INTRODUCTION

Because malpractice liability is felt by many interested parties to be a contributor to health care cost escalation, numerous medical malpractice reform provisions have been proposed both as components of comprehensive health care reform bills and as separate pieces of legislation. [1] A number of the proposed reforms have already been implemented in some States. To understand whether and how Federal adoption or encouragement of these reforms might affect current trends in medical malpractice, it is important to examine the experience of States that have tried them.

This chapter describes the malpractice reforms that have been implemented or proposed to date. It focuses exclusively on strategies that would change the way malpractice claims are handled in the legal system--strategies commonly referred to as "tort reforms." [2] For each type of reform, it offers a brief description of the rationale and mechanism. discusses State experience (if any), and raises what have been or are likely to be key issues of concern, Appendix B briefly discusses constitutional challenges to State reforms and the implications of these challenges for Federal tort reform efforts. Chapter 3 provides a comprehensive and critical review of the existing empirical evidence of the impact of these reforms on medical malpractice claims and insurance premiums.

OVERVIEW OF MALPRACTICE REFORM APPROACHES

Tort reform approaches range from modest to comprehensive. Some would largely retain the current system for resolving malpractice claims but change some of its legal rules; others would entail broader changes in the forum for deciding malpractice claims; still others would eliminate the current fault-based system and create an entirely new system for compensating victims of adverse medical outcomes.

The goal behind many of the reforms that have been implemented to date is to reduce the frequency and/or payouts for malpractice claims. Some do this by limiting malpractice awards (e. g.. caps on damages): others, by limiting access to the courts (e. g., pretrial screening): and still others. by changing the legal rules for determining physician negligence (e. g., use of practice guidelines to establish the legal standard of care).

It should be noted that concern for patient s--e. g., increasing access to the courts for the many meritorious claims that are never filed and reducing the incidence of malpractice has been conspicuously absent from the rationale supporting many of the existing reforms. Rather, most reforms have been driven by the perception of a "malpractice crisis, " in which high litigation rates and questionable financial incentives are viewed as the culprits.

One exception is procedural reforms. such as alternative dispute resolution (ADR), which attempt to reduce the costs of resolving a malpractice suit, facilitate quicker resolution of suits, create more rational and uniform damage awards, and/or decrease the adversarial nature of the litigation process, Many ADR procedures are already available but are not widely used in medical malpractice. More comprehensive ADR proposals, such as the American Medical Association/Specialty Society Medical Liability Project (AMA/SSMLP) administrative system, would require legislative action to implement and are now merely proposals. The potential impact of these procedural reforms is difficult to predict. To the

extent that they lower the costs of bringing a suit, or otherwise make litigation more appealing, they may prompt additional suits. However, if these strategies discourage or weed out nonmeritorious suits, they may enable more deserving victims to receive compensation without greatly increasing costs.

Some recent reform proposals aim to change the malpractice system in a more fundamental way. For example, enterprise liability is designed to remove personal liability from the physician and place it on the health care organization in which the care was given. The goals of enterprise liability include improving quality control in the provision of health care, reducing overall premiums, and simplifying the resolution of malpractice claims. Another proposal would reform liability through private contracts, allowing providers and patients to contract for different liability arrangements. This reform rests on the assumption that uniform legal rules for liability may not serve the interests of all providers and patients. Providing them with the authority to contract for different liability systems may prove more efficient in terms of cost, time, and psychological effort involved in resolving a malpractice claim.

Finally, there are proposals to replace the fault-based malpractice system with a no-fault system (e.g., one that is analogous to workers' compensation). There are several arguments for such a change, including the need to increase the percent of injured persons who receive compensation, to control administrative costs, and to remove the stigma of a malpractice claim for the physician.

Most of the tort reforms proposed or considered at the Federal level have been implemented in a number of States over the past two decades (see table 2-1).[3] In recent years, a few States have begun experimenting with more innovative reforms, such as limited no-fault programs and the use of practice guidelines in determining the legal standard of care. Some proposals have been debated mainly in academic journals and by interest groups, not in legislatures. All of these reform proposals are discussed below.

REFORMS TO REDUCE THE FREQUENCY AND COST OF MALPRACTICE SUITS

Economic theories of behavior postulate that a patient's decision to sue is based in part upon the expected return, net of legal fees and other costs of litigation (16), The patient's attitudes toward risk and the judicial system may also play a role (4 1.92). A number of reforms attempt to 1imit the frequency and cost of malpractice litigation by altering the financial incentives to sue or by changing the legal rules of the system to discourage lawsuits. Some of these reforms simply attempt to reduce the number and monetary size of lawsuits, irrespective of their merit. Others discriminate more carefully between meritorious and nonmeritorious claims in their attempt to stem litigation.

Several reforms attempt to discourage plaintiffs from pursuing claims by raising the transaction costs of bringing a suit or by placing restrictions on damages. A second class of reforms attempts to reduce the number of suits by changing the process or the incentives for filing a lawsuit. For example. limits on attorney fees both lower transaction costs and control lawyers' financial incentives to take on plaintiffs cases. Shortening the statute of limitations and requiring pretrial screening present additional barriers for individuals who want to pursue litigation. A third class of reforms attempts to reduce the probability of a plaintiff's success by changing the legal rules for determining physician negligence.[4]

Limiting Access to the Courts

Several reforms limit plaintiffs' access to the legal system. Statutes of limitations act to cut off all access after a certain period of time. Most other reforms focus on limiting the number of nonmeritorious suits brought, although in practice they may discourage other meritorious suits.

Shortening Statutes of Limitations

Statutes of limitations are legal rules that determine how long after the injury one can bring a lawsuit. Part of the rationale for limiting the time in which a plaintiff can file a lawsuit is (hat evidence becomes stale over time (e.g., witnesses leave or die, evidence is lost, and the accepted standard of care may change). At some point, the plaintiff's right to bring a suit is outweighed by the defendant's interest in not being subjected to a suit in which some of the evidence needed to defend himself or herself is no longer available. The limitations also allow individuals and insurers to anticipate future liability from past conduct (66).

Requiring a patient to bring a lawsuit within a certain number of years after the injury may appear reasonable; however, in some cases medical injuries are not discovered for a long time. To address this problem, the courts adopted a "discovery rule" in which the period during which a suit can be brought does not begin until it was reasonable for the plaintiff to have discovered the injury (66). Most medical malpractice statutes of limitations now include such a "discovery" provision. The standard leaves judges to decide when it was "reasonable" to have discovered an injury and may therefore still allow some claims to be filed long after the medical treatment that caused the injury. In a study of *48,550* medical malpractice claims closed between 1985 and 1989, the average time elapsed between the date of the incident and the date it was reported to the malpractice insurance company was 20 months: however, the time elapsed exceeded 3 years in approximately 10 percent of the claims studied (111).

Every State has some statute of limitations for medical malpractice claims. During the 1970s, a number of States shortened the statutory limits in hopes of decreasing the number of old suits brought. The new statutes of limitations usually make exceptions only in cases involving fraud, deliberate misconduct, or foreign obiects left inside a patient during surgery (see app. A, table A-4). The traditional provisions for minors (which typically extended the statute of limitations until a specified time after the child has reached the age of 18 or 21) have often been limited as well (14). A number of restrictions on statutes of limitations have been overturned by State courts, especially restrictions for minors.[5]

Today, most States require that a malpractice suit be brought within a specified time of the date of the negligent care or injury (in most States within 2 years) or, in cases where the injury cannot be discovered easily, within 6 months to 3 years after the injury is discovered or should have reasonably been discovered (table A-4). In California. for example, a malpractice suit must be brought within 1 year of reasonable discovery of the injury, or within 3 years of the date of the injury (Ann. Ca. Code C.C.P. $340.5 (West 1982)). In only eleven States, the statutes of limitations do not contain a discovery provision.

Pretrial Screening Panels

Another reform that limits access to the courts is the use of pretrial screening panels to review cases before they go to court.[6] These panels may offer a mandatory or voluntary screening process by which the merits of the case can be reviewed and nonmeritorious suits weeded out (14). The typical panel consists of a physician or other health care worker, a legal professional (e. g.. retired judge or lawyer), and a

Table 2- --Summary of State Medical Malpractice Tort Reforms[a]

State	Medical Malpractice Arbitration Provisions[b]	Attorney Fee Limits[c]	Caps on Damages	Collateral Source Offset	Periodic Payment of Awards	Pretrial Screening Panels
				= Mandatorv	D = Discretionarv	= Voluntarv
Alabama			U	n	M	
Alaska	√		7	)	C	M
Arizona		√		n	M	
Arkansas					C	V
California	√	v	√	)	M	
Colorado	√		√	M	M	
Connecticut		7		M	C	V
Delaware		√			C	V
D C						
F o da			O	M	D	O
Georgia	√			U		
Hawaii	√	√	√			M
Idaho			1-	M	D	M
Illinois	√	√	U	M	M	U
Indiana		√	√	D	n	M
Iowa		√		M	D	
Kansas		√	√U	MU	U	V
Kentucky				n		
Louisiana	√		7-		M	M
Maine		√		M	M	M
Maryland		√	1-	D	D	M
Massachusetts		√	√	M		M
Michigan	√	√	7	M	M	M
Minnesota					D	
Mississibbi						
Missouri			√		M	C
Montana				M	D	M
Nebraska		√	√			M
Nevada						M
New Hampshire		√	O	O	O	V
New Jersey	√	√		M		
New Mexico			7-	M	M	M

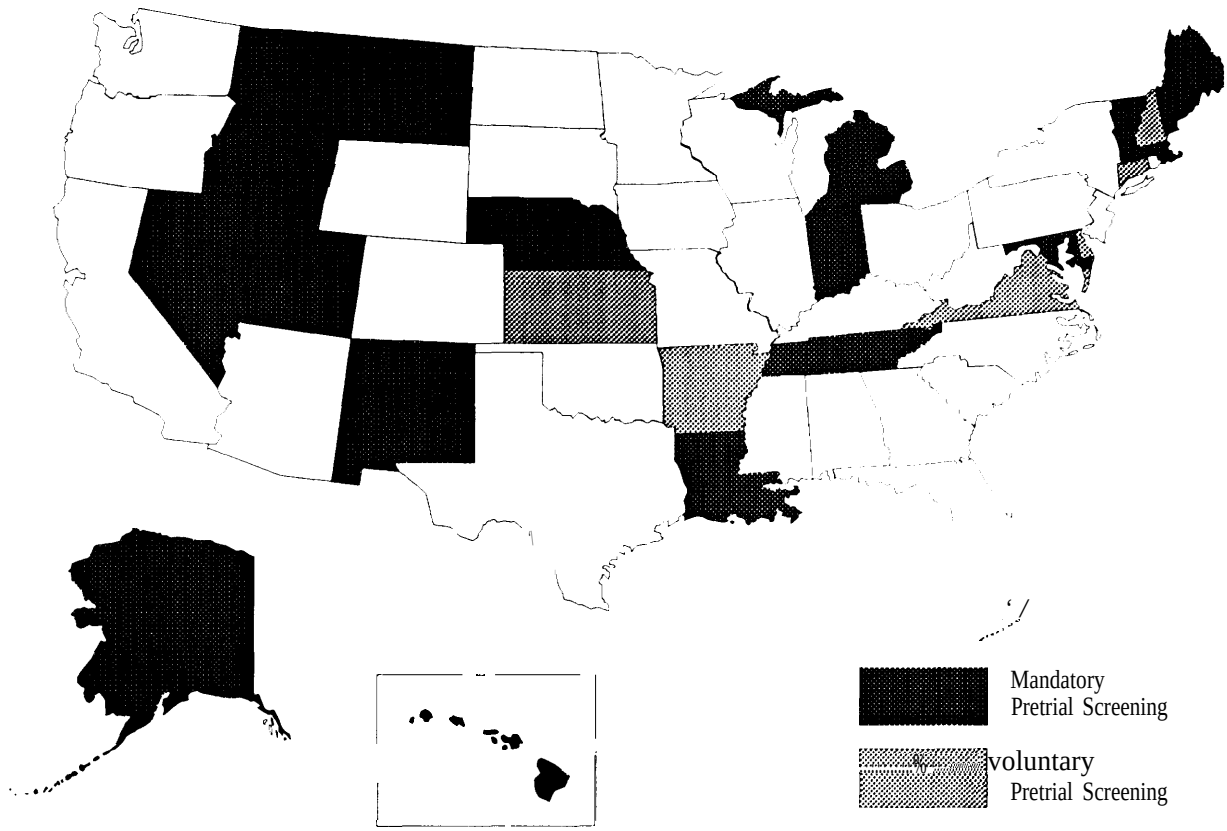
State	Medical Malpractice Arbitration Provisions[b]	Attorney Fee Limits[c]	Caps on Damages	Collateral Source Offset	Periodic Payment of Awards	Pretrial Screening Panels
				M = Mandatory	D = Discretionary	V = Voluntary
New York	√	√		M	D	
North Carolina						
North Dakota			0	DO	D	
Ohio	√		0	M	M	
Oklahoma		√				
Oregon			√	D	D	
Pennsylvania		0		0		0
Rhode Island				M	D	0
South Carolina					D	
South Dakota	√		√	D	M	
Tennessee		√		M		M
Texas			0			
Utah	√	√	√	M	M	M
Vermont						M
Virginia	√		√			V
Washington		√	0		M	
West Virginia			√			
Wisconsin		√	√			
Wyoming						0

Abbreviations:
M = Mandatory
D = Discretionary
V = Voluntary
O = A malpractice specific provision was overturned by Court. In certain States, the legislature corrected the constitutional deficiency.

