, or loss of means of support by reducing future damages to their present day value. Evidence of projected future earnings and loss of future earning capacity cannot be based on inflationary changes or general economic statistics and must be reasonably certain to occur. Those statutory changes affecting the actual amount paid in a verdict will be facilitated by a new provision requiring the jury to break down its assessment of damages into past and future damages and to further specify the amount of intangible losses within those two categories.

3. Contingent Attorneys’ Fees

The traditional contingent attorneys’ fee arrangement is also changed by the 1986 reform. Pursuant to the new legislation, contingent attorneys’ fees will be based on the award as adjusted to comply with the new collateral source rule. Any subrogated provider of collateral sources must pay the same percentage of attorneys’ fees as paid by the plaintiff and its proportionate share of the costs if it is not separately represented by counsel in its action to recover collateral payments.

179. Id. § 88 (to be codified at MINN. STAT. § 548.23, subd. 2 (1986)). Note also that subdivision 4 of section 548.23 makes it clear that "this section does not create a new cause of action for intangible loss." Id.
180. Id. § 88 (to be codified at MINN. STAT. § 548.23, subd. 1 (1986)).
181. Id. § 88 (to be codified at MINN. STAT. § 548.23, subd. 3 (1986)).
182. Id. § 86 (to be codified at MINN. STAT. § 604.07, subd. 2 (1986)).
183. Id. § 86 (to be codified at MINN. STAT. § 604.07, subd. 3 (1986)).
184. Id. § 89 (to be codified at MINN. STAT. § 549.24 (1986)).
185. Id. § 80 (to be codified at MINN. STAT. § 548.36, subd. 4 (1986)).
186. Id. This section appears to encourage plaintiff’s counsel to represent the subrogated collateral source provider as well as the plaintiff in order to maintain attorneys’ fees equivalent to the pre-adjustment award.
C. Modifying Evidentiary and Procedural Requirements

1. Punitive Damages

Pretrial procedures have been altered by the 1986 legislation. First, punitive damages may not be claimed in the summons and complaint in any civil action.\(^{187}\) The legal basis for punitive damages must be alleged in a motion to amend the complaint.\(^{188}\) The motion must be supported by one or more affidavits stating the factual basis for the claim.\(^{189}\) The movant has the burden of proving with prima facie evidence of the allegations before the court may grant the motion.\(^{190}\)

2. Access to Treating Physician’s Opinions

The second pretrial alteration affects only medical malpractice claims. Formerly, a plaintiff bringing a claim for medical malpractice was deemed to have waived his physician-patient privilege. Defendants were thus able to gain access to a plaintiff’s medical records and obtain deposition testimony relating to a plaintiff’s medical condition. Pursuant to the new legislation, claims commenced or pending on August 1, 1986, will also allow defendants access to a plaintiff’s treating physician by permitting informal interviews if the treating physician consents.\(^{191}\) The defendant is required to give prior notification to plaintiff’s counsel of the informal conference so that he may attend.\(^{192}\)

3. Ad Damnum Clause

In 1978, the Minnesota Legislature required that *ad damnum* clauses in actions for damages of unliquidated amounts state only that they are deemed to be over $50,000, unless the amount requested was less than $50,000.\(^{193}\) As in other jurisdictions, the asserted purpose of this legislation was to reduce

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187. *Id.* § 82 (to be codified at MINN. STAT. § 549.191 (1986)).
188. *Id.*
189. *Id.*
190. *Id.* The statute also provides: “For purposes of tolling the statute of limitations, pleadings amended under this section relate back to the time the action was commenced.” *Id.*
191. *Id.* § 84 (to be codified as amended at MINN. STAT. § 595.02, subd. 4 (1986)). If the treating physician does not consent to an informal meeting, his deposition may be taken by defendant without a court order. *Id.*
192. *Id.*
D. Insurance Regulation

The 1986 legislature passed several insurance reporting and regulating provisions. One provision requires liability insurers such as those providing medical malpractice coverage, to provide the Commissioner of Insurance with annual reports, including direct writings in Minnesota and the United States, direct premiums written, net investment income, incurred claims, reserves, actual increased expenses and net operation, and underwriting gains or losses. This measure increases the accountability of the professional liability insurer. Prior legislation already required Minnesota professional liability insurers to report, on a quarterly basis, any medical malpractice awards or settlements made on behalf of their insureds. In addition, such insurers are required to report and maintain records of the subject doctors. The pre-1986 legislation also provided for Attorney General investigations of those doctors as necessary. Neither the newly enacted reporting measures or the previously existing statutes directly address a solution to the medical malpractice crisis, but rather, exist to

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194. MINN. STAT. § 544.36 (1984). The statute provides:
In a pleading in a civil action which sets forth an unliquidated claim for relief, whether an original claim, cross-claim, or third-party claim, if a recovery of money is demanded in amount less than $50,000, the amount shall be stated. If a recovery of money in an amount greater than $50,000 is demanded, the pleading shall state merely that recovery of reasonable damages in amount greater than $50,000 sought.

