

# A MEDICAL LIABILITY TOOLKIT, INCLUDING ADR

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## PART I: THE NATURE OF TORT LAW

### 1. *The Cost of Tort Litigation*

“A billion here, a billion there, and pretty soon you’re talking about real money.” When the late Sen. Everett M. Dirksen from Illinois offered his famous quip about government spending almost 50 years ago, no one imagined that the same words might be used today to describe the American tort system. Fifty years ago medical malpractice insurance premiums were minuscule, and product liability coverage was thrown in as a “freebie” for manufacturers who insured their premises. Not so today. In 2000, a Florida jury awarded punitive damages of \$145 billion to a class of plaintiffs.<sup>1</sup> Two years later, a California jury delivered a \$28 billion tort verdict to a single individual.<sup>2</sup> In 1998, four major cigarette companies agreed to the mother of all settlements: a quarter-trillion-dollar sum to reimburse states for the costs to them of smoking-related illnesses. People are living longer than ever, though (i.e., life is less risky than before) – so either the increase in tort liability is unwarranted or tort liability in the past was lacking, and we are only now taking up the slack.

The U.S. Chamber of Commerce charges that the tort system is wrecking our economy. From 1930 until 1994, growth in litigation costs has been four times the growth of the overall economy.<sup>3</sup> Over

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<sup>1</sup> The verdict, *Engle v. Liggett Group*, was eventually overturned by the Florida Supreme Court, else it would have bankrupted the defendants. Individual “Engle suits” continue against Big Tobacco in Florida.

<sup>2</sup> J. Broder, *California Jury Allots Damages Of \$28 Billion To Ill Smoker*, NEW YORK TIMES, Oct. 2, 2002, available at [query.nytimes.com/gst/fullpage.html?res=9500E4D7173BF936A35753C1A9649C8B63](http://query.nytimes.com/gst/fullpage.html?res=9500E4D7173BF936A35753C1A9649C8B63) (last visited Dec. 11, 2011).

<sup>3</sup> R.W. Sturgis, *Tort Costs Trends: An International Perspective*, 1995.

the last 50 years, tort liability in the U.S. has increased more than a hundredfold, while overall economic production (as measured by gross domestic product) has grown by a factor of 37 and population has grown by a factor of less than 2. The Chamber reports that federal class actions have tripled over the past 10 years, while similar filings in state courts ballooned by more than 1,000 percent.<sup>4</sup> The estimated aggregate cost of the tort system in 2004, including the administrative costs of dealing with claims, was \$246 billion<sup>5</sup>, or roughly \$1,000 for every man, woman, and child in America, according to the Tillinghast group of Towers Perrin, a respected actuarial firm that works for many insurance companies. The share of this cost that goes to trial (i.e., plaintiffs') lawyers – roughly \$40 billion – is 150 percent of the annual revenues of Microsoft or Intel, and twice those of Coca-Cola.<sup>6</sup> The cost of our tort system represented 2.23 percent of the nation's gross domestic product, or the equivalent of a 5 percent tax on wages.<sup>7</sup> This cost of \$845 per American in 2004 compares to a cost of \$12 per American in 1950.<sup>8</sup> In real dollars, the cost of tort has increased 929% since 1950.

Medical malpractice liability (either for misfeasance during a procedure or for failure to obtain "informed" consent before undertaking the procedure) has been particularly affected by recent trends. Since 1975,<sup>9</sup> the increase in medical malpractice costs has actually outpaced the significant increases in overall U.S. tort costs. From 1975 until 2004, medical malpractice costs have risen an average of 11.8% per year, compared to an average annual increase of 9.2% per year for all other tort costs.<sup>10</sup> The compounded impact of this 29-year difference in growth rates is that medical malpractice

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<sup>4</sup> See Tresa Baldas, *Verdicts Swelling from Big to Bigger*, NAT'L L.J., November 25, 2002.

<sup>5</sup> Tillinghast (div. of Towers Perrin), *U.S. Tort Costs: 2004 Update, Trends and Findings in the Cost of the U.S. Tort System*, January 2005.

<sup>6</sup> *Trial Lawyers Inc.*, Center for Legal Policy, Manhattan Institute, 2003.

<sup>7</sup> Hechler, *Study Sees Rise in Cost of Tort System. Is It Right?* NAT'L L.J., December 22, 2003, at 12.

<sup>8</sup> *Id.*

<sup>9</sup> 1975 is chosen because it is the first year for which insured medical malpractice costs were separately identified by A.M. Best, the worldwide insurance rating and information agency.

<sup>10</sup> Tillinghast (Div. of Towers Perrin), *U.S. Tort Costs: 2004 Update, Trends and Findings in the Cost of the U.S. Tort System*, January 2005, at 10.

costs have increased by a factor of 23 since 1975, while other tort costs have grown by a factor of 12. At nearly \$27 billion in 2003, direct medical malpractice costs (not including indirect costs to be discussed below) themselves translated to \$91 per person. This compares to \$5 per person in 1975.<sup>11</sup>

The upsurge in med-mal litigation (and the concomitant rise in insurance premiums) has had the expected incentive effects in a system where patients do not directly pay for duplicative care. More than 90% of Pennsylvania doctors surveyed admit to engaging in medically unnecessary behavior as a defensive guard against malpractice suits, according to an exhaustive article published in 2005 in the *Journal of the American Medical Association*.<sup>12</sup> Fifty-nine percent said they often order more diagnostic tests than were medically needed, while 52% said they refer patients to other specialists even when such referrals were not indicated by sound practice guidelines. A large majority of nurses (66%) and hospital administrators (84%) who participated in a 2002 survey of health care professionals reported that they deliver or order unnecessary or excessive care to avoid groundless litigation.<sup>13</sup> In 2002, economists Daniel Kessler and Mark McClellan found that 5 to 9 percent of total health care expenditures for heart disease patients are due to unneeded defensive medicine.<sup>14</sup>

That the cost of tort in general, and of medical malpractice in particular, in America has been rising is not seriously questioned. But some scholarship maintains that there are still too few tort suits, and that litigation is only beginning to catch up to harms wrongfully inflicted. One 1991 study, for example, concluded that for every eight instances of medical error leading to harm in America, only one malpractice suit is filed – and that one suit, likely as not, is launched in a case without merit.<sup>15</sup> The New York City-based

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<sup>11</sup> *Id.* at 2.

<sup>12</sup> Studdert *et al.*, *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609 (2005).

<sup>13</sup> Harris Interactive, *Fear Of Litigation: The Impact On Medicine*, April 11, 2002, at 19.

<sup>14</sup> Daniel Kessler & Mark McClellan, *How Liability Law Affects Medical Productivity*, 21(6) J. HEALTH ECON. 491, 491-522 (2000).

<sup>15</sup> PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* (1991); *See also, e.g.*, Studdert *et al.*, *Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?*, 60 LAW &

Committee to Reduce Infections maintains that hospital infections rank as the fourth-highest cause of death in the country, killing more people than AIDS, breast cancer, and auto accidents combined.<sup>16</sup> The Centers for Disease Control and Prevention confirm that approximately two million Americans are sickened, and that 100,000 die, each year from infections contracted in healthcare facilities – many apparently caused by unclean hands and inadequately cleaned equipment, according to a recent study by Boston University.<sup>17</sup>

It is far from clear that these medical “errors” equate to legal *negligence*, of course: humans are not robots, and even careful behavior will stochastically result in missteps.<sup>18</sup> What is increasingly clear, however, is that medical liability is both more frequent and (to a significant extent) random. Indeed, medical liability insurers generally do not even “experience rate” their policies (*i.e.*, a physician’s future premiums are in general not a function of past individual claims), meaning that actuaries find that lawsuits are like lightning strikes: uncorrelated with the quality of care likely to be provided by the insured physician.<sup>19</sup>

## 2. *Why Have Medical Liability?*

Public law is that subset of our legal system that regulates rights and obligations between citizens and the state. Various types of public law are, in essence, common knowledge. Constitutional litigation (where citizens attack executive and legislative action that is allegedly in breach of our higher law) makes headlines. Judicial attitudes toward public law dominate confirmation hearings. Criminal trials

CONTEMP. PROBS. 1 (1997); Paul C. Weiler, *Fixing the Tail: The Place of Malpractice in Health Care Reform*, 47 RUTGERS L. REV. 1157 (1995); PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993); Richard L. Abel, *The Real Tort Crisis—Too Few Claims*, 48 OHIO ST. L.J. 443 (1987); and PHILIP SLAYTON AND MICHAEL J. TREBILCOCK, THE PROFESSIONS AND PUBLIC POLICY (1978).

<sup>16</sup> *Your Hospital Stay Could Kill You*, ABC NEWS REPORT, March 30, 2006, abcnews.go.com/GMA/OnCall/story?id=1785701 (consulted on 12/11/2011).

<sup>17</sup> P. C. Carling, MD et al., *Identifying Opportunities to Enhance Environmental Cleaning in 23 Acute Care Hospitals*, 29 INFECT. CONTROL HOSP. EPIDEMIOL. 1 (2008).

<sup>18</sup> See, e.g., *Rinaldo v. McGovern*, 587 N.E.2d 264, 267 (N.Y. 1991) (“even the best professional golfers cannot avoid the occasional ‘hook’ or ‘slice’ . . .”).

<sup>19</sup> Sloan, *Experience Rating: Does It Make Sense for Medical Malpractice Insurance?* 80 (2) AM. ECON. REV. 128 (May 1990).

(where governments sue citizens for breach of conduct) are also prime-time fodder. Notwithstanding this valid interest in public ordering, however, in a free society *private law* issues are more vital.<sup>20</sup>

Private law (roughly, rules regulating the allocation of rights and the sharing of risks among citizens) and private ordering (the possibility for people to “self-determine” through interaction amongst themselves) are in fact arguably what distinguish free societies from totalitarian ones.<sup>21</sup> All countries have public law institutions – prisons and police and legislatures of some kind. But only in free countries is the private law of contract, property, tort, and family law the principal way to acquire and exchange rights and obligations. Private law does this by allowing citizens to transfer entitlements (and to assume risks) voluntarily (through contract law) or involuntarily in one of two ways: when one’s choices wrongfully cause harm to another (tort) and through blood or marriage ties (family law). Most of us will never have a serious run-in with the police or with any government agency. But all of us interact daily in the private sphere – we work, we buy, we sell, we parent families, and sometimes we “collide” with others doing the same thing. Tort law, which assigns obligations to wrongdoers who cause harm to others in those “collisions” and which includes medical malpractice as a subset, is an essential component of private ordering.

### 2-1. *What Tort Is Not*

What is the essence of tort?<sup>22</sup> This important question is perhaps best broached by sketching what tort law is *not*:

#### **Tort law is not insurance against unfortunate losses.**

Tort law does not exist in order to provide protection against risks. Free societies have a “thick” (*i.e.*, competitive) contractual market for insurance policies that does just that.<sup>23</sup> Most losses happen without any tort – lightning may strike us, we may get sick and

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<sup>20</sup> See, *e.g.*, RANDY BARNETT, *THE STRUCTURE OF LIBERTY: JUSTICE AND THE RULE OF LAW* (1998).

<sup>21</sup> See, *e.g.*, FRIEDRICH A. HAYEK, *THE CONSTITUTION OF LIBERTY* (1960); BRUNO LEONI, *FREEDOM AND THE LAW* (1991).

<sup>22</sup> ERNEST WEINRIB, *THE IDEA OF PRIVATE LAW* (1995).

<sup>23</sup> Peter Bell, *Analyzing Tort Law: The Flawed Promise of Neocontract*, 74 MINN. L. REV. 1177 (1990); Jane Stapleton, *Tort, Insurance and Ideology*, 58 MOD. L. REV. 820 (1995).

miss work, or a medical procedure may fail through no fault of the physician. Homeowners' insurance, health insurance, and life insurance (commonly called "first-party insurance" because they protect the insured party against losses she suffers) are widely available and administratively inexpensive.<sup>24</sup>

If insurance against catastrophic loss is the desired goal, it can be obtained through contract law and a competitive first-party insurance market. If "free insurance" (otherwise known as "social insurance") for the poor, or for all, is desired, then public law (modifications to welfare law, tax law, and the like), *not* tort law, is the appropriate vehicle. Public law socializes risk, removing it from the realm of private ordering. We should and do debate how many risks should be socialized – removed from private ordering and borne by the state. But neither socialized risk nor personally assumed risk has anything to do with tort law. However, if a loss is one of those rare ones that result from a wrongful act by a third party (including a physician), the victim may recover from that third party, called the tortfeasor.<sup>25</sup> That *third-party* liability is tort law, and if potential tortfeasors wish to insure against such liability they purchase "third-party insurance."

**Tort law is not a national compensation scheme for innocent victims.**

Tort's essence is not compensation for all innocent "casualties" (although tort does compensate certain victims in certain circumstances). Rather, the essence of tort law is to reallocate risks when one person has wrongfully and without consent caused harm to another.<sup>26</sup>

Many innocent people suffer losses that, though tragic, do not and should not lead to a tort recovery. Indeed, the vast majority of

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<sup>24</sup> The loading cost of first-party insurance is roughly 10 percent; that is, of every dollar in premium paid about 90 cents go to cover losses. The remainder covers administrative fees and profit.

<sup>25</sup> Of course, the victim may not recover from the tortfeasor if the victim has already been paid by her first-party insurer and has transferred her tort entitlement to that insurer. If that transfer (called subrogation) has not taken place, the victim has a suit against the person who has wrongfully harmed her.

<sup>26</sup> See Ernest J. Weinrib, *The Special Morality of Tort Law*, 34 MCGILL L. REV. 403 (1989).

good people to whom bad things happen should have no recourse in tort. The pedestrian killed in an earthquake, the merchant who loses everything she owns to a more efficient business competitor, the baby born with a congenital birth defect, the patient who dies on the operating table despite heroic efforts by medical staff, and many, many others, are all deserving of our compassion. But this compassion can and should find no solace in tort law. Just because something sad has happened does not mean tort law should provide a remedy. *Tort law is not an equalizer of risks.* Only replacement of tort law by social insurance could equalize chances and compensate all innocent victims.<sup>27</sup>

**Tort law is not a creation of state “public policy.”**

Government is not a party to a tort suit – unless, of course, the government (through one of its employees, say) has either committed a tort or suffered damage to its property (as when a motorist negligently runs into a government building). Though of course state courts may be called on to decide tort disputes, they do this by neutrally applying private law principles, not by enacting legislative policy.

Instead, public policy is a quintessential yield of public ordering. Every citizen has the right to intervene in the legislative process that produces public policy, but only parties directly involved in a tort suit are permitted to intercede in that suit. Our legislative process, which guarantees to all the right to voice their views, is the constitutional forum for policymaking. Common law judges are not public policymakers.<sup>28</sup>

**Tort suits are not a mechanism to express public outrage.**

Vindication of public outrage is the province of criminal law, a

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<sup>27</sup> New Zealand has abolished tort law for unintentional harms, and has replaced it with government compensation of victims, funded through traditional tax sources. For a defense of the replacement of tort law with such social insurance, see Michael Whincup, *Compensation for accident victims: The exemplary model of New Zealand*, 7 J. CONSUMER POL’Y 497, 497-405 (2004).

<sup>28</sup> Misunderstanding of this distinction used to be rare among judges, though it occasionally reared its head: see, e.g., Warren A. Seavey, *Res Ipsa Loquitur: Tabula in Naufragio*, 63 HARV. L. REV. 643 (1950). Today, especially in certain states, the confusion of roles is both common and quite damaging. See Michael Krauss, *Tort Law and Private Ordering*, 35 ST. LOUIS U. L.J. 623 (1992).

leading component of public ordering.<sup>29</sup>

**Tort law is not about punishment.**

Criminal adjudication, a branch of public law replete with constitutional protections, punishes violators of public order; common law torts, on the other hand, require compensation or rectification of the wrongfully imposed risk, not punishment.<sup>30</sup>

**Tort law is an inappropriate vehicle for redistribution of resources.**

Redistribution is the province of tax and welfare law, components of public ordering. Coerced transfer through public ordering is typically based on conceptions of *distributive* justice – the view that certain citizens have “too much” and others “not enough.” In tort, however, forced transfers are based on notions of *corrective* justice – the view that when a defendant has wrongfully caused a loss to a plaintiff, the plaintiff should receive compensation for that loss. The notion of corrective justice has no distributive punch; that is, if a defendant – no matter how poor and pitiful – wrongfully<sup>31</sup> harms a victim – however rich and powerful – the victim is owed compensation in tort.

Tort law is, in sum, essential to private ordering. To see this, imagine that tort were replaced by social insurance, as has to some extent taken place in New Zealand. This would signify, in essence, that every loss is a “public” loss, with government providing protection against risks in life. Imagine also that government proceeds to sue (*i.e.*, prosecute) all those who cause such “claims” on its resources. In such a society there would be no need for tort law – government recoupment of its payouts would consist of fines or other criminal

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<sup>29</sup> JULES COLEMAN, *RISKS AND WRONGS* (1992).

<sup>30</sup> It is true that modern-day some products liability suits are characterized by significant punitive damages – here some kind of public regulation is arguably being attempted. Punitive damages are extremely rare in other tort adjudication, including medical malpractice. See Bureau of Justice Statistics, *Civil Justice Survey of State Courts, 1996 Tort Trials and Verdicts in Large Counties* (2005).

<sup>31</sup> Some may object that strict liability (the rule for products liability, but not for other torts) does not require wrongdoing for tort liability. But even in products cases, defendant’s liability requires some misbehavior (poor design, poor instructions) or breach of contract (in defective manufacturing cases).



penalties.<sup>32</sup> There would also be no meaningful property law in a world where all risks are borne by government, since ownership as we understand it entails the assumption of the risk of loss.<sup>33</sup>

Socialization of risks substitutes public for private ordering. In other words, socialization of risk substitutes regulations and criminal liability for contract and tort. Wrongs against persons in a free society become offenses against the state. Political processes, not private conduct, determine who secures and loses entitlements in a publicly ordered society.

## 2-2. Torts And Contracts as Risk Assignment Mechanisms

It is of the essence of private ordering that transfer of risks through tort be subjugated to consensual transfer through contract. If I assume a risk voluntarily, through contract, trying to force that risk (if it materializes) on my co-contracting partner amounts to a repudiation of my word. If I purchase a home in a one-industry town, I may not blame my seller two years later if the factory has shut down and my house has lost most of its value, for I assumed that risk through contract by buying the house.

When a victim expressly or implicitly assumes a risk of loss through contract, tort should decline to shift that risk. Medical procedures are inherently risky, and patients should be fully informed of reasonably significant risks before consenting to a procedure.<sup>34</sup> Medicine is not like plumbing: the extent of our knowledge is much more limited and therefore outcomes are always more probabilistic. The mere fact that an operation is not always successful is often trag-

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<sup>32</sup> In 1992, New Zealand was obliged to reinstitute many aspects of a fault-based (*i.e.*, tort) system after 20 years of experimentation with social insurance because government costs were spiraling out of control. For a summary of developments, see Colleen M. Flood, *New Zealand's No-Fault Accident Compensation Scheme: Paradise or Panacea*, 8 HEALTH L. REV. 3 (2000).

<sup>33</sup> "Owners" would in fact become "tenants" of government in such a system; the only party that would truly absorb a loss would be government. But a new risk would emerge in such a system: the risk that government would decide that one's holdings more properly belonged to someone else. This political risk of publicly ordered societies has proven to be one of the downfalls of Marxist collectivism.

<sup>34</sup> "Full" warning by physicians before operating is neither possible (not all risks are known) nor socially desirable. See, *e.g.*, B.M. Patton, *Death Related to Informed Consent*, 72 TEX. MED. 49 (December 1978).

ic, but tragedy is not sufficient basis for a tort remedy. Yet, when a medical procedure has been less successful than was hoped and anticipated, the undesired result is typically used as evidence (under the doctrine of *res ipsa loquitur*) of the physician's or medical center's negligence, as is discussed below in the illustrative case of obstetrics.

## PART II: MEDICAL MALPRACTICE LAW IN CRISIS

### 3. Manifestations of "Crisis"

Medical malpractice has been more prone to cries of "crisis" than many other areas of tort law. Manifestations of the alleged medical liability crisis are, among others:

#### Significant increases in medical liability costs

Since 1975, when insurers first began to itemize tort costs attributable to medical liability, those costs have grown at a compound annual rate of 11.8 percent, which is fully 28 percent more rapidly than the 9.2 percent annual increase already bemoaned for all U.S. tort costs.<sup>35</sup> Those medical liability costs have been translated into uneven, sometimes drastic, increases in medical liability premiums, as liability insurers periodically hemorrhage money – for every dollar of premium earned in 2001, for example, insurers paid out \$1.38 nationally. In addition, the much-publicized 2002 decision by St. Paul, the nation's biggest single medical liability insurer, to cease writing new medical liability policies contributed to a drop of approximately 15 percent of the premium-writing capacity of the industry nationwide.<sup>36</sup> Median malpractice premiums rose faster than the increase in total health care spending from 2003 to 2005, perhaps as a result of the drop in supply.<sup>37</sup> For medical malpractice cases going to trial, median jury awards more than doubled from \$280,000 in 1992 to \$682,000 in 2005 (a 60% greater rise than would be anticipated by inflation alone).<sup>38</sup>

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<sup>35</sup> *U.S. Tort Costs – 2003 Update*, published by Tillinghast–Towers Perrin.

<sup>36</sup> James D. Hurley, "A New Crisis for the Med Mal Market?", 2002/4 *Emphasis* at 2 (Tillinghast, Div. of Towers Perrin, quarterly magazine).

<sup>37</sup> Insurance Information Institute, *Medical Malpractice*, May 2007, available at [www.iii.org/media/hottopics/insurance/medicalmal](http://www.iii.org/media/hottopics/insurance/medicalmal).

<sup>38</sup> *Civil Bench and Jury Trials in State Courts, 2005* (Bureau of Justice Statistics, U.S. Depart-

### **A rise in mammoth claims and awards**

According to one database, the percentage of payments over \$1 million sextupled, to slightly more than 21 percent of medical liability claims, from 1995 to 2005.<sup>39</sup> In several specialties, including obstetrics-gynecology (“OB-GYN”; see below), the *average* claim is now over \$1 million. Mammoth claims affect medical liability insurance rates and insurability much more than do smaller claims, as they significantly increase risk for insurers and therefore increase their desire to engage in “nuisance settlements” of dubious or even invalid claims (in order to avoid the small risk of a massive award).

### **Widespread anecdotal allegations of alienation of physicians**

These anecdotes include stories of massive “early retirement,” of restriction of practice to existing (and new low-risk) clientele, and of reduction in supply of certain specialty fields, especially OB-GYN, in many states.<sup>40</sup>

### **Exacerbation of medical inflation**

This is said to occur not only because high liability awards are directly factored into insurance premiums and therefore into fees for services, but also and quite importantly because redundant and expensive tests, procedures, and referrals are said to be performed by physicians (and strongly encouraged by malpractice insurers) as prophylactics against medical liability. A survey by Aetna Insurance reported that 79% of physicians polled in 2002 ordered more tests than they felt were medically appropriate (these tests are, of course, paid for by patients’ insurance carriers, so patients don’t typically object to them) in order to provide a buffer against malpractice liability.<sup>41</sup> One telling illustration of this in a particularly afflicted field of medical practice is highlighted immediately below.