Footnotes:
[a]For additional details on all categories, see app. A.
[b]A "√" indicates States with voluntary, binding arbitration provisions that are designed Specifically for medical malpractice cases. Voluntary, binding arbitration is an option in every State under general arbitration statutes. In Hawaii the provision applies to mandatory non-binding arbitration.
[c]A "√" in "Attorney Fees" means the statutory provision limits attorney fees to a specific percent of award. In a few States the courts are given the authority to determine or approve attorney fees (see app. A).

SOURCE: Office of Technology Assessment, 1993.

Figure 2-1--Pretrial Screening Panels for Medical Malpractice



Source: Office of Technology Assessment, 1993.

layperson. The panel's judgment usually does not preclude the parties from going to court; however, the judgment is often admissible in any subsequent trial and may influence the jury (20,48).

OTA identified 22 States with some form of pretrial screening. In 16 of these States the provision is mandatory (although in some States it can be waived if requested by one or both parties), and in an additional six it is voluntary (table 2-1; figure 2-l). The details of screening panel composition and function vary among States and can change the panel effectiveness. One recurring problem is recruiting professionals willing to sit on screening panels. States that require more members on the panel may experience considerable delay (20).

The panel role and the admissibility of its decision in subsequent proceedings may also determine its influence on the disposition of the claims. In some States the panel can render an opinion on damages, while in others the panel can address only liability (20). The admissibility of the panel decisions in further judicial proceedings and the evidentiary weight accorded to the decision also vary. Some States allow the decision to be admitted if both parties agree. At least one State does not permit the

decision to be introduced in further proceedings unless it was unanimous. One State--Maryland--requires that the decision (on both fault and damages) be admitted in subsequent trials, and the jury is instructed to presume that the panel's decision is correct unless rebutted by the party rejecting the finding (Ann. Code of Md. Cts. & Jud. § 3-2A-06 (Michie 1989)). In other States, the decision is admissible but is not regarded as definitive evidence. (See appendix A for further details.)

Pretrial screening provisions have been overturned in six States on the grounds that they infringe upon State constitutional guarantees of right to trial or access to courts.[7] In five other States, pretrial screening provisions were passed but then repealed through legislative action (table 2-1).

A less involved approach to screening suits is the requirement that the parties meet for a settlement conference prior to trial. The parties may be required to submit a reasonable settlement offer at the conference. This is not a novel idea, and many courts have implemented it without explicit legislative directives. Finally. some States require the plaintiff to file a certificate of merit prior to filing a suit. A certificate of merit is basically an affidavit by a physician attesting to the fact that the plaintiff's case has merit (see. e.g., 735 ILCS 5/2-622 (West 1992); Ann. Code of MD. Cts. & Jud. § 3-2A-04(b) (Michie 1989)).

Limits on Attorney Fees

Under the traditional system, plaintiffs' attorneys are paid on a contingency basis; i.e., they are paid only if they win (see ch. 1). Attorneys collect on average 33 percent of the plaintiff's award (142). Since financial incentives play a role in lawyers' decisions whether or not to take on malpractice cases (1 12), the number of malpractice suits might be reduced by restricting fees. However, such reductions might occur at the expense of further discouraging attorneys from taking on meritorious cases whose expected financial returns are low. About one-half of the States either specify a limit on attorney fees or authorize the courts to set attorney fees (table 2-1; figure 2-2). In most cases, attorney fee limits are not direct limits on the amount attorneys can charge their clients. Rather. they are limits on the portion of the damage award that may be applied toward attorney fees. The form of the limitation varies from State to State (app. A; table A-6).

Costs Awardable in Frivolous Suits

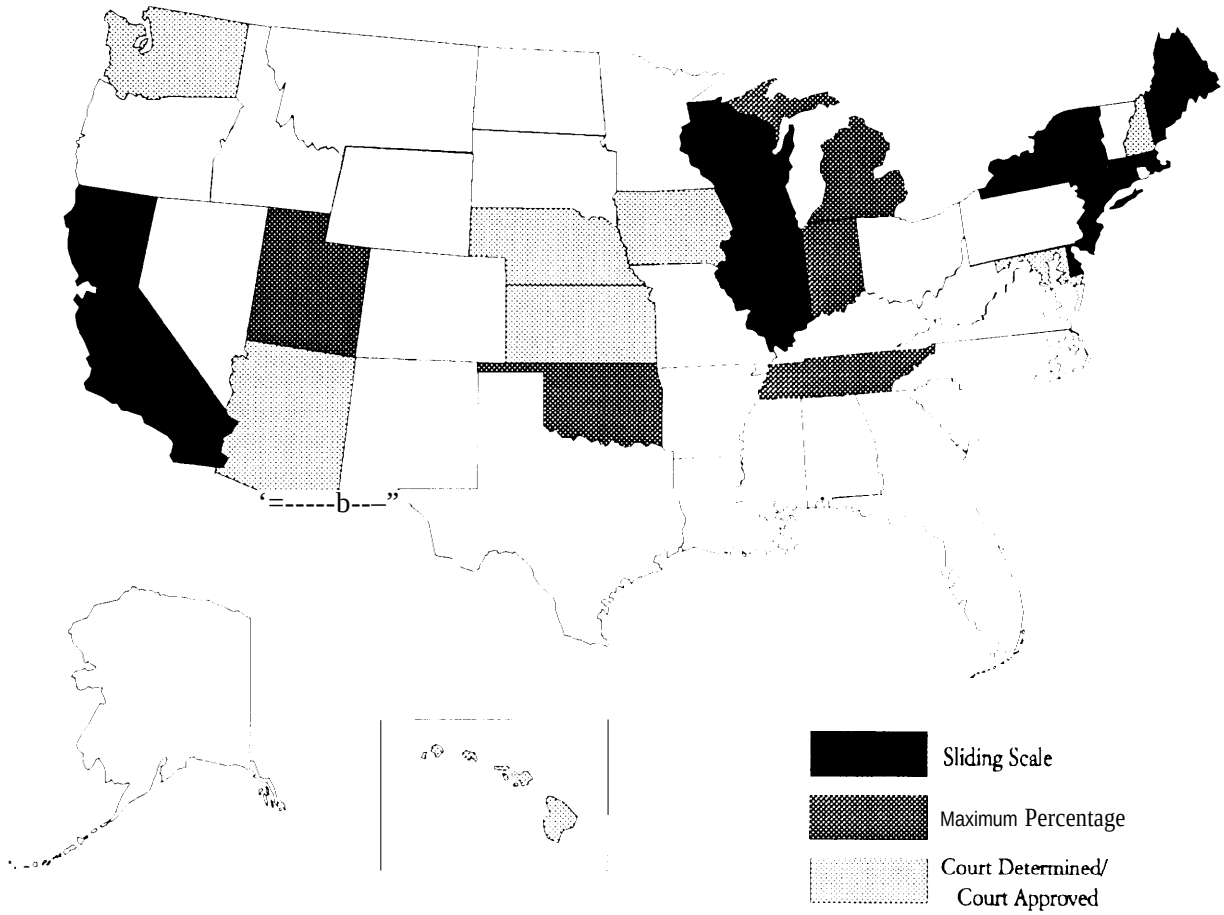
At least 15 States have passed legislation giving the courts authority to force the losing party in a medical malpractice case to pay the opposing party's court costs and/or reasonable attorney fees if the suit was frivolous, fraudulent, or in bad faith. This applies to a very limited number of cases, if any, since a case may ultimately be nonmeritorious without being frivolous. These statutes are not to be confused with the so-called "English Rule, " in which the loser pays the winner's attorney fees, regardless of the merit of the suit (4). OTA knows of only one State that attempted to implement the "English Rule," and that statute was repealed by the legislature after it was discovered that only relatively wealthy losers (i. e.. defendants) were paying (I 4).

Several tort reforms seek to limit physician liability and create more predictability at the outset as to what will constitute negligent behavior. The most significant of these recent changes is the development and use of practice guidelines in determining the legal standard of care. In addition, States have also limited physician liability by altering common law doctrines of informed consent and *res ipsa loquitur.*

Judicial Limits on the Standard for Informed Consent

Physicians need a patient's consent prior to treatment. For many years the adequacy of the consent was judged by professional standards (78). In 1972, two separate legal

Figure 2-2--Attorney Fee Limits



Source: Office of Technology Assessment, 1993

opinions allowed a patient to recover damages resulting from medical care that met the standard of care, because it was determined that the patient would not have consented to the care if all material information had been provided. [8]

Several courts moved to a more patient-oriented standard for judging the adequacy of informed consent. Some legislatures responded with legislation that either codified a list of information to be provided the patient, thereby enabling physicians to develop standard consent forms: or the legislation set forth the defenses a physician could use when faced with claims alleging failure to adequately inform the patient [9] (78). The latter statutes often establish professional or customary standards of disclosure as a defense and further require the plaintiff to establish that a reasonable person would not have undergone the treatment if he or she had been fully informed of the risks (78). (The plaintiff must also prove that the lack of informed consent was the proximate cause of the injury (78).

While the expansion of the informed consent doctrine in the 1970s may have led to more claims, recent data indicate it is a minor issue today in liability claims. [10]

Restricting the Use of Res Ipsa Loquitur

The legal doctrine of *res ipsa loquitur* ("the thing speaks for itself") allows plaintiffs with certain types of injuries to prevail without having to introduce expert testimony of negligence. The plaintiff must prove only that the procedure or incident causing the injury was under the exclusive control of the physician and that such injuries do not normally occur in the absence of negligence (78). The classic case in which *res ipsa loquitur* might be invoked is when a clamp or sponge is left in a patient's body after surgery.

The doctrine of *res ipsa loquitur* is thought to be very unpopular with the medical profession because it reduces the need for expert testimony, allowing the plaintiff to reach the jury without direct evidence of negligence (14,78). However, expert testimony is often not necessary because the doctrine largely applies when the negligent act can be inferred by common knowledge (66). When common knowledge is not sufficient. the influence of negligence can be informed and rebutted by expert testimony (66).

As of 1989, 13 States had passed legislation either disallowing the application of res *ipsa loquitur* in medical malpractice altogether or limiting the circumstances under which it can be applied (129).

Changing the Rules for Determining Physician Negligence

The legal standard of care in a given case is established through the expert testimony of physicians--thus, courts defer to professional judgment rather than some objective standard to determine what was appropriate care in a given case. Over the last three decades. the customary standard has evolved from a "strict locality" formulation (i.e.. only physicians in the community could testify as to the standard of care) to an "expanded locality" formulation (i. e.. what a reasonable physician in a similar specialty/community would do under the same or similar circumstances). The exact legal formulation of the standard varies by jurisdiction. Part of the rationale for abandoning the strict locality rule was the difficulty of finding physicians willing to testify against their local peers and concern that the locality rule could insulate a community of substandard care (79). As such, expanding the locality rule would theoretically increase the number of successful plaintiffs' cases.

The use of professional judgment to establish the legal standard of care often leads to a courtroom "battle" between experts testifying for the plaintiff and defendant. Critics contend that lack of an objective and specific standard of care makes the outcome of medical malpractice proceedings unpredictable and consequently encourages defensive medicine. Despite the fact that a number of States have codified the legal standard of care in medical malpractice cases, these laws do not alter the existing standard of care, but instead merely document that physicians will be held to the standard of care provided by their profession (1 15).