Id. A similar proposal was discussed by the Legislature in 1976, but was not passed. See Heins, Statutory Changes in Minnesota Tort Law-1978, HENNEPIN LAW., Sept.-Oct. 1978, at 6.

195. MINN. STAT. § 65A.32 (1984) (amended by section 42 of the bill to include liability and casualty insurers in the FAIR plain); MINN. STAT. § 70A.04, subd. 2 (market insurance rates); MINN. STAT. § 70A.06, subd. 1 (every licensed insurer must file rates with Commissioner before they may become effective and Commissioner may require supporting data); and MINN. STAT. § 70A.11, subd. 1 (if Commissioner disapproves of rates, policy holder receives a refund plus interest).

196. MINN. STAT. § 147.111 (Supp. 1985). Subdivision 1 of section 147.11 provides:
Four times each year as prescribed by the Board, each insurer authorized to sell insurance described in Section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to physicians . . . against whom medical malpractice settlements or awards have been made to the plaintiff.

Id.

197. MINN. STAT. § 147.073 (1985).

198. Id.
provide the Insurance Commissioner and the public with information regarding the medical malpractice insurance industry, and a mechanism to identify incompetent physicians. Hopefully, the data gathered pursuant to these statutes will shed some light on the role that the insurance industry plays in the medical malpractice crisis.

In addition to the previously discussed reporting requirements, the 1986 legislative session renewed the Joint Underwriting Association Act (JUA). The JUA provides that all insurers authorized to provide personal injury coverage in Minnesota fund an association created to provide professional liability insurance to health care providers unable to obtain insurance on the voluntary market. Acknowledging that the insurance crisis is more widespread than just medical malpractice, the legislators promulgated an all-purpose JUA to be used by “any person or entity” unable to obtain liability insurance through ordinary means.

V. The National Response

In response to the medical malpractice crisis, the “Medical Offer and Recovery Act” (Act) was introduced in Congress in the Spring of 1984. The Act attempts to add uniformity to ad hoc state tort reforms. The Act is modeled after a proposal advanced by Professor Jeffrey O’Connell. It adopts a no-
fault scheme permitting a health care provider to extinguish a patient's common law remedy to sue in tort. The health care provider is allowed to promptly tender an offer to pay the patient's net economic losses once a patient makes a claim.204 The offer itself extinguishes the patient's access to the legal system, thereby giving the defendant the choice of implementing this Act, or utilizing the existing tort system.205 The advantages of this proposal to the defendant are that it relieves the defendant health care provider from paying any non-economic damages206 or amounts previously paid to the claimant through collateral sources,207 and that it eliminates the burdens and cost of complex, expensive litigation.

Under the Act, the patient must accept the tendered offer in total satisfaction of his personal injury claim, because once the offer is made, the patient is left with no other remedy. The Act specifically precludes claims for non-economic loss, loss of earning capacity,208 claims for wrongful death,209 and injuries intentionally inflicted by health care providers.210

After the offer is made, the claimant is required to submit proof of wage loss and medical costs, including rehabilitation costs and replacement services resulting from the claimant's injuries.211 The claimant is compensated for 100% of his wage loss, reduced by any substitute work performed.212 The claimant is further compensated for products, services, and accommodations reasonably needed for medical care, remedial treatment, rehabilitation, and occupational training.213 Replacement services are defined as reasonable expenses incurred by the patient's family in obtaining the ordinary and reasonable services that the patient provided to the family.

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205. Id.
206. Id. § 1822(b)(3).
207. Id. (b)(4).
208. Id. (b)(3).
209. Id. § 1821(a)(1)(B)(ii).
210. Id. (a)(3). In the case of an intentionally inflicted injury, the injured individual may elect, within 90 days of the date of an offer tendered by a health care provider, to receive benefits under the Act within 90 days after the date of an offer tendered by a provider. Id.
211. Id. §§ 1822(d)(1)(2); 1823(a)(1)(A).
212. Id. § 1822(b)(2)(B).
213. Id.
before the personal injury.\textsuperscript{214} The patient may receive services necessary to treat pain and suffering attributable to the injury, even though the Act does not provide compensation for pain and suffering.\textsuperscript{215}