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ment of Justice 2008).

<sup>39</sup> *Id.* at 5.

<sup>40</sup> See, e.g., U.S. Department of Health and Human Services, *Addressing the New Health Care Crisis*, March 2003, at 3-4, for representative examples.

<sup>41</sup> Insurance Information Institute, *Medical Malpractice Insurance*, INSURANCE ISSUES SERIES, Vol. 1, No. 1 (June 2003).

#### 4. *Obstetrics: A Case Study*

A two-volume study from the National Institute of Medicine (“IOM”) in 1990 illustrates the medical liability crisis in striking detail. The study, entitled *Medical Professional Liability and the Delivery of Obstetrical Care*, contained the findings of an interdisciplinary committee that investigated the effects of litigation on the practice of obstetric medicine. The study IOM conducted had no institutional bias toward physicians or patients. It commissioned over 20 research papers and reviewed more than 50 existing surveys, as well as other scholarly research.

The study found that greater than 7 in 10 obstetricians had been sued at least once. Suits invariably followed “imperfect” births, which constitute (depending on one’s definition of “imperfect”) upwards of 5 percent of all births today. Plaintiffs in such cases typically claim that had the obstetrician delivered the baby earlier, by Caesarian section, the baby would have been “perfect.” Such claims are rampant; the IOM committee found, for instance, that in Massachusetts fully 80 percent of obstetrical malpractice claims included a charge of failure to perform a Caesarian section.

Such claims, based on hindsight and unsupported by any individualized evidence of wrongdoing or causation, never would have been filed in earlier times – the baby likely would have died in childbirth, an occurrence that was frequent enough to be culturally accepted and which, of course, had relatively little economic cost. But today children with cerebral palsy survive and need expensive care – and suits against doctors have been allowed to go to juries, who often suspect that the defendant physician is insured against liability. That knowledge, coupled with a fear of mammoth awards for pain and suffering to parents, leads insurers to propose settlements that result in substantial increases in medical liability premiums, even for physicians who have done nothing wrong.

Today, thankfully, babies with neurological problems can be saved and maintained throughout their lives. But these maintenance costs are extremely high, and of course handicapped babies have limited prospects for earning income when they reach adulthood. Whereas in the past parents were wont to conclude that divine will,

or in some cases the parents' own misbehavior during pregnancy, were likely causes of their child's "defect" or death, today very large amounts of money are at stake. As a result, it is much easier to convince an anguished parent that someone else is to blame for their misfortune. Plaintiffs' lawyers in "bad baby" cases are often anxious to get before a jury and ask for compensation for the innocent baby from the doctor's large, faceless medical liability insurer. Infant neurological claims against obstetricians accounted for the absolute majority of suits against OB-GYNs in many states by the time the IOM study was published.

Typically, OB-GYN medical liability suits seek millions and often tens of millions of dollars in damages (the cost of rearing a "defective" child). Classically, the plaintiff's claim is that the obstetrician failed to monitor the fetus adequately, which in turn led to the failure to perform a Caesarian section.

Not surprisingly, the IOM study found a distinct relationship between the medical liability system and Caesarian sections. The study documented a startling increase in the number of Caesarian section births as defensive medicine. By 1990, Caesarians accounted for 25 percent of all deliveries in the country, easily the highest rate in the world and a fivefold increase from the 5 percent rate in 1970. The nationwide billing for unnecessary Caesarian section deliveries was estimated at \$1.15 billion per year in 2005 dollars, not including any of the costs of negative side-effects of surgery.

The expansion of OB-GYN liability prompts the question: have doctors become more negligent over time, or has technology afforded a greater opportunity for "perfect hindsight"? Electronic fetal monitoring, or "EFM," was developed in 1972. The idea was that by monitoring the fetus, the doctor could detect distress and intervene (typically by Caesarian section) to ensure a normal birth. Cerebral palsy claims quickly became "negligent failure to monitor" claims. Even by 1990, however, the IOM knew that most cases of fetal brain damage were not due to delivery events. *Widespread use of fetal monitoring strips has not reduced the incidence of cerebral palsy*, as the strips are prone to many and costly "false positive" results. The IOM report concluded that overwhelming evidence establishes that "EFM

[with subsequent Caesarian section] has not reduced neonatal morbidity and death, and . . . has not reduced the frequency of developmental disability."<sup>42</sup> Yet EFM not only remains in (costly) use, but it is still considered standard procedure if an obstetrician hopes to defend against charges of negligence.

Consider, for example, a settled case that resulted in what was at the time the largest medical liability payout in the history of Connecticut: *Sabia v. Humes*. This case is the subject of Barry Werth's thorough case study, *Damages*.<sup>43</sup> Despite an utter absence of evidence of any causal negligence on her part, the *Sabia*'s OB-GYN and her insurer agreed to a multi-million dollar settlement of a "bad baby" case. Nothing special about Connecticut law allowed *Sabia* to happen. Indeed, "*Sabias*" happen, as it were, across the country every month. Recently, the award in *Sabia* was dwarfed by another Connecticut case where, again, the jury found that a baby suffering from cerebral palsy should have been delivered by C-section following fetal monitoring. The baby was present at trial, and the jury forewoman commented, "we all wanted to reach out and hug him."<sup>44</sup> This baby received \$36.5 million, even though, to repeat, most clinicians do not believe that babies acquire cerebral palsy from the failure to be delivered by C-section.<sup>45</sup>

The IOM committee found that in every state, sizeable numbers of family practitioners had eliminated obstetrics from their practice by 1990. They did so because the increase in liability insurance premiums made the obstetric part of their practice unprofitable. Obstetrical specialists, for their part, reduced or eliminated services to high-risk women. One common way for OB-GYNs to screen out high-risk pregnancies is to cut Medicaid caseloads. This is because, statistically, Medicaid patients are more likely to have engaged in poor prenatal care. In addition, the pro-rated cost of obstetric liabil-

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<sup>42</sup> Institute of Medicine, 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 79 (1989).

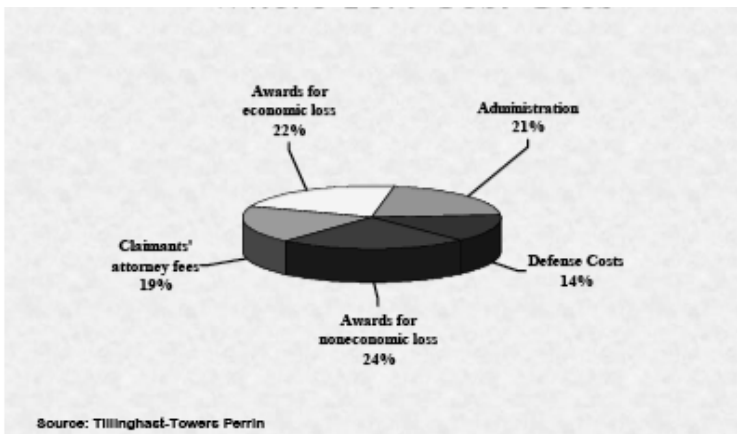
<sup>43</sup> Barry Werth, *Damages*, (1999).

<sup>44</sup> Stephanie Reitz, "Hospital, Doctor Faulted: Boy Suffered Brain Damage During Birth", *Hartford Courant*, Nov. 29, 2005, A1

<sup>45</sup> Alastair MacLennan *et al.*, *Who Will Deliver Our Grandchildren: Implications of Cerebral Palsy Litigation*, 294 JAMA 1688 (2005).

ity insurance all by itself is often greater than Medicaid reimbursement OB-GYN's can expect to receive for a delivery.

This is clearly perverse. The purpose of private ordering (see above) is not achieved by transferring a risk from a possibly<sup>46</sup> innocent parent to an equally innocent doctor. This is not tort law – this is forced third-party insurance, increasingly used in the United States as an extraordinarily inefficient financing mechanism for gravely injured children. Verdicts and settlements are paid for out of physicians' medical liability insurance, which of course is third-party insurance. But third-party insurance has a direct load effect of over 100 percent – that is, it costs more than \$2 in premiums to get \$1 to a needy person. Indeed, only 22 cents of the medical liability insurance dollar goes to litigants to pay for their actual economic losses. Much of the remainder gets parceled out to lawyers, expert witnesses, and the like. This insurance is paid for by practitioners, of course, and carves out a considerable portion of their gross income. This is shown in Exhibit 1, below:



This forced insurance thwarts many doctors' idealistic career goals. Inevitably, a doctor who has been sued (an absolute majority

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<sup>46</sup> Poor pre-natal care and failure to inform one's physician of risky incidents make the mother's "innocence" less than certain in some cases. In the *Sabia* case, for example, the pregnant mother never reported a violent attack by her husband to the OB-GYN. Nor was the mother's alcohol and marijuana consumption strictly monitored or reported to her doctors.

of OB-GYNs have been sued) will often, despite her best intentions, subconsciously consider patients as future adversaries, not as “friends” in need of loving care. The doctor who treats patients as potential adversaries cannot provide the caring healing *which itself increases cure rates*. By increasing the alienation doctors feel from patients, the medical liability explosion actually contributes to the injury rate. Overuse of knowingly needless and expensive procedures and equipment (like EFMs), just because they exist and because an “expert” is prepared to argue, Monday-morning quarterback style, that they were needed, is one of many ways in which medical liability’s costs filter down to the entire population. Demoralization of the healing arts is another way in which this misdeed is done. The first type of cost can be captured in actuarial studies. The second type of damage is hidden and possibly more insidious.

It is crucial to understand that advances in technology constantly provide new ammunition for those in search of a “reason” for a bad medical result. (“Why didn’t you use this device or that technique? It might *possibly* have made a difference.”) The ubiquity of third-party malpractice insurance surely eases jurors’ pain in assigning blame, even if deep down they know that causal negligence has not been established by a preponderance of the evidence.<sup>47</sup>

And such negligence is apparently quite rare, despite studies indicating that “medical errors” abound. In the famous Harvard Medical Practice Study in New York state, alluded to above, researchers put 31,000 randomly selected hospital records from 51 New York hospitals through a two-stage review process to identify the rate of negligent medical injuries among that sample. The two sets of reviewers (who had no axe to grind and were not paid by any party) identified the same negligently caused injuries only **four times** in 318 potentially flagged (adverse outcome) cases.<sup>48</sup> This concurrence emerges far less frequently than do plaintiffs’ medical liability ver-

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<sup>47</sup> The bankruptcy of Virginia’s principal med-mal insurer has left many providers “bare” (*i.e.*, vulnerable in their personal assets) for past coverage. I am very reliably informed that the success rate of med-mal suits against physicians who are left “bare” is considerably lower than it is for insured physicians.

<sup>48</sup> Troyen A. Brennan *et al.*, *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 NEW ENGLAND J. OF MED. 370 (1991).



dicts and pro-plaintiff settlements.

In addition, as mentioned above, a tremendous indirect load of inappropriate liability, not captured in Figure 1, is the “common pool” of “CYA” redundant and inefficient care paid for by health insurers (first party insurance) and ultimately by patients themselves. The real losers are, thus, doctors and patients alike, who suffer a decline in supply and an increase in the price of medical services. In ways similar to that afflicting obstetrics, other specialties and even general practice have been afflicted by this desire of juries to turn tort law into health insurance. This is a perversion of private ordering. Only tort reform can cure it.

### PART III. STATE LIABILITY MEDICAL MALPRACTICE REFORM

#### *5. Impact of State Legislative Reform*

Almost all 50 states have enacted some kind of tort reform applicable to medical liability. In some states, the reform enacted was general (*i.e.*, it was applicable to all tort suits), while in others the reform applied only to medical liability. Appendix A contains an up-to-date compendium of several of these reforms, state-by-state.

The experience of our most populous state is an instructive introduction. California, once seen as a tort plaintiff’s paradise, enacted the Medical Injury Compensation Reform Act (“MICRA”) in the 1980s. Now, with a \$250,000 cap on non-economic loss and several other reforms, the Golden State has among the lowest medical liability insurance costs of states with 10,000 or more physicians. California’s average claim payment, reflecting MICRA, is consistently below that of many states not considered to be lawyers’ paradises. California’s malpractice insurance premiums, as compared to average medical liability premiums across the nation, have been dropping ever since its courts upheld the constitutionality of MICRA in 1985. Between 1985 and 2001, California malpractice premiums decreased from 16.9 percent to 9.1 percent of total malpractice premiums paid across the country. Med-mal premiums paid did rise from \$350 million to \$500 million from 1976-2000, but these pre-

miums increased from \$1 billion to over \$5.5 billion in the rest of the country during the same period.<sup>49</sup> In the same time, California's population increased slightly as a percentage of the national population, from 11 percent to 12 percent. In California there has been a decrease in both the chance a physician will be held liable and the extent of damages the physician will have to pay if held liable.

It is useful to canvass eight principal types of reforms that have been adopted, noting the advantages and drawbacks of each proposed reform as I see it.

### *6. Types of State Legislative Reform*

#### **6-1. Compulsory Non-Binding Alternative Dispute Resolution**

This reform typically mandates that would-be plaintiffs first seek relief through some alternative adjudication process (such as non-binding arbitration of the claim by an expert panel of medical professionals) before any medical liability suit can be brought. The panel can recommend or not recommend compensation, but its recommendation does not prevent the "losing" party from filing a tort suit. The goal, presumably, is to nip in the bud the most frivolous lawsuits by showing the plaintiff's lawyer that he has no hope of success, and to do this at very low cost to innocent physician defendants. The thinking is that if an arbitration result is relatively certain and relatively cheap, the defendant's insurer will be less likely to offer generous "nuisance settlements" that drive up premiums. Moreover, with a reduced prospect of any such settlement, a contingent fee attorney will more likely drop a losing claim rather than invest hundreds of hours of his own labor in it. Many states have incorporated a version of this reform. Other states have statutory language appearing to strongly recommend this route.

Most versions of this reform have proven somewhat ineffectual. Parties tend to consider required arbitration a delaying tactic. Plaintiffs who "lose" before the medical panel tend not to feel terribly disadvantaged when the panel's report is produced at trial, so long

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<sup>49</sup> U.S. Department of Health and Human Services, *Addressing the New Health Care Crisis*, March 2003, Figure 1, at 24.

as they are able to find an expert who disagrees with the panel and who agrees with their assessment of defendant's behavior: such expertise is typically obtained before trial has begun. Of course, *binding* arbitration through tort reform (*i.e.*, precluding any trial after the panel has rendered its sentence) is not allowed, as 49 states and the federal system all constitutionally guarantee their citizens the right to a jury trial of judiciable civil disputes. Plaintiffs often feel comfortable going forward with their expert before a jury even if a panel has not found in their favor.

One proposed reform arguably would have a substantial impact if it is adopted. An example is "Bill 902," adopted by the North Carolina Senate in September 2003. The bill gives trial judges discretion to order mandatory non-binding arbitration before a panel of three expert "referees," one chosen by each side, and a third jointly or by the judge. After reviewing a medical liability case, the panel would either recommend that the defendant settle (if the plaintiff's case had merit) or that the plaintiff drop his or her suit if the case was without merit. The bill provided that if a party (the plaintiff in most cases) loses before the arbitration panel *and again before the jury*, that party is liable for all court costs, including the lawyers' fees of the winning side. Such a provision, were it enacted and upheld against the expected constitutional challenge,<sup>50</sup> would arguably dissuade a plaintiff's lawyer from pursuing a dubious suit after an adverse arbitral sentence.<sup>51</sup> Of course, settlements could not be easily subjected to the "loser-pays" rule, so a significant number of last-minute settlement offers from the losing party would likely ensue. On the other hand, insurers would be far less likely to advocate nuisance settlements when their bargaining position is fortified by a fee-shifting threat.

## 6-2. Limiting Contingent Fees

Some jurisdictions have capped plaintiffs' lawyers' contingent

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<sup>50</sup> Litigants would likely have claimed that the fee-shifting provision "chilled" the plaintiff's exercise of his or her right to a jury trial. Some states' courts have upheld analogous challenges to tort reform, while others have not.

<sup>51</sup> I assume that contingent fee attorneys will bear this cost (*i.e.*, they will agree to "hold harmless" their clients against any claim of attorney's fees by the defendant physician).

fees at 33 percent or some lower figure derived from a sliding scale as the amount obtained through judgment or settlement increases. Such caps on fees have often (though not always) been upheld by state courts applying their own constitutions. For its part, the United States Supreme Court has not found fee caps to adversely affect any federal right to counsel.<sup>52</sup>

But there is question of whether this reform results in a perverse incentive for plaintiffs' attorneys. Some researchers believe that caps on contingent fees lead attorneys to inflate the amount they demand for non-economic damages (especially in states that have not capped such damages) in order to emerge with the same fee (a lower percentage applied to a higher amount) they previously received. There is insufficient empirical research to properly evaluate this claim, which actually seems a bit odd (why would a jury cooperate to increase a plaintiff's lawyer's take?). Presumably attorneys could also equalize their income by taking more (and therefore less valuable or founded) cases and spending less time on each case. Another potential effect of contingent fee caps, like all price controls, is to induce unethical "side payments" to attorneys who are particularly in demand and who would otherwise equilibrate supply and demand by increasing the contingent fee. State bar associations need adequate additional enforcement resources to prevent such side-payments.

Little known to tort reformers is that, even under current law, many contingent fees are arguably violations of states' ethics codes. Virtually all states' Rules of Professional Responsibility require that contingent fees be "reasonable" (*i.e.*, given the work invested by the lawyer and the true risk of non-recovery assumed by the attorney) and the clear implication is that contingent fees must also be subsidiary (*i.e.*, that a client who prefers to pay an hourly or fixed fee be given that option). Many contingent fees fail one or both of these tests, and are therefore vulnerable to challenge as unethical and therefore unenforceable.<sup>53</sup>

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<sup>52</sup> See, *e.g.*, *In re Berger*, 498 U.S. 233 (1991) (capping fees for capital defendant's attorneys practicing before the Supreme Court).

<sup>53</sup> See, *e.g.*, Peter Passell, *Windfall Fees in Injury Cases Under Assault*, N.Y. TIMES, February 11, 1994 at A1; LESTER BRICKMAN ET AL., RETHINKING CONTINGENT FEES: A PROPOSAL TO

### 6-3. Modifying the “Collateral Source” Rule

To understand the common law “collateral source” rule, assume a patient is wrongfully injured by a physician, and suffers \$10,000 in damages. Before the plaintiff can sue, neighbors organize a benefit car wash, and make good the \$10,000 loss. Should the patient nonetheless have the right to sue the physician for \$10,000?

Common law’s collateral source rule does not allow a tortfeasor to deduct from what he owes his victim most sums given to the victim by third parties.<sup>54</sup> Originally, this provision was meant to ensure that gratuities made to, or insurance policies purchased by, the victim benefitted the victim, not the tortfeasor.<sup>55</sup> Thus, if a doctor negligently disabled a patient, causing him to miss a day’s work, but the patient’s employer then gratuitously donated to the patient his or her salary for the missed day, the patient could nonetheless recover the lost salary by suing the physician.<sup>56</sup> Insurers (in their first-party insurance policies), employers, and all other benefactors who indemnify victims are of course free to require “subrogation” (*i.e.*, assignment of the victim’s rights) as a condition of their policy, in which case the victim is liable to reimburse the benefactor for sums paid out after he or she has been made whole by the tortfeasor.

The proliferation of third-party payments has made the collateral source rule look like a boondoggle for plaintiffs in some cases. For example, in a case from Virginia, an employee-doctor of *Kaiser Permanente*, which was both the victim’s health care provider and his first party insurer, bungled an operation. A second procedure was required to repair the damage caused by the Kaiser doctor’s negligence. Kaiser offered to pay for this second operation (which was performed by an outside physician) – but it would have had to pay

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ALIGN THE CONTINGENCY FEE SYSTEM WITH ITS POLICY ROOTS AND ETHICAL MANDATES (1994).

<sup>54</sup> See Michael Krauss & Jeremy L. Kidd, *Collateral Source: Explanation and Defense*, 48 LOUISVILLE L. REV. 1 (2010).

<sup>55</sup> If the victim’s first-party insurance policy has a subrogation clause (*i.e.*, a clause allowing the insurance company to recover its payment from any available tortfeasor), then that clause will be enforced and the insured will not be “paid twice.” The collateral source rule applies, therefore, to third-party payments that are not made subject to subrogation clauses.

<sup>56</sup> *Bullard v. Alfonso*, 595 S.E.2d 284 (Va. 2004).

for this operation, tort or no tort, since it was the victim's first-party insurer. The victim underwent the second (successful) procedure and then sued Kaiser Permanente for its commercial value (*i.e.*, what the victim would have had to pay for that second operation at market rates)! Kaiser was ordered to pay a second time for this operation under the collateral source rule.<sup>57</sup> Another example of the modern workings of the rule: plaintiffs have been allowed to sue hospitals for the very high "list price" cost of additional medical procedures made necessary by a physician's negligence, even though the costs they paid for such procedures was far "under list" because their health insurer had obtained "discount" rates – the discount is seen as a collateral benefit.

Blanket abrogation of the collateral source rule, as has occurred in some states, will reduce liability payouts – at least in the short run. But in the long run, such receipts (for example, gifts to the victim or insurance payments received by the victim) would likely be contractually modified to require subrogation or reimbursement to the benefactor/insurer if a solvent tortfeasor becomes available. That is because neither the donor nor the purchaser of first-party insurance typically wishes to benefit a solvent tortfeasor. In that sense, the common law collateral source rule reflects the situation that would likely prevail in its absence.

#### **6-4. Periodic Payments ("Structured Settlements")**

Under this very common reform, a defendant may pay accrued future economic damages (typically, medical payments) on a periodic basis, instead of paying a lump sum of present and estimated future damages as the common law provides. Proponents of mandatory structured settlements believe that they will reduce exaggerated damage claims by the plaintiff and overly generous lump sum awards by the jury. But periodic payment reforms have not proven very popular. In practice, they must be accompanied by detailed bonding provisions, because the defendant must give some guarantee that he will not dissipate his assets between this year's and next

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<sup>57</sup> *Karsten v. Kaiser Foundation Health Plan*, 808 F. Supp. 1253 (E.D. Va. 1992). Kaiser obviously had no subrogation clause, else it would have been subrogated against itself, so to speak, and could cancel its debt.

year's tort payments. The guarantee must be a bond or an annuity, the purchase of which requires a lump sum payment by the defendant – this payment of course goes to the provider of the bond (typically an insurance company), not to the plaintiff. This is cumbersome administratively, and requires an estimate of future damages by someone (the insurance company, who will charge for this service) as well as the annual administrative cost of having that year's damages calculated by a jury. Additionally, periodic payments encourage patients to malingering (so as to maximize next year's payment); the yearly disbursement has the same perverse incentive as welfare payments. Malingering is discoverable, of course, but is costly to discover. On the other hand, lump sum awards encourage plaintiffs to get well as soon as possible – even sooner than was predicted when the award was made, as plaintiffs will receive a windfall for so doing. It is in society's interest to have potentially productive citizens back in the workforce sooner rather than later. Periodic payment provisions have thus not caught on where they have been made optional by law.