Using Clinical Practice Guidelines as Evidence of' the Standard of' Care--Clinical practice guidelines, published by physician groups and, more recently, the Federal Agency for Health Care Policy and Research, are increasingly being looked at as possible standards for medical care. Under the customary practice formulation, clinical practice guidelines based on a reasonable degree of professional consensus would presumably be valuable evidence of the applicable standard of care. However, there are a number of I imitations to the usefulness of guidelines in deciding medical malpractice cases. First, existing rules of evidence limit the use of guidelines in establishing the legal standard of care. Second, guidelines have only been written for a small portion of medical practice; thus, not all medical malpractice cases would be able to invoke specific, relevant guidelines. In addition,

because guidelines often purposefully leave much of the ultimate judgment to the physician discretion, they may not be explicit enough to be used as a rigid legal standard of care.

Under the current system, courts generally bar guidelines from being admitted as evidence under the "hearsay rule, " which prohibits the introduction of out-of-court statements as evidence (67). In these cases, guidelines would only color the evidence to the extent that expert witness testimony reflected their contents. However, guidelines or medical textbooks that are considered to reflect comprehensive analysis of scientific evidence and broad consensus among members of the profession may sometimes be admitted as evidence under the "learned treatise" exception to the hearsay rule (158, 159).

If recognized under this exception, the guidelines generally have to be read into evidence in conjunction with expert testimony, rather than be admitted as exhibits (77).[11] Once admitted, they carry no greater legal weight than other expert testimony (67). In other words, in the current system a guideline, if admitted as evidence, cannot conclusively establish the standard of care in a particular case. The guidelines can be rebutted by the expert witness of the opposing party. However, if juries place more weight on guidelines from authoritative sources than on conflicting testimony from expert witnesses, guidelines may play a greater role in determining the outcome of a case than the court's legal instructions might suggest.

OTA has been unable to document how often guidelines are actually used as evidence in medical malpractice litigation, although studies are underway to answer this question. OTA knows of no studies that examine outcomes of cases involving guidelines or the reactions of juries to the use of guidelines as evidence.

In order to increase the role of guidelines in determining physician negligence, three States--Maine, Minnesota, and Vermont--have recently passed legislation that accords greater weight to certain guidelines in the litigation process.

In 1991, Maine began a five-year demonstration project that makes State-developed guidelines admissible as a defense in medical malpractice proceedings (24 MRSA §§ 2972-2978 (1990)). 12 The statute permits physicians who elect to participate in the demonstration to use these guidelines as an affirmative defense in medical malpractice trials and in pretrial proceedings. Under the affirmative defense provision, use of guidelines as evidence is no longer a matter of the judge's discretion. If a physician introduces the guideline as a defense, the plaintiff must either (a) prove that the physician did not follow the guideline or (b) prove. through expert testimony, that the guidelines are not applicable to the given case. If the plaintiff is unable to do this, the physician is not negligent.

Another provision of the Maine statute prohibits a plaintiff from introducing the guideline as evidence of the standard of care in an effort to prove that the physician's performance was substandard (24 MRSA § 2977 (1990)). This provision was included to allay fears on the part of physicians that the guidelines, instead of serving to protect them from liability, would be used against them. Some critics, however, claim that this provision may be subject to challenge on State and/or Federal constitutional grounds because it selectively denies plaintiffs the use of evidence that may be critical to proving malpractice (132). A hearing of the constitutional challenge will probably not occur for several years. As of July 1993. the State's largest medical malpractice insurance carrier had not yet received any claims for which the adopted guidelines were relevant (18).

Minnesota recently passed legislation that allows guidelines developed and/or adopted by a special State commission to be used as an absolute defense in malpractice litigation (95).13 Like the Maine statute, Minnesota's law also bars the plaintiff from introducing the guideline as evidence that the physician failed to meet the standard of care. As of August 1993. the first round of guidelines had yet to be officially approved in Minnesota (45).

Some patient rights advocates may oppose the approach taken by Maine and Minnesota because it offers no safeguard against "bad" guidelines--i. e., the plaintiff cannot contest the reasonableness of the guideline itself (106). Some critics contend that the use of guidelines as rigid legal standards may be problematic due to the continual evolution of medical practice and the inability of written guidelines to reflect changes in a timely manner (56).

Vermont's approach is more moderate, amounting to a change in the rules of evidence that will allow a wider variety of guidelines--e.g., guidelines developed by health care professional groups, the Federal government, or health care institutions--to be directly admitted as evidence of the standard of care by either the plaintiff or the defendant in future mandatory medical malpractice arbitration proceedings (18 V. S. A.. part 9, chapter 21 § 1 (1992)). 14 This provision would make it easier to introduce guidelines as evidence. but would not give them any greater legal weight than other expert testimony.

In an interesting departure from the strategy embraced by Maine, Minnesota, and Vermont, legislation recently passed in Maryland mandates the development of State guidelines but explicitly prohibits them from being introduced as evidence by any party in a malpractice suit (80). Florida recently adopted legislation authorizing the development of guidelines and encouraging consideration of their use in the future as legal standards of care (43).

One concern that State guidelines initiatives such as these raise is the potential for conflict between national, State, and even institutional guidelines. Most of Maine's guidelines were modeled closely from nationally recognized standards, but others were developed de novo by Maine. physicians (36) and could be construed as setting a precedent for reconversion to a more local standard of care. Developers of guidelines in Minnesota anticipate using national guidelines as models and amending them if necessary to conform to the realities of health care delivery in the State (45). In Vermont, the statutory description of guidelines could be interpreted as including even written institutional protocols.

Guidelines in theory should be able to help clarify the standard of care. However, the recent expansion of guideline-writing efforts has produced hundreds of new guidelines, some of which present conflicting information. If courts and legislatures are not selective about which guidelines are introduced as evidence, these conflicts may find their way into the courts and further confuse rather than clarify the process of determining negligence.

Limiting Malpractice Awards

Many States have adopted reforms that limit the amount the plaintiff can recover in a malpractice suit. These reforms may limit the absolute amount that can be recovered. the amount of certain types of damages, the amount that can be paid out in one lump sum, or limit a single defendants liability

Collateral Source Offsets

Under traditional rules of evidence, the defendant may not introduce into evidence the fact that the plaintiff has insurance (health, disability, etc.) covering some of his or her losses. Consequently, the plaintiff may be able to recover both from the defendant and from other "collateral sources " of compensation.

Very often the traditional collateral source rule does not result in double payment because most health and disability insurance policies have a provision requiring the plaintiff to reimburse the insurance company for any such payments received from the tort system (3,4). This provision is called a right of subrogation. For example, the Federal government requires that medical expenses paid by Medicaid and Medicare be reimbursed from tort awards

(42 U.S.C. § 2651 (1992)); however, Social Security Disability Insurance, the primary public disability program, does not have subrogation rights (137).

If health and disability insurers collect the tort awards from plaintiffs, the net effect of the collateral source rule is to make medical malpractice insurers responsible for the costs of medical injuries caused by physicians' negligence. OTA has not examined whether health and liability insurers exercise their right of subrogation in most cases.

When double payment does exist, it appears to some to be a windfall. Yet, collateral source payments result from the plaintiff's investment in insurance. Decreasing the defendant's liability in such cases would allow the defendant to unfairly benefit from the plaintiff's investment, reducing the deterrence effect of the award. 15 In addition, plaintiffs must pay attorney fees out of their awards, and juries are not permitted to compensate successful plaintiffs for attorney fees.

Concern over rising malpractice insurance rates in the 1970s and 1980s led some States to amend the collateral source rule so as to shift some of the burden of paying for medical expenses from malpractice insurers to health insurers. The collateral source rule can be amended in one of two ways. First, the jury can be permitted to hear evidence of the plaintiff's collateral sources and decide whether or not to reduce the award accordingly *(discretionary* collateral source offset). Or, the judge or jury can be required to offset the award by the amount available from collateral sources once those sources are entered into evidence *(mandatory* collateral source offset).

At least 30 States have amended the traditional collateral source rule (table 2-1; figure 2-3). Approximately 19 States have a mandatory collateral source offset, but these provisions are often triggered only if the defendant enters evidence of the plaintiff's collateral sources, In the other 11 States that have amended the rule, collateral source offset is discretionary (table 2-1; figure 2-l). In five additional States, collateral offset provisions were passed but later overturned in the courts, but in two of these States a new statute was passed correcting the constitutional deficiencies (table 2-1). A number of these statutes have significant exceptions; for example, excluding the plaintiff's health or disability insurance contract if the contract already contains subrogation rights (15 1). In addition, OTA identified at least two States that do not include as collateral sources most types of insurance coverage, for example, disability insurance or insurance that is purchased by the plaintiff. 16

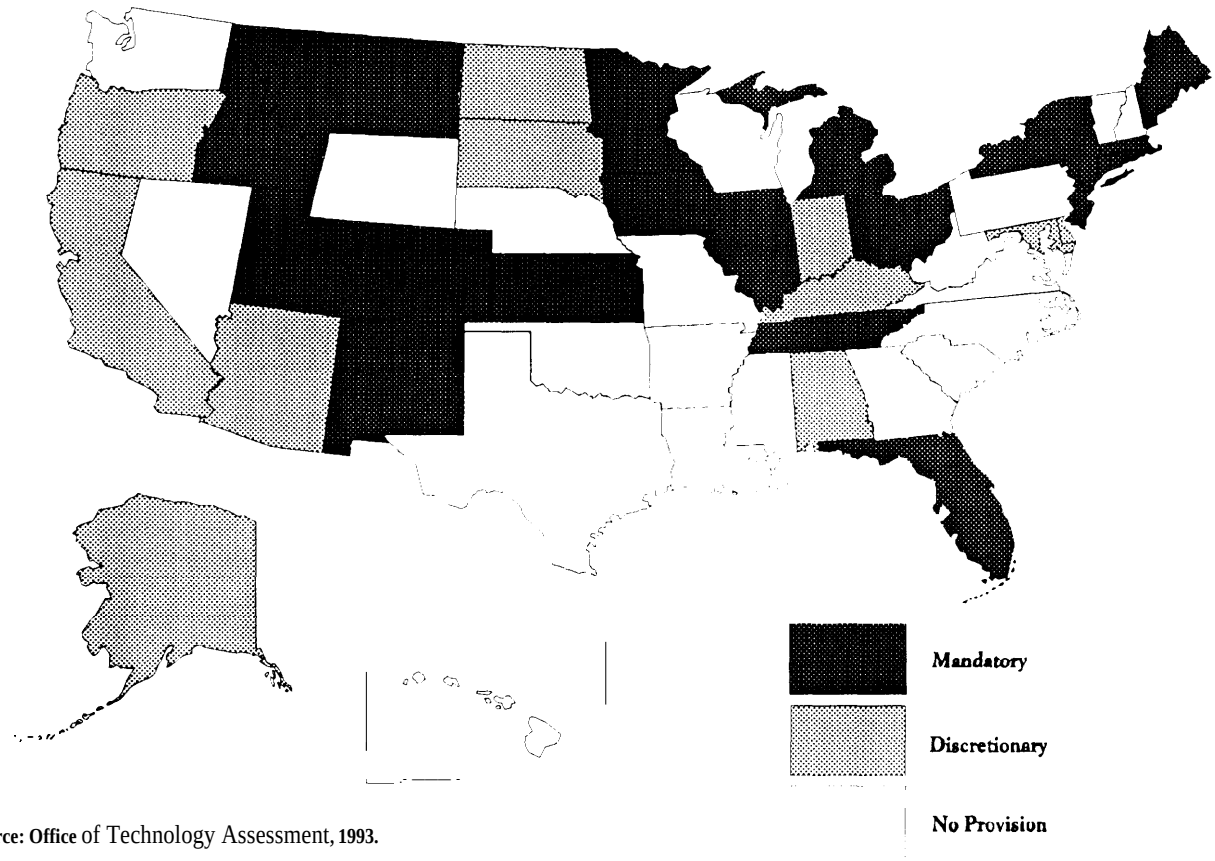
Caps on Damages

The most direct way to limit the payment per paid claim is to set limits on damage awards. As mentioned earlier, malpractice damage awards have three components:

- direct economic losses, such as health care expenses, job-loss expenses, and other direct consequences of the injury;
- noneconomic damages (often referred to as damages for "pain and suffering") such as payments for physical and emotional pain, suffering, emotional distress, mental anguish, disfigurement, loss of enjoyment, loss of Companionship, and other nonpecuniary losses; and
- punitive damages, awarded in cases where the defendant conduct is intentional, malicious. or outrageous, with a willful disregard for the plaintiff's well-being. (Punitive damages are rarely awarded in medical malpractice cases.)