The provider must pay the claimed amount within 30 days of the submission of proof of cost.\textsuperscript{216} The amount paid is reduced by any funds recovered by the claimant from a collateral source.\textsuperscript{217} Court approval is mandatory for settlements over $5,000.\textsuperscript{218} Additionally, a court will be consulted in the event of a dispute over issues involving discovery, physical or mental examinations, amount or type of compensation to be paid, or patient refusal to submit to a type of treatment or surgery recommended by the health care professional.\textsuperscript{219}

The Act encourages states to enact similar legislation. In the absence of a similar state law, the Act would apply to all federally funded health care programs, such as Medicare, Medicaid, and VA benefits. The Act further encourages states to establish assigned claims plans with participating insurance companies.\textsuperscript{220} Failure to do so permits the Secretary of Health & Human Services to maintain such a program within the state.\textsuperscript{221}

Although based on O’Connell’s proposal, the Act implements all of the plaintiff-limiting elements, but does not provide a \textit{quid pro quo} to balance the parties’ interests.\textsuperscript{222} The original proposal was amended in 1985 to incorporate two major provisions to alleviate that problem. First, absent any action by the defendant, the patient may initiate arbitration proceedings to determine whether the defendant should be required to pay economic losses.\textsuperscript{223} This determination is based on the fault, if any, of the defendant.\textsuperscript{224} This addition is an attempt to balance the decision-making power between the physician and the patient, giving the patient a means to trigger

\begin{footnotes}
\item[214.] \textit{Id.} (b)(2)(C).
\item[215.] \textit{Id.} (b)(1)(A).
\item[216.] \textit{Id.} § 1823(a)(1)(A).
\item[217.] § 1822(b)(1).
\item[218.] \textit{Id.} § 1825(a).
\item[219.] \textit{Id.} § 1824(a)(2); \textit{id.} (b)(1); \textit{id.}(b)(3)(c).
\item[220.] \textit{Id.} § 1826(b)(1).
\item[221.] \textit{Id.} (b)(2).
\item[222.] § 1821(a)(1)(B).
\item[223.] \textit{Id.}
\item[224.] \textit{Id.}
\end{footnotes}
his entry into the system. Second, if the patient refuses the defendant's offer to pay economic losses, the patient may sue in court, but for general damages only. In other words, the patient is no longer foreclosed from a common law remedy, but if the patient chooses the tort system, the patient loses the possibility of recovering economic damages. Conversely, if the patient accepts the offer, the patient foregoes the possibility of recovering non-economic damages. This latter change is based on the idea that once a patient has refused a defendant's offer to pay economic damages, he has "waived" compensation for those items.

CONCLUSION

The excessive costs involved in medical malpractice litigation, both monetary and emotional, result from the parties' failure to work together toward their common goals. Doctors, insurance companies, and patients share common goals: to reduce the occurrence of medical malpractice; to adequately compensate victims of medical malpractice; and to decrease the costs of litigation and medical care. Each interest group, however, continues to vehemently advocate its own position, rather than pooling resources with the other groups. The problem should be approached with a more realistic attitude toward compromise. The new legislation in Minnesota appears to adopt a more realistic approach. The legislation, however, does not require compromise from all parties involved—notably physicians. Physician discipline was not addressed by the legislation. There is no question that medical negligence is occurring, yet none of the recently enacted legislation ad-

225. In O'Connell's proposal, the patient is guaranteed that if the defendant fails to tender an offer and the patient brings a lawsuit, the defendant-physician cannot assert any defenses based on the patient's fault. This proposal further enhances the patient's position by shifting the burden of proving "no fault" to the defendant-physician once the patient has established a prima facie case of liability.

226. This second change is most likely drawn from a suggestion by O'Connell that additional elements may be necessary to encourage the use of his new system and that adding a term such as the second one "would serve as further inducement to claimants with substantial economic losses to accept settlement. . . ." O'Connell, supra note 98, at 624.

addresses this aspect of the problem. Although many of the Minnesota Medical Malpractice Commission's recommendations became cornerstones for the recent state tort reform, the recommendations of the Commission addressing this issue were not adopted. Minnesota is not alone in its reluctance to address physician discipline. Virtually no effective physician disciplinary process is utilized in any of the states.

With time, the effect of the recent statutory changes on medical negligence litigation in Minnesota will be ascertainable. The information obtained by the Insurance Commissioner will help to assess the adequacy of the insurance market, and provide consistent accurate data with which to evaluate the effect of the legislative changes. The lack of objective data in the past has been a considerable stumbling block in analyzing the medical malpractice crisis. The absence of physician disciplinary measures, however, guarantees that the incidence of malpractice will not decline. This is the next area of tort reform which should be addressed by the legislature.