## 6-5. Damage Caps

This is the most typical type of tort reform. Caps come in many different varieties, but it is useful here to outline two general species:

### 6-5.1. Non-Economic Damage Caps

Just over half of the amount received by tort victims who obtain final judgment compensates for non-economic damages, also known as “general damages” or “pain and suffering.” Some studies indicate that non-economic damages currently make up *well over* 50% of med-mal awards.<sup>58</sup> Pain and suffering are real phenomena, and a wrongdoer should not have *carte blanche* to inflict them on innocent victims. On the other hand, pain and suffering are impossible to objectively quantify, because no explicit market for pain infliction

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<sup>58</sup> The Florida Department of Insurance Closed Claims Database revealed that non-economic damages comprised 77% of 2002 awards. In Texas, 70% of the average (\$2.1 Million) judgment is apparently now for non-economic damages. See U.S. Department of Health and Human Services, *Addressing the New Health Care Crisis*, March 2003, at 13 (and notes 71 and 72).

or pain relief exists. Are the physical pain and the anxiety caused by a second operation (required because of a physician's negligence) "worth" \$5,000, or \$500,000, or \$5,000,000? Is a mother's suffering while raising a child paralyzed by a physician's negligence worth \$50,000 or \$50,000,000? Is the suffering occasioned by a patient's knowledge that he or she is scarred "worth" \$10,000, or \$1 million, or \$100,000,000?

Despite ingenious attempts by economists to quantify pain and suffering, the fact remains that these efforts are very tentative. In any case, juries are not instructed on economic theory, and the amounts demanded for pain and suffering are often more a function of the physician's liability coverage than of any objective calculation. It is not surprising therefore that jury awards for non-economic damages vary enormously. For economic damages (lost wages, the cost of past and future operations and physical therapy, etc.), on the other hand, market evidence is more robust; thus it is easier for a judge to strike down jury awards that are beyond the pale of the evidence. If a patient loses a week's salary because of a doctor's negligence, the judge will not allow the jury to award the patient two months' pay. But a judge who personally believes that a scar is "worth" \$10,000 of "suffering" cannot honestly strike down a jury award of \$1 million, as scars in particular, and suffering in general, have no consensus market value.

A cap on non-economic damages through common law (as was done by Canada's Supreme Court in 1978<sup>59</sup>) or legislatively (as has been done in a majority of states<sup>60</sup>), can chop one extreme tail off this curve. Capping non-economic damages only affects a small number of awards. But this small number of huge awards affects liability insurers' expected payout significantly. High variance awards therefore have a very significant effect on willingness to settle,<sup>61</sup> so caps on non-economic damages are meaningful in the ex-

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<sup>59</sup> The imposed cap was CDN\$100,000, adjusted annually for inflation which equates to about CDN\$375,300 today. The cap was imposed in a trilogy of cases: *Arnold v. Teno* (1978) 83 D.L.R. (3d) 609, *Andrews et al. v. Grand & Toy Alberta Ltd.* (1978), 83 D.L.R. (3d) 452 and *Thornton v. School District No. 57* (1978) 83 D.L.R. (3d).

<sup>60</sup> See Appendix A for a table of state liability caps.

<sup>61</sup> The higher the variance of awards, the greater the risk for the defendant and his/her



treme. A cap of \$250,000, like the one in place in California under MICRA, may be insufficient these days; not only are extreme cases of excruciating pain perhaps “worth” much more than \$250,000 as a pure matter of corrective justice (the victim might have valued his freedom from suffering more than that amount of money, or might now have to pay that amount or more to deal with the psychological trauma his injury has wrought), but practically the lower the legislated cap, the greater the likelihood that a state court will find that plaintiffs have been denied their constitutional right to seek full redress for harm wrongfully caused.

Some state legislative caps on non-economic damages have been quashed as running afoul of state constitutional prohibitions against limiting damages to be recovered for injuries or death.<sup>62</sup> In many other states, plaintiffs’ lawyers have challenged non-economic damage caps on “due process” grounds. In a few states (like Ohio), such challenges were broadly sustained on the ground that courts, not the legislature, are entrusted with compensation of tort victims. But in the majority of states, reasonable legislative caps on non-economic damages have survived state constitutional scrutiny.

A cap on non-economic damages, while allowing total recovery for all economic damages (lost pay, cost of future care, etc.) remains the single best way to reduce variance and increase certainty of risk for physicians’ insurers. California’s MICRA contained nearly a dozen reforms of tort law, but the Government Accountability Office report on medical malpractice demonstrated that it was the cap on non-economic damages that had the single greatest effect in reducing liability insurance premiums.<sup>63</sup> States with caps on non-economic damages experienced an average medical liability insurer-

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insurer, and therefore the greater the likelihood of high nuisance settlements, for instance.

<sup>62</sup> See, e.g., § 54 of Kentucky’s constitution, as currently interpreted. *O’Bryan v. Hedgespeth*, 892 S.W.2d 571 (Ky. 1995).

<sup>63</sup> See Nicholas M. Pace, Daniella Golinelli & Laura Zakaras, *Capping Non-Economic Awards in Medical Malpractice Trials California Jury Verdicts Under MICRA* (Rand 2004), available at [www.rand.org/pubs/monographs/2004/RAND\\_MG234.pdf](http://www.rand.org/pubs/monographs/2004/RAND_MG234.pdf) (MICRA’s non-economic damages cap reduced the overall liabilities of the defendants by 30 percent. In death cases, defendants’ liabilities were reduced by 51 percent, compared with a 25 percent reduction in non-fatal injury claims. The median reduction in noneconomic awards was \$366,000.).

ance premium increase of 12% in 2001, compared with 44% for states with no caps.<sup>64</sup>

### 6-5.2 Comprehensive Medical Liability Caps

Virginia has no cap on non-economic damages. But it, and to some extent several other states, has enacted a cap on *total* medical liability damages, whatever their source. Given a comprehensive medical liability cap of, say, \$2 million (the current Virginia number), no judgment may be obtained for more than that amount, even if a negligent physician caused a patient to require 10 remedial operations at a cost to the patient of \$5 million. Under Virginia's cap, the patient and (via bankruptcy and Medicaid) third parties (from the taxpayer, to the patient's creditors, to the hospital that provides the remedial services), not the negligent physician, will assume the economic cost incurred as a result of the physician's negligence.

A comprehensive medical liability cap is difficult to defend. It surely reduces maximum awards, but only by making victims of the most egregious injuries, and (as discussed immediately above) third parties, bear part, or most, of the damage caused by the negligent provider. This is not compatible with the nature of tort law, as I have tried to show in the first part of this toolkit. Why should a negligent doctor compensate a minimally injured victim of medical malpractice for 100 percent of her injuries, while a dreadfully injured person gets, say, only 25 percent of her damages? This inequality has resulted in the quashing of several comprehensive caps, usually on "equal protection" grounds. In Virginia itself, the global med-mal cap is under increasing legislative attack.<sup>65</sup>

### 6-6. No-Fault Compensation (Elimination Of Tort Law)

One effort to stem the abuse of tort law in the OB-GYN field entails removing recovery from tort law and treating the issue as

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<sup>64</sup> Robert Hartwig *et al.*, Insurance Information Institute, *Medical Malpractice Insurance*, INSURANCE ISSUES SERIES, Vol. 1, No. 1 at 8 (June 2003) (citing the Department of Health and Human Services).

<sup>65</sup> Peter Veith, *Med-mal cap fight on horizon for 2009*, 23 VIRGINIA LAWYERS' WEEKLY 1 (August 4, 2008). For example, in 2011 Virginia amended the cap with a table of increases, increasing the cap by \$50,000 a year. VA Code Ann. § 8.01-581.15.

one of social insurance having nothing to do with negligence. Virginia implemented this solution in 1987 with its *Birth-Related Neurological Injury Compensation Act*.<sup>66</sup> That act created the Birth-Related Neurological Injury Compensation Fund, often referred to as the “bad baby” fund.

Participation in the Virginia program is not mandatory for either physicians or hospitals. Obstetricians who wish to participate pay \$5,000 each year, while all other physicians licensed in the state (including those who do not practice obstetrics and who do not participate in the fund) are assessed \$250 per year. Participating hospitals pay \$50 multiplied by the number of deliveries made the prior year, with a cap of \$150,000 per hospital per year. If the fund’s assets are inadequate to maintain it on an actuarially sound basis, a premium tax of up to one-quarter of one percent of net direct medical liability premiums written in the state will be assessed on liability insurance carriers (and presumably passed on to all physicians). All these sums go directly into the compensation fund, which is designed to be self-sufficient.

If a participating hospital or physician is sued for a neurological birth-related injury (defined as an injury “occurring in the course of labor, delivery or resuscitation necessitated by a deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery”), the hospital or physician may elect to refer the case to the fund. Upon a determination by Virginia’s Workers’ Compensation Commission that an infant comes within the terms of the act, the commission awards a remedy limited to “net” economic loss (deducting all amounts received from collateral sources). The award is paid out periodically, rather than as a lump sum. In addition to reasonable medical expenses, the award compensates for other reasonable expenses, including modest attorney’s fees and loss of earnings from the age of 18 onward. No non-economic (pain and suffering) damages are allowed, and no recourse to a court is permitted. If a newborn dies soon after birth, the commission may award up to \$100,000 even if there were no economic damages. On the other

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<sup>66</sup> Florida has similar legislation. FLA. STAT. §§ 766.301-316.

hand, if economic damages are quite substantial, there is no ceiling on recovery once the act is invoked: Virginia's comprehensive medical liability cap of \$2 million, discussed in the previous section, does not apply.

Interestingly, the Birth-Related Neurological Injury Compensation Fund has not proven very popular among OB-GYNs in Virginia. Many have opted not to pay the \$5,000 per year for the coverage the fund affords, perhaps because any medical liability award would be limited by the state's comprehensive medical liability cap. To complicate matters further, much litigation has centered on whether a given baby's injury qualifies as a "birth related neurological injury";<sup>67</sup> a skillful plaintiff's attorney intent on obtaining common law tort relief can characterize a child's injury in ways that maximize the chance that the commission (intent on minimizing payoffs to ensure solvency of the fund) will turn down the physician's referral. Additionally, since the mother (but not the father) of a neurologically impaired infant may sue her OB-GYN in a common law court for the mother's own injuries, including pain and suffering (these are not covered by the fund), the statute has not been fully successful in thwarting access to common law courts. Only a half-dozen claims per year, on average, have been resolved through the fund.<sup>68</sup> Those tend to be mammoth economic damage suits, where the plaintiff uses the Fund to skirt Virginia's comprehensive medical liability cap.

In essence, Virginia has attempted to transplant the rationale of workers' compensation into medical malpractice. As is typically the case under workers' compensation, the fund results in partial com-

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<sup>67</sup> The statute requires that the following conditions be met: (1) the infant was born alive; (2) an injury occurred to the spinal cord or brain; (3) the cause of injury was deprivation or mechanical injury during labor, delivery, or resuscitation; (4) the infant is permanently disabled as a result and is "in need of assistance in all activities of daily living; (5) the injury was not caused by "congenital or genetic abnormality, degenerative neurological disease, or maternal substance abuse"; and (6) the injury was either caused by a physician participating in the program or occurred in a participating hospital. As the *Sabia* case described by Werth in *Damages* shows, however, the cause of the child's damage is precisely what is disputed in virtually all these cases.

<sup>68</sup> Randall R. Bovbjerg *et al.*, *Administrative Performance of 'No-Fault' Compensation for Medical Injury*, 60(2) LAW & CONTEMP. PROBS. 71 (1997).

pensation only (because of the ban on non-economic damages) and has no disincentive effect on truly negligent parties (indeed, a physician who has reason to believe he is very likely to be negligent has a greater incentive to enroll in the program). On the other hand, unlike workers' compensation (workers themselves are at fault in many of their compensated injuries; for other injuries employers are at fault, and yet cannot be sued in tort, presenting a dual moral hazard), newborn babies are surely not to blame for their birth-related traumas, and so this insurance scheme presents a moral hazard only on one side of the equation.

### **6-7. Stop-Loss Fund**

One reform that has received considerable attention is Maryland's (among other states') recent implementation of "insurance stabilization," often referred to as a "stop-loss" fund. The fund is to absorb all insurers' costs in excess of the (presumably low) medical liability premiums insurers charge physicians. Those who provide revenue for the fund are HMO customers (Maryland imposed a tax on HMOs to provide for the fund, thereby indirectly increasing costs for its poorest citizens, who tend disproportionately to be HMO clients).

From a political standpoint, the Maryland plan placates both physicians (it effectively caps liability insurance premiums) and the plaintiffs' bar (it allows attorneys to continue to obtain high judgments, which will henceforth be indirectly paid by taxpayers instead of by physicians through insurance premiums). From the perspective of private law theory, this is another version of the New Zealand plan, though not as overt. Establishing a stop-loss fund retains the form and stigma of private law liability while in fact placing state government in the role of *uber*-insurer. The implication seems to be that private insurance companies are not doing their jobs adequately; but there is little if any evidence that the insurance market has broken down in Maryland or in any other state implementing a "stop-loss" fund.

### **6-8. Statute Of Limitations Reform**

Every state has a "statute of limitations" that governs the time af-

ter an injury during which a civil suit may be filed. The typical statute allows victims of medical malpractice to launch a suit up to one year from the date a wrongfully caused injury was discovered or should have been discovered. A cause of action involving an infant, however, is often “tolled” (*i.e.*, the one-year deadline does not begin to run) until the infant reaches age 18.

The “discovery” rule can have devastating effects on OB-GYNs. Alleged negligence at birth can be raised for the first time 19 years later, when a physician’s ability to defend him or herself is much weaker. As one physician stated, in reaction to a tolling provision, “I’ve known gray-haired obstetricians who were sued based on something they did during their residency – and the attending physician [who could testify that the obstetrician had behaved correctly] had long since died.”<sup>69</sup> “Tail insurance” for retiring physicians must now take into account the possibility of these delayed lawsuits. Indeed, the “discovery rule” permits suits by former children even when their parents were aware of negligence and failed to act. But it accomplishes this at the expense of fairness to physicians who are placed in the position of trying to explain and defend actions that were taken as long ago as 19 years ago, in the face of stale evidence. In case a patient dies, however, even if the patient was a minor or a newborn baby, a legal representative must typically be appointed within a year of the wrongful death and a suit filed within a year of the appointment for the right of action to be preserved. Thus, for wrongful death of a newborn, for example, at most two years would be allowed for suit.<sup>70</sup> It seems incongruous to allow at most two years for a malpractice suit in the case of infant death (when distraught parents might easily neglect to consult an attorney, and therefore to appoint a personal representative for the deceased child, in a timely manner), and up to 19 years in case of survival.

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<sup>69</sup> C. Dolinski, *Liability Obligation Could Last 21 Years After Patient’s Birth*, GAZETTE NEWSPAPERS, Baltimore, July 2, 2004 at 1.

<sup>70</sup> See *Ky. Baptist Hosp. v. Gaylor*, 756 S.W.2d 61 (Ky. App. 1997).

## PART IV. FEDERAL TORT REFORM IN THE MEDICAL FIELD

### 7. *Constitutional Issues*

The Constitution provides that Congress can “regulate Commerce . . . among the several States.” Over the past 65 years, courts have read the Commerce Clause broadly, using it to uphold federal legislation concerning non-commercial activity. Would that power include pre-empting state tort law through federal reforms?

One possible justification for substantive federal intervention might be that state laws, including tort rules, “affect” commerce. However, the fact that a state law affects commerce is not typically enough to justify federal intervention unless such laws actually impede the flow of trade among the states. In 1995 the Supreme Court reaffirmed this important principle in *United States v. Lopez*, which held that the Gun-Free School Zones Act of 1990 (which banned the possession of firearms within 1,000 feet of any school) exceeded Congress’s authority under the Commerce Clause.<sup>71</sup> In 2000, the Court extended *Lopez* in *U.S. v. Morrison*, which held that a federal tort action for sexual battery under the Violence Against Women Act was unconstitutional, even though Congress had issued findings that sexual assaults affected interstate commerce.<sup>72</sup>

Obviously, state laws regularly affect interstate commerce without raising constitutional concerns. California, for example, requires special catalytic converters on cars sold in that state, a permissible use of California’s police power that doesn’t directly affect interstate trade. If California tried to regulate catalytic converters on every car that crossed its state boundary, however, that would make federal intervention to preserve interstate travel more legitimate, for cars traveling interstate would have to stop at the border and turn back – clearly a burden on interstate commerce. California also requires that those who practice medicine in the state be admitted to the California Medical Association, a clear limitation on the ability to cross state lines to practice one’s trade – but just as clearly

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<sup>71</sup> 514 U.S. 549 (1995).

<sup>72</sup> 529 U.S. 598 (2000).

a constitutional limitation with which the federal government should not lightly tamper.

### 8. *Types of Federal Malpractice Reform*

Can federalism and the federal government's legitimate concern to protect the citizens of one state from laws adopted in another state be squared with federal medical malpractice reform ideas? Presumably this depends on the type of tort reform envisaged.

Federal intervention is rarely authorized for the purpose of altering substantive rules of state tort law. This is because most medical malpractice suits involve "internal" activities. Such suits typically pit an in-state individual plaintiff against an in-state individual defendant. When litigated in a state court before a local jury, this type of case creates no intrinsic predisposition against either party. What is sometimes termed a "public choice" problem, which creates a prisoners' dilemma hostile to interstate commerce, is absent: the plaintiff cannot persuasively ask the jury to bring "outside" money into the locality without harming anyone locally.

A second type of tort suit – exemplified by negligence claims invoking *respondeat superior* (suits against an employer for damages caused by wrongful behavior by its employee)<sup>73</sup> – usually sets in-state *individual* plaintiffs against in-state *corporate* defendants. Because juries are always composed of individuals and never of corporations, corporate defendants might experience systemic prejudice: a jury may be tempted to transfer wealth from an entity that does not "feel pain" to a suffering real person with whom it can identify. But such temptations are typically offset by the jury's desire to maintain employment and economic activity in the state, especially if the defendant corporation maintains a large local presence. It is hard to predict how offsetting incentives will ultimately unfold in a specific case. In any event, those problems derive from the *corporate* nature of the defendant, not its state of domicile. States are unlikely to want existing employers to pack up and leave.

Early product liability suits tended to be of the intrastate kind.

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<sup>73</sup> *Respondeat superior* holds an employer vicariously liable for negligent behavior by an employee while on the job. *Hern v. Nichols*, 91 Eng. Rep. 256 (Ex. 1708).



Most products were manufactured near their place of consumption, as transportation costs made far-flung markets unreachable. Thus, local individual plaintiffs filed lawsuits against local corporate defendants concerning allegedly defective products.<sup>74</sup> But with the advent of “paradigm shifters” such as assembly-line production, interstate highways, and electronic auctions, markets for goods (though not yet services) have today become largely national. Modern product liability suits characteristically set in opposition an *in-state* individual plaintiff and a corporate *out-of-state* defendant. In a typical suit today, a consumer purchases a product, is allegedly injured while using it, and sues its far-off manufacturer to recover damages. Most purchases take place close to home; almost all product use takes place near the home or the workplace; and no state is home to a majority of manufacturers’ head offices or factories. The confluence of those factors means that a plaintiff ordinarily files a product liability suit in her home state, which is also the state where she was injured and where she purchased the allegedly defective product. In the vast majority of cases, however, the product was designed and manufactured in another state. Assume for a moment that the victim sues in her home state. There, the court agrees it has jurisdiction to try the suit and concludes that its own product liability law applies to resolve the dispute. Such a suit would now pit a local individual against an out-of-state corporation, in the local plaintiff’s court and subject to the local plaintiff’s state law. That situation creates a risk of bias that is unlikely to be remedied by political and economic forces within the state. Such a situation is ripe for federal tort reform.

Medical malpractice is closest to the first type of tort situation — a suit by an in-state patient against an in-state hospital or physician. Most people do not cross state lines to visit their physician or hospital. To the extent that abusive state medical liability practices oper-

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<sup>74</sup> See Neal Miller, *An Empirical Study of Forum Choices in Removal Cases under Diversity and Federal Question Jurisdiction*, AM. U.L. REV. 41, 369, 408–9 (1992) (attorneys responding to a survey indicated that out-of-state status was more frequently the cause of jury bias than corporate status or type of business) and Alexander Tabarrok *et al.*, *Court Politics: The Political Economy of Tort Awards*, 42 J.L. & ECON. 157, 161–64 (1999).

ate like a tax on productive activity, the greater the abuse, the greater the decline in productivity or wealth. Customers will pay more for in-state services if the providers of those services have to pay for injuries they did not wrongfully cause. Physicians will avoid practicing in jurisdictions with unreasonable malpractice rules. These kinds of tort pressures are endemic to the states: for instance, local children and their parents will suffer if playgrounds are not built because park authorities fear being held liable for every accident. The costs incurred when local services are no longer provided produce powerful in-state lobbies for tort reform. As stated above and detailed in Appendix A, since the first “liability crisis” in the mid-1980s, almost every state has enacted some form of medical malpractice tort reform.

### *9. Justification for Federal Substantive Intervention in Medical Liability*

Defense of federal intervention in the medical liability field in particular appears to be twofold. First, federal limitations on medical malpractice suits are allegedly warranted because the federal government spends money on health care; after all, the Constitution’s spending power<sup>75</sup> presumably allows Congress to impose conditions on parties that benefit from federal expenditures. Not only does the federal government fund Medicare and Medicaid, it also provides direct care to members of the armed forces, veterans, and patients served by the Indian Health Service, as well as tax breaks to workers who obtain health insurance through their employers. The administration projected budget savings of at least \$25 billion a year if proposed medical malpractice reforms in 2005 were put in place. It does

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<sup>75</sup> Technically, there is no “spending power” in the Constitution. Some authorities believe that the spending power is implicit in the power to tax; see U.S. CONST. Art. I, § 8, cl. 1. Other authorities, myself included, believe that spending is authorized only if it is necessary and proper; see U.S. CONST. Art. I, § 8, cl. 18, for executing powers enumerated elsewhere in the Constitution. We need not resolve that controversy here; the constitutionality of federal spending for medical care in the context of malpractice reform has not been challenged. The dispute here is not whether federal medical spending is legitimate but whether malpractice reform can be and has been legitimately imposed as a condition on state recipients of the spending.

seem clear that the federal government can condition the expenditure of its resources, though it should be noted that the Supreme Court has invalidated conditions imposed on the recipients of federal spending unless, among other things, the conditions are unambiguous and reasonably related to the aim of the expenditure.<sup>76</sup> At any rate, only limitations placed on federal funding, not limitations on all state tort actions, would be authorized here.

What about the view that physicians are allegedly “forced” to move to another state, or to retire from practice altogether (thus removing their services from the “stream of interstate commerce”), by hikes in malpractice premiums? At the margin, it is surely true that malpractice abuse has steered some patients across state lines to find better health care and has led potential providers to avoid certain states<sup>77</sup> or to retire early. It surely has affected choice of specialty inside medical schools.<sup>78</sup> But *intrastate* regulation of in-state conduct is not interference with *interstate* commerce – otherwise, as the court pointed out in *Morrison*, there is no area immune from federal jurisdiction. Naturally, there’s an effect on commerce when any individual or company ceases economic activity in a state. But if the withdrawal is related to unjust negligence claims, absent discrimination against out-of-state defendants, then the effect is not uniquely related to the *interstate* aspect of commerce.