There are two different types of damage caps: those that cap noneconomic damages (i.e., damages for pain and suffering) alone; and those that put a total cap on both economic and noneconomic damages. [17] Several States

Figure 2-3--Collateral Source Offset Provisions for Medical Malpractice Damages



Source: Office of Technology Assessment, **1993.**

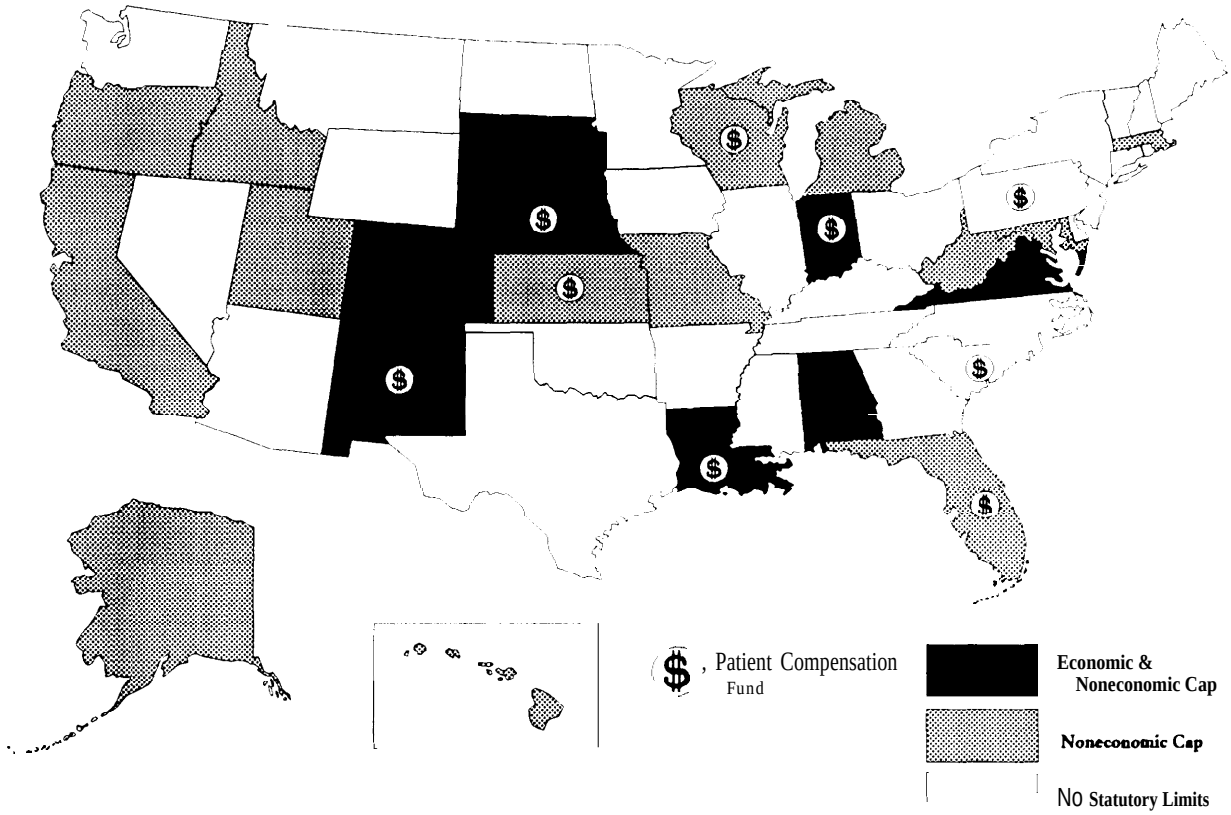
have capped punitive damages, but such damages are rarely awarded in medical malpractice cases (3,4,94,107). Capping them is therefore unlikely to have a significant impact on medical malpractice costs.

Statutory limits on damage awards are highly controversial and have been declared unconstitutional in some States. At least 15 State supreme courts have overturned caps on damages on State constitutional grounds, [18] and the State legislature in two other States repealed the provision (app. A, table A-2). A number of other States have upheld caps on damages. [19] (See App. B for a detailed discussion of constitutional challenges to State tort reforms.)

Total Damage Caps--Only eight States have a cap on total damages (economic and noneconomic damages combined) (table 2-1: figure 2-4). Permitted damages range from $500,000 to $1 million. Four of these States also have PCFs.

Noneconomic Damage Caps--The most frequent type of damage cap is on the noneconomic component of an award. Large noneconomic damage awards are concentrated in a handful of what may be the more serious cases. For example, in a 1984 study of paid claims for which data on noneconomic losses were available, [20] 2.1 percent of cases accounted

Figure 2-4--Caps on Damages for Medical Malpractice



Source: Office of Technology Assessment, 1993.

for 62 percent of pain and suffering damages awarded for the entire sample of cases in which an indemnity payment was made (142).

Losses for pain and suffering are very difficult to quantify and juries are provided no clear standards for determining them, Critics contend that the emotional desire of the jury to do something for the victim often causes unduly high awards (15).

OTA identified 14 States that place some limit on noneconomic damages (table 2-1; figure 2-2). These limits range from $250,000 to $1 million dollars, and in a number of States there are exceptions to the limit (see app. A). The Michigan cap on noneconomic damages does not apply in cases in which the patient has an injury to the reproductive system or has lost vital bodily function. As a result of these exceptions, the cap has yet to apply to a single malpractice case (154). In Massachusetts, noneconomic damages are capped at $500,000, but judges can grant exceptions in extreme cases (Mass. Ann. Laws ch. 231 § 60 H). Finally, a number of States impose separate damage caps on claims in which the defendant is a public facility or a public facility employee.

Florida has an unusual provision in which the cap is linked to the decision to arbitrate. If a defendant refuses a plaintiff's request to arbitrate, there is no limit on damages in a trial, but if the plaintiff declines a defendant's request to arbitrate. then the award at trial is limited to economic damages plus noneconomic

damages of $350,000 per incident (Fla. Stats. § 766.209 (1991)). Florida also limits noneconomic damages in arbitration to only $250,000 (Fla. Stats. $766.207 (1991)).

Guidelines for Noneconomic Damages--Some malpractice researchers propose to rationalize noneconomic damage awards by providing the jury specific guidelines for determining pain and suffering based on the age of the victim and severity of injury.[21] One proposal would fix the level of damages once the jury determined severity and age. Alternatively, the jury could be given ranges within the categories and have the discretion to go outside these ranges (15). If the jury's assessment deviated substantially, it would provide reasons for its decision, thereby facilitating judicial review. Another proposal is to provide the jury with typical injury scenarios and associated dollar values. These would be nonbinding benchmarks but could serve to guide the award and review by trial and appellate judges. In each of these proposals, the proposed ranges would be derived from previous cases *(15).* None of these proposals have been tried in the States.

Periodic Payments

One way to help reduce the impact of large awards on malpractice insurers is to allow damages to be awarded according to a schedule of periodic payments. If a victim is severely injured, the damages are based on medical and other expenses that will be incurred over a lifetime. If the insurance company can pay out the award as the expenses are incurred, the net cost of the malpractice award will be lower. This approach to structuring awards also reduces the risk that the plaintiff will deplete funds that are intended to be used to pay future medical and economic costs (152).

OTA identified 14 States with a provision mandating periodic payments of future economic damages if damages exceed a threshold level (table 2-l). In most cases the threshold is $100,000 to $250.000. Another 16 States allow for, but do not mandate, periodic payments (table 2-1). In these States, periodic payment can be requested by the par-ties; in others, it can be imposed at the court discretion. The remaining States (including the District of Columbia) have no provision for periodic payments, although in two States provisions were passed and later overturned in State courts (table 2-1).

Reform of Joint and Several Liability

To ensure the plaintiff fully recovers damages for his injury, States have traditionally held tort defendants who are jointly responsible for an injury "jointly and severally " liable regardless of their individual degree of responsibility (3,4). Joint and several liability means that a plaintiff can sue all responsible defendants and recover from each one in proportion to their fault (i. e., joint liability) or the plaintiff can sue any one defendant and recover the total amount of damages, even if the defendant is only partially responsible (i. e., several liability) (78). This does not mean the defendant will ultimately pay the entire amount because he or she can sue the other defendants for their share (78). This rule effectively allocates the risk of one defendant insolvency to the other defendants, rather than to the plaintiff. In medical malpractice, insolvency may not be a critical concern because most physicians are insured.

About two-thirds of the States have modified the traditional joint and several liability doctrine (151). In some States, several liability was eliminated. More often, however, the statutes require that several liability be limited depending upon the degree of the defendant's or plaintiff's fault or the ability of other defendants to pay the claim (151). In Iowa, for example, if the defendant is less than 50 percent responsible for all damages, he or she is liable only for his or her proportion of damages: however, if the defendant's responsibility exceeds that level he or she can be held severally liable for the entire amount of

damages (Iowa Code § 668.4 (West 1987)). A number of States make several liability conditional on the defendant's meeting a certain threshold of responsibility (150,151).

ALTERNATIVE DISPUTE RESOLUTION

Although most malpractice cases do not reach trial, the civil litigation system is often criticized for being slow, expensive, and unpredictable. The best available estimate is that plaintiffs receive roughly $0.50 for every $1.00 spent by insurers on processing a malpractice case, with a large portion of the administrative costs being spent on legal fees.[22] The expense is likely to increase with the length of the proceedings (127), and trials can add significant costs. A recent review of malpractice defense costs in 45 malpractice cases that went to trial in North Carolina found that close to 53 percent of the expense was spent preparing for the trial (pretrial conferences, preparation of trial exhibits, meeting with witnesses immediately prior to trial and related actions) or in trial (87). The remaining money was spent in discovery (uncovering and analyzing evidence, interviewing experts and witnesses, taking or defending depositions, etc.) (87).

The high cost of malpractice trials may also raise the amount a defendant is willing to offer in a settlement, because settlements reflect in part the expected amount at trial minus the savings possible from avoiding trial .23 The high cost of a trial may create incentives for plaintiffs to settle for less in order to avoid the costs and risks of a trial. In one study of 5,832 claims closed between 1974 and 1976, smaller claims (i. e., less serious injuries) were more frequently dropped with no payment than were larger claims (34). Plaintiffs with lower potential awards may not be able to afford the high fixed costs of pursuing a claim through the legal system (34).

As a broad remedy to these problems, States have established procedures that allow the replacement of the trial and jury system with a less formal process involving professional decision-makers. These approaches are collectively referred to as alternative dispute resolution (ADR) procedures. In addition, the AMA and 31 national medical specialty societies have proposed a sweeping reform that would remove malpractice claims from the civil court system completely, substituting an administrative process of dispute resolution (hereinafter "AMA/SSMLP administrative proposal").

The goals of ADR are several: to use a more experienced decision-maker than a lay jury (although a lay person may be chosen as one of the decision-makers), to reduce the cost of resolving a dispute, to reduce the anxiety of formal legal proceedings, to reduce the costs of resolving small claims, and to efficiently screen out nonmeritorious suits (88). The actual procedures used to reach these goals are diverse. States have permitted several forms of ADR: voluntary binding arbitration, court-annexed nonbinding arbitration, mediation, and, to a limited extent, summary jury trials. Arbitration is the form of ADR that has been the subject of most legislative activity. On the whole, however, ADR has not been used extensively in malpractice cases. In addition, the AMA/SSMLP administrative proposal has yet to be implemented by any State. Each of these alternative approaches is discussed in the following sections. Forms of alternative dispute resolution that have not been used extensively in malpractice or otherwise are summarized in box 2-A.