Fear of malpractice liability leads doctors to order redundant and expensive diagnostic tests and operations, as has been seen. High malpractice insurance premiums may encourage competent senior physicians to retire and discourage promising junior physicians from arriving, leaving geographic areas underserved.<sup>79</sup> This is part of the

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<sup>76</sup> See, e.g., *South Dakota v. Dole*, 483 U.S. 203 (1987).

<sup>77</sup> See, e.g., Michelle M. Mello et al., *Effects of a Professional Liability Crisis on Residents’ Practice Decisions*, 105 OBSTETRICS & GYNECOLOGY 1287 (2005) (finding that one third of residents in their final or next-to-last year of residency planned to leave Pennsylvania because of the lack of availability of affordable malpractice coverage. Although, in general, residents’ geographic decisions are influenced by a range of factors, those who are about to leave Pennsylvania named malpractice costs as the primary reason 3 times more often than any other factor.).

<sup>78</sup> See, e.g., Aaron Deutsch et al. “Why Are Fewer Medical Students in Florida Choosing Obstetrics and Gynecology?” 100(11) SO. MED. J. 1095 (November 2007).

<sup>79</sup> See Gary M. Fournier et al., *The Case for Experience Rating in Medical Malpractice Insurance:*

substantive debate over medical malpractice reform, but is not sufficient to justify *federal* reform. For federal intervention is typically neither “necessary” nor “proper” here. The two litigants in a medical malpractice suit are usually a local (in-state) plaintiff and a local (in-state) physician or healthcare provider. As a result, excessive liability will be directly felt in the state, where it will translate into high insurance premiums for doctors and high costs for patients. Doctors who retire or relocate to other states when they find liability too onerous exert pressure on local juries and state legislatures to temper excesses.

State medical malpractice reform is, as has been noted, ubiquitous as a direct result of this. More than three dozen states have passed damage caps. All 50 states have passed or considered some kind of medical malpractice reform. If a state legislature has chosen not to enact reform – and perhaps to suffer an increase in the cost or a decline in the quantity of medical care, or both, from a presumed “optimal” level – that is not a federal crisis. Rather, that is a matter for the state’s voters to resolve.

### *10. Federal Uniformization and Publicity as Medical Malpractice Reform*

Nothing prevents the federal government from using its national coordination powers to inform physicians and clients about state medical malpractice law, to encourage them to avail themselves of the opportunities to contract afforded by such law (arbitration,

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*An Empirical Evaluation*, J. OF RISK AND INSURANCE 68, 274 (2001) (physicians, especially rural obstetricians, are choosing to limit practice or self-insure rather than pay soaring premiums unrelated to their own claims experience); *Echo Malpractice Mess*, editorial, CHARLESTON GAZETTE AND DAILY MAIL, January 3, 2002, at 4A (physicians are leaving West Virginia because lawsuits are increasing the cost of insurance coverage); Ovetta Wiggins, *Doctors to Protest Premium Increases*, PHILADELPHIA INQUIRER, April 23, 2001, at B1 (Pennsylvania Medical Society asserts that 11 percent of Pennsylvania physicians “have either moved out of state, retired [prematurely], or scaled back their practices [due to] ‘skyrocketing’ malpractice insurance rates.”); and Patricia Post-Reilly, *Malpractice Maelstrom: Skyrocketing Malpractice Insurance Premiums Have Doctors and Healthcare Professionals Here—and Around the State—Clamoring for Reform*, LANCASTER NEW ERA/INTELLIGENCER JOURNAL/SUNDAY NEWS, December 17, 2001, at 1 (high jury awards pushing up insurance rates and forcing physicians to retire early, move to more rate-friendly states, or limit patient access to medical care).

etc.), and possibly even to standardize contract terms so as to reduce transaction costs, as explained in Part V immediately below.

## PART V. PRIVATE CONTRACTS AND THE PHYSICIAN-PATIENT RELATIONSHIP

### *11. Alternative Dispute Resolution Mechanisms*

As indicated in Part I, tort law is an intrinsic part of private ordering. Private ordering need not result in tort adjudication of all disputes – indeed, as argued above, tort should give way to consensual allocation of risks when feasible and when important citizen protections are not at stake. Potential parties to a tort suit are almost always free to provide for other dispute resolution mechanisms after the dispute arises, and they are sometimes free to provide for alternative dispute resolution mechanisms beforehand. Sometimes, of course (as in the case for automobile accidents, for instance), pre-dispute agreements are not practical; the parties do not know each other and cannot conveniently negotiate alternative arrangements. In the medical malpractice field, however, parties are almost always in “privity”; that is, there is almost always already a contract that specifies rights and obligations of both the health care provider and the patient. Presumably this contract could cost-effectively include clauses that determine alternate dispute resolution mechanisms or even alternate liability rules in many cases.

#### **11-1. Arbitration in Consumer Disputes**

Arbitration is typically a less expensive and quicker method of resolving disputes than civil litigation. The Federal Arbitration Act<sup>80</sup> and similar (often identical) state statutes encourage the use of arbitration over litigation. Recent studies show that arbitration can be quite fair to consumers. For example, a study by Ernst & Young found that consumers prevail in the majority of credit-card disputes that go to arbitration.<sup>81</sup> A report by Navigant Consulting considered

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<sup>80</sup> 9 U.S.C. § 1.

<sup>81</sup> *Credit Card Holders Not Disadvantaged in Arbitration, Study Says*, Dispute Resolution Journal, May-July 2005. E&Y studied 226 cases administered from Jan. 1, 2000-Jan. 1, 2004 by the Minneapolis-based National Arbitration Forum (NAF). It also reviewed NAF’s elec-

34,000 arbitration cases involving California consumers from 2003 to 2007, and concluded that consumers prevailed in arbitration proceedings at the same or a higher rate than they did in debt collection lawsuits. It is noteworthy that consumers rarely pay fees for arbitration – unlike court cases, where directly (costs, experts) and indirectly (contingent fees) they pay dearly. In the 33,935 cases where an arbitration fee was paid, the consumer paid no fee in 99.3% of the cases. In the 0.7% cases where the consumer paid an arbitration fee, the median fee paid was \$75.

Arbitration protected consumers even when consumers were not present. “Claims against consumers were reduced in 22.6% of cases heard in which the consumer failed to show up for the hearing or respond in any way, suggesting that consumer rights were given consideration even when the consumer was not represented.”<sup>82</sup> A 1999 study of individuals participating in securities arbitration found that 93.49% felt that it was fair and handled without bias.<sup>83</sup> This and other data flatly contradict the position of groups such as Public Citizen, which in 2007 released a report entitled “The Arbitration Trap: How Credit Card Companies Ensnare Consumers,” based on analysis of results with two minor firms in two states. A scholarly study by Catholic University law professor Peter Rutledge presents decisive empirical evidence that the Public Citizen study is methodologically flawed at best, and perhaps squarely biased at worst.<sup>84</sup>

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tronic files and paper documentation and collected data on the nature of the claim, award dates, claim and award amounts, and who prevailed. The study found that consumers in NAF arbitrations prevailed more often than businesses in cases that went to an arbitration hearing (55% of the cases were resolved in the consumers’ favor). Consumers obtained favorable results in close to 80% of the reviewed cases.

<sup>82</sup> *National Arbitration Forum Highlights New Independent Study Demonstrating That Arbitration Offers Benefits for Consumers*, National Arbitration Forum, [www.adrforum.com/newsroom.aspx?&itemID=1419&news=3](http://www.adrforum.com/newsroom.aspx?&itemID=1419&news=3).

<sup>83</sup> Gary Tidwell *et al.*, *Party Evaluation of Arbitrators: An Analysis of Data Collected from NASD Regulation Arbitrations*, Paper presented at Aug. 5, 1999 meeting of Academy of Legal Studies in Business p. 3 (Aug. 5, 1999), available at [www.finra.org/web/groups/med\\_arb/documents/mediation\\_arbitration/p009528.pdf](http://www.finra.org/web/groups/med_arb/documents/mediation_arbitration/p009528.pdf). See also Linda J. Demaine *et al.*, *Volunteering to Arbitrate Through Predispute Arbitration Clauses: The Average Consumer’s Experience*, 67 L & CONTEMP. PROBS. 55 (Winter/Spring 2004).

<sup>84</sup> Peter B. Rutledge, *Arbitration – A Good Deal for Consumers: A Response to Public Citizen*, Washington, U.S. Chamber Institute for Legal Reform, 2008.

## 11-2. Binding Arbitration Agreements in Medical Care Contracts

Should the use of arbitration agreements be extended to situations where physical injury (not just economic loss) occurs, as is the case in the typical medical liability suit? It is reported that a growing number of physicians, nursing homes, and health care facilities are asking patients to sign binding arbitration agreements before offering services. Typically the agreements provide for a binding, alternative dispute resolution; sometimes, however, the agreements sometimes also purport to change the underlying law applicable to the parties. In Florida it is reported that some agreements seek caps on potential damages that are smaller than those allowed by the tort law of the state, for example.<sup>85</sup> In Virginia, one compulsory (if one wishes to obtain service) arbitration agreement used in an Alexandria clinic includes a promise that the patient will limit any future claim for non-economic damages to \$250,000 and a promise to pay the attorney's lawyer's fees if an unsuccessful claim is filed.<sup>86</sup>

Such agreements are on the increase, though until recently they were quite rare. The Rand Corporation's Institute for Civil Justice surveyed physicians and hospitals in 1999, and found that 91% did not ask patients to sign arbitration agreements.<sup>87</sup> Of the 9% who did, only about one in five (2% in total) would refuse to provide care without a signature. Fully 71% of the managed care organizations (HMOs, etc.) surveyed by Rand asked new enrollees to sign arbitration agreements, but in the vast majority of cases these agreements only covered contract disputes (*e.g.*, disputes over which benefits were covered by their health plan), as opposed to disputes over the quality of care received. Only 28% of the HMOs asked patients to sign agreements covering alleged medical malpractice. When physicians and hospitals were asked why they did not use arbitration agreements, many noted that they struck "the wrong

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<sup>85</sup> Vesna Jaksic, *Patient Arbitration Pacts Are Alarming Attorneys*, LAW.COM, March 28, 2008, [www.law.com/jsp/article.jsp?id=1206614812624](http://www.law.com/jsp/article.jsp?id=1206614812624), last consulted Dec. 12, 2011.

<sup>86</sup> See Appendix B.

<sup>87</sup> Rand Institute for Civil Justice, *Binding Arbitration is Not Frequently Used to Resolve Health Care Disputes*, Research Brief 9030 (1999).

tone” with new patients; on the other hand, most of the few physicians who did ask patients to agree to binding arbitration reported that they were following the recommendation or the instruction of their malpractice insurer. Physicians win approximately 65% of malpractice suits that go to jury verdict but only about 60% of arbitration awards, which might explain why few insurers insisted on the arbitration form. One Kaiser health plan dropped an arbitration clause from its contracts, apparently because it found arbitrators to be lawless, inclined to compromise decisions regardless of whether there had been any physician negligence at all.<sup>88</sup> On the other hand, jury trials are much more expensive, and have a possible “tail” risk of high damage awards in states without non-economic damages caps. Presumably insurers differ about their preference for one forum or the other. Some state medical associations (especially in states with high liability risks and malpractice insurance premiums) now favor arbitration clauses rather explicitly: for example, the Florida Medical Association promotes them at Continuing Medical Education programs and furnishes a sample contract to its members.<sup>89</sup>

The Federal Arbitration Act (“FAA”) provides that written arbitration agreements are “valid, irrevocable and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.”<sup>90</sup> The FAA only covers transactions “involving [interstate] commerce,” but even a contract with tenuous interstate connections (*e.g.*, one that implicates disbursement of insurance or Medicare funds) meets this criterion. As implied above, such federal intervention is highly appropriate. It does not interfere with general state contract law (“grounds as exist at law or in equity for the revocation of any contract”) and it allows and facilitates, but does not impose, a contractual remedy. In any case, all 50 states, the District of Columbia, and Puerto Rico have some form of general arbitration statute mod-

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<sup>88</sup> See Physician Insurers’ Association of America, *A Comprehensive Review of Alternatives to the Present System of Resolving Medical Liability Claims*, Lawrenceville NJ, 1989, at 49.

<sup>89</sup> Tanya Albert, *Patients in Liability Hot Spots Asked to Arbitrate*, AMERICAN MEDICAL NEWS, Feb. 10, 2003.

<sup>90</sup> 9 U.S.C. § 2 (1999).



eled on the Uniform Arbitration Act, proposed by the National Conference of Commissioners on Uniform State Laws to cover purely local situations.

Despite state and federal arbitration statutes, and despite federal preemption of state laws incompatible with the Federal Arbitration Act,<sup>91</sup> several states have limited the use of medical arbitration agreements when medical care is contracted for. For example, a Georgia statute provides that a patient can agree to arbitration only after the alleged negligence has occurred, and only after consulting with an attorney<sup>92</sup> – this statute may be vulnerable under the preemption clause of the Federal Arbitration Act. A 1999 Utah law that allows medical care professionals to use arbitration agreements was amended in 2004 to provide that a physician cannot deny treatment if a patient refuses to sign such an agreement. This presumably precludes the physician's malpractice insurer from offering a lower premium to reflect lower expected outlays under arbitration, since those patients most likely to sue are also those most likely to decline the physician's invitation to sign the arbitration agreement. Without lower premiums, the physician's incentive to promote the arbitration clause is dulled.

### **11-3. Enforceability of Binding Arbitration Provisions**

Even when no state statute discourages arbitration, there is no guarantee that common law courts will enforce a contractual provision that mandates binding arbitration. This is important, because the Federal Arbitration Act expressly allows for invalidation of arbitration agreements under general provisions of state contract law.

#### **11-3.1. Cases Where a Medical Arbitration Agreement Was Not Enforced**

1. *Obstetrics and Gynecologists v. Pepper*.<sup>93</sup> Obstetrics and Gynecologists, a walk-in clinic, required its patients to sign a standard

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<sup>91</sup> See, e.g., *Allied-Bruce Terminex Cos. Inc. v. Dobson*, 513 U.S. 265 (1995) (Alabama law invalidating all pre-dispute arbitration agreements held to violate FAA); *Citizens Bank v. Alafabco, Inc.*, 539 U.S. 52 (2003).

<sup>92</sup> GEO. CODE ANN. § 9-9-61.

<sup>93</sup> *Obstetrics and Gynecologists v. Pepper*, 693 P.2d 1259 (Nev. 1985). See also *Wheeler v. St. Joseph Hospital*, 133 Cal. Rptr. 775 (1976).

agreement before receiving any treatment. The agreement provided that all disputes arising between the parties would be submitted to independent binding arbitration, both parties expressly waiving their right to a jury trial. Evidence suggested that the fees of Obstetrics and Gynecologists were more modest than those charged by comparable groups whose contracts did not contain an arbitration clause. Following the standard procedure of the clinic, a receptionist hands patients the arbitration agreement along with two information sheets, and informs them that any questions concerning the agreement will be answered. Patients must sign the agreement before receiving treatment; the physician signs later. If a patient refuses to sign the arbitration agreement, the clinic declines to administer treatment. Ms. Pepper entered the clinic to obtain a prescription for an oral contraceptive. Her signature appeared on the arbitration agreement, though she disclaimed any recollection of either signing or reading it. Nine months after receiving her prescription Ms. Pepper unfortunately suffered a stroke that left her partially paralyzed. She sued Obstetrics and Gynecologists, claiming that it should have refused to prescribe the contraceptive because of her peculiar medical history. Defendant moved to stay the lawsuit pending binding arbitration. The Nevada Court of Appeals confirmed the lower court decision that the arbitration agreement was an “adhesion contract,” that the plaintiff was a “weaker party” who had “no choice as to its terms,” and that the agreement was “unduly oppressive.” The clinic’s motion to force binding arbitration was rejected, and a jury trial granted. This result is not pre-empted by the FAA, because Nevada’s unconscionability rules do not single out arbitration agreements for special treatment.<sup>94</sup>

2. In the oft-cited case of *Broemmer v. Abortion Servs. of Phoenix*,

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<sup>94</sup> *Prima Paint Corp. v. Flood & Conklin Mfg. Co.*, 388 U.S. 395, 402 (1967); *Sosa v. Paulos*, 924 P.2d 357 (Utah 1996) (Patient who was asked to sign one-sided arbitration agreement less than one hour before knee-reconstruction surgery, and while dressed in surgical garb, is not bound by agreement for reasons of unconscionability); *Vicksburg Partners, L.P. v. Stephens*, 911 So.2d 507 (Miss. 2005) (daughter who was legal guardian of her father admits him to a nursing facility and signs binding arbitration including a cap on damages of \$50,000; held, damage provision stricken but arbitrability survives because the clause severed the cap from other provisions);

*Ltd.*,<sup>95</sup> the Arizona Supreme Court refused to enforce a contract to arbitrate because it was presented to the patient as a condition of treatment, contained no explicit waiver of the right to jury trial, and provided that any arbitrator be an obstetrician–gynecologist.

3. In *Wheeler v. St. Joseph Hospital*,<sup>96</sup> the arbitration clause was to be effective unless the patient initialed the form at a specific spot signifying that he did not agree to arbitration, or unless he sent a written communication to the hospital within 30 days of his discharge stating that he did not consent to arbitration. The patient did not read the hospital admission form, was not given a copy of the form, and neither he nor his wife knew of the existence of the arbitration provision until the wife's attorney informed her that the hospital was attempting to compel arbitration. The court stated that the hospital's standard printed admission form possessed all of the characteristics of a contract of adhesion and was unconscionable, as the patient, who is typically directed by his treating doctor to be admitted to the hospital where the doctor enjoys staff privileges, normally feels that he has no choice but to seek admission to the designated hospital and to accede to all of the terms and conditions for admission.

4. In *Miner v. Walden*,<sup>97</sup> New York's high court refused to enforce an arbitration agreement that it found to be an unconscionable contract of adhesion. Prior to each of the patient's operations, she was called into the doctor's office, and in the presence of the doctor and a nurse, an explanation was made to her as to the meaning and purpose of the arbitration form, an authorization for surgery, and other papers. These forms were enclosed in an envelope and mailed to the plaintiff with a covering letter, which indicated that the form consenting to arbitration "required" her signature. The court held that the average, uneducated person was not disposed to question or doubt a doctor's treatment, nor does the average person leave a

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<sup>95</sup> *Broemmer v. Abortion Services of Phoenix, Ltd.*, 840 P.2d 1013 (Ariz. 1992) (arbitration agreement signed by young woman before undergoing abortion procedure held not enforceable under Arizona contract law).

<sup>96</sup> *Wheeler v. St. Joseph Hospital*, 173 Cal. Rptr. 775 (Cal. App. 1976).

<sup>97</sup> *Miner v. Walden*, 422 N.Y.S.2d 335 (Sup. Ct. 1979).

doctor they rely upon to shop for another who does not require an arbitration agreement to be signed. An agreement to arbitrate must also be mutually binding, said the court. The agreement at issue did not require the doctor to arbitrate claims of money due for services rendered.

5. In *Sosa v. Paulos*,<sup>98</sup> the Utah Supreme Court refused to enforce an arbitration agreement of which the patient was given a copy mere minutes before she was to undergo surgery, while dressed in surgical clothing, and with no explanation of the content of the agreement or of the patient's option not to sign it.

On the other hand, there is no doubt that medical malpractice disputes are in principle arbitrable under state law. Courts have also held, for instance, that statutes governing arbitration of medical malpractice claims are not *per se* violations of state constitutional provisions guaranteeing access to the courts and trial by jury.<sup>99</sup> It is useful here to summarize how courts have dealt with medical arbitration clauses.

### 11-3.2. Cases where courts have held valid an arbitration clause

1. In *Guadano v. Long Island Plastic Surgical Group, P.C.*,<sup>100</sup> a federal court applying New York law held that a patient failed to make out a case that an arbitration clause was unconscionable and unenforceable. The patient had undergone elective cosmetic surgery and had been sent the arbitration agreement by mail prior to her preoperative office visit. A cover letter accompanying the agreement explained the nature of the arbitration process, that it was a substitute for decision by judge or jury, and that signature on the agreement was required. The nurse also testified that she advised the patient that some of the reasons for the agreement to arbitrate were the increase in malpractice actions, rising insurance premiums, court costs, and large jury awards in medical malpractice cases. There was further information about the process consisting of the nature of the

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<sup>98</sup> *Sosa v. Paulos*, 924 P.2d 357 (Utah 1996).

<sup>99</sup> *University of Miami v. Echarte*, 618 So. 2d 189 (Fla. 1993).

<sup>100</sup> *Guadano v. Long Island Plastic Surgical Group, P.C.*, 607 F. Supp 136 (E.D.N.Y. 1982).

arbitrators, the relinquishment of the right to trial by jury, the finality of the arbitration findings, the right to be represented by counsel at the proceeding, and the availability of booklets provided by the American Arbitration Association, together with the opportunity to speak to the doctor if the patient had any objections or questions concerning the agreement. The court observed that the consequences of the agreement were explained to the patient, that the surgery was elective and necessary for cosmetic reasons only, and that the success of the operation did not require that it be performed within any particular timeframe. Furthermore, said the court, the patient failed to allege any special circumstances, for example, that the parties had a prior relationship that might indicate unequal bargaining power. Note that this decision by a federal trial court has no precedential effect whatsoever.

2. In *Cleveland v. Mann*,<sup>101</sup> an arbitration agreement between a patient and a surgeon was found not to be a procedurally unconscionable adhesion contract by a bare majority of the Mississippi Supreme Court. The patient did not appear to the surgeon to be under any pain or stress at the time he signed the agreement fully 19 days before surgery, and the agreement allowed for subsequent changes if desired by the patient and presented to the clinic for approval. Note that this decision by a closely divided state supreme court has some, if weak, precedential effect.

3. In *Buraczynski v. Eyring*,<sup>102</sup> a unanimous Tennessee Supreme Court found that although an arbitration agreement was a contract of adhesion, it was not unconscionable, oppressive, or outside the reasonable expectations of parties and was enforceable. This case, which has high precedential value, is discussed in more detail below.

In general, none of the cases invalidating arbitration clauses refutes the strongly pro-arbitration case of *Buraczynski*. If a patient is not required to agree to arbitration in order to receive medical treatment, has a lengthy opportunity to discuss the clause, and is not agreeing to an arbitration procedure that gives “unfair advantage” to the medical practitioner (such as, for example, the requirement that

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<sup>101</sup> *Cleveland v. Mann*, 942 So. 2d 108 (Miss. 2006).