Voluntary Binding Arbitration

Binding arbitration (i.e., where the arbitration replaces the trial) is typically a voluntary process. The alternative approach, to make binding arbitration mandatory, raises serious constitutional

Box 2-A--Selected Approaches to Alternative Dispute Resolution

Type of ADR	Procedure	Extent Used in Medical Malpractice
Neutral Evaluation	Parties present cases to neutral attorney for assessment of merits. If parties do not settle as a result of assessment, they can proceed to trial and the neutral evaluator's opinion is kept confidential,	Used frequently in Federal courts and therefore little impact on medical malpractice litigation, which is typically brought in State courts,
Court-annexed Nonbinding Arbitration	Court can require parties to submit their case to arbitration prior to proceeding to trial, The decision of the arbitrator(s) is not binding on the parties,	Most programs limit the use of this procedure to cases with expected damages below a certain threshold, typically ranging from $10,000 to $50.000. Alleged damages in malpractice cases are rarely so low, The one exception is Hawaii, where court-ordered arbitration applies to all civil tort actions with potential damages of $150,000 or less (Hawaii Rev, Stats, Sec. 601-20 (1992)) However, medical malpractice cases may bypass arbitration if a decision is rendered under Hawaii mandatory medical malpractice screening panel (Hawaii Rev, Stats. Sec. 671-16.5 (1992)).
Summary Jury Trials	An abbreviated trial (usually less than one day) using a summary of the evidence. Lay jurors render a decision and make a finding for damages; however, their decision is not binding on the parties, The parties have the opportunity to interview the jury members and assess the strengths and weaknesses of their case,	Not often used in medical malpractice,
Mediation	Parties bring their case before a mediator whose role is to facilitate negotiation, not to make a finding on the merits, The mediator is not constrained by legal principles, but strives instead to find a practical solution that both parties will accept, It is not an adversarial process	Some States encourage mediation of malpractice disputes: others make mediation available for all civil cases. Mediation has been used extensively in family law, but not in medical malpractice, Wisconsin appears to be the only State that requires pretrial mediation of medical malpractice cases (Wis. Stat, Sec. 655 445).

SOURCES. T.B.Metzloff, "Alternative Dispute Resolution Strategies in Medical Malpractice, " Alaska Law Review 9(2):429-457, 1992; T.B.Metzloff, "Reconfiguring the Summary Jury Trial," Duke Law Journal 41 (4):806-866, 1992

Issues because federal and State constitutions grant plaintiffs a right to a jury trial (see app. B for discussion of constitutional issues). Some States do require or allow courts to order smaller cases (rarely including medical malpractice cases) to go through nonbinding arbitration before proceeding to court (see box 2-A). This is more analogous to pretrial screening, however, because the parties still have the option of proceeding to trial.

The agreement to arbitrate can be made after the injury occurs or before care has been rendered. In all States, voluntary binding arbitration is available upon agreement *after* the injury. The terms of the agreement will likely specify how arbitrators are to be selected and other procedural rules. The arbitrator(s) will hear evidence and render a decision in lieu of a judge or jury. Typically, the decision of the arbitrator is final and is not appealable except in limited cases, such as fraud.[24]

Few claimants agree to arbitrate after the injury has occurred. This is not surprising because the relationship between the parties has broken down and they may not want to negotiate an arbitration agreement. For this reason, having an agreement to arbitrate in place prior to an injury may better promote the use of arbitration.

Some State courts have been reluctant or unwilling to enforce pretreatment arbitration contracts because of the perceived differences in bargaining power between the providers and patients (88).[25] California courts were an exception, As early as 1965, the California Supreme Court upheld an HMO's pretreatment arbitration clause which the HMO imposed as a condition of membership (See Doyle v. Guiliucci, 404 P.2d 1 (Cal, 1965)). More than a decade later, the California Supreme Court upheld the application of Kaiser Permanence's arbitration clause in the case of a member who claimed that he did not explicitly agree to the provision when he selected his employer-based health care plan (Madden v. Kaiser Foundation Hospitals, 552 P.2d 1178 (1981)).[26]

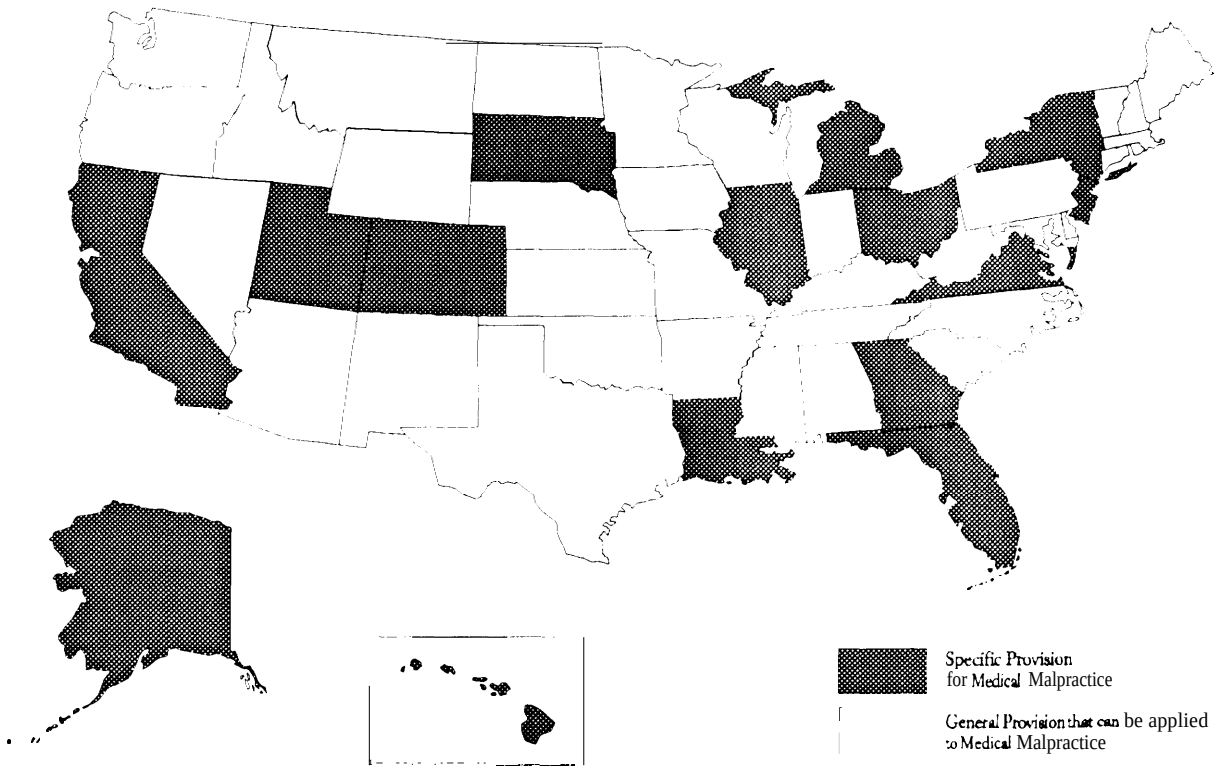
Fifteen States have specific statutes that authorize voluntary binding arbitration specifically for medical malpractice cases (table 2-1; figure 2-5). These statutes authorize pretreatment arbitration agreements but many have specific disclosure requirements or allow the patient to revoke the agreement within a certain period after signing; in some cases *after* an injury has occurred (143). OTA found only two State statutes that specifically prohibit pretreatment arbitration agreements for medical malpractice (Neb. R.R.S. § 25-2602 (Lexis 1993); S.C. Code Ann. $15-48-10 (Lexis 1993)). In States without specific malpractice arbitration statutes, arbitration is still an option--either under Uniform Arbitration Act (UAA) procedures (139) or under a general provision of the State's own crafting. The enforceability of pretreatment agreements in these States is governed by the statutory language and case law.

Whether having a specific statute for malpractice arbitration promotes arbitration or inhibits it is unknown. The UAA provisions are very genera], whereas some of the State statutes impose restrictive conditions--e. g., on the number of arbitrators, the selection of arbitrators, or the enforcement of arbitration agreements. These restrictions are probably designed to protect plaintiffs, who may have less bargaining power, but an unintended result may be to remove some of the flexibility of arbitration (88.89).

Of the 15 States with specific malpractice arbitration statutes, only Michigan has a formal program to encourage arbitration. The Michigan law requires all hospitals that are *not self-insured* to offer patients the opportunity to sign a pretreatment arbitration agreement. The patient must be provided a booklet on arbitration and be informed that by signing the agreement he or she is waiving the right to a jury trial. The patient is also given the right to revoke an arbitration agreement 60 days after discharge (the hospital has no option to revoke) (78; Michigan Comp. Laws $$500.3051-3062, 600.5033-5065 (West 1987)).

Participant ion has been disappointing .27 Only one-half of Michigan hospitals must participate and the remaining hospitals apparently see no benefit in entering the program and

Figure 2-5--Arbitration



Source : Office &Technology Assessment, 1993.

spending resources to train personnel to offer arbitration agreements and to learn the program's requirements (143). While the administrative costs of setting up an arbitration program may not be significant in terms of total operating costs, the hospitals apparently concluded that the investment would not save money (143). Physicians say they are reluctant to offer patients pretreatment arbitration agreements because they are uncomfortable discussing malpractice at that point and are concerned that such a discussion may undermine patients' confidence in their abilities (143).

In sum, despite the fact that arbitration is specifically authorized for medical malpractice by statute in 15 States and is allowed in all others, very few medical malpractice cases are resolved through arbitration (88, 143),[28] Why the reluctance to arbitrate? Some critics attribute the reluctance to plaintiffs attorneys, who believe the choice of forum is a strategic decision and may think arbitration is appropriate only for smaller claims (69). Defense attorneys may also have strategic reasons for preferring trials. For example, arbitrated decisions are not generally appealable, except in cases of fraud. The ability to appeal an adverse decision may be an opportunity that both the plaintiff and the defense counsel are reluctant to relinquish (69).

AMA/SSMLP Proposed Administrative System

The AMA/SSMLP administrative proposal would remove malpractice cases from the civil jury system and set up an administrative board to hear malpractice claims (5). To date, no State has adopted such a system.

Under the AMA/SSMLP's proposal, State medical boards would be established to discipline doctors and resolve medical malpractice cases. The AMA/SSMLP's proposal has several possible advantages over the present system. First, filing a claim would be greatly simplified, and legal counsel would be provided to claimants who could not afford counsel. Second, the boards would be given authority to change certain legal rules, for example, change the definition of the standard of care, limit attorneys' fees, and use guidelines to promote consistency in damage awards. Finally, the proposed system would tie medical malpractice to the physician licensing and disciplining process, thereby using the medical malpractice system more directly to monitor physician quality,

Hearing examiners and the medical boards could be given significant control over the process and could create strong incentives for not accepting settlement offers and pursuing oral hearings. Review by the judiciary would be very limited (5). Such a system might facilitate hearings on many more claims, but the nature of the process would be greatly abbreviated and might interfere with the full development of the plaintiff's case.

Questions have been raised whether the AMA/SSMLP proposal would, instead of increasing efficiency, create a new bureaucracy and require a massive expenditure of public funds (90). Consumer advocates express concern about having quality control be left largely to State medical licensing boards (46). To date, State Medical Licensing Boards have little experience with disciplining doctors with respect to their clinical competence.[29] A new formal system would also likely be subject to legal challenges (91). In addition, such an agency could become too responsive to physicians' viewpoints, given that physicians are likely to be the agency's most organized constituency (156).

NO-FAULT MEDICAL COMPENSATION

Every malpractice case requires a determination of whether or not the physician's treatment fell below the standard of care of his or her peers and whether the physician's actions caused the patient's injury. This fault-based system is expensive and subject to error. Furthermore, a significant number of people who are injured as a result of negligent medical care do not seek redress in the legal system (17,29). The time and expense of pursuing a claim may be a factor in this decision (see ch. 1).

Almost all of the reforms described earlier tinker with certain aspects of the process of determining fault. However, some critics of the existing system question whether it is necessary and/or appropriate to base compensation for medical injury on a finding of negligent fault. These critics advocate eliminating negligence as a criterion for providing compensation to victims injured by medical care. Under a no-fault system, some or all injuries *caused* by medical care (iatrogenic injuries) would be compensated regardless of whether the physician's conduct fell below a standard of care. The intent of a no-fault system is to compensate as many victims as possible for harm done as a result of medical care. By eliminating the cost of determining fault and restricting damages, such a system may be able to compensate more victims at a lower cost. To compensate for the loss of the deterrent effect of the fault-based system, a no-fault system would be coupled with an enhanced quality control system to monitor and minimize physician error.

No-fault eliminates the question of negligence, but the question of causation (i.e., was the injury caused by medical care?) remains. As discussed in chapter 1, causation in the legal sense means that the physician's conduct was more likely than not to have caused the injury. This must be proven with a preponderance of the evidence. This may not always be a simple question to answer, however, because adverse medical outcomes are not necessarily caused by medical treatment, but rather may result from an underlying medical condition (65). By comparison, in workers' compensation, the largest no-fault injury compensation scheme in

the United States, the fact the injury was cause by the work environment is often more obvious.[30] As a result, few medical no-fault proposals are pure no-fault proposals. Instead, they attempt to identify a prescribed set of medical injuries that can be addressed through a no-fault compensation system.

State Experience with Limited No-Fault Systems

To date, only two very limited no-fault programs have been established--in Virginia and Florida.[31] Both programs were designed to address only birth-related neurological injuries. The cause of neurological damage in infants is not always clear,[32] and it may be even more difficult to establish whether or not the injury was preventable. Yet according to the American College of Obstetrician and Gynecologists, such injuries accounted for 31 percent of claims against obstetricians (103).[33] Obstetric providers, who see these claims as unpredictable, may take a number of defensive measures of debatable efficacy in the hope of reducing their risk of suit (60). These reasons, coupled with high malpractice insurance premiums, make obstetric cases a good testing ground for no-fault programs.

Virginia--The Virginia Birth-Related Neuro-logical Injury Compensation Act was passed in 1987. The medical societies in Virginia had been working on a no-fault proposal for several years; however, the impetus for legislation came from a Federal district court's ruling (later overturned) that Virginia's cap on damages was unconstitutional, thereby letting stand an $8.3 million verdict against an obstetrician, 34 That decision led malpractice insurers in the State to place limits on malpractice insurance coverage for obstetricians and other practitioners (38, 136). In addition, there were reports of obstetricians limiting their involvement in high-risk cases or withdrawing from obstetric practice altogether (38).

To be eligible for compensation under Virginia's system, the claimant must establish that the infant's injury:

- was to the spinal cord or brain;
- was caused by a deprivation of oxygen or mechanical injury that occurred in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital;
- rendered the infant permanently "motorically disabled" and developmentally or cognitively disabled such that assistance in all activities of daily living is required: and
- was not caused by congenital or genetic factors, degenerative neurological disease, or maternal substance abuse (Va. Code Ann. § 38.2-5001 (1992)).

The injury must have been caused by a physician who participates in the program (see below) or at a participating hospital (Va. Code. Ann. $38.2-5008 (1992)).[35]

Physicians and hospitals participate in the program by their own choice. As of 1992, 75 percent of obstetricians and 38 percent of hospitals in Virginia were participating (44, 122), Claims for compensation are filed with the Virginia Birth-Related Neurological Injury Compensation Fund (hereinafter the "Fund"), which is funded through annual assessments on physicians (primarily obstetricians) and hospitals .36

A claimant files a claim with the Workers Compensation Commission. -[37] The claimant also serves a petition on the Fund, which administers the program. The Fund has 30 days from receiving notice of the claim to respond to the Workers Compensation Commission on the issue of whether the injury falls within the definition. The Fund investigates the claim

itself, sending it to its medical experts. If the Fund determines that the injury is compensable under the act, the Workers Compensation Commission Board will issue an order without a hearing .38 The case is also sent by the Workers Compensation Commission to a medical review panel consisting of three qualified and impartial physicians. The panel reviews the case and makes a recommendation to the Workers Compensation Commission as to whether the injury falls within the statutory definition. If the Fund does not determine that the case falls within the act, the Commission holds a hearing in which the panel's recommendation is likely to be given significant weight. although it is not determinative (Va. Code Ann. § 38.2-5008(6)(B) (1992); (38)).

Once it is determined that an injury falls within the definition, compensation is determined and payment made in accordance with statutory provisions. The plaintiff does not have the option of an alternative remedy if the delivery was performed by a participating physician in a participating hospital .39 There is opportunity to request that the Commission review the evidence, and final appeal may be made to the Virginia Court of Appeals (Va. Code Ann. § 38.2-5011 (1992)).

Claimants have up to 10 years to initiate a claim, but once a claim is brought, a hearing must be held within 120 days. The process is designed to take a maximum of 5 months. Compensation is limited to economic damages, collateral sources of payment are offset, and payments are made periodically (rather than in a lump sum). By the end of 1992, only four claims had been brought under Virginia program (1 13), well below the 40 per year originally predicted by the Virginia State Medical society *(44).* The balance of the Fund in 1993 was approximately $53 million (122).

To ensure continued quality assurance in obstetrics cases, the Virginia statute requires that all cases reported to the Commission be automatically referred to the Board of Medicine and the Department of Health, which have licensing and disciplinary authority (respectively) over physicians (Va. Code Ann. § 38.2-5005 (1992)). The Medical Board may (but is not obligated to) examine the patterns of claims brought and may use these cases to develop professional standards (38).

Florida--Legislation authorizing the Florida Birth-Related Neurological Injury Compensation Fund was passed a year after Virginia's and is similar to Virginia's in many respects. Florida's program, however, applies only to live infants over 2500 grams who are both "rendered permanently and substantially mentally and physically impaired. " Unlike Virginia, it is not required that the infant need assistance in all activities of daily living. Florida limits the time to tile a claim to 5 years. As in Virginia, compensation is limited to medically necessary economic damages that are paid as incurred. Florida, however, provides for periodic payment of up to $100,000 to the parent or legal guardian of the infant.

Participation in the program is optional for physicians, but about 90 percent of all Florida obstetricians were participating as of January 1993 (37). All private hospitals are required to contribute to the Fund through a tax assessment, but they only benefit from its protection when the physicians practicing in the hospital are participants. If a delivery in the hospital is made by a participating physician and the infant's injuries fall under the statute. the exclusive remedy is against the physician; the hospital, or any other person or entity that participated with the labor, delivery, or post-delivery resuscitation, cannot be sued (Fla. Stat. § 766.303 (1991)). If the physician is not participating, however, the hospital is not protected from liability. Not surprisingly, some hospitals pay the assessments of the physicians delivering in their hospitals or require their physicians to participate (37)--a fact that may explain the relatively higher level of participation in Florida compared with Virginia.

The Fund was seeded with $40 million in appropriations at the outset and is maintained through annual assessments on physicians and

hospitals .40 Currently the Fund receives approximately $16.3 million in premiums annually. Only $3.6 million comes from obstetricians; $7.7 million comes from nonparticipating physicians and approximately $5 million comes from hospitals (37). As of August 1993, 69 claims had been filed under the program (37).

Accelerated Compensation Events

Both the Virginia and Florida no-fault programs base eligibility for compensation on a narrow, adverse, clinical outcome. One no-fault proposal would take this approach--defining specific medical outcomes that are compensable--and apply it to many other areas of medical practice. Under this proposal certain kinds of adverse medical events or injuries, called "Accelerated Compensation Events" (ACES), would be compensated under a no-fault system. ACES are defined as adverse patient outcomes that are generally avoided by good medical care (1 34). Using defined, specific, clinical outcomes in a no-fault compensation system should eliminate the need to determine causality (134). ACES would be handled as if they were part of a compensation insurance system, thus reducing the costs of the disposition.

A clear example of an ACE would be the discovery of a foreign object left in a patient who had recently undergone surgery. In other cases, the question of avoidability is not so clear, and judgments would have to be made at the outset as to which injuries would be eligible for compensation (1 34).

As proposed, injuries that fall outside of the ACE system could be pursued under the tort system or another alternative dispute process. Thus, the overall impact on the medical malpractice system of using ACES would depend on their ability to move a significant number of adverse events into the no-fault compensation system.

One way to maximize the impact of an ACE system is to target it to high-litigation areas of medical practice. Tancredi and Bovbjerg developed a list of ACES for obstetrics/gynecology. general surgery. and orthopedic surgery (133)--three specialties that accounted for 33 percent of medical malpractice claims in 1984 and approximately 48 percent of payments (142). The list includes 48 ACES for obstetrics/gynecology, 62 for general surgery, and 36 for orthopedic surgery. The list was developed using actual claims data.[41]

NEW REFORM PROPOSALS

Enterprise Liability

Recent attention has centered on the concept of "enterprise liability" as a malpractice reform that might be incorporated into a larger health care reform initiative. Under enterprise liability, responsibility for defending malpractice claims is placed on institutions or organizations that provide care instead of on individual doctors. Enterprise liability has been suggested as a reform that is compatible with a system of managed competition. in which comprehensive health plans are responsible for all care delivered to their enrolled patients. or with a no-fault system in which the hospital or HMO pays for all injuries that occur within the institution (156). Yet it has also been suggested as a malpractice reform that makes sense even without these reforms. About 80 percent of malpractice claims arise from care given in hospitals (142), and the hospital could be the "enterprise" responsible for this care (1).

Enterprise liability is not a new concept. Pieces of the idea are in practice today in some large health care organizations. HMOs that employ physicians directly (as in staff-mode] HMOs) bear legal responsibility for their staff physicians,[42] although claims can still be

instituted against the specific physician. Typically, HMOs indemnify their staff physicians and purchase malpractice insurance on their behalf. Some large hospitals have joined with their physician staffs to buy a malpractice insurance policy that requires a unified defense (84).

But the distinguishing feature of enterprise liability is that the plaintiff ***would not be able*** to name an individual physician in a suit. Although it is likely the physician would still be called to testify should the case go to trial, his or her role would be more limited, both in time and expense, than it is presently. Moreover, not being personally named in a suit may remove some of the anxiety or stigma that a malpractice suit reportedly causes. Yet, because a finding of negligence on the part of the physician would still be made, enterprise liability may preserve some of the deterrent effect of a medical malpractice suit.

According to its proponents, the potential benefits of enterprise liability are three-fold. First, it would create stronger incentives for institutions (be they hospitals, HMOs, or health plans) to expand their already existing quality assurance and risk management programs to incorporate risk management activities for doctors practicing under their plans.[43] Institutions are in a stronger position than small medical practices to improve the quality of care through quality assurance and risk management programs, and insurance premiums can be experience-rated at the institutional level. Reduction of medical injuries could save both malpractice and general health care costs.

Second, enterprise liability might reduce insurers' administrative costs by reducing the number of individual policies that must be written and the number of separate claims that must be resolved .44 Reducing the number of defendants in a case may also make it easier to settle or use alternative dispute resolution procedures (69, 156).

Third, enterprise liability instituted in an environment of managed competition could potentially reduce defensive medicine, as health plans establish practice guidelines reelecting the tradeoff between cost-effectiveness and malpractice risk.[45] Again, this may begin to happen even in the absence of enterprise liability.

Enterprise liability also has limitations. Perhaps the most important is that, in the existing health care system, enterprise liability would not cover all patients. Thus, physicians would still be required to carry malpractice insurance for the portion of claims arising from care given outside the purview of the organization. This could eliminate potential savings from consolidating insurance. Also. the location of the alleged negligent care (or failure to render care) would sometimes be unclear, possibly leaving the door open for expensive proceedings, Enterprise liability could lead to an increase in suits if patients are more comfortable suing a corporation instead of their physicians.

In addition. the potential reduction in injuries due to enhanced quality control may be overstated. Because many large HMOs and hospitals are already buying policies that cover physicians practicing in those institutions,[46] incentives already exist to implement strong risk management programs. Even if the hospital is not purchasing insurance for attending physicians, hospital insurance premiums are experience-rated, and limiting the number of adverse events in the hospital limits the hospital exposure to suit.

The AMA has opposed enterprise liability because physicians fear the encroachment on professional authority by health plans or hospitals (84). In essence, enterprise liability would mean the end of physicians as "independent agents" under the law. Other experts believe it is very unlikely that hospitals and HMOs will impose strict guidelines aimed at limiting malpractice by physicians, Limits

on physician autonomy are more likely to arise from efforts to control overall health care costs, rather than malpractice (27).

Although elements of enterprise liability have been introduced in HMOs and some hospitals, a regime of enterprise liability does not currently exist in any State; consequently, the effects of such an approach on malpractice indicators have not been tested.

Contracting for Liability

Just as arbitration is implemented by contract, some legal scholars and economists claim that all tort reforms can be implemented through contracts between patients and health care providers, rather than by legislative action.[47] Theoretically, contract reforms would allow consumers to structure malpractice liability to suit their own needs, balancing price and quality (53).[48] According to its proponents, contracts would allow individuals to choose the amount of risk they are willing to assume with respect to medical injuries. Moreover, contracting would allow tort reforms to be implemented without a political battle.

In analyzing proposals for malpractice reform through contracts, it is useful to separate contracts that would alter the procedure for resolving a malpractice suit from those that would alter substantive rules of malpractice liability, such as the proper standard of care or level of damages. While both types of contracts are based on the view that the market for health care can accommodate different arrangements to address physician liability, procedural changes are likely to be given greater deference by the courts than substantive changes because of the differential impact on consumers.