<sup>102</sup> *Buraczynski v. Eyring*, 919 S.W.2d 314 (Tenn. 1996).

all arbitrators be other physicians in the same field – this is frequently held to be evidence of “unequal bargaining power” favoring the medical practitioner<sup>103</sup>), the arbitration clause is much more likely to be upheld under general state contract law.<sup>104</sup> In *Buraczynski*, the Tennessee Supreme Court listed a number of aspects of an arbitration agreement that make it much more likely to be upheld. Given current case law, these reasons are compelling:

1. The agreement is not contained within a longer clinic or hospital admissions contract, but on a separate, one page document;
2. A short explanation is attached to the document, encouraging the patient to discuss questions;
3. The procedure specified does not favor the practitioner (see above);
4. The agreement contains 10-point block letter red type, just above the signature line, specifying that “BY SIGNING THIS CONTRACT YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL”;
5. The agreement contains no buried terms;
6. The agreement is revocable within 30 days;
7. Most importantly, the agreement does not change the doctor’s duty of care or limit liability for breach of that duty, but merely shifts disputes to a different forum.<sup>105</sup>

Samples of real, current binding arbitration clauses currently used in the medical liability field are attached in Appendix B. As the reader will note, these samples do not meet the criteria of *Buraczynski*, though each may have been upheld. Each is at more or less risk of being found unconscionable and unenforceable. The Virginia form seems particularly vulnerable, as it implies that consent is necessary for care while diminishing plaintiff’s substantive common law rights in addition to the already-low Virginia global medical mal-

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<sup>103</sup> See, e.g., *Beynon v. Garden grove Medical Group*, 100 Cal. App. 3d 698 (Cal. App. 1980).

<sup>104</sup> See, e.g., *Buraczynski v. Eyring*, 919 S.W.2d 314 (Tenn. 1996) (upholding the enforceability of an arbitration clause between physicians and patients). Note that collective bargaining agreements are less likely to be seen as oppressive. See *Madden v. Kaiser Foundation Hospitals*, 552 P.2d 1178 (Cal. 1976), upholding a collectively negotiated arbitration clause.

<sup>105</sup> *Buraczynski v. Eyring*, 919 S.W.2d 314, 321 (Tenn. 1996).

practice cap. A possible use of this toolkit would be federal distribution to physicians, with this checklist of factors that make it more likely that an alternative dispute resolution mechanism would be found enforceable highlighted.

In closing this section, it is important to note that federal intervention *preventing* recourse to contract under state law has been proposed but not adopted. The Arbitration Fairness Act of 2007<sup>106</sup>, which advanced in the House of Representatives but did not become law, would have invalidated all pre-dispute agreements to arbitrate “consumer” disputes (among others), defined as “a dispute between a person other than an organization who seeks or acquires . . . services, . . . and the seller or provider of such . . . services.” The preamble to the Act indicates that “protection” of medical consumers is one of the concerns prompting it, so medical care is clearly one of the “services” that are being contemplated.

## PART VI. CREATION OF NEW FORUMS: HEALTH COURTS?

### *12. Health Courts’ Nature and Feasibility*

**H**ealth Courts, like mandatory arbitration, are devices designed to take the decision-making process in medical liability cases away from juries and leave it to panels of experts. Whereas arbitrators may “split the difference,” encouraging claimants to file weak claims, courts presumably must justify their decisions under law. Common Good, a nonpartisan tort reform organization, has sought to implement health courts, notwithstanding the guarantee in both the federal and 49 state<sup>107</sup> constitutions of the right to a jury trial to decide citizens’ disputes. Common Good’s plan attempts to create a rate-schedule for injury-specific non-economic damages.<sup>108</sup>

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<sup>106</sup> S. 1782, H.R. 3010, 110th Congress.

<sup>107</sup> To my knowledge, only Colorado has not “constitutionalized” the right to a civil jury trial. See “*The Fragile Right to a Civil Jury Trial in Colorado*,” 27(1) THE COLORADO LAWYER 49 (January 1998).

<sup>108</sup> Common Good, “*An Urgent Call for Special Health Courts: America Needs a Reliable System of Medical Justice*,” 2005.

In 2005, the Fair and Reliable Medical Justice Act<sup>109</sup> was introduced in response to pleas by Common Good. The Act would have authorized the Secretary of Health and Human Services to award up to ten demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.

Had it been adopted (the bill never emerged from the Senate Committee on Health, Education, Labor, and Pensions), the Fair and Reliable Medical Justice Act would have required states pursuing grants to: (1) develop an alternative to current tort litigation; and (2) promote a reduction of health care errors by allowing for patient safety data related to such disputes to be collected and analyzed by organizations that engage in voluntary efforts to improve patient safety and the quality of health care delivery. The bill set forth model alternatives to current tort litigation that applicant states could utilize, including notably a “Special Health Care Court” presided over by judges with health care expertise and authority to make binding rulings on causation, compensation, standards of care, and related issues with reliance on independent expert witnesses commissioned by the court.

To work, health courts require modifications in all states’ (save Colorado’s) constitutions or, alternatively, voluntary submission of disputes by parties waiving their right to a jury trial. But of course parties can already waive such right, at least post-injury, and submit disputes to binding arbitration. One Michigan statute required hospitals to offer arbitration to prospective plaintiffs (*i.e.*, after the alleged negligence had occurred), but very few such offers were accepted.<sup>110</sup> Only mandatory jurisdiction is likely to have an impact on medical liability, and I detect no groundswell of support in favor of abolishing the right to jury trials.

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<sup>109</sup> S. 1337 (109th Congress).

<sup>110</sup> See U.S. General Accounting Office, *Medical Malpractice: Few Claims Resolved Through Michigan’s Voluntary Arbitration Program*, Washington 1990.



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APPENDIX A

STATE STATUTES APPLICABLE TO MEDICAL LIABILITY AND DEROGATORY OF COMMON LAW, AS OF 12/1/2011

STATE	Previously Enacted Laws	Comments
ALABAMA	<b>Limits on Damage Awards</b> No limitations. Limits declared unconstitutional by State Supreme Court.	Current through End of 2011 Regular Session
	<b>Statutes of Limitations</b> 2 years from date of injury, <i>Crosslin v. Health Care Authority of City of Huntsville</i> , 5 So. 3d 1193, 1196-97 (Ala. 2008), or 6 months from discovery. No suit may be brought 4 years after date of injury. Minors under 4 by age 8 if statute would have otherwise expired by that time. Ala. Code §6-5-482.	Current through End of 2011 Regular Session.
	<b>Collateral Source Rule</b> Evidence of payment or reimbursement of plaintiff's medical or hospital expenses is discoverable and admissible into evidence. Ala. Code §§ 6-5-545, 12-21-45.	Upheld as constitutional against a due process and equal protection challenge in <i>Marsh v. Green</i> , 782 So. 2d 223 (Ala. 2000) (overruling <i>American Legion Post No. 57 v. Leahy</i> , 681 So.2d 1337 (Ala.1996)).
ALASKA	<b>Limits on Damage Awards</b> Noneconomic damages limited to \$250,000; limited to \$400,000 for wrongful death or injury over 70% disabling; limits not applicable to intentional or reckless acts or omissions. Alaska Stat. § 09.55.549.	Current through the 2011 of the First Regular Session and First Special Session of the 27th Legislature.
	Punitive damages limited to \$500,000 or 3 times compensatory damages. Alaska Stat. § 09.17.020.	Held to be constitutional in <i>Evans ex rel. Kutch v. State</i> , 56 P.3d 1046 (Alaska 2002).
	<b>Statutes of Limitation</b> Two years. Alaska Stat. § 09.10.070. An attempt to reduce statute of limitations for minors was held unconstitutional.	Current through the 2011 of the First Regular Session and First Special Session of the 27th Legislature.
	<b>Joint &amp; Several Liability</b> Defendants are proportionally liable for damages awarded according to percentage of fault. Alaska Stat. § 09.17.080.	Held to be constitutional in <i>Evans ex rel. Kutch v. State</i> , 56 P.3d 1046 (Alaska 2002).
	<b>Collateral Source Rule</b> Common law collateral source rule is abrogated in most cases. Alaska Stat. § 09.55.548(b).	Held not to violate substantive due process rights in <i>Reid v. Williams</i> , 964 P.2d 453 (Alaska 1998).
ARIZONA	<b>Limits on Damage Awards</b> No limitations. Limits declared unconstitutional by State Supreme Court.	Current through the First Regular Session and Third Special Session of the Fiftieth Legislature (2011).
	<b>Statutes of Limitation</b> 2 years after cause of action, not afterward for personal injury and wrongful death. AZ St. § 12-542. However, <i>Anson v. American Motors Corp.</i> , 747 P.2d 581, 587 (Az. 1987) (holding that the two year statute of limitations is unconstitutional with respect to wrongful death actions).	

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STATE	Previously Enacted Laws	Comments
	<p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable for damages awarded according to percentage of fault, unless defendant acted in concert with another person. AZ St. §12-2506.</p>	Current through the First Regular Session and Third Special Session of the Fiftieth Legislature (2011).
	<p><b>Limits on Attorney Fees</b> Not limited, but court may review reasonableness of fees upon request of either party. AZ St. §12-568.</p>	Current through the First Regular Session and Third Special Session of the Fiftieth Legislature (2011).
	<p><b>Expert Witness Qualification</b> Only practitioners may testify as experts in medical malpractice cases AZ St. §12-2604.</p>	Sesinger v. Siebel, 203 P.3d 483, 494 (AZ 2009) (upholding AZ statute § 12-2604(A) as constitutional because it is substantive and does not violate the state's separation of powers doctrine.
	<p><b>Burden of Proof</b> Medical malpractice against physicians and hospitals providing in certain emergency and disaster situations must be proved by clear and convincing evidence. AZ St. §12-572</p>	Current through the First Regular Session and Third Special Session of the Fiftieth Legislature (2011).
	<p><b>Collateral Source Rule</b> Defendant may introduce evidence of collateral payments. AZ St. § 12-565.</p>	Held to be constitutional in <i>Eastin v. Broomfield</i> , 570 P.2d 744 (Ariz. 1977).
ARKANSAS	<p><b>Limits on Damage Awards</b> Punitive damages limited to \$250,000 per plaintiff or 3 times amount of economic damages. Not to exceed \$1 million. Limits adjusted for inflation at 3-year intervals beginning in 2006. Requires recklessness or malice. Ark. St. §§ 16-55-205 to 16-55-209.</p>	
	<p><b>Statutes of limitations</b> 2 years from date of injury. Foreign objects: 1 year from discovery. Minors: before age 9, until age 11. Ark. St. §16-114-203.</p>	Held to be constitutional in <i>Adams v. Arthur</i> , 969 S.W.2d 598 (Ark. 1998).
	<p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable for damages awarded according to percentage of fault. Ark. St. §16-55-201.</p>	Thomas v. Rockwell Automation, Inc. 2009 Ark. LEXIS 274 (holding that the non-party fault provision of the Arkansas code (§16-55-202) was unconstitutional as in violation of the separation of powers, and
	<p><b>Collateral Source Rule</b> Arkansas St. § 16-55-212(b) limiting recovery to medical expenses actually paid</p>	Thomas v. Rockwell Automation, Inc. 2009 Ark. LEXIS 274, holding that Arkansas St. § 16-55-212(b) limiting the evidence that may be introduced relating to medical expenses as unconstitutional because rules of evidence are in the province of the supreme court).
CALIFORNIA	<p><b>Limits on Damage Awards</b> \$250,000 limit for noneconomic damages. Ca. Civil Code §3333.2.</p>	Held constitutional in <i>Hoffman v. United States</i> , 767 F.2d 1431 (9th Cir. 1985).
	<p><b>Statutes of Limitations</b> 3 years after injury or 1 year after discovery, whichever is first. No more than 3 years after injury unless caused by fraud, concealment, or foreign object. Minor under age 6: 3 years or before age 8, whichever is</p>	Photias v. Doerfler, 53 Cal. Rptr. 2d 202, 204 (1996) (holding the statute of limitations unconstitutional to the extent that it treats minors more harshly than adults, with respect to tolling the statute of limitations for medical claims).

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STATE	Previously Enacted Laws	Comments
	longer. Ca. Code of Civil Procedure §340.5.	
	<b>Joint &amp; Several Liability</b> Defendants are proportionally liable for noneconomic damages according to percentage of fault, but jointly and severally liable for economic damages. Ca. Civil Code §1431.2.	<i>Cadlo v. Metalclad Insulation Corp.</i> , 91 Cal. Rptr. 3d 653 (2009) (holding that pre-judgment interest is owed jointly and severally).
	<b>Attorney Fees</b> Sliding scale, not to exceed 40% of first \$50,000, 33 1/3% of next \$50,000, 25% of next \$500,000, and 15% of damages exceeding \$600,000. Ca. Code of Business and Professions §6146.	Current with urgency legislation through Ch. 745 of 2011 Reg. Session and all 2011-2012 1st Ex. Session laws.
	<b>Collateral Source Rule</b> Defendant can introduce evidence of collateral source payments. Cal. Civ. Code § 3333.1 (West).	Held not to violate equal protection or due process clause. <i>Miller v. Sciaroni</i> , 172 Cal. App. 3d 306 Cal. Rptr. 219 (Ct. App. 1985).
COLORADO	<b>Limits on Damage Awards</b> \$1 million total limit on all damages; \$300,000 noneconomic limitation. C.R.S.A. §13-64-302.	Held to be constitutional in <i>Scholz v. Metro. Pathologists</i> , 851 P.2d 901 (Colo. 1993).
	<b>Statute of Limitations</b> 2 years from date of injury, no more than 3 years from act. Foreign objects: 2 years from discovery. Minors under age 6: before age 8. C.R.S.A. §13-80-102.5.	Current through the end of the First Regular Session of the 68th General Assembly (2011).
	<b>Joint &amp; Several Liability</b> Defendants are proportionally liable for damages awarded according to percentage of fault, unless act proved deliberate. C.R.S.A. §13-21-111.5.	Current through the end of the First Regular Session of the 68th General Assembly (2011).
	<b>Insurance</b> Repeals existing provisions allowing medical malpractice insurers to use loss experiences from other states and nationwide experiences in certain situations when setting rates; specific information factors not to be included. C.R. S.A. § 10-4-403 (West).	Current through the end of the First Regular Session of the 68th General Assembly (2011).
	<b>Collateral Source Rule</b> Common law collateral source rule is abrogated by C.R.S.A. § 13-21-111.6.	In <i>Volunteers of Am. Colorado Branch v. Gardenswartz</i> , 242 P.3d 1080 (Colo. 2010), the Colorado Supreme Court interpreted an exception in the statute broadly to allow the use of the collateral source rule in most cases. Legislation proposed to clarify that the Colorado legislature intended to abrogate the common law collateral source rule. See 2011 Colorado House Bill No. 1106.
CONNECTICUT	<b>Statute of Limitations</b> 2 years from date of injury, but no later than 3 years of the act or omission. C.G.S.A. §52-584.	Current through 2011 Jan. Reg. Sess. and June Sp. Sess.
	<b>Joint &amp; Several Liability</b> Defendants are proportionally liable accord-	Current through 2011 Jan. Reg. Sess. and June Sp. Sess.

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STATE	Previously Enacted Laws	Comments
	<p>ing to percentage of fault for damages awarded. C.G.S.A. §52-572h.</p> <p><b>Limits on Attorney Fees</b> Sliding scale, not to exceed 1/3 of first \$300,000; 25% of next \$300,000; 20% of next \$300,000; 15% of next \$300,000; and 10% of damages exceeding \$1.2 million. C.G.S.A. §52-251c.</p> <p><b>Insurance</b> Eliminates requirements that medical professional liability insurance policies issued on a claims-made basis provide prior acts coverage without additional charge to insured; extended reporting coverage liability insurers must provide under certain circumstances. C.G.S.A. §38a-394, (See 2006, P.A. 06-108, § 1.)</p> <p><b>Collateral Source Rule</b> The common law collateral source rule is abrogated except where subrogation can be had. C.G.S.A. § 52-225a.</p>	<p>Current through 2011 Jan. Reg. Sess. and June Sp. Sess.</p> <p>Current through 2011 Jan. Reg. Sess. and June Sp. Sess.</p> <p>Current through 2011 Jan. Reg. Sess. and June Sp. Sess.</p>
DELAWARE	<p><b>Limits on Damage Awards</b> Punitive damages may be awarded only on finding of malicious intent to injure or willful or wanton misconduct. No mandated limit. 18 Del.C. § 6855.</p> <p><b>Statutes of Limitations</b> 2 years from injury; 3 years from discovery if latent injury. Minor: age 6 or same as adult. 18 Del.C. § 6856.</p> <p><b>Limits on Attorney Fees</b> Sliding scale, not to exceed 35% of first \$100,000; 25% of next \$100,000; and 10% of all damages exceeding \$200,000. 18 Del.C. § 6865.</p> <p><b>Patient Compensation or Stabilization Fund</b> Stabilization Reserve Fund created. 18 Del.C. § 6833.</p> <p><b>Arbitration</b> Medical malpractice actions must first be brought in before a medical negligence review panel, whose opinion in favor of the plaintiff may serve a prima facie evidence of negligence in a court action. Del.C. §§ 6803-14</p>	<p>Current through 78 Laws 2011, ch. 1-125.</p> <p>Current through 78 Laws 2011, ch. 1-125.</p> <p>Current through 78 Laws 2011, ch. 1-125.</p> <p>Current through 78 Laws 2011, ch. 1-125.</p> <p>Current through 78 Laws 2011, ch. 1-125.</p>
FLORIDA	<p><b>Limits on Damage Awards</b> Noneconomic damages limited to \$500,000 per claimant. Death or permanent vegetative state, noneconomic damages not to exceed \$1 million. F.S.A. §766.118. Punitive damages limited to the greater of 3 times amount of economic damages or \$500,000. If deliberate intent to harm, no</p>	<p>Current through Chapter 236 (End) of the 2011 Second Regular Session of the Twenty-Second Legislature.</p>

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STATE	Previously Enacted Laws	Comments
	limit on punitive damages. F.S.A. §768.73.	
	<p><b>Statutes of Limitations</b>            2 years from injury or discovery, no more than 4 years from injury. Minors: age 8. If fraud, concealment of injury or intentional misrepresentation prevented discovery within 4-year period, 2 year limit from discovery, not to exceed 7 years after the act. Limitation does not apply to intentional torts resulting in death. F.S.A. §95.11.</p>	Current through Chapter 236 (End) of the 2011 Second Regular Session of the Twenty-Second Legislature.
	<p><b>Joint &amp; Several Liability</b>            Defendants are proportionally liable according to percentage of fault for damages awarded, monetary limits in liability according to percentage as level of fault increases. F.S.A. §768.81.</p>	Proposed legislation: 2011 Florida House Bill No. 201 to clarify intent of the law after a recent Florida Supreme Court decision.
	<p><b>Limits on Attorney Fees</b>            Limits attorney fees in malpractice lawsuits to 30% of first \$250,000; 10% of any award over \$250,000. Adopted 2004: Florida Constitution, Article I, Section 26.</p>	No further legislative enactments.
	<p><b>Patient Compensation or Stabilization Fund</b>            Florida Birth-Related Neurological Injury Compensation Plan is the exclusive remedy for children with neurological injuries, except in cases of malicious purpose. F.S.A. § 766.303 (West).</p>	Current through Chapter 236 (End) of the 2011 Second Regular Session of the Twenty-Second Legislature.
	<p><b>Expert Witnesses</b>            An expert witnesses in a medical malpractice case must obtain an expert witness license before he or she can testify. F.S.A. 458.3175; 459.0066; 466.005. An expert witness may not testify on a contingency basis. F.S.A. §766.102.</p>	Current through Chapter 236 (End) of the 2011 Second Regular Session of the Twenty-Second Legislature.
<b>GEORGIA</b>	<p><b>Limits on Damage Awards</b>            Previously, noneconomic damages in medical malpractice actions limited to \$350,000 against physicians regardless of number of defendants. Noneconomic damages limited to \$350,000 against single medical facility; \$700,000 against multiple facilities. Aggregate amount of noneconomic damages limited to \$1.05 million. Ga. Code Ann., § 51-13-1 (enacted 2005).</p>	Held unconstitutional by <i>Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt</i> , 691 S.E.2d 218 (Ga. 2010).
	<p><b>Statutes of Limitations</b>            2 years from injury or death; in no event longer than 5 years from act or death. Foreign object: 1 year from discovery. Minors: 2 years from age 5 if action arose before 5th birthday. Ga. Code Ann. §9-3-71, 72, 73.</p>	Current through end of the 2011 Regular Session.
	<p><b>Joint &amp; Several Liability</b>            Multiple defendants liable for apportioned</p>	Current through end of the 2011 Regular Session.