Procedural Contract Reforms

Contracts for Alternative Dispute Revolution--Plaintiffs and health care providers can always agree to alternative dispute resolution procedures (e. g.. arbitration) after an injury occurs, but this is rarely done. The real issue for contracting is whether patients can enter contracts in which they agree prior to treatment to submit any future malpractice claim to binding alternative dispute procedures rather than pursue that claim in court.

The courts have specifically allowed contracts requiring patients and providers to engage in arbitration to resolve any future malpractice claims; but they generally scrutinize these contracts carefully to insure that they were freely negotiated and that the patient was not pressured into an agreement as a condition of treatment.[49] Because arbitration and other alternative dispute resolution contracts change the procedure for determining liability, but do not limit the plaintiff's substantive right to compensation for negligence, concerns about unequal bargaining power between patient and provider may not be as great for this class of contracts as they are for the others (88).

Contracting for Enterprise Liability--Allowing providers, health care institutions, and patients to contract for enterprise liability may be a more feasible way than legislation to implement this reform (156). The contract between the provider and the institution would place all liability for the physician's actions with the health care institution, and there would likely be a provision governing the institution's right to discipline the physician. The courts would probably not scrutinize the fairness of this contract because physicians and health care institutions are on relatively equal bargaining ground. HMOs and some large hospitals have already contracted with their providers to pay for their liability costs (l). However, the plaintiff would retain his or her right to sue the physician unless an additional contract among the patient, physician, and the health care institution was executed. Under this contract, the consumer would agree that all complaints about the quality of care received would be brought solely against

the institution. Again, a court's response to such a contract is difficult to predict, but if the consumer's right to sue is still preserved, the contract is likely to be seen as procedural in nature and there would be strong arguments in favor of enforcing it.

Contracts That Change the Substantive Law of Medical Malpractice

Contracts that Alter the Standard of Care--When health care providers have attempted to eliminate their liability through contracts with patients, the courts have uniformly invalidated these contracts on the basis of unequal bargaining power and public policy concerns. [50] Rather than eliminating all liability. advocates of contract reforms argue that consumers have ample power through their representatives---employ ers, labor unions, HMOs, and PPOs--to bargain with providers and alter the standard of care in return for price concessions ***(46(a)).*** This argument assumes. however, that the interests of employers, HMOs and PPOs coincide with those of consumers. Given the number of uninsured persons and the evidence that many Americans feel vulnerable about their medical coverage, consumer bargaining power may be overstated (23, 148). Further, there is no evidence that consumers desire to contract with their providers for a new standard of care (7).

It may prove very difficult to define a new standard of care with enough specificity so as to avoid litigation over the meaning of the contract. From a practical perspective, to develop a legally enforceable contract for a more limited standard of care, the provider would likely need to transfer "excessive quantities of i nform at i o n" on all possible risks, both anticipated and unanticipated (39). This burden of information led one early advocate of contract reform to later conclude that contracts for the standard of care may not be an improvement over the present standard of care used in malpractice cases (39).

Finally, providers might open themselves to the criticism that they are asking consumers to submit to an unreasonably risky standard of care, if the standard developed in the contract were to differ materially from the prevailing legal standard, which reflects medical custom (7, 156). An alternative, however. is to contract for the application of specific clinical guidelines. The courts might be more comfortable with enforcing a standard of care that reflects medical consensus. The court would likely focus on the process used to develop the applicable guideline.

Contracting for Damages--Plaintiffs enter the malpractice system with different financial means; consequent y, some consumers might prefer to contract for limited liability damages before services are rendered in return for lower health care costs. Such contracts could address issues such as collateral source payments, periodic payments, and calculation of economic losses or pain and suffering awards. Whether such contracts could withstand legal challenge is debatable, but they may have better prospects than contracts involving changes in the standard of care. While consumers differ in terms of financial resources, they do not differ in their need for quality medical care. For this reason, the courts are likely to be more comfortable with consumers limiting their potential compensation. especially if they have other financial resources. [51]

Currently, there is little agreement on the proper level of pain and suffering damages, Courts provide juries with very little guidance, if any, on calculating pain and suffering damages, and such assessments appear to be inconsistent (15). Consequently, agreements on guidelines governing pain and suffering awards might be acceptable to both courts and policymakers. [52] To date, however, such contracts between patients and providers are extremely rare (if they exist at all), and OTA has not found any case law testing their feasibility.

CONCLUSION

Almost all of the malpractice reforms that have been considered to date are in place in at least a few States. (Table 2-1 provides a gross State-by-State summary of selected reforms. Appendix A provides further detail on specific State programs and provisions.) Over half the States have amended the traditional collateral source rule, allowed for periodic payments of damage awards, shortened or modified the statute of limitations, implemented pretrial screening, and/or placed some type of limit on attorney fees. In some States these provisions are voluntary (i. e., left to the discretion of the court or involved parties), while in others they are mandatory.

In addition, just under half of the States have set statutory caps on noneconomic or total damage awards. The actual limits on awards range widely. In reality. damage caps address only a small minority of claims--in general, those claims by patients with the most severe injuries. It is for this reason that caps on damages have been the most controversial.

A recent approach that attempts to clarify the standard of care to which physicians are held involves using clinical practice guidelines in determining physician negligence or non-negligence. Increased development and adoption of these guidelines, regardless of whether their role in the medical malpractice tort system is further formalized, may lead to more uniform jury and court decisions in medical malpractice cases and help physicians avoid future instances of malpractice. However, a number of problems inherent in the structure of clinical practice guidelines may limit their usefulness or appropriateness as definitive legal standards of care. The debate over guidelines development methodology has in a sense just begun; hence, adoption of clinical practice guidelines as definitive legal standards may be premature, Only three States have attempted to formalize the role of guidelines in malpractice litigation and these efforts have yet to yield even anecdotal results.

More comprehensive reforms of the malpractice system, such as mandatory ADR measures, have not been widely adopted, largely because of concerns over potential constitutional challenges (see app. B). To date, ADR procedures such as arbitration have been implemented only on a voluntary basis and have not been used extensively in medical malpractice cases. Fifteen States have specific statutes authorizing voluntary, binding arbitration for medical malpractice, but only Michigan has actively encouraged arbitration, with limited success. As long as ADR remains a voluntary adjunct to the civil jury system, its success will depend upon the State's willingness to promote the process and convince plaintiffs and defendants that it is in their interest to elect it. Some critics contend that ADR could be promoted to a greater extent if courts would be more willing to allow patients to contract for arbitration in advance of treatment (by focusing on whether the alternative dispute resolution procedures are fair) rather than scrutinizing the circumstances surrounding that waiver of right to trial. However, perhaps the largest road block to ADR is the unwillingness of plaintiffs and defendants to use available alternative dispute resolution procedures in the 10 to 20 percent of cases that go to trial.

An extension of voluntary contracts for ADR is to allow all aspects of medical malpractice--e, g. awards, standards of liability, forum, etc.--to be negotiated by contract between patients or businesses and health care insurers. To date, judicial suspicion of the fairness of such contracts has been one barrier to such an approach (118).

Limited no-fault programs have been implemented in only two States (Virginia and Florida). Both of these programs apply only to

very particular types of birth-related neurological injuries. The number of claims processed through both systems combined in their first 5 years of operation is less than 100.

More comprehensive proposals, such as ACES, attempt to address the issue of causality in a no-fault system but have yet to be tried. The potential costs of no-fault programs are likely to be a stumbling block, because the focus of legislatures has been largely to limit the cost of the malpractice system.

The fact that some State courts have been willing to overturn malpractice reform measures has important implications for future Federal malpractice reform. Statutory caps on damage awards have been particularly vulnerable to challenge under State constitutions. In general, courts have been reluctant to support provisions they view as depriving individuals of their right to judicial recourse, unless these provisions can be reasonably expected to further a legitimate legislative purpose. Selective no-fault programs in two States may have passed a limited challenge to their constitutionality, but a specific challenge on the constitutionality of removing these claims from the judicial system has yet to be brought.

As mentioned earlier, most of the reforms implemented to date have been passed to address a perceived activity "crisis" in malpractice claims or tort liability in general (14). As a result, they have focused on limiting suits, and hence have not attempted to increase injured parties' access to fair compensation. Recent data on the rate of negligent injury and the corresponding claim rate for those injuries has somewhat refocused the debate. The more recent reform proposals--no-fault and expanded ADR proposals--now address patient's access to compensation, as well as the cost of resolving claims. The new theme that runs through these recent proposals is to increase access by injured patients, limit damages, and look to quality control mechanisms other than the medical malpractice system. However, any reform that is effective in streamlining the existing process for resolving medical malpractice cases could indirectly improve access to the system.

Footnotes for Chapter 2

[1] For a description of proposed malpractice reform legislation in the 102d and 103d Congresses, see (146).

[2] Other strategies for addressing the malpractice problem include malpractice insurance industry reforms, such as the establishment of joint underwriting associations. These approaches, although discussed briefly in an historical context in chapter 1, are not the focus of this background paper.

[3] Tables in appendix A provide further detail on specific State provisions.

[4] This classification of tort reforms is largely taken from (14).

[5] Hardy v, VerMeulen, 512 N.E.2d 626 (Ohio 1987) cert. *denied* 484 U.S. 1066, 108 S. Ct. 1029 (1988) (overturning restriction on discovery rule); Schwan v, Riverside Methodist Hospital, 452 N.E.2d 1337 (Ohio 1983) (overturning 1 year limitation that applied to minors over 10 years of age); Neagle v. Nelson, 685 S.W.2d 11 (Tex. 1985); Nelson v. Krusen, 678 S.W.2d 918 (Tex. 1984) (statute of limitation cutting off cause of action before discovery held unconstitutional); Barrio v. San Manuel Div. Hosp. for Magma Copper Co., 692 P.2d 280 (Ariz. 1984) (limitations for minors violates fundamental right to recover for tort); Kenyon v. Hamrncr, 688 P.2d 961 (Ariz. 1984); Austin v. Litvak, 682 P.2d 41 (Colo. 1984); Shessel v. Stroup, 316 S.E.2d 155 (Ga. 1984); Strahler v. St. Luke's Host)., 706 S.W.2d 7 (Me. 1986) (statute of limitations for minors violates right of access to courts).

[6] Although pretrial Screening panels are regarded by some as a form of alternative dispute resolution (ADR), wc discuss them separately because they add a preliminary step to the existing system for deciding malpractice cases rather than replacing the judicial system. Other forms of ADR arc discussed below.

[7] In Florida and Pennsylvania the pretrial screening panel was not found unconstitutional in and of itself, but instead, the long delays *in* bringing cases through the pretrial screening process made it unconstitutional in practice (Mattes v. Thompson, 421 A.2d. 190 (Pa. 1980); Aldana v. Holub, 381So.2d. 231 (Fla. 1980)).

[8] *See* Canterbury v. Spence, 464 F.2d. 772 (D.C. Cir. 1982); Cobbs v. Grant, 502 P.2d. 1 (Cal. 1972).

[9] Legally recognized exceptions to informed consent requirements include: (1) life-threatening emergency situations, (2) situations where divulging the information could threaten the patient's medical condition, and (3) situations where the patient indicated he/she did not want to know the risks of treatment (62).

locational data from 1985-1989 show that "failure to instruct or communicate with the patient" was the principal alleged departure from accepted medical practice in only 2 percent of claims (11 1).

[11] The rationale for this is that lay juries may not be able to interpret the scientific language of the guidelines without the assistance of an expert. Some States have exceptions that give courts discretion to allow learned medical treatises to be admitted into evidence without accompanying expert testimony (67,77).

[12] Guidelines for selected areas of practice in obstetrics/gynecology, emergency medicine, radiology, and anesthesia were developed by four medical specialty advisory committees appointed by the Maine Board of Registration in Medicine,

[13] Although Minnesota's statutory language describes the provision as an "absolute defense," the legal meaning is essentially the same as Maine's "affirmative defense" provision--i, e., in order to establish the physician's negligence the plaintiff must prove that the physician did not follow the guideline or that the guideline is not applicable to the specific case.

[14] The arbitration and Practice guideline provisions of the Vermont statute will not go into effect unless and until a legislatively created board implements a universal access plan for the State--expected to happen in July 1994.

15 This rationale for the tradition] collateral source rule is undermined by the fact that malpractice insurers, not individual physicians, pay the vast majority of malpractice awards and there is little experience rating of malpractice insurance premiums.

16 In North Dakota, for example, collateral sources do not include any life insurance or other death or retirement benefits or any other insurance or benefit that *was purchased* by the party recovering economic damages (N. D.C.C. § 32-,03.2.06 (1993)). Washington excludes information on insurance payments from all insurance policies purchased by the plaintiff or purchased by an employer for the plaintiff (R.C.W. § 7.70.080 (Lexis 1991)).

17 Four of the eight States that have caps on total damages also have State Patient Compensation Funds (PCFs), which provide additional insurance beyond that guaranteed by the defendant's malpractice insurance policy. In the typical PCF, the physician is required to carry insurance to pay for the first $100,000 to $200,000 of the award, and the PCF pays the remainder of the award up to a set amount (typically $350,000 to $1 million). PCFs in and of themselves do not place a cap on damages but are a form of additional State-supported insurance. The cap on total damages, however, limits the fund's exposure (see app. A, table A-2). Three of the five States that have a PCF without an explicit cap on total damages limited their fund's liability to $800,000 or $1 million.

18 Barbara Moore v. Mobile Infirmary Association, 592 S.2d 156 (Ala. 1991); Brannigan v. Ustilato, 587 A.2d 1232 (N.H. 1991); Morris v. Savoy, 576 N.E.2d 765 (Ohio 1991); Trujillo v. The City of Albuquerque, 798 P.2d 571 (N.M. 1990) (cap on damages applied only to suits against government health care facilities); Sofie v. Fibreboard, 771 P.2d 711 (Wash. 1989); Condemarin v. University Hospital, University of Utah, 775 P.2d 348 (Utah 1989) (cap on damages for suits brought against government health care facilities); Kansas Malt) ractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988); Lucas v. United States, 757 S.W.2d 687 (Tex. 1988); Smith v. Dept. of Insurance, 507 So.2d 1080 (Fla. 1987); Baptist Hospital of S.E. Texas v. Barber, 672 S.W. 2d 296 (Tex. App. 1984) *aff'd.* 714 S.W. 2d 310 (Tex. 1986); White v. State, 661 P.2d 1272 (Mont. 1983) (cap applied only to governmental tort liability) *overruled* Meech v. Hillhaven West 776 P.2d 488 (Mont. 1989); Carson v. Maurer, 424 A.2d 825 (N.H. 1980); Arneson v. Olson 270 N.W. 2d 125 (N, D. 1978); Jones v. State Bd. of Medicine, 555 P.2d 399 (Idaho 1976) (remanded to determine whether cap bore fair and substantial relation to legislative objective) cert. *denied* State Board of Medicine v. Jones, 431 U.S. 914 (1977); Wright v, Central Dupage Hosp. Assn., 347 N.E.2d 736 (111, 1976).

19 Scholz v. Metropolitan Pathologists, 851 P.2d 901 (Co. 1993); Vincent v. Vernon Johnson 833 S.W.2d 859 (Me. 1992); Samsel v. Wheeler Transportation Service Inc., 789 P.2d 541 (Kan. 1990) (cap applied to all personal injury suits); Etheridge v. Medical Ctr. Hospitals, 376 S.E.2d 525 (Va. 1989); Williams v. Kushner, 549 So.2d 294 (La. 1989); Fein v. Permanence Medical Group, 695 P.2d 665 (Cal. 1985) *cert. denied 474* U.S. 892, 106 S. Ct. 214 (1985); Johnson v. St. Vincent Hosp.. Inc., 404 N.E.2d 585 (Ind. 1985); Sibley v. Board of Supervisors, 477 So.2d 1094, *request for appeal denied 496* So.2d 325 (La. 1986) *modified on rehearing 477* So.2d 585 (La. 1985) (conditional remand on equal protection grounds); Prendergast et al. v. Nelson, 256 N.W.2d 657 (Neb. 1977).

20 Of the sample of claims, only 43 percent resulted in a payment to the plaintiff. Of those with a payment, data on noneconomic damages were provided for less than one-half of the claims. In addition, because most suits were settled, data on noneconomic damages are based on insurers' estimates. The sparsity of data on noneconomic damages from the insurers may be a result of insurers not being able to provide accurate estimates (68,142).

21 Age and severity of injury were chosen because in a regression analysis Of noneconomic damage awards in personal injury cases, severity of injury was the strongest explanatory variable, followed by age of the victim (15). A study of 6,612 medical malpractice closed claims from Florida, including jury verdicts and settlements, found that severity of injury accounted for 40 percent of the variation in payments (128).

[22]This estimate includes only plaintiffs' and insurers' legal fees and expenses in processing claims and does not include court expenditures, the cost of the defendant's time, or the plaintiff's time (61). In 1978, the National Association of Insurance Commissioners reported that the average expenses for insurance companies were 28 percent of total indemnity paid. If one adds the plaintiffs' attorney fees, usually one-third of the award, then the plaintiff is receiving approximately $0.50 of every dollar spent by the malpractice insurer on processing and paying the claim (97).

[23]The classic economic models predict that claims will be settled when the *difference* between the two parties' valuation of the case (taking into account the perceived likelihood of winning and expected damages at trial) is less than the expense of taking the cases to trial (16). See (127) for a discussion of the economic literature on settlement of claims.

[24]The California Supreme Court, for example, recently issued a decision that arbitration decisions are not generally reviewable even if there is evidence that the arbitrator's error will cause substantial injustice to the parties (Moncharsh v. Heily Blase, 832 P.2d 899 (Cal. 1992)).

[25]In general, contracts between two parties may be held unenforceable if the bargaining power of the parties is disparate and the party with greater power unfairly limits the rights of the weaker party (24,25,69).

[26]*But, see* Brocmmcr v. Abortion Services of Phoenix, Ltd., 840 P.2d 1013 (Ariz. 1992) (arbitration agreement made between high school graduate, who was 16 to 18 weeks pregnant, and abortion clinic was not enforceable).

[27]In the 13 years since the program has been operational, only 800 claims have been filed for arbitration, compared with 20,000 where a legal suit was filed (143).

[28]There are exceptions. Kaiser Permanente, a health maintenance organization, has mandated arbitration for all health care claims in California, Colorado, Hawaii, and Washington; however, Kaiser recently dropped the arbitration requirement in Oregon (82). As of 1992, Kaiser enrolled approximately 5.5 million people in these States (including Oregon) (14-4). Ross-Loos, an HMO located in Southern California with approximately 1 million enrollees, also makes arbitration a condition of its HMO contract (144).

[29]Most disciplinary actions have involved charges of substance abuse, inappropriate writing of prescriptions, conviction of felony or fraud, and other unethical behavior (102,147,153).

[30]However, Workers' compensation claims involving difficult judgments about causation (e.g., allegations of occupational diseases) are often disputed (3).

[31]Bills to create similar programs for birth-related neurological injuries were presented in North Carolina and New York in 1991 and 1990, respectively (13,101).

[32]There is some evidence that many birth-related injuries attributed to lack of oxygen during the birthing process have prenatal causes that are yet unexplained (57,99,100,104,113).

[33]In 1992 in California, birth injury cases accounted for 16 percent of all medical malpractice cases and 30 percent of all indemnity (86).

[34]Boyd v. Bulala, 647 F.Supp. 781 (W.D. Va. 1988). The decision on the cap was overturned on appeal (Boyd v. Bulala, 877 F.2d 1191 (4th Cir. 1990); Boyd v. Bulala, 905 F.2d 1190 (4th Cir. 1990)). The Federal court relied largely on the Virginia Supreme Court's decision to uphold the cap on damages in 1989 (Etheridge v. Medical Center Hospitals, 376 S.E.2d 525 (Va. 1989)).

[35]The definition of neurological injury was altered slightly in 1990 to identify eligible infants more easily and earlier (113,123). However, the severity of injury required did not change (122).

[36]Participating physicians and midwives pay $5,000 per year, and participating hospitals pay $50 per delivery, up to a maximum of $150,000. Non-participating physicians originally paid $250 per year; however, because the Fund has remained actuarially sound, this assessment was waived for 1993 (38,113). At present, liability

insurance carriers do not contribute; however, the statute authorizes the fund to assess them at up to 0.25 percent of each carrier's net direct premiums (Va. Code Ann. $38.2-5020 (1992)).

37The claimant must provide a brief statement of the facts and circumstances surrounding the birth-related neurological injury, and include all medical records, relevant documentation from medical evaluations, prognoses, and documentation of expenses and services incurred to date (Va. Code Ann. $38.2-5004 (1992)).

38In three Cases, the Fund accepted the liability and there was no hearing (123).

39If the birth was attended by a nonparticipating physician or occurred in a nonparticipating hospital, the claimant may decide to sue the nonparticipating doctors or hospital. If the claimant makes this election, he or she cannot name the participating physician or hospital in the legal suit and the claimant loses his or her opportunity to receive compensation from the Fund (Va. Code Ann. § 38.2-5002 (1992)).

40Nonparticipating physicians contribute $250 annually, participating physicians contribute $5,000 annually, and private hospitals contribute $50 per live birth (excluding infants born to charity patients or certain Medicaid patients) (Fla. Stat. $766.314 (1991)).

41The authors examined 2,300 closed claims from Florida for these specialties from 1985 to 1988 (134).

42The HMO can be held liable under the doctrine of *respondeat superior,* which provides that an employer is directly liable for the negligent acts of his or her employees (8). Hospitals, too, are directly responsible for their physician employees, such as medical residents and salaried hospital physicians. In recent years hospitals have increasingly been held liable for incidents due to actions of nonemployee physicians with admitting privileges under several different legal doctrines (8). Courts have concluded that the hospital has a legal duty to the patient to insure a certain quality of care.

43To be accredited by the Joint Commission for the Accreditation of Healthcare Organizations (a requirement for receiving Medicare reimbursement), hospitals must establish risk management programs, and at least 10 States require risk management as a condition of hospital licensure (96).

44In 1984, approximately 25 percent of medical malpractice claims involved multiple defendants, with many naming hospitals or HMOS as well as physicians (142).

45If enterprise liability were implemented without managed competition, hospitals' incentives to reduce defensive medicine might be no greater than they are today.

46It is not uncommon for a large hospital to purchase insurance for the institution and then allow physicians who practice in the institution to purchase under a single policy (40,63).

47 For a review of the proposals and several critiques, see (70).

48What constitutes "quality" medical care is difficult to define. Proponents of using contracts to define a new legal standard of care argue that professional custom, which is currently used to determine the proper standard of care, may not necessarily be good practice. Medical custom has developed in a health care system with few cost constraints, and may therefore be highly inefficient and not promote quality care. Advocates of contracts question the legal system's implicit assumption that a single standard for good medical care can be derived from medical custom (52). Opponents note that the legal standard of care reflects the care that would be provided by the average skilled physician, and includes exceptions for minority opinions or mistakes in judgment, and is therefore more accurately characterized as a "reasonable care" standard (7), As such, it is basically the same standard used in all tort actions. Nonetheless, if it is proven that the existing legal standard for "reasonable care" far exceeds what is reasonable, then the medical malpractice liability standard should be changed rather than having some malpractice claims subject to an inefficient standard (7).

49*See,* e.g., Broemmer v. Abortion Services of Phoenix. Ltd., 840 P.2d 1013 (Ariz. 1992) (agreement to arbitrate signed by plaintiff at abortion clinic was unenforceable because of failure to adequately explain to the plaintiff the implications of the waiver and that the arbitrator would be a physician; (Madden v. Kaiser Foundation

Hospitals, 552 P.2d 1178 (1981); Wheeler v. St. Joseph Hospital, 133 Cal. Rptr. 775 (Cal. Ct. App. 1976). *See generally* (19).

50 Tunkl v. Regents of the University of Cal., 383 P,2d 441 (Cal. 1963); Tatham v. Hoke, 469 F.Supp. 914 (W. D.N.C. 1979) *aff'd. without opinion 622* F.2d. 584 (4th Cir. 1980) (agreement requiring plaintiff to submit claim to arbitration within 30 days or lose right for recovery and providing for $15,[)00 limitation on recovery was invalid); (53).

51 A contract may b, unenforceable if a court determines there is a disparity in bargaining power such that one of the parties docs not have a realistic opportunity to bargain (Broemmer v, Abortion Services of Phoenix, Ltd., 840 P.2d 1013 (Ariz. 1992)). An agreement to limit malpractice damages made by a patient with financial resources to pay for medical injuries may not raise as many concerns about unequal bargaining powe r as an agreement by a patient with few financial resources. Of course, any analysis of the contract will also depend on the concessions made by the provider.

52 For a possible mode] on scheduling pain and suffering damages, *see* (15).