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STATE	Previously Enacted Laws	Comments
	<p>damages according to percentage of fault of each person. Damages reduced by court in proportion to percentage of fault if plaintiff is found partially responsible for injury. Plaintiff not entitled to receive any damages if found 50% or more responsible for injury. Ga. Code Ann. §51-12-33. (enacted 2005).</p> <p><b>Patient Compensation or Stabilization Fund</b> Health care corporation regulations require insurers to establish and maintain reserve funds for unpaid claims and other known liabilities. Ga. Code. Ann. §33-20-13 (c).</p> <p><b>Standard of Proof</b> Medical malpractice actions against emergency service providers must be prove gross negligence by clear and convincing evidence. Ga. Code Ann. § 51-1-29.5.</p> <p><b>Collateral Source Rule</b> Abrogation of collateral source rule was held unconstitutional in <i>Amalgamated Transit Union Local 1324 v. Roberts</i>, 434 S.E.2d 450 (1993).</p>	<p>Current through end of the 2011 Regular Session.</p> <p>Current through end of the 2011 Regular Session.</p> <p>Current through end of the 2011 Regular Session.</p>
<b>HAWAII</b>	<p><b>Limits on Damage Awards</b> Damages for pain and suffering in medical tort actions limited to a maximum award of \$375,000. H.R.S. § 663-8.5, 8.7.</p> <p><b>Statutes of Limitations</b> 2 years from discovery, not to exceed 6 years from act. Minors: age 10 or within 6 years, whichever is longer. H.R.S. § 657-7.3. Arbitration tolls statute until 60 days after panel's decision is delivered. HRS § 671-18.</p> <p><b>Joint &amp; Several Liability</b> When negligence is less than 25%, noneconomic damages awarded in proportion according to degree of fault. H.R.S. § 663-10.9.</p> <p><b>Limits on Attorney Fees</b> Attorney fees must be approved by court. H.R.S. § 607-15.5.</p> <p><b>Arbitration</b> Medical malpractice claims must be submitted to a medical claim conciliation panel before they can be brought in court. H.R.S. § 671-12.</p>	<p>Pending legislation to limit noneconomic damages to \$250,000. 2011 Hawaii Senate Bill No. 270.</p> <p>Current through the 2011 Regular Session of the Hawai'i Legislature.</p> <p>Current through the 2011 Regular Session of the Hawai'i Legislature.</p> <p>Current through the 2011 Regular Session of the Hawai'i Legislature.</p> <p>Current through the 2011 Regular Session of the Hawai'i Legislature.</p>
<b>IDAHO</b>	<p><b>Limits on Damage Awards</b> \$250,000 limit on noneconomic damages, adjusted annually according to state's average annual wage. Punitive damages limited to \$250,000 or amount 3 times of</p>	<p>Held not to violate separation of powers. <i>Kirkland v. Blaine County Med. Ctr.</i>, 4 P.3d 1115 (Idaho 2000).</p>

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STATE	Previously Enacted Laws	Comments
	<p>compensatory damages. Idaho § 6.1603; §6.1604.</p> <p><b>Statutes of Limitations</b> 2 years from injury. Foreign object: 1 year from reasonable discovery or 2 years from injury, whichever is later. Idaho § 5-219.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded, except in cases of intentional act. Idaho § 6-803.</p> <p><b>Collateral Source Rule</b> Common law collateral source rule is abrogated. Idaho § 6-1606.</p> <p><b>Arbitration</b> Before bringing a medical malpractice action in court, a plaintiff must have a non-binding hearing provided by the state board of medicine. Idaho § 6-1001.</p>	<p>Current through the 2001 Ch. 1-335 (end).</p> <p>Current through the 2001 Ch. 1-335 (end).</p> <p>Current through the 2001 Ch. 1-335 (end).</p> <p>Current through the 2001 Ch. 1-335 (end).</p>
ILLINOIS	<p><b>Limits on Damage Awards</b> Noneconomic damages limited to \$500,000 against individual physician, \$1 million against hospital. 735 ILCS 5/2-1706.5.</p> <p>Punitive damages not recoverable in medical malpractice cases. 735 ILCS 5/2-1115.</p> <p><b>Statutes of Limitations</b> 2 years from discovery but not more than 4 years from act. Minors: 8 years after act but not after age 22. 735 ILCS 5/13-212. Wrongful death: 2 years if limitation on personal injury still valid at time of death. 740 ILCS 180/2.</p> <p><b>Joint &amp; Several Liability</b> No separation of joint and several liability. 735 ILCS 5/2-1117.</p> <p><b>Limits on Attorney Fees</b> Sliding scale, not to exceed 1/3 of first \$150,000; 25% of \$150,000 to \$1 million; 20% of damages over \$1 million. 735 ILCS 5/2-1114.</p> <p><b>Collateral Source Rule</b> Medical malpractice judgments are reduced post trial by 50% of lost wage or disability programs and 100% of medical collateral benefits received provided that the reduction is not more than 50% of the entire judgment. 735 ILCS § 5/2-1205.</p>	<p>Found Unconstitutional in <i>Lebron v. Gottlieb Mem'l Hosp.</i>, 930 N.E.2d 895 (Ill. 2010), reh'g denied (May 24, 2010). Legislation pending to remove the cap from the code. 2011 Illinois Senate Bill No. 1888.</p> <p>Current through P.A. 95-982 of the 2008 Reg. Sess.</p> <p>Current through P.A. 95-982 of the 2008 Reg. Sess.</p> <p>Proposed legislation to create a system of proportional fault. 2011 Illinois Senate Bill No. 1974.</p> <p>Current through P.A. 95-982 of the 2008 Reg. Sess.</p> <p>Proposed legislation to reduce judgment by payments made by a collateral source in excess of amount actually paid to a medical provider. 2011 Illinois House Bill No. 3153.</p>
INDIANA	<p><b>Limits on Damage Awards</b> \$1,250,000 total limit. Liability limited to \$250,000 per health care provider. Any award beyond limits covered by Patient Compensation Fund. I.C. §34-18-14-3.</p>	<p>Held not to be unconstitutional under the Indiana constitution. <i>Indiana Patient's Comp. Fund v. Wolfe</i>, 735 N.E.2d 1187 (Ind. Ct. App. 2000).</p>

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STATE	Previously Enacted Laws	Comments
	<p><b>Statutes of Limitations</b> 2 years from act, omission, or neglect. Minors: under age 6 until age 8. I.C. §34-18-7-1.</p> <p><b>Limits on Attorney Fees</b> Plaintiff's attorney fees may not exceed 15% of any award made from Patient Compensation Fund. I.C. §34-18-18-1.</p> <p><b>Patient Compensation or Stabilization Fund</b> Patient Compensation Fund pays awards over \$250,000 up to \$1,250,000. I.C. §34-18-6.</p> <p><b>Collateral Source Rule</b> Evidence of collateral benefits may be submitted as evidence. Ind. Code Ann. § 34-44-1-2 (West)</p> <p><b>Arbitration</b> Before an action for medical malpractice can be brought in court, it must first be presented to a medical review panel. I.C. § 34-18-8-4.</p>	<p>Repealed. This statute had been found unconstitutional as applied in several cases. (See <i>Martin v. Richey</i>, 711 N.E.2d 1273, 1274+ (Ind. Jul 08, 1999); <i>Shah v. Harris</i>, 758 N.E.2d 953, 954+ (Ind.App. Nov 16, 2001); <i>Jacobs v. Manhart</i>, 770 N.E.2d 344, 345+ (Ind.App. Jun 05, 2002); <i>Herron v. Anigbo</i>, 866 N.E.2d 842, 842+ (Ind.App. May 23, 2007)).</p> <p>Current through end of 2011 1st Regular Session.</p> <p>I could not find any provision that mentions award amounts. Section IC 34-18-6-3 has been repealed.</p> <p>Current through end of 2011 1st Regular Session.</p> <p>Upheld as constitutional in <i>Hines v. Elkhart Gen. Hosp.</i>, 465 F. Supp. 421, 433 (N.D. Ind. 1979) <i>aff'd</i>, 603 F.2d 646 (7th Cir. 1979) and <i>Johnson v. St. Vincent Hosp., Inc.</i>, 273 Ind. 374, 404 N.E.2d 585 (1980) <i>overruled on other grounds by In re Stephens</i>, 867 N.E.2d 148 (Ind. 2007).</p>
IOWA	<p><b>Statutes of Limitations</b> 2 years from reasonable discovery but not more than 6 years from injury unless foreign object. Minors under age 8: until age 10 or same as adults, whichever is later. Mentally ill: extends to 1 year from removal of disability. I.C.A. § 614.1.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault. Several liability not granted for economic damages when defendant is found more than 50% at fault. I.C.A. § 668.4.</p> <p><b>Limits on Attorney Fees</b> Court to review plaintiff attorney fees in any personal injury or wrongful death action against specified health care providers or hospitals. I.C.A. § 147.138.</p> <p><b>Collateral Source Rule</b> Common law collateral source rule is abrogated for medical malpractice actions. I.C.A. § 147.136.</p>	<p>Current through Acts from the 2011 Reg.Sess.</p> <p>Current through Acts from the 2011 Reg.Sess.</p> <p>Current through Acts from the 2011 Reg.Sess.</p> <p>Pending legislation to exempt payments from family members and Iowa's medical assistance program from the scope of the statute's abrogation. 2011 Iowa Senate File No. 542.</p>
KANSAS	<p><b>Limits on Damage Awards</b> \$250,000 limit on noneconomic damages recoverable by each party from all defendants. K.S.A. 60-19a02. Punitive damages</p>	<p>K.S.A. 60-3702 was held to unconstitutionally violate the seventh amendments trial by jury because it allows the judge to determine punitive damages; the court did not analyze</p>



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STATE	Previously Enacted Laws	Comments
	<p>limited to lesser of defendant's highest gross income for prior 5 years or \$5 million. K.S.A. 60-3702.</p> <p><b>Statutes of Limitations</b> 2 years from act or reasonable discovery, but can be up to 10 years after reasonable discovery. K.S.A. §60.513.</p> <p><b>Limits on Attorney Fees</b> Attorney fees must be approved by court. K.S.A. §7.121b.</p> <p><b>Patient Compensation or Stabilization Fund</b> Health Care Stabilization Fund pays claims over \$200,000, maximum payout of \$300,000 per year on claim. Mandatory participation by medical professionals. K.S.A. §40-3403.</p> <p><b>Collateral Source Rule</b> Attempt to abrogate collateral source rule held unconstitutional in <i>Thompson v. KFB Ins. Co.</i>, 850 P.2d 773 (Kan. 1993).</p>	<p>severability. <i>Capital Solutions, LLC v. Konica Minolta Bus. Solutions U.S.A., Inc.</i>, 695 F. Supp. 2d 1149, (D. Kan. 2010). However, Kansas courts have continued to apply this statute noting that the jury trial requirement can differ between state and federal courts. <i>Baraban v. Hammonds</i>, WL 1338083 (Dist. Ct. of Kan. 2011). Pending legislation is 2011 Kansas Senate Bill No. 158.</p> <p>Current through End of 2011 Reg. Sess.</p> <p>Current through End of 2011 Reg. Sess.</p> <p>Current through End of 2011 Reg. Sess.</p> <p>Current through End of 2011 Reg. Sess.</p>
<b>KENTUCKY</b>	<p><b>Statutes of Limitations</b> 1 year from act or reasonable discovery, but not more than 5 years after act. KRS § 413.140.</p> <p><b>Joint &amp; Several Liability</b> When court apportions percentage of fault, defendant is only liable for comparable share of damages. KRS § 411.182.</p> <p><b>Collateral Source Rule</b> Statute abrogating the common-law rule was held unconstitutional in <i>O'Bryan v. Hedgespeth</i>, 892 S.W.2d 571 (Ky. 1995).</p>	<p>Current through end of 2011 legislation.</p> <p>Current through end of 2011 legislation.</p>
<b>LOUISIANA</b>	<p><b>Limits on Damages</b> \$500,000 limit for total recovery. Health care provider liability limited to \$100,000. Any award in excess of all liable providers paid from Patient's Compensation Fund. LSA RS 9:5628</p> <p><b>Statutes of Limitations</b></p>	<p>Amended in June 2008 to reflect that: "cost for which a health care provider...may be assessed by a trial court shall be limited to the cost incurred prior to the rendering of a final judgment against the health care provider, not as a nominal defendant, after a trial on a malpractice claim, including but not limited to, costs assessed pursuant to Code of Civil Procedure Article 970 in any instance where the board was not the offeror or offeree of the proposed settlement amount. The health care provider shall not be assessed costs in any action in which the fund intervenes or the health care provider is a nominal defendant after there has been a settlement between the health care provider and the claimant."<sup>9</sup></p> <p>Current through the 2011 1st Extraordinary</p>

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STATE	Previously Enacted Laws	Comments
	<p>1 year from act or date of discovery, but no later than 3 years from date of injury. LSA-RS §9.5628. Wrongful death: 1 year from death. LSA-C.C. Art. 2315.2.</p> <p><b>Joint &amp; Several Liability</b> Defendants are liable only for percentage of fault unless conspiracy of intentional or willful act. LSA-C.C. Art. 2324.</p> <p><b>Patient Compensation or Stabilization Fund</b> Patient Compensation Fund pays claims over \$100,000. Physicians levied surcharge directly into fund for purpose of paying malpractice claims. RS §40:1299.44. Medical malpractice claims must be submitted first to a panel. La. Rev. Stat. Ann. § 40:1299.47</p>	<p>Session.</p> <p>Current through the 2011 1st Extraordinary Session.</p> <p>Current through the 2011 1st Extraordinary Session.</p>
MAINE	<p><b>Limits on Damage Awards</b> Comparative Negligence of plaintiff to reduce award in personal injury or wrongful death cases. Jury to specify amount of damages award to be paid by each defendant in a multiple-defendant medical malpractice complaint; Damage limits granted only in wrongful death cases. Noneconomic damages limited to \$500,000, punitive damages limited to \$250,000. 18-A M.R.S.A. § 2-804.</p> <p><b>Statutes of Limitations</b> 3 years from cause of action. Minors: 6 years after accrual or within 3 years of minority, whichever is first. Foreign objects: accrue from reasonable discovery. 24 M.R.S.A. § 2902.</p> <p><b>Limits on Attorney Fees</b> Sliding scale, not to exceed 1/3 of first \$100,000; 25% of next \$100,000; and 20% of damages exceeding \$200,000. 24 M.R.S.A. § 2961.</p> <p><b>Insurance</b> Statement or conduct acknowledging sympathy, apology or fault made by health care provider to patient or patient's representative relating to injury or death as result of unanticipated medical outcome not admissible as evidence of admission of liability. 24 M.R.S.A. § 2907.</p> <p><b>Collateral Source Rule</b> Evidence of collateral payments can be submitted to the court post-verdict to reduce damage award. 24 M.R.S.A. § 2906.</p> <p><b>Arbitration</b> Claims must first be submitted to a pretrial panel. 24 M.R.S.A. § 2851-8.</p>	<p>Current with legislation through the 2011 First Regular Session of the 125th Legislature.</p> <p>Current with legislation through the 2011 First Regular Session of the 125th Legislature.</p> <p>Current with legislation through the 2011 First Regular Session of the 125th Legislature.</p> <p>Current with legislation through the 2011 First Regular Session of the 125th Legislature.</p> <p>Legislation pending.</p>

## A MEDICAL LIABILITY TOOLKIT, INCLUDING ADR

STATE	Previously Enacted Laws	Comments
<b>MARYLAND</b>	<p><b>Limits on Damage Awards</b> Noneconomic damages limited to \$650,000 from 2005 to 2008, thereafter increasing by \$15,000 per year beginning on January 1 of applicable year. MD Code, Courts and Judicial Proceedings, § 3-2A-09.</p>	Current through all chapters of the 2011 Regular Session and the 2011 Special Session of the General Assembly.
	<p><b>Statutes of Limitations</b> 5 years from act or 3 years from discovery. MD Code, Courts and Judicial Proceedings, § 5-109.</p>	This law was held unconstitutional by <i>Piselli v. 75th Street Medical</i> , 808 A.2d 508, 509, 371 Md. 188, 188+ (Md. Oct 08, 2002) (NO. 2 SEPT.TERM 2001).
	<p><b>Insurance/Stabilization Fund</b> Premium 2% tax exemption repealed, tax assessed on HMOs and MCOs to offset medical liability premium rates. §6-101 - 104; 6-301.</p>	Current through all chapters of the 2011 Regular Session and the 2011 Special Session of the General Assembly.
<b>MASSACHUSETTS</b>	<p><b>Limits on Damage Awards</b> \$500,000 limit for noneconomic damages, some exceptions released from limitations. M.G.L.A. 231 § 60H.</p>	Legislation regarding this statute has been introduced but not finalized. Proposed legislation can be found at: - 2011 Massachusetts House Bill No. 2194.
	<p><b>Statutes of Limitations</b> 3 years from injury and no more than 7 years, unless foreign object discovered. §260.4. Minors: before age 6 until age 9, no longer than 7 years from injury. §231.60D.</p>	Current through Chapter 141 of the 2011 1st Annual Session.
	<p><b>Limits on Attorney Fees</b> Sliding scale, not to exceed 40% of first \$150,000; 33.33% of next \$150,000; 30% of next \$200,000 and 25% of award over \$500,000. §231.60I.</p>	Current through Chapter 141 of the 2011 1st Annual Session.
	<p><b>Collateral Source Rule</b> Collateral Source rule is abrogated for medical malpractice actions. § 60G.</p>	Legislation pending: 2011 Massachusetts Senate Bill No. 834.
	<p><b>Arbitration</b> Before bringing a medical malpractice action in court, a plaintiff must present his or her claim to a tribunal. If the tribunal finds for the defendant, the plaintiff can only proceed in court if he or she posts a \$6000 bond to cover defendant's litigation costs in the event that the defendant prevails at trial. § 60B.</p>	Legislation pending: 2011 Massachusetts Senate Bill No. 834.
<b>MICHIGAN</b>	<p><b>Limits on Damage Awards</b> \$280,000 limit on noneconomic damages; \$500,000 limit on noneconomic damages applies to certain other circumstance. Limit adjusted annually by state treasurer according to consumer price index. M.C.L.A. 600.1483.</p>	Constitutionality was questioned in <i>Wiley v. Henry Ford Cottage Hosp.</i> , 668 N.W.2d 402 (Mich. App.2003) but was bound by a previous panel decision. The constitutionality has been resolved. See <i>Jenkins v. Patel</i> , 688 N.W.2d 543, 544 n.1 (Mich. App. 2004).
	<p><b>Collateral Source Rule</b> Collateral source rule is abrogated. M.C.L.A. § 600.6303.</p>	Held constitutional in <i>Heinz v. Chicago Rd. Inv. Co.</i> , 549 N.W.2d 47 (Mich. App.1996).
	<p><b>Arbitration</b> Medical malpractice action must first be</p>	

STATE	Previously Enacted Laws	Comments
	<p>mediated M.C.L.A. § 600.4903.</p> <p><b>Statutes of Limitations</b>                      2 years from injury. M.C.L.A. 600.5805.                      6 months from reasonable discovery. No more than 6 years from injury. M.C.L.A. §600.5838a. Minors under age 8: the latter of 6 years or age 10. Reproductive injuries until age 13. M.C.L.A. §600.5851.</p> <p><b>Joint &amp; Several Liability</b>                      Defendants are proportionally liable according to percentage of fault for damages awarded, except when uncollectible shares are reallocated among solvent defendants. M.C.L.A. §600.2925a.</p>	<p>Pending Legislation. 2011 Michigan House Bill No. 4318.</p> <p>Current through the end of the 2011 Regular Session.</p>
MINNESOTA	<p><b>Limits on Damage Awards</b> No limitation for punitive damages but are only allowed if defendant proven to have deliberate disregard to safety. Award subject to judicial review. M.S.A. § 549.20.</p> <p><b>Statutes of Limitations</b>                      4 years from injury or termination of treatment. M.S.A. § 541.076. Disability extends limitation to 7 years. M.S.A. § 541.15.</p> <p><b>Joint &amp; Several Liability</b>                      Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is assessed greater than 50% of fault, or proven to have intentional malice. M.S.A. § 604.02.</p> <p><b>Collateral Source Rule</b>                      Collateral source rule is abrogated. M.S.A. § 548.251.</p>	<p>Constitutional challenge rejected in <i>GN Danavox, Inc. v. Starkey Laboratories, Inc.</i>, 476 N.W.2d 172 (Minn. Ct. App. 1991) (cert. denied).</p> <p>Current through the end of the 2011 Regular Session.</p> <p>Current through the end of the 2011 Regular Session.</p> <p>Held to be constitutional in <i>Imlay v. City of Lake Crystal</i>, 453 N.W.2d 326 (Minn. 1990).</p>
MISSISSIPPI	<p><b>Limits on Damage Awards</b> \$500,000 limit on noneconomic damages. Miss. Code Ann. § 11-1-60. Punitive damages only awarded if willful malice or gross negligence proved. Court determines if award granted and amount. Damages limited based on defendant's net worth. M.S.A. §11-1-65.</p> <p><b>Statutes of Limitations</b>                      2 years from act or reasonable discovery, no more than 7 years. M.S.A. § 15.1.36.</p> <p><b>Joint &amp; Several Liability</b>                      Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is proven to have intentional malice. M.C.A. § 85-5-7.</p> <p><b>Insurance</b>                      Provided temporary market of last resort to make medical malpractice insurance available for hospitals, institutions for the aged or</p>	<p>Current through End of 2011 Regular Session.</p> <p>Pending Legislation. 2011 Mississippi Senate Bill No. 2008.</p> <p>Current through End of 2011 Regular Session.</p> <p>Repealed by Laws 2006, Ch. 567, § 5, eff. July 31, 2008.</p>

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STATE	Previously Enacted Laws	Comments
	<p>infirm, or other licensed health care facilities; also for physicians, nurses and any other personnel licensed to practice in any health care facility including hospitals. Miss. Code Ann. § 83-48-3.</p>	
<b>MISSOURI</b>	<p><b>Limits on Damage Awards</b> Noneconomic damages limited to \$350,000 regardless of number of defendants. (Inflation index repealed.) V.A.M.S. 538.210. Punitive damages limited to \$500,000 or 5 times net amount of judgment. V.A.M.S. 510.265.</p> <p><b>Statutes of Limitations</b> 2 years from act. Foreign object: 2 years from discovery. Amended 2005: Minor under 8: until age 20, or 2 years from 18th birthday. In no event longer than 10 years from injury. V.A.M.S. 516.105.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded; jointly liable if found more than 51% at fault. V.A.M.S. 537.067.</p> <p><b>Patient Compensation or Stabilization Fund</b> Tort Victim's Compensation Fund does not apply in actions of improper health care. V.A.M.S. 538.300.</p>	<p>V.A.M.S. 538.210 held unconstitutional as applied retroactively to a cause of action already accrued. <i>Klotz v. St. Anthony's Med. Ctr.</i>, 311 S.W.3d 752 (Mo. 2010) (En Banc). Pending legislation to remove the damage limit and replace it with a pilot health court program. 2011 Missouri House Bill No. 1014. Pending legislation to reduce punitive damage cap to \$250,000 or 2 times the net amount of judgment. 2011 Missouri House Bill No. 606.</p> <p>Current through the end of the 2011 First Extraordinary Session of the 96th General Assembly, pending corrections received from the Missouri Revisor of Statutes.</p> <p>Pending legislation to require proportional liability in all cases. 2011 Missouri House Bill No. 364; 2011 Missouri Senate Bill No. 211.</p> <p>Current through the end of the 2011 First Extraordinary Session of the 96th General Assembly, pending corrections received from the Missouri Revisor of Statutes.</p>
<b>MONTANA</b>	<p><b>Limits on Damage Awards</b> \$250,000 limit on noneconomic damages. MCA 25-9-411. Liability for punitive damages determined by court, defendant must have been proven guilty of deliberate malice. MCA 27-1-221. Damages for negligence awarded based on "reduced chance of recovery." MCA §27-6-103 (Enacted 2005.)</p> <p><b>Statutes of Limitations</b> 3 years from injury or discovery, no more than 5 years from act. Minors under age 4: age 11 or death, whichever occurs first. MCA §27-2-205.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is assessed greater than 50% of fault. MCA §27-1-703.</p> <p><b>Patient Compensation or Stabilization Fund</b> Insurance Commissioner to perform study of medical liability insurance market; create market assistance plan, joint underwriting</p>	<p>Current through 2011 laws.</p> <p>Pending legislation to lower the statute of limitations to 2 years. 2011 Montana House Bill No. 408.</p> <p>Pending legislation to change the effect of settlements on the remaining defendant's liability. 2011 Montana House Bill No. 531.</p> <p>Current through 2011 laws.</p>

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STATE	Previously Enacted Laws	Comments
	association, or stabilization reserve fund based on findings. MCA §33-23-503; §33-23-507-510; (Enacted 2005.)	
	<b>Collateral Source Rule</b> Damages in excess of \$50,000 are reduced by collateral sources provided there is no right of subrogation. MCA § 27-1-308.	Current through 2011 laws.
	<b>Arbitration</b> Medical malpractice claims must first be submitted to a panel. MCA §§ 27-6-101-106	Current through 2011 laws.
NEBRASKA	<b>Limits on Damage Awards</b> Total damages limited to \$1,750,000. Health care provider liability limited to \$500,000. Any excess of total liability of all health care providers paid from Excess Liability Fund. Neb.Rev.St. § 44-2825.	Held to be constitutional in <i>Gourley ex rel. Gourley v. Nebraska Methodist Health Sys., Inc.</i> , 265 Neb. 918, 663 N.W.2d 43 (2003).
	<b>Statutes of Limitations</b> 2 years from injury or 1 year from reasonable discovery; in no event longer than 10 years from injury. Neb.Rev.St. § 44-2828.	Current through the 102nd Legislature First Regular Session 2011.
	<b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for noneconomic damages awarded, and jointly liable for economic damages. Neb Rev St 25-21,185.10.	Current through the 102nd Legislature First Regular Session 2011.
	<b>Limits on Attorney Fees</b> No limitations, but court can review for reasonableness at request of prevailing party. Neb.Rev.St. § 44-2834.	Current through the 102nd Legislature First Regular Session 2011.
	<b>Patient Compensation or Stabilization Fund</b> Excess Liability Fund participation required and surcharge assessed to physicians. Pays claims over \$500,000 per defendant up to \$1,750,000. Neb.Rev.St. § 44-2829-2831.	Current through the 102nd Legislature First Regular Session 2011.
	<b>Collateral Source Rule</b> Insurance benefits are deducted from damage awards. Neb.Rev.Stat. § 44-2819	Current through the 102nd Legislature First Regular Session 2011.
	<b>Arbitration</b> Medical malpractice claims must first be brought before a medical review panel. Neb.Rev.Stat. § 44-2840.	Current through the 102nd Legislature First Regular Session 2011.
NEVADA	<b>Limits on Damage Awards</b> \$350,000 limit on noneconomic damages, no exceptions. N.R.S. 41A.035. Punitive damages limited to \$300,000 or 3 times compensatory damages; only awarded by court for fraud, oppression, or malice. N.R.S. 42.005.	Punitive damage statute is generally constitutional. <i>Republic Ins. Co. v. Hires</i> , 810 P.2d 790, 792 (Nev. 1991).
	<b>Statutes of Limitations</b>	Current through the 2009 75th Regular

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STATE	Previously Enacted Laws	Comments
	4 years from injury or 2 years from reasonable discovery if injury or wrongful death prior to Oct. 1, 2002. If after Oct. 1, 2002, 3 years from injury or 1 year from discovery. N.R.S. 41A.097.	Session and the 2010 26th Special Session and technical corrections received from the Legislative Counsel Bureau (2010).
	<b>Joint &amp; Several Liability</b> Defendants proportionally liable according to percentage of fault for economic and noneconomic damages awarded. N.R.S. 41A.045.	Current through the 2009 75th Regular Session and the 2010 26th Special Session and technical corrections received from the Legislative Counsel Bureau (2010).
	<b>Limits on Attorney Fees</b> Sliding scale for attorney fees, not to exceed 40% of first \$50,000; 33 1/3% of next \$50,000; 25% of next \$500,000; 15% of any amount over \$600,000. N.R.S. 7.095.	Current through the 2009 75th Regular Session and the 2010 26th Special Session and technical corrections received from the Legislative Counsel Bureau (2010).
	<b>Patient Compensation or Stabilization Fund</b> State insurance commissioner may create insurance coverage through regulation if access to essential insurance in voluntary market is limited. N.R.S. 686B.180.	Current through the 2009 75th Regular Session and the 2010 26th Special Session and technical corrections received from the Legislative Counsel Bureau (2010).
	<b>Collateral Source Rule</b> Statute abrogating collateral source rule has been repealed. N.R.S. § 42.020.	Repealed.
	<b>Arbitration</b> Statute repealed. N.R.S. § 41A.016.	Repealed.
<b>NEW HAMPSHIRE</b>	<b>Limits on Damage Awards</b> No limitations. Limits declared unconstitutional by State Supreme Court.	No further legislative enactments.
	<b>Statutes of Limitations</b> 2 years from injury or 2 years from discovery. Minors under age 8: until age 10. N.H. Rev. Stat. § 507-C:4.	This statute was held unconstitutional by <i>Carson v. Maurer</i> , 424 A.2d 825, 826, 120 N.H. 925, 925, 12 A.L.R.4th 1, 1 (N.H. Dec 31, 1980) (NO. 80-017, 80-099, 80-136, 80-191, 80-252, 80-273, 80-291) with regards to 2 year statute of limitations as applied to infants and mentally incompetents.
	<b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded. N.H. Rev. Stat. § 507:7-d.	Updated with laws through the end of the 2008 Regular and Special Session, not including changes and corrections made by the State of New Hampshire, Office of Legislative Services.
	<b>Limits on Attorney Fees</b> Sliding scale, not to exceed 50% of first \$1000; 40% of next \$2000; 1/3 of next \$97,000; 20% of excess of \$100,000. If settled out of court, fee limited to 25% of up to \$50,000. N.H. Rev. Stat. § 507-C:8.	This statute was held unconstitutional by <i>Carson v. Maurer</i> , 424 A.2d 825, 826, 120 N.H. 925, 925, 12 A.L.R.4th 1, 1 (N.H. Dec 31, 1980) (NO. 80-017, 80-099, 80-136, 80-191, 80-252, 80-273, 80-291) inasmuch as the contingent fee scale provisions' "relationship with overall purpose of contending medical injury reparations system cost is questionable and it not only unfairly burdens malpractice plaintiffs and, to a lesser extent, their attorneys, but also unjustly discriminates by interfering with freedom of contract between a single class of plaintiffs and their activities."

STATE	Previously Enacted Laws	Comments
NEW JERSEY	<p><b>Collateral Source Rule</b> Statute declared unconstitutional in <i>Carson v. Maurer</i>, 424 A.2d 825 (N.H. 1980).</p>	
	<p><b>Limits on Damage Awards</b> \$350,000 limit on punitive damages, or 5 times compensatory damages, whichever is greater. NJ ST. §2A:15-5.14.</p>	Proposed legislation is pending:2010 New Jersey Senate Bill No. 1919.
	<p><b>Statutes of Limitations</b> 2 years from accrual of claim or discovery. Minor from birth: until age 13. NJ ST. §2A:14-2.</p>	Pending legislation: 2010 New Jersey Assembly Bill No. 710, 2010 New Jersey Assembly Bill No. 715, 2010 New Jersey Senate Bill No. 760, 2010 New Jersey Assembly Bill No. 1150, 2010 New Jersey Assembly Bill No. 1982, 2010 New Jersey Senate Bill No. 2405, 2010 New Jersey Assembly Bill No. 3622.
	<p><b>Joint &amp; Several Liability</b> Defendants only responsible for share of fault if less than 60% . Defendants found more than 60% at fault subject to modified rule. NJ ST. § 2A:15-5.2.</p>	Current with laws effective through L.2011, c. 136 and J.R. No. 8.
	<p><b>Limits on Attorney Fees</b> Sliding scale, not to exceed 1/3 of first \$500,000; 30% of next \$500,000; 25% of third \$500,000; and 20% of fourth \$500,000. 25% limit for minor or incompetent plaintiff. N.J. Ct. R. 1:21-7</p>	Current with amendments received through 8/15/11.
NEW MEXICO	<p><b>Collateral Source Rule</b> Collateral source rule abrogated.</p>	This statute is preempted by ERISA claims. <i>Levine v. United Healthcare Corp.</i> , 402 F.3d 156, 166 (3d Cir. 2005).
	<p><b>Limits on Damage Awards</b> \$600,000 total limit on all damages. Health care providers not liable for any amount over \$200,000; any judgment in excess paid from Patient’s Compensation Fund. N. M. S. A. 1978, § 41-5-6.</p>	Current through the First Regular Session of the 50th Legislature (2011).
	<p><b>Statutes of Limitations</b> §41.5.13. 3 years from injury. N. M. S. A. 1978, § 41-5-13.</p>	This statute was held unconstitutional in <i>Jaramillo v. Heaton</i> , 100 P.3d 204, 205, 136 N.M. 498, 498+, 2004-NMCA-123, 123+ (N.M.App. Aug 17, 2004) (NO. 21,613), as applied to a minor child (due process violation).Proposed legislation: 2011 New Mexico House Bill No. 267, 2011 New Mexico Senate Bill No. 390, 2011 New Mexico Senate Bill No. 333.
	<p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is proven to have intentional malice. N. M. S. A. 1978, § 41-3A-1.</p>	Current through the First Regular Session of the 50th Legislature (2011).
	<p><b>Arbitration</b> Claims must first be submitted to the medical review commission. . N. M. S. A. 1978 § 41-5-15.</p> <p><b>Patient Compensation or Stabiliza-</b></p>	Current through the First Regular Session of the 50th Legislature (2011).



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STATE	Previously Enacted Laws	Comments
	<p><b>tion Fund</b> Patient's Compensation Fund only expended for purposes provided in authorizing Act. Superintendent has authority to purchase insurance for fund and its obligations. N. M. S. A. 1978, § 41-5-25 – 41-5-29.</p>	Pending legislation: 2011 New Mexico House Bill No. 267, 2011 New Mexico House Bill No. 333.
<b>NEW YORK</b>	<p><b>Statutes of Limitations</b> 2 1/2 years from injury, 1 year from discovery. McKinney's CPLR § 214-a. Minors: statute tolled until disability ceases, not to exceed 10 years. McKinney's CPLR § 208.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for noneconomic damages awarded, unless found more than 50% at fault. Defendants can be held jointly liable for economic damages. McKinney's CPLR § 1600 – 1601.</p> <p><b>Limits on Attorney Fees</b> Sliding scale, not to exceed 30% of first \$250,000; 25% of second \$250,000; 20% of next \$500,000; 15% of next \$250,000; 10% over \$1.25 million. McKinney's Judiciary Law § 474-a.</p> <p><b>Collateral Source Rule</b> Collateral source rule is abrogated by statute. McKinney's C.P.L.R. § 4545.</p> <p><b>Arbitration</b> Defendants can offer to concede liability in exchange for arbitration. Plaintiffs must respond to this offer. N.Y. C.P.L.R. 3045 (McKinney)</p>	<p>There are at least 5 pieces of proposed legislation pending.</p> <p>Proposed legislation is pending: 2011 New York Senate Bill No. 3187; 2011 New York Assembly Bill No. 4381.</p> <p>Pending legislation: 2011 New York Assembly Bill No. 1360.</p> <p>Current through L.2011.</p> <p>Current through L.2011.</p>
<b>NORTH CAROLINA</b>	<p><b>Limits on Damage Awards</b> \$250,000 limit on punitive damages, or 3 times economic damages, whichever is greater. N.C.G.S.A. § 1D-25.</p> <p><b>Statutes of Limitations</b> 3 years from act or 1 year from reasonable discovery, not more than 4 years after injury. Foreign object: 1 year from discovery but not more than 10 years. Minors: until age 19. N.C.G.S.A. § 1-15.</p> <p><b>Joint &amp; Several Liability</b> No separation of joint and several liability. N.C.G.S.A. § 1B-7.</p>	<p>Current through Chapter 18.</p> <p>Current through Chapter 18.</p> <p>Current through Chapter 18.</p>
<b>NORTH DAKOTA</b>	<p><b>Limits on Damage Awards</b> \$500,000 limit on noneconomic damages. NDCC, 32-42-02. Economic damage awards in excess of \$250,000 subject to court review. NDCC, 32-03.2-08.</p> <p><b>Statutes of Limitations</b> 2 years from act or reasonable discovery but not more than 6 years after act unless</p>	<p>Current through the 2007 Regular Session of the 60th Legislative Assembly</p> <p>Current through the 2011 Regular Session.</p>

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STATE	Previously Enacted Laws	Comments
	<p>concealed by fraud. NDCC, 28-01-18. Minors: 12 years. NDCC, 28-01-25.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is proven to have intentional malice. NDCC, 32-03.2-02.</p> <p><b>Patient Compensation or Stabilization Fund</b> Reserve fund enacted but not implemented unless majority of doctors in state have difficulty securing malpractice insurance. NDCC, 26.1-14-01 through 26.1-14-09.</p> <p><b>Collateral Source Rule</b> Responsible parties can request reduction of damage award by the amount of collateral payments. re NDCC, § 32-03.2-06.</p>	<p>Current through the 2011 Regular Session.</p> <p>Current through the 2011 Regular Session.</p> <p>Current through the 2011 Regular Session.</p>
<b>OHIO</b>	<p><b>Limits on Damage Awards</b> \$250,000 limit on noneconomic damages or three times plaintiff's economic loss, determined by court. Maximum noneconomic damages \$350,000 per plaintiff or \$500,000 per occurrence. No limit for permanent injury that prevents victim from independently caring for self. R.C. § 2315.18. Punitive damages limited to twice amount of economic damages or percentage of defendant's net worth. No limit where defendant acted knowingly. R.C. § 2315.21.</p> <p><b>Statutes of Limitations</b> 1 years after the cause of action accrued. R.C. §2305.11.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable for economic damages according to percentage of fault for damages awarded, unless found more than 50% at fault. Severally liable only for noneconomic damages. R.C. § 2307.22.</p> <p><b>Limits on Attorney Fees</b> No limitations but court must approve if fees exceed limits on damage award. R.C. § 2323.43.</p> <p><b>Collateral Source Rule</b> Defendant may introduce evidence of collateral sources. R.C. § 2323.41.</p>	<p>A previous version of R.C. § 2315.18. was held to be unconstitutional in <i>State ex rel. Ohio Acad. of Trial Lawyers v. Sheward</i>, 715 N.E.2d 1062, 1091 (Ohio 1999).</p> <p>R.C. § 2315.21 has been held to be unconstitutional to the extent that it mandates bifurcated trials. <i>See Myers v. Brown</i>, 950 N.E.2d 213 (Ohio App. 2011).</p> <p>A previous version of R.C. § 2315.18. was held to be unconstitutional in <i>State ex rel. Ohio Acad. of Trial Lawyers v. Sheward</i>, 715 N.E.2d 1062, 1091 (Ohio 1999). Pending Legislation: 2011 Ohio Senate Bill No. 72; 2011 Ohio House Bill No. 7.</p> <p>Current through 2011 Files 1 to 27, 29 to 47, and 49 of the 129th GA (2011-2012), apv. by 9/26/2011, and filed with the Secretary of State by 9/26/2011.</p> <p>Current through 2011 Files 1 to 27, 29 to 47, and 49 of the 129th GA (2011-2012), apv. by 9/26/2011, and filed with the Secretary of State by 9/26/2011.</p>
<b>OKLAHOMA</b>	<p><b>Limits on Damage Awards</b> \$300,000 limit on noneconomic damages;</p>	<p>Noneconomic Damage limit has expired. There is pending legislation to reinstate the</p>

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STATE	Previously Enacted Laws	Comments
	<p>also specific to obstetric and emergency room care. No limits for negligence or wrongful death. 63 Okl.St. Ann. § 1-1708.1F-1 (expired). Punitive damages based on misconduct. 23 Okl.St. Ann. § 9.1.</p> <p><b>Statutes of Limitations</b> 2 years from reasonable discovery. 76 Okl.St. Ann. § 18. Minors under 12: 7 years. Minors over 12: 1 year after attaining majority but in no event less than 2 years from injury. 12 Okl.St. Ann. § 96.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded. 23 Okl.St. Ann. § 15.</p>	<p>limit at \$250,000. 2011 Oklahoma House Bill No. 1774.</p> <p>There are a number of bills pending to amend Okl.St. Ann. § 18.</p> <p>This statute was recently amended. Causes of action accruing prior to November 1, 2011 are governed by the provisions of the previous law. Under that law, defendants found more than 50% at fault or guilty of willful misconduct or reckless disregard are jointly and severally liable.</p>
	<p><b>Limits on Attorney Fees</b> Fee may not exceed 50% of net judgment. 5 Okl.St. Ann. § 7.</p>	<p>Current through Chapter 385 (End) of the First Regular Session of the 53rd Legislature (2011).</p>
	<p><b>Patient Compensation or Stabilization Fund</b> State Insurance Fund authorized to offer malpractice insurance and/or reinsurance based on claims and loss ratio. State Board for Property and Casualty Rates must approve prior to release. 76 Okl.St. Ann. § 22.</p>	<p>Current through Chapter 385 (End) of the First Regular Session of the 53rd Legislature (2011).</p>
OREGON	<p><b>Limits on Damage Awards</b> No limitations. Limits declared unconstitutional by State Supreme Court; 2004 ballot measure to institute noneconomic damage limits rejected by voters. Punitive damages not awarded if physician is found acting in scope of duties without malice. O.R.S. § 31.740.</p>	<p>Current with 2011 Reg. Sess. legislation effective through 9/29/11.</p>
	<p><b>Statutes of Limitation</b> 2 years from injury or reasonable discovery, not more than 5 years from act. O.R.S. § 12.110.</p>	<p>Current with 2011 Reg. Sess. legislation effective through 9/29/11.</p>
	<p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded. O.R.S. § 31.610.</p>	<p>Legislation pending: 2011 Oregon Senate Bill No. 283.</p>
	<p><b>Limits on Attorney Fees</b> No more than 20% of punitive damages to attorney, no limitation of percentage of economic damages. Joint &amp; Several Liability O.R.S. § 31.735.</p>	<p>Current with 2011 Reg. Sess. legislation effective through 9/29/11.</p>
	<p><b>Patient Compensation or Stabilization Fund</b> Professional Liability Fund established to</p>	<p>Current with 2011 Reg. Sess. legislation effective through 9/29/11.</p>

STATE	Previously Enacted Laws	Comments
	<p>pay sums as provided that members are legally obligated to as result of malpractice. Maintained by Director of Department of Consumer and Business Services. O.R.S. § 752.035.</p> <p><b>Collateral Source Rule</b>                      Damage awards may be reduced by the amount of collateral benefits. O.R.S. § 31.580.</p>	<p>Legislation pending: 2011 Oregon Senate Bill No. 876.</p>
PENNSYLVANIA	<p><b>Limits on Damage Awards</b>                      No limitations. Constitutionally prohibited. Punitive damages granted only if defendant found guilty of willful misconduct or reckless disregard. 40 P.S. § 1301.812-A.</p> <p><b>Statutes of Limitations</b>                      2 years from injury or discovery. 42 Pa.C.S.A. § 5524, <i>declared unconstitutional by Com. v. Neiman</i>, 2010 PA Super 162 (Pa. Super. Ct. Sept. 8, 2010) (Pa. Aug. 10, 2011). The pending legislation noted addresses this issue.                      Minor: 2 years after age of majority. 42 Pa.C.S.A. § 5533.</p> <p><b>Joint &amp; Several Liability</b>                      Defendants are proportionally liable except where their negligence is greater than 60% or where they committed an intentional tort or misrepresentation. 42 Pa.C.S.A. § 7102.</p> <p><b>Patient Compensation or Stabilization Fund</b> Medical Professional Liability Catastrophe Loss Fund to provide up to \$700,000 per occurrence. Participating physicians pay annual surcharge. 40 P.S. § 1301.703.</p> <p><b>Collateral Source Rule</b>                      Collateral Source Rule has been abrogated except for life insurance benefits and certain public or government benefits. 40 P.S. § 1303.508.</p>	<p>Statute on punitive damages repealed by 2002, March 20, P.L. 154, No. 13, § 5104(a)(2), imd. Effective.</p> <p>Legislation pending: 2011 Pennsylvania Senate Bill No. 196; 2011 Pennsylvania House Bill No. 832; 2011 Pennsylvania House Bill No. 795.</p> <p>Several bills are pending with respect to this statute.</p> <p>Repealed. 1980, Oct. 15, P.L. 971, No. 165, § 5, imd. Effective.</p> <p>Current through 2011 Acts 1 to 81.</p>
RHODE ISLAND	<p><b>Limits on Damage Awards</b>                      Collateral source rule requires jury to reduce award for damages by sum equal to difference between total benefits received and total amount paid to secure benefits by plaintiff. R.I. ST. 1956, § 9-19-34.1.</p> <p><b>Statutes of Limitations</b>                      3 years from injury, death or reasonable discovery. R.I. § 9-1-14.1. Minors and incompetents: 3 years from removal of disability. R.I. § 10.7.2.</p>	<p>Held unconstitutional in <i>Maguire v. Licht</i>, 2001 WL 1006060, *1+ (R.I. Super. Aug 16, 2001) (NO. C.A. PC1999-3391, C.A. PC2001-0150, C.A. PC2000-0120, C.A. PC2000-5386).</p> <p>The statute is current but there is proposed legislation pending: 2007 RI H.B. 5790 (NS), 5790 (NS), 2007 Rhode Island House Bill No. 5790, Rhode Island (Feb 28, 2007), VER-SION: Introduced, PROPOSED ACTION: Amended.</p> <p>Current through End of 2010 Reg. Sess.</p>
SOUTH CAROLINA	<p><b>Limits on Damage Awards</b>                      Noneconomic damages limited to \$350,000 against single health care provider or facility; limit of \$1.05 million for multiple</p>	

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STATE	Previously Enacted Laws	Comments
	<p>defendants. Limits increased or decreased annually based on Consumer Price Index. No limits on noneconomic or punitive damages for cases of willful negligence or misconduct. S.C. ST. § 15-32-220 (Enacted 2005).</p> <p><b>Statutes of Limitations</b> 3 years from act or omission, or 3 years from discovery, not to exceed 6 years. Foreign object: 2 years from discovery. Minors: tolled for up to 7 years while a minor. S.C. ST. § 15-3-545.</p> <p><b>Joint &amp; Several Liability</b> No separation of joint and several liability. S.C. ST. § 15-38-10.</p> <p><b>Patient Compensation or Stabilization Fund</b> Patients' Compensation Fund to pay portion of malpractice claim, settlement or judgment over \$200,000 for each incident or over \$600,000 in aggregate for one year. S.C. ST. § 38-79-420.</p>	<p>Current through End of 2010 Reg. Sess.</p> <p>Current through End of 2010 Reg. Sess.</p> <p>Amended by 2008 South Carolina Laws Act 348 (S.B. 669). After the amendment, the fund may not grant retroactive coverage to members and the fund is liable only for payment of claims against licensed health care providers and includes reasonable and necessary expenses incurred in payment of claims and the fund's administrative expense.</p>
<b>SOUTH DAKOTA</b>	<p><b>Limits on Damage Awards</b> \$500,000 limit on noneconomic damages. S.D. ST. § 21-3-11.</p> <p><b>Statutes of Limitations</b> 2 years from act or omission. S.D. ST. § 15-2-14.1.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault; defendants found less than 50% liable not jointly liable for more than twice percentage of fault allocated. S.D. ST. § 15-8-15.1</p> <p><b>Collateral Source Rule</b> Evidence of collateral compensation is admissible for special damages. S.D. ST. § 21-3-12.</p>	<p>Current through the 2011 Special Session, Executive Order 11-1, and Supreme Court Rule 11-17.</p> <p>Current through the 2011 Special Session, Executive Order 11-1, and Supreme Court Rule 11-17.</p> <p>Current through the 2011 Special Session, Executive Order 11-1, and Supreme Court Rule 11-17.</p>
<b>TENNESSEE</b>	<p><b>Statutes of Limitations</b> 1 year from injury or discovery, no more than 3 years from act unless foreign object. TN ST § 29-26-116.</p> <p><b>Joint &amp; Several Liability</b> Joint and several liability provisions in statute, declared unconstitutional by State Supreme Court.</p> <p><b>Limits on Attorney Fees</b> Fees limited to 1/3 of award to plaintiff. TN ST. § 29-26-120.</p>	<p>Current through end of 2008 Second Reg. Sess.</p> <p>No further legislative enactments.</p> <p>Many bills pending to amend this statute.</p>
<b>TEXAS</b>	<p><b>Limits on Damage Awards</b> \$250,000 limit per claimant for noneconomic damages. \$500,000 limit per claim-</p>	<p>Current through the end of the 2011 Regular Session and First Called Session of the 82nd Legislature.</p>

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STATE	Previously Enacted Laws	Comments
	<p>ant for noneconomic damages in judgments against health care institutions. TX Civil Practice &amp; Remedies Code § 74.301.</p> <p><b>Statutes of Limitations</b> 2 years from occurrence, no more than 10 years. Minors under 12: until age 14. TX Civil Practice &amp; Remedies Code § 74.251.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded, unless found more than 50% at fault. TX Civil Practice &amp; Remedies Code § 33.013.</p>	<p>Held unconstitutional as applied to minors in <i>Adams v. Gottwald</i>, 179 S.W.3d 101, 101+ (Tex.App.-San Antonio Aug 17, 2005) (NO. 04-04-00569-CV).</p> <p>Legislation pending: 2011 Texas House Bill No. 1121; 2011 Texas House Bill No. 1122; 2011 Texas Senate Bill No. 98.</p>
UTAH	<p><b>Limits on Damage Awards</b> \$400,000 limit on noneconomic damages adjusted annually for actions arising after July 1, 2002 and before May 15, 2010. \$450,000 limit for actions arising after May 15, 2010. . UT ST § 78-14-7.1.</p> <p><b>Statutes of Limitations</b> 2 years from discovery but not more than 4 years from act; foreign object or fraud: 1 year from discovery, applies to all persons regardless of minority or disability. UT ST § 78-14-4.</p> <p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded. UT ST § 78-27-40.</p> <p><b>Limits on Attorney Fees</b> Contingency fee not to exceed 1/3 of award. UT ST § 78-14-7.5.</p> <p><b>Collateral Source Rule</b> Evidence of collateral source payments is admissible in medical malpractice actions. UT ST§ 78-14-4.5.</p> <p><b>Arbitration</b> Medical malpractice claims are first brought before an informal prelitigation panel. UT ST § 78-14-12.</p>	<p>Held to be constitutional in <i>Judd v. Drezga</i>, 103 P.3d 135 (Utah 2004). Renumbered as § 78B-3-410 by Laws 2008, c. 3, § 716, eff. Feb. 7, 2008.</p> <p>Renumbered as § 78B-3-404 by Laws 2008, c. 3, § 710, eff. Feb. 7, 2008.</p> <p>Renumbered as § 78B-5-820 by Laws 2008, c. 3, § 852, eff. Feb. 7, 2008.</p> <p>Renumbered as § 78B-3-411 by Laws 2008, c. 3, § 717, eff. Feb. 7, 2008.</p> <p>Renumbered as § 78B-3-405 by Laws 2008, c. 3, § 711, eff. Feb. 7, 2008.</p> <p>Renumbered as § 78B-3-416 by Laws 2008, c. 3, § 722, eff. Feb. 7, 2008.</p>
VERMONT	<p><b>Statute of Limitations</b> 3 years from incident or 2 years from discovery, whichever is later. No later than 7 years. Fraud: no statute of limitations. Foreign object: 2 years from discovery. 12 V.S.A. § 521.</p>	<p>Current through the laws of First Session of the 2011-2012 Vermont General Assembly (2011).</p>
VIRGINIA	<p><b>Limits on Damage Awards</b> \$2.0 million limit on recovery damages in 2011. Increased by \$50,000 a year. VA Code Ann. § 8.01-581.15.</p> <p><b>Statutes of Limitations</b> 2 years from occurrence, no more than 10 years unless under disability. Foreign object:</p>	<p>Held to be constitutional. <i>Boyd v. Bulala</i>, 877 F.2d 1191 (4th Cir. 1989).</p> <p>Current through End of 2011 Regular Session.</p>

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STATE	Previously Enacted Laws	Comments
	<p>1 year from discovery. VA Code Ann. §8.01-243.                      Minors have at least until their 10th birthday. VA Code Ann. §8.01-243.1.</p> <p><b>Patient Compensation or Stabilization Fund</b>                      Birth-Related Neurological Injury Compensation Fund to provide compensation for infant sustaining brain damage during birth delivery. Physicians pay annual assessment. VA Code Ann. §38.2-5000-5020.</p> <p><b>Insurance</b>                      Risk Management plan allowing certain physicians and community hospitals to purchase malpractice insurance extended from 2006-2008. VA Code Ann. § 2.2-1839. Limits circumstances in which insurers are required to provide notice of reduction in coverage or increase in premiums; specified deadlines for medical malpractice policies. VA Code Ann. § 2.2-2818.</p> <p><b>Arbitration</b>                      Either party can request that a claim be submitted to a medical malpractice review panel prior to litigation. Va. Code Ann. § 8.01-581.2 (West)</p>	<p>Current through End of 2011 Regular Session.</p> <p>Legislation pending.</p> <p>Current through End of 2011 Regular Session.</p>
<b>WASHINGTON</b>	<p><b>Limits on Damage Awards</b>                      No specific limits on damage awards. Judgment for noneconomic damages cannot exceed formulation of average annual wage and life expectancy of injured. WA ST § 4.56.250.</p> <p><b>Statutes of Limitations</b>                      3 years from injury or 1 year from discovery, whichever is later. No more than 8 years after act. WA ST § 4.16.350.</p> <p><b>Joint &amp; Several Liability</b>                      Defendants are proportionally liable according to percentage of fault for damages awarded, unless found to be deliberately acting in concert with others. WA ST § 4.22.070.</p> <p><b>Limits on Attorney Fees</b>                      Court to determine reasonableness of each party's attorney fees. WA ST. §7.70.070.</p> <p><b>Insurance</b>                      Medical quality improvement program. Medical liability insurance providers required to report all closed claims to Insurance Commissioner beginning in 2008. WA ST § 18.71.015.</p> <p><b>Collateral Source Rule</b></p>	<p>Held unconstitutional in <i>Sofie v. Fibreboard Corp.</i>, 771 P.2d 711, 712+, 112 Wash.2d 636, 636+, 57 USLW 2655, 2655+, Prod.Liab.Rep. (CCH) P 12,169, 12169+ (Wash. Apr 27, 1989) (NO. 54610-0) Pending Legislation.</p> <p>Held unconstitutional in <i>DeYoung v. Providence Medical Center</i>, 960 P.2d 919, 920+, 136 Wash.2d 136, 136+ (Wash. Aug 27, 1998) (NO. 65373-9). Pending Legislation.                      Many bills pending.</p> <p>Pending Legislation: 2011 Washington Senate Bill No. 5672; Washington Senate Bill No. 5672; 2011 Washington House Bill No. 1360; 2011 Washington House Bill No. 1360.</p> <p>Current with all 2011 Legislation.</p> <p>Current with all 2011 Legislation.</p>

STATE	Previously Enacted Laws	Comments
WEST VIRGINIA	<p>Common law collateral source rule has been abrogated. WA ST § 7.70.080.</p> <p><b>Limits on Damage Awards</b>                      \$250,000 limit for noneconomic damages. \$500,000 limit for compensatory damages, limit goes up beginning in 2004 according to inflation index. Physicians must carry at least \$1 million malpractice insurance to qualify for limits. WV ST § 55-7B-8.</p> <p><b>Statutes of Limitations</b>                      2 years from injury or reasonable discovery, no longer than 10 years after injury. Minors under 10: 2 years from injury or age 12, whichever is longer. WV ST § 55-7B-4.</p> <p><b>Joint &amp; Several Liability</b>                      Defendants are proportionally liable according to percentage of fault for damages awarded. WV ST § 55-7B-9.</p> <p><b>Patient Compensation or Stabilization Fund</b>                      Medical Liability Fund to assist in making malpractice insurance more readily available to specific health care providers. WV ST § 29-12B.1-14.</p> <p><b>Arbitration</b>                      Mandatory arbitration statute held unconstitutional in. <i>Waples v. Yi</i>, 234 P.3d 187 (Wash. 2010) and <i>Putman v. Wenatchee Valley Med. Ctr., P.S.</i>, 216 P.3d 374 (Wash. 2009).</p>	<p>Held to be constitutional <i>Verba v. Ghaphery</i>, 552 S.E.2d 406 (W. Va 2001).</p> <p>Current through End of the 2011 Second Extraordinary Session.</p> <p>Current through End of the 2011 Second Extraordinary Session.</p> <p>Current through End of the 2011 Second Extraordinary Session.</p>
WISCONSIN	<p><b>Limits on Damage Awards</b>                      Noneconomic damages for medical malpractice limited to 750,000\$; Board of Injured Patients and Families Compensation Fund to report to legislature every 2 years any suggested changes to damages limit. Wis. ST § 893.55,</p> <p><b>Statutes of Limitations</b>                      3 years from injury or 1 year from discovery, not more than 5 years from act. Foreign object: 1 year from discovery or 3 years from act, whichever is later. Minors: by age 10 or standard provision, whichever is later. Wis. ST § 893.55.</p> <p><b>Joint &amp; Several Liability</b>                      Defendants are proportionally liable according to percentage of fault for damages awarded, unless found to be deliberately acting in concert with others or found more than 50% at fault. Wis. ST § 895.045.(2).</p> <p><b>Limits on Attorney Fees</b>                      Sliding scale, not to exceed 1/3 of first \$1 million, or 25% of first \$1 million recovered if liability is stipulated within time limits, 20% of any amount exceeding \$1</p>	<p>Although prior versions have been held unconstitutional this statute is current through 2007 Act 84, published 03/26/2008. See <i>Bartholomew v. Wisconsin Patients Comp. Fund &amp; Compcare Health Services Ins. Corp.</i>, 717 N.W.2d 216 (WI 2006).</p> <p>Although prior versions have been held unconstitutional this statute is Current through 2011 Act 31, Acts 33 to 36, and Acts 38 to 44, published 08/23/2011.</p> <p>The statute is current but there is proposed legislation pending: 2011 Wisconsin Assembly Bill No. 1.</p> <p>Current through 2011 Act 31, Acts 33 to 36, and Acts 38 to 44, published 08/23/2011.</p>



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STATE	Previously Enacted Laws	Comments
	million. Wis. ST § 655.013.	
	<p><b>Patient Compensation or Stabilization Fund</b> Injured Patients and Families Compensation Fund pays amounts in excess of statutorily prescribed future damages awards. Health care providers required to pay into fund annually. Wis. ST § 655.27.</p>	Current through 2011 Act 31, Acts 33 to 36, and Acts 38 to 44, published 08/23/2011.
	<p><b>Collateral Source Rule</b> The collateral source rule has been abrogated.</p>	Previous version held unconstitutional on other grounds. <i>Bartholomew v. Wisconsin Patients Comp. Fund &amp; Compare Health Services Ins. Corp.</i> , 717 N.W.2d 216 (WI 2006).
<b>WYOMING</b>	<p><b>Limits on Damage Awards</b> Limits prohibited.</p>	Wy. Const. Art. 10, § 4 reads: (a) No law shall be enacted limiting the amount of damages to be recovered for causing the injury or death of any person. (Ratified Nov. 2, 2004). Current through amendments approved by the voters on November 4, 2008.
	<p><b>Statutes of Limitations</b> 2 years from injury or reasonable discovery. Minors: until age 18 or within 2 years, whichever is later. Legal disability: 1 year from removal. WY ST § 1-3-107.</p>	Current through the 2011 General Session.
	<p><b>Joint &amp; Several Liability</b> Defendants are proportionally liable according to percentage of fault for damages awarded. WY ST § 1.1.109.</p>	Repealed by Laws 1986, ch. 24, § 2.
	<p><b>Limits on Attorney Fees</b> Recovery \$1 million or less: 1/3 if claim settled prior to 60 days after filing; 40% if settled after 60 days or judgment; 30% over \$1 million. Wyo. Ct. Rules Ann., Contingent Fee R. 5.</p>	Current with amendments received through 5/15/11.
	<p><b>Patient Compensation or Stabilization Fund</b> Medical Liability Compensation Fund to provide malpractice insurance coverage in event of cause of action. Participating physicians pay surcharge. WY ST § 26-33-105.</p>	Current through the 2011 General Session.
	<p><b>Insurance</b> Department of Health program to provide loans to physicians for medical malpractice insurance premiums assistance extended until March 2007. WY ST § 35-1-902.</p>	Current through the 2011 General Session.
	<p><b>Arbitration</b> Mandatory arbitration requirement held unconstitutional in <i>Hoem v. State</i>, 756 P.2d 780 (Wyo. 1988).</p>	

## APPENDIX B

### SAMPLE ARBITRATION AGREEMENTS IN THE MEDICAL LIABILITY FIELD<sup>111</sup>

#### *I. Duke Arbitration Agreement*<sup>112</sup>

##### AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION

In accordance with the terms of the United States Arbitration Act, I agree that any dispute arising out of or related to the provision of health care services to me by Duke University, the Private Diagnostic Clinic (PDC), or their employees, physician partners, and agents, shall be subject to final and binding resolution exclusively through the Health Care Claim Settlement Procedures of the American Arbitration Association, a copy of which is available to me upon request. I understand that this agreement includes all health care services which previously have been or will in the future be provided to me and that this agreement is not restricted to those health care services rendered in connection with this admission or visit. I understand that this agreement is voluntary and is not a precondition to receiving health care services.

NOTE: If the individual signing this agreement is doing so on behalf of his or her minor child or any other person for whom he or she is legally responsible, the signature below affirms that he or she has the authority or obligation to contract with Duke University and the PDC for the provision of health care services to that minor child or other person, and that his or her execution of this agreement is in furtherance of that authority or obligation.

12-8-1999 X (signature)

DATE Patient, Parent, Guardian, or Authorized Representative

The arbitration agreement also states under the signature line:

If the signature is not that of the Patient, Parent, or Guardian, indicate below the relationship of person signing for the Patient and the reason Patient is unable to sign.

Relationship: \_\_\_\_\_

Reason Patient unable to sign: \_\_\_\_\_

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<sup>111</sup> K. DeVile, "The Jury is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims", 28 J. Leg. Med. 333, 391 (2007).

<sup>112</sup> *Wilkerson v. Nelson*, 395 F. Supp.2d 281 (M.D.N.C. 2005).

II. Arbitration Agreement in *Colorado v. Morrison*<sup>113</sup>

ARBITRATION OF CLAIMS

A. SCOPE OF ARBITRATION. Any claim arising from alleged violation of a duty incident to this Agreement, irrespective of the basis for the duty or of the legal theories upon which the claim is asserted, shall be submitted to binding arbitration if the claim is asserted:

(1) By a Member, or by a Member's heir or personal representative, or by a person claiming that a duty to him or her arises from a Member's relationship with Health Plan, Hospitals or Medical Group incident to this Agreement ("Claimant/s"),

(2) For any reason, including, but not limited to, death, mental disturbance, bodily injury or economic loss arising from the rendition or failure to render services, or the provision or failure to provide benefits under this Agreement or the consideration or defense of claims described in this Section,

(3) For monetary damages exceeding the jurisdictional limit of the Small Claims Court, and

(4) Against one or more of the following ("Respondent/s"):

(a) Health Plan,

(b) Hospitals,

(c) Medical Group,

(d) Any Physician, or

(e) Any employee or agent of the foregoing.

B. INITIATING ARBITRATION. Claimant/s shall initiate arbitration by serving a Demand for Arbitration that specifies the nature and legal basis of the claim and the type of loss sustained, including, with specificity, the alleged (1) nature of the injuries suffered, (2) acts or omissions that caused the injuries, and (3) date and place of the acts or omissions. All claims against Respondent/s based upon the same incident, transaction or related circumstance must be arbitrated in one proceeding. Colorado Rules of Civil Procedure and Colorado Revised Statutes pertaining to the prerequisites for the filing and maintenance of a civil action will govern the Demand for Arbitration, except as otherwise provided in this Section 8.

Claimant/s shall serve all Respondent/s reasonably servable, and the arbitrators shall have jurisdiction only over Respondent/s actually served. All Respondent/s served with a Demand for Arbitration must be parties.

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<sup>113</sup> *Colorado v. Morrison*, 983 F. Supp. 937 (D. Colo. 1997).

Natural persons must be served as in a Colorado civil action, and any other Respondent/s must be served by registered letter, postage prepaid addressed to Respondent/s in care of Health Plan and the address provided in Section 10-K.

C. FEES AND COSTS. No party shall be entitled to recover pre-award interest separate and apart from the principal amount of any award entered at arbitration, if any. Costs, excluding the fees and expenses of the arbitrators, shall be awarded by the arbitrators at the conclusion of the arbitration pursuant to Colorado Rules of Civil Procedure and Colorado Revised Statutes. Attorney fees may be awarded by the arbitrators at the conclusion of the arbitration pursuant to Colorado Revised Statutes.

D. SELECTION AND POWERS OF ARBITRATOR/S. Unless the parties otherwise agree, within 30 days after service of a Demand for Arbitration, Claimant/s and all Respondent/s served shall each designate an arbitrator and give written notice of such designation to the other. No Claimant or Respondent may act as his or her own arbitrator. Within 30 days after these notices have been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection to Claimants and all Respondents served. The parties shall bear the fees and expenses of the neutral arbitrator equally. Each party shall bear the fees and expenses of the arbitrator that it selects. The three arbitrators shall hold a hearing within a reasonable time thereafter. Except where otherwise agreed to by the parties, arbitration shall be held within the Service Area at the time and place designated by the neutral arbitrator.

E. GENERAL PROVISIONS. A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claims is served, the claim, if asserted in a civil action, would be barred by the applicable Colorado statute of limitations, or (2) the Claimants fail to pursue the arbitration claim in accord with the procedures prescribed herein with reasonable diligence. All notices or other papers required to be served or convenient for the conduct of arbitration proceedings following service of the Demand for Arbitration shall be served by mailing the same, postage prepaid, to such address as each party gives for this purpose. After initial service on Respondents has been made pursuant to Section 8-B above, Claimants and Respondents may conduct discovery as in a Colorado civil action. All discovery must be concluded no later than twenty-one (21) days prior to the hearing on the claim set by the arbitrators. Disclosure of witnesses, expert witnesses, exhibits and pre-arbitration legal issues shall be governed by the provisions of Colorado Rules of Civil Procedure 16, or

*A MEDICAL LIABILITY TOOLKIT, INCLUDING ADR*

as otherwise ordered by the arbitrators.

F. SPECIAL PROVISIONS FOR MEDICARE PLUS MEMBERS. For Medicare Plus Members, the provisions of the Section 8 apply only to claims asserted on account of death, mental disturbance or bodily injury arising from rendition or failure to render services under this agreement.

G. WAIVER. The arbitration procedures required by this Section 8 may be waived only upon written agreement of the Claimants and Respondents.

H. UNIFORM ARBITRATION ACT. This arbitration clause is made subject to and incorporates by reference the Colorado Uniform Arbitration Act of 1975, C.R.S. § 13-22-201, et. seq. (1986 Cum. Supp.). The decision of the arbitrators shall be deemed final and binding as to all claims which were made or could have been made against any and all persons or entities who could have been Respondents as described in Section 8-A(4), whether or not a Demand for Arbitration was actually made against such persons or entities.

*III. Sample Arbitration Agreement:*

*Association of American Physicians and Surgeons, Inc.*

PATIENT'S REQUEST FOR MEDICAL SERVICES

Perhaps you have heard reports of a "malpractice crisis." Lawsuits can be costly, time-consuming and distracting. This form is for patients requesting medical care by the [MEDICAL PRACTICE NAME], and its employees and affiliates, including but not limited to [DOCTORS' NAMES] (jointly and severally, the "Clinic"). Feel free to decline to sign this form, or see a different doctor. You may freely use our phones to call anyone for advice in filling out this form.

Are you having an emergency at this time? (write yes or no) \_\_\_\_\_  
Patient's initials: \_\_\_\_\_

If the answer is "yes", then stop now and request emergency help immediately. I irrevocably agree (i) to submit any and all claims against the Clinic to arbitration rather than to a judge or jury, (ii) that the Clinic may submit any claim by me to binding arbitration, and (iii) to be bound by the result even if I decline to participate:

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Patient's initials: \_\_\_\_\_

I irrevocably agree to limit any claim relating to any diagnosis, treatment or care by the Clinic to \$250,000 for all non-economic damages, including pain and suffering or inconvenience:

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Patient's initials: \_\_\_\_\_

In the event I assert a claim against the Clinic and it is denied, then I agree to pay for the reasonable attorney and expert fees of the Clinic's defense:

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Patient's initials: \_\_\_\_\_

I request services from the Clinic in full agreement with and understanding of the above. I do not rely on any oral representations by anyone on staff in completing this form and am not under any pressure to sign. This form applies to all past and future services rendered by the Clinic and shall bind me and my heirs, legal representatives and assigns. Each provision shall be severable from the remainder and enforceable to the fullest extent of the law.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_

A copy of this signed form was received from the patient by:

Staff member's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff member's name: \_\_\_\_\_

#### *IV. My Urgent Care, Inc., Walk-In Clinic, Lake Ridge, Virginia*

##### ARBITRATION AGREEMENT

All the doctors working at this clinic feel that there is a "malpractice crisis" that threatens medical care. Lawsuits can be costly and time-consuming, and often interfere with care for sick patients.

All the doctors working at this clinic ask patients to complete this form. You may decline to do so and may see a different doctor. You may also use our phone to call anyone locally for advice in filling out this form.

I am having an emergency at this time: YES \_\_\_ NO \_\_\_

I agree to submit any and all claims against all the doctors working at this clinic to arbitration by the American Arbitration Association rather than to a judge or jury: YES \_\_\_ NO \_\_\_

I agree that all the doctors working at this clinic may submit any claim asserted by me to binding arbitration before the American Arbitration Association, and I agree to be bound by that arbitration even if I decline to participate: YES \_\_\_ NO \_\_\_

I agree to limit any claim in relation to any diagnosis, treatment or care by all the doctors working at this clinic to \$250,000 for all non-economic damages, including pain and suffering or inconvenience: YES \_\_\_ NO \_\_\_

In the event I assert a claim against any of the doctors working at

## A MEDICAL LIABILITY TOOLKIT, INCLUDING ADR

this clinic and it is denied, then I agree to pay for the reasonable attorney and expert fees of the defense: YES \_\_\_ NO \_\_\_

I have been informed and I understand that all the doctors working at this clinic are not employees of this clinic but are independent contractors. I agree to limit any claims whatsoever, only against the doctors and not against this clinic: YES \_\_\_ NO \_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_

A copy of this signed form was received from the patient by:

Staff member's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff member's name: \_\_\_\_\_

### *V. Sample Arbitration Clause, National Arbitration Forum*

#### PATIENT/ENROLLEE ARBITRATION AGREEMENT

By signing this agreement, the (patient/enrollee) agrees with the (provider/plan) that any dispute between you and us and any dispute relating to (medical/other) services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the (patient/enrollee), including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whomever made (including, to the full extent permitted by applicable law, third parties who are not signatories to this agreement) shall be resolved by binding arbitration by the National Arbitration Forum, under the Code of Procedure then in effect. Any award of the arbitrator(s) may be entered as a judgment in any court having jurisdiction. In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective and the remainder of the agreement shall remain effective. Information may be obtained and claims may be filed at any office of the National Arbitration Forum, at [www.arbitration-forum.com](http://www.arbitration-forum.com), or by mail at P.O. Box 50191, Minneapolis, MN 55405. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

This agreement binds all parties whose claims may arise out of or relate to treatment or service provided by the (physician/other), including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

This provision for arbitration may be revoked by written notice deliv-

ered to (the physician/other) within \_\_\_\_\_ days of signature.

The (patient) understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the (physician or hospital/other), cